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Attitude of the Adults towards Mentally Ill

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ABSTRACT

Background: Mental illness produces a disharmony in the person's ability to meet the human needs comfortably and effectively. Even if mental illness is a medical illness its discrimination by people had led to the formation of wide spread stigmatising attitudes towards mentally ill among public.

Objective: To assess the attitude of adults towards mentally ill and to determine the association of attitude with the socio-demographic characteristics of adults.

Materials and method: A descriptive survey approach was used for the study. A sample of 200 adults was selected by using convenient sampling. Data was collected by Community Attitude towards Mentally Ill (CAMI) Scale.

Results: The findings of the study showed that the mean attitude score of the adults towards mentally ill patients was high i.e. 152.62 (SD=15.67). The mean score was highest in the domain of benevolence whereas it was least in the domain of authoritarianism. There was a significant association of the attitude with place of residence ($p< 0.05$) of adults.

Conclusion: The adults showed stigmatizing attitudes towards mentally which points out the need of implementing appropriate interventions in the community.

Keywords: *Adults, Attitude, Community, Mental illness, Mentally ill*

INTRODUCTION

Mental and behavioural disorders are understood as clinically significant conditions characterized by alterations in thinking, mood (emotions) or behaviour associated with personal distress and/or impaired functioning.[1] There are many categories of mental disorders among which common forms are mood disorders, schizophrenia spectrum disorders, anxiety disorders and substance abuse disorders. Most people can lead a productive and fulfilling life with appropriate treatment and support.

More than 450 million people suffer from a type of mental disorder.[2] Mental health disorders account for 13–14% of the world's total burden from ill-health.[3] India is estimated to have 10–20 persons out of 1,000 suffer from severe mental illness and three to five times more have an emotional disorder.[4] A report of National Institute of Mental Health and Neuro-Sciences (NIMHANS) in 2008, showed that in India 70 million people suffer from mental ailments and 50-90 percent of them are not able to access corrective services due to less awareness and negative attitude or stigma towards mental illness.[5]

Mental illnesses are some of the least understood conditions in the society. Many people do not consider mental illness as an illness, but possessions by the evil spirit or the curse that has befallen on the patient or family because of the past sins. Mental illness is perceived as frightening, shameful, imaginary, feigned, and incurable, while the patients are characterized as dangerous, unpredictable, untrustworthy, unstable, lazy, weak, worthless, and/or helpless in the community.[6,7,8] These beliefs and misconceptions among individuals lead to the stigmatizing attitudes towards mentally ill and they face prejudice and discrimination in their everyday lives. The stigmatized individual experiences social distancing, fear, rejection and ill treatment from others in the society. The

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shame and fear of the discrimination prevent the mentally ill from seeking help and availing treatment. Stigma of mental illness also affects those closely associated with the mentally ill person, that is, family members, friends, service providers and others. [9] Studying the attitudes towards mentally ill will help in providing mental healthcare services for the community.

MATERIALS AND METHOD

A descriptive survey approach was used for the study. Permission to conduct the study in various inpatient departments of Father Muller Medical College Hospital was obtained from the hospital authorities. The hospital was chosen as the setting as it caters services to all people from different cultures, religions and socio-economic background. A sample of 200 adults was chosen by convenient sampling. The inclusion criteria for the subjects were as follows: adults who were the caregivers of the patients and in the age group of 21-60years, and able to read and understand Kannada, Malayalam or English. Those diagnosed with mental disorders, those who have mentally ill first degree or second degree relatives and health care professionals were excluded from the study.

The attitudes of adults towards mentally ill were measured using the Community Attitude towards the Mentally Ill scale (CAMI) by Taylor and Dear (1979).[10] CAMI scale is a likert type scale having 40 items. The scale consists of four subscales- Authoritarianism, Benevolence, Social restrictiveness and Community mental health ideology. *Authoritarianism* refers to a view of the mentally ill person as someone who is inferior and requires supervision and coercion. *Benevolence* corresp onds to a humanistic and sympathetic view of mentally ill persons. *Social Restrictiveness* covers the belief that mentally ill patients are a threat to society and should be avoided. *Community Mental Health Ideology* concerns the acceptance of mental health services and the integration of mentally ill patients in the community. Each subscale has 10 items – five positively and five negatively stated. The items were rated as 'strongly agree', 'agree', 'undecided' 'disagree' and 'strongly disagree', and were scored 1, 2, 3, 4 and 5 for positively stated items. Reverse scoring was done for negatively stated items. . Higher scores indicated high stigma against persons with mental illness. Overall stigma scores were calculated by adding the scores of subscales. Taylor and Dear reported satisfactory (*Authoritarianism*, $\alpha = 0.68$) to good values (*Benevolence,* $\alpha = 0.76$; *Social Restrictiveness*, $\alpha = 0.80$; *Community Mental Health Ideology*, $\alpha = 0.88$) for the internal consistency of the subscales. The tool was translated into Malayalam and Kannada.

Statistical Analysis: Data was analyzed using SPSS version 14. Data was described using frequency, percentage, mean and standard deviation. Bivariate analysis was done using Chi square test. All statistical tests were two-tailed and significance level set at 0.05.

RESULTS

Socio-demographic characteristics

A total of 200 participants were included in the study and the results are presented under various domains as frequencies and percentages.

The mean age of the subjects were 37.81(SD= 12.12). Among the subjects 51.5% were females and 48.5% were males. About half of the subjects were hindus, whereas 31% were Christians and 18.5% were muslims. Maximum number of subjects (34%) was high school certificate holders and 21% each were graduates or middle school certificate holders. 29% of the subjects were unemployed, 24.5% were business/technical/skilled workers and 22% were daily wagers. The mean monthly income of the subjects was Rs 10685(SD=1651). Majority of them were from nuclear family (68%) and from urban area (76%)

Table 1. Attitude of the adults towards mentally ill

Minimum Score Obtained	Maximum Score Obtained	Mean	SD
108	196	152.62	15.67

Maximum score=200

The mean attitude score was high i.e.152.62 (SD=15.67) with a mean percentage of 76.31 which show the stigmatising attitudes of adults towards mental illness.

Table 2. Domain wise attitude of the adults towards mentally ill

Domains	Minimum Score Obtained	Maximum Score Obtained	Mean	SD
Authoritarianism	20	48	33.15	5.82
Benevolence	28	50	40.54	4.67
Social restrictiveness	26	50	39.26	5.32
Community mental health ideology	21	50	39.68	5.28

In all the domains of attitude, the mean scores were high, showing stigmatizing attitudes. The highest mean score was found in the domain of benevolence whereas the domain of authoritarianism had lowest mean score. However, all the domains had high mean scores indicating the stigmatizing attitudes

The association of attitude with socio-demographic variables of adults (age, gender, religion, education, occupation, income, type of family and place of residence) was determined. There was significant association of place of residence with attitude (p=0.033). Participants from rural area showed more stigmatizing attitudes.

DISCUSSION

The aim of the present study was to assess the attitudes of adults towards mental illness. The overall attitude scores were high indicating stigmatizing attitudes of the adults towards mental illness. The stigma score was high in all the four subscales of CAMI scale. There was a significant association of attitude with place of residence. Compared to the urban adults, rural adults showed more stigmatizing attitudes towards mentally ill which may be due to the lack of knowledge regarding mental illness and beliefs prevailing in the rural areas regarding mental illness. Curse of God, influence of spirits and past sins are still considered as the causes of mental illness in the community.

The findings of the present study show the persistence of stigmatizing attitudes of the community towards the mentally ill. However, the sample size was 200 which limit the generalization of findings. The selected setting was in urban area where people from both urban and rural areas visit. The high stigmatizing attitudes among rural population was found in a survey conducted in a rural area of Maharashtra, India. Although the community was relatively accepting of people with mental disorders, false beliefs and negative attitudes were evident. Desired social distance was consistently greater for the person depicted in the psychosis compared to the depression. The main predictor of greater social distance was perceiving the person as dangerous, For psychosis, labelling the disorder as a mind/brain problem, and believing the cause to be lack of control over life or genetic factors increased social distance[11]

The change of attitude is usually expected with the health care reforms and better accessibility of health services. There is a constant effort from mental health professionals to educate the public regarding the mental illness through the available resources. However to compare the attitudinal change over years, there is no data available from the present setting. A study was conducted on changes of attitudes towards psychiatric treatment and people with mental illness in German states. Two population surveys were conducted among German citizens in 1990 and 2011 showed that the attitudes towards those with mental illnesses remained unchanged or worsened even if attitudes towards mental healthcare providers and the treatment offered by them improved considerably in Germany over 20 years.[12] This shows the need of planning and implementing specific interventions aimed at changing the stigmatizing attitudes of the public towards mental illness.

Inconsistent findings were shown in a community based study conducted on Perception and Attitude towards Mental Illness in an Urban Community in South Delhi. Community showed kind, non-stigmatizing but pessimistic attitude toward the future of the people with mental illness. At the same time, participants also felt that social relationship with these people should be restricted. Although participants did not support isolating person with mental illness from the society, restrictive attitude was observed with regards to marriage or child bearing.

Socially desirable responses hiding the true stigmatizing attitude of the community might have been the reason for the findings.[13]

Lack of factual information about mental illness, and strong negative emotional reactions towards people with mental illness may be the reasons for the present study findings. A study was conducted on the labels used to stigmatize people with mental illness among young students. 400 of the 472 participating students (85%) provided 250 words and terms to describe a person with mental illness. Five themes were identified from the data. The first theme called 'popular derogatory terms' (116 items) accounted for nearly half of the words examined. The second theme occurred less often and was described as 'negative emotional state' (61 items). The third theme demonstrated the confusion of young people between physical disabilities, learning difficulties and mental health problems (38 items). The use of psychiatric diagnoses (15 items) and terms related to violence (9 items) were unexpectedly uncommon.[14]

One of the reasons of present study findings may be the non- acceptance of the mental illness as a medical disorder by majority of the individuals in the community, but as due to lack of will power or stress related . Consistent findings were found in another study conducted to investigate the knowledge and attitudes of the general South African public toward mental illness. Treatment advocated was more often to talk the problem over than to consult professional medical help. Psychotherapy was the preferred treatment option, particularly in vignettes where symptom presentation was subtle, and in cases of substance abuse.[15]

The educational level of subjects was lower and more than half of the subjects (55%) of the present study were middle school or high school certificate holders. Portrayal of mentally ill by social media as violent, uncontrollable and dangerous can be another reason which attributed for the stigmatizing attitudes found in present study. A study which assessed public perceptions and attitudes towards and causal beliefs about mental health problems in Singapore showed consistent findings. About 38.3% believed that people with mental health problems were dangerous and 49.6% felt that the public should be protected from them. A negative attitude towards mental health problems correlated with greater age and less education. The Chinese were more likely to want to hide their illness when they become mentally unwell while the Malayas seemed to have a more tolerant attitude ($p = 0.032$).[16]

CONCLUSION

The present study findings showed stigmatizing attitudes of adults towards mentally ill. Higher stigmatizing attitudes were found in rural adults. These attitudes may be due to lack of knowledge or the beliefs and perceptions prevalent in the community regarding mental illness. It is the responsibility of each mental health care professional, especially the mental health nurses to initiate the public education regarding mental illness and fight against stigma by being role models.

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Conflict of Interest: Nil

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Assessment of Effectiveness of Psychodrama on Level of Awareness Regarding Ill-effects of Substance Abuse among Railway Employees, Perambur, Chennai

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ABSTRACT

Background: Substance abuse refers to a pattern of pathological use of alcohol, cannabis, opiates, hallucinogens, inhalants, nicotine and caffeine. The most widely abused substances in industrial population are alcohol, cannabis and nicotine. In low quantities it causes people to become less inhibited but, in higher doses it can cause serious physical, psychological, family, work related, and societal problems. As part of the contemporary dynamic of globalization there has been an increased use of psychoactive substances such as Alcohol, Cannabis and Nicotine has been acknowledged to have multiple consequences to healthy society and economy. So, it is highly essential to enhance the level of awareness regarding ill-effects of abusing Alcohol, Cannabis & Nicotine. **Aim & Objective:** The main objective of this study was to study to assess the effectiveness of Psychodrama on level of awareness regarding ill-effects of substance abuse among Railway employees, Perambur, Chennai. Material and methods: The quantitative quasi-experimental research approach and one group pretest- posttest design was chosen for the study. The demographic profile and Five point rating scale questionnaire was used to collect the data from 60 employees selected out of 200 for the study by Lottery method of simple random sampling technique. **Result:** With regard to age majority 24(40%) of employees were in the age group of above 46 years. The comparison of pre and post test scores revealed that 't' value was 25.95 for level of awareness regarding ill effects of substance abuse among Railway employees which showed a high statistical significance at $^{***}p<0.001$ level.

Conclusions: This study result revealed that there was an enhancement in level of awareness after the psychodrama session on ill-effects of substance abuse therefore intervention was found effective.

Keywords: *Effectiveness, Psychodrama, Awareness, Ill-effects.*

INTRODUCTION

Substance abuse is the major social health problem. Chronic and excessive alcohol ingestion is one of the major causes of liver disease, gastritis, peptic ulcer, carcinoma of stomach, pancreatitis, malabsorption syndrome and psychological disorders. The persistent use of cannabis (Ganja) increases the risk of psychosis called cannabis induced psychosis, and amotivational syndrome. It is manifested with hallucinations, delusions; depersonalization, impaired cognition, impaired memory and difficulty in coordination, emotional instability and decreased intention to start any activities. The problems related to Cigarette smoking are heart disease, hypertension, and skin disease, hoarseness of voice, bronchitis, Chronic Obstructive Pulmonary Diseases (COPD) and lung cancer. The article published in "Times of India" (2008), stated that long term heavy use of marijuana may cause two important brain structures to shrink. Brain scans showed that the hippocampus and the amygdala were smaller in men who were heavy marijuana users compared to non-users. The men had smoked atleast 5 marijuana cigarettes daily for on average 20 years. The hippocampus regulates the memory and emotion, while the amygdala plays a critical role in fear and aggression. The study also found that the heavy cannabis users earn lower scores than non-users in a verbal learning task – trying to recall a list of 15 words (Murat Yucel of ORYGEN Research)[7].

Arendt (2005) stated that cannabis induced psychotic symptoms are the important risk factors for the subsequent

development of Schizo spectrum disorder[1].

So, awareness enhancing is an important component for the right understanding in order to prevent the ill-effects of substance abuse and to lead the right life.

OBJECTIVES

1. To assess the pre intervention level of awareness regarding ill–effects of substance abuse among Railway employees.
2. To assess the post intervention level of awareness regarding ill–effects of substance abuse among Railway employees.
3. To compare the pre and post intervention level of awareness regarding ill–effects of substance abuse among Railway employees.
4. To associate the mean improvement level of awareness regarding ill effects of substance abuse among railway employees with selected demographic variables.

MATERIAL AND METHOD

The research approach chosen for the study was quantitative quasi experimental study approach. The research design adopted for the study was one group pretest - posttest design.

Group	**O_1**	**X**	**O_2**
Railway employees N=60	**Pre test**	**Intervention**	**Post test**
	Existing level of awareness regarding ill-effects of substance abuse.	Psychodrama on ill-effects of substance abuse (Alcohol, Cannabis and Nicotine).	Level of Awareness regarding ill-effects of substance abuse after the Psychodrama.

The study population comprises of about 200 Southern Railway employees (Fitters, welders and painters) working for afternoon shift in Wagon works, Perambur, Chennai.The Simple random sampling technique was carried out to select 60 employees by lottery method from 200 employees. The tool developed for the study was a structured questionnaire.

Section A: Demographic variables

Section B: Five point rating scale questionnaire to assess the level of awareness regarding the ill effects of substance abuse.

1. Physical problems (15 items)
2. Psychological problems (15 items)
3. Family problems (10 items)
4. Occupational problems (10 items)
5. Social problems (10 items)

A formal/ ethical permission was obtained from Production Engineer, Southern Railway, Wagon Works, Perambur, Chennai for conducting the study. Content validity of the tool was obtained from 2 Psychiatrists, 1 psychiatric Nurse, 1 Clinical Psychologist and 1 Social Welfare Officer. Reliability of the tool was established by split half method and 'r' value was r = 0.82. **PSYCHODRAMA:** It is a type of role play to explore the ill-effects of substance abuse to enhance awareness level among Railway Employees. It consists of 5 components such as protagonists, auxillary egos, psychodramatist, audience and stage (setting).

Protagonists were the clients (Southern Railway employees) experiencing the problems of substance abuse such as alcoholic cirrhosis, cannabis induced psychosis and respiratory diseases.

Auxiliary Egos were the actors (MSW students) of the psychodrama to enact the roles of protagonist such as client suffering with alcoholic cirrhosis, cannabis induced psychosis and respiratory problems and finally seeks treatment after getting awareness teaching from psychiatric nurse educator for their problems due to substance abuse.

Psycho dramatist: Psychodrama group leader or director (Investigator) who directed the psychodrama group members to enact their roles specifically. Here investigator acted as a psychiatric nurse in psychodrama. The psychiatric nurse investigator gives awareness teaching regarding ill-effects of substance abuse to the Auxiliary Egos.

Audiences were viewing members of psychodrama were the Fitters, Welders and Painters working in Wagon Work Shop, Carriage, Perambur.

Stage was arranged at Basic Training Centre, Wagon Work Shop, Carriage, Perambur.

Effectiveness refers to the outcome of psychodrama on awareness regarding ill-effects of substance abuse among Railway Employees.

Awareness means the level of understanding gained regarding ill-effects of substance abuse based on experience through an exploratory role play.

Ill-effects refer to problems due to alcohol consumption, ganja use and cigarette smoking.

CONCEPTUAL FRAMEWORK

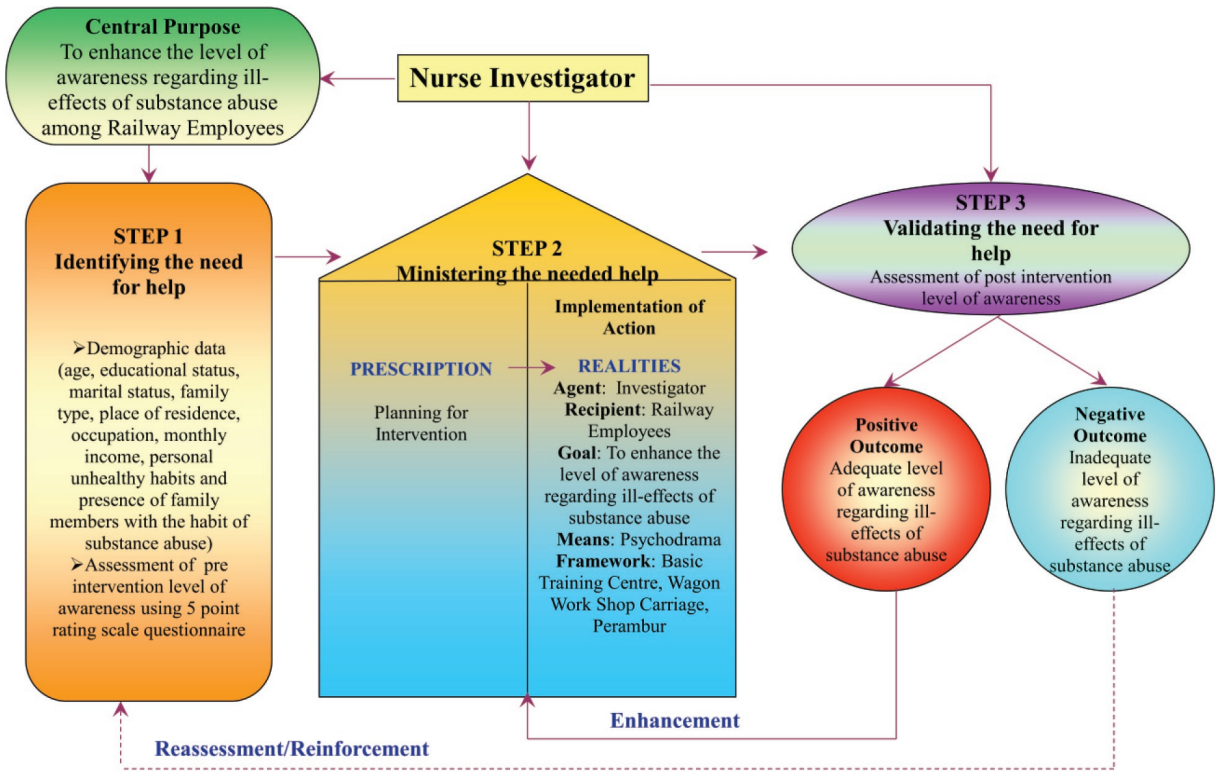

Fig.1: Conceptual framework based on wiedenbach's helping art of clinical nursing theory

RESULT

Table 1 : Frequency and percentage distribution of pre intervention level of awareness regarding ill- effects of substance abuse among Railway employees. N= 60

Awareness regarding ill- effects of substance abuse	Inadequate awareness (≤60%)		Moderately adequate awareness (61-80%)		Adequate awareness (≥81%)	
	No.	%	No.	%	No.	%
Physical problems	38	63.3	22	36.7	0	0
Psychological problems	48	80.0	12	20.0	0	0
Family problems	51	85.0	9	14.3	0	0
Occupational problems	43	71.7	17	27.0	0	0
Social problems	45	75.0	15	23.0	0	0

With respect to physical problems majority of 38 (63.3%) employees, psychological problems 48 (80.0%) employees, Family problems 51(85.0%) employees, Occupational problems 43 (71.7%) employees and Social problems 45 (75.0%) employees had inadequate level of awareness regarding ill effects of substance abuse.

Table 2 : Frequency and percentage distribution of post intervention level of awareness regarding ill-effects of substance abuse among Railway employees. N= 60

Awareness on ill effects of substance abuse	Inadequate awareness (≤60%)		Moderately adequate awareness (61-80%)		Adequate awareness (≥81%)	
	No.	%	No.	%	No.	%
Physical problems	0	00.0	7	11.7	53	88.3
Psychological problems	0	00.0	4	6.7	56	93.3
Family problems	0	00.0	7	11.7	53	88.3
Occupational problems	0	00.0	6	10.0	54	90.0
Social problems	0	00.0	5	8.3	55	91.7

With respect to Physical problems majority of 53(88.3%) employees, psychological problems 56(93.3%) employees, Family problems 53(88.3%) employees, Occupational problems 54(90.0%) employees and Social problems 55(91.7%) employees had adequate level of awareness regarding ill effects of substance abuse.

Table 3: Comparison of pre and post intervention level of awareness regarding ill effects of substance abuse among Railway employees. N = 60

Domain	Pretest		Post test		Paired‘t’ value	P-value
Awareness	Mean	SD	Mean	SD		
	182.23	19.75	271.70	23.38	25.95***	0.001

***p<0.001

The comparison of pre and post test scores reveals that ‘t’ value was 25.95 for level of awareness regarding ill effects of substance abuse among Railway employees which showed a high statistical significance at p<0.001 level.

Table 4 : Association of the mean improvement level of awareness scores of Railway employees with selected demographic variables such as age, educational status, marital status and family type. N= 60

S. No.	Demographic variables	Pre test		Post test		Awareness improvement		ONEWAY ANOVA
		Mean	SD	Mean	SD	Mean	SD	
1.	**Age**							
	a. ≤25 yrs	196.50	11.53	285.75	14.28	89.25	19.34	
	b. 26 – 35 yrs	184.13	22.40	275.40	18.65	91.27	28.47	F=1.19
	c. 36 – 45 yrs	181.23	16.16	281.08	11.40	99.85	23.11	
	d. ≥46 yrs	176.83	20.37	259.63	27.94	82.79	28.88	
2.	**Educational status**							
	a. Illiterate	174.00	2.83	235.00	8.49	61.00	11.31	
	b. Primary	190.75	14.60	263.13	15.40	72.38	14.05	
	c. Elementary	181.65	18.74	270.09	28.41	88.43	26.12	
	d. Secondary	182.65	19.23	272.93	20.73	90.14	26.14	F=3.36**
	e. Higher secondary	188.75	21.70	283.00	14.74	94.25	23.57	
	f. Diploma	162.60	26.00	286.00	7.65	123.40	26.71	
	g. Graduate	-	-	-	-	-	-	
3.	**Marital status**							
	a. Single	196.50	11.53	286.00	14.28	89.25	19.34	
	b. Married	180.04	19.91	269.54	23.84	89.50	27.81	F=0.03
	c. Divorced	-	-	-	-	-	-	
	d. Widower	-	-	-	-	-	-	
4.	**Family type**							
	a. Joint family	182.14	21.22	273.23	21.22	91.09	31.48	
	b. Nuclear family	181.68	19.03	270.03	24.63	88.35	24.22	F=0.96
	c. Broken family	205.00	-	300.00	-	95.00	-	

***p<0.05 **p<0.01 ***p<0.001**

Analysis revealed that there was a statistical significant association of mean improvement awareness score regarding ill-effects of substance abuse among Railway employees with selected demographic variables such as educational status p<0.01level.

Table 5: Association of the mean improvement level of awareness scores of Railway Employees with selected demographic variables such as place of residence, occupation, income and personal habits

N= 60

S. No.	Demographic variables	Pre test		Post test		Awareness improvement		ONEWAY ANOVA
		Mean	SD	Mean	SD	Mean	SD	
5.	**Place of residence**							F=1.39
	a. Rural	180.20	20.90	277.40	23.92	97.20	27.24	
	b. Urban	181.20	19.17	267.57	22.89	86.37	27.37	
	c. Semi urban	197.60	15.19	277.80	23.06	80.20	11.65	
6.	**Occupation**							F=4.80*
	a. Fitter	180.47	21.24	276.63	21.33	96.16	26.63	
	b. Welder	187.38	16.33	272.00	20.27	84.62	25.05	
	c. Painter	182.22	18.28	250.44	26.18	68.22	16.72	
7.	**Income**							F=3.02*
	a. ≤Rs.4000	165.25	6.24	221.50	17.14	56.25	13.65	
	b. Rs.4001-6000	192.25	12.45	273.42	20.00	81.17	15.74	
	c. Rs.6001-8000	186.85	13.99	275.15	17.79	88.31	24.24	
	d. RS.8001-10000	186.09	20.74	278.91	24.82	92.82	24.22	
	e. >Rs.10000	174.50	23.57	274.50	17.77	100.00	31.31	
8.	**Personal habits**							F=1.09
	a. Alcohol consumption	176.20	14.89	264.50	28.27	88.30	30.03	
	b. Ganja use	169.33	32.96	275.67	6.81	106.33	38.84	
	c. Cigarette smoking	182.78	19.89	260.11	32.97	77.33	19.09	
	d. In combination	-	-	-	-	-	-	
	e. None	184.71	19.89	276.03	19.29	91.32	26.36	

*p<0.05 **p<0.01 ***p<0.001

Analysis revealed that there was a statistical significant association of mean improvement awareness score regarding ill-effects of substance abuse among Railway employees with selected demographic variables such as occupation and income at p<0.01 and p<0.03 level respectively.

DISCUSSION

The first objective was to assess the pre intervention level of awareness regarding ill effects of substance abuse among Railway employees.

The overall pre intervention level of awareness score among railway employees were analyzed, it has revealed that 45(75 %) of railway employees had inadequate awareness, 15(25%) of railway employees had moderately adequate level of awareness.

This may be due to inadequate exposure towards prevailing problems of substance abuse and lack of awareness programmes to industrial population.

The study findings were supported by a descriptive study conducted by Ramakrishnan Nair, A.N on causes of absenteeism among railway employees. In this study 13,000 employees of the Carriage and Loco workshops of Perambur were included. Case record of 10,872 employees who reported sick in 2005 were analyzed. The study result showed that the most important causes of

absenteeism were substance abuse, Respiratory diseases, Gastro-intestinal problems Injuries and Chronic illness[5].

The study findings were consistence with the findings of the Campa Magall. J conducted a descriptive study among industrial workers. In this study 129 industrial workers participated. Data were collected by means of structured questionnaire and rating scales (CAGE & AUDIT). The study result showed consequence of substance abuse were- physical problems (44.2%), psychological problems (29.5%), decreased work performance (9.5%) and other problems in the work area are 21.7% mainly due to inadequate level of awareness regarding ill-effects of substance abuse[3].

The second objective was to assess the post intervention level of awareness regarding ill effects of substance abuse among Railway employees.

The overall post intervention level of awareness score among railway employees were analyzed, it has revealed that 54 (90 %) of railway employees had adequate awareness, 6(10 %) of railway employees had moderately adequate level of awareness.

The study findings showed that after the psychodrama there was a definite improvement in the level of awareness regarding ill-effects of substance abuse among railway employees.

The study findings were supported by the quasi experimental study conducted by Sujatha.R to assess the impact of psycho education and person dependent on alcohol, cannabis and cigarette. Simple random sampling technique was followed. One group pretest- post test design was used. The study was conducted by a social worker of de-addiction centre, NIMHANS, Bangalore. The study results clearly showed that after the Psycho education 87% of clients gained adequate awareness regarding ill-effects of substance abuse[6].

The third objective was to compare the pre and post intervention level of awareness regarding ill-effects of substance abuse among railway employees.

Based on the objective, the effectiveness of psycho drama was assessed by comparing pre and post intervention level of awareness score using paired‘t’ test.

The mean score of pre intervention level of awareness regarding ill-effects of substance abuse was 182.23 with S.D. of 19.75. The mean score of the post test was 271.70 with S.D. 23.38. This showed that there was a high statistically significant difference in the level of awareness at $p<0.001$ level based on‘t’ test result. Hence the null hypothesis NH_1 stated earlier that there is no significant difference in pre and post intervention level of awareness regarding ill-effects of substance abuse was rejected.

The study finding was supported by the quasi experimental study conducted by Gray .E and

Mc Cambridge to assess the effectiveness of single session of psycho drama on reducing drinking, cigarette and cannabis smoking in 160 young people who were daily cigarette smokers, weekly drinkers or weekly cannabis smokers. The study results showed that stronger evidence 80% subjects reduce the habit substance abuse[4].

The fourth objective was to associate mean improvement score level of awareness regarding ill effects of substance abuse among railway employees with selected demographic variables.

The association of demographic variables with pre and post test was done using one way analysis of variance (ANOVA) of the 9 variables tested age, educational status, marital status, family type, occupation, monthly income, personal unhealthy habits and family members with substance abuse list for association of mean improvement score level of awareness regarding ill effects of substance abuse among railway employees.

The findings revealed that there was significant association in mean awareness scores with the selected demographic variables of railway employees such as educational status and occupation are moderately significant at $P<0.01$ level and income of Railway employees are low significant at $P<0.03$ level.

Hence null hypothesis NH_2 stated that there is no significant association of mean improvement level of awareness regarding ill-effects of substance abuse among Railway employees was rejected

The study findings were supported by the comparative study conducted by Bennett, J.B to compare the influence of personal background and work environment factors on job risk and industrial employee substance abuse. The study result showed those employees who work in jobs with physical risk and less income report more substance abuse due to lack of awareness about

problems of substance abuse because of poor educational background[2].

CONCLUSION

Substance abuse is one of the biggest problems people facing today. "Prevention is better than cure". Primary prevention covers the specific protection and health promotion measures. Many of the study results stated that substance abuse is common among industrial workers. So it was essential to provide awareness regarding ill-effects of substance abuse to industrial workers in order to reduce substance abuse. Psychiatric nurses and social workers play an important role in the improvement of awareness regarding holistic care dimensions (physical, psychological, family, occupational and social).

The study result revealed that the effectiveness of psychodrama on level of awareness regarding ill-effects of substance abuse among Railway employees was highly significant at $P<0.01$ level.

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A Qualitative Study on the Experiences of Nurses Working in Psychiatry Ward in Selected Hospitals at Mangalore

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ABSTRACT

Objective: The study aimed to assess the lived experiences of nurses working in psychiatry ward. This qualitative study focuses on the unique experiences of nurses working in psychiatry ward to improve the working condition of the nurses which contributes to the better patient outcome and nurse's satisfaction.

Methodology: A phenomenological, qualitative study design was selected to explore the experience of nurses working in psychiatry ward. By adopting purposive sampling technique, ten nurses were included in the study. Although the researcher had purposed to include more samples, the data was saturated after interacting with ten participants. In-depth audio-taped interview and field notes were used for data collection.

Result: Colaizzi's data analysis framework was used to analyze transcripts for this study. From the analysis of data, six themes emerged from the experiences of nurses. The reliability of the formulated meaning, subthemes and themes were established by consulting five experts. The themes are as follows:

Theme 1: Prejudice vs. Strong motive

Theme 2: Lack of induction training and resources

Theme 3: Adaptation and challenges in working area

Theme 4: Better multidisciplinary approach of care

Theme 5: Socio-cultural prejudice

Theme 6: Safety and security issues

Conclusion: The findings of the study shows that induction training of the staff, provision of adequate resources, organisational support, adequate security for nursing personnel and awareness regarding mental illness and mental health nursing could improve the working condition of the mental health nurses and enhance their efficiency.

Keywords: *Phenomenology, experiences, mental health nurses.*

INTRODUCTION

"Health is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity." – World Health Organization[1].

Good mental health is crucial for living a long and healthy life. Good mental health can enhance one's life, while poor mental health can prevent someone from living an enriching life. The WHO defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". Mental Health is not just the absence of mental illness[2].

Mental health nursing is one of the most complex and demanding areas of nursing. It has been reported as a stressful speciality, with low job satisfaction. A mental health nurse may be part of a team caring people who may have been excluded from services. The range of

conditions is vast: neuroses, psychoses, psychological and personality disorders all come under the broad heading of mental health[3].

The most consistent finding in the study "Nurses in Mental Health 2007" is the severe shortage of nurses providing mental health care in most low and middle income countries. Lack of adequate opportunities for education and training in mental health during both initial nursing training and continuing education of nurses is also obvious from the results[4].

Mental illness is associated with poor image and stigma. Lack of focus on mental health nursing in nursing education and perception of increased violence in the field of mental health has led to shortage of nurses. Despite the growing prevalence and healthcare needs of people living with mental illness, the stigma associated with mental health nursing continues to present challenges to recruiting new nurses to this sector. Negative and stigmatizing beliefs regarding mental health nursing discredit the valuable contributions of mental health nurses, but more importantly, these beliefs discredit the needs of people who access mental health care[6].

Psychiatric nurses work everywhere from dedicated psychiatric hospitals to inpatient/outpatient units at general hospitals, community, clinics and in private practice if they are certified to prescribe medications. They work with patients who are often at their worst and most vulnerable state. They have to treat patients with dignity and rationality even though patients may be out of control. It is a challenging work. Working as a psychiatric nurse can be emotionally and physically draining, one needs to be able to find a place of peace within themselves[8].

METHODOLOGY

A qualitative approach with phenomenological design was selected to explore the experiences of nurses working in psychiatry ward. The study was conducted in Justice K. S. Hegde Medical Academy, Mangalore, DK, India and Father Muller's Medical College and Hospital, Mangalore, DK, India after obtaining administrative approval. Nurses working in the selected hospitals as staff nurse with experience of more than six months and less than five years were included in the study. Ten nurses were selected purposively for the study. Although the researcher had purposed to include more samples, the data was saturated after the interaction with tenth participant. The tool used for the study consisted of two parts. The first part consisted of questions related to demographic profile and the second part consisted of semi- structured interview questionnaire for exploring the experiences of nurses working in psychiatry ward. In-depth interview was used to explore experiences of nurses. Prior to data collection, permission was obtained from the concerned authority of the hospitals. The researcher contacted participants in the respective units of psychiatry wards, once they agreed to participate, before the interview to prepare them for actual meeting and to answer any preliminary question. At the time of interview, after obtaining informed consent, the interviews were audio taped and field notes were also maintained.

In keeping with Colaizzi's approach, seven procedural steps of analysis were followed.

1. Each transcript was read and re-read in order to obtain a general sense about the whole content.

2. For each transcript, significant statements that pertain to the phenomenon under study was extracted.

These statements were recorded on a separate sheet noting their pages and lines numbers.

3. Meanings were formulated from these significant statements.

4. The formulated meanings were sorted into categories, clusters of themes, and themes.

5. The findings of the study were integrated into an exhaustive description of the phenomenon under study.

6. The fundamental structure of the phenomenon was described.

7. Finally, validation of the findings was done from the research participants to compare the researcher's descriptive results with their experiences.

RESULTS

The analysis is presented under the two headings:

Section I: Demographic characteristics of the participants

Section II: Analysis of verbatim of participants

The data collected for this study were analysed according to Colaizzi's phenomenological data analysis

method. During the analysis, oral description given by the participant were read and re-read by researcher to gain a general understanding. Significant statements and phrases about the objectives of the study were identified. Meanings were formulated from the significant statements and phrases. The formulated meanings were then organized into clusters of themes. Results of the data analysis were integrated into a description of the experience. In order to achieve the rigorousness, the researcher strived for openness, sensitivity and objectivity throughout the whole process.

The reliability of the formulated meaning and themes was established by seeking experts view. To achieve the final reliability, participants were contacted again to discuss the result. They agreed that the analysis had accurately represented their personal experiences.

Section I: Demographic characteristic of the participant

Table 1: Demographic characteristic of the participants (n =10)

S.No.	Characteristics	Categories	Number	Percentage (%)
1	Age (in years)	22-26	6	60
		27-31	3	30
		32-36	1	10
2	Gender	Male	4	40
		Female	6	60
3	Religion	Hindu	1	10
		Christian	9	90
4	Marital status	Married	2	20
		Unmarried	8	80
5	Type of family	Joint	1	10
		Nuclear	9	90
6	Professional qualification	GNM	3	30
		Pb B. Sc. Nursing	1	10
		B. Sc. Nursing	6	60
7	Place of residence	Home	6	60
		Hostel	4	40
8	Area of work	General psychiatry	5	50
		Family psychiatry	3	30
		De-addiction	2	20
9	Duration of work	6months- 1year	4	40
		1 - 2 yrs	2	20
		2 - 3yrs	3	30
		3 - 4yrs	1	10

Section II: Analysis of verbatim of participants

The transcripts were analysed using Colaizzi's framework for data. From the analysis of the data, six themes were emerged from the experiences of nurses working in psychiatry ward and they were as follows:

Theme 1: Prejudice vs. Strong motive

Theme 2: Lack of induction training and resources

Theme 3: Adaptation and challenges in working area

Theme 4: Better multidisciplinary approach of care

Theme 5: Socio-cultural prejudice

Theme 6: Safety and security issues

Theme 1: Prejudice vs. Strong motive

Most of the participants (six) expressed that they were scared to work in psychiatry ward. Four participants expressed that they were scared because of aggressive, violent nature of patient which might be difficult to handle. Two participants expressed that they were interested in psychiatry and satisfied with their posting in psychiatry ward.

Initially I did not know what to do..... I was tensed because ...I knew many patients will be there.....very aggressive and difficult to handle. (Participant no. 7)

Theme 2: Lack of induction training and resources

Three participants expressed that they had difficulty in communicating with the patient initially. Two of them expressed the feeling of inadequacy to interact with the clients. Five out of ten participants shared that managing the aggressive and violent patient was quite difficult task in the beginning. Two of them expressed that they felt more difficulty to work with inadequate nursing personnel. Participants expressed that with proper guidance from the in-charge they were able take care of the patients.

I felt scared about psychiatric patient because they are irritable, walking here and there, aimlessly. I did not know how to talk to them, interact with them. (Participant no. 10)

Theme 3: Adaptation and challenges in working area

All participants expressed satisfaction for working in psychiatry ward. All of the participants expressed that they had faced physical and verbal assault during their duty.

They expressed that physical assaults were sudden and unpredictable. Two participants expressed that learning opportunity is less in psychiatry. All of the participants expressed that they felt sad for mentally ill client as they come with relapse. All of the participants felt difficulty and irritated working in psychiatry ward at some point of time. Most of the participants expressed that they were exhausted due to workload,violent patients and with inadequate and inexperienced staff nurses.

Before it was difficult for me,.....I was not knowing how to deal with the patient. Now, I am used to this ward.....so it's ok....I am satisfied working here... (Participant no.8)

One day.....I was loading injection and the patient was calling me, "sister can you please come here?" I went, then he slapped me!!*.....That was unpredictable... ...then....again one morning..... I went to give injection to one patient.....suddenly the other patient threw tea over me.....my uniform was spoiled.* (Participant no.10)

Theme 4: Better multidisciplinary approach of care

All of the participants expressed that the communication among doctors, social workers, counsellors, nurses was good. They expressed that all the team members were cooperative. All of the participants expressed that communication among co-workers was good, effective and ward in-charge was supportive.

Interaction of the health team members is good, even the social workers are communicating good....when the patient party is not coming to take the patient, they manage and help them. (Participant no. 2)

Our in-charge is supportive. In each of the matter she is responsible.....work and responsibilities...she divides the work among staff and so it is easy to work for us. (Participant no. 2)

Theme 5: Socio-cultural prejudice

Majority of the participants (eight) ventilated that their family members were concerned about their safety and security, wanted them to change the ward. More than half of the participants (six) stated that their friends, relatives made fun of them since they are working with

mentally ill and alcoholic patient. They also expressed that their relatives, friends suggested them to change their working area for better job experience.

My fiancée, he will say, "like if the patient gets violent they will beat .....or they will do something...so change your ward that is better.....something will happen to you". (Participant no. 9)

My friend tells, "you will not get any experience.....so change to other department like medicine, surgery" (Participant no. 5)

Theme 6: Safety and security issues

Participants expressed that safety and security for staff is not adequate. Most of the nurses expressed that open hall set up would be better for observation than rooms. Three participants expressed lack of organisational support in case of safety and security issues.

DISCUSSION

The study was set out to ascertain the experience of nurses working in psychiatry ward. Six themes emerged from the study based on the analysis of the data. The finding of this study is consistent with the another study where similar themes emerged, (1) perception of psychiatric nursing; (2) patient aggression; (3) patients family involvement; (4) nurse-doctor relationship; (5) responsibility and worries; and (6) shift in practice and educational standards9. The study finding is consistent with a study where burnout was significantly associated with inpatient environment, managers, nurse-physician relationship and nurse-to-patient staffing ratio[10].

In the present study, all participants expressed satisfaction for working in psychiatry ward. This finding is in accordance with the study which concluded that job satisfaction is influenced by work location, work routine, team work and working environment[11].

All of the participants expressed that, they had faced physical and verbal assault by the patient during their duty. This finding is similar to the study conducted in Turkey which revealed that nurses' rate of exposure to physical and verbal assault by the patient and their relatives is high. The study concluded that nurses' are under risk to safety and they need protection and support, both in emotional and legal terms[12]. Another study revealed that verbal abuse and threats were experienced by 80-90% of the psychiatry nurses. Sexual harassment or intimidation was also experienced by 68%, particularly by female and young staff members[13].

All of the participants felt difficulty, irritated, working in psychiatry ward at some point of time due to workload, violent patient, and with inadequate and inexperienced staff nurses. This finding is consistent with the study in which 70% of the nurses suffered from physical or mental health problem associated with work related stress. The stressors identified were: workload/lack of staff, violence and aggression, poor team-working practices[6]. However in the present study, all of the participants expressed better communication and teamwork in psychiatry ward.

Majority of the participants (eight) ventilated that their family members were concerned about their safety and security and wanted them to change their working area. More than half of the (six) participants stated that their friend made fun of them since they were working with mentally ill and alcoholic patients. A study conducted on Perceived characteristics of psychiatry nurses: stigma by association revealed that psychiatry nursing is the least preferred speciality. The finding suggested that psychiatry nursing may be stigmatized by association[14].

IMPLICATIONS

• The care provided by the nurse to patient is affected by their preconception, knowledge and competency in psychiatric skills. Therefore in order to render better nursing care to the patient, a nurse must be aware of her own fear and fantasies regarding mentally ill client.

• Systematic clinical supervision, use of the knowledge embedded in practice and to improve the efficiency, working environment, and the cooperation of team members.

• Orientation courses for newly appointed staff should be planned and executed.

• Nurse administrators must organize continuing educational programs so that the nurses are acquainted with recent trends in caring the mentally ill patient.

• Training of newly appointed staff nurses on the use of fundamental therapeutic communication skills would help to decrease their anxiety and establish better nurse-patient relationship.

• Attention to organisational deficits like inadequate nursing staff, inadequate security, and wardboys should be addressed.

• Provision of safe and secured infrastructure to facilitate good working environment.

CONCLUSION

Mental health nursing is one of the most complex and demanding areas of nursing. They treat everyone from children to elderly, who are delusional, angry, manic, depressed, those who have attempted suicide, etc. They work with patients, who are often at their worst and most vulnerable, when their mental illnesses are acute.

Thus, having an insight towards nurses' experience reveals nurses' needs and can help them to have a better picture of themselves. Deep understanding on nurses' experiences in psychiatric wards has a significant and fundamental influence on quality of care given to the patients with psychiatric and mental disorders. It helps not only nurses, but all members of the psychiatric team.

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Indian Media and Mental Illnesses: Beyond the Love Hate Relationship

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ABSTRACT

There are reviews about portrayal of Psychiatry in print and electronic media, Bollywood movies. Impact of cine media is extremely important in regional movies where actors and actresses are being worshipped as god. Initial stigmatization about madness is gradually changing to some strong social messages. 'Bollywood' films generally feature strong messages, often reinforcing traditional principles such as family values and acceptance by society. The media portrayal; cinema and emotion; attitudes towards mental illness; socio-economic factors and cinema in India; Indian personality, villainy and history; and psychoanalysis in the films of the 60s has been discussed.

Keywords: *Bollywood movies, Mental Illness, Media, Stigmatizarion, Social messages.*

INTRODUCTION & BACKGROUND

The relationship between media and mental illness is complex since times immemorial. This review searches various online accesse including PubMed, Google Scolar, PsychInfo and various search engines and found both the positive and the negative portrayals of mental illnesses by the media. The Media has also been blamed for the genesis or escalation of stigma of mental illnesses like eating disorders and substance use disorders in early days. However nobody can deny the potential influence of the media to understand the psychopathology and plight of those having psychiatric disorders. The media, if judiciously used can reduce the stigma of mental illnesses.[1]

The terminology Media in these days includes Internet (the World Wide Web), television, radio, newspapers, magazines, newsletters and various forms of print media.[2] The aim of media is primarily to provide education and entertainment to its audience.

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The inter-relationship between Media and Mental illnesses has been given in a simplified way in Figure 1.

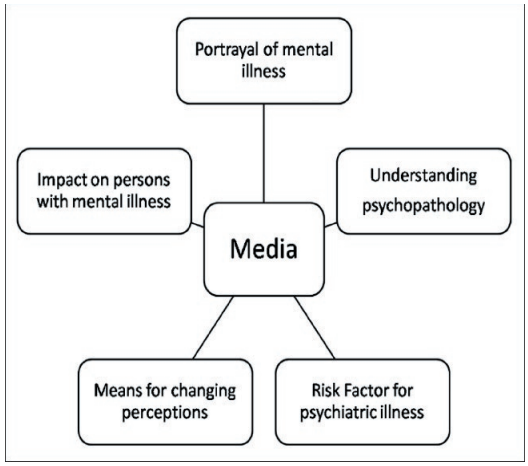

Figure 1: Media and mental illness – interplay

The perception and attitude of people towards mental illnesses is largely dependent on Media and it can act as risk factors for certain forms of mental illnesses. The feature films and cinemas can be used as a means for the purpose of psycho education. The unrestricted Indian media has tremendous potential as it can influence the perception of mass and it can be used as a change agent for removing stigma and negative stereotypes of mental illnesses. The homicides involving mentally ill person is depicted by media in such a way that labels a person shrude, unpredictable, violent and dangerous. [3,4]

MATERIALS & METHOD

Indian Movies & Mental illnesses: The description of various mental illnesses in movies, the psychiatrist's definition of schizophrenia and manic depression, portrayal of possession states, trance and reincarnation are there since the inception. In most of the films, psychosis is poorly defined, with people shown hearing and responding to voices. This depiction of mental illness is not solely the filmmaker's interpretation as these films were adapted from popular novels, which sold millions of copies at railway stations around India. [5,6,7]

The depiction of ECT, lobotomy, forced medication as a mode of punishment or management of psychosis has been highlighted in various bollywood movies like Raja, Damini, Khamoshi, Jewel Thief, Rat aur Din, etc. In India, psychiatrists have been framed as villain in old bollywood movies. In contrast, contemporary hollywood movies like 'As Good as it gets' attempted to portray mental illness almost accurately. Nowadays electronic, print (newspaper., magazines) started portraying mental illness as important as the physical illnesses and organizing including live chats and interviews.

The media can be an indirect tool of psycho education, the outline of some mental illnesses which are being focussed in various bolywood movies are given in Table 2. [8,9,10]

Table 2: Depiction of psychiatric disorders in Bollywood movies.

Disorders	Bollywood movies
1. Dissociative disorders	Bhool Bhulaiya (2007); Kartik calling Kartik (2010)
2. Schizophrenia	15 Park avenue (2005); Woh Lamhe (2005)
3. Substance use disorder	Devdas (2002); Dev-D (2009)
4. Personality disoreder	Raaz (2002)
5. Anxiety disorders	Chhoti si baat (1975)
6. Intellectual disability & Pervasive developmental disorder	My name is Khan (2010); Barfi (2012)
7. Dyslexia	Taare Zameen Par (2007)

FINDINGS

The protagonist and supporter of various viewpoints, daily professional columnists are attempting to spread awareness about mental illnesses nationwide. The media portrayal had a negative impact on the lives of mentally ill persons raising their anxiety and depression with hostile behaviours from neighbours and friends.[11,12]

ROLE OF MEDIA IN PAST AND PRESENT DAYS:

The love and hate relationship between other fields and media especially politics and sports is quite enjoyable but the same between mental illnesses and media is complex. Most of the time media remains negligent over these issues. In the past decade the depiction of mental illnesses by media has improved and they are playing a constructive role in promotion of mental health, giving emphasis on family and societal support and reversibility of mental illnesses; chances of getting cured on regular treatment. [13,14,15]

The "Werther effect" in western counterpart ("The Sorrow's of Youmg Werther") and in India 18 cases of 'copycat suicides' has been reported following one judicial hanging which is mostly prevalent among young children. The same adventurous 'copy cat' reports has also been reported among kids following popular movies and teleserials like 'Shaktimaan', "Batman", 'Krish' etc. Some reports about farmer suicides however generated awareness of plight and stress of farmers sensitized the authorities to take immediate actions. These movies had considerable mass-market appeal, and were seen by a significant slice of the Indian population. Undoubtedly, political factors colored the portrayal of mental illness. In the 80s and 90s, whilst India was amid much political restlessness, successful films made at that time included a psychopathic hero who always gets punished for his bad deeds. Cinema audiences would cheer on their wayward hero, despite knowing that retribution for his behaviour was inevitable. [16,17,18,19]

Compared with Hollywood's portrayal of mental illness, Indian cinema is perhaps less enlightened. There are fewer Bollywood films that look at mental illness in a serious sympathetic way. Only few films discuss psychoanalysis at length and depictions generally refer to asylums or the traditional model of psychiatric hospitals. This gives an impression that Indian cinema may be 30 to 40 years behind Hollywood's image of psychiatry. This may again reflect differing social attitudes to mental illness. There are cultural differences where family contact, religion and pilgrimage may be

the 'nonprofessional' ways of dealing with it. There are different views, whether negative attitudes are more common in certain communities. In African-Caribbean community the stigma with mental illness is less than UK. In a daily newspaper almost 40-70% of the news item describes violence. Approximately 85% of animations and cartoons depicts a 'crazy character'. These coverage generate negative view and stigmatizes mental illnesses. For times immemorial, person having mental illnesses are being called as 'mad' in public and in literatures, movies the mental illnesses thought to be a state of possession by demons, incurable and a mentally ill person is a 'violent, unpredictable, criminal. Many people in India still visit temples and shrines before visiting a doctor. The social issues are not being covered though and the reflection of society is not properly obtained. [20,21,22]

The media can act as risk factors also. The 'size zero" concept has lead to eating disorders, body image disturbances and low self-esteem and media can act as a trigger with a lots of fan-follower of the celebrities and people can 'copy cat' their idols. This has spread from western culyure with influence of media post 1990s. [23,24,25]

DISCUSSION

Suggested steps to reduce stigma: The media, being the powerful weapon has the potential to both increase and decrease the stigma of mental illnessesn and can be utilized for later purpose if judiciously used. A documentary film like people suffering from schizophrenia are not dangerous in media can spread awareness more effectively. It's also very important how the mental health professionals will interact to media houses and it's utmost needed to select and carefully use sensitive words or viewpoints. Speculations and dichotomy must be avoided to reduce confusion by hearing the message of a psychiatrist. The professional integrity should get the highest priority. The language plays an important role in communication which is printed or broadcasted in various media. Very recently, the office bearers of Indian Psychiatric Society (IPS) have signed a MOU wiht Deepika Padukone, the famous actress of bolywood to spread awareness of "depression". Following suggestions is given to IPS from the desk of Media & Mental Health

1. Issuance of letter to media houses can be given requesting not to stigmatize mental illness and help to promote awareness.

2. Arrangement of talk show involving psychiatrists on weekly basis in reputed National Television and FM channels on weekly basis for general public to build awareness.

3. Requesting local administrations especially at the village level to jointly work out to spread awareness by distributing leaflets, posters and participating in village, city or district welfare monthly meeting (conducted by CMOH) with representation from IPS (like IMA & IAP).

4. An operational guideline must be issued by IPS and should be sent to our members requesting them to abide the official viewpoint over a national issue/current affairs to reduce miscommunications and diverse comments over an isuue.

5. Media houses should be requested not to sensationalize mental illnesses as 'hitchcock thriller', not to report events in the front page with highlights, responsible media reporting over celebrity with mental illnesses, suicides etc, non-disclosure of identity of mentally ill person taking care of their non-violation of basic human rights.

By using films for teaching, one can get an interesting combination of entertainment and education. However, this method is not without its drawbacks. One has to be aware that commercial films are primarily made for entertainment and not education. They may not be made based on sufficient research and hence may reflect how an individual understands a mental illness rather than presenting a scientific understanding of the same. There may be distortion of data in order to make the stories more compelling and get better reviews and public attention. Similarly, diagnoses may not be always clear, in which case one has to always consider differential diagnosis and not ICD-10 or DSM IV categories. There is also a disadvantage of distortion and increased stigmatization of mental illness and the mentally ill in their portrayals in films that may lead to stronger stereotypes in the viewer's minds.

By addressing these issues, a broader aim of the project is to influence public attitudes and foster a more sympathetic understanding of mental illness. In India, families that care for the mentally ill are in need to realize that this is a genuine illness and not an act or a hysterical phenomenon. This narration may encourage

film directors to modify their portrayal of the mentally ill and thus reduce the stigma attached to mental illness. The Bollywood cinema is a cultural and ideological force that creates and reinforces perceptions and attitudes in its viewers As such; it could have a profound influence on the Indian population's attitudes to a mental health.

MEDIA IN CHANGING PARADIGM

Their are two hypothetical constructs about the influence of media on attitudes, behaviours and views of individual; "social cognitive theory" and "cultivation theory". A major component of social cognitive theory is "symbolizing capability," which means that people process and transform transient experiences into cognitive models using symbols that act as guides for judgment and action. The cultivation theory states that the more one views certain material, the more likely it becomes the reality for him, i.e. people who watch a lot of television are more likely to express opinions and hold values similar to those represented on television and the content watched. [26,27,28]

Back in the day when the Aarushi murder case was playing out, some journalists were part of the minority that took a stand against trial by media and the purveying of smut. Some media are searching out, in explicit detail, the "incest angle". The media is aggressive for their competitiveness and quest for gaining TRP. There is also the little matter of a legal proscription on revealing the identity of victims of sexual abuse. Ever since this crime being covered by electronic and print media, the social networking sites and blogs are being flooded with comments due to curiosity and attraction of the case with criticism of media directly or by posts in blogs and sites full of satire. These sensational sagas will be viewed and net-searched in the days ahead and will cause mental trauma and agony to the accused before the verdict itself. As before, the media seems to feel hugely secure about stigmatising those caught up, in one way or another, in murder investigations, knowing it will probably never be called to account. The media is safe because almost no fear of defamation as legal battle that could last years, least of all those who have been caught up in a murder case. The psychological trauma on repetitive telecast of such shocking incident can affect the vulnerable individuals. For psychological well being at large it is recommended that the media should be responsible with proper coverage. [29,30]

CONCLUSIONS

The advertising is responsible for up to 30% of adolescent tobacco and alcohol use and advertisement and exposure to smoking approximately doubles the tobacco use. The sponsorship of Mega events like ICC champions trophy or bravery awards promote tobacco and alcohol use among teenagers. The internet addiction, gaming, uer of E-cigarettes, cyberporn etc growing rapidly with the easy availability of modern technology causing behavioural addiction. The complex and sensitive issues of social media sites like facebook. WhatsApp, Tweeter etc causing lots of troubles including cybercrime, relationship breakup, hacking, forgery, genderbending etc. The wide coverage of 9/11 attacks has resulted in PTSD amongst 5.4% of children who were exposed to the event. [31]

FUTURE DIRECTIONS

Media sensitization and press-briefing from time to time with our cured mainstream patients describing their own lifetime experiences is utmost needed who may or may not be necessarily a celebrity. The psychotropic medicines have acquired less acceptance to society than other like antihypertensives, antianginal drugs. Many people fears loosing control which is fuelled by negativistic media reports.

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A Quasi Experimental Study to assess the Effectiveness of Assertiveness Training on Assertive Behaviour and Self Esteem among Adolescent Girls in Selected Government Schools of Panipat, Haryana, 2015

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ABSTRACT

Background: As adolescent health has become an increasingly important focus for governments, foundations, and behavioral researchers in contrast to other age groups. Mortality and morbidity rates for 10-25 year olds have been increasing in the past few decades. Self esteem is the most dominant and powerful predictor of happiness and life satisfaction but it is estimated that up to a half of adolescents will struggle with low self esteem and research had shown that, teens self esteem levels drop markedly in girls more than boys.

Aim: To study the effectiveness of assertiveness training on self esteem and assertive behavior among adolescent girls of selected government schools.

Method: Investigator developed a conceptual framework based on the Nola Pander's Health Promotion Model. The research approach adopted for the present study is a quantitative approach and the design selected was a quasi-experimental design (non equivalent pre test post test control group).The setting selected for the study was government senior secondary schools of district Panipat. Purposive sampling technique used to gather 40 adolescent girls in experimental and control group each. Data collected using socio-demographic variables and with standardized Rosenberg self esteem scale (r=0.94) and Rathus assertiveness schedule(r=0.732). Assertiveness training given for 5 days and post test-1 done after 15 days. Then the investigator administered the same intervention to the wait list control group. Post test-2 in experimental group assessed after two months of intervention.

Results: The mean post test-1 self esteem score in experimental group was 20.78 as compared with the mean post test self esteem score in control group was 13.55).The mean difference found was 7.225. secondly, considering for assertive behavior mean post test-1 score in experimental group was 23.28 as compared with mean post test assertive behavior score in control group - 4.23 and the mean difference shown 27.5.While comparing the post test-1 and post test-2 in experimental group, both self esteem and assertive behavior increased a little.

Conclusion: It is concluded that the assertiveness training is effective in building the level of self esteem as well as improving the assertive behavior among adolescent girls and the findings also reveals that it improve while time progress.

Keywords: *Assertiveness training, self esteem, assertive behavior, adolescent girls, wait-list control group, selected government schools.*

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INTRODUCTION

Adolescence, is a word comes from Latin word which means "to grow up" and is a transitional stage of physical and mental human development. According to Erik Erikson's stages of human development, an adolescent is

generally a person between the ages of 13 and 19.[1]

Braden N (1969) briefly defined Self esteem as the experience of being competent to cope with the basic challenges of life and being worthy of happiness.[2] Alberti, Emmon define Assertive behaviour is the behaviour which enables the person to act upon his own best interest and to stand up for himself without undue anxiety and to express his honest feeling comfortably or to exercise his own rights without denying the rights of others.[3]

Assertiveness Training (AT) was introduced by Andrew Salter (1961) and popularized by Joseph Wolpe[4] Fensterheim, Baer (1975) revealed that there is a positive relationship between assertiveness and self esteem. Rotheram (1987) indicated that there was a significant positive correlation among self esteem, assertiveness and interpersonal problem solving ability.[5]

Morganett (1990) told that the group-based intervention programs are beneficial especially for adolescents Counseling groups provide an atmosphere of acceptance, encouragement and safe experimentation for new behaviors.[6] Gazda (1989) reveals that peers strongly influence the young adolescent group counseling enhances the possibility that youths will attempt new behaviors[7]

Investigator personally witnessed many adolescent girls having problems of low self esteem and non- assertive behavior and also influenced by Beti Bachao Beti Padhao Yojna a National Campaign launched by Prime Minister Narender Modi on 22 January 2015, in Panipat, Haryana with the objective to improve the drastic condition of female in India.

OBJECTIVES

1. To assess the level of self esteem before and after the assertive training programme among adolescent girls in experimental and control group.

2. To assess the level of assertive behaviour before and after the assertive training programme among adolescent girls in experimental and control group.

3. To compare the post test level of self esteem and level of assertive behaviour among adolescent girls in between experimental and control group.

4. To find out the association between mean difference of the level of self esteem and assertive behaviour among adolescent girls with their selected socio demographic variables in experimental and control group.

MATERIAL & METHOD

- In this study, quasi-experimental design (non equivalent control group pre test post test design) was used, experimental and control groups are selected without randomization. The sample size considered for the present study 80 adolescent girls (40 experimental and 40 control group) studying in government senior secondary schools of Rajakheri and Chhajpur of district Panipat, Haryana by using power analysis and purposive sampling used for study. The tool used in the study were standardized tool to assess the self esteem and assertive behavior The tool will be consisting,Tool 1: Rosenberg's Self Esteem Scale , Tool 2: Rathus assertiveness schedule

RESULTS

SECTION-I: DESCRIPTION OF STUDY PARTICIPANTS

Demographic variables of sample revealed that in Experimental group majority of adolescent girls, were in the age group 15-16 years 26 (65%), and were hindus 39 (97.5%) and their fathers having secondary education 14 (35%), and their mothers were non-literate 14 (35%) respectively according to mother's educational status, were self employed 17 (42.5%) respectively according to father's occupation, and their Mothers were housewife 38 (95%), and having Rs.5000-10000/month 26 (65%) Family income per month. Maximum of them were residing in rural area 36(90%) and were coming from nuclear family 25 (62.5%) and no one having previous exposure to assertiveness training programme.

Where as in Control Group majority of samples, were both in the age group 13 -14 and 15-16 years 15 (37.5%) and were Hindus 39(97.5%) and, were having secondary education 20 (50%)) respectively according to father's educational status, were non-literate 22 (55%) respectively according to mother's educational status, were self employed 15 (37.5%) according to father's occupation, their mother were housewife 37 (92.5%), were having 5000-1000/month 35 (87.5%) family

income per month, were residing in rural area 39 (97.5%) and coming from nuclear family 26 (65%) and not attended previously any assertiveness training programme. Both the group found homogenous as homogeneity calculated by chi square test.

SECTION II - TESTING OF HYPOTHESES

Objective 1: To assess the level of self esteem before and after the assertive training programme among adolescent girls in experimental and control group.

Table:-1 Frequency and percentage distribution of pretest and post test level of self esteem among adolescents girls in experimental and control group. (N=80)

S.NO	Level of self esteem	Score	Experimental Group				Control Group			
			Pretest		posttest		Pretest		Posttest	
			(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
1.	GOOD	20-30 (67%-100%)	0		24	60	0		0	97.5
2.	AVERAGE	10-19 (34%-66%)	39	97.5	16	40	34	85	39	2.5
3.	POOR	0-9 (<33%)	1	2.5	0		6	15	1	

Maximum score: 30 **Minimum score: 0**

Table 1, reveals that in pretest experimental group and control group, majority of the adolescent girls 39 (97.5%) and 34 (85%) were having average level of self esteem. No girls falls in the category of good level of self esteem. Where as in post test experimental group, maximum number of the adolescent girls 24(60%) were having good level of self esteem but In post test control group, majority of the adolescent girls 39 (97.5%) were having average level of self esteem

Objective 2: To assess the level of assertive behavior before and after the assertive training programme among adolescent girls in experimental and control group.

Table:- 2 Frequency and percentage distribution of pre test level of assertive behavior among adolescents girls in experimental and control group. (N=80)

S.NO	Level of assertive behaviour	Score	Experimental Group		Control Group	
			Pretest		Pretest	
			(n)	(%)	(n)	(%)
1	Probably Aggressive	+41 to +90	0		0	
2	Assertive	+21 to +40	0		1	2.5
3	Somewhat Assertive	0 to 20	11	27.5	18	45
4	Situationally Non –Assertive	-20 to -1	22	55	12	30
5	Very Non-Assertive	-90 to -21	7	17.5	9	22.5

Maximum score: +90 **Minimum score: -90**

Table 2, shows that in pre test experimental group,majority of the adolescent girls 22 (55%) were Situationally non-assertive as compared with 11 (27.5%) and 7(17.5%) adolescent girls with Somewhat assertive and Very non assertive respectively. No adolescent girls were showing assertive and Probably aggressive.In pretest control group, maximum adolescent girls 18(45%) were Somewhat assertive followed by 12(30%) and 9(22.5%) adolescent girls having Situationally non assertive and Very non assertive respectively. It isinteresting to inform that,1(2.5%)adolescent girls were having assertive behaviour and no one falls in the probably aggressive category.

In post test experimental group, after assertiveness training programme majority of the adolescent girls 28 (70%) were Assertive and 12 (30%) adolescent girls were somewhat assertive. In post test control group, the more number of adolescent girls19 (47.5%) were Somewhat assertive, 12(30%) were Situationally non assertive 8(20.%) respectively. Aggressive behaviour in post test control group remains almost same as seen in pretest.

Objective 3: To compare the post test level of self esteem and level of assertive behaviour among adolescent girls in between experimental and control group.

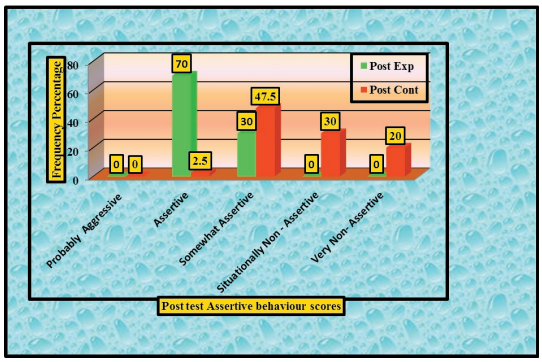

Fig.1 Frequency percentage distribution of post test level of assertive behaviour score in both the groups.

Table:-3 Comparison of the post test mean level of self esteem and assertive behaviour scores among adolescents girl in experimental and control group. (N=80)

p<0.05

(N=80)

GROUPS / t TEST	EXPERIMENTAL GROUP	CONTROL GROUP	EXPERIMENTAL GROUP	CONTROL GROUP
	Self Esteem Scores		Assertive Behaviour Scores	
	Post test-1	Post test	Post test-1	Post test
MEAN SCORE	20.78	13.55	23.28	-4.23
SD	3.526	2.275	6.653	15.724
MEDIAN SCORE	20.5	13.5	23.5	-0.5
MEAN PERCENTAGE	69.25	45.17	25.86	-4.69
Mean % Difference	24.1		30.6	
Mean Difference	7.225		27. 500	
T Test Value	10.888		10.187	
P Value	0.0000		0.0000	
Table Value At 0.05	1.99		1.99	
RESULT	Significant			

p<0.05

Table 3, iilustrates that in experimental group, the mean post test level of self esteem 20.78 is higher than the mean post test level of self esteem score 13.55 in control group and the mean difference shown is 7.225 and the obtained 't' value is 10.888 (p= 0.000).

Next for assertive behaviour in experimental group, the mean post test level was 23.28 is higher than the post test level of assertive behaviour -4.23 in control group.The mean difference shown is 27.500 and the obtained 't' value is 10.187 (p= 0.000) and found to be stastically significant at 5% level of significance.

Therefore the post test level of self esteem and assertive behaviour of experimental group is significantly higher than the control group, the assertiveness training programme was effective to build self esteem and improve the assertive behaviour of adolescent girls.

Hence, H_1 and H_2 is accepted and H_0 Rejected.

Table:- 4 Comparison of the mean level of self esteem and assertive behaviour scores between post test 1 and post test 2 among adolescents girls in experimental group. (N=80) P<0.05

GROUPS / t TEST	EXPERIMENTAL GROUP (Self esteem Score)		EXPERIMENTAL GROUP (Assertive behaviour scores)	
	Post test 1	Post test 2	Post test 1	Post test 2
MEAN SCORE	20.78	21.20	23.28	23.98
SD	3.526	3.797	6.653	6.241
MEDIAN SCORE	20.5	20	23.5	24
MEAN PERCENTAGE (%)	69.25	70.67	25.86	26.64
MEAN % DIFFERENCE	1.4		0.8	
MEAN DIFFERENCE	0.425		0.700	
t TEST VALUE	1.681		2.014	
P VALUE	0.1009		0.0509	
TABLE VALUE AT 0.05	2.02			
RESULT	Not Significant			

P<0.05

Table 4, shows the comparision of the mean level of self esteem and assertive behaviour score between post test 1 and post test 2 among girls in experimental group.

The mean level of self esteem score in both post test 1 and post test 2 are 20.78 and 21.20 respectively. The mean difference is 0.425 and the obtained 't' value is 1.681(p=1.1009). It is found stastically not significant at 5% level of significance.

The mean level of assertive behaviour score in both post test 1 and post 2 are 23.28 and 23.98 respectively. The mean difference is 0.700 and the obtained 't' value is 2.014 (p=0.0509)

Eventhough the result is not significant, a small increase of mean level of self esteem and assertive behaviour score in post test 2 according to post test 1 shows the gradual building up of self esteem and the assertive behaviour among adolescent girls is consolidating while time progress.

Objective 4 :- To find out the association between the mean difference of level of self esteem and level of assertive behaviour among adolescent girls with their selected socio demographic variables in experimental and control group.

In pretest level of self esteem score selected socio demographic variables father's occupation, mother's occupation, family income per month the 't' value is 4.708, 6.425, 3.871 respectively. Hence they are found **statistically significant** at 0.05 level of significance.

In pretest level of assertive behaviour score the selected socio demographic variables socio-demographic variable religion have the 't' value 2.213 respectively and was found **statistically significant** at same 5% level of significance.

Table: 5 Association of pretest level of self esteem score with selected socio demographic variables among adolescent girls in control group.

S.NO.	Sample Characteristics	n	Mean	SD	DF	P Value	F/T Test
1.	Age (in years)						
	a) 13-14 years **b)** 15-16 years **c)** 17-19 years	15 15 10	15.60 13.20 10.60	2.59 2.83 1.65	2/37	0.000	12.165*
2.	Father's Occupation status						
	a) Unemployed	11	10.64	1.75			
	b) Self-employed	15	14.93	2.74	3/46	0.001	6.425*
	c) Private	14	14.07	3.05			

*- Significant at 0.05 Level NS- Not Significant at 0.05 Level.

Table 5, depicts that age, father's occupation were significantly associated with the pretest level of self esteem score in control group but no variable was significantly associated with pretest level of assertiveness behavior in same group.

DISCUSSION

The results of this study indicated the self esteem and assertive behavior after the assertiveness training programme had a significant positive effect and this is consistent with the previous findings that indicated assertiveness training programme had a significant effect on experimental group. In support of the pretest level of self esteem Nagar S, Sharma S, Chopra G, (2008) conducted a study on self esteem on 112 adolescent girls in Kangra district of Himachal Pradesh.[8] The findings of the study is supported by Mahmoud S, Hamid RA (2013) to determine the effectiveness of assertiveness training on self esteem and assertiveness in adolescent girls of secondary school, which is a quasi- experimental study and used the tool Rosenberg self esteem Scale and assertiveness inventory[9]

Another study which supports the present study was conducted by Tannous, Adel G, Alkhawaldeh,

Mohammad K (2011) to assess the effect of assertiveness training in improving self esteem and shows that there was a significant difference in favour of experimental group on self esteem[10] Rezan A, Ero C, Zengel M (2009) to assess the effectiveness of an assertiveness training prograame on adolescent girls assertive level, which was also a quasi experimental study where, they used the Rathus assertiveness schedule as tool and the ANCOVA analysis results have shown that assertiveness training was effective on adolescents assertive level.[11]

CONCLUSION

It is concluded that the assertiveness training is effective in building the level of self esteem as well as improving the assertive behavior among adolescent girls and the findings also reveals that it improve while time progress

LIMITATIONS

- There was no randomization and study was limited to 80 adolescent girls only.
- The study was limited to adolescent girls in selected senior secondary govt. schools of District Panipat, Haryana.

RECOMMENDATIONS

- The study can be replicated on large samples and can be initiated through a long term time series research design.
- A comparative study can be carried out by comparing assertiveness behavior therapy with any other therapy for building self esteem and assertive behavior.

Ethical Clearance – Taken from Ved Nursing College Baroli, Paniapt (Haryana)

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Conflict of Interest - Nil

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In Defense of Defending Reduction in Age Bar of Adolescents in Case of Heinous Crimes – An Indian Perspective

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ABSTRACT

Psychological human development generally occurs during the period from puberty to legal adulthood (age of majority). Adolescence is a transitional stage of physical, psychological and emotional development[1,2,3]. The period of adolescents is most closely associated with the teenage years [4,5] though its physical, psychological and cultural experiences may begin earlier and end later. For example, although puberty has been historically associated with the onset of adolescents' development [6] it rather typically begins prior to teenage years and there has been a normative shift of it occurring in pre-adolescence, particularly in female (precocious puberty)[7] physical growth, as distinct from puberty (particularly in males), and cognitive development generally seen in adolescence, can also extend into the early twenties. Thus chronological age provides only rough marker of adolescence and the authors can say that reason may be attributed to less parental control and heightened desire to experiment and explore the unknown. This paper dwells upon multiple factors that are contributory to crime.

Keywords: *heinous crimes, adolescence, Juvenile Justice Act (JJA), age bar, reduction*

INTRODUCTION

Possible attributive factors: The juvenile offender is deemed to be treated under the Juvenile Justice Act. The board is aided by experts in making that decision. For many offenders, the root of criminality lay in adolescence. Important differences between the adolescence of criminals and that of others may lie even at birth. There may be some partials factor involved in future criminality. Criminality is possibly the result of poor parenting, learnt from parents and others, encouraged by some types of community and affected by the differential opportunities for crime available in some types of community. The new juvenile justice (care, protection of children) bill, 2015 has a provision that allows juvenile accused aged between 16-18 years and who is accused of heinous crime like rape, murder etc. to be tried under the Indian Penal Code.

According to the proposed law, matters are to be presented to the Juvenile Justice Board on case- by-case basis, which shall be decided - based on assessment of the mental states of the adolescences as it is assumed that they may have committed heinous crime without an understanding of its consequences. The Act provides for a special approach towards the prevention and treatment of juvenile and provides a framework for the protection, treatment, rehabilitation of children and adolescences in purview of the juvenile justice system. The law, brought in compliance of the 1989 UN Convention on the Rights of the Child (UNCRC), repealed the earlier Juvenile Justice Act of 1986 after India signed and ratified the UNCRC in 1992. This act has been further amended in 2006 and 2010.

Juvenile Justice Act was enacted by our parliament in order to provide care, protection, treatment, development and rehabilitation of neglected or delinquent juveniles and for the adjudication of certain matters relating to disposition of delinquent juvenile as a uniform system of juvenile justice mechanism throughout our country [8].

Under the Acts of 1986, Section 2 (a) defined the term juvenile as a boy who has not attained the age of 16 years and girls who has not attained the age of 18 years, but later on the parliament enacted juvenile justice

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Act 2000 and the age bar was raised to 18 years for both girls and boys. The Juvenile Justice Act, 2000 lays down that juvenile in conflict with law may be kept in an observation home during the pendency of proceedings before the competent authority. This provision in contradistinction with the earlier Acts which provides for keeping all children in an observing home during the pendency of their proceedings, presuming children to be innocents till proved guilty of crime. And juvenile justice Acts 2000 immunes the child who is less than 18 years of age bar at the time of the commission of the alleged offence and from trial through criminal court or any punishment under criminal law in view of Section 17 of the Juvenile Act. Statistically speaking heinous crimes by minors are on the rise among other crimes committed by juveniles from 2002-2012 as per the figures made public by the National Crime Records Bureau (NCRB). There have been a 143% increases in the number of rapes and murder by juveniles. In the same period, murder, rape and aggravated sexuality offenses committed by minors went up by 87% while there has been a whopping 500% increase in the number of kidnappings of women and females by minors and heinous crimes like rape and murder added just about 8% of total spectrum of crimes by minors [9].

DISCUSSION

Possible attributive factors associated with adolescence in case of heinous crimes:

1-Precocious puberty:

The precocious puberty is a biologically-driven development transition with complex secondary effect on social, emotional and sexual developments [10]. Inter individual variation in the timing of puberty process creates a period of contrast in which same-age males and females differs significantly with respect to highly salient physical attributes such as menses, distribution of subcutaneous fat, waist ratio and body hairs. Females mature earliest are at go more risk factor for a range of psychological, behavior and social problems in adolescence, including higher rates of conduct problems e.g. substance drugs- related problems[11] and precocious sexuality[12]. Most of the evidences also suggested increased risk of adolescents' depression, anxiety and general emotional problems and other evidence is mixed in relation to educational outcomes[13]. The period of increased risk persists across adolescence even after later-developing peers have physically matured[14]. But sometime I can say that adolescence in early maturing males and females to show higher levels of self-reported criminality, substance use problems like drug-addiction and abuse, social isolation, early sexual behavior and psychiatric problems. By young adulthood most of these differences had attributed like functioning for early matures improved in some areas- a phase of recovery. Early matures were also more likely to have had mainly sexually partners. The effects of early pubertal living on adolescent psychosocial and psychological problems are reported to be wide ranging.

2- **Intake of healthy food:**

There are major gaps in our understanding of the way shifts in the physical and social environments affects changes in dietary due to intake of healthy food. Physical activity patterns and weight change. Some researcher suggested that intake of healthy food and involved substance drugs and soda may be linked to violence in young people. Heavy soda drinkers were much more prone to violent behavior than other criminal adolescents.

3- **Fast communication and heightened awareness:**

Fast communication and increase in the awareness of societal change may adversely affect the behavior of adolescents. Though literature is lacking on this topic but the possibility cannot be altogether waived off.

It may be acknowledged that there are many regulations introduced by the government designed to curb crime. Punish criminal is a recognized function of all civilized states for countries. But with the changing, patterns of modern societies, the approach like deterrent, retributive and reformation of punishment effective in all such conditions in which the criminal committed crime in ignorance and compelled by circumstances or where this criminal tendency is aided to a considerable degree by mental or physical aberration. But the reform of criminal who willful violates moral laws is not so easy a proposition. Penologists are concern with crucial problems about the quantum of punishment to be meted out of juveniles.

In 1977, a survey showed that two or third of polish citizens were not afraid of crime in the slightest[15]. Another quarter said that they were rarely afraid of

crime. The researcher can be little contradictory at first sight. Increasing crime figures are a seemingly objective indication that society is disintegration, that people cannot be believed anymore and that neighbors no longer care. There was a time when doors did not have to be locked for fear of burglars. Whether or not there was such a golden age free from crime has little's relevance to modern experience. The fear of crime touches people emotionally in all sorts of unexpected ways. There is little that is common sense or predictable in the fear of crime- the research findings tend to be complex or superficially at least, a little inconsistent. I can say that; fear of crime is not clearly related to the statistical risk of being a victim of crime.

SUMMARY

There are three main ways in which the fear of crime might be effective:

1- Our direct knowledge about crime in the immediate community and beyond, this may include personally being victimized, member of our family being victimized.

2- The fast communication heightens awareness and the mass media contain a lot of crime news. Our beliefs about crime may be affected from those sources. A number of difficulties are involved when considering this possible connection. Media crime news is massively selective in favors of the more serious and sensational crime [16,17].

Generally speaking, it is difficult to find a correspondence between the fast communication and media of an individual chooses and their perception of levels of crime.

3- People tend to read little of the crime mass media and newspaper available to them [18]. So it is somewhat unpredictable what information they become aware of another aspect of our personality and social characteristics may wake us more or less fear of crime. For example, researcher suggested that fear of victimization at home related to factor such as feeling lonely, having poorer educational standards and believing that one's lives among neighbors who are not trustworthy and lack of vigilance when it comes to crime [19]. Yet when look to show that, statistically the most likely to be victim of violence the victims turnout to be much the group as late adolescents and early adult years- the very group least bother by the risk of being victimized. But we can say that women seen to have higher levels of fear of crime than males. Feminists have claimed that women are discouraged from being independent through being inculcated with a fear of an unpredictable attack by a stranger [20]. But men are actually most at risk factors of attack in public places.

4- Judicial dispensation fast and effective.

5- Policing should be wide.

6- The quantum of punishment for the second or more offense should be three times than for the first offense.

CONCLUSION

With the above ongoing discussion it is presumably important to realize that crimes by adolescents need to be curbed and restricted. This can only happen when the punitive action is swift, predictable, and definite. The physical development and electrifying communication cannot be reined for this section of society. Hence, the lowering of age for heinous crimes by adolescents is fully justified. However, let there be a massive debate before the law may be amended. Justification is there. Social acceptance of the proposed change has to be attained without the least murmur, only then the principle of legal harmony in conformation to societal change would be acceptable.

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Targeted Approach to Reduce Teen Smoking

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ABSTRACT

The purpose of this article is to review current knowledge regarding teen smoking initiation and identify relevant strategies to reduce incidence. This evolved from research focused on differences among smokers, resisters, and smoking naives of a convenience sample of 328 Asian Americans aged 16-19 in New York City. This study identified that adolescents who smoke do so to be liked and fit in; to make friends, and because they are curious and want to experiment. The authors focused on identifying specific strategies focused on socialization, conformity and experimentation. Clearly more research involving this and other adolescent groups is needed to decrease smoking usage in the future.

Keywords*: Asian American and Pacific Islander Adolescents (AAPI) Smoking Initiation, Conformity, Acculturation, Experimentation*

INTRODUCTION

One important goal of research is to identify patterns of behavior so that deleterious ones can be changed. As part of a comprehensive research study focused on smoking and Asian-American adolescents interesting information was discovered regarding the reasons these youth initiate cigarette smoking.

What are some of the commonly reported reasons why youth smoke?

1. Their parents smoke- certainly growing up in a home where the adults smoke increases the likelihood that the children will also smoke.

2. Their friends smoke. Previous authors reported that Asian American children who didn't want to make others smoke alone were more than five times more likely to have smoked than Asian American children who did not engage in this behavior.

3. Other studies suggested that many adolescents start smoking because they want to fit in. Adolescents in this situation all have to deal with "peer pressure" and most will be asked by their friend at one time or another to smoke with him/her. Since everyone wants to fit in with their friends they will most likely be too afraid to say no when their friend asks them.

4. A belief that smoking could help them lose weight. Although frequently reported this response is not validated by research.

5. In the process of researching smoking behavior among Asian-American adolescents in New York City, a high rate of depressive symptoms was discovered in both smokers and nonsmokers who prompted the investigators to explore the correlates of depression among the Asian-American adolescents. Cultural marginalization is significantly related to depressive symptoms in Korean, Chinese, and Japanese- American adolescents and the parents in the US[1]. Depression and language acculturation correlate with smoking among Asian-American adolescents in NYC[2].

BACKGROUND

Reports from the CDC[3] national report on teen tobacco use indicated that the lifetime prevalence of ever having smoked a cigarette was 58.4% of high school students in 2003, down from 70.1% in 1991. The report also stated that 22% of high school students report that they are current smokers. Asian/Asian American and multiethnic middle school youth are at increased risk for

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smoking initiation compared with other ethnic middle school youth, especially as they move on to high school[4]. It appears that tobacco prevention programs may not be reaching significant portions of the United States' ethnically diverse middle school populations.

Chen et al[5] reports that adolescents from various ethnicities not only demonstrate differing rates of tobacco usage but additionally respond in differing ways to pro-tobacco media. The challenge of promoting tobacco prevention among Asian American youth in the United States is compounded by a more global problem that of tobacco use in Asia and the Pacific Islands. According to estimates of Jha and colleagues[6], the highest percentages of smokers 15 years and older reside in East Asia and the Pacific.

Asian Americans are one of the fastest growing major racial/ethnic groups in the United States with a 43% population increase from the 1990s to year 2000; this group accounts for 4.3% of the population nationwide[7]. Because 67% of the AAPI population is foreign born, tobacco use overseas may have a major impact on use among AAPI groups in the United States[8]. Unfortunately, there is still very limited published information on tobacco use among AAPIs particularly in terms of smoking initiation among Asian American adolescents[2]. Many more studies are needed in order to gain a better understanding of the smoking initiation and behaviors of Asian American adolescents.

Adolescents smoke for many of the same reasons that they use alcohol and other abusive drugs[2]. Initiation of tobacco use may be more closely associated with environmental factors--parents', siblings', and peers' smoking, and exposure to media advertising[8, 9], while progression from the first cigarette to additional cigarettes appears to be more influenced by personal and pharmacologic factors[10,11,12].

Initiation and prevalence of smoking among adolescents typically rises with increasing age and grade[4]. Although historically, the prevalence of smoking has been higher among men than women, data collected in the past 10 years reveal that the rate of smoking and initiation to smoking are now approximately equal for the two genders[6].

The high rates of cigarette smoking and experimentation with other behaviors in adolescents may result from transitional or maturational processes. Erikson's (1963) psychoanalytical view posits that behaviors are a result of developmental crises. Adolescents are transitioning from child to adult. During this period, the adolescent hopes to attain autonomy from the family and to develop a sense of personal identity as opposed to role confusion[13]. It is during this period that the adolescents struggle to develop an individual sense of identity, and smoking may be part of developing that new identity.

In addition, Bandura's social cognitive theory[14] explains that it is through the complex interaction between environmental (family and peer influence); personal (age, gender, ethnicity and acculturation, living arrangements, family size, and socioeconomic status); and behavioral factors (hopelessness, low self-esteem, social skills, communication skills, and refusal skills); that one can explain the intricacy of human actions such as cigarette smoking.

METHOD

This survey study concerning the first smoking experiences of Asian American adolescents was conducted at several organizational sites in New York City (NYC) that serve Asian American adolescents. Affiliates and liaisons of the organizations helped recruit study participants and assisted in administering the questionnaires. The data-gathering procedure at each participating organization was slightly different and was tailored according to participants' availability. Participants were recruited from the members, friends, and affiliates of an Asian American mentoring organization that provides test preparation classes for the Scholastic Aptitude Test (SAT) for high school students; from patrons of an eatery in Bayside, NY, where a large number of Asian American teenagers were known to meet and socialize with friends; from an Asian American human services organization providing youth programs; from college-related Asian American fraternities in the NYC area; and from a church-related Asian American organization in Queens, NY.

PARTICIPANTS

A total of 328 Asian American adolescents--from 16 to 19 years old, who lived in NYC--participated in the study. There were more female participants (n = 179) than male participants (n = 149) in the study. The mean age of the participants is 17.2 (SD = 1.13). A small number of participants marked themselves as "multiethnic" (n = 2) and *other* (n = 4). These participants were collapsed into

a single *other* category, along with Japanese American (*n* = 1) and Vietnamese American (*n* = 2) participants, owing to their small number. Approximately 60% (*n* = 196) of participants were born in the United States, whereas all other participants were born outside of the United States.

PROCEDURE

Letters of support were obtained from the Asian American organizations (except from the eatery site), which indicated their willingness to recruit participants and provide space for data collection. Liaisons and representatives from the organizations were instructed and trained to give a brief explanation to participants about the study and about how the questionnaires would be administered.

Most of the challenges in the data collection involved getting the parents to sign the parental consent forms. The 16–17-year-olds were eager to participate in the study but were hesitant to have their parents sign the consent forms. In most instances, though, the liaisons were able to convince the skeptical adolescents to obtain their parents' consents to participate in the study. The participants were told that the study was conducted with full regard for the protection of the rights of human participants and the approval from Columbia University, Teachers College Institutional Review Board (IRB), for the study of human subjects.

The self-administered questionnaires took approximately 20–40 min to complete. The questionnaire packet included: *Demographic Questionnaire, Smoking Opportunity Survey Questionnaire, Smoking Experience, Nine-item Reasons Why Kids Smoke for the First Time Survey*.

LIMITATIONS

There are several limitations of this study. The generalizability of the findings may be limited in several ways because of the nature of the sample. First, the study used a convenience sample of Asian American adolescents living in New York City. While useful in understanding factors affecting first smoking experiences of Asian American adolescents in New York City, the data would only represent the experiences of those who volunteered to participate in the study

Second, the study was based on retrospective accounts of the actual and imagined first smoking experiences of the adolescents and the reliance upon the adolescents' memory of the first smoking experiences may be flawed. Eleven percent (n = 36) of the adolescents could not recall the details regarding their first cigarette use or the first resisted smoking opportunity. Third, the survey questionnaires are based on self-reports, caution should be exercised when interpreting the data since the adolescents may not be truthful about their responses. In addition, the data may be biased by selective recall.

Our research yielded these results:

Adolescents who smoke identified these reasons for initiating smoking:

- Wanted to fit in; be liked by others (conformity)
- Wanted to make friends (socialization)
- Wanted to see what it was like (experimentation).

Our next step is to design a targeted prevention program.

Our prevention program is focused on the three identified categories[15,16,17,18]:

Conformity: It is a typical response of adolescents to want to fit in; and be liked by their peers. Thus the strategies need to target both individual needs of conformity as well as group needs.

1. Parents need to ask their teen how he or she feels about smoking and if any friends smoke. Ask if your teen has felt pressured to try smoking. Ask how many friends do and do not smoke. What are some of the reasons these friends give as to why they smoke? Discuss if your teen thinks these reasons are valid. Teens can be very insightful.

Tell your teen that you do not approve of smoking. It is especially helpful if you and your spouse do not smoke. If you do, be honest about the reasons why; as well as the consequences of your smoking. Be honest about the costs: money-wise, appearance-wise and health wise. Do not smoke in your home; and do not smoke in front of your teen. Discuss the addictive nature of cigarette smoking and the challenges of quitting.

Help your teen decide how to respond to peer pressure. Rehearse possible responses.

2. Schools need to have open discussions whether

within classes or groups; whether by teachers of the school nurse. Discuss the consequences of smoking on one's health. Also talk about pressures to smoke- from friends; from advertisements; from media. Discuss the students' perceptions of smokers: cool; glamorous; famous. Create group discussions; role play situations. Consider inviting smokers to talk about their negative experiences. Involve teens in campaigns to decrease smoking- creating posters; discussion groups- this can help to solidify their resolve not to smoke.

SOCIALIZATION

This is complicated by the acculturation process for Asian-American adolescents. Acculturation is a selective process of deciding to accept aspects of another culture while trying to retain important aspects of one's own culture.

1. Identify role models for this group. Determine what messages these role models provide. If positive, reinforce. If these role-models smoke discuss the teens' perceptions of this behavior. It may take time to elicit these responses and guide the teens in such a discussion.

2. Depression can play a role in the acculturation process if the transition is difficult. Research has indicated an increased risk of smoking among depressed adolescents. It is important to screen for depression; and provide treatment if discovered.

3. Community organizations need to play a role in ensuring that the environment is smoke-free and monitor the types of pressures adolescent participants are exposed to in their setting.

4. Engage local sports and media to reduce images of teen smoking and to deliver positive messages. 5. Also engage tobacco companies to ensure that there are clear health warning labels on cigarette packages; and ensuring that the design of the cigarette package is not attractive (plain). This includes colors, pictures, etc.

EXPERIMENTATION

Adolescence is a time of experimentation; in fact the developmental task based on Erikson's theory involves adopting one's identity through a process of trying on differing roles.

1. Restricting access by higher prices; increasing age for purchase; random law enforcement checks to ensure that all purchasers provide proof of age. Increase smoke-free zones not only in public buildings but all parks and venues where teens may congregate.

2. Create community resources for teens that promote healthy behaviors and decision making- after-school programs; community sports, technology, and social groups; volunteer sand community-service opportunities for teens.

3. Engage parents and teachers in early identification and harm reduction communication.

4. Create new, and enhance existing, community groups for all newly immigrated youths, families to ensure that they are aware of community resources and services.

Use innovative technology to engage youth. As reported by Tanjasiri[19] et al geographic mapping and photovoice use by AAPI community-based organizations resulted in identification and plans to address youth tobacco smoking. This approach is very interesting since many adolescents today are technology sophisticated and thus more likely to be involved.

CONCLUSIONS

This approach evolved from previous research into factors why this group either initiated or resisted first smoking experience. Clearly more research involving this and other adolescent groups is needed to decrease smoking usage in the future.

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Effectiveness of Psycho-education Regarding Eating Disorders on Knowledge among Adolescent Girls

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ABSTRACT

Introduction: Eating disorders are psychiatric illnesses characterized by an all-consuming desire to be thin, concerned about distorted body image and an intense fear of weight gain that are affecting adolescent girls with increasing frequency. Due to the inadequate knowledge they are following wrong techniques such as over dieting, misuse of laxatives and over exercising that may results in other somatoform disorders like malnutrition, anaemia. **Aim of the study:** To assess the effectiveness of psycho-education to bring a significant change in the knowledge of adolescent girls regarding eating disorders. **Method and material:** True experimental research design, pre test post test control group design was used to conduct the study. A structured knowledge questionnaire was used to collect data. Sample included 30 adolescent girls in experimental and 30 adolescent girls in control group, was selected by simple random method i.e. lottery method. The data collected before and after the administration of psycho-education programme were analyzed using descriptive and inferential statistics. **Results:** Pre-test mean level of knowledge in experimental group and control group was 9.40 and 8.57 respectively. The post-test mean level of knowledge in experimental group and control group was 8.57 and 11.13. Hence, statistically mean level of knowledge of both groups was significant. But mean difference in experimental group was more than that of control group in post-test. **Conclusion:** The overall findings of study revealed that there was significant increase in the knowledge of adolescent girls after administration of planned psycho-education programme. Hence it is concluded that the planned psycho-education programme was highly effective in improving the knowledge of adolescent girls.

Keywords: *Knowledge, adolescent girls, eating disorders, psycho-education.*

INTRODUCTION

An eating disorder is a psychiatric illness characterized by an all-consuming desire to be thin, concerned about distorted body image and an intense fear of weight gain. Eating disorders can cause dangerous medical problems. The fear of weight gain is so great that the person may feel compelled to either limit food intake to dangerously small amounts or to use other compensatory methods (laxatives, vomiting) to control weight. The onset of an eating disorder typically occurs during pre-adolescence or adolescence. Therefore, it is vital that parents and educators make a conscious effort to be aware of this problem and to be prepared to provide support when needed.[1]

Many kids, particularly teens, are concerned about how they look and can feel self conscious about their bodies. This can be especially true when they are going through puberty, and undergo dramatic physical changes and face new social pressures.[2]Now a day more adolescent girls (13-21 years) are more concerned towards the physical maintenance of the body. Due to the inadequate knowledge they are following wrong techniques such as over dieting, misuse of laxatives and over exercising that may results in other somatoform disorders like malnutrition, anemia.[3]

Knowledge of what to eat and in what quantities is a pre-requisite to healthy and happy life. As such, eating is a crucial self regulatory activity. However, it can also assume importance and meaning beyond that of nutrition and become associated with biopsychosocial processes that promote or inhibit adaptive functioning. As a pattern of self regulation, properly controlled eating contributes to psychological, biological and sociocultural health and

well-being. Adaptive eating responses are characterized by balanced eating patterns, appropriate caloric intake and body weight that are appropriate for height.[4]

Adolescence and young adulthood is recognized as a period of heightened risk for the development of eating disorders. International epidemiological studies estimate 75% of anorexia nervosa (AN) and bulimia nervosa (BN) cases onset before the age of 22.[5] Eating disorders are recognized as a significant public health issue with Australian data indicating that they represent the second leading cause of disability due to mental disorder in females aged 10–24 years.[6]

Nutritional intake during adolescence is important for growth, long term health promotion and development of lifelong eating behaviour. Nutritional intake during this period may have long term health implications. Meal pattern of adolescents are often chaotic. Several physical, psychological and behavioural changes may affect food habits during adolescence and long term consequences on adult health status.[7]

The above facts clearly show that adolescent girls are more concerned towards the physical maintenance of the body. The school environment is a suitable place to implement health promotion programs because adolescent students are accessible and motivated to become involved in educational activities, thus the researcher felt that it is important to create awareness and provide adequate knowledge regarding eating disorders and its management to adolescent girls in schools.

MATERIAL AND METHOD

The present study was conducted by quantitative research approach with true experimental, pre test post test control group design at selected private senior secondary schools of District Sri Muktsar Sahib, Punjab.

After random assignment of schools in experimental and control group, sample was selected by simple random method i.e. lottery method like the list of adolescent girls studying in 12th standard were taken from each school and the slips were made and the 60 subjects were selected by lottery method from the schools (30 in experimental group and 30 in control group). Dependent variable was knowledge level of adolescent girls and independent variables was psycho-education programme. Ethical approval for the study was taken from the college and university. Permission from various concerned schools was taken before data collection. Written consent was taken from subjects. The research tool for data collection consists of two parts:

Part I: Socio-demographic profile: It consists of items seeking information pertaining to the selected variables of adolescent girls such as age, residence, 10+2 stream, type of family, religion, family monthly income, source of information regarding eating disorders and hobbies.

Part II: Structured knowledge questionnaire: This part consists of multiple choice questions regarding eating disorders. The total of 30 questions was included and each question carries 1 mark and unanswered and incorrect answer carries 0 marks. So, maximum score was 30 and minimum score was 0.

Reliability was established by split half method and it was 0.82, thus the tool was found to be highly reliable. To ensure content validity of the tool, it was submitted to experts in the field of mental health and language experts in English and Punjabi. The intervention (psycho-education programme) was developed and procured from the internet source, books, discussion with supervisor and co-supervisor and was administered to the experimental group for 45 min.

Formal administrative approval was obtained from the principals of schools. Sixty subjects were assigned by simple random sampling technique i.e. lottery method (30 adolescent girls in each group) in experimental and in control group from randomly selected schools. Pre test of experimental group as well as control group was conducted by using structured knowledge questionnaire after obtaining consent. Psycho-education programme was administered to experimental group only. No intervention was given to control group. Statistical analysis was done through differential and inferential statistics using SPSS 18 where $p<0.05$ was considered as significant.

RESULT

Table 1 shows that in relation to age, majority of adolescent girls was in age group of 17 years but in control group it was in age group of 17 and 18 years. In accordance to residence, majority of adolescent girls was from rural area in both experimental and control group. In relation to 10+2 stream, majority of adolescent girls was of arts group in both experimental and control group. With regard to type of family, in experimental group

majority of adolescent girls was from nuclear family whereas in control group it was from joint family. In relation to religion, majority of adolescent girls was Hindu in experimental group whereas in control group it was Sikh. In respect to family monthly income, majority of adolescent girls was less than 10,000 rs, in both experimental and control group. In relation to source of information regarding eating disorders, majority of adolescent girls was from family & friends in both experimental and control group. In accordance to hobbies, majority of adolescent girls was reading books in both experimental and control group.

It was also found that both the groups were same and comparable at base line except their residence, religion, type of family and source of information regarding eating disorders.

Table 1: Frequency and Percentage distribution of selected demographic variables of sample and baseline comparison of experimental and control group N=60

Variables	Experimental group (n=30)	Control group (n=30)	χ^2 df p value
	f (%)	f (%)	
Age (in years)			
16	2 (6.7)	3 (10.0)	1.734
17	18 (60.0)	13 (43.3)	df=3
18	9 (30.0)	13 (43.3)	p= 0.629^{NS}
19	1 (3.3)	1 (3.3)	
Residence			38.571
Rural	4 (13.3)	28 (93.3)	df=1
Urban	26 (86.7)	2 (6.7)	p= 0.001***
10+2 stream			
Arts	20 (66.7)	13 (43.3)	
Medical	2 (6.7)	9 (30.0)	7.006
Non medical	8 (26.7)	7 (23.3)	df=3
Commerce	0 (0)	1 (3.3)	p= 0.072^{NS}
Type of family			
Joint	12 (40.0)	21 (70.0)	5.976
Nuclear	16 (53.3)	7 (23.3)	df=2
Extended	2 (6.7)	2 (6.7)	p= 0.050*
Religion			
Sikh	13 (43.3)	25 (83.3)	10.551
Hindu	16 (53.3)	5 (16.7)	df=2
Christian	1 (3.3)	0 (0)	p= 0.005*
Family monthly income (in Rs.)			
10,000	15 (50.0)	12 (40.0)	
10-001-20,000	5 (16.7)	9 (30.0)	1.619
20,001-30,000	6 (20.0)	6 (20.0)	df=3
above 30,001	4 (13.3)	3 (10.0)	p= 0.655^{NS}
Source of information regarding eating disorders			
Family & friends	24 (80.0)	16 (53.3)	
Radio & television	0 (0)	8 (26.7)	15.600
Magazines & newspapers	6 (20.0)	2 (6.7)	df=4
Internet & social sites	0 (0)	4 (13.3)	p= 0.004*
Any other specify…	0 (0)	0 (0)	
Hobbies			
Playing games	4 (13.3)	9 (30.0)	
Listening songs	11 (36.7)	3 (10.0)	7.495
Watching T.V	3 (10.0)	6 (20.0)	df=3
Reading books	12 (40.0)	12 (40.0)	p= 0.058^{NS}

Level of significance $p<0.05$.

Assessment of pre test and post test level of knowledge in experimental group and control group

It represents that during pre test of experimental group majority 22(73.3%) and in control group majority 26(86.7%) were in poor category, whereas during post test in experimental group majority 18(60%) was in average category and in control group majority 15(50%) was in both average and poor category.

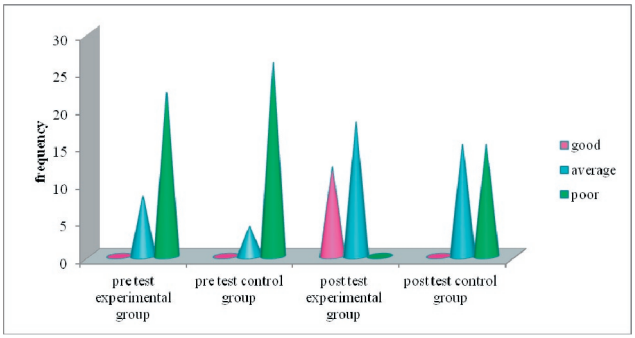

Fig 1: Comparison of pre test and post test level of knowledge in experimental group and control group

Table 2: Comparison of the pre test and post test level of knowledge in experimental group and control group (N=60)

Group	Pre test Mean±s.d	Post test Mean±s.d	t-test, df, p value
Experimental (n=30)	9.40±2.621	20.20±3.078	t=25.941, df=29, p= .000***
Control (n=30)	8.57±1.995	11.13±2.432	t=1.612, df=29, p=.000***

Table 2 depicts that in experimental group during the pre test mean± SD is 9.40±2.621 and during post test mean± SD is 20.20±3.078 (t=25.941, df=29, p value= .000) showing significance at the level of $p<0.05$. So it is concluded that there was a significant difference between pre test and post test level of knowledge in experimental group and planned teaching programme seems to be effective in improving knowledge of adolescent girls regarding eating disorders.

Findings of association of pre test knowledge level with the selected demographic variables of experimental and control group shows that there was no significant association at level p=0.05 of pre test knowledge level with selected demographic variables of adolescent girls.

DISCUSSION

Findings of the present study revealed that the pre-test mean knowledge was found to be 9.40 and 8.57 in experimental group and control group respectively. It is supported by a similar study by Shriharsha C (2014)[8] revealed in a pre-experimental one group pre-test, post-test design study that knowledge mean score of pre-test was 8.92 which depicted that adolescent girls had poor level of knowledge.

Findings of the present study revealed that the post-test mean knowledge was found to be 20.20 in experimental group and 11.13 in control group respectively. These results were supported by a similar study by Shriharsha C (2014)[8] to assess the effectiveness of planned teaching programme on eating disorders revealed that knowledge mean score of post-test was 19.42 which depicted that the level of knowledge of adolescent girls increased from poor to good.

The findings of the present study revealed that in experimental group and control group there was no significant association of pre test knowledge level with selected demographic variables of adolescent girls. It was similar to the study conducted by Praveena PS (2013)[9]which revealed that there was no significant association of level of knowledge on eating disorders among adolescents between other selected demographic variables like age and type of family.

IMPLICATIONS AND RECOMMENDATIONS

As the findings of the present study concluded that education regarding eating disorders is important for the adolescent girls so it is then important for the staff nurses that they should also have the detailed knowledge about this aspect and they should be educated regarding this aspect so that they can impart knowledge to their adolescent patients on regular basis. Nurses and nursing students should conduct research and workshops on eating disorders among adolescents.

The study recommends that the study can be generalized by applying it on large sample. A descriptive study can be carried out to assess the knowledge of adolescent girls regarding eating disorders and other interventions can be used to improve the knowledge of adolescent girls like psychoeducation or web based education.

CONCLUSION

The present study concluded that most of the study subjects were having poor knowledge about the eating disorders. Adolescent students studying in schools should be regularly assessed for their knowledge regarding eating disorders. Planned psycho-education programme is effective in increasing knowledge of adolescent girls and it can be used in school setting by school health nurse.

LIMITATIONS

In present study attitude regarding eating disorders was not assessed. The size of sample was small i.e. 60, hence it was difficult to make a broad generalizations.

Conflict of Interest: None

Source of Funding: Self

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A Study to assess Care Givers Burden among Primary Care Givers in Selected Hospitals, U.K.

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ABSTRACT

Background of the study: Caregiver is an individual who has the responsibility of meeting the physical, psychological needs of the dependent patient. As the disease progresses, it carries with it a tremendous increase of burden on the caregiver who does the care giving. Care giving has been identified as a basic component of human nature and a primary element of close relationship. **Objectives of the study**: 1. Assess the care givers burden among primary care givers. 2. Categorize the range of four dimensions of care givers burden tool in three areas.3. Compare the four dimensions of care givers burden among three areas. 4. Compare the level of care givers burden among three areas. 5. Associate the level of care givers burden with selected demographic variables. **Materials & Method:** The investigator has selected descriptive research design & convenience sampling technique is a type of non-probability sampling was found for this study & the study was conducted among of 218 care givers in three areas. **Results & Conclusion:** The obtained data was analyzed and interpreted by descriptive and inferential statistics. The finding reveals that economical burden (55.1%) is high than other dimensions such as physical, emotional, and social, among three areas. This study concludes that care givers burden of medically ill patients (89.5%) were more than Pediatric and psychiatric patients caregivers. In Medical surgical & Pediatrics care givers there is no significant association between any of the variables. In psychiatric care givers there is significant association between short tempered, number of days hospitalized and remaining variables were not found to be significant at P 0.001 level

Keywords: *Caregivers, Burden, Dimensions.*

INTRODUCTION OF THE STUDY

Caregiver is an individual who has the responsibility of meeting the physical, psychological needs of the dependent patient. The term "caregiver burden" is used to describe the physical, emotional, and financial toll of providing care. As the disease progresses, it carries with it a tremendous increase of burden on the caregiver who does the care giving. Care giving has been identified as a basic component of human nature and a primary element of close relationship.[1.]

In India, since professional services both in public and private sectors are not adequately developed due to shortage of trained human resources and infrastructure, the family support system plays a major role in caring for people with mental illnesses.[2.] The vast majority of care givers 87% are what gerontologists refer to as "informal caregivers". More than 34 million unpaid care givers provide care to someone aged 18 and older who is ill or has a disability. According to (NAC 2004) survey (73%) of care givers are praying to cope with stress.

As per NAC record care givers having difficulty in finding time for one's self (35%), managing emotional and physical stress (29%), and balancing work and family responsibilities (29%).[3.] Many authors opine that the level of burden does not correlate with the duration of illness, but has enough variability with age, gender and educational status. Most care givers are spouses, parents, but family members and friends can also be care givers. The most common mental health consequences identified are depression, anxiety and burnout which occur when a caregiver slips beyond exhaustion or depression. [4.]

Studies conducted and showed that caregivers reported burden in different areas including effects on family functioning, social isolation, financial problems, and health. It is also known that caring for someone with psychiatric illness is associated with a higher level of

stress than caring for someone with functional impairment from other chronic medical illnesses.[1.]

A descriptive study was conducted to measure the burden of pediatric burn injury for parents and care givers. The study concluded that parental problems occurred during the child's initial hospitalization.[5.]In view of above consideration the researcher felt that the need to do the comparative study in three areas.

Statement of the problem: A study to assess care givers burden among primary care givers in selected hospitals, U.k.

OBJECTIVES

1. Assess the care givers burden among primary care givers.

2. Categorize the range of four dimensions of care givers burden tool in three areas.

3. Compare the four dimensions of care givers burden among three areas.

4. Compare the level of care givers burden among three areas.

5. Associate the level of care givers burden with selected demographic variables.

Materials and methods: The investigator has selected descriptive research design. The convenience sampling technique is a type of non-probability sampling was found appropriate for the study. Each caregiver was explained about the study and consent was taken. The setting for the study is Sushila Tiwari Medical Hospital, Haldwani. The Psychiatric sample included alcoholism (15cases), depression (24cases), bipolar disorder (3casses), Mania (16cases), OCD (7cases) and caregivers of patients suffering from chronic Medical illnesses such as infectious diseases(28), inflammatory diseases (26), malignancy (21), surgical case(1), also the pediatric sample included infectious diseases(34), inflammatory diseases (14), malignancy (1), disorder (28). The care givers were classified into three various departments such as Medical (76 cases), Pediatric (77 cases), Psychiatric (65 cases), totally 218 samples were included in this study. Care giver burden scale was administered to each care giver. The questionnaire was categorized into 4 dimensions such as physical, emotional, social, and economical. Each dimension consists of 5 items with item responses; each response was given a score from 0 to 3.

Tool for data collection*:* In the present study the tool consists of 2 parts.

Part-I: Demographic data.

Part-II: Comprises of questionnaire regarding care giver burden.

Analysis and interpretation: The data was collected from caregivers was analyzed and interpreted by descriptive and inferential statistics. Analysis was done based on the objectives of the study.

Table 1: Distribution of Demographic Variables of primary care givers. N= 218

	Pediatric	Medical Surgical	Psychiatric	Total
Age in years				
20-30 years	49(59.7%)	14(18.4%)	16(24.6%)	76(34.9%)
31-40 years	21(27.3%)	30(39.5%)	24(36.9%	75(34.4)
41-50 years	7(9.1%)	19(25.0%)	19(29.2%)	45(20.6%)
Above 50 years	3(3.9%)	13(17.1%)	13(17.1%)	22(10.1%)
Gender				
Female	31(40.3%)	43(56.6%)	44(67.7%)	118(54.1%)
Male	46(59.7%)	33(43.4%)	21(32.3%)	100(45.9%)
Diagnosis				
Infectious	34(44.2%)	28(36.8%)	0(0%)	62(28.4%)
Inflammatory	14(18.2%)	26(34.2%)	0(0%)	40(18.3%)
Malignancy	1(13.1%)	21(27.6%)	0(0%)	22(10.1%)
Disorder	28(36.4%)	0(0%)	0(0%)	28(12.8%)
Surgery	0(0%)	1(1.3%)	0(0%)	1(0.5%)
Alcoholism	0(0%)	0(0%)	15(23.1%)	15(6.9%)

Cont... Table 1: Distribution of Demographic Variables of primary care givers. N= 218

Bipolar	0(0%)	0(0%)	3(4.6%)	3(1.4%)
Depression	0(0%)	0(0%)	24(36.9%)	24(11.0%)
Mania	0(0%)	0(0%)	16(24.6%)	16(7.3%)
OCD	0(0%)	0(0%)	7(10.8%)	7(3.2%)
Educational status				
Literate	57(74%)	46(60.5%)	42(64.6%)	145(66.5%)
Illiterate	20(26%)	30(39.5%)	23(35.4%)	73(33.5%)
Occupation				
Daily wages	41(53.2%)	22(28.9%)	16(24.6%)	79(36.2%)
Govt. Employee	0(0%)	16(21.1%)	12(18.5%)	28(12.8%)
Private Employee	5(6.5%)	10(13.2%)	14(21.5%)	29(13.3%)
Business	4(5.2%)	9(11.8%)	23(35.4%)	36(16.5%)
Unemployed	27(35.1%)	19(25.0%)	0(0%)	46(21.1%)
Relationship with the care receiver				
Mother/Father	70(90.9%)	10(13.2%)	20(30.8%)	100(45.9%)
Son/Daughter	0(0%)	27(35.5%)	15(23.1%)	42(19.3%)
Husband/wife	0(0%)	34(44.7%)	17(26.2%)	51(23.4%)
Brother/sister	1(1.3%)	5(6.6%)	13(20.0%)	19(8.7%)
Grandfather	6(7.8%)	0(0%)	0(0%)	6(2.8%)
Cared ill patient				
Yes	44(57.1%)	36(47.4%)	33(50.8%)	113(51.8%)
No	33(42.9%)	40(52.6%)	32(49.2%)	105(48.2%)
Duration of illness				
Less than 1 year	70(90.9%)	48(63.2%)	26(40.0%)	144(66.1%)
1-3 year	4(5.2%)	24(31.6%)	26(40.0%)	54(24.8%)
3-5 year	0(0%)	2(2.6%)	13(20.0%)	15(6.9%)
More than 5 year	3(3.9%)	2(2.6%)	0(0%)	5(2.3%)
Hours of care per day				
1-3 hours	49(63.6%)	47(61.8%)	27(41.5%)	123(56.4%)
3-6 hours	28(36.4%)	29(38.2%)	21(32.3%)	78(35.8%)
6-9 hours	0(0%)	0(0%)	17(26.2%)	17(7.8%)
Physical Disability				
Yes	11(14.3%)	2(2.6%)	3(4.6%)	16(7.3%)
No	66(85.7%)	74(97.4%)	62(95.4%)	202(92.7%)
Short tempered				
Yes	24(31.2%)	50(65.8%)	29(44.6%)	103(47.2%)
No	53(68.8%)	26(34.2%)	36(55.4%)	115(52.8%)
Number of days hospitalized				
1 week	55(71.4%)	31(40.8%)	21(32.3%)	107(49.1%)
2 weeks	16(20.8%)	26(34.2%)	28(43.1%)	70(32.1%)
3 weeks	4(5.2%)	14(18.4%)	14(21.5%)	32(14.7%)
4 weeks	2(2.6%)	5(6.6%)	2(3%)	9(4.1%)

Demographic characteristics of the respondents: table 1 shows the Demographic distribution of characteristics of respondents in this majority of the respondents of Pediatric, Medical surgical Nursing, and Psychiatric, were in the age group of 20-30 yrs (59.7%), 31-40 yrs (39.5%), and 31-41 yrs (36.9%) respectively. With regard to the gender majority were in Pediatric, Medical Surgical Nursing, and Psychiatric, is male (59.7%), female (56.6%), and female (67.7%) respectively. The data on diagnosis reveled in Pediatric, Medical Surgical Nursing, and Psychiatric, majority

had infectious disease (44.2%), infectious (36.8%), and alcoholism (23.1%) respectively. Regarding the educational status majority respondent's of Pediatric, Medical Surgical Nursing, and Psychiatric, was literate (74%), literate (60.5%), and literate (64.6%) respectively. With regard to the occupation majority respondents of Pediatric, Medical Surgical Nursing, and Psychiatric, was daily wages (53.2%), daily wages (28.9%), and business (35.4%), respectively. Regarding the relationship with the care receiver majority were in Pediatric, Medical Surgical Nursing, and Psychiatric, mother/father (90.9%), husband/wife (44.7%), and mother/father (30.8%) respectively.

Among the cared ill patient majority had answered in Pediatric, Medical Surgical Nursing, and Psychiatric, yes (57.1%), no (52.6%), yes (50.8%) respectively. In duration of illness majority of Pediatric, Medical Surgical Nursing, and Psychiatric, less than 1 yr (90.9%), less than 1 yr (63.2%), and less than 1 yr (40%) respectively. The data on hours of care per day revealed that majority were in Pediatric, Medical Surgical Nursing, and Psychiatric, 1-3 hrs (63.6%), 1-3 hrs (61.8%), 1-3 hrs (41.5%) respectively. With regard to the physical disability majority had in Pediatric, Medical Surgical Nursing, and Psychiatric, no (68.8%), no (34.2%), (55.4%) respectively. Regarding the short tempered majority responded to Pediatric, Medical Surgical Nursing, and Psychiatric, no (68.8%), yes (65.8%), no (55.4%) respectively. With regard to the number of days hospitalized majority hospitalized in Pediatric, Medical Surgical Nursing, and Psychiatric, 1 week (71.4%), 1 week (40.8%), 2 weeks (43.1%), and respectively.

Table 2: Distribution of Overall score of mean, mean%, and SD value of primary care givers burden N=218

Mean	Mean %	SD
31.93	53.92%	8.344

Table 2 reveals overall primary care givers burden and the mean score is 31.93, mean percentage is 53.92%, and SD value is 8.344.

Table 3: Distribution of comparison of four dimensions with, mean, SD, mean percentage, and range in three areas (medical, pediatric, Psychiatrics). N=218

Dimension in areas	Mean	SD	Mean%	Range
Pediatric				
Physical Burden	7.10	1.944	47.4	2-12
Emotional Burden	6.86	2.228	45.7	1-11
Social Burden	7.19	2.065	48.0	1-12
Economical Burden	7.43	2.463	49.5	1-12
Care giver Burden	28.58	6.622	47.6	12-47
Medical Surgical				
Physical Burden	6.74	2.950	44.9	0-14
Emotional Burden	6.67	2.235	44.5	0-11
Social Burden	7.50	2.978	50.0	1-14
Economical Burden	7.50	2.821	50.0	0-14
Care giver Burden	28.41	6.557	47.3	6-45
Psychiatric				
Physical Burden	10.37	2.742	69.1	5-15
Emotional Burden	9.86	2.518	65.7	4-15
Social Burden	9.60	2.171	64.0	5-14
Economical Burden	10.17	2.589	67.8	4-15
Care giver Burden	40.00	6.267	66.7	30-55
Total				
Physical Burden	7.95	3.012	53.0	0-15
Emotional Burden	7.69	2.713	51.3	0-15
Social Burden	8.02	2.652	53.5	1-14
Economical Burden	8.27	2.897	55.1	0-15
Care giver Burden	31.93	8.344	53.2	6-55

Table 3 shows Distribution of comparison of four dimensions with, mean, mean %, SD, and range in three areas. Among Pediatric care givers physical burden mean, SD, mean %, and range are 7.10, 1.944, 47.4 and 2-12 respectively. Emotional burden mean, SD, mean %, and range are 6.86, 2.228, 45.7 and 1-11 respectively. Social burden mean, SD, mean %, and range are 7.19, 2.065, 48.0, and 1-12 respectively. Economical burden mean, SD, mean %, and range are 7.43, 2.463, 49.5, and 1-12 respectively. Overall care giver burden among Pediatric care givers mean, SD, mean %, and range are 28.58, 6.622, 47.6 and 12-47 respectively.

Among Medical surgical care givers physical burden mean, SD, mean %, and range are 6.74, 2.950, 44.9, and 0-14 respectively. Emotional burden mean, SD, mean %, and range are 6.67, 2.235, 44.5, and 0-11 respectively. Social burden mean, SD, mean %, and range are 7.50, 2.978, 50.0, and 0-14 respectively. Economical burden mean, SD, mean %, and range are 7.50, 2.821, 50.0, and 0-14 respectively. Overall care giver burden among Medical surgical care givers mean, SD, mean %, and range are 28.41, 6.557, 47.3 and 6-45 respectively.

Among Psychiatric care givers physical burden mean, SD, mean %, and range are 10.37, 2.742, 69.1, and 5-15 respectively. Emotional burden mean, SD, mean %, and range are 9.86, 2.518, 65.7, and 4-15 respectively. Social burden mean, SD, mean %, and range are 9.60, 2.171, 64.0, and 5-14 respectively. Economical burden mean, SD, mean %, and range are 10.17, 2.589, 67.8 and 4-15 respectively. Overall care giver burden among Psychiatric care givers mean, SD, mean %, and range are 40.00, 6.267, 66.7 and 30-55 respectively.

Overall physical burden among three areas mean, SD, mean %, and range are 7.95, 3.012, 53.0, and 0-15 respectively. Emotional burden mean, SD, mean %, and range are 7.69, 2.713, 51.3, and 0-15 respectively. Social burden mean, SD, mean %, and range are 8.02, 2.652, 53.5, and 1-14 respectively. Economical burden mean, SD, mean %, and range are 8.27, 2.897, 55.1, and 0-15 respectively. The results reveals that overall care givers burden among three areas mean, SD, mean %, and range are 31.93, 8.344, 53.2, and 6-55 respectively also concludes that economical burden 55.1% is high than other dimensions such as physical, emotional, and social, among three areas.

Table 4: Comparison of level of primary caregiver burden among three areas. N=218

Level of Care giver Burden	Pediatric %	Medical surgical %	Psychiatric %	Total %
Low	13.0	7.9	0.0	7.3
Medium	85.7	89.5	56.9	78.4
High	1.3	2.6	43.1	14.2

Table 4 shows that Comparison of level of primary caregivers burden among three areas that results that care givers burden of medically ill patients (89.5%) were more than Pediatric and psychiatric patients.

Table 5: Compare the score of mean, SD, with ANOVA. N=218

Dimension in areas	Mean	SD	F-value	Df	p-value
Physical Burden Pediatric	7.10	1.944	41.410	2&215	0.000**
Medical Surgical	6.74	2.950			
Psychiatric	10.37	2.742			
Emotional Burden Pediatric	6.86	2.228	40.739	2&215	0.000**
Medical Surgical	6.67	2.235			
Psychiatric	9.86	2.518			

Cont... Table 5: Compare the score of mean, SD, with ANOVA. N=218

Social Burden Pediatric	7.19	2.065	19.594	2&215	0.000**
Medical Surgical	7.50	2.978			
Psychiatric	9.60	2.171			
Economical Burden Pediatric	7.43	2.463	24.149	2&215	0.000**
Medical Surgical	7.50	2.821			
Psychiatric	10.17	2.589			
Care giver Burden Pediatric	28.58	6.622	71.553	2&215	0.000**
Medical Surgical	28.41	6.557			
Psychiatric	40.00	6.267			

** **ANOVA is significant at 0.01 level**

Table 6: Association between level of caregiver burden and demographic variables in three areas

S.no	variables	Calculated value
1	Psychiatric : 1. Short tempered 2. Number of days hospitalized	 0.006** 0.001**
3	**Medical surgical & Pediatrics** None of the variables are significant	

**** Association is significant at 0.01 level**

Discussion: The findings are discussed corresponding to the objectives of the study.

Assess the care givers burden among primary care givers

In present study overall care givers burden the mean score is 31.93, mean percentage is 53.92%, and SD value is 8.344.

Categorize the range of four dimensions of care givers burden tool in three areas

The results reveals that overall care givers burden among three areas mean, SD, mean %, and range are 31.93, 8.344, 53.2, and 6-55 respectively.

Compare the four dimensions of care givers burden among three areas**.**

The results reveals that overall care givers burden among three areas mean, SD, mean %, and range are 31.93, 8.344, 53.2, and 6-55 respectively also reveals that economical burden 55.1% is higher than other dimensions such as physical, emotional, and social, among three areas.

A similar comparative study was conducted to assess financial burden among schizophrenia and chronic lung disease patients. The results revealed that financial burden was more in schizophrenia caregivers. Even economic burden was focused in developed countries.[6.]

Compare the level of care givers burden among three areas:

Majority of care givers burden in Pediatric, Medical surgical, Psychiatric burden levels were medium 85.7%,

89.5%, and 56.9% respectively.

The similar study found that 36% of the caregivers had mild burden, 60% had moderate burden and only 4% had severe burden. A similar case study was conducted to assess the stress, burden of caregiver, and health effects among family caregivers of adult cancer patient who got admitted for hematopoietic stem cell transplantation (HSCT). The care giver reported extremely high levels of psychological distress, including anxiety, depression, worry, and extreme loneliness, prior to the transplant.

Associate the level of care givers burden with selected demographic variables:

In Medical surgical & pediatrics care givers there is no significant association between any of the variables. In psychiatric there is significant association between short tempered, number of days hospitalized and remaining variables were not found to be significant.

CONCLUSION

As the disease progresses, it carries with it a tremendous increase of burden on the caregiver who does the care giving. The researcher suggests that there is necessary to develop intervention to reduce burden of caregivers. Interventions for caregivers should be considered by four central aspects: information & training, professional support, effective communication, public and financial support. Another effective relief is the support given to caregivers by family members, friends and acquaintances.

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

Conflict of Interest: None

Source of Funding: None

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Level of Depression among Geriatric Clients attending a Tertiary Referral Hospital, South India

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ABSTRACT

Aim: The study aimed to assess the level of depression among geriatric clients and to identify the association of the level of depression with the selected demographic variables.

Method and materials: This is a cross-sectional descriptive study. The study samples included 200 geriatric clients who fulfilled the inclusion criteria. Geriatric depression scale was used to assess the level of depression.

Results: Majority (53.5%) of the subjects were females. There was a significant association between gender, marital status, occupation and income with the level of depression ($p<0.05$).

Conclusion: The results of the study showed that 56.5% of geriatric clients had severe depression and 31% had mild depression. It also revealed that the mean depression score was significantly more among clients who had no spouse ($p<0.001$).

Keywords: *Depression, Geriatric clients, Geriatric depression scale.*

INTRODUCTION

Ageing is an inevitable and universal phenomenon. It is a progressive, generalized impairment of function resulting in loss of adaptive response to stress and at increasing risk of age related diseases and disabilities[1]. Central Bureau of Health Intelligence[2] found that major areas of health concern among the elderly are medical and psychological problems, such as hypertension, cataract, osteoarthritis, chronic obstructive pulmonary disease, ischemic heart disease, diabetes and depression. In old age, depressive symptoms often affect people with chronic medical illness, cognitive impairment or disability. In addition to personal suffering and family disruption, depression worsens the outcomes of many medical disorders and aggravates disability.

Sidik et al. (2003)[12] have shown in their study that depression is the most common psychiatric disorder in elderly and projected to be the second leading cause of disability worldwide by 2020. Depression manifests as a combination of feelings of sadness, loneliness, irritability, worthlessness, hopelessness, agitation, and guilt, accompanied by an array of physical symptoms. It is commonly misdiagnosed and under treated because of the misconception that depressive symptoms are part of aging rather than a treatable condition.

World Health Organization (1992) declared depression as a severely debilitating psychiatric illness that can challenge a person's ability to perform even the simplest task of daily living. Depression is a treatable disease but as elders may have multiple complaints, the diagnosis and treatment becomes particularly difficult. In India, mental health professionals are not available at the community level. Moreover, the aged people do not approach the medical facility because of their physical immobility. Those who approach the health care are not able to continue their treatment because of poor financial and social support and longer duration of the treatment. Further, the untreated depressed elderly clients have significant clinical and social implications as these disorders decrease an individual's quality of life and increase dependence on others. It also increases the mortality and morbidity.

MATERIALS AND METHOD

This is a cross-sectional descriptive study. The study samples comprised of 200 geriatric clients attending outpatient departments of JIPMER (Jawaharlal Institute of Post Graduate Medical Education and Research) hospital, Puducherry, India. JIPMER hospital is a tertiary care referral hospital providing comprehensive health care to the people of Pondicherry as well as to its surrounding states. Geriatric clients attending outpatient departments of JIPMER hospital and the clients who were in the age group of more than or equal to 60 years, belonging to both sex were included in the study as samples by using convenience sampling. Clients with acute medical illness and who had the diagnosis of known psychiatric illness were excluded from the study because of the fact that they will not be in a position to provide the information needed for the study. Socio demographic data consisted of age, sex, marital status, occupation, education and residence of the subjects.

Geriatric depression scale (American Psychological Association, 1986) was used to assess the level of depression. It is 15 item questionnaire and each item has two choices (yes or no). The score ranges from 0-15. 0-4 indicates no depression, 5-10 indicates mild depression and 11-15 indicates severe depression. A written informed consent was obtained from the study participants after explaining the details of the study. The subjects were assured of confidentiality. The ethical clearance of the study was obtained from Institute Ethics (Humans) committee, JIPMER.

RESULTS AND DISCUSSION

Ageing is often accompanied by decline in health status. The 2001 census has shown that the elderly population of India accounted for 77 million. The Indian elderly population is currently the second largest in the world and expected to reach 18.4% by 2025. Grover (2010)[3] reported that there was significantly more morbidity in population in the age group of 70-74 years as compared to normal population.

The statistical analysis was carried out using both descriptive and inferential statistics. Frequency and percentage were used to analyze the distribution of clients' socio-demographic variables. Independent student's t test and ANOVA were used to assess the association between the level of depression and socio-demographic variables based on the number of groups involved. All statistical analysis was carried out at 5% level of significance and P value <0.05 was considered as statistically significant.

The study results showed that majority (53.5%) of the subjects was females and 46.5% were males. Ankur et al (2010)[1] found that female gender is a non-modifiable factor significantly associated with depression in geriatric population whereas Al-Jawad et al (2007)[4] reported the prevalence of depression was 67% with more depression in males resided at elderly home in Malaysia.

It was observed that the mean score (10.8) of geriatric clients who had lost their partner or living separately was significantly higher as compared to those who were living with their partner. This finding is supported by the findings by Ghosh et al[6] which states that loss of spouse, living alone are significantly associated with depression. This study was conducted in the continents of Asia, Europe, Australia, North America and South America. A survey by Ramachandran et al[8] also revealed that depression was found to be significantly higher in the elderly who were never married, widowed, divorced or separated. The study also demonstrated that the geriatric clients who were jobless/housewives had high level of depression as shown by the higher mean score of 10.6 as compared to those who were working. This finding is similar to other researchers such as Ramachandran et al[8]. and Ozer et al[10]. which revealed that not being able to work actively and low income status were significantly correlated with the level of depression.

The analysis of our study showed that even though clients residing in rural areas had higher level of depression (mean score of 9.9) when compared to those who lived in urban areas, it was not stastically significant. In contrast, Licht-strucnk et al[7] found that the depression was more in clients who lived in urban areas. A cross sectional study by Taqui et al[5] which used 15 item Geriatric Depression scale concluded that female sex, being single or widowed, unemployment, having a low level of education were independent predictors of depression.

Further, the present study revealed that there was no significant association between the diagnosis and the level of depression among geriatric clients. The various illness present in our study subjects were: arthritis (19.28%), diabetes mellitus (15.06%), hypertension (14.45%), Cancer stomach (9.03%) and psoriasis (6.02%). Higher level of depression was found among clients who were

diagnosed to have chronic illnesses such as ca. stomach (mean score of 11.93), psoriasis (11.7), DM (9.7) and hypertension (9.5). The similar finding was reported by Lehman & Kelly[11]. The authors suggested that their study results showed that level of depression was found to be significantly higher in clients with chronic diseases ($p<0.01$). Also, according to a study conducted by Rajkumar et al[8] on factors associated with depression among the elderly in a rural South Indian community demonstrated that physical ill health and morbidity are risk factors for depression among elderly.

The findings of the study showed that 56.5% of geriatric clients attending various outpatient departments of JIPMER hospital had severe depression, 31% had mild depression and 12.5% had no depression. This finding is slightly higher when compared to the study conducted by Radhakrishnan[13] in Karnataka. He found that 17% of geriatric clients attending outpatient general hospitals had severe depression and 63% had mild to moderate depression. He also found that loss of life partner had significant association with the level of depression.

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

Variables	Category	Frequency	Percentage
Gender	Male	93	46.5
	Female	107	53.5
Education	No formal education	118	59
	Primary/high school	81	40.5
	Graduate	1	0.5
Occupation	Coolie	35	17.5
	Agriculture	13	6.5
	Skilled	8	4
	Jobless/housewife	144	72
Marital status	Married	113	56.5
	Single	10	5
	Living separately/Lost partner	77	38.5
Income	Nil	55	27.5
	<1000	93	46.5
	1000 - 3000	25	12.5
	3000 - 5000	19	9.5
	>5000	8	4
Residence	Urban	95	47.5
	Rural	105	52.5

Table 2: Distribution of subjects based on level of depression (n=200)

Level of Depression					
No depression (score: 0-4)		**Mild (score: 5-10)**		**Severe (score: 11-15)**	
Number of subjects	Percentage (%)	Number of subjects	Percentage (%)	Number of subjects	Percentage (%)
25	12.5	62	31	113	56.5

Figure 1: Comparison of mean depression score in relation to occupational status

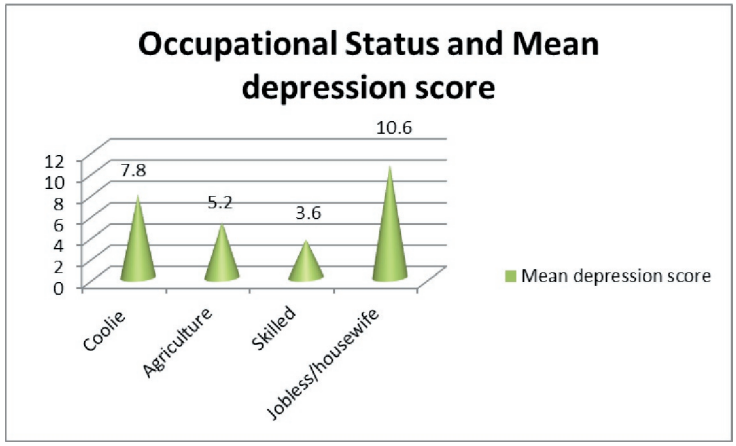

Table - 3: Association of the subjects' level of depression with socio-demographic variables (n=200)

Variables	Categories	Number of Subjects	Mean	S.D	F value/t-value	P value
Gender	Male	93	8.1	4.1	t=4.77	<0.001 ***
	Female	107	10.7	3.5		
Income in rupees	Nil	55	10.9	2.8	F=16.24	<0.001 ***
	<1000	93	10.2	3.5		
	1000-3000	25	8.4	4.4		
	3000-5000	19	5.8	4.3		
	>5000	8	2.8	1.9		
Educational Status	No formal education	118	9.4	3.8	t=0.285	0.78 (N.S)
	Primary/High school	82	9.6	4.3		

*** Significant at p<0.001 level, N.S - Not significant

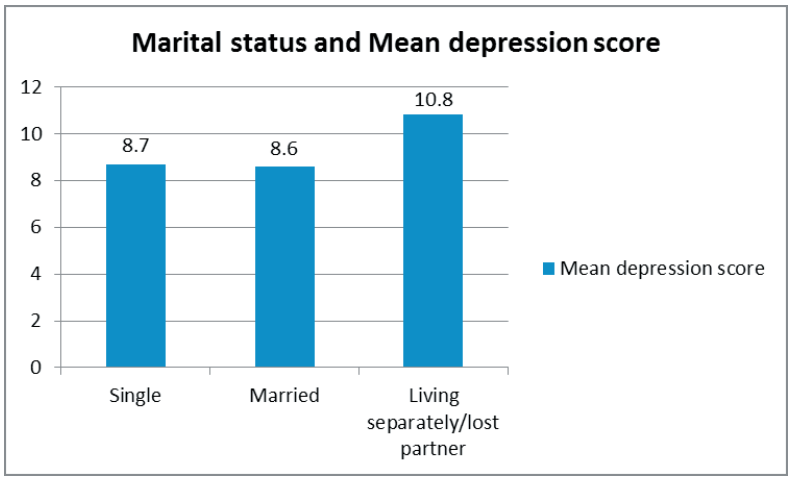

Figure 2: Comparison of depression in relation to marital status

CONCLUSION

Based on the findings of the study, it is concluded that many of our geriatric clients attending various outpatient departments of general hospitals have depression at various levels which needs to be addressed appropriately by health care professionals and they need to be given treatment to enhance the quality of life in old age. The results revealed that the mean depression score (which was assessed by 15 item Geriatric Depression Scale) was high among clients without spouse and being female gender and it was statistically significant at $p<0.001$ level. The mean depression score was high in jobless/housewives. There was no significant association between the educational status and the level of depression. The results of the study were similar to many previous studies conducted in the same area of research but very few studies contradicted our findings.

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Sources of Funding: Nil

Conflicts of Interest: Nil

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Assess Depression and Life Events among Institutionalized Geriatric Populations of Selected Old Age Homes

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ABSTRACT

Old age is a time of losses. It is the stage of life when an individual gradually or suddenly loses his physical vigor, physiological resources of body functions, occupation, friends and spouse. These life events keep on occurring continuously in the life of an old person. Depression is a common condition in older people affecting about 17-30% of community dwellers over the age of 65 years. The objectives of the study were to assess depression among geriatric population, to assess the life events among geriatric population and to find the correlation between depression and life events among geriatric population. The study was conducted using Descriptive co- relational research design. The study was confined to 30 geriatric people from Gharkul old age Home, Belgaum. A descriptive study was conducted. Data collection was done through standardized questionnaire. Data obtained were tabulated and analysed in terms of objectives of the study using descriptive statistics. Findings revealed that life events played an important role in depression among institutionalized geriatric population.

Keywords*: Depression, Life events, Geriatric population.*

INTRODUCTION

Ageing is a natural process and it is considered as a normal, biological and an inevitable process. This is a major life change, which is a psychological step or transition that alters one's relation to the world around him and demands new responses. Life events either aggravate or precipitate the depression. An accumulation of various events in succession may also produce a non specific vulnerability for the development or precipitation of various disorders including depression. If and when these stresses become too severe or too numerous they may affect the physical and/or psychic equilibrium producing maladaptive patterns of adjustment including physical and mental disorders especially depression. It is also known that life events cause depression in only those who are predisposed to develop depression. The present study was to systematically review life events and depression in people aged 65 and older.

OBJECTIVES

1) To assess depression among geriatric population by using standardized Geriatric Depression scale.

2) To assess the life events among geriatric population by using standardized Life event stress scale.

3) To find the correlation between depression and life events among geriatric population.

METHODOLOGY

The study was confined to 30 geriatric people from Gharkul old age Home, Belgaum. A Descriptive study was conducted. The tool used for gathering relevant data was standardized Geriatric Depression scale and Life events stress scale to assess depression and life events among geriatric people.

INTERPRETATION

The major findings indicated that

1. Finding related to demographic variables:

In the present study it was found out that , majority 13(43%) belonged to the age group of 80-89 years , maximum 26(87%) people were females, 11(37%) had an income of Rs.6001-8000, maximum 18(60%) were widows and half of patients 15(50%) were household

workers.

2. Findings related to Depression scores of geriatric people

Table 1: Distribution of depression scores of subjects n=30

Level of depression scores	Frequency	Percentage
Normal(0-9)	7	23%
ssMild(10-19)	17	57%
Severe(20-30)	6	20%

Table 1 indicated that among 30 geriatric population, 17 (57%) had mild depression and the minimum 6(20%) had severe depression.

3. Findings related to Psychological life event scores of geriatric people

Table 2: Distribution of life events scores

n=30

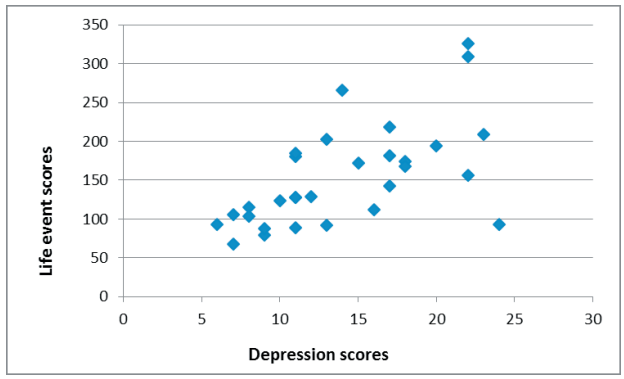
Level of life event scores	Frequency	Percentage
Low susceptibility to stress related Illness(0-149)	15	50%
Medium susceptibility to stress related illness (150-299)	13	43%
High susceptibility to stress related Illness(>300)	2	6%

Table 2 revealed that among50 geriatric population, half of the patients 15 (50%) had low susceptibility to stress related illness and minimum 2(6%) had high susceptibility to stress related illness.

4. Findings related to relationship of depression with life event.

Pearson's co-efficient of correlation was used to compute the correlation of depression with life events. The correlation between depression and life events was found to be **rxy**= 0.6.

GRAPH1



Scatter diagram showing the correlation of depression with life event.

Since 0< **rxy** <1, there was a positive correlation between depression and life events.

Discussion

In the present study it was found that, out of 30 geriatric population majority 13(43%) belonged to the age group of 80-89 years, maximum 26(87%) people were females. Majority 11(37%) had an income of Rs.6001-8000, maximum 18(60%) were widows and half the population 15(50%) were household workers.

The depression scores revealed that among 30 geriatric population, 17 (57%) had mild depression and minimum 6(20%) had severe depression. The findings of the study corresponds with the study conducted by Kraaij V revealed that negative life events played a major role in depression among elderly.[9]The life event scores of 30 geriatric populations revealed that half of population 15(50%) had low susceptibility to stress related illness. The findings were supported with the study done by Agarwal N revealed that elderly depressed patients experienced significantly higher number of stressful life events and more commonly found in females.[1]

Pearson's co-efficient of correlation denoted that there was positive correlation between depression and life events which indicates that life stress events played a major role in depression. The findings were supported with the study conducted by Kishi R reported that various stressful life events experienced by the elderly increase the risk of depression.[10]

CONCLUSION

The findings of the study revealed that This indicated life events played an important role in depression among

institutionalized geriatric population.

Ethical Clearance- Taken from KLE University ethical clearance committee.

Source of Funding- Self

Conflict of Interest - Nil

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Relaxation Techniques for reducing Maternal Stress and Anxiety

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ABSTRACT

Individuals experience stress as a daily fact of life; it cannot be avoided. It is generated by both positive and negative experiences that require adjustment to various changes in ones current routine. Stress is a biological, social, or chemical factor that causes physical or emotional tension and may be a factor in the etiology of certain illnesses. Relaxation is a state of refreshing tranquility. Nurses are in an ideal position to assist individuals in the management of stress in their lives. Here the therapeutic benefits and various methods of relaxation techniques are described

Keywords: *Stress, anxiety, pregnant mother, relaxation techniques.*

INTRODUCTION

Modern medicine recognizes the potential impact of stress on physical well being, but can the stress pass through the mother to the fetus? Indeed, it has been hypothesized that maternal chronic stress can alter the uterine environment and may affect length of gestation, fetal growth, birth weight and spontaneous preterm birth, similarly research on cortisol levels in fetuses and mothers had formal that anxiety in mothers can affect the function of the placenta with so much evidence pointing to the interaction between maternal psychological well being and fetal wellness, there has become an increased need to find effective, non pharmacological interventions for pregnant women[1].

RELAXATION TECHNIQUES

Relaxation is more than state of mind it physically changes the way of the body functions. Relaxation Techniques consciously produce the body's natural "relaxation response" Characterized by slower breathing, lower blood pressure and a feeling of calm and well being. When the body is relaxed breathing slows, blood pressure and oxygen consumption decrease and some people report an increased sense of well being. This is called relaxation response. Being able to produce the Relaxation responses, using the Relaxation Techniques may counteract the effect of long term stress[5].

The Benefits of relaxation techniques during pregnancy

1. Feeling a better ability to cope with stress
2. Allows time out from problems, difficulties and responsibilities, provides the body with a 'rest' from the effects of stress.
3. Improve the feelings of well being.
4. Reduces anxiety**.**
5. Reduces the effects of fatigue and tiredness caused by stress.
6. Less aches and pains are felt, as these can be due to increased Muscle tension.
7. Blood pressure may be reduced by practicing relaxation.
8. The baby will gain a more relaxed mum and enjoy the benefits of less physical tension within the body during pregnancy.

Types of Relaxation techniques:

1. Autogenic relaxation
2. Biofeed Back
3. Deep breathing or Breathing exercises
4. Progressive Muscle Relaxation
5. Guided imagery Relaxation techniques
6. Self hypnosis

Relaxation Techniques During Pregnancy

If pregnant mothers are stressed, tensed and overtired or anxious. They may have trouble in sleeping. To calm

the mind, relax the muscles, rest the body and give sound sleep, these simple techniques may be tried.

1 a. Breathing Exercise During Pregnancy:

Developing your breathing awareness, will benefit the pregnant mother and the baby during pregnancy and childbirth. During pregnancy breathing deeply and rhythmically can cause muscle tension, lower the mothers heart rate and help you fall asleep faster. Exhale slowly through the mouth, cheeks relaxed, so that the lungs empty completely. Pause and rest.

b. Breathing Exercise During Labor:

During labor the breathing responds to the way the pregnant woman feel. By breathing calmly and deeply, the mother will be able to centre herself and surrender to the natural rhythm of contractions practice positions for second stage, visualizing contractions. Focusing the breath on the exaltation. Centering the awareness on the pelvic floor expanding and opening, and the vagina stretching and opening as the baby descends.

2. Massage

During pregnancy increased pressure on the body can cause pain and discomfort. By using gentle massage techniques one can reduce the pain and increase the mobility. A gentle massage will relax tense or tied muscles. It is recommended to seek a professional masseur that specializes in pregnancy techniques, as too much pressure could be damaging[5].

3. Yoga and Stretching

Yoga and stretching will help the muscle relaxation and will also keep it toned and flexible during pregnancy. Some are designed specifically for pregnant women and create with simple moves for your neck and shoulders, back, waist, calves and hamstrings.

4. Muscle Relaxation

The pregnant mother should take several wear as to master muscle relaxation. Mastering it will really help in good sleeping. The technique can be practiced by lying on your bed or even on the floor releasing tight muscles by first tensing and then completely relaxing them focus on one group of muscles at a time and alternate between the right and left side. Start by tensing and releasing your hand and forearm muscles, followed by the biceps, triceps, face, Jaw, chest, shoulders, stomach, thighs, etc until reaching the feet, rotate the angels and squeeze and release the toes. It is important to work on the feet circulation as the additional weight the mothers carrying puts a deal of pressure her feet[5].

5. Aromatherapy

Not all essential oils are safe during pregnancy, Gentler oils are recommended and always use minimum quantities. Oils may be used during the bath by a diffuser or with a massager. Massage oil for labor can be used on the back, but use it only once or twice on abdomen during first stage. Suitable massage oil for labor may be15 drops of almond, lavender, rose, jasmine, tangerine, mandarin, grapefruit, roman chamomile, neroli or geranium oil[3].

6. Imagination

The pregnant mother should picture herself in a quiet, relaxing scene: relaxing on a warm sandy beach or walking through a rain forest or sitting under a shady tree. During that time the imaginations flow to detain the scene, including the sounds, smells, tastes and textures around. To overcome the trouble in starting the relaxing scene use a photograph or image from a magazine to start it . To calm the anxious or restless mind and slip into a deep sleep[5].

7. Herbs

a. Chamomile

Drinking chamomile tea calm the mind and reduce nervous tension. It is safe for pregnant and breast feeding women.

b. Lavender

Revered by aroma therapists worldwide, lavender has a soothing scent that may help the pregnant mother. The lavender oil can be used by drift off to sleep. sprinkling a few drops on the pillow or adding them to a warm bath with some lemon balm.

CONCLUSION

There is no single relaxation technique that is best for everyone. When choosing a relaxation technique, consider the specific needs, preferences fitness level and the way a pregnant mother tend to react to stress.

Ethical Clearance: - Taken from Nehuru Nursing College, Vallioor, Ethical Committee Member Dr. Chandran Sekaran M.Sc. (Nug) Ph.d

Source of Funding- Self/ Information collected from Library Books.

Conflict of Interest - Nil

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Quality of Care in a Psychiatric Unit: Client's Perspective

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ABSTRACT

Improving health care quality and patient safety are currently high on the national health agenda, a focus that will only intensify going forward. The present research study was to find out deficits in expressed quality of care by clients in a psychiatric unit. The design adopted for the study was descriptive using a structured interview schedule in accordance expressed quality care standards i.e. structure standard, process standard and outcome standard. The participants consisted of 30 clients with insight grade ≥3. The structured interview was taken on the day of discharge. Findings of the study revealed that in structure standard, affordability of treatment was major deficit area. In process standard, assessing need for improvement in education, providing recreational activity, were deficit areas. In outcome standard, getting information about medication benefits and side effects and their management, getting information about disease process, getting information about care and treatment at home, drug compliance were deficit areas. Thus, it was concluded that clients in psychiatric unit were able to evaluate their care and did find the deficit areas of consideration in quality care.

Keywords: *Quality of care, Insight, Expressed quality care standards, structure, process, outcome, Insight grade.*

INTRODUCTION

Nowadays patients have broad knowledge and great expectations with regard to what care is available, including effectiveness, quality of service and treatments and they are more aware of their problems and diagnosis. **(**Shelton PJ, 2000)[1]. The Indian government estimates that 1% to 2% (10 to 20 billion) of the Indian population suffers from major mental disorders and around 5% (50 billion) suffer from minor mental disorders. There are 37 government-run psychiatric hospitals in India, most of which are managed by state governments. These facilities have a total capacity of 18,000 inpatients; almost half of available beds are occupied by long stay patients. (Reddy VM, Chandrashekar CR, 1998)[2].

To remain competitive, all health care facilities need to provide quality services, be cost effective, and ensure customer satisfaction. For individual members of a complex health care delivery system, it is important to achieve a sense of connectedness related to standards of quality in the work place or on specific units in large institutions. Professionals, such as physicians, nurses and the therapists, must be confident in addressing the issues related to quality care and treatment outcome. These issues can be resolved in a way that meets the needs of the clients, their families, the staff of the unit and the institution. (Demarco R, Flaherty L, Merril N, Plasse M, 2004)[3].

Quality of care is a complex and multidimensional concept (Wilde B, Starrin B, Larsson G & Larsson M, 1993)[4]. Donabedian, who is perhaps the foremost researcher in quality of care, maintains that the essence of quality is constituted by the balance between benefit and harm (Donabedian, 1979)[5]. Donabedian (1980)[6] made a synthesis of earlier attempts to define quality of care where the patient's wishes concern three closely interrelated factors: technical care, interpersonal relationship and amenities in the care environment.

Campbell SM, Roland MO & Buetow SA, (2000)[7] define quality of care in terms of "the ability to access effective care on an efficient and equitable basis for the optimisation of health benefit/well-being for the whole

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population" and of "whether individuals can access the health structures and processes of care which they need and whether the care received is effective". The definition is twofold because researchers differentiate between use of the concept quality of care with reference to the population and use of it with reference to the individual. They regard the latter use as being the more meaningful. This is in line with Wilde B, Larsson G, Larsson M & Starrin B, (1994)[8], who considers that wide ranging definitions of quality tend to be vague and difficult to operationalize and concretize.

There is no existing gold standard for measuring quality of care in the psychiatric setting and consequently one of the major problems in this area of research is the lack of uniform methods and instruments. This means that it is difficult to compare one set of results with another. Still**,** we can assess experiences and expressions of clients and their significant relatives to know about their perception of quality care and the deficits in present scenario of care provided. The present research study is a stepping stone to assess deficits in expressed quality care standards. These kinds of small researches may help in improvement of quality care in mental health facilities and may provide a basis for further research.

Objective: To find out deficit areas in expressed quality care standards in psychiatric unit as expressed by hospitalised clients.

MATERIALS AND METHOD

Quantitative research approach with descriptive research design was adopted to assess deficits in expressed quality care standards by clients in the psychiatric unit of CMC & H, Ludhiana with a criterion measure of ≥ 75%= Low quality (Standards not met), <75%= High quality (Standards met) and structure, process and outcome quality care standards were assessed using a structured interview schedule. Before conducting the study, ethical clearance was obtained from head of psychiatry department of CMC & H.

Using a purposive sampling technique, hospitalised mentally sick clients with an insight grade of ≥3 and a hospital stay of ≥ 3 days were included with a sample size of 30. After giving self introduction, Researcher discussed type and purpose of research study with clients. Written consent was obtained thereafter.

Each interview took 25-30 minutes, which was conducted on the day of discharge. Responses for each query in structured interview schedule vary from always, usually, sometimes or never; Not at all, somewhat, Quite a bit, A great deal; No, unsure, sometimes, yes; not showed any interest, casual response, little bit, warmly according to individual items. Client has to select the correct answer according to his perspective which was scored later to assess deficits in expressed quality care standards.

Analysis of the data was done in accordance with objectives of the study. It was done by using the descriptive statistics such as percentage, mean, mean percentage, standard deviation as well as inferential statistics i.e. 't' test and ANOVA were used. Bar diagrams were used to depict findings.

FINDINGS

Majority of the clients were males (76.7%), matric-10+2 (53.3%), of age 41-60 years (46.7 %) married (90%), having joint family (80%), and professional or were doing business (60%).

Table- I shows the deficit areas in expressed quality care standards score as expressed by clients. **In structure standard,** area of least quality of care was affordability of treatment (55% and Rank I) with no deficits in physical infrastructure of ward (82.8% and rank II), and followed by canteen facilities (85% and rank III) and availability of staff (96.3% and rank IV), cleanliness of ward (100% and rank V).

In process standard, area of least quality of care was assessing need for improvement in education (42.5% and rank I), followed by providing recreational activity in ward (45% and rank II), with no deficits, in providing care (73.8 % and rank III), followed by maintaining therapeutic communication pattern (90% and rank IV) and providing sense of security with regard to care (92.1% and rank V).

In outcome standard, maximum deficit were in information about medication benefits and side effects and their management (30% and rank I), followed by information about disease process (42.5% and rank II), followed by getting information about care and treatment at home, getting information about rules and policies of ward (50% and rank III), followed by drug compliance (60% and rank V) and reduction in symptoms of illness (77.5% and rank VI), client satisfaction (88.8% and rank VII), recommending health care facility to other need(97.5% and rank VIII).

Hence, it was concluded that mean percentage

indicates that affordability of treatment was deficit area in structure standard. In process standard, mean percentage indicates that assessing need for improvement in education, providing recreational activity, were deficit areas. In outcome standard, mean percentage suggests that getting information about medication benefits and side effects and their management, getting information about disease process, getting information about care and treatment at home, drug compliance were deficit areas.

Table I: Mean, Mean percentage and rank order of deficits in Expressed quality care score of clients according to Expressed quality care standards (EQCS) N=30

Expressed quality care standards (EQCS)	Deficits in Expressed quality care score		
	Mean	Mean %	Rank Order
1.Structure			
1.1 physical infrastructure of ward	26.5	82.8	II
1.2 cleanliness of ward	4	100	V
1.3 canteen facilities	3.4	85	III
1.4 availability of staff	7.7	96.3	IV
1.5 affordability of treatment	2.2	55	I
2. Process			
2.1 maintaining therapeutic communication pattern	18	90	IV
2.2 providing security and comfort while treatment	25.8	92.1	V
2.3 providing care	23.6	73.8	III
2.4 assessing need for improvement in education	5.1	42.5	I
2.5 providing recreational activity in ward	1.8	45	II
3. Outcome			
3.1 Awareness about care and treatment at home	2	50	III
3.2 reduction in symptoms of illness	3.1	77.5	VI
3.3 got information about disease process	1.7	42.5	II
3.4 got information about rules and policies of ward	2	50	III
3.5 got information about benefits and side-effects of medication and their management	1.2	30	I
3.6 client's satisfaction	7.1	88.8	VII
3.7 drug compliance	2.4	60	V
3.8 recommending health care facility to other needy	3.9	97.5	VIII

DISCUSSION

Client care needs to be evaluated from client's point of view also. This would be helpful not only in evaluation, but will also improve client satisfaction and faith towards health care personnel. There is not enough literature regarding evaluation of client care from clients only. The findings of the present research study may help in changing attitude of community towards mentally sick as they have proven to be good decision maker in improving the care provided to them.

The common deficit areas encountered in care provided were not giving complete information and drug compliance which are major concerns to improve expressed quality care standards.

These findings of research study were supported by Brooker DJR & Dinshaw CJ, (1998)[9] who revealed that patients were more positive about the physical environment and Gigantesco A, Morosini P & Bazzoni A, (2003)[10] and Schroder A & Lundqvist LO, (2013)[11] who reported that highest ratings were found for the secluded-environment dimension. These findings were also supported by Howard PB, El-Mallakh P, Rayens MK & Clark JJ, (2003)[12] who reported that Respondents reported satisfaction with time available to be with other patients, staff availability, and their degree of comfort talking to staff.

Acknowledgement: Researcher highly appreciate interest of HOD of psychiatry department DR. R.S. Deswal in present research study who gave permission to evaluate expressed quality care standards in psychiatric unit to find out deficit areas in quality of care. Researcher would also like to give heartily thanks to all the study participants.

Conflict of Interest: There was no conflict of interest in present research study.

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A Study to assess Clinical Stress and Stress Reaction among Nursing Students Studying in Delhi

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ABSTRACT

Background: Professional education can be very stressful experience which often affects the physical and mental health. It is important to assess the psychological well-being of the nursing students. This study was planned with an objective to identify and analyse the Clinical stress& stress reactions among nursing students

Materials & Method: A descriptive Study was conducted among 139 students of a nursing college in Delhi selected from different years of professional study by Purposive Sampling method. Data was collected using a self-administered questionnaire consisted of items on socio-demographic profile, clinical stress& stress reaction after getting written informed consent. Data was analysed using SPSS (Version 17). Coefficient of correlation between clinical stress and stress reaction was calculated and *p* value less than 0.05 was considered significant.

Results:- A majority (70.5%) of study subjects were in the age group of 20-22 years, educated up to senior secondary school (83.4%) and belonged to nuclear families (86.3%). The mean clinical score for stress was 56.8±15.7. Maximum number of study subjects (76.97%) reported moderate degree of stress with a mean stress score of 60.18. study subjects reported both psychological and physical stress reaction but physical reactions (average-160.2) were more evident.

Conclusions:- Stress was evident among nursing students with variety of physical and psychological reactions. Effective interventional strategies should be taken for reducing stress among nursing students.

Keywords: *Clinical Stress, Stress Reaction, Nursing students*

INTRODUCTION

Professional education can be a very stressful experience which often affects the physical and mental health. Distress in the educational years of life may lead to impairments in the practicing years of a professional career. Academic stress among college students, especially fresher who are particularly prone to stress due to the transitional nature of college life is an area of interest.[1] Students may need to develop entirely new social contacts and are expected to take responsibility for their own needs. They may have difficulty adjusting to more rigorous academic expectations and the need to learn to deal with individuals of different cultures and beliefs.[2] Tests, grades, competition, time demands, teachers, class environment and concern about future careers are major sources of academic stress.[3] If stress is not dealt effectively, feelings of loneliness and nervousness, as well as sleeplessness and excessive worrying may result. Student perception of high stress levels can lead to poor academic performance, depression and serious health problems. Methods to reduce student's stress often include effective time management, social support, positive appraisal and engagement in leisure pursuits.[4] The stresses reported among nursing students have been categorized as academic, clinical and personal sources

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of stress.[5] Coping has been viewed as a stabilizing factor that may assist individuals in maintaining psychosocial adaptation during stressful events. It can be positive or negative depending upon situation and content.[2]

AIM

Keeping the above aspect in view, it is important to assess the psychological well-being of the nursing students so that effective interventional strategies can be made. This study was planned with objective to identify and analyse the level of stress, stress reactions in response to the clinical stress among nursing students studying in a nursing college in Delhi.

OBJECTIVES

1. To identify level of Clinical Stress among nursing students.

2. To analyse areas of Clinical Stress among nursing students

3. To identify Clinical Stress reactions among nursing students.

MATERIALS AND METHOD

Research Approach and Design:

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

Study settings and Population:

B.Sc nursing students constituted the study population studying in selected nursing college in Delhi.

Sample and Sampling Technique:

A total of 139 nursing students were selected by purposive sampling method as per inclusion criteria and exclusion criteria.

Tool for Data Collection:

Sociodemographic Performa consisted of 5 demographic variables namely age, education, monthly family income, type of family & number of family members. Data was collected using a self-administered questionnaire after getting written informed consent. The schedule consisted of three parts; I – socio-demographic details like age, education, type of family and family income; II – clinical stress; III – stress reaction. In part II, items pertaining to clinical stress which were placed in seven stressor areas. For each question there is provision for selecting one out of four possible responses and weights were given as: severe stress (3), moderate stress (2), mild stress (1) and no stress (0). Total scores were summed up for the individual and categorized the degree of stress as "mild", "moderate" and "severe". The mild stress was with score 1-44, moderate stress with score 45-88 and severe stress having score of 89-132. In part III, items pertaining to stress reaction which was categorized into physical and psychological reactions. The stress reaction questionnaire consists of 26 items related to physiological and psychological reactions. It is a four point scale with the responses and assigned weights accordingly: frequently (3), occasionally (2), rarely (1) and never (0). As per frequency of stress reaction, the total responses were categorized as rarely with stress reaction score of 1-26, occasionally with stress reaction score of 27-52 and frequently with score of 53-78.

Tool Validity & Reliability Analysis:

The content validity of the tool was established by giving it to experts in the fields of clinical psychology, psychiatric nursing, psychiatrist educationist, and administrator. Most of the experts agreed on most of the items and necessary modifications were made as per their suggestions. Pilot testing was done on adequate sample of nursing students of another nursing college. The reliability of the tool was established using Cronbach's alpha method. The reliability of the clinical stress was 0.99 and for stress reaction it was 0.84.

DATA ANALYSIS

Data was analysed using SPSS software (version 17). Results were presented in proportion, mean (M) and standard deviation (SD) wherever applicable. Coefficient of correlation between clinical stress and stress reaction was calculated and "p" value less than 0.05 was considered significant. Ethical clearance was taken from institutional ethical committee.

RESULTS

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.

Sample Characteristics	Frequency	Percentage (%)
Age		
17-19 years	40	28.78
20-22 years	98	70.50
23-25 and above	1	0.72
Education		
Intermediate/Pre-degree/10+2	116	83.45
B. Sc./ B.A./B.Com	22	15.82
Any other	1	0.72
Type of Family		
Nuclear	120	86.33
Joint	19	13.67
Monthly Family Income (₹):		
< ₹10000	31	22.30
₹10001-₹15000	32	23.02
₹15001-₹20000	33	23.74
₹20001 and above	43	30.93
Number of Family Members:		
1-4	104	74.82
5-10	32	23.02
11-15	3	2.15

This table shows that majority of nursing students 98 (70.50%) are in the age group of 20-22 years. 116 (83.45%) of the. nursing student nurses had education of Intermediate/Pre-degree/10+2. The family-wise classification shows that majority of the student nurses 120 (86.33%) came from nuclear families whereas only 19 (13.67%) came from joint family. Majority of the nursing students (30.93%) had a family income above Indian rupees twenty thousand.

Objective 1: To identify level of Clinical Stress among nursing students.

Table 2: Level of Clinical stress among nursing students

Degree of Stress	Frequency (Percentage)	Mean score
Mild (1-44)	27 (19.42)	35.33
Moderate (45-88)	107 (76.97)	60.18
Severe (89-132)	5 (3.59)	100.2

Table 2 shows that maximum number of student nurses 107(76.97%) had moderate level of stress with a mean stress score of 60.18. Five student nurses (3.59%) experienced severe stress with a mean score of 100.2 and 27 students (19.42%) experienced only mild stress with a mean of 35.33.

Objective 2: To analyse areas of Clinical Stress among nursing students

Table 2: **Mean score of Areas of Clinical Stress among Nursing Students**

Clinical Stress area	Mean score (μ)
Interaction with clinical faculty	207.7
Interaction with health team members	203.6
Clinical rotation and assignments	184.5
Nursing procedures	181.7
Interaction with peer group/senior students	169.8
Patients' disease condition	164.8
Interaction with patients and relatives	134.5

Table 2 depicts the highest and lowest clinical stress area of nursing students, an area wise computation of mean was done. Mean score calculated by adding up the scores of each item of one area and dividing it by the number of items. Data shows that the highest mean stress score was in the area of "Interaction with clinical faculty" (μ = 207.71) followed by "Interaction with health team members" (μ = 203.6). The least stress scores were in the area of "Interaction with patients and relatives" (μ = 134.5).

Objective 3: To identify Clinical Stress reactions among nursing students.

Table 3: Stress Reaction Score of physical and Psychological Stress Reactions of nursing students

Physical Stress Reactions	Stress reaction score	Psychological Stress Reactions	Stress reaction score
Do you suffer from headaches?	179	Do you feel depressed?	196
Do you have disturbed sleep?	178	Do you experience restlessness?	192
Do you experience palpitation?	169	Do you find it difficulty in concentration?	188
Do you feel lethargic?	166	Do you feel nervous while Speaking and doing procedures?	183
Are you troubled by indigestion?	162	Do you experience mood change?	182
Do you experience muscular tensions and pains?	159	Do you feel irritated easily?	176
Do you over eat?	155	Do you find difficulty in taking decisions?	159
Do you suffer from Diarrhea?	148	Do you want to be left alone?	152
Do you feel thirsty frequently?	145	Do you get panicky in emergency situations?	151
Do you experience increased perspiration?	141	Do you perceive unknown fears?	139
Average	160.2	Do you get tried easily?	138
		Do you experience inferiority feelings?	134
		Do you feel threatened in the Clinical setting?	134
		Do you lose your self- control?	131
		Do you find yourself disorganized and disoriented?	128
		Do you feel like harming who disturb you?	101
		Average	155.25

Table 3 depicts that Mean stress reaction score was 29.4 with standard deviation of 13.10. The stress reactions were divided into two areas-physical (10) and psychological reactions (16). Item wise mean score of physical and psychological stress reaction were computed to identify the most frequent and least frequent stress reactions as shown in Table. Although students experience both psychological and physical reactions but physical reactions (average-160.2) were more evident among students than psychological stress reactions (average-155.25).

When inquired about frequency of stress reactions, 57 (41%) said *rarely*, 77 (55.39%) said *occasionally* and *frequently* was reported by 5 (3.6%). Mean coping strategy score was 42.5 with standard deviation of 7.96.

DISCUSSION

It was observed in the present study that stress levels were higher among nursing students. Moderate stress levels were present in majority of nursing students. The findings are consistent with a study conducted by Singh N. in a nursing college where mean perceived stress score of students was 28.67 (SD = 5.32) with least stress levels in third year students.[6]

Other studies also indicated that experienced higher levels of stress and higher levels of physiological and psychological symptoms among nursing students.[7] Interaction with faculty, nursing procedures were main sources of stress. Nolan G et.al also found that main sources of stress were associated with relationships in the clinical environment; clinical workload; matching competence and responsibility; and simultaneous clinical and academic demands.[8]

A number of physical and psychological symptoms were perceived by students like headaches, lethargy, disturbed sleep, palpitations, depressed mood etc. This is consistent with the study carried out by Sheu S et.al which revealed that stress for students came mainly from the lack of professional knowledge and skills as well as caring of patients. The most common response to stress was social behavioural symptoms.[9]

Conflict of Interest: None

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.

CONCLUSION AND RECOMMENDATIONS

It is concluded that educators must take a close look at the clinical education process which encompasses the methods of teaching and evaluation choice of clinical faculty and the attitudes towards clinical expectations. Effective measures should be taken for reducing stress among students.

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A Pre Experimental Study to assess the Perceived Stress among Male Prisoners before and after Aerobic Laughter Therapy in District Jail Karnal, Haryana, 2015

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ABSTRACT

Background: Prisoners are those people who were found guilty and convicted as per India Penal Code and staying inside the jails. The stress behind the bars of those prisoners can leads to serious psychological problems. Aerobic laughter is a fun and easy technique that enables us to laugh long and hearty without the use of jokes or comedy and the benefits of it are emotional release, promotes empathy, improves communication, consolidate co-operation with authority and reduces disciplinary problems. It also improves the mood and health by reducing anger and stress. **Aim and Objectives:** The main objective of the study is to assess the effectiveness of aerobic laughter therapy on perceived level of stress among male prisoners. For the purpose of the study a conceptual framework was developed based on modified Von Ludwig Bertallanffy's general system model. **Material and Method:** A pre experimental one group pre test post test research design was used. The pilot study was conducted in district jail Sonepat, Haryana and the reliability of the tool was found 0.84 through split half method which is highly reliable .The study was conducted on 50 samples from district jail, Karnal, Haryana, selected by purposive sampling technique. The intervention was given for 21 days and the perceived stress was assessed with Cohen's perceived stress scale before and after intervention. The data collected was edited, compiled, tabulated and analysis done by descriptive and inferential statistics. **Result**: The perceived level of stress of majority of prisoners before intervention was severe, which was reduced to moderate after the intervention. The mean pre-test perceived stress score 25.66 (SD = 4.018) was higher than the mean post test perceived stress score 16-80 (SD = 3.912) with a mean difference of 8.86. The't' value is 14.766 ($p<0.05$) is more than the table value 2.01 ($p<0.05$) was significant. The marital status of male prisoners was statistically associated with the mean difference in pre-test perceived stress. **Conclusion:** It was inferred that the aerobic laughter therapy was significantly effective to reduce the perceived stress of male prisoners.

Keywords: *Perceived stress, male prisoners, aerobic laughter therapy, district jail.*

INTRODUCTION

Stress is a biological term for the consequences of the failure of a human or animal to respond appropriately to emotional or physical threats to the organism, whether actual or imagined (Hans Selye).[1]It is a major health issues associated with certain particular life events such as financial crisis, overwork, physical health problems, family problems, loneliness and even solitary confinement.[2] Prisoners are those people who were found guilty, convicted and kept inside the jails.[3] The stresses behind the bars include separation from their family members, living conditions due to overcrowding, improper diet, sensory deprivation, exposure to a high density of hard – core offenders and a variety of uncertainties, fear and frustrations, loss of social status, uncertainty of outcome of the trial, fear of punishment, staying in an unusual place, jail and the financial upsets harass the individual.[4] As the old proverb says

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"Laughter is the best medicine" laugh can make miracles. Laughter therapy is an easy to implement and can vary substantially improve the physical, mental and emotional wellness of prisoners.[5]Laughter yoga is being practiced in several prisoners in India.Many prisons in India have found this therapy an effective tool to release their negative emotions. There are positive changes in prisoner attitude and better prisoners – staff relations and reduced violence.[6]Its benefits are emotional release, reduce anger and reduce violence, stress reduction, laughter promotes empathy and communication, improves cooperation with authority, and reduces disciplinary problems, improves mood, improves health.[5]

OBJECTIVES

1. To assess the level of perceived stress among male prisoners before aerobic laughter therapy.

2. To assess the level of perceived stress among male prisoners after aerobic laughter therapy.

3. To compare the mean level of perceived stress among male prisoners before and after aerobic laughter therapy.

4. To test the association between pre level of perceived stress score and selected demographical variables.

MATERIALS AND METHOD

A pre experimental one group pre test post design was selected to carry out the study. The study sample comprised of male prisoners of district jail Karnal. Probability sampling technique was used for the selection of 50 male prisoners who fulfilled inclusion criteria of the study. Male prisoners who were residing for more than 6 months in jail, who were willing to participate in the study were included in the study and female prisoners and participants not present at the time of data collection were excluded from my study. Tool used for the study were structured Cohen's Perceived Stress Scale and divided into two sections. **Section A:** Socio demographic Variables **Section B:** Structured Cohen's Perceived Stress Scale.

RESULT

Frequency and percentage distribution of male prisoners regarding socio demographic variables

Socio demographic variables reveals the age of male prisoners, half (50%) were in the age group 18-30 years, nearly half (48%) of were married and majority belongs to Hindu religion. About (38%) of male prisoners were having primary education. In occupational status more than half of the samples (56%) were self employed. Majority (64%) of their family income was 5000-10000 / month. More than half of male prisoners were residing in rural area. (38%) of them have committed violent crime and other type of crimes. Most of samples (44%) were not having habit of any type of drug use. (74%) were staying for more than 3 years. As the previous imprisonment history, majority (82%) were never being imprisoned, maximum (94%) never attended any session of laughter therapy and alternative methods for stress reduction (36%) were doing morning or evening walk was used by male prisoners.

Table 1 Frequency and percentage distribution of pre- test level perceived stress among male prisoners. N= 50

Pre – test level of Perceived Stress	Score	Frequency (n)	Percentage %
Mild Stress	0-11	0	0
Moderate Stress	12-20	6	12
Severe Stress	21-40	44	88

Table 1 depicts that, in pre test maximum male prisoners 44(88%) were having severe stress as compared to the 6 (12%) moderate stress among male prisoners. It is interesting to interfere that no male prisoners were having mild stress

Table 2: Frequency and percentage distribution of post – test level of perceived stress among male prisoners. **N=50**

Post Test Level of Perceived Stress	Score	Frequency (n)	Percentage (%)
Mild Stress	0-11	4	8
Moderate Stress	12-20	38	76
Severe Stress	20-40	8	16

Table 2 depicts that, in post test majority of male prisoners 38(76%) were having moderate stress, following by 8(16%) were having severe stress and

4(8%) male prisoners stress level reduced to mild stress.

Table 3: **Comparison of the pre-post test level of perceived stress score before and after aerobic laughter therapy**. **N = 50**

	Mean	SD	Mean difference	P Value	't' Value
Pre test	25.66	4.018	8.86	0.002	14.766*
Post Test	16.80	3.912			

Maximum Score: 40

$p < 0.05$ level of significance

Minimum Score: 0 * Significant

Table 3**,** reveals the effectiveness of aerobic laughter therapy on perceived stress among male prisoners. The mean Pre-test perceived Stress score 25.66 (SD= 4.018) was higher than the mean post test perceived stress score 16.80 (SD= 3.912) among male prisoners. The mean difference is 8.86.The obtained 't' value on perceived stress score before and after aerobic laughter therapy, $t = 14.766$ ($p < 0.05$) is more than the table value 2.01 ($p<0.05$), was statistically significant. Hence, it is inferred that the aerobic laughter therapy was significantly effective to reduce the perceived stress among male prisoners.

Table 4 : **Descriptive statistics regarding Pre test and post test perceived stress score among male prisoners of district jail, Karnal, Haryana N=50**

Descriptive Statistics	Perceived Stress Pre- test	Perceived Stress Post test
Mean Score	25.66	16.80
S.D	4.018	3.912
Median Score	26.5	17
Maximum Possible Score	40	40
Minimum Possible Score	0	0
Range of Possible Score	40	40
Maximum obtained score	33	25
Minimum Obtained Score	13	7
Range of obtained Score	20	18
+Scored	1283	840
Total Score	2000	2000
Mean Percentage	64.15	42.00
Possible gain Score (%)	35.85	58.00
Mean difference	8.860	
Paired 't' test	14.766	
P value	0.000	
Table value of 0.05 df 49	2.01	
Result	Significant	

Maximum Score: 40 $p < 0.05$ Level of significance

Maximum Score: 0

Table 4 shows the descriptive statistics regarding pre test – post test perceived stress score among male prisoners.

The mean pretest stress score 25.66 (S.D. = 4.018) decreased after intervention. Post test stress score 16.80 (S.D. = 3.912) with a mean difference of 8.860.The calculated paired 't' test value is 14.766 which is more than the table value 2.01 shows it is statistically significant. This indicates the effectiveness of aerobic laughter therapy in male prisoners.

Table-5: Association of mean pre test level of perceived stress and selected socio demographic variables among male prisoners. N =50

SOCIO- DEMOGRAPHIC VARIABLES		PRE- TEST					
		N	mean	SD	P Value	DF	F/ T Value
1. Age (in years)	a) 18-30 year	25	26.40	2.96	0.411	3/46	0.979^{NS}
	b) 31- 45 years	20	24.50	5.12			
	c) 46-60 years	4	26.25	3.40			
	d) Above 60 years	1	28.00	-			
2.Marital status	a) Married	24	26.54	3.72	0.033	2/47	3.671^{*}
	b) Unmarried	20	25.75	3.13			
	c) Divorced	0	-	-			
	d) Widower	6	21.83	6.01			
3.Religion	a) Hindu	39	25.03	4.06	0.062	2/47	2.952^{NS}
	b) Muslim	1	24.00	-			
	a) Sikh	10	28.30	2.91			
	b) Christian	0	-	-			
	c) Any other	0	-	-			
4.Educational status	a) Non- literate	0	-	-	0.845	2/47	0.169^{NS}
	b) Primary education	19	25.32	4.27			
	c) Secondary education	15	26.13	3.50			
	d) Graduate & above	16	25.63	4.36			
5.Occupation before imprisonment	a) Unemployed	16	25.44	5.06	0.965	3/46	0.090^{NS}
	b) Self employed	28	25.89	3.68			
	c) Private	5	25.00	3.08			
	a) Government	1	26.00	-			
6.Family income per month	a) 5000- 10,000/month	32	25.59	4.23	0.836	3/46	0.285^{NS}
	b) 10,001- 15,000/month	8	26.75	2.87			
	c) 15,001-20,000/month	4	25.25	5.19			
	b) Above 20,001/ month	6	24.83	4.12			
7. Place of domicile	a) Urban	21	26.14	3.58	0.475	48	0.716^{NS}
	b) Rural	29	25.31	4.34			
	c) Slum	0	-	-			

Cont... Table-5: Association of mean pre test level of perceived stress and selected socio demographic variables among male prisoners. N =50

8.Type of crime	a) Property crime	11	24.64	3.88	0.133	3/46	1.961^{NS}
	b) Cyber crime	0	-	-			
	c) Organized crime	1	24.00	-			
	d) White collar crime	0	-	-			
	e) Violent crime	19	27.37	3.52			
	f) Any Type of crime	19	24.63	4.27			
9. Type of substance use	a) Use of alcohol	11	25.09	4.37	0.281	4/45	1.309^{NS}
	b) Use of Ganja	4	25.50	2.89			
	c) Use of nicotine	10	28.20	3.29			
	d) Any other	3	25.33	4.16			
	e) Nil	22	24.86	4.14			
10. Period of staying in prison	a) 6 month –1 year	2	26.00	1.41	0.558	3/46	0.698^{NS}
	b) 1 year – 2 years	6	27.67	1.97			
	c) 2 years – 3 years	5	26.40	1.52			
	d) Above 3 years	37	25.22	4.49			
11.History of pervious imprisonment	a) Never	41	25.49	4.27	0.416	2/47	0.894^{NS}
	b) Once	8	27.00	2.14			
	c) Twice	1	22.00	-			
	d)More than 2 times	0	-	-			
12. Previous exposure to aerobic laughter therapy	a) Yes	3	24.00	4.36	0.466	48	0.730^{NS}
	b) No	47	25.77	4.02			
13. Alternative method for stress reduction	a) Yoga	7	23.86	3.24	0.146	3/46	1.881^{NS}
	b) Morning or evening walk	18	26.33	3.69			
	c) Meditation	11	24.00	4.52			
	d)No Experience	14	27.00	3.98			

$p < 0.05$ Level of significance NS – Not Significant *- Significant

Table-5 illustrates that only marital status was significantly associated with the pre test level of perceived stress in male prisoners and remaining other variables like age, religion, educational status, family income , previous imprisonment, substance abuse, alternative method for stress reduction were not significantly associated with pre test score of perceived stress. Hence, the hypothesis was accepted only for the marital status and rejected for all other socio demographic variables.

DISCUSSION

The findings of the study are: According to the frequency and percentage distribution , it was inferred that majority of the male prisoners were, aged between18-30 year, married, Hindus, having primary education , self employed before imprisonment, having a family income between 5000-10,000 per month, residing in rural area, committed violent and other types of crime, not using any type of substances, staying in the prison for more than 3 years, never imprisoned previously, not attended any aerobic laughter therapy before and using morning or evening walk as an alternative method for stress reduction. The aerobic laughter therapy was significantly effective to reduce the perceived stress of male prisoners. The severe stress of majority of male prisoners reduced to moderate and low level of stress after the intervention.

Regarding association of mean pretest level of perceived stress and selected socio- demographic variable among male prisoners, all the selected socio- demographic variables are statistically not significant except marital status. The marital status of male prisoners was statistically associated with the mean difference in pretest perceived stress scale.

CONCLUSION

To put it in nutshell, the aerobic laughter therapy was effective in reducing the perceived stress of male prisoners because the mean difference in pre and post test level of perceived stress was 8.86 and the 't' value obtained is 14.766 ($p<0.05$) and inferred as aerobic laughter therapy was significantly effective to reduce the perceived stress of male prisoner. Regarding association all the selected socio-demographic variables are statistically not significant except marital status of male prisoners in pre test. So the marital status of male prisoners in pre test was independently influenced in reducing the perceived stress. The majority of the male prisoners participated in the study were aged between 18-30 years, married, Hindu, having primary education, self employed before imprisonment, having a family income 5000-10,000/month, residing in rural area, committed violent and other types of crime, not using any other type of substance, staying in the prison for more than 3 years, never imprisonment previously, not using morning or evening walk has an alternative method for stress reduction.

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Disability in Individuals with Substance Abuse and Rehabilitation Needs of Their Caregivers

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ABSTRACT

Introduction- Substance abuse is a major health problem which strikes its victim at a very young age. It may cause disability and psychosocial rehabilitation is important for the management of this disability. The present study aims to assess level of disability among substance abusers and perception of rehabilitation needs by their caregivers.

Method- A cross sectional pilot survey was carried out at a tertiary care hospital at Punjab. A convenience sample of 20 substance abusers attending psychiatric outpatient department were studied to assess disability by using Indian Disability Evaluation and Assessment Scale (IDEAS) and Rehabilitation Needs Assessment Schedule (RNAS) to identify rehabilitation needs of their caregivers. Appropriate descriptive statistics was applied to make the results.

Results- The study result revealed that out of 20 substance abusers, 11 substance abusers had 100% disability followed by 3 had 71-99% and remaining 6 substance abusers had 40-70% disability. Need for vocational training sought by 70%, need for psycho social modification was sought by 60% of the family members. Need for leisure time activity (45%), and social relationship need fulfillment was also sought in similar manner (25%).

Conclusion: A successful home rehabilitation should be always need based. Types and severity of disability of the patient will also play an important role in designing a structured rehabilitation programme. This study warrant further study based on large sample size to design a successful home based rehabilitation for substance abusers.

Keywords- *Substance abusers, rehabilitation, needs, disability, caregiver*

BACKGROUND

Substance abuse is a quite common problem worldwide and India is being no exception for that. It has very detrimental effects on all systems of an individual and makes the life miserable to survive. As a result of change in mental health care system in India, the majority of the people with substance abuse spend most of their life in their own community rather than large mental health institutions[1]. Therefore, it became obligation for family members to meet their rehabilitation needs at their home. In India, cultural expectation and societal norms also makes the caregivers or family members to take up role of caregiving of individual as they fall sick or disturbed. The concept of rehabilitation is still new in many developing countries including India and in still in stagnant phase[2].

Rehabilitation is designed structured programme to bring the patient in his/her previous normal healthy state by meeting his different needs by the family member, and arranging employment to reintegrate him in to the community or society. The main motives to identify the needs of rehabilitation is to helps in designing the home based rehabilitation programme and priorities social and other interventions at home setting. Meeting

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the desired rehabilitation needs of the substance abusers who is disabling, crippled and handicapped facilitates opportunity for the individuals to reach at maximum independent level of functioning in the society. Need identification could be an initial step in planning, designing and evaluating the efficiency of mental health services at community level and national. Furthermore, it can also help to develop requirement of the persons with substance abuse and enable them to maintain an independent status in the community.

Indeed, population with substance abuse constitutes a diverse millions population with unique needs in their rehabilitation, treatment and social support[3]. Moreover, it is also true that complete recovery of any disease condition depends on meeting diverse needs of the individual with effective implementation. Needs could be of different types i.e. met, unmet, perceived and assessed in an individual. Family caregivers have different needs at different stages of the patient's illness. Cameron and Gignac summarized five different stages of caregiver support needs across the care continuum as follows: event/diagnosis, stabilization, preparation, implementation, and adaptation[4]. Of these five stages, the first two occur during acute care, the third occurs during acute care or inpatient rehabilitation, and the final two stages occur in the community. The present study focused on community rehabilitation needs of caregivers of individual with substance abuse.

Disability is the most common complication of any medical condition. However, the severity and intensity of disability again depends upon disease related aspects and health seeking behaviour of an individual and family member. It is defined as an inability to participate or perform at a socially desirable in different activities i.e. self care, social relationship, work, and social acceptable behaviour[5]. Disability results directly from impairment. Substance abuse is figured one of the six neuropsychiatric problem causing top twenty causes of disability worldwide[6]. Disability could be in the form of limitations in social activities, self care, occupational functioning, and cognitive reservations. Disability prevents an individual to do a particular task with full competency and interest[7]. Therefore, assessing perception of the family members towards rehabilitation needs could be corner stone to plan the mental health services at community and national level. Although, the government efforts are extremely appreciable but alarming demand of increasing population outweigh the resources and services offered to the population.

Therefore, the present pilot survey was planned to assess disability status in substance abusers and perception of family members towards rehabilitation needs to design and strengthening home based rehabilitation programme and therefore helps in planning, implementation and evaluation of mental health services at community and national level.

RESEARCH METHODOLOGY

A descriptive survey was conducted at in-patient psychiatric department of Si Guru Ram Das Institute of Medical Sciences and Research, Amritsar Punjab. The study population comprised of substance abusers diagnosed as per ICD-10 and their caregivers. 20 substance abusers and their 20 caregivers were selected through convenience sampling technique. Inclusion criteria included healthy caregivers aged more than 18 years or more, staying with patient and are involved in the direct care of the patient. The caregivers, who refused to participate in the study and having chronic psychiatric and medical conditions, were excluded from the study. The caregivers who were coming for follow up along with the patient were interviewed in the hospital.

RESEARCH TOOLS

The tools used for the study were information data sheet, Indian Disability Evaluation and Assessment Search (IDEAS) and Rehabilitation Needs Assessment Schedule (RNAS). The permissions for using all the tools were sought from each concerned authority.

Indian Disability Evaluation and Assessment Search (IDEAS)[8]: This tool was developed by the rehabilitation committee of the Indian Psychiatric Society for assessing and qualifying psychiatric disability. It is now been gazette by the Ministry of Human Resources and Empowerment, Government of India as the recommended instrument. It has four subscales 1) Self care, 2) Interpersonal activities (social relationships), 3) Communication and understanding, and 4) Work. Each item is scored on a 4 point scale namely 0-No disability to 4- Profound disability.

Rehabilitation Needs Assessment Schedule (RNAS)[9]- It is an open ended schedule cover purely quantitative information and therefore does not need any observer rating. It cover the following areas 1)Employment, 2) Vocational training/guidance, 3)Accommodation, 4)

Leisure activities, 5) Psychosocial attitude modification, 6) Skill training,7)Any other help needed by the family, 8) Any other need not covered in the schedule.

DATA COLLECTION PROCEDURE

A written permission was obtained from concerned authority of hospital to collect the data from substance abusers and their caregivers. After explaining the study objectives, a written informed consent was also sought from the substance abusers and their caregivers. While interview, it was assured that subjects were free from all types of distractions to furnish the necessary details. It took around 20-25 minutes to furnish the asked details.

ETHICAL CONSIDERATION

The permission for data collection was obtained from the competent authorities in the Institutes. After screening the subjects as per the inclusion and exclusion criteria, an informed verbal consent was obtained from them. It took around 10-15 minutes to conduct complete interview. Anonymity and confidentiality of the subjects was maintained during the study and they were given full autonomy to withdraw from the study at any time. The data was then transferred into SPSS 20.0 Evaluation Version and was analyzed using descriptive statistics.

RESULTS

The demographic profile of the subjects' is shows in table 1. As the treatment center population comprises almost exclusively of males, only men were recruited for the study and their caregivers attending follow-up were taken. Mean age of patient were 34±10.47 (20-55years) with a mean duration 6.37±5.23 years of illness. Further findings revealed that 50% patient were married and came from nuclear family structure (55%), belong to urban (40%), rural domicile (45%) and educated up to high school and graduation (70%) and working (80%) with a family income of more than 10001 rupees per month.

Table 1. Socio-demographic profile of subjects (n=40)

Variables	Patient f(%) (n=20)	Caregiver f(%) (n=20)
Age (mean±SD)	34±10.47	49.20±17.06
Gender		
Male	20 (100)	07(35)
Female	-	13(55)
Currently living with patient# /relationship with patient*		
Parents	14 (70)	07(35)
Wife	04(20)	05(25)
Siblings	04(20)	01(5)
Others ^	01(5)	07(35)
Type of family		
Nuclear	09(45)	-
Joint	11(55)	
Marital status		
Married	09(45)	01(05)
Unmarried	10(50)	14(70)
Others**	01(05)	05(25)
Domicile		
Rural	08(40)	-
Urban	03(15)	-
Semi-urban	09(45)	
Education status		
Up to secondary	06(30)	10(50)
High school and above	14(70)	10(50)
Occupation status		
Employed	04(20)	04(20)
Unemployed	16(80)	16(80)
Monthly income		
<10000	02(10)	-
>10001	18(90)	
Leisure activities #		
Entertainment (TV & Radio)	17(85)	09(45)
Play and games	05(25)	03(15)
Religious activities	02(10)	15(75)
Others***	01(5)	02(10)
Duration of illness in years (mean±SD)	6.37±5.23	-

*-for caregiver it should be read as relationship with patient;**-separated, divorced, widow;***- hobbies, artistic, & painting ;#- multiple frequency application;^-grandmother, grandfather, in-laws

In term of use of leisure time activities, It was revealed that patient use 85% entertainment (TV & radio) followed by 25% play and other activities for passing their leisure time. Majority of patient (90%) reported availability of social support and currently living with parents (70%).

In regards of caregivers, the mean age of caregivers was 49.20 years (SD=±17.06). Findings also revealed that 55% of caregivers were female, were parents in relationship (35%), and unmarried (70%). Further, findings projected that around 50% caregivers were equally educated up to secondary and high schools, were employed (80%) and 75% were practicing religious activities for recreation and support to cope the distress due to caregiving and maintain good health and mental well being.

DISABILITY STATUS

Table 2 depicts level of disability among substance abusers. The findings revealed that 55% of patients had 100% disability followed by 15% had 71-99% and reaming 30% had 40-70 5 disability.

Table 2. Level of disability among substance abusers (n=40)

Disability level	f (%)
No Disability (0, 0%)	-
Mild Disability (1-6, <40%)	-
Moderate Disability (7-13, 40-70%)	06(30)
Severe Disability (14-19, 71-99%)	03(15)
Profound Disability (20, 100%)	11(55)

REHABILITATION NEEDS

Table 3 depicts the rehabilitation needs among caregivers. The findings revealed that family members need helps in family education, dealing with family burden, stress reduction intervention, group meetings and measures to deals uncontrolled emotions, were given priority by most of the family member (100%). Need for vocational training sought by 70%, need for psycho social modification was sought by 60% of the family members. Need for leisure time activity (45%), and social relationship need fulfillment was also sought in similar manner (25%). No other special needs were expressed by the family members of the substance abusers.

Table 3. Rehabilitation needs- Help for the family and level of disability(n=40)

Disability	Help for family- Yes	Help for Family –No	Total
Moderate	06	-	06
Severe	03	-	03
Profound	11	-	11
Total	**20**	**-**	**20**

Table 4. Rank order of the help for the family needs (n=40)

Needs -help for the family	f	%	Rank
Dealing with expressed emotion and stress	20	100	1
Family psycho education	19	95	2
To deals with burden and distress	16	80	3
Need for employment	14	70	4
Telephone family counseling	12	60	5
To improve coping skills	09	45	6
Social meeting	05	25	7

DISCUSSION

Rehabilitation plays an important role in recovery of a patient with substance abuse. A healthier and social relationship speeds up the recovery of the patient and helps to regain the independency and self respect in the society. Along with psychopharmacological intervention, meeting the needs and fulfilling them timely and appropriately is equally important in recovery of the patient. It is a neglected domain of psychiatric treatement and could be one reason of ineffective utilization of mental health services.

In present study majority (55%) of the substance abusers had profound level of disability and their family

members looking for one or another need to get help in rehabilitation of their patient. Similarly, study conducted by Shihabuddeen I et al (2012)[2] represent that around 76.66% sample had disability less than 40% and are in need of different rehabilitation needs. This evidenced that despite of advancement in mental health services, still majority of the population not getting their rehabilitation need fulfilled in order to get early recovery and make the survival independent. Moreover, Country like India where family system play an important role in taking care and meeting the needs of the patient, emphasize the collaboration role between family member and health system to treat such kind of disorders which need long term rehabilitation services.

The present study and previous study[2,10] also reports that family members are in need of education, developing positive coping strategies, telephonic counseling and ways to deals with burden and emotional problems. Therefore, it is equally important to take care the family members of substance abuse patients to make the outcome and recovery helpful. Moreover, the paid caregiver concept is not so prevalent in India and hence, the level of burden and distress in caregivers would be more as compared to western population that subsequently may have detrimental effects on the physical and psychological health of the caregivers. So, exploring the needs of the family members will not only helps to design successful home rehabilitation for the substance abusers but also help to prevent birth of many psychological and physical problems in family members as well.

CONCLUSION

Despite of government efforts and many private non-governmental agencies (NGOs) initiative, rehabilitation is still in stagnation phase in country. Identification of rehabilitation needs of patient and family members will be a great attempt to make rehabilitation successful and therefore effective implementation and utilization of mental health services. Assessment of needs will also play a crucial role in planning, executing and evaluating the utilization of the mental health services. A large scale longitudinal study can give sound findings that can work as a key to open the door of home rehabilitation programme in India.

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Impact of Video Assisted Teaching Module on Knowledge regarding Multi Disciplinary Parent Education among the Caregivers of Children with Autism in Autism Therapy Centre Bhubaneswar, Odisha

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ABSTRACT

Autism is a challenge not only to any nation but also to the entire human race. Appropriate early intervention is important to treat child with autism. The parents, physicians, and specialists should discuss what is best for the child. Parents should be educated regarding behavioral techniques so that they can participate in all aspects of the child's care and treatment. Special education classes are available for autistic children as well as for caregivers.Hence the investigator had undertaken this study a study to assess the effectiveness of VATM on knowledge regarding Multidisciplinary parent education among the caregivers of children with Autism in Autism Therapy Center, Bhubaneswar, Odisha.

Method- A pre experimental study with pre and post test without control group design was undertaken on 30 caregivers of autism in Autism Therapy Centre, Bhubaneswar, Odisha selected by purposive sampling technique. Data was collected from through multiple choice close ended questionnaire. The data collected were analyzed by using descriptive and inferential statistics.

Results -The study findings reveal that there was highly significant difference in pre test and post test knowledge scores was obtained by paired 't'test whose value is 15.67 at 5% level of significance. The study findings reveal that the chi square test was calculated and found that there was significant association between post test knowledge scores with gender and previous knowledge of the caregivers at 5% level of significance where as no significant association was found between post test knowledge scores with age, education, religion, marital status, areas of living, types of family, socio economic status of the caregivers.

Conclusion- Statistical analysis of data revealed that VATM was effective in improving knowledge regarding MDPE among the caregivers of children with Autism.

Keywords- *Video Assisted Teaching Module(VATM), Multidisciplinary Parent Education (MDPE), Autism, caregivers.*

INTRODUCTION

Autism is not a puzzle, nor a disease. Autism is a challenge but certainly not a divesting one. It is about finding a way to survive in an overwhelming confusing world. It is about developing differently in a different pace and with different leaps. . [1-2]

A child with autism may also show abnormalities in relating to both people and his or her environment. These types of behaviors could include being unresponsive to verbal communication, making little or no eye contact, seeking attention in abnormal ways, being content when left alone for abnormally long periods of time, and inability or unwillingness to take turns during play. The DSM-IV-TR defines these types of behaviors as

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impairments in the use of nonverbal behaviors that help regulate social interaction, failure to develop friendships at developmentally appropriate times, and failure to spontaneously share positive events with others. When relating to his or her environment, a child with autism will display a preoccupation with restricted or stereotyped interests, have rigid, impractical routines, engage in stereotyped repetitive behaviors, and show abnormal interests in parts of objects primarily because the child has a serious emotional disturbance.[3-6]

Raising a child with autism is one of the hardest things a parent will ever have to do. It is an overwhelming challenge physically and emotionally adding anxiety on the person caring for the child. Rearing a child with autism often contributes to marital problems, problems with other children, and job instability. Unfortunately, there are no reliable treatments for autism, and the responsibility of upbringing, developmental and behavioral problems of the autistic child falls largely on the family. Although there is nothing that we can do to change the origin of the problem, there are strategies which family members can do to reduce the level of abnormal behavior and increase the child's ability to cope.[7]

A comparative study was conducted to determine the views of teachers and parent on autism .Surveying of beliefs regarding various aspects of the disorder was done among 47 teachers and parents of autistic children. Parent and teacher responses were compared to those obtained from a group of 22 "specialists" in autism, drawn from across the country. Both parents and teachers were found to harbor misconceptions regarding cognitive, developmental, and emotional features of autism.[8]

From the above mentioned information, caregivers are lacking knowledge regarding the disabilities of children with Autism . So the researcher found it relevant to provide a Video Assisted Teaching Module of Multi Disciplinary Parent Education on autism which includes definition, incidence, etiology, risk factors, signs and symptoms and role of caregiver in management of children with autism in order to create awareness among the caregiver and improve their knowledge in assisting the autism children. .

STATEMENT OF PROBLEM

A study to assess the effectiveness of video assisted teaching module on knowledge regarding multi disciplinary parent education among the caregivers of children with autism in autism therapy centre, Bhubaneswar, Odisha

OBJECTIVES OF THE STUDY

- To assess the knowledge regarding multidisciplinary parent education among care giver of Autism
- To evaluate the effectiveness of VATM regarding multidisciplinary parent education on Autism
- To find out the association between the level knowledge with demographic variables.

HYPOTHESIS

H_1: There will be significant difference between mean post test knowledge of caregiver with the mean pretest knowledge score regarding MDPE

H_2: There will be significant association between selected socio demographic variables with the mean post test knowledge level of caregivers of children with Autism on Multi Disciplinary Parent Education.

MATERIAL AND METHOD

A pre experimental study with pre and post test without control group design was undertaken on 30 caregivers of children with autism in autism therapy centre, Bhubaneswar, Odisha selected by purposive sampling technique. The tool was developed in 2 sections. Section-A includes the demographic variable and Section B include close ended questionnaire related to knowledge regarding MDPE on Autism.

Permission was obtained from the Director of Autism Therapy Center, Bhubaneswar, Odisha to conduct the study. Informed consent was obtained from the caregivers taken part in the study. Pretest was conducted by using closed ended questionnaires followed implementation of VATM. After 7 days post test was done. The data collected were analyzed by using descriptive and inferential statistics.

FINDING

Distribution of caregivers according to their demographic variables

Among 30 respondents the maximum percentage(43.3%) of the caregivers were in the age group 35-40yrs. As per the education the maximum percentage (53.4%)

of the caregivers were having graduate. Religion shows that highest percentage (90%) of the caregivers were Hindu. Marital status reveals that the most of (96.7%) the caregivers were married. According to area of living depicts that 70% of caregivers were from urban area. As per the type of family revealed that most of 60% caregivers were from nuclear family**.** As per sex most of the caregivers 60% were female where. It was also found that most of the caregivers 66.6% hadn't previous on MDPE.

Table No 1: Frequency and percentage wise distribution of Demographic Variable

N- 30

Variable	**Frequency**	**Percentage**
Age in year		
31-35yrs	12	40%
35-40yrs	13	43.3%
Above 40 yrs	5	16.7%
Gender		
Male	12	40%
Female	18	60%
Educational qualification		
Primary	1	3.3%
Matriculation	7	23.3%
Higher secondary	6	20%
Graduation	16	53.4%
Religion		
Hindu	27	90%
Muslim	2	6.6%
Christian	1	3.4%
Others	0	0
Marital status		
Married	29	96.7%
Unmarried	1	3.3%
Areas of living		
Rural	9	30%
Urban	21	70%
Slum	0	0
Type of family		
Nuclear	18	60%
Joint	12	40%
Extension	0	0
Socio economic status		
Low	6	20%
High	5	16.7%
Middle	19	63.3%
Previous knowledge on MDPE		
Yes	10	33.3%
No	20	66.7%

Table 2: Area wise distribution of mean, standard deviation, mean percentage of pre test and post test knowledge scores of caregiver regarding Autism and MDPE.

SL NO	**AREA**	**PRE TEST**			**POST TEST**			**MEAN DIFFERENCE Y-X**
		MEAN	**SD**	**MEAN% X**	**MEAN**	**SD**	**MEAN% Y**	
1	General information on autism and MDPE	10.63	2.09	62.52%	14	1.66	82.35%	19.83%
2	Aspects of MDPE	5.5	1.196	36.66%	9.67	0.99	64.47%	27.81%
3	Decreasing parental stress and depression	2.13	1.11	26.62%	6.03	1.03	75.37%	48.75%
4	Over all	18.26	3.095	45.65%	29.7	2.58	74.25%	28.6%

Table-2: It is observed that overall pre test mean score is 18.26 with SD of 3.095 and mean percentage is 45.65%. The post test mean score is 29.7 with SD of 2.58 and mean percentage is 74.25% .The difference in mean percentage is 28.6% reveals the effectiveness of video assisted teaching module on MDPE.

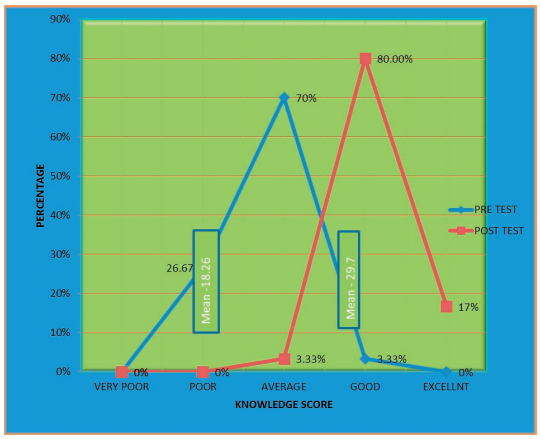

Figure 1: Comparison of level of knowledge of pre test and post test knowledge scores of caregivers regarding MDPE

Figiuer -1 : Depicts that during pretest majority 70% of them had avergaee knowledeg where as during post test 80 of them had good knowledeg showing the effectiveness of of video assisted teaching module on MDPE.

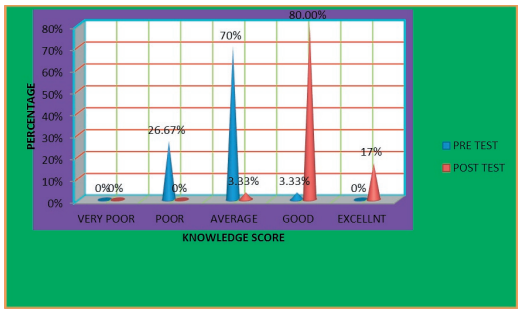

Figure 2: Line graph showing the comparison between pre test and post test knowledge score

Foig-2: Line graph drawn to compare the pretest and post test knowledge score reveals that highest pre test mean score was between 17-24 which was obtained by 70% of caregivers and the lowest mean score between 25-32 obtained by 3.33% of caregivers and none of them secured between 0-8 and 33-40.The highest post test mean score is between 25-32 which is obtained by 80% of caregivers where as the post test lowest mean score was between 17-24 obtained by 3.33% of caregivers. None of them secured between 0-8 and 9-16 which shows higher effectiveness of knowledge after VATM.

H1 – There will be significant difference between pre and post-test knowledge scores of caregivers on MDPE.

Table 3 Area wise comparison between difference of pre test and post test knowledge scores of caregivers on MDPE

AREA	't' VALUE	LEVEL OF SIGNIFICANCE
General information about Autism and MDPE	6.93	Highly significant
Components of MDPE	14.89	Highly significant
Decreasing parental stress and depression	14.18	Highly significant

(df = 29), (Table value= 2.05), (P≤ 0.05)

Table-3: Paired 't'test is calculated to assess the significant difference between pre and post test knowledge scores which shows highly significant difference between area wise score values of pre test and post test knowledge scores. Hence, the statistical hypothesis is accepted. Thus it can be interpreted that video assisted teaching module is effective for all the areas and there is a difference between pre and post-test knowledge scores of caregivers of children with Autism on MDPE.

H2 – There will be a significant association between post-test knowledge scores with selected demographic variables.

Table 4 : shows Association between post test knowledge scores of the caregivers of children with Autism on MDPE their selected demographic variables

Demographic variables	Chi square value ($\chi 2$)	Df	Table value	Level of significance
Age of caregiver	1.42	3	7.82	Not significant
Education	2.95	3	7.82	Not significant
Religion	1.95	3	7.82	Not significant
Marital status	0.6	1	3.84	Not significant
Ares of living	0.72	2	5.99	Not Significant
Types of family	0.21	2	5.99	Not significant
Socio economic status	4.88	2	5.99	Non Significant
Gender	3.32	1	3.84	Significant
Previous knowledge	18.33	1	3.84	significant

(P≤0.05)

Chi square was calculated to find out the association between post test knowledge scores of the caregivers with their selected demographic variables. from chi square test it was interpreted that there is significant association between post test knowledge scores among caregivers on MDPE when compared to gender and previous knowledge on MDPE at 5% level of significance. There is no significant association between post test knowledge scores among caregivers when compared with age, education, religion, marital status, types of family, areas of living, and socio-economic status at 5% level of significance.

RECOMMENDATIONS

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

- A similar study can be under taken among school teachers.
- A similar study can be conducted with a very large sample size for generalize the findings.
- A similar study can be undertaken in other setting like psychiatric centers.
- A similar study can be under taken by considering control group.
- A similar study can be conducted by using various instructional media for obtaining the most effective method e.g. Demonstration, Simulation, SIM etc.

CONCLUSION

From the findings of the present study is concluded that Video Assisted Teaching Module on Multi Disciplinary Parent Education among caregivers of children with autism is effective for improving knowledge of caregivers.

Conflict of Interest: None

Source of Funding: Self

Ethical Clearance: Ethical clearance was obtained from the Director of Autism Therapy Center, Bhubaneswar, Odisha to conduct the study. Inform consent was obtained from the caregivers taken part in the study on permission.

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Effect of Assertiveness Teaching on Assertiveness among Final Year Student Nurses in Selected College of Nursing, Dehradun, Uttarakhand

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ABSTRACT

Background: Nursing profession mostly based on the communication and if nurses are not able to communicate properly with their patient then she doesn't know about the need of the patient and also not provide proper care to the patient and it prevents the nurses from positive outcomes in giving care to the patients. It's very important in nursing profession that nurses need to be assertive when professional nurse interact with the patients, colleague, and other health care personnel's because lack of assertiveness demoralized the nurses. **Aim & Objective:** The main objective of this study was to assess the assertiveness among final year student nurses before and after giving assertiveness teaching in selected college of nursing Dehradun, Uttarakhand. **Material and method**: The study has adopted pre-experimental research design. The data was collected from 39 student nurses by administrating demographic profile and Simple Rathus Assertiveness Schedule. Samples were selected by using convenient and consecutive sampling technique. **Result:** Majority of (89.7%) participants were in the age of group of 20-24 years and 10.3% fall in age group of 25-30 years. All the participants (100%) were female. The study showed that the post test mean of student nurses was 129.69 (SD = 15.30) which is higher than the pre test mean 105.18(SD= 11.21). The mean difference was 24.51. The't' value was 12.7 and found statistically significant at ($p < 0.05$) level of significance. It is indicating that the increase in assertiveness was not by chance but because of the intervention. Hence, it was interpreted that assertiveness teaching was significantly effective in increasing the assertiveness of the student nurse.

Conclusions: This study demonstrated that there was strengthening in assertive behavior after giving assertiveness teaching program therefore intervention was effective.

Keywords: *Assertiveness, Effectiveness, Assertiveness teaching.*

INTRODUCTION

Assertiveness is one of the important skills for every profession. According to Calberti and Emmon, 2008 assertive behavior is the behavior which enables the people to act upon his own best interest and to stand up for himself without undue anxiety and to express his honest feelings comfortably or to exercise his own rights without denying or violating the rights of others.[1] Assertiveness training is an effective non-pharmacological and productive method for reducing academic anxiety and also it can improve academic performance and can increase self confidence.[2] When we approach people, we need to have confidence in our self. Whether it is a difficult doctor or a hurting patient, we have the confidence in our self and our ability to speak whatever we want to speak.[3]

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OBJECTIVE

(1) To assess the assertiveness among final year student nurses before giving assertiveness teaching.

(2) To evaluate effectiveness of assertiveness training on assertiveness among final year student nurses after giving assertiveness training.

(3) To find out the association between pre assertiveness score and selected demographical variables.

MATERIAL AND METHOD

A pre experimental one group pre test post design was selected to carry out the study. The study comprised of all student nurses of selected Himalayan College of Nursing, Dehradun, Uttarakhand. Non probability convenient and consecutive sampling technique was used for the selection of 39 student nurses who fulfilled inclusion criteria of the study. Tool used for the study were questionnaire to assess the assertiveness of student nurses divided into two sections in **Section A:** socio demographic profile, **Section B** Simple Rathus Assertiveness Schedule

Before beginning with the study, Formal administrative permission was obtained from the Principal, Himalayan college of nursing S.R.H.U, ethical permission was taken from ethical committee of the Himalayan Institute Hospital and Trust and permission obtained.

RESULT

Frequency and percentage distribution of study participants with their socio- demographic characteristics

In demographic variable of sample revealed that Majority (89.7%) participants were in the age of group of 20-24 years. All the participants (100%) were female. Most (84%) of them were living in nuclear family. Majority (51.3%) of them belonged to urban area. Parents' of (79.5%) participants were married. The majority (56.4%) participants joined nursing course after intermediate. Majority (41.0%) participants' mothers' were having primary education. Mothers' of maximum (53.8%) participants were govt. servant. Majority (51.3%) participants' fathers were having high school education. Father's of maximum (66.7%) participants were govt. servant. Monthly family income of maximum of participants (53.8%) was below Rs 20,000.Most (56.4%) had Hindi as medium of instruction till intermediate. 56.4% participants had good reading skills in English. 41.0% participants had good writing skills in English. 46.2% participants had average speaking skills in English.

Table No 1: Comparison of pre test and post test mean of the assertiveness among student nurses. N=39

Assertiveness	Range	Mean ± SD	MD	t –value	p-value
Pre test	80-131	105.18±11.21	24.51	12.7	0.001
Post test	92-153	129.69±15.30			

df =38 *Significant at 0.05 level **Paired't' testTable no. 1**. The post test mean of assertiveness score 129.69 (SD = 15.30) was higher than the pretest mean of assertiveness score 105.18(SD= 11.21). The mean difference was 24.51. The 't' value was 12.7 and found statistically significant at ($p < 0.05$) level of significance. Hence, it was interpreted that assertiveness teaching was significantly effective in increasing the assertiveness of the student nurse.

Table No. 2. Associations between pre test assertiveness score and selected demographic variables. N=39

S. No.	Selected variables	N	Mean ± SD	CI 95% L-U	t-value	p-value
1.	**Age** 20-24 years 25-30 years	 35 4	 104.7±11.6 109.2±4.7	16.2-7.5	0.7	0.13
2.	**Types of family** Nuclear family Joint family	 33 6	 104.9±10.5 106.3±15.7	11.5-8.8	0.27	0.37

Cont... Table No. 2. Associations between pre test assertiveness score and selected demographic variables.

N=39

3.	**Place of residence** Rural area Urban area	 19 20	 107.4±9.2 103.0±12.6	2.0-11.7	1.25	0.42
4.	**Parent's marital status** Married Widow	 31 8	 105.3±12.2 104.3±6.4	8.1-10.1	0.22	0.11
5.	**Medium of instruction till intermediate.** Hindi English	 22 17	 104.00±9.2 106.7±13.4	10.0-4.6	0.74	0.12
6.	**Family income monthly** Below 20,000 Above 20,000	 21 18	 105.2±10.1 105.1±12.6	7.27-7.5	0.03	0.54

df=37, p<0.05 **Independent t-test**

Table no.2 depicts that there was no significance association between the pre test assertiveness level and selected socio- demographic variables like age, type of family, place of residence, parent's marital status, medium of instruction and family income monthly. Hence, the researcher accepted null hypothesis.

Table no. 3: Associations between pre test assertiveness score and selected socio demographic variables.

N=39

S.No.	Selected variable	N	Mean ± SD	F	p-value
1.	**Additional qualification before joining nursing program.** After+2 Graduation or above Any Diploma	 22 11 06	 105.8±9.8 107.2±8.7 98.8±18.3	1.2	0.2
2.	**Mother's level of education** Primary education High school education Graduation or more	 16 14 9	 104.6±8.7 108.8±11.0 100.3±14.3	1.7	0.1
3.	**Mother's employment status** Govt. servant Private Self employed	 21 11 7	 104.6±12.7 108.8±11.0 100.3±14.1	0.5	0.5
4.	**Father's level of education** Primary education High school education Graduation or more	 3 20 16	 100.0±2.6 103.8±10.6 107.8±12.6	0.8	0.4
5.	**Father's employment status** Govt. servant Private Self employed	 26 7 6	 107.9±9.5 105.00±13.1 93.3±9.0	5.0	0.01

df=38 Significant at 0.05 level 'One Way ANNOVA'

Table no.3 depicts that only father's employment status was significantly associated with the pre test assertiveness level of the student nurse and remaining other variables like additional qualification, mother's level of education, mother's employment status, and father's level of education were not significantly associated with pre test score of assertiveness. Hence, the hypothesis was accepted only for the father's employment status and rejected for all other socio demographic variables.

Table no. 4: Comparison of mean of positive and negative statement before and after giving assertiveness teaching. N=39

Statements	Pre test	Post test	MD	t- value	p- value
	Mean ± SD				
Positive statement	54.23±5.56	62.16±5.40	7.93	8.943	0.001
Negative statement	50.95±9.82	67.56±12.64	16.61	10.246	0.001

df=38, p<0,05 Paired 't' test

Table no. 4 depicts that for positive statements, the post test mean 62.16 (SD = 5.40) was higher than the pretest mean 54.23(SD= 5.56).The mean difference was 7.93. The 't' value was 8.943 and found statistically significant at ($p < 0.05$) level of significance. Whereas for negative statements, the post test mean 67.56 (SD = 12.64) was higher than the pretest mean 50.95(SD= 9.82). The mean difference was 16.61. The 't' value was 10.246 and found statistically significant at ($p < 0.05$) level of significance. It was interpreted that student response for both positive and negative statement has been improved after giving assertiveness teaching.

Table no. 5: Comparison of means of positive statements before and after giving assertiveness teaching. N=39

S no.	Statements	Pre test	Post test	t-value	p-value
		Mean ±SD	Mean ±SD		
1.	When I am eating out and the food I am served is not cooked the way I like it I complain to the person serving it.	3.51±1.604	5.07±1.010	5.331	0.001
2.	I try as hard to get ahead in life as most people like me do.	3.10±1.465	4.10±1.641	3.164	0.003
3.	If a famous person was talking in a crowd and I thought he or she was wrong I would get up and say what I thought.	2.41±1.409	3.48±1.652	4.732	0.000
4.	I am open and honest about my feelings.	5.30±0.893	5.82±0.451	3.620	0.001
5.	I complain about poor service when I am eating out or in other places.	3.89±1.553	4.71±1.025	3.452	0.001
6.	If a couple near me in a theatre were talking rather loudly, I would ask them to be quiet or to go somewhere else and talk.	2.76±1.662	4.43±1.483	4.800	0.000
7.	I am quick to say what I think.	4.00±1.451	4.82±1.073	2.840	0.007

Df= 38, p<0,05 Paired 't' test

Table no. 5 depicts that out of 13 positive statements 7 positive statements were found statistically significant

Table no. 6 Comparison of means of Negative Statements before and after giving assertiveness teaching.

N=39

S no.	Statements	Pre test	Post test	t- value	p-value
		Mean± SD	Mean± SD		
1.	Most of people stand up for themselves more than I do.	2.48±1.097	4.25±1.390	6.649	0.001
2.	At times I have not made ors gone on dates because of my shyness.	3.56±1.789	4.48±1.335	3.650	0.001
3.	I am careful not to hurt other people's feelings, even when I feel hurt.	1.92±1.156	3.58±1.634	6.212	0.000
4.	I often don't know what to say to good looking people of the opposite sex.	3.82±1.775	4.51±1.275	2.869	0.007
5.	I do not like making phone calls to business or companies.	2.61±1.532	3.33±1.951	2.096	0.043
6.	I feel silly if I return things I don't like to the store that I bought them from.	2.66±1.737	4.17±1.335	5.509	0.000
7.	If a close relative that I liked where upsetting me I would hide my feelings rather than ay that I was upset.	2.41±1.551	3.51±1.355	4.018	0.000
8.	I have sometimes not asked questions for fear of sounding stupid.	3.15±1.159	3.89±1.021	2.994	0.005
9.	I often hard time saying 'no'	1.97±1.112	3.64±1.646	6.099	0.000
10.	I don't to show my feelings rather than upsetting others.	2.25±1.044	3.07±1.080	5.229	0.000
11.	When someone says I have done much done very well I sometimes just don't know what to say.	3.48±1.848	4.46±1.553	2.836	0.007
12.	There are times when I just can't say anything.	2.12±1.174	3.87±1.609	5.605	0.001

df- 38, p<0,05 Paired 't' test

Table no. 6 depicts out of 17 negative statement 12 negative statements were found statistically significant.

DISCUSSION

Findings of the present study showed that majority of (89.7%) participants were in the age of group of 20-24 years. All the participants (100%) were female. Most (84.6%) of them were living in nuclear family. Majority (51.3%) of them belongs to urban area. Parents' of (79.5%) participants were married. The majority of (56.4%) participants joined nursing program after intermediate. Majority of (41.0%) participants' mothers' were having primary education. Mothers' of maximum (53.8%) participants were govt. servant. Majority of (51.3%) participants fathers were having high school education. Father's of maximum (66.7%) participants was govt. servant. Monthly family income of maximum (53.8%) participants was below Rs 20,000. Most of (56.4%) participants had Hindi as medium of instruction. 56.4% participants had good reading skills in English. 41.0% participants had good writing skills in English. 46.2% participants had average speaking skills in English. None of had attended any assertiveness teaching previously.

The findings were consistent with a quasi experimental study conducted by Abed G.A, Amrosy. EI S.H and Atia M.M on the effectiveness of assertiveness training program on improving self esteem of psychiatric nurses at psychiatric and addiction treatment hospital in Mit Khalf at Menoufyia, Egypt(2015**)** in which majority of (63.3%) nurses were females whereas 36.7% were males. Regarding residence 63.3% were from rural area. 56.7% were attended assertiveness workshop whereas remaining 43.3% were not attended any workshop of

assertiveness.[11]

Section B: - Effectiveness of assertiveness teaching on assertiveness among final year student nurses before and after giving assertiveness teaching.

Findings of the study showed that the post test mean of assertiveness 129.69 (SD = 15.30) was higher than the pretest mean of assertiveness 105.18(SD= 11.21). And found statistically significant at ($p < 0.05$) level of significance. Hence, it was interpreted that assertiveness teaching was significantly effective in increasing the assertiveness of the student nurse.

The findings were consistent with a similar study conducted by Rezan A, and Zengel Cecen- Eroul Mustafa it can be seen experimental and control groups pre-test scores mean were close to each other [experimental group (X = -12.66; SD=14.30), control group (X = -15.00; SD=8.83)]. Experimental group post-test Rathus Assertiveness Schedule mean scores (X=25.60; SD=17.49) were higher than control group mean scores (X=8.81; SD= 20.88). However control group post test scores (X=8.81; SD=20.88) were also higher than pretest control group scores(X= - 15.00; SD=8.83).[15]

CONCLUSION

The study demonstrated that there was strengthening in assertive behavior after giving assertiveness teaching program therefore intervention was effective.

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Sleep Quality among Shift and Non-shift Working Staff Nurses in Selected Hospital of Dehradun, Uttarakhand

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ABSTRACT

Objectives - This study aimed at comparing sleep quality of shift and non-shift working staff nurses. Also the association between quality of sleep of both groups was determined with their selected demographic variables.

Material and Method- Here, Quantitative approach with Non experimental, exploratory, cross sectional study design' was used. 100 staff nurses (50 shift nurses and 50 non shift nurses) were selected through Simple random sampling technique from selected hospital of Dehradun, Uttarakhand. Sleep quality was measured using Pittsburgh Sleep Quality Index and Baseline data.

Results- Data revealed that, there was no statistically significant difference between sleep quality of shift and non shift nurses. There was no statistical significant association between demographic variables of nurses and quality of sleep of nurses.

Keywords: *Quality of sleep, Shift working staff nurses, Non Shift working staff nurses.*

INTRODUCTION

"Each night, when I go to sleep, I die and the next morning, when I wake up, I am reborn".[1]

The above stated saying by Mahatma Gandhi clearly defines that sleep makes everything new and fresh. Sleep, which is a period of rest accompanied with varying degree of unconsciousness and relative inactivity,[2] is also been explained by Abraham Maslow (1968) in his holistic human needs.

In today's era shift work is preferred.[3][4] Due to that, shift workers have hampered sleep which is fulfilled in daytime but, the body finds it difficult to adjust to sleep in daytime.[5][6][7][8] According to International Classification of Sleep Disorders, 5-8% of population exposed to night works suffers from Shift Workers Sleep Disorder.[9] [10][11]

The nurses, being the back bone of health care team services works round the clock.[12] A study done in Udaipur (India), revealed that shift work has negative effect on health of nurses.[13][14] [15] Poor sleep quality among hospital staff nurses leads to decreased vigilance, a lower work performance, occupational injury and a higher risk of medical errors which may somehow affect patient's safety.[16].[17] [18] [19].

METHOD

Participants

50 -shift duty nurses and 50 - non-shift duty nurses were randomly selected from selected hospital of Dehradun, Uttarakhand, India for present study .The staff nurses included in study were those who were:

- Working in General duties and Shift duties
- Willing to participate in study.
- Knew Hindi and English language.

The staff nurses who were not present at the time of data collection were excluded from the study.

Measures

The tools used to generate the necessary data was **Baseline data** of staff nurses and **Pittsburgh Sleep Quality Index.**[20] Permission and approval to use PSQI was obtained from Professor Buysse and MAPI Research Trust.

Data collection process:

Data was collected from 24.02.2015 to 28.02.2015 after taking necessary administrative permissions from concerned authorities. Informed written consent was signed by each participant before data collection.

RESULTS

Table.1a: Socio-demographic characteristics of staff nurses (N=100)

S .N	Variable	Shift nurses (n=50) (f)	(%)	Non Shift nurses (n=50) (f)	(%)	X2	P value
1.	**Age #** 23-32yrs 33-42yrs 43-52yrs	 40 8 2	 **80** 16 4	 24 23 3	 **48** 46 6	9.83	0.007
2	**Gender *** Male Female	 15 35	 30 70	 20 30	 40 **60**	1.09	**0.402**
3	**Marital status*** Married Unmarried	 25 25	 **50** **50**	 32 18	 **64** 36	1.99	**0.225**
4	**Number of children #** No children One child Two children Three children	 34 8 6 2	 **68** 16 12 4	 21 5 24 0	 42 10 **48** 0	13.05	0.004
5	**Age of children #** 0-7 yrs 8-14 yrs 15-21 yrs 22-28 yrs	 15 9 0 2	 **57.69** 34.61 0 7.69	 26 22 4 1	 **49** 41.5 7.54 1.88	1.336	**0.72**
6	**Family type*** Nuclear Joint	 33 17	 **66** 34	 35 15	 **70** 30	0.184	**0.83**

* signifies Chi square test is used.

#signifies Chi square with Yates correction is used

P value >0.05 shows homogeneity between groups

Table.1b: Socio-demographic characteristics of staff nurses (contd) (N=100)

S .N	Variable	Shift nurses (n=50) (f)	(%)	Non Shift nurses (n=50) (f)	(%)	X2	P value
7	**Area of work #** General ward General duty Critical ward	 37 0 13	 **74** 0 26	 15 29 6	 30 **58** 12	37.41	**0.00**
8	**Years of experience #** 1-9yrs 10-18yrs 19-27yrs	 40 8 2	 **80** 16 4	 23 23 4	 **46** **46** 8	10.55	0.005
9	**Regularity of menstrual cycle #** Regular Irregular	 31 4	 **88.57** 11.42	 25 5	 **83.33** 16.66	0.062	**0.803**
10	**Use of drinks before sleep #** Tea Coffee Milk None	 8 3 16 23	 16 6 32 **46**	 2 0 23 25	 4 0 46 **50**	4.77	**0.18**
11	**Use of items before sleep #** TV Mobile phone Laptop Relaxation therapy None	 21 19 1 6 3	 **42** 38 2 12 6	 19 15 2 10 4	 **38** 30 4 20 8	0.85	**0.93**
12	**Environment during sleep #** Silent Dark Noisy Bright	 34 7 7 2	 **68** 14 14 4	 42 5 3 0	 **84** 10 6 0	2.12	**0.54**

* signifies Chi square test is used.

#signifies Chi square with Yates correction is used

P value >0.05 shows homogeneity between groups

Table 2. Comparison between duty of staff nurses and components of PSQI (N=100

S.No	Components of PSQI	Shift nurses (n=50) (f)	(%)	Non shift nurses (n=50) (f)	(%)	X2	P value
1	**Subjective Sleep Quality#**						
	Good	**45**	**90**	**50**	**100**	3.368	0.066
	Poor	5	10	0	0		
2	**Sleep latency***						
	Good	**33**	**66**	**41**	**82**	3.326	0.068
	Poor	17	34	9	18		
3	**Sleep duration***						
	More than 6hrs	**44**	**88**	**46**	**92**	0.44	0.50
	Less than 6hrs	6	12	4	8		
4	**Habitual sleep efficiency***						
	More than 85%	**31**	**62**	**36**	**72**	1.131	0.28
	Less than 85%	19	38	14	28		
5	**Sleep disturbances***						
	Not present	10	20	5	10	1.961	0.16
	Somewhat present	**40**	**80**	**45**	**90**		

* signifies Chi square test is used.

#signifies Chi square with Yates correction is used

P value <0.05 shows significance

(df =1) for all components

Table 3. Comparison between Quality of sleep among shift and non shift staff nurses (N=100)

Global score	Shift nurses (n=50) (f)	(%)	Non shift nurses (n=50) (f)	(%)	X2	P value
Good sleep(<5)	**29**	**58**	**34**	**68**	1.07	0.30
Poor sleep(≥5)	21	42	16	32		

Global score is the sum of all the components of PSQI
df =1
T-tab = 3.84

Table 1 summarizes the sample characteristics. All the demographic variables of both groups were found to be homogeneous, except age, number of children and years of experience. 80% of shift nurses were between the age group of 23-32years which was significantly greater than that of non-shift nurses (48%). Most of them in shift group (70%) and non-shift group (60%) were females. Half of shift nurses and 64% of non shift nurses were married. 68% of shift nurses had no children whereas 48% of non shift nurses had two children. Age of children of 57.69% of shift nurses and 49% of non shift nurses ranged from 0-7years. 66% of the shift nurses and 70% of non shift nurses belong to nuclear family. 74% of shift nurses worked in general ward while 58% of non-shift nurses worked in general duty from past one year. Working experience of 80% of shift nurses ranged from 1-9 years, whereas among non shift nurses the experience of 46% nurses ranged between 1-9 years and another 46% nurses ranged between 10-18years. 88.57% of shift nurses and 83.33% of non shift nurses had regular menstrual cycle. 46% of shift nurses and 50% of non-shift nurses preferred no drink before going to sleep. 42% of shift nurses and 38% of non shift nurses preferred to watch TV before going to sleep. 68% of shift nurses and 84% of non shift nurses used to get silent environment

during sleep.

Table 2 shows comparison between duty of staff nurses and sleep quality measured by PSQI. It was found that the subjective sleep quality of 90% shift nurses and 100% of non shift nurses ranged in good category. The nurses with good sleep latency were 66% in shift group and 82% in non shift group. Among shift nurses 88% and non shift nurses 92% had sleep duration of more than 6 hours during last one month. The habitual sleep efficiency of more than 85%, was found 62% in shift nurses and 72% in non-shift nurses. 80% of shift nurses and 90% of non shift nurses had somewhat presence of sleep disturbances. Almost all shift nurses (98%) and non shift nurses (92%) never used sleep medicine during past month. 66% of the participants in shift group and 56% in non shift group reported no daytime dys-functioning due to sleep. Slight difference was found among both groups in relation with PSQI components. But, no statistically significant difference was found between components of PSQI and duty of nurses.

Table 3 shows comparison between global score of shift and non-shift working staff nurses. Data revealed that 34(68%) of non shift nurses experienced good sleep which was more as compared to shift nurses 29(58%). But, there was no statistically significant difference between sleep quality of shift nurses and non shift nurses.

DISCUSSION

34(68%) of non shift nurses experienced good sleep which was more as compared to shift nurses 29(58%). There was no statistical significance between quality of sleep (Global Score) and duty of nurses. Therefore it can be stated that shift and non-shift duty nurses had good sleep, but many studies[21][22] does not support this finding.

Here, 68% non-shift nurses and 58% shift nurses experienced good sleep quality (as PSQI). The possible reason may be the duty system, as here night duties for staff nurses is for seven days per month. They are allowed to have break in night duties as for example they can work three days of night duties in previous fifteen days of month and remaining night duties in last fifteen days of month. This probably helps shift nurses to be free of sleep debts.

Secondly, nurses here avail two days night off after completion of night duties. This acts as very important factor for fulfilling the sleep debts faced by nurses and resulting in good sleep quality of shift nurses. Therefore,a slight difference was found in sleep quality of both groups which was more towards good sleep quality, but this difference was not proven statistically.

It was also found that none of the variables included in present study affects the sleep quality of staff nurses. Studies [23],[24] are contradictory to the findings that demographical variables are associated statistically with sleep quality of nurses.

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School Teachers' Awareness on Early Recognition and Prevention of Teen Substance Abuse at School

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ABSTRACT

A descriptive study was undertaken with an aim to assess the school teachers' awareness regarding early recognition and prevention of teen substance abuse at school. School teachers (n=120) were randomly selected from different secondary schools in Kothamangalam area of Ernakulam District, Kerala state. A researcher made and content validated structured awareness questionnaire was used for data collection. Majority (47.5%) of the participants were aged between 31to 40 years and females (77.50%). Seven teachers reported that they use substances. Eighteen teachers (14.03%) reported that they dealt with teenagers having substance abuse before. Study revealed that the teachers are aware about the teen substance abuse in general. However, the awareness related to substance-specific symptoms and complications are still lacking a lot among them. School based prevention strategies are also not known much to the teachers in schools. It warrants immediate remedial measures in terms of more substance-specific preventive training programs for teachers at school.

Keywords: *Teen substance abuse, school teachers, awareness.*

INTRODUCTION

Substance abuse is one of the severe problems affecting youth in the world.[1] The increasing problem of substance abuse and dependence has drawn both public and scientific attention. Substance abuse and dependence may occur at any age, but seem to be most common during adolescence and young adulthood.[2] Recent studies reported the prevalence of substance abuse among teenagers is increasing alarmingly across India.[3-6] The problem of substance abuse has been aggravated in the recent past because of complications caused by a number of factors. Earlier the consumption of substance in a specific society was determined by the availability of the Substance in that area and its traditions. Now there is a change in trends of substance abuse.[7] Easy availability of manufactured substances such as Khaini, Panparag, Deluxe, 5000, etc. have further complicated the crisis of the drug abuse among teenagers at school.[8] Although, the substance abuse problem is complex and large in magnitude, there is extensive amount of evidence based research need to be accessible to physicians, community leaders and schools to execute interventions that can reduce teen substance abuse rates.

School based interventions would be much beneficial towards early identification, prevention and treatment of teen substance abuse as the adolescent children spent most of their active time in the school.[9,10] School teachers are most responsible for ensuring that the teenagers are effectively identified if they have a maladaptive behavior and ensuring their school environment free of substance misuse.[11] Health professionals could assist school teachers in identifying the teenagers' symptoms specific to substance misuse, exploring effective management strategies, and deciding best strategies in specific situations.[12] Assessing school teachers' awareness regarding early identification and prevention of substance abuse among teenagers is a preliminary step towards enabling them to build-up a substance-free school milieu.

MATERIALS AND METHOD

Problem Statement

A study to assess the school teachers' awareness on teen substance abuse, recognizing its symptoms & complications and prevention & management strategies at school

OBJECTIVES

1. Assess the school teachers' awareness on symptoms and complications of teen substance abuse

2. Assess the school teachers' awareness on complications and management of teen substance abuse at school

3. Correlate the awareness with the selected socio-demographic variables of school teachers

Operational definitions

- *School teachers* refer to a professionally qualified person teaching students of 8th to 12thgrades on a regular basis in a school.
- *Substance abuse* refers to excessive use of alcohol or tobacco (cigarettes or chewed form) or cannabis which is characterized by inability to reduce consumption and apparent impairment in academic performance and school behavior.
- *Teenagers* are students ageing between 13 to 19 years enrolled into secondary level of education at selected schools
- *Awareness* refers to knowledge and understanding gained through experience or through education.

RESEARCH APPROACH

A quantitative non-experimental research approach and Descriptive co-relational design was used in this study.

Setting

The study was conducted at four higher secondary schools at Kothamangalam region of Ernakulam District. The primary media of instruction in all these schools were Malayalam with average student occupancy in each of these schools was about 1500.

Sample and sampling technique

Samples in this study were teachers from the selected higher secondary schools. Teachers who met the selection criteria (n=120) were selected through simple random sampling method referring to their attendance registers.

Inclusion Criteria

The teachers who included were

- Teaching students of 8th, 9th, 10th 11th or 12th grades
- Ageing between 25 to 45 years

Tools/instrument

Tool was developed on the basis of objectives of the study. The tool consists of 2 sections;

Section A: Socio demographic data of the working mother and children and Section B: Awareness Questionnaire

Development /Selection of tool

Based on wide reading of literature and discussion with guide self-administered structured questionnaires was prepared. The steps followed were:

- Review of relevant literatures (Text books, Journals, Periodicals and Websites)
- Discussion with subject experts: Nursing faculty, Clinical Psychologist, teachers and Psychiatric social worker.

Description of the tool

Section A: Socio demographic data of school teachers

This section aims at collecting demographic data of school teachers. It includes personal and social information like age, religion, education, teaching experience in years, grades where teaches, subjects taught, having a teenager child, dealt with teenagers having substance abuse, and status of substance usage by the teacher.

Section B: Awareness Questionnaire

It consisted of 30 items related to teen substance abuse and were grouped under 5 domains, viz. General information, cause and risk factors, symptoms specific to substance abuse, complications, prevention and management at school-level. Twenty five items were multiple choice questions and 5 were dichotomous questions. Each correct answer was given 1 mark and no marks for wrong answers, with maximum score of 30.

Content Validity

In order to establish content validity, tools were submitted to 12 experts from various disciplines along with the validation criteria checklist. The experts were from the field of Psychiatry (1), Psychiatric Nursing (5), Teachers (4), Pediatric Nursing (1), and Psychiatric Social Work (1). Minor modifications as per suggestions given by the experts were incorporated in the tool in consultation with the guide. Modified tools was translated to Malayalam and retranslated back to English to confirm language consistency with the help of experts in the field of Malayalam and English literature.

RELIABILITY

Reliability of the tool was established by split half method, and the score awareness questionnaire was found to be in the acceptable range, (*r=0.73*).

RESULTS

Socio-demographic characteristics of school teachers

Majority (47.5%) of the participants was between the ages of 31to 40 years and female teachers were more (77.50%). Only 32.5% of the teachers have a teenager child in their home. Majority (60.84) of the teachers were completed their postgraduate level of education and 39.17% teachers had a teaching experience of 10-15 years. Most (59.16%) of the participants were taking classes for 8th to 10th graders. Science is the most (45%) commonly taught subject.

Seven teachers reported that they use substances. Eighteen teachers (14.03%) reported that they dealt with teenagers having substance abuse before.

Awareness on symptoms and complications of teen substance abuse

Most (80%) of the teachers failed to identify the most commonly abused substance by teenagers and were not able to answer what does intolerance mean. Lack of social responsibility was reported as the most (81.67%) common risk factors for teen substance abuse. Changes in physical function were identified as the frequent (90.0%) indicator of teen substance abuse by the school teachers. Table 1 shows the mean score under domains.

Table 1: Mean± standard deviation and Mean % of domain-wise awareness score

Domains	Max score	Mean±SD	Mean %
General information	6	2.43±1.14	40.56
Causes & Risk factors	6	3.48±1.38	57.92
Symptoms of substance abuse	8	4.50±1.32	64.29

Awareness on complications and management of teen substance abuse at school

Most (*92.50%*) of the teachers are aware about the complications associated with teen nicotine abuse but many (*75%*) gave wrong answers on questions related to teen-alcohol abuse. Teachers were little known to the primary prevention of teen substance abuse at school, many (*78.33%*) answered wrongly. Table 2 shows the mean score under domains.

Table 2: Mean±standard deviation and Mean % of domain-wise awareness score

Domains	Max score	Mean±SD	Mean %
Complications	5	3.98±0.95	66.25
Prevention & reatment	5	2.73±1.21	54.67
Overall	30	17.12±3.09	57.06

Correlation of awareness with the selected socio-demographic variables of school teachers

Table 3: Correlation between awareness and selected socio-demographic variables (*n=120*)

Variables	Test of correlation	
	Test value	p-value
Age in years	4.46	0.22
Gender	0.99	0.32
Having a teenager child	3.49	0.18
Education	8.17	*0.02*
Experience in years	7.66	0.11
Grades being handled	3.48	0.18
Subjects taught	0.18	0.84
Substance abused by the teacher	0.75	0.45
Experience in dealing teenage substance abuse	0.86	0.39

The overall mean awareness scores among teachers was not significantly (*p<0.05*) different in relation to their age, gender, having a teenager child, education, grades being taught, subjects taught, substance used by them or experience in dealing teenage substance abuse before. It was observed that awareness scores among teachers found to be decreasing as their age increases. Females had higher mean awareness scores (*17.3±3.17*) than male (*16.6±2.78*) participants. Teachers having post graduate education scored significantly (*p=0.02*) high score (*17.7±0.28*) than those who with other educational qualifications.

DISCUSSION

This study was conducted among school teachers (n=120) with an aim to assess their awareness regarding teen substance abuse at school. Majority of the study participants were in the age group of 31-40 years. This was similar to previous studies done to assess the knowledge of school teachers on substance abuse among students.[13,14] Female teachers were more in the study group, it may be associated with the fact that Kerala is one of the few places in world where women outnumber men. Secondly, teaching profession is one of the preferred choices for women. Many teachers were completed their post-graduate studies; Kerala is the most literate state in India.

In the present study 68% of the participants scored above average mean scores. It indicated that teachers do have some knowledge regarding teen substance abuse. This may be due to their attendance with state-run programs at school level.[15] Many programs utilize teachers as counselors, coordinators etc., especially because of non-availability of qualified counselors.[16,17] Indeed, Indian studies have considered teachers as a reliable resource who can be equipped to fill the service gap by training them in the requisite skills, and this approach is being considered as the best strategy in the Indian context of resource constraints as it ensures "coverage, continuity and cost-effectiveness".[18] However, the awareness related to substance-specific symptoms and complications are still lacking a lot among school teachers. School based prevention strategies are also not known much to the teachers in schools. It warrants immediate remedial measures in terms of more substance-specific preventive training programs for teachers at school.

Limitations

- Dealt with awareness aspect alone
- Skills & Practice strategies towards teen substance abuse, identification and prevention was not assessed
- Teachers of secondary schools were only included

Recommendations

- Other studies can also be undertaken, viz.,
  - o Effectiveness of an intervention on awareness regarding teen substance abuse at school among school teachers
  - o Awareness and its correlation with practicing strategies on substance abuse prevention among school teachers
  - o Replication of the present study on a large sample.

CONCLUSION

This descriptive study was undertaken to assess the awareness about teen substance abuse, recognizing it's symptoms & complications and prevention & management strategies at school among randomly selected school teachers (n=120) from Kothamangalam region of Kerala state, India. From the study findings it is concluded that teachers are known to the teenage substance abuse in a brief. Though the awareness related to substance-specific symptoms and complications are still lacking a lot. School based prevention strategies are also not known much to the teachers in schools. It warrants immediate remedial measures in terms of more substance-specific preventive training programs for teachers at school.

Ethical Clearance: Ethical clearance was obtained from Institutional Ethical Review Board, Head of the schools where study conducted and an informed consent was also obtained from the study participants prior to the data collection.

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