ISSN-2394-9465 (Print) • ISSN-2395-180X (Electronic)

Volume 5 / Number 1 / January-June 2019

International Journal of Psychiatric Nursing

Website: www.ijpn.co

International Journal of Psychiatric Nursing

International Journal of Psychiatric Nursing

Print- ISSN: 2394-9465, Electronic - ISSN: 2395-180X
Frequency: Six Monthly

International Journal of Psychiatric Nursing is a double blind peer reviewed international journal. It deals with all aspects of **Psychiatric Nursing**.

Website: www.ijpn.co

Editor

Dr. R.K. Sharma
Institute of Medico-legal Publications
Logix Office Tower, Unit No. 1704, Logix City Centre Mall, Sector- 32,
Noida-201 301 (Uttar Pradesh)

Printed, published and owned by

Dr. R.K. Sharma
Institute of Medico-legal Publications
Logix Office Tower, Unit No. 1704, Logix City Centre Mall, Sector- 32,
Noida-201 301 (Uttar Pradesh)

Published at

Institute of Medico-legal Publications
Logix Office Tower, Unit No. 1704, Logix City Centre Mall, Sector- 32,
Noida-201 301 (Uttar Pradesh)

International Journal of Psychiatric Nursing

www.ijpn.co

CONTENTS

Volume 5, Number 1 January-June 2019

DOI Number: 10.5958/2395-180X.2019.00001.X

Effectiveness of Planned Series of Activity Sessions on Peer Relationship and Self-Esteem among Adolescents

Divya Kunta[1], Sr. Mary Rappai[2], Anumol Joseph[3]

[1]M.Sc (N) Psychiatry Nursing Final Year Student, [2]Associate Professor, [3]Assistant Professor, Mental Health Nursing, Vijay Marie College of Nursing, Hyderabad

ABSTRACT

Introduction: The activity sessions planned and implemented that helped to learn new interpersonal skills that can make peer interaction mutually satisfying and productive and can be effective in improving peer relation and self-esteem among adolescents. The researcher for the present study had chosen certain activities like magical box, special candy game, challenging game, brochure about me, and book of my friend.

Aim: To assess the effectiveness of planned series of activity sessions on peer relationship and self-esteem.

Method and Materials: Research design selected for the present study was pre experimental one group pretest and post test group design. The study setting was a selected school of Hyderabad. The sample size was 60 adolescents in the age group of 12-15 yrs. The simple random sampling technique was used for the selection of sample. Modified peer relation rating scale and modified Rosenberg's Self Esteem scale's comprising of 40 questions was used to collect the data from the subjects.

Results: The effectiveness of planned series of activities was effective in increasing peer relations. The mean of experimental group before the planned activity session was 29.83 and after was 39.83. The calculated t-value was calculated to be 17.234. The effectiveness of planned series of activities are effective in increasing self-esteem the mean of experimental group before is 29.23 and after is 36.63. The calculated t- value was 14.381. Hence it can be stated that planned series of activities are effective in increasing peer relationship and self-esteem.

Conclusion: Participatory activity sessions like the one prepared for this study to enhance peer relationship and self-esteem can be added as a part of curriculum.

***Keywords**: Effectiveness, planned series of activity sessions peer relationship, self-esteem adolescents.*

INTRODUCTION

There is an estimated 1.2 billion adolescent population - one in every five people in the world today[1]. India has the largest population of adolescents in the world. Twenty percent of people in our country comprise of adolescents[2]. Adolescence is a developmental period marked by many physiological and psychological changes that influence body image. Peer network is a supportive setting for achieving the two primary development tasks of adolescence 'identity' and 'autonomy,' that are very essential for the development of self-esteem[3]. Adolescents with a better self-esteem are perceived to have adequate coping with better adjustment, self-dependence, and able to resolve conflicts enhancing the development of productive and efficient citizens for the country[4]. Research studies have found that some physical activity interventions can help relieve symptoms of depression and anxiety, and increase self-esteem. These interventions that help to learn new interpersonal skills can make peer interaction mutually satisfying and productive and can be effective in improving peer relation. The researcher for the present study has chosen certain activities like magical box, special candy game, challenging game, brochure about me and book of my friend.

Corresponding Author:
Mrs. Anumol Joseph
Assistant Professor Mental Health Nursing,
Vijay Marie College Of Nursing, Hyderabad
Phone: 9177101682
Email: anujoseph14@hotmail.com

"Magic box" is one which can be any kind of a box with a mirror placed to reflect the face of anyone who looks inside. Begin the activity by asking the group, "Who do you think is the most special person in the whole world?" After allowing the client to respond individually, continue: "I have a magic box with me today, and each of you will have a chance to look inside and discover the most important person in the world and also it has slip which tells why the person is important." The challenge game it is a game that consisted 6 to 12 members divided into 2 groups a player challenges another team to perform a stunt. If the opposing team does not perform the stunt correctly, the team earns a point.

Examples of challenges:

1. Most baskets made with a wad of paper into a trash can wins
2. Loudest whistle
3. Most sit-ups
4. Fastest reader of a paragraph out of a book.
5. Bend thumb back and have the same thumb touch the forearm.

Special candy game is an activity where adolescents are made to sit in circle and are given with few candies in hand and are asked about things at which they are good. They were asked to give a chocolate to a child with similar talent and the child who received should again find another person with the same talent as he had. At the end the child who had the maximum number of candies was declared as the leader of the group. This entire activity enhanced the self-esteem by revealing their talents to others and also by identifying their hidden talents.

Brochure about me is an activity in which a paper of brightly colored paper is used and folded in threes. Have the participants decorate the front flap with their name in any manner they want. Ask them to draw their picture and write few adjectives about themselves. Then everyone passes their brochure to the person on their right, when they receive a brochure from their neighbor they have to notice who it belongs to, and give a positive compliment and turn it over and at the end all the children are asked to place their broachers in the classroom.

Book of my friend: Make a "friend book", encouraged each adolescent to prepare a book for the other adolescent with whom they are interested to make friendship, based on the brochures that are displayed in the classroom and giving them surprise by presenting them to the particular person on the day of discussion by shaking their hand, giving a hug and saying we are friends.

MATERIALS AND METHOD

Research approach for the present study was quantitative, pre experimental pretest and posttest group design was adopted. The research setting was Geetanjali Olympiad high school SR.Nagar, Hyderabad, Telangana. The sample was class VII, IX and X students. The sample size was 60. The sampling technique chosen was simple random sampling. The data was using interview through a structured questionnaire. Reliability was 0.91 indicating perfect reliability which was calculated by Karl Pearson's method. Section –A consisted of sociodemographic profile which included age, gender, socio- economic status, religion, family size, do you like sports/game, number of siblings. Modified peer relation rating scale was administered to students which consisted of 1-10 positive items and 11-20 negative items. Also Modified Rosenberg's self-esteem scale was administered to students which consisted of 1-10 positive items and 11-20 negative items. The total scores ranges from

0-20 indicated low self-esteem

21-40 indicated moderate self-esteem

41-60 indicated higher self esteem

RESULTS

Table 1: Frequency and percentage distribution of adolescents according to demographic variables

(n = 60)

Background variables	Frequency (f)	Percentage (%)
Age		
12-13years	5	16.7
13-14 years	11	36.7
14-15 years	14	46.7
Gender		
Male	19	63.3
Female	11	36.7

Conted…

Socio economic status		
Lower income group	2	6.7
Middle income group	16	53.3
Upper middle income group	4	13.3
Higher income group	8	26.7
Religion		
Hindu	24	80.0
Christian	3	10.0
Muslim	2	6.7
Others	1	3.3

Table 1 Most of the study subjects 5 (16.7%) of the adolescents belonged to the age group of 12- 13 years, 11(36.7%) belonged to 13- 14 years, 14(46.7%) belonged to 14-15 years in the

11(36.7%) , 4(13.3%) of adolescents belonged to low income group, 14(46.7%) belonged to middle income group, 10(33.3%) belonged to upper middle class, 2(6.7%) belonged to higher income group, 2(6.7%) of adolescents belonged to low income group, 16(53.3%) belonged to middle income group,4 (13.3%) belongs to upper middle income group,8(26.7%) .Majority of subjects that is 20 (66.7%) were Hindus, 5(16.7%) were Christians, 2(6.7%) were Muslims, 3 (10%) were others.

Table 2: Mean, Standard deviation, t- value of peer relationship levels among adolescents in experimental group

(n = 60)

Peer-Relationship	Before Planned Activities Sessions	After Planned Activities Sessions
Mean	29.67	39.83
Std. Deviation	5.013	1.007
Paired t-test	17.234	
Df	29	
Table value	2.05	

p<0.05

Table 2 indicated mean value of peer relationship among adolescents before planned activities session was 29.67 and after planned activities session was 39.83, standard deviation before planned activities session was 5.013 and after planned activities session was 1.007, t-value was17.23 at table value 2.05 at degree of freedom 29.

Table 3: Mean and standard before and after planned series of activity sessions among adolescences' self-esteem before and after the planned series of activities

(n=60)

Self Esteem	Before Planned Series of Activity Sessions	After Planned Series of Activity Sessions
Mean	29.23	36.63
Std. Deviation	6.084	5.732
Paired T-test	14.381	
Df	5.014	
Table value	2.57	

P<0.05

Table 3 indicated mean value of self-esteem of adolescents before planned activities session was 29.23 and after planned activities session was 36.83, standard deviation before planned activities session was 6.084 and after planned activities session was 5.732, t- value was14.38 at table value 2.05 at degree of freedom 5.014.

Table 4: Association between pre-test peer relation and self-esteem scores and selected background variables of adolescents

Demographic Variables	Chi square value	Df	Table value	Level of Significance
Age	.693	2	5.99	NS
Gender	1.292	1	3.84	NS
Socio economic status	.833	3	7.82	NS
Religion	2.222	3	7.82	NS

There is no significant association existing between peer relationship and self-esteem and demographic variables, age, gender, socio economic status, religion, type of family, do you like sports/games, number of siblings.

DISCUSSION

The present study revealed high peer relations (39.83) and positive self esteem (36.63) (on performing like magic box, special candy game, brochure about me, Book of my friend, challenging game) among the subjects which similar to the findings of a quasi

experimental study **of "**Avelinmanova[4]done on juvenile inmates in Bangalore and the results found that the subjects developed high positive peer relation and self esteem after the participation in the activities. It was also found that the activity sessions were effective in enhancing peer relation and self esteem among juvenile home inmates.

The study results is consistent with the correlational study to assess the effect of a planned series of activity sessions on multiple facets of positive peer relationship and self esteem among 60 adolescent students were studied using pre-experimental design. Simple random sampling technique was used. Peer relation scale and Rosenberg's self esteem inventory were used to collect data. The study finding findings revealed positive peer relations and self esteem [5].The present study revealed higher peer relation and higher self-esteem among adolescents.

Ethical Clearance: Permission was obtained from the competent authority of the rehabilitation center.

Source of Funding: No funding was required

Conflict of Interest: Nil

REFERENCES

1. Introduction to the subject, adolescent global scenario. [Internet]. The International Paediatric Association 2009. Available from: URL:www.ipa-world.com/program-Areas/..../Introductiontothesubject.aspx.
2. India has largest adolescent population in the world. [Internet]. 2011 [cited 2011 Nov 13]. Availablefrom: URL:http://www.hindustantimes.com/India-news/Guwahati/India-has-largest-adolescent-population-in-the-world/Article1-667147.aspx
3. Srikal B, Kishore KK. Empowering adolescents with life skill education in schools-school mental health programme: Indian J Psychiatry 2010 Oct; 52(4):344-9.
4. Avelinmanova T Thomas, planned series of activity on peer relationship and self esteem among adolescent juvenile home inmates[M.N Thesis].St John's CON;RGUHS:2012
5. Vidya P. Planned series of activity sessions on positive peer relationship and self-esteem among adolescent students. The Nurse :2012 ;4(2):13

DOI Number: 10.5958/2395-180X.2019.00002.1

Critical Incidents in Psychiatric Inpatient Units of a Tertiary Care Hospital in South India−A Retrospective Analysis based on Psychiatric Nurses' Perspective

Jinto Philip[1], Anu Baby[2], Bivin JB[3], Praveen C. Thulasi[4]

[1]Associate Professor, [2]Assistant Professor, Maniba Bhula Nursing College, Uka Tarsadia University, Surat, Gujrat; [3]Staff Nurse, Male Forensic Unit, Government Mental Health Center, Thiruvananthapuram, Kerala; [4]Assistant Professor, Sree Gokulam Nursing College, Thiruvananthapuram, Kerala

ABSTRACT

This study aimed to enlist the incidents in psychiatric inpatient units of a hospital, which were experienced as 'critical' by staff nurses who were working in that area. A mixed approach was used here. The critical incidents were collected using Critical Incident Data Extraction Schedule (CIDES), a researcher-made, content-validated data extraction instrument. Clinical records (n=104) were retrieved from Medical Records Department and were evaluated using the CIDES. The most commonly reported critical incident was 'patient abscond/escape (40%)' following which is the 'physical violence (34%).' Critical incidents were usually reported during second shift (37.5%) and from the wards (42.3%). Evaluation of critical incidents and nurses' experience will give the opportunity to learn about the incidents, important strategies to be adopted and the possible constraints that could arise.

Keywords*: Critical incidents, Abscond, Suicide*

INTRODUCTION

Nurses who work in psychiatric units face a lot of work related stress. It is much stressful for those who work in acute inpatient psychiatric wards since they have to confront with multiple critical incidents. [1] Critical incidents are the situations provoked by patients and the clinical matters related with nurses' everyday work. [2,3] The most commonly reported critical incidents created by the patients are violent outbursts, abscond, self-harm and suicidal attempts.

Researches describe the prevalence of aggressive episodes vary widely[4,5,6] with typical estimates around 10-15% of admissions. A range of factors have been associated with inpatient aggressive incidents, including: age[5,7,8] gender,[9] previous psychiatric admission[5,7,10]; involuntary admission[7,11]; and duration of stay[12,13,14] and setting-related factors. [1,15] Increased rates of inpatient aggression have also been associated with several diagnostic groupings, including: schizophrenia and acute psychoses[5,13,15,16]; mania[15,16]; and personality disorder[14,17]; while lower rates have been reported among patients with depression and adjustment disorder. [10,15] The risk for patient aggression in acute psychiatric wards differ from a community and other psychiatric settings. [17]

In addition to aggression, there have been attempts to synthesize the absconding research literature. Incidents of absconding remain a significant concern, with social, economic and emotional costs. [18] Literature suggests that incidents of absconding from the mental health setting can be high, with rates of reported incidents of up to 35%.[19] An increased risk of absconding has been associated with: being younger, male or single; admitted as an involuntary patient; having substance use problems[19]; or a diagnosis of personality disorder or schizophrenia. [20,21,22] The risk associated with patient absconding include risk of suicide and self harm, risk of aggression and violence, risk of self-care neglect or death and risk of loss of confidence. [18]

Corresponding Author:
Bivin JB.
Staff Nurse, Male Forensic Unit,
Government Mental Health Center
Peroorkada, Thiruvananthapuram, Kerala-05
Email: bivin.jb@gmail.com

Direct self-harm has been described with deferent terms, including deliberate self-harm, self-injury, attempted suicide, self-mutilation, or para-suicide.[23,24] The risk for repetitive self-harm and suicide is greatest in the first two years after the first episode of self-harm and this risk may persist over a period of several years. [25] Nurses working in an acute mental health settings have a high chance of experiencing a patient suicide or suicide attempt. [26,27] The occurrence of an inpatient suicide or suicide attempt is indisputably a tremendously stressful and upsetting experience for nurses. [28]

A small number of researches have been realized in order to investigate the type of critical incidents, that nurses face in their work. Very few researches included mental health nurses and data has been presented in comparisons with nurses of general departments. In India, the specialized nursing services are limited in scope and thus it is an open field for research.

AIM & OBJECTIVES

The present study aimed at exploring the incidents in psychiatric inpatient units of a tertiary care hospital, which were reported as 'critical' by staff nurses working in those areas. Based on this the following objectives were formulated; 1) to assess the types of critical incidents reported by staff nurses from psychiatric inpatient units, 2) to explore the clinical, personal and environmental correlates to those critical incidents and 3) to explore the experience of psychiatric nurses with those critical incidences.

METHODOLOGY

A mixed approach using systematic, inductive and open type evaluation of the written information from the clinical records of those patients whom the nurses reported to have involved in a critical incident. This was performed with reference to the incident records maintained by the staff nurses in each of the psychiatric inpatient units. The incident reports maintained for the previous 10 years were checked and were included in the present study. There were 156 critical incidents that the researchers could identify from the incident records. Those clinical records corresponding to the incidents were traced from the Medical Records Department (MRD) using its Inpatient Register (IP) Number. These clinical records were evaluated for the critical incidents and the details of which is being recorded in it. The details of the critical incidents were collected in terms of the items given in a Critical Incident Data Extraction Schedule (CIDES).

Critical Incident Data Extraction Schedule (CIDES): CIDES is a researcher-made, content-validated data extraction instrument. It consists of items on 1) Socio-demographic profile and 2) Clinical profile of the patient whom was reported to be involved in an incident, 3) Type of the incident, 4) Location of the incident including the type of inpatient unit from which it is being reported, and 5) experience and records of the nurses specific to the incidents. CIDES provided a structural approach to evaluation of the records on the critical incidents in the clinical records.

In addition to the clinical record review, the nurses who were presented during the time of the incidents were interviewed in person. Prior to the data collection, assurances were given to nurses concerning confidentiality and anonymity. The purpose of the study was explained in detail. The nurses were asked to write about their experience with the particular incident. Content analysis was applied and the data was coded in a variety of important themes.

RESULTS

The researchers could retrieve 104 clinical records from the MRD, with any report of critical incidents during inpatient stay. Based on the available data from the case records, the result is as follows;

1. **Types of critical incidents:** The types of critical incidents reported from inpatient psychiatric units of the hospital by nurses is being depicted in the Figure 1.

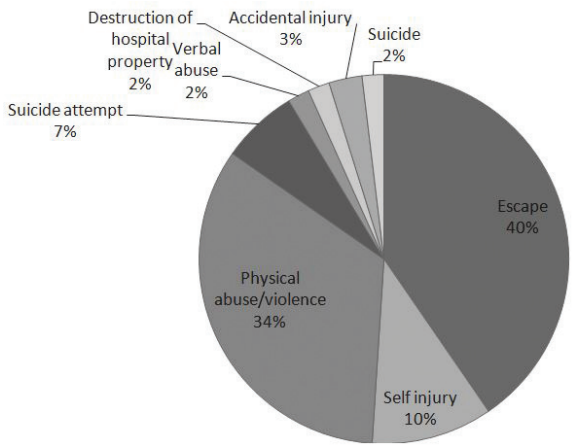


Figure 1: Distribution of type of critical incidents reported from Inpatient units

2. Characteristics of Patients who was involved in a reported critical incident: Most of patients were male (84.6%) and having family support (73.1%). Majority of the patients were Hindu in religion and only two (1.9%) foreign nationals were involved in any form of critical incident.

Table 1: Clinical profile of the patients who involved in a critical incident (s)

(n = 104)

Sl. No.	Variables		Frequency	Percentage
1.	Type of admission	Voluntary	56	53.8
		Involuntary	23	22.1
		Reception order	16	15.4
		Criminal	9	8.7
2.	Psychiatric diagnosis in present admission	No	3	2.9
		Yes	101	97.1
3.	Past history of psychiatric illness	No	59	56.7
		Yes	38	36.5
		Not available	7	6.7
4.	Previous psychiatric diagnosis	No	60	57.7
		Yes	37	35.6
		Not available	7	6.7
5.	Family history of psychiatric illness	No	52	50.0
		Yes	38	36.5
		Not available	14	13.5
6.	Present history of Substance abuse	No	61	58.7
		Yes	41	39.4
		Not available	2	1.9
7.	Past history of Substance abuse	No	59	56.7
		Yes	43	41.3
		Not available	2	1.9

Patients who sought voluntary admission and treatment were more involved in critical incidents than those who sought involuntary admission. Most (97.1%) of them have been diagnosed to have a mental illness in the present admission and were in treatment for the same. Forty-one patients have a co-morbid diagnosis of substance abuse whereas 43 have a previous history of substance abuse.

3. Location of the incidents

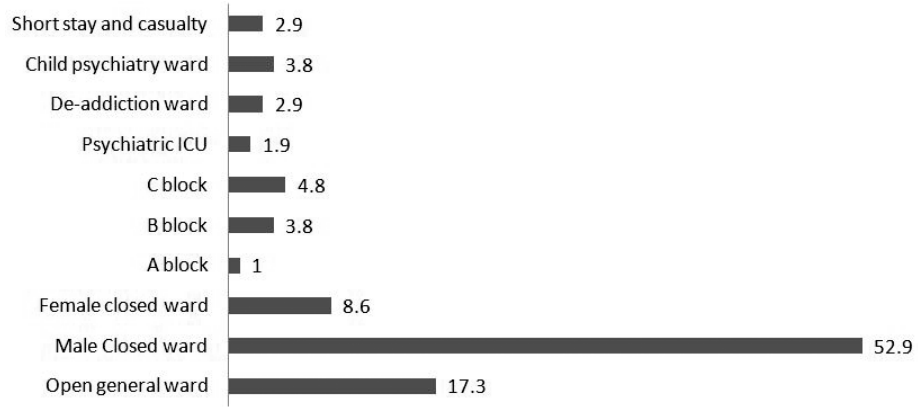


Figure 2: Type of the ward where patient admitted at the time of incident

More than half of the incidents were reported from Male closed word whereas very few incidents were from A block, which is a paying patients' block.

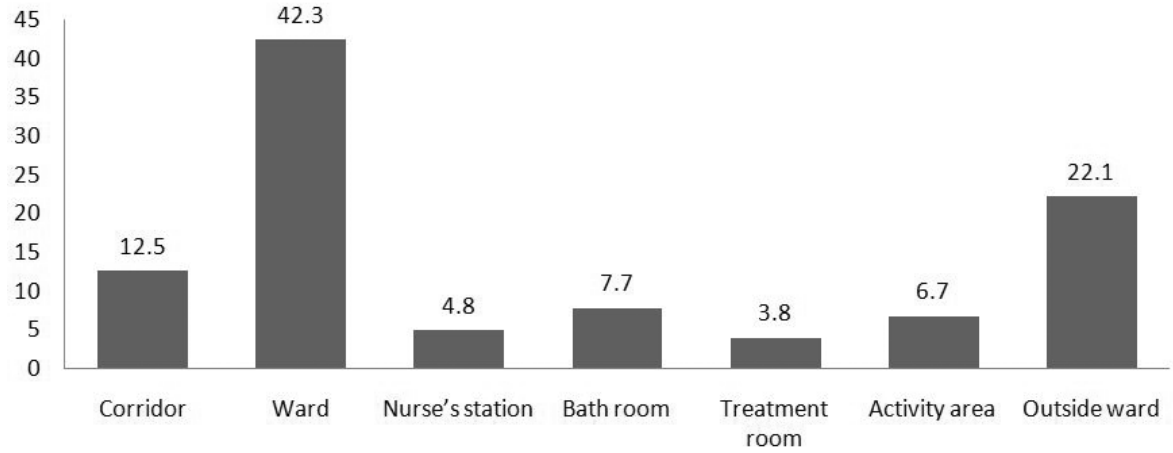


Figure 3: Distribution based on place at which incident occurred

4. **Nursing action with the critical incidents:** Table 3 shows that majority (48.1%) of the critical incidents were known to the nurses in the area, were reported immediately (<24 hours) after the occurrence of the incidents (85.6%) and were recorded appropriately in the case records (96.2%). It was reported that most of the incidents were during the second shift of the nurses (37.5%).

Table 2: Distribution based on nurses experiences with critical incidents

(n = 104)

No.	Variable		Frequency	Percentage
1.	Nurse know about the incident	She/he discovered	50	48.1
		Was told by other patients	4	3.8
		Was told by other hospital staff	34	32.7
		Other	16	15.4
2.	Previous incidents reported	Yes	37	35.6
		No	67	64.4
3.	Attempts during present hospitalization	Yes	38	36.5
		No	66	63.5
4.	Precautions taken to prevent the incident	Yes	31	29.8
		No	73	70.2
5.	Reporting of incident	<24 hours	89	85.6
		>24 hours	15	14.4
6.	Nurse's record regarding incident	No	4	3.8
		Yes	100	96.2

DISCUSSION

Nurses reported 40% of the critical incident as patients' abscond in this study. Literature review gives an estimate of 34% cases with abscond in psychiatric inpatient units. [18,19] Other directed violence is another major concern among patients with mental illness. This may be associated with their psychotic symptoms such as delusions or hallucinations. Physical violence was reported to be 34% in this study. Non physical forms of aggression (E.g. Verbal threats) were reported about 2%.

The majority of the patients who were involved in any critical incident were males (84.6%) and never

married (50%), a reminder that severe mental illness require treatment under admission is a problem among males and those who do not have a supportive relationship. Overall, the patient sample was severely and acutely unwell, which is reflected in the high proportion of involuntary admissions (22.1%) including admission under reception order (15.4%) and the high rates of patients with a confirmed psychiatric diagnosis (97.1%). Substance use disorders, schizophrenia and related psychoses were the commonest psychiatric diagnoses reported to be associated with the critical incidents reported before[1] in contrast to the present study findings. Overall, the clinical and sociodemographic characteristics of the present sample were very similar to those reported by Koukia E, Zyga S. [2]

It was reported that most of the incidents were during the second shift of the nurses (37.5%) and were observed the nurses themselves (48.1%). The recurrence of the incidents is associated to the nurses inability to adopt preventive measures on time. The incidents were commonly reported from wards. About the nurses experiences shared through interview, the usual primary intervention was to call the physician and majority of them commented the lack of autonomy as the main problem in the management.

SUMMARY AND CONCLUSION

This paper is on the types of critical incidents that were commonly reported from the psychiatric inpatient units by nurses. The critical incidents and its clinical, personal correlates of the patient who is been involved in the incident also explained. Nurses' experience with the critical incidents and the strategies adopted by them to manage it also evaluated through focused interviews. Written critical incidents and corresponding interventions gave nurses the opportunity to explain the incidents, important strategies adopted and the constraints they faced. Nurses choose rather limited number of interventions when dealing with critical incidents.

The recommendations of the study is the future realization of a more in-depth interview concerning total interventions in every critical incidents, in order to analyze and clarify psychiatric nurses' actual role in the critical incident management.

Ethical Clearance: Obtained from the Institutional Ethical Committee, National Institute of Mental Health & Neurosciences, Bengaluru.

Source of Funding: Self

Conflict of Interest: Nil

REFERENCES

1. Carr VJ, Lewin TJ, Sly KA, Conrad AM, Tirupati S, Cohen M, et al. Adverse Incidents in Acute Psychiatric Inpatient Units: Rates, Correlates and Pressures. Aust N Z J Psychiatry 2008; 42: 267.
2. Koukia E, Zyga S. Critical cases faced by mental health nurses and assistant nurses in psychiatric hospitals in Greece. International Journal of Caring sciences. 2013; 6(3): 465-471.
3. Lima EC, Bernardes A, Baldo PL, Maziero VG, Gamelo SHH, Balsanelli AP. Critical incidents connected to nurses leadership in Intensive care units. Rev Bras Enferm. 2017; 70(5):1018-25
4. Jonker EJ, Goosens PJJ, Steenhuis IHM, & Oud NE. Patient aggression in clinical psychiatry: perceptions of mental health nurses. J Psychiatric Mental Health Nurs. 2008; 15: 492-499.
5. Ross J, Bowers L, Stewart D. Conflict and containment events in inpatient psychiatric units. J Clin Nurs 2012; 21: 2306–15.
6. Cookson A, Daffern M, Foley F. Relationship between aggression, interpersonal style, and therapeutic alliance during short-term psychiatric hospitalization. International Journal of Mental Health Nursing 2012; 21: 20–29.
7. Ketelsen R, Zechert C, Driessen M, Schulz M. Characteristics of aggression in a German psychiatric hospital and predictors of patients at risk. J Psychiatr Ment Health Nurs.2007; 14:92-99
8. Cornaggia CM, Beghi M, Pavone F, Barale F. Aggression in psychiatry wards: A systematic review. Psychiatry Research 2011; 189: 10–20.
9. Krakowski M, Czobor P. Gender differences in violent behaviors: relationship to clinical symptoms and psychosocial factors. Am J Psychiatry 2004; 161(3): 459–65.

10. Pekurinen V, Willman L, Virtanen M, Kivimaki M, Vahtera J & Valimaki M. Patient aggression and the wellbeing of nurses: A cross-sectional survey in psychiatric and non-psychiatric settings. International Journal of environmental research and public health. 2017; 14: 1245-56.

11. Serper MR, Goldberg BR, Herman KG et al. Predictors of aggression on the psychiatric in-patient service. Compr Psychiatry. 2005; 46:121127.

12. Grassi L, Biancosino B, Marmai L et al. Violence in psychiatric units: a 7-year Italian study of persistently assaultive patients. Soc Psychiatry Psychiatr Epidemiol. 2006; 41:698-703.

13. Chou KR, Lu RB, Mao WC (2001). Factors relevant to patient assaultive behavior and assault in acute inpatient psychiatric units in Taiwan. Arch Psychiatr Nurs. 16:187195.

14. Stevenson KN, Jack MS, O Mara L, LeGris J. Registered nurses experiences of patient violence on acute care psychiatric inpatient units: An interpretive descriptive study. BMC Nursing. 2015; 14: 35-48.

15. Dack C, Ross J, Papadopoulos C, Stewart D, Bowers LA. Review and meta-analysis of the patient factors associated with psychiatric in-patient aggression. Acta Psychiatr Scand 2013; 127: 255–268.

16. Biancosino B, Delmonte S, Grassi L, Santone G, Preti A, Miglio R, et al. Violent behavior in acute psychiatric inpatient facilities: a national survey in Italy. J Nerv Ment Dis 2009; 197(10): 772–82.

17. Vaaler AE, Iversen VC, Morken G, Fløvig JC, Palmstierna T, Linaker OM. Short-term prediction of threatening and violent behaviour in an Acute Psychiatric Intensive Care Unit based on patient and environment characteristics. BMC Psychiatry 2011; 11: 44.

18. James R, Maude P. A focus on absconding in mental health: a review of the literature. Int J Health Sci Res. 2015; 5(12):400-409.

19. Muir-Cochrane E, Mosel KA. Absconding: A review of the literature 1996-2008. International Journal of Mental Health Nursing,2008; 17: 370- 378.

20. Bowers L, Simpson A, Alexander J. Real world application of an intervention to reduce absconding. Journal of Psychiatric and Mental Health Nursing, 2005; 12: 598-602.

21. Mosel K, Gerace A, Muir-Cochrane E. Retrospective analysis of absconding behavior by acute care consumers in one psychiatric hospital campus in Australia. International Journal of Mental Health Nursing, 2010; 19: 177-185.

22. Muir-Cochrane E, Mosel K, Gerace A, et al. The profile of absconding psychiatric inpatients in Australia. Journal of Clinical Nursing, 2011; 20: 706-713

23. Tofthagen R, Talseth AG, Fagerstrom L, Mental health nurses' experiences of caring for patients suffering from self harm. Nursing research and Practice, 2014; 1(2): 210-215.

24. G. R. Jenkins, R. Hale, M. Papanastassiou, M. J. Crawford, and P. Tyrer, "Suicide rate 22 years after para-suicide: Cohort study," British Medical Journal, 2002; 325, (7373):1155.

25. Kapur N, Hunt I, Windfuhr K, Rodway C, Webb R, Rahman M, Shaw J & Appleby L. Psychiatric in-patient care and suicide in England, 1997 to 2008: a longitudinal study. Psychological Medicine. 2013:43(1):61-71.

26. Loos TM, Willetts G AP, Kempe AE, A sudden death on clinical placement: A student perspective of nurse grief. Contemporary nurse: A Journal for the Australian Nursing Profession. 2014; 47(1/2), 190-196

27. Robertson M, Peterson B, Lauder B, Fenton R and Gavin J. Accounting for accountability: A discourse analysis of psychiatric nurses' experience of a patient suicide. The open nursing journal, 2010; 4, 1-8.

28. Nielssen O, Large MM. Homicide in psychiatric hospitals in Australia and New Zealand. Psychiatr Serv 2012; 63(5): 500–3.

DOI Number: 10.5958/2395-180X.2019.00003.3

Prevalence and Preventive Aspects of Abuse and Maltreatment of Elderly-A Descriptive Study Conducted at a Rural Area of Thrissur District Kerala

Lt Col Regina PF.

Asst. Prof., Nehru College of Nursing, Po: Panayur, Ottapalam, Palakkad Dt. Kerala

ABSTRACT

Today the care of elderly is a difficult problem to be tackled, because 7% of the Indian population is elderly, in which two-thirds are in villages and almost half of them are in poor conditions. The purpose of this study was to bring out the prevalence and preventive aspect of abuse and maltreatment of our elderly population.. The implication and preventive aspects will be discussed. Most often incidents of abuse are not reported because elderly sufferers give prime importance to the family status and love towards the children. The results provide evidence that reporting elder abuse has multifactorial elements.. This paper examines different types of elder abuse in light of available data and suggests some remedies to minimise and prevent the problem.

Keywords*: Elder abuse, maltreatment, prevalence, preventive aspect.*

INTRODUCTION

Information on the extent of abuse in elderly populations is scant. The few population-based studies that have been conducted suggest that between 4% and 6% of elderly people have experienced some form of abuse in the home. The elderly are also at risk of abuse in institutions such as hospitals, nursing homes and other long term care facilities. In a survey in the United States, for example, 36 % of nursing-home staff reported having witnessed at least one incident of physical abuse of an elderly patient in the previous year, 10% admitted having committed at least one act of physical abuse themselves, and 40% said that they had psychologically abused patients.[1]

It is predicted that by the year 2025, the global population of those aged 60 years and older will more than double, from 542 million in 1995 to about 1.2 billion.[2]

Corresponding Author:
Lt Col Regina PF.
Asst. Prof., Nehru College of Nursing,
Po: Panayur, Ottapalam, Palakkad -679522, Kerala
Phone: +91 952 696 7712
Email: tlvc901@gmail.com

Elder abuse is a violation of human rights and a significant cause of illness, injury, loss of productivity, isolation and despair. India is growing old! The stark reality of the ageing scenario in India is that there are 77 million older persons in India today, and the number is growing to grow to 177 million in another 25 years. With life expectancy having increased from 40 years in 1951 to 64 years today, a person today has 20 years more to live than he would have 50 years back.[3]

Population aging in Kerala is always ahead of the national scenario as 11 per cent of the total 77 million elderly (above 60) population of India in 2001 was from Kerala. People above 60 constitute 13 percent of the states population of about 3.34 crore according to the 2011 census.[4] The researcher believe that focusing on measures to tackle abuse, would empower older people and help to prevent victimization as abuse.

OBJECTIVES

1. To determine the prevalence of abuse and maltreatment of elderly by using interview technique with the help of semi structured questionnaire.
2. To discuss the preventive aspects of abuse and maltreatment of elderly.

REVIEW OF LITERATURE

CE Pickering Ziminski et-al conducted a study to assess the barriers to self- reporting of elder physical abuse in community- dwelling older adults. The findings of the study shows that participants have a constant perception of physical abuse and its reporting is multifactorial. The study also implies for educational interventions.[5]

M. Charpentier and M. Soulieres conducted a descriptive study among 20 residents in Quebec, Canada on elder abuse and neglect in institutional settings .Data was collected by semi structured interview method. According to the researcher elder abuse is limited to physical mistreatment.[6]

C. Naughton et al conducted a national survey in Ireland to examine the relationship between awareness of elder abuse and disclosure of abuse. Findings showed that prevalence of elder abuse including stranger abuse was 5.9%. There was no association between experience of financial abuse and neglect and awareness of the term older abuse.[7]

METHODOLOGY

A descriptive study approach was used. Non experimental simple descriptive research design was used. The setting was rural community area of Pazhanji, Thrissur District. Total Sample size was 100. Male: 50 Female:50

Inclusion Criteria: Elderly people above 65yrs who is able to answer the questions and willing to participate in the study.

Sampling Technique: Purposive sampling. Samples from consecutive houses of a particular area. Females 50 and Males 50 identified.

Tool and Technique: Preformed, pre-tested, semistructured interview schedule.

Total Questions: 36 (Demographic data 11 items, other items 27)

Section 1: Demographic Data: It deals with the demographic characteristics of the samples which includes age, sex, educational qualification, employment, religion, marital status, number of children, stay about self and spouse, general health and awareness about old age home.

Section II: Semi structured questionnaire with the objective to detect the different types of elder abuse and maltreatment.

Data collection: Interview technique using semi structured questionnaire and adding description if required. Informed written consent taken prior to data collection.

RESULTS AND INTERPRETATION

Table 1: Frequency and percentage distribution of samples according to their demographic variables. (N = 100)

Sl. No	Demographic variable	Frequency	Percentage
1.	**Age in years**		
	65-70	54	54
	71-75	34	34
	>75	12	12
2.	**Educational qualification**		
	Primary	92	92
	Upto 12th	06	06
	Degree	01	01
	Diploma	01	01
3.	**Sex**		
	Female	50	50
	Male	50	50
4.	**Employment**		
	Agriculture	30	30
	Private/Govt	07	07
	Labourer	18	18
	Nil	45	45
5.	**Religion**		
	Hindu	50	50
	Muslim	33	33
	Christian	17	17
6.	**Marital status**		
	Married	78	78
	Unmarried	05	05
	Widow	14	14
	Divorcee	03	03

Conted…

7.	**No. of children**		
	Nil	03	03
	3 & below	52	52
	4 & above	45	45
8.	**Respondent staying**		
	Alone	23	23
	With son	56	56
	With daughter	13	13
	With others	08	08
9.	**Spouse stays with**		
	Spouse	74	74
	Children (but not with spouse)	21	21
	Someone else	05	05
10.	**General health**		
	Healthy	55	55
	On regular medication	31	31
	Need frequent hospitalization	14	14
11.	**Awareness about old age home**		
	Yes	30	30
	No	70	70

Table II: Data showing the frequency percentage of samples revealed/not revealed incident of any type of abuse

N = 100

Sl. No.	Responses of Samples	Frequency	Percentage %
1.	Revealed abuse experience	48	48
2.	Not revealed any abuse experience	52	52

Table III: Data showing the frequency percentage of samples according to different types of abuses and maltreatment of elders

Sl. No.	Abuses/ Maltreatment	Frequency	Percentage %
1.	Psychological	16	33.3
2.	Verbal	10	20.8
3.	Financial	7	14.6

Conted…

4.	Neglect	6	12.5
5.	Physical	5	10.4
6.	Social	3	6.3
7.	Sexual	0	0

Table IV: Data showing the frequency percentage of category of abusers of the victims (N48)

Sl. No.	Category of abuser	Frequency	Percentage
1.	Daughter in law	13	27.1
2.	Sons	10	20.8
3.	Daughter	9	18.7
4.	Son in law	7	14.6
5.	Spouse	5	10.4
6.	Others	3	6.2
7.	Grandchildren	1	2

RESULTS AND INTERPRETATION

Demographic data: Total data collected from females and males 50 each. Majority of the sample (52%) were in the age group between 65-70yrs. Among that 30 were females and 22 were males. Maximum sample (92%) had only primary education. Among the sample, 21% had five children and above, 28% had 4 children, 31% had 3 children, 13% had 2 children, 4% had only one child and 3% had no children. The findings revealed that maximum (78%) of them are presently staying with their children, that is 68% is staying with their son and 10% with their daughters. Rest 18% are staying alone and 4% stays with others.

Data regarding prevalence of elder abuse: Total data collected from 100 elders among which 48 persons, revealed that they had experience of different types of abuses and maltreatments, 52% did not reveal any abuse incidents. Among the respondents 30 (62.5%) were females. In this study it was found that majority of the samples 16 (33.3%) were victims of psychological abuse. Among the elders 10 (20.8%) had verbal abuse in the form of shouting very often for silly reasons and quarrelling. Seven (14.6%) had financial exploitation in the form of using his/her money by the home people, forcibly signing the blank cheques, threatening and getting the property shared and neglect them later. Five respondents (10.4%) experienced physical abuse

like looking after grandchildren only by self, doing household works without rest, getting physical assaults in the form of pushing down, dragging to bathroom, beating and locking inside the room. Six (12.5%) experienced care neglect in the form of not assisting in daily activities, not getting medical aid if required, not providing basic requirements properly. Three of them (6.3%) had social abuse in the form of separating from friends and relatives, keeping away from social activities and not allowing to accompany with family members even to church or temple. Nobody (0) reported of any situation of sexual abuse.

The data revealed that most of the abuses are domestic abuses. Among the abusers 27.1% are daughter in laws, 20.8% are sons, 18.7% are daughters, 14.6%are son in laws, 10.4% are spouses, 6.2% are others and 2%are grandchildren.

Among the respondents of abuse only 10.4% are aware of their abuse. When asked to whom they would like to complain or share the incident, the maximum sample 60% replied religious leaders.

DISCUSSION

According to point of view, most of the abuses are domestic abuses. But our elders are not ready to make any complaints against them. Total data collected from 100 elders among whom 48 persons revealed that they had experience of different types of abuses and maltreatments, 52% did not reveal any abuse incidents.

The statistics on elder abuse show that it is low, somewhere between 4% and 6% of the elderly population.[2] However, O'Connor et al (2009) suggest that the statistics are so low because elders are afraid of reporting abuse and that many do not have the opportunity to report abuse even if they wanted to.[8]

The researcher described the prevalence of different types of elder abuses. Psychological abuse 33.3%, Verbal abuse 20.8%, Financial abuse 14.6%, Care neglect 12.5%, Physical abuse 10.4%, Social abuse 6.3%, Sexual abuse Nil. At a time the samples suffers from different types of abuses. For example the financial abuse and psychological abuse, psychological and social abuse.

Review conducted by Sooryanarayanan Rajini and et al (1990-2011) suggested the need for screening and or reforming existing systems to protect the health and welfare of elder people. Physical abuse was among the least encountered, with psychological abuse and financial exploitation being the most common types of maltreatment reported.[9]

The data evidenced that elders are facing more than one abuse at a time. For example the care neglect abusers are facing psychological and social abuse, physically abused elders have psychological abuse also. This aspect of the research was supported by Elkinds. T and O'Neill. C (2009) in the literature suggested that abuse perpetrated against an individual elder is often not limited to only one form.[10]

In this study it was found that majority of the samples 16 (33.3%) were victims of psychological abuse. Psychological abuse was perceived as central in determining the severity or impact of abuse on an older person**.** The least type (0) is sexual abuse.

This result is supported by Roberts (1993) who highlighted economic abuse is one of the most frequently reported forms of abuse, followed by neglect, psychological or emotional, and finally physical abuse. Sexual abuse of elders is not reported as frequently as any other type of abuse.[11]

The data of this study revealed that most of the abuses are domestic abuses. Among the abusers 27.1% are daughter in laws, 20.8% are sons, 18.7% are daughters, 14.6%are son in laws, 10.4% are spouses, 6.2% are others and 2%are grandchildren. These findings supported by the study conducted (2012) in 24 cities of Kerala including Thiruvananthapuram, which shows that daughters-in-law constituted 44 per cent of the abusers, followed by daughters (32 per cent) and sons (24 per cent).

Interventions and Preventive aspects: In this study it is found that even though there are abuses and maltreatment exists among elders, they don't want to complain against the culprits. May be due to fear of further consequences or because of family bond. But this will aggravate the condition of abuses. Hence in the community there should be some place where these victims can rely and lodge a complaint in person. Other option is that at different locations of an area, there should be complaint box placed where they can drop the complaint at any time. The young generation should be taught the value of elder respect and need for caring them. For this in each house the young parents should be the rolemodel.

The youth should have some awareness programmes regarding aging as anyone's future.

The primary reason behind the elder abuse is unawareness and non-preparedness. Endorsing the view, Rath at Agewell Foundation said, that most of the present day old people have not seen their own parents living up to that age; therefore they do not have any preparedness to deal with the problem of the old age. Highlighting the importance of sensitization, Cherian at HelpAge India, expressed the need to teach our children and youngsters to love and respect our elders which is something non-negotiable. Moral education is the need of the hour. While supporting the above view, Rath at Agewell Foundation expressed the need of school curriculum to include moral education classes where the students will be taught how to respect elders. Also emphasized that it is the duty of parents to teach their respective sons that everybody is equal in the society.[4,12]

While making Govt. Policies, steps should taken to build sustainable communities where older people can access resources and supports that enable social inclusion, choice and access to information. In Indian setup this can be ensured from Primary Health Centre level or Panchayat Raj level, which will provide older people with the means to assert themselves. Otherwise some type of complaint box or drop boxes can be placed near a police station where the legal authorities also can be included to assist the elders to lodge a complaint. This would include promoting social inclusion among older people as a way of helping to prevent elder abuse occurring.

Health care facilities should develop uniform protocols that could aid in recognition and management of elder neglect and abuse. In order to educate the masses healthcare workers must themselves become more aware about abuse and neglect. Programmes must be designed in hospitals, convalescent homes and clinics. Medical schools must incorporate the plight of elders in curriculum. Goals for prevention include enhancing quality of life, preventing family breakdown and keeping the elderly persons in their homes as long as possible. Intervention appears to be one of the best ways of prevention.

Hudson and Margaret F in their study emphasized the need for prevention of elder abuse and neglect in our society, and we restore respect for and honour to our older adults. In addition it will require that we educate everyone about ageing, instill the value of people over material objects, and establish the resources needed to provide quality care for our aged members.[13]

- Recommendations
- Similar study can be conducted at a large scale in an urban setting.
- Study can be conducted in an institutional setting.

Comparative study can be done with rural and urban setting.

CONCLUSION

Old age is one of the inescapable truths of life. Old age is indeed second childhood as more than anything they become helpless as small children. This attribute is often exploited both psychologically and physically by others-that too by family members itself. Elder abuse and neglect continues to be one of society's great embarrassment. Institutions where elderly are treated and cared for must train their personnel to appropriately care for and protect the elderly. Awareness to the young generation about their own future-that is old age, as a prime step will be useful as a preventive measure to elder abuse.

Ethical Clearance: Taken from the Medical Superintendent, Porkulam Primary Health Centre. Kunnumkulam, Thrissur Dist.

Source of Funding: Self

Conflict of Interest: Nil

REFERENCES

1. WHO World report on Violence and health, Chapter 5 "Abuse of the Elderly" pp 125-145
2. WHO/INPEA. Missing voices. Views of elder persons on elder abuse. Geneva WHO, 2002.
3. WHO "World report on violence and health summary" Geneva 2002. Pp 1-44.
4. Help Age India. Elder abuse in India 2013 report
5. Ziminski Pickering CE, Rempusheski V F. Examining barriers to self reporting of elder physical abuse in a community dwelling elder adults. Geriatrics Nursing 2013 Nov.20

6. Charpentier M and M. Soulieres, "Elder abuse and neglect in Institutional settings" The residents' perspective. Journal of Elder abuse and neglect 25 (4): 339-54 Aug.2013.

7. Naughton c, Drennan etal, "Elder abuse and neglect in Ireland", results from a national prevalence survey Age ageing 2012. 4: 98-103

8. O'Connor etal, "Assessing capacity within a context of abuse or neglect", Journal of Elder abuse and Neglect 2009, Vol 21, pp156-69

9. Soorya Narayanan Rajani etal, BMJ open Journal Vol. 7, Issue 8, Public Health Research.

10. Elkins. T and O' Neill, 'Stradtegic review of the elder abuse prevention Programme', Final report V.2. 2009, pp 1-36

11. Roberts, J, ' An analysis of situations of elder abuse and neglect in Brisbane and other Australian Studies ' Crime and older people, Conference Paper Feb 1993 23-25.

12. H. Rath, Agewell foundation study on "Isolation in old age" national study Jan 2010.

13. Hudson MF etal. Elder abuse: Two native American views. Gerontologist, 1999: 119-139.

DOI Number: 10.5958/2395-180X.2019.00004.5

A Descriptive Study to Assess the Effects of Social Networking Sites on the Academic Performance of Students in Selected Colleges of Gandhinagar, Gujarat

Divya Gigy

Assistant Professor, Apollo Institute of Nursing, Gandhinagar, INC and GNC affliated

ABSTRACT

A descriptive study on the effects of social networking sites on the academic performance of selected college students of Gandhinagar, Gujarat. The 'General System Model' adopted from Ludwig Von Bertalanaffywas used as the conceptual frame work. A quantitative approach with descriptive survey design was used to achieve the objectives of the study. The samples consisted of 120 students of selected colleges of Gandhinagar. The convenient sampling technique was used to collect the sample. A structured questionnaire was used to assess the knowledge regarding effects of social networking sites among college students. The study shows that the majority were in the age group of 18-20 years. Maximum numbers of college students were females. The study showed that the majority of college students had good effects of social networking sites that is 93%. Their parents were aware about their SNS use. There was no significant association between effects of social networking sites and selected variables that is age and gender.

Keywords*: SNS, academic performance, college students*

INTRODUCTION

The internet has an indescribable power to influence, connect and mobilize the current population. Technological advances are no longer shocking but simple expected. Today's society has different expectation for all types of relationship. Relationships are now different because the tools used to maintain peer-to-peer connections have undergone a vast alteration. The primary focus is on the internet and with that, the development of Social Networking Site.

The global digital statistics shows out of 7.1 billion people in the world, 35% of them have access to the internet, while 26% of them are active users of social media platform for various reasons. Based on the same report the numbers of users of same web-sites key to this platform by ranking are; facebook with 1.184m users, goggle with 300m users twitter with 232m active users etc.[1]

Social networking sites have facilitated communication. Members of such site can easily form groups and share their opinions among themselves through discussion threads, forums and polls. Through these sites servers good in many ways, it has its negative effects too such as cyber crimes which have become a privacy threat to the people worldwide. Although advantageous in many ways by building new relationship and reconnecting with lost or old contacts, it also brought up some behavioral changes among the youth, not only the behavioral changes but also their social behavior and approaches. It has also ended up as a nightmare for a few people.[2]

Social Media has become a popular method for students to share information and knowledge and to express emotions. They enable students to exchange videos files, text messages, pictures and knowledge sharing. They provide an opportunity for students to

Corresponding Author:
Divya Gigy
Assistant Professor,
Apollo Institute of Nursing, Gandhinagar
143, Vraj Homes, off Sardar Patel Ring Road,
Near Shanti Asiatic School,
Shela, Bopal, Ahmedabad-580038
Mobile: +919227179266
Email: address-divyajosnedu@gmail.com

improve social networking and learning processes, which promotes knowledge in society.

In India at present the usage of Social Networking Sites amongst college going students has vastly increased and the usage of SNSs has extensive influence on these students in numerous ways, particularly on their interpersonal relationships.

NEED OF THE STUDY

The purpose of the study was to determine, if SNSs are effective learning tool, and can, in fact, be more effective in enhancing students' learning experience by tapping into a medium in which they are already comfortable and familiar and interact with on a daily basis. SNSs have the potential to change the overall dynamic of the traditional lecture classroom, SNSs are an appropriate tool for learning, with students citing familiarity, ease of use, and the ability to make a connection with the faculty and with fellow students. Another benefit is that for learners with disabilities and special needs, social media gives them an opportunity to participate equally with everyone in the class.

OBJECTIVES

1. To assess the effects of social networking sites on the academic performance of selected college students of Gandhinagar, Gujarat.
2. To identify the association between the effect of social networking sites and selected variables of selected college students of Gandhinagar, Gujarat.

REVIEW OF LITERATURE

According to study conducted by Junco.R, Heiberger. G and Loken. E the effect of twitter on college student engagement and grades. A total of 125 students taking a first year seminar course for pre – health professional majors participated in the study, with the experimental group; twitter was used for various types of academic and co-curricular discussions. Engagement was quantified by using a 19 – items scale based on the national survey of student engagement. To assess differences in engagement and grades, mixed effects analysis of variance (ANOVA) models was used, with class sections nested within the treatment groups. Content analyses of sample of twitter exchanges were also conducted. The ANOVA result showed that the experimental group had a significantly greater increase in engagement than the control group, as well as higher semester grade point averages. Analyses of twitter communications showed that student and faculty were both highly engaged in the learning process in ways that transcended traditional class room activities. This study provides experimental evidence that twitter can be used as an educational tool to help engage student and to mobilize faculty into a more active and participatory role.[3]

Rikka.T, Minna.S and Leena.S discussed social skills are developed by social media, which enable students to communicate together not depending on time and place. 95% of students were using the social media in education. 53% nursing school reported using social media application. Social media is very useful in nursing education, but it has also some disadvantages. 61.4% of students use their social media in their free time than their study time.[4]

MATERIAL AND METHOD

The 'General System Model' adopted from Ludwig Von Bertalanaffywas used as the conceptual frame work. It was a quantitative research approach and descriptive survey design was used. The study was conducted on students of selected colleges of Gandhinagar, Gujarat. Total sample size was 120 and convenient sampling was used.

For data collection technique and tool, paper and pencil method was employed. This technique was considered appropriate as the sample was literate and it helped the respondents to maintain their anonymity and hence helped them to respond frankly even to sensitive and confidential items in the questionnaires. The tool was divided into 2 parts: Part 1:Consisted of 12 questions related to demographic data and information relatedto social networking sites. Part 2:Consisted of 41 questions on information regarding effects of social networking sites which were in the form of likert scale. This was a 3-point scale and the option for all the items were: 'Agree', 'Disagree' and 'Neutral'. The scoring was done as follows: 'Agree' was marked as 3; 'Neutral' was marked as 2; 'Disagree' was marked as 1. The scores were interpreted as: Scores from 1 – 41 Poor effects on academics, 42 – 82 Average effects on academics, 83 – 123 Good effects on academics.

RESULTS AND DISCUSSION

The table 1 presents the age and gender of the college students. The data shows that 111 out of 120 college students were in the age group of 18-20 years, 9 students were in the age group of 21-23.The gender wise breakup revealed that the maximum numbers of college students under study were females i.e., 65 and remaining were males 55.

Table 1: Frequency and percentage distribution of college students by their sample characteristics (n = 120)

Sr. No.	Sample Characteristics	Frequency	Percentage
1.	**Age of college students (in years)**		
	18-20	111	92.5
	21-23	9	7.5
2.	**Gender**		
	Male	55	45.83
	Female	65	54.16

The data in Table2 presents the knowledge regarding social networking sites by the college students. The table depicts that 112 out of 120 college students were using social networking sites and 5 out of 120 college students were not using social networking sites. 86 students' parents were aware about their usage of SNSs while 34 students' parents were unaware about it. 42 students were having more than 250 friends, 33 students having less than 50 friends, 30 students having less than 150 friends and 15 students having less than 250 friends in social networking sites.75 students were using formal language, 40 students were using informal language and 5 students were using slang language while using social networking sites.56 students were using social networking sites to keep in touch with everyone, 42 students were using to keep their self updated, 15 students were using SNSs to solve their social problems and 7 students were using to while away time.

Table 2: Frequency & percentage distribution of college students by their knowledge regarding social networking sites on academic performance (n = 120)

Sr. No.	Knowledge regarding SNSs	Frequency	Percentage
1.	**Using SNSs**		
	Yes	112	93.33
	No	8	6.66
2.	**Parents' awareness**		
	Yes	86	71.66
	No	34	28.33
3.	**Total number of friends in SNSs**		
	Less than 50	33	27.5
	Less than 150	30	25
	Less than 250	15	12.5
	250+	42	35
4.	**Language usage**		
	Formal	75	62.5
	Informal	40	33.33
	Slang	5	4.16
5.	**Reason for SNSs use by higher institutes**		
	To keep in touch with everyone.	56	46.66
	To while away time.	7	5.83
	To keep updated.	42	35
	Solving social problems	15	12.5

The data given in table 3 indicate that the possible ranges of scores were 1-123 and range of obtained score for the subject was 32-123. The mean value of total scores of knowledge regarding social networking sites of college students was 91, median 94 and the standard deviation was 22.

Table 3: Mean, Median, and Standard Deviation, possible range of scores, range of obtained scores of effects of social networking sites on college students by their academic performance (n = 120)

Group	Possible ranges of scores	Range of obtained scores	Mean	Median	Standard Deviation
College Students	1-123	32-123	91	94	22

The data in figure 2 reveals that out of 120 college students, 112 had good effects on their academic performance with the use of SNSs, 6 had little effects on their academic performance and only 2 had poor effects on their academic performance.

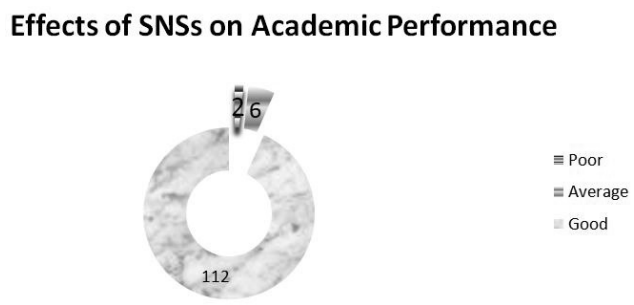


Figure 1: A Donut Diagram Showing Frequency Distribution of Effects of SNSs on Academic Performance of College Students by their Response

The data presented in table 4 shows that the calculated Chi square value was 0.6952, and the p value is 5.99 which is greater than the calculated Chi square therefore, this indicates that there was no significant association between the effects of social networking sites and age of the college students. Also, the data shows that the calculated Chi square value was 2.46722 and p value was 5.99, which is greater than calculated Chi square therefore, this indicates that there was no significant association between the effects of social networking sites and gender of the college students.

Table 4: Chi square value showing the association between the effects of social networking sites on academic performance and age, gender of the college students

(n = 120)

Category	Poor	Average	Good	Chi-Square	p-value
Age (years)					
18-20	2	6	103	0.6952	5.99
21-23	0	0	9		
Gender					
Male	2	3	50	2.467	5.99
Female	0	3	62		

DISCUSSION

According to data we collected from the questionnaire, most college students prefer to use SNSs and therefore they spend vast hours checking SNSs. Whatsapp and twitter is very popular among college students, even though students would use it when they had classes. Ninety Percentages of the students spend their time on education and collecting information from SNSs, however there were not too many college students who preferred using SNSs for entertainment. Eighty percentage of the sample admitted that their writing skills have got affected because of SNSs use. Perhaps, use of SNSs has affected their efficiencies to some extent. Even students have accepted that SNSs has cause distraction in their studies, even late night awakening and absenteeism has also increased.

SNSs are attractive; it not really provides college students another world to make friends, also provides a good way to release stress. Fifty percent of the students accepted that SNSs has help them in searching jobs This research also indicates that college students should thinks more about the balancing equation of SNSs and academics.

The present study shows that the frequent use of social networking sites by students has no negative effects on their studies. The result obtained from the study findings supports that the SNSs does not have adverse effects on the academic performance of college students. It is also in line with the study of Jahan, Ahmed.I, Zabed.M.S[5] which conforms that majority of students agreed that the SNSs have positive influence on their academic performance.

Gender differences were revealed in multiple aspect of SNSs use. Females were prone to spend more time on SNSs. Females were found to use SNSs more than males which is in contrary to the report of EstatsIndia.com[6] social media users and usage in 2014. Male users of social networking sites are marginally higher than the females.

In this study, it was examined that ninety percent college students used SNSs for sharing knowledge and essential information and to interact with past friends and students of other colleges. This study also revealed that SNSs technologies in college have help in better learning, which is similar to Rikka.T, Minna.S and Leena. S[4] study, which enable students to communicate together not depending on time and place. 95% of students were

using the social media in education. 53% nursing school reported using social media application.

In this research study, 50% acknowledged that SNSs can have negative social effects on individual and society. Through it, people can easily be duped or even lured into immorality even though this study didn't had any negative effect on the academic performance of the college students. This finding was similar to Michel and Shonna[7] who stated that approximately 51% of 21 millions of use/ students that engage in social media sites on daily bases have been socially affected more of negatively.

The presents study revealed that, there is no significant association between the effects of SNSs and the age, gender of college students. On the contrary, the study of Tham.J[8] concluded that there was significant relation between usage of SNSs and age and gender.

IMPLICATION

Nursing Education

- The implications of these findings, encourage college faculty to adopt the use of social networking services as part of the teaching and learning process with a specific focus on building learning communities and increasing student's engagement.
- SNSs can be the potential for current use to provide cost and time effective nursing education.
- The utilization of technology in education should be understood as an opportunity, not just the technology itself. In this way, we can enable deep learning and learning development.

Nursing Practice

- SNSs provides way to connect with other nurses, it provides a powerful medium to educate patient.
- Nurses can have conferences with one and other through SNSs with visual components, sharing cases, asking advice, collaborating and learning.
- With the increasing number of patients using the internet for healthcare information, nurses need to consider being actively present to provides sounds, information through internet and SNSs.

CONCLUSION

Previous research in spheres of social networking sites and its impact on college students in different global and demographic context provided an extensive secondary source base for the study. As with many technologies, adoption of the Internet especially for its social uses has seen its highest levels of usage among young college students in India. The majority of college students experienced good effects on academic performance with the use of SNSs while very few students had some effects. They are aware of the danger and risk involved in these sites is a positive indicator that Indian college students are not only techno-savvy and socially active through social networking sites but they also possess social consciousness. It is recommended to replicate similar study on large sample with similar baseline characteristics.

Ethical Clearance: Ethical clearance was not required. Permission was obtained from the competent authority of the colleges.

Source of Funding: No funding was required

Conflict of Interest: Nil

REFERENCE

1. Gonxhe.B. The Impact of Social Media on Higher Education in Kosovo: The Student's Perspective. Academic journal of Interdisciplinary Studies MCSER Publishing. 2014; Vol-3(2). Available from : http://www.mcser.org/journal/index.php/ajis/article/viewFile/ 2961/ 2921 & sa=U & ei=7wp LVea1LY3ZoAThYCQDQ & ved = 0CBAQFjAC & usg=AFQjCNEMrlLlMW5tkZ78HGdbMfZ9n17Ryg.
2. Neelamalar.M & Chitra.P. A Study on the impact of social networking sites on Indian youth. Journal of New media and society. 2009: 125-145. Available from: http://www.ec.ubi.pt/ec/06/pdf/neelamalar-new-media.pdf.
3. Junco.R, Heibergert.G & Loken.E. The effect of twitter on college student engagement and grades. Blackwell publishing. 2010; Vol 27(2): 1-13. Available from: http://www.ferris.edu/HTMLS/admistration.
4. Rikka.T, Minna.S, Leena.S. Social media in nursing education: The view of the students.

Journal of Education Research International. Hindawi Publishing. 2014; Vol 6(1): 1-6. Available from: http://www.hindawi.com/journals/edri/2014/929245.

5. Jahan, Ahmed.I, & Zabed.M.S. Students' perceptions of academic use of social networking sites: a survey of university students in Bangladesh. Journal of Sage. 2012; 28(3): 235-247. Available from: https://journals.sagepub.com/doi/ abs/ 10.1177/ 0266666911433191? journalCode = idva.
6. Vikram. Social media users and usage in India. EstatsIndia.com internet research & consulting. 2013: 1-8. Available from: https://www.slideshare.net/Vicks18/social-media-users-usage-in-india-2014-report.
7. Michele.W, and Shonna.LS. Methodology to assess college students risk taking behaviour in SNSs. APHA Scientific Session and Event Listing. Journal of advanced pharmacy education and research. SPER publication. 2007; Vol.7(3): 194-196. Available from: https://japer.in/storage/article/file/AC245Article.pdf
8. Tham.J, Usage and implication of social networking sites: a survey of college students. Journal of Interpersonal, intercultural and mass communication. 2011; Vol-2(1): 1-11. Available from: https://www.academia.edu/1965705/Usage_and_Implications_of_Social_Networking_Sites_A_Survey_of_College_Students
9. Kumar.A, Kumar.R. Use of social networking sites: A study of Maharishi Dayanand University, Rohtak, India. E-journal of library philosophy and practice. 2013: 1-12. Available from: http://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=2415&context=libphilprac
10. Polit.DF & Beck.CT. Nursing research: principles & method, 7th edition, New Delhi, Wolters Kluwer Health Pvt ltd, 2007.
11. Manjunatha S. The Usage of Social Networking sites Among the College Students in India. International Research Journal of Social Sciences. 2013; Vol. 2(5): 15-21. Available online at: http://www.isca.in/IJSS/Archive/v2/i5/3.ISCA-IRJSS-2013-065.pdf

DOI Number: 10.5958/2395-180X.2019.00005.7

Effectiveness of Exercise Program on Mobility, Activity of Daily Living and Quality of Life among Elderly Residing at Rural Area

G Vimala

PhD Scholar, Pravara Institute of Medical Sciences (DU), College of Nursing, Loni (Bk), Tal. Rahata, Dist. Ahmednagar MS

ABSTRACT

Introduction: Aging is considered as normal and natural process of every human being, and regarded as an unavoidable biological happening. The ever changing dynamics of demographics have affected the elderly at large; wherein the impact is enormous throughout world including the developing countries like India. Elderly people face a variety of problems like inactivity, functional loss, psychiatric morbidity and diminished quality of life. The scientific evidences highlight that practice of exercise program enhances mobility, activity of daily living and quality of life. Thus the present communication was carried out to assess the effectiveness of exercise program on mobility, activity of daily living and quality of life among elderly.

Materials and Method: It's a true experimental study, where post test only design with control group was used among 150 randomly selected elderly people (75 was in control and 75 was in study group) residing at rural area. The elderly above 60 years of age, able to perform exercise and willing to participate (consent) were enrolled in the study. Structured interview schedule was used to assess the study variables. The collected data was analyzed with help of descriptive and inferential statistics methods.

Results: The results revealed that elderly who received the exercise interventions had improved mean scores on mobility and quality of life than the elderly who received the routine care, notably it was statistically significant at $p<0.05$ level. A significant association was existed between mobility, quality of life with socio demographic variables like age, gender and type of family at $p<0.05$ level.

Conclusion: This study demonstrated that exercise intervention was well accepted by elderly population and has significant effect towards the improvement of mobility and enhancement of health related quality of life. It should be emphasized that the practice of regular exercise programme for the reduction in physical deformities and improved wellbeing and quality of life.

Keywords*: Exercise program, Mobility, Activity of daily living, Quality of life and elderly*

INTRODUCTION

Ageing is a normal, biological and universal phenomenon, and occurs in a unique way with every human being. It's a multi faceted progress where the individual's wellbeing, functional health status are inclined by a diverse factors[1]. It is estimated that nearly two thirds of total population aged 60 years and above are living in developing countries like India. The elderly population will increase swiftly in the next decades, and by the year 2050 nearly 8 out of 10 aged populations will live in developing regions[2].

Corresponding Author:
Mrs G Vimala
PhD Scholar, Pravara Institute of Medical Sciences (DU), College of Nursing
Loni (Bk), Tal. Rahata, Dist. Ahmednagar, MS–413736
Mobile: +91 9960540093
Email: sivavimal.guru@gmail.com

India has around 104 million elderly persons (i.e. 8.6% of the population is comprised of 60+ aged) and the number is expected to increase to 296.6 million and constituting 20% of total population by 2050. An overwhelming majority of elderly live in rural areas, and nearly 3 out of 5 older person are poor and about two thirds of them completely economically dependent[3]. The elderly in India face amalgamation of numerous physical, psychological and social health problems. As age advances there is an increased morbidity, inactivity, functional loss and diminished quality of life[4].

A community based study on quality of life of elderly of rural area highlights that an elderly had significant lower level of quality of life in domains like social relation and environment than the urban population[5]. The elderly who did not had education, not receiving pension, not along with partner, having musculoskeletal disorders and belongs to nuclear family had significantly lower Quality of Life score[6].

Given the rate of aging population that developing countries like India are experiencing, there is a necessity to focus on ageing related issues particularly on activity of daily living and quality of life. Scientific evidence had indicated that physical activities impacts on both physical and mental health i.e. the more active elderly enjoyed a higher quality of life and wellbeing status. The practice of regular and constant exercise program and physical activities improve different domains of quality of life, especially physical, social and role taking which leads to individual's independence in doing their daily activities[7]. Physical exercise programme and activities does have a positive correlation with healthy aging in elderly population, thus the present study was carried out to assess the effectiveness of exercise program on mobility, activity of daily living, quality of life among elderly population.

MATERIALS AND METHOD

A true experimental study was carried out on elderly residing at rural area of Rahata Taluka, Ahmednagar District, Maharashtra. Sample size was calculated using Openepi, open source calculator – SSCC. The estimated sample size for case – control study was 150 i.e. 75 in cases and 75 in controls, by Fleiss method with correction factor. Elderly were selected by using simple random sampling technique, based on criteria's of selection. The elderly who were 60 years or older, ability to undergo exercise programme and willing to participate were included, wherein elderly who were institutionalized, acutely ill, unable to perform exercises and has cognitive impairment or chronic disorders were excluded from the study.

An ethical approval was obtained from Institutional Ethics Committee of Pravara Institute of Medical Sciences (Deemed to be University), Loni (Bk). The purpose of study was explained to the elderly, and a written informed consent was taken before the enrollment. After collecting baseline data, 150 elderly were randomized to study group (n=75) and to the control group (n=75) respectively. From the study population odd number elderly is chosen (first sample) was enrolled in study group and even number elderly (second sample) in the control group and so on… till the achievement of determined sample size. Elderly in study group received exercise program administered by a principal investigator, whereas elderly in control group received routine care. Exercise program consists of a) Basic exercise i.e. warm up and stretching exercise b) Muscle strengthening exercise c) Balance and gait training and d) Home exercise – are performed two sets of exercises minimum 30 minutes for atleast three times a week. Exercise record diary was provided to elderly to record the performance for 3 months, and the investigator was followed up the elderly once in a 15 days.

Pre tested structured interview schedule was used to gather data, it consists of section A – Socio demographic characteristics, section B – Elderly mobility scale, section C – Activity of daily living scale and Section D – WHO QOL BREF scale. The elderly of study group received exercise program for three months (three times a week for minimum of 30 min), while the post test was carried out for both groups after three months of post intervention. All the data were gathered and recorded; further collected data was tabulated and analyzed by applying appropriate statistical tests like mean, SD, Z test and chi square test. The statistical level of significance was calculated at $p<0.05$ level.

RESULTS

A total of 150 elderly were participated in the study, and baseline data were well balanced between the control and study group. Table 1 shows the distribution of elderly population in the study according to their socio demographic data.

Table 1: Distribution of elderly according to socio demographic data

Socio demographic data	Control group (n=75)		Study group (n=75)	
	No (f)	Percent (%)	No (f)	Percent (%)
Age				
60 – 65 years	32	42	27	36
66 – 70 years	18	24	20	27
> 70 years	25	34	28	37
Gender				
Male	38	51	30	40
Female	37	49	45	60
Marital status				
Married	46	61	41	55
Widow/Widower	29	39	34	45
Education				
No formal education	04	05	02	02
Primary	58	78	60	80
Secondary	07	09	07	09
Higher secondary	06	08	06	09
Occupation				
Home maker	30	40	39	53
Daily wages	06	08	05	06
Agriculture	28	37	28	37
Private employee	11	15	03	04
Monthly income				
Below Rs.3000	52	69	50	66
Rs 3001 – 6000	09	13	12	17
Rs 6001 – 9000	04	05	04	05
Above Rs. 9001	10	13	09	12
Type of family				
Nuclear	15	20	18	24
Joint	53	71	49	65
Extended joint	07	09	08	11
Religion				
Hindu	51	68	48	64
Christian & Muslim	24	32	27	36
Residential status				
Living alone	05	07	03	04
Living with spouse	16	21	20	27
Living with spouse and children	48	64	45	60
Living with son/ daughters	06	08	07	09

Table 2: Effectiveness of exercise program on mobility, activity of daily living and quality of life of elderly

Variable	Control group (n=75)		Study group (n=75)		Z value
	Mean	SD	Mean	SD	
Mobility	16.21	3.19	18.04	1.79	3.19*
Activity of daily living	5.84	0.57	6.00	1.13	0.81
Quality of life	79.29	8.71	90.52	9.86	4.86*
a) Physical domain	22.75	3.11	25.75	3.92	
b) Psychological domain	18.52	2.83	21.52	3.38	
c) Social domain	10.63	1.37	10.49	0.71	
d) Environment domain	27.41	2.54	32.07	4.11	

* Significant, Table value: 1.96 at $p<0.05$ level

Based on data in table 2, the post test mean scores of mobility (18.04±1.79) and quality of life (90.52±9.86) in the study group was higher than control group (16.21±3.19) and (79.29±8.71) respectively, and the difference between two groups was statistically significant. However the results from Z test did not show significant difference in activity of daily living at $p<0.05$ level. It interprets that the exercise program was effective in improving the mobility and quality of life of elderly population.

Table 3: Association of mobility, activity of daily living and quality of life with socio demographic data

Variables	df	Mobility (χ2 value)	Activity of daily living (χ2 value)	Quality of life (χ2 value)
Age	1	3.97*	0.31	5.71*
Gender	1	5.27*	0.06	0.69
Education	1	0.03	0.62	0.22
Monthly income	1	1.35	0.09	1.68
Occupation	1	2.73	1.79	1.28
Type of family	1	0.62	0.91	3.86*

*Significant, Table value: 3.84 at $p<0.05$ level

Table 3 depicts that the elderly in study group had a statistically significant association between mobility and age and gender; similarly the quality of life had association with age and type of family. However the other variable i.e. activity of daily living did not had association with any of the socio demographic variables at $p<0.05$ level. There was a moderately positive correlation ($r=0.52$) was existed between variables such as mobility and quality of life of elderly.

DISCUSSION

Evidences have envisage that the elderly has problems in mobility, activity of daily living and reduced quality of life, wherein the national health policy for elderly presents a directive for the promotion of active and healthy aging that refer to maintenance of functional independence and autonomy throughout aging, allowing the involvement in social, economic, cultural, spiritual and civic activities[8].

It was evident from the findings that the elderly who practiced exercise programme had statistically improved enhanced quality of life than the elderly who did not perform exercises. It interpret that the exercise program is important to maintain quality of life, and effective in improving the mobility and quality of life. This finding was consistent with study that a low intensity physical exercise programme contributes in maintaining quality of life as well as the psychological aspects of elderly people[9].

The study findings reinforced the importance of physical activity and exercise for elderly people to improve the mobility and functionality. Exercise is an essential component for mobility and functional maintenance for all including the elderly people, this fact was well documented in a study that exercise program group showed improvement in mobility, balance and flexibility than the elderly who had walking activity[10].

There was a significant association existed between quality of life and socio demographic variables like age and type of family; and a positive correlation was prominent between the mobility and quality of life of elderly. It was in congruence with study results that a significant correlation was found between age, gender of elderly with the quality of life score[11]; and found a strong positive relationship between quality of life, activity of daily living and elderly mobility[12].

In addition to this study results, numerous systematic reviews had recommended that the exercise is one of the effective and non pharmacological intervention to improve the quality of life of elderly. As a health service provider, nurses needs to assess the problems of elderly and tries to minimize or resolve problems and improves the wellbeing, self esteem with specific nursing interventions. In conjunction with it is important to create awareness on exercise programme through education and training to improve the understanding and compliance with exercise therapy of elderly.

CONCLUSION

The elderly suffers with variety of health problems including mobility, functionality and poor quality of life. The low intensity exercise program consist of basic exercises like warm up and stretching exercises, muscle strengthening exercises and balance and gait training exercises contributes in improvement of mobility, wellbeing and various aspects of quality of life of elderly population. The results of study highlight the same in lucid manner along with statistical inference. It is a cost effective non pharmacological intervention to

be applicable in most of elderly in Indian settings for better health related outcomes. The exercise training programmes must be provided to all elderly and encourage them to practice with sufficient compliance for the long term sustainable health related outcomes.

ACKNOWLEDGMENT

The author expresses sincere thanks to Pravara Institute of Medical Sciences (Deemed to be University), Institutional Research/Ethics Committee, Block Development Officer and VAO of selected villages and the elderly population for their kind cooperation and support.

Source of Funding: Self

Conflict of Interest: Nil

REFERENCE

1. Government of India. Eleventh five year plan document 2007 – 2012, New Delhi: Ministry of Planning.
2. World Population Ageing 2013. Department of economics and social welfare, United Nations (UN), New York; USA
3. Report on the status of elderly in select states of India, 2011. United Nations Population Fund (India) available at http://india.unfpa.org/drive/AgeingReport_2012_F.pdf accessed on 21.05.2017
4. The status of elderly in Maharashtra, 2011. United Nations Population Fund (India)
5. Mudey A, Ambekar S, Goyal RC. Assessment of quality of life among rural and urban elderly population. Ethno Med, 2011; 5 (2): 89 – 93
6. Kumar GS, Majumdar A, Pavithra G. Quality of life and its associated factors using WHOQOL – BREF among elderly in urban Pondicherry, India. Journal of Clinical and Diagnostic Research, 2014; 8 (1): 54 – 57
7. Ghasemtalebi S, Omran HN, Ghrohi F. Effect of aerobics exercises on quality of life in elderly women. International Journal of Sport Studies, 2015; 5 (3): 263 – 66
8. Ministry of health and family welfare. New Delhi: Director General of Health Services, MOHFW, Government of India; 2011. National Program for Health Care of the Elderly (NPHCE): Operational Guidelines 2011.
9. Aveiro MC, Driusso P, dos Santos JG, Kiyoto VD, Oishi J. Effects of a physical therapy program on quality of life among community dwelling elderly women: A randomized controlled trial. Fisioter Mov, 2013; 26 (3): 503 – 13
10. Roma MF, Busse AL, Betoni RA, Melo AC, Kong J, Santarem JM et al. Effects of resistance training and aerobic exercise in elderly people concerning physical fitness and ability: A prospective clinical trial. Einstein, 2013; 11 (2):153 – 57
11. Dawane J, Pandit V, Rajopadhye B. Functional assessment of elderly in Pune, India – Preliminary study. J Gerontol Geriat Res, 2014, 3 (3): 10 – 15
12. Ahmed HI, Mohamed EE, Sahar MA. Effect of mobility on quality of life among older adults in geriatric home. Advances in Life Science and Technology, 2014; 17: 39 – 50

DOI Number: 10.5958/2395-180X.2019.00006.9

A Descriptive Study to Assess the Knowledge about Misconceptions Regarding Mental Illness among the People Attending the Psychiatric OPD, SGRD, Hospital Amritsar

Gurjeet Kaur[1], Rajwant Kaur[2]

[1]Assistant Professor, [2]Assistant Professor, Sri Guru Ram Das College of Nursing, SGRD Medical Institute of Sciences and Research, Amritsar, Punjab

ABSTRACT

Many mentally ill people are the victims of stigma and misconceptions. This leads to additional suffering and humiliations. The knowledge of these misconceptions helps in management of mentally ill in our society. The present study was undertaken to assess the knowledge about misconceptions regarding mental illness among the people attending the psychiatric OPD, SGRD, Hospital, Amritsar. The objective of the study was to assess the knowledge about misconception regarding mental illness. The data was collected from 30 subjects by convenient sampling technique attending the psychiatric OPD with the help of misconception regarding mental illness interview schedule. Descriptive design was adopted for the study. The data was analyzed and interpreted using descriptive statistics. The major finding of the study revealed that more than half (60%) subjects had below average knowledge about misconception regarding mental illness, 33.3% had average knowledge and only 6% had good knowledge. The findings of the study revealed that majority below average knowledge about misconception regarding mental illness. It is recommended to conduct similar study on large sample of subjects and further can be conducted in community setting.

***Keywords**: Mental illness, Misconception*

INTRODUCTION

Many people with serious mental illness are challenged doubly. On one hand, they struggle with the symptoms and disabilities that result from disease. On the other, they are challenged by the stereotypes and prejudice that result from the misconceptions about mental illness. As a result of both, people with mental illness are robbed of the opportunities that define a quality life: good jobs, safe housing, satisfactory health care, and affiliation with a diverse group of people.[1] In rural areas of India, many villagers still believe mental illness is caused by evil spirits angry that the sick person had killed a cow during a past life.[2]

Many mentally ill people are the victims of stigma and misconceptions. This leads to additional suffering and humiliations. Negative stereotypes and pre judicial attitudes against them are often reinforced by their media representation as unpredictable, violent and dangerous. Hence the importance of the study of these misconceptions helps in the management of the mentally ill in our society.[3]

In our society the persons with psychiatric illness often received as unwanted elements and societal stigma prevents them from seeking help and treatment. In recent years the awareness about mental illness has been changed a lot, even still the misconceptions about mental illness still present in society. Many studies done by WHO and other agencies point the need of awareness programs in the society for eradicating stigma. The Indian Mental Act, 1987, is an amendment of the Indian lunacy act, 1912 recognize the crucial role of treatment and care of mentally ill persons. But still in some part of our country mental illness considered as a sins and witch craft, these believes prevent them from seeking medical help.

Mental and behavioral disorders account for approximately 7.4 percent of the global burden of disease and represent the leading cause of disability worldwide.[5]Medical health professional can play a major role in prevention of misconceptions among communities.[3] According to department of health and family welfare census report (2001), 1.7% of the Punjab's population is suffering from mental illness.[6]

OBJECTIVE

To assess the knowledge about misconceptions regarding mental illness among people attending psychiatric OPD.

MATERIAL AND METHOD

The study was conducted in the psychiatric OPD of SGRD Hospital, Amritsar, Punjab in May 2014. A descriptive research design was used and 30 subjects were selected by convenient sampling technique. Data was collected by using self structured interview schedule which includes 18 items on misconceptions regarding mental illness. The reliability of tool was calculated by test retest and Karl Pearson coefficient method and it was 0.8.

RESULTS

The socio demographic variable includes data related to age, gender, hostility, type of family and previous knowledge regarding misconceptions. The most of subjects (40%) were belonged to age group 47-55 years. Half of subjects (50%) were higher secondary passed, followed by 26.6% were illiterate. More than half of subjects (63.3%) were females and 36.6% were males and 70% had rural habitat. As per type of family 63.3% subjects were from nuclear family and half of subjects (50%) were private job holders. Majority of subjects (76.6%) had not any previous knowledge about misconceptions regarding mental illness.

Sr. No.	Level of knowledge	Scoring	F	Percentage
1.	Good	13-18	2	06.6
2.	Average	07-12	10	33.3
3.	Below average	00-06	18	60

Table1. shows the level of knowledge regarding misconceptions regarding mental illness divided into 3 levels good (13-18), average (07-12), below average (00-06). The more than half of subjects (60%) had below average, 33.3% had average and only 6.6% had good level of knowledge about misconceptions regarding mental illness.

DISCUSSION

Recommendation

- Conduct study on large population by involving more hospitals.
- Assess correlation between demographic variables and misconceptions regarding mental illness.
- Conduct survey regarding awareness in community.

CONCLUSION

This study was conducted with the motive to assess level of knowledge about misconception regarding mental illness among people attending psychiatric OPD. As the general population play important role in early detection and preventing from misguiding of society with superstitions. So it's necessary to assess their awareness level and plan according to that for creating awareness regarding mental illness. This study present that still majority of people are having below average knowledge about mental illness and only 6.6% that is too less and indicate that society needs an community based awareness programme to create awareness in general public.

Ethical Clearance: Written permission was obtained from Head of department of psychiatry, Sri Guru Ram Das Hospital, Amritsar. Written consent was obtained from each subject after giving assurance of confidentiality.

Source of Funding: Self

Conflict of Interest: Nil

REFERENCES

1. Patrick W Corrigan and Amy C Watson. Understanding the impact of stigma on people with mental illness. World Psychiatry. 2002Feb;1(1):16-20.PMCID:PMC1489832.
2. Mark Magnier, India battles misconceptions on mental illness, Los Angeles Times; July 05,2013. Available from: http://articles.latimes.com/2013/jul/05/world/la-fg-india-mental-health-20130705
3. Prince P N, Prince CR. Perceived stigma and community integration among clients of assertive community treatment. Psychiatric Rehabilitation Journal 2002.25(4)323-331.
4. Kapoor Bimla. Textbook of psychiatric nursing Publishers, New Delhi 2005, volume 2 edition 2nd 445-446.
5. Pike M Kathleen, Pincus Harold. Towards a healthier 2020, advancing mental health as a global health priority. Public Health reviews. 2015; 35 (1): 8
6. Department of health and family welfare: Government of Punjab. IJP. 2006; 4(2): 3-9

DOI Number: 10.5958/2395-180X.2019.00007.0

Effectiveness of Self Instructional Module on Antipsychotic Drugs among Family Members of Psychiatric Patients in Selected Tertiary Hospitals Coimbatore

M. Baskaran[1], A. Jayasudha[2], Arockia Darshana[3], Anni Cinto[3], Annie Grace Pushpam[3], Aswany Thomas[3], Bishmi Sharen[3]

[1]Associate Professor, Department of Mental Health (Psychiatric) Nursing, [2]Principal, [3]BSc Nursing, Department of Mental Health (Psychiatric) Nursing, PSG College of Nursing, Coimbatore, Tamil Nadu

ABSTRACT

Introduction: Today Mental and behavioral disorders are common and affect more than 25% of all People at some time during their lives. One in four families is likely to have at least one member with a behavioral or mental disorder. Care for severely mentally ill individuals may carry a heavy burden and stress particularly true for close family members such as Parents, who take care of their mentally ill children for long.[1]

Objectives:

- To assess the level of knowledge on antipsychotic drugs among family members
- To assess the effectiveness of self instructional module on promoting knowledge on antipsychotic drugs among family members.
- To associate the level of knowledge with selected demographic variables

Research Methodology: The research methodology selected for this study is pre experimental - one group pretest post test design. The research participants were 15 family members of psychiatric patients admitted at the study was conducted at PSG Hospital in Coimbatore, After Ethical clearance obtained from the IHEC committee, PSG IMS&R.

Results: Among 15 family members in psychiatric ward, 13 had adequate knowledge, 2 had moderate knowledge and no one had inadequate knowledge after the implementation of *self* instructional module.

Conclusion: The self instructional module has helped the family members to know about the action and complication of antipsychotic drugs and they can well known to differentiate side effect of antipsychotic drugs.

Keywords*: Self Instructional Module, Antipsychotic drugs, Family members, Psychiatric patients, Tertiary hospitals.*

INTRODUCTION

Today Mental and behavioral disorders are common and affect more than 25% of all People at some time during their lives. One in four families is likely to have at least one member with a behavioral or mental disorder. It is estimated that mental disorders contribute a large share to the global disease burden and account for 33% of the years lived with the disability worldwide. It is estimated that two to three persons in every thousand adults suffer from serious mental illness such as affective disorders and schizophrenia. Care for severely mentally ill individuals may carry a heavy burden and stress particularly true for close family members such as Parents, who take care of their mentally ill children for long.[1]

Corresponding Author:
Mr. M. Baskaran, M.Sc (N), PhD Scholar
Associate Professor
Department of Mental Health (Psychiatric) Nursing.
PSG College of Nursing, Coimbatore. Tamil Nadu
Email: baskirathi@gmail.com

NEED FOR THE STUDY

An antipsychotic drugs are administered to control the symptoms of psychosis such as hallucinations and bizarre or paranoid behavior. These drugs calm without sedation or reduction in alertness. A number of antipsychotic medication fall into two generations: first generation drugs and second generation drugs. Among the most important first generation drugs are haloperidol, chlorpromazine, thioridazine, fluphenazine, and trifluoperazie[2]

In recent years the second generation antipsychotics drugs are atypical antipsychotic drugs such as ripiprazole, respiridone, colazipine, olanazipine, quetiapine, and ziprasidone have replaced the first generation drug nearly completely. The side effects of first generation drug including weight gain, diabetes, high blood pressure, heart diseases, and other complication. Side effects from second generation antipsychotics vary among different agents, but weight gain has proven among most troublesome complication. These drugs tend to stimulate appetite, and the result is often significant weight gain.[2]

Temporary withdrawal symptoms including insomnia, agitation, psychosis, and motor disorders may occur during dosage reduction of antipsychotics, and can be mistaken for a return of the underlying condition. The development of new antipsychotics with fewer of these adverse effects and with greater relative effectiveness as compared to existing antipsychotics, is an important ongoing field of research. The most appropriate drug for an individual patient requires careful consideration.[3]

REVIEW OF LITERATURE

The study was conducted among 100 caregivers of mentally ill patients receiving atypical antipsychotic drugs. The data were collected through a self-administered knowledge questionnaire on atypical antipsychotic drugs. Results showed that 45% of them had good knowledge and another 45% of them had an average knowledge, 6% of them had excellent knowledge and 4% had poor knowledge. The mean percentage of knowledge score was 63% in management, 42% in prevention, 52% general concept and 47% in the areas of side effects and precaution. There was a significant association between demographic variables such as monthly income ($\chi2=0.115$; $p=0.013$), previous exposure to atypical antipsychotics ($\chi2=0.010$; $p=0.001$), patient's diagnosis ($\chi2=0.177$; $p=0.022$), age ($\chi2=0.641$; $p=0.014$), education ($\chi2=0.001$; $p=0.001$), occupation ($\chi2=0.01$; $p=0.002$) and knowledge score at 0.05 level of significance.[4]

A descriptive study was conducted to assess the Knowledge Regarding Adverse Effects of Selected Antipsychotic Drugs among the Caregivers of Patients Receiving Antipsychotic Drugs. Non Probability sampling by using convenient sampling technique was used to select 30 samples. Data was collected by means of a Standardized Structured Knowledge Questionnaire which was divided into 2 sections which consisted socio-demographic variables and variables to assess the knowledge regarding adverse effects of anti psychotic drugs. The study findings revealed that majority of caregivers 24 (80%) had average knowledge, 5 (16.66%) had good knowledge, 1 (3.33%) had poor knowledge about adverse effects of antipsychotic drugs. There is statistically significant association found between demographic variables with knowledge score regarding adverse effects of antipsychotic drugs at the 0.05 level of significance.[5]

This study was conducted to find out the effectiveness of informational booklet for caregivers regarding care of a patient receiving antipsychotic drugs. The study was conducted in Mansik Arogya sala, Mental Hospital Gwalior with 250 beds. An evaluator approach with one group pre-test – post-test design was used for the study. The sample consisted of 30 caregivers selected by convenience sampling method. The collected data were analyzed by using descriptive and inferential statistics ('t' test). This study revealed that the mean post-test knowledge score ($x_2 = 24$) was higher than the mean pre-test knowledge scores ($x_2 = 16$). The 't' value computed ('t' = 13.38; $P < 0.05$) showed a significant difference suggesting that the IB was effective in increasing the knowledge of caregivers. The mean post-test area-wise scores $x_2 = 2.43$, 1.8, 3.73, 2.3, 4.03, and 10.13 respectively were higher than the mean pre-test area-wise scores ($x_1 = 1.6$, 1.06, 2.46, 1.76, 2.83, and 3.96). There was no association between the pre-test knowledge scores and selected variables like education, religion, income and previous experience of caring for mentally ill patients.[6]

STATEMENT OF THE PROBLEM

Effectiveness self instructional module on antipsychotic drugs among family members of psychiatric patients in PSG Hospitals, Coimbatore.

OBJECTIVES OF THE STUDY

1. To assess the level of knowledge on antipsychotic drugs among family members.
2. To assess the effectiveness of self instructional module on promoting knowledge on antipsychotic drugs among family members
3. To associate the level of knowledge with selected demographic variables.

OPERATIONAL DEFINITIONS

Effectiveness: In this study, effectiveness refers to the efficiency of the self instructional module in increasing the family member's knowledge regarding care of patient receiving antipsychotic drugs.

Self instructional module: In this study self instructional module refers to the brief description on knowledge regarding indication, contraindication, side-effects, complications and care of patients while receiving antipsychotic drugs.

Antipsychotic drugs: Antipsychotic is a major tranquilizing psychiatric medication primarily used to manage psychosis, particularly in schizophrenia and bipolar disorder.

Family members: In this study family members refers, persons who are giving primary care to the patients who are receiving antipsychotic drugs.

Assumptions: The self instructional module will help the family members to improve their knowledge regarding care of patient receiving antipsychotic drugs and thereby they can improve the drug complaints.

Hypothesis

H_1: There is a significant difference in the pre and post test level of knowledge on antipsychotic drugs among family members.

H_2: There is a significant association of the level of knowledge on antipsychotic drugs with selected demographic variables among family members.

RESEARCH DESIGN

The research design selected for this study is pre experimental design, one group pretest – posttest design. Here the test acts as a measurement tool for the evaluation effect on post test.[7]

VARIABLES

Independent Variables: Self instructional module

Dependant Variable: Level of knowledge on antipsychotic drugs.

Settings: The setting for the study conducted in PSG hospitals Coimbatore.

Population: The population is family members of psychiatric patients from PSG hospital in Coimbatore.

Sample Size: 15 family members of psychiatric patients from PSG hospital.

Criteria for Selection of Sample

Inclusion Criteria:

- Family members of psychotic patients receiving antipsychotic drugs
- Family members who are willing to participate in the study.

Exclusion Criteria:

- Family members who were already exposed to this type of study within last six months.

Sampling Technique: Convenient sampling technique.

Tool for Data Collection

Section A: Demographic profile: It consist of age of the family member (in years), Gender, Educational status, Occupational status, Type of family, Religion, Marital status, Relationship with the patient, Duration of illness, Previous information regarding antipsychotic therapy.

Section B: Structured questionnaire to assess the knowledge on antipsychotic drug among family members: It consist of 15 questions which includes introduction, action, side effects and drug non compliance

Section C: Modified Glasgow Antipsychotic Side-effect Scale (GASS): The Modified Glasgow

Antipsychotic Side-effect Scale (GASS) consists of 22 items. They are

1-2 = Sedation and CNS side effects, 3-4 = Cardiovascular side effects, 5-10 = Extra-Pyramidal side effects, 11-13 = Anti cholinergic side effects, 14 = Gastro-Intestinal side effects, 15 = Genitourinary side effects, 16 = Screening for diabetes mellitus, 17-21 = Prolactinaemic side effects, 22 = Weight Gain.

Scoring Key:

Section1 B: Scoring for correct answer 1 mark was awarded and for wrong answer '0' mark was awarded.

Section C: The investigator used 4 point scale to assess the Modified Glasgow Antipsychotic Side-effect Scale (GASS)

Never : 0 point.
Once : 1point.
A few times : 2.
Every day : 3.

For questions 20 and 21 award 3 points for a "yes" answer and 0 points for a "no".

0-21 = Absent/Mild side effects
22-42 = Moderate side effects
43& over = Severe side effects

Scoring Interpretation:

≤ 50 - Inadequate knowledge
51–75 - Moderately adequate knowledge
>75 - Adequate knowledge

Interventions: In this study self instructional module refers to the brief description on knowledge regarding general information, action, indication, contraindication, side-effects, complications and care of patients while receiving antipsychotic drugs.

Table 1: Comparison of level of knowledge among the family members regarding antipsychotic drugs

n = 15

Level of Knowledge	Pre test			Post test		
	>75%	51-75%	<_50%	>75%	51-75%	<_50%
General information	5	2	8	15	0	0
Action of antipsychotic drugs	11	0	4	15	0	0
Regarding home care management of antipsychotic drugs.	0	5	10	10	3	2
Side effects antipsychotic drugs.	6	9	0	0	1	4

Table 2: Comparison of Modified Glasgow Antipsychotic Side-effect Scale among the family members regarding antipsychotic drugs

n = 15

Glasgow Antipsychotic Side-effect Scale	Pre test	Post test
Mild side effects	0	8
Moderate side effects	4	7
Severe side effects	11	0

Table 3: Mean and standard deviation of pre test and post test level of knowledge among the family members of psychiatric patients

n = 1

S. No.	Test done	Mean	S.D	t test
1.	Pre test	17.93	16.82	10.4*
2.	Post test	26.46	25.56	

*SP<0.05 level significant

- There was a significant association of level of knowledge on antipsychotic drugs with selected demographic variables such as occupational status, marital status and duration of illness(x^2=3.17, $x2$=2.84, x^2=2.84) which was greater than the table value of 2.78 and it was highly significant at p<0.05 level.

DISCUSSION

Out of 15 family members selected, a majority of family members 9 had adequate knowledge (60%), 5 had moderate knowledge (33.3%),1 had inadequate knowledge(6.6%) of antipsychotic drugs during pre test. In the posttest 13 had adequate knowledge (86.6%), 2 had moderate knowledge (13.3%) and no one had inadequate knowledge of antipsychotic drugs.

The above finding was contradictory to the descriptive study conducted on Knowledge on atypical antipsychotic drugs among caregivers of mentally ill patients. The sample were100 caregiver. The data were collected through a self-administered knowledge questionnaire on atypical antipsychotic drugs. Results showed that 45% of them had good knowledge and another 45% of them had an average knowledge, 6% of them had excellent knowledge and 4% had poor knowledge. The mean percentage of knowledge score was 63% in management, 42% in prevention, 52% general concept and 47% in the areas of side effects and precaution.[4]

CONCLUSION

Among 15 family members in psychiatric ward, 13 had adequate knowledge, 2 had moderate knowledge and no one had inadequate knowledge. The self instructional module has helped the family members to know about the action and complication of antipsychotic drugs and they were able to differentiate side effect of antipsychotic drugs. This study helped in promoting effective knowledge related to antipsychotic drugs among the family members.

ACKNOWLEDGMENT

The study was conducted in PSG Hospitals Coimbatore after obtaining formal permission from the PSG IMS&R. Ethical clearance obtained from PSG IMS&R Institutional Human Ethics Committee. My heartfelt thanks to my research group students B. Sc Nursing IV Year Ms. Arockia darshana, Ms. Anni cinto, Ms. Annie grace pushpam, Ms. Ansu m Varghese, Ms. Asha joy, Ms. Ashly George, Ms. Aswany Thomas, Ms. Bishmi sharen for their support. This study is submitted in 2011 Batch partial fulfillment of the requirement for the degree of Bachelor of Science in Nursing from The Tamil Nadu Dr. M.G.R Medical University, Chennai.

Conflict of Interest: Nil

Source of Funding: Self funded

REFERENCES

1. Jairakini A. A study on burden, social support and family wellbeing among caregivers of mentally ill patients in a selected hospital in Mangalore. Dissertation. Bengaluru:; 2005.
2. Mary C. Townsend. Essentials of psychiatric mental health nursing : concepts of care in evidence-based practice. 6th ed. Philadelphia : F.A. Davis Co; 2014.
3. Varda Peller Backus, M.D. Practical Management of the Side Effects of Psychotropic Drugs Managing Side Effects of Psychotropic Drugs. Psychiatric Services. 2000; 51(1): p. 124-125.
4. Benedicta Jane, Josna Mary Joseph, Glory J Waghela, Asha., Akshatha., Nami Ria Kurian, Shalini G Nayak. Knowledge on atypical antipsychotic drugs among caregivers of mentally ill patients. Journal of Nursing Science & Practice. 2015; 5(3).
5. Sheela S. Ranbhise, Ashok M. Kamat. A Study to Assess the Knowledge Regarding Adverse Effects of Selected Antipsychotic Drugs among the Caregivers of Patients Receiving Antipsychotic Drugs. International Journal of Nursing Education and Research. 2014; 4(2).
6. Dinesh Kumar Sharma, Himanshu Vya, Jeenath Justin Doss. K. A Study to Assess the Effectiveness of Informational Booklet (IB) for Caregivers Regarding the Care of Patients Receiving Antipsychotic Drugs at Selected Hospital of Gwalior. International Journal of Nursing Education and Research. 2016; 4(1).
7. Denise F Polit, Cheryl Tatano Beck. Essentials of nursing research : appraising evidence for nursing practice. 9th ed. edition I, editor. Philadelphia : Wolters Kluwer; 2017.

DOI Number: 10.5958/2395-180X.2019.00008.2

Activity Based Group Therapy on Interpersonal Relationship Among the Mentally Ill Clients in Selected Halfway Home, Coimbatore

M. Baskaran[1], A. Jayasudha[2], Saravana Kala S.[3], Sasikumar S[3], Sherin Ann Mathew[3], Sherin Farhana S[3], Steffie Jose P.[3]

[1]Associate Professor, Department of Mental Health (Psychiatric) Nursing, [2]Principal, [3]BSc Nursing, Department of Mental Health (Psychiatric) Nursing PSG College of Nursing, Coimbatore, Tamil Nadu

ABSTRACT

Introduction: The activities that we do every day provide a foundation for our lives. Psychiatric illness often interferes with a person's ability to perform the activities that are part of everyday living.

Objectives: To assess the effectiveness of Activity based group therapy promoting the interpersonal relationship among the mentally ill clients in selected setting, Coimbatore.

Methodology: Pre experimental one group pretest – posttest design was adopted. Convenient sampling technique was used and 15 mentally ill clients were selected at Cheshire home, Peelamedu, Coimbatore. The data was collected, organized and analyzed in terms of both descriptive and inferential statistics.

Result: The analysis revealed that the mean value of pretest was 24.47 and was increased in posttest to 63.20. The't' value was 11.7, which had high statistical significance at $p<0.05$ level and which confirms that there was a statistically significant difference between pretest and posttest interpersonal relationship.

Conclusion: This study proves that "Activity based group therapy was effective in improving interpersonal relationship", who resides in halfway home.

Keywords*: Activity based group therapy, Interpersonal Relationship, Mentally ill clients, Halfway home.*

INTRODUCTION

The activities that we do every day provide a foundation for our lives. Psychiatric illness often interferes with a person's ability to perform the activities that are part of everyday living. When one considers the kinds of symptoms that psychiatric patients exhibit (e.g., disturbances in thinking, judgment, reality testing, and communication; social withdrawal, anhedonia, and dysphoria), problems in daily functioning are not surprising. Functional difficulties are most severe when symptoms are exacerbated to the extent that hospitalization is required.[1]

Need for the Study: A survey was conducted on physical activity patterns in adults with severe mental illness. The sample were surveyed outpatients with schizophrenia and affective disorders at two psychiatric centers in Maryland and compared physical activity patterns to an age-gender-race-matched national sample (National Health and Nutrition Examination Survey III) of the general population. The major finding of the study was that people with severe mental illness are overall less physically active than the general population, although the proportion with recommended physical activity levels was equal. The participants with severe mental illness were more likely to walk as their sole form of physical activity. Within the severe mental illness group, those without regular social contact and women had higher odds of being inactive.[2]

Corresponding Author:
Mr. M. Baskaran, M.Sc (N), PhD Scholar
Associate Professor
Department of Mental Health (Psychiatric) Nursing.
PSG College of Nursing, Coimbatore. Tamil Nadu
Email: baskirathi@gmail.com

Social support is important for people experiencing serious mental illness and is also important during the initiation and maintenance of exercise. The sample of the study was 11 men with serious mental illness. The findings of the study was informational, tangible, esteem, and emotional support were both provided for and given by participants through exercise. The conclusion of study were experiences of both receiving and giving diverse forms of support in this way are significant for some people living with and recovering from serious mental illness.[3]

A systematic review and was used on social Participation Interventions for Adults with Mental Health Problems. Sixteen articles reporting 14 unique interventions met the inclusion criteria, and findings across the studies were categorized by delivery mode and intervention strategy. Positive outcomes were found in asset-based approaches, social skills development, building trusting relationships between workers and service users, and resource finding to enhance community participation. However, only four studies were found to have a low overall risk of bias. The findings of this review suggest further evidence-informed interventions, and robust evaluations, are needed as current evidence is limited to inform mental health social work practice.[4]

REVIEW OF LITERATURE

A longitudinal study investigates the relationship between social participation in associations and self-rated psychological health. The paper uses five waves of the British Household Panel Survey (BHPS) from 1991 to 1995 (unbalanced panel N=45,761). Ordered logit fixed effect methods were used to study the longitudinal link between structural social capital (being a member, active, and both a member and active in associations) and self-rated psychological health assessed by single items of the General Health Questionnaire (GHQ-12) controlling for age, marital status, household size, number of children, education, income, economic status, number of visits to the GP and health problems. The result of the study shows that being only a member and only active in associations has no statistical relationship with almost all the items of the GHQ-12. Instead, being both a member and active in associations is linked to all "positive" items of self-rated psychological health and to two main "negative" items of psychological wellbeing. These findings highlight the protective role of being both a member and active in associations against poor psychological health outcomes.[5]

A meta-analysis was conducted to estimate the effectiveness of theory-based occupational therapy interventions in improving occupational performance and well-being among people with a mental health diagnosis. It included 11 randomized controlled trials with a total of 520 adult participants with a mental health diagnosis. Outcomes were occupational performance, well-being, or both. The results indicated a medium effect of intervention on improving occupational performance (mean Hedge's g 5 0.50, Z 5 4.05, p <. 001) and a small effect on well-being (mean Hedge's g 5 0.46, Z 5 4.96, p <. 001). The study concluded that theory-based occupational therapy interventions may be effective in improving occupational performance and well-being among people with a mental health diagnosis and should be an integral part of rehabilitation services in mental health.[6]

The observational study investigated the outcomes of a community-based rehabilitation program that was designed to enhance social functioning, social inclusion, and well-being of people with mental illness who were considered treatment failures by psychiatric professionals in Italy. Of the 144 patients who entered the program, 131 started the program and 109 completed either 12 or 18 months of treatment. Illness severity was assessed by the Health of the Nation Outcome Scales (HoNOS) and social functioning by the Social and Occupational Functioning Assessment Scale (SOFAS). On the HoNOS, 33% of patients showed reliable change. On the SOFAS, 27% showed reliable change, although the change was substantial for few patients. The findings of the study were warrant further research based on controlled studies.[7]

STATEMENT OF THE PROBLEM

Effectiveness of activity based group therapy promoting the interpersonal relationship among the mentally ill clients in halfway home, Coimbatore.

OBJECTIVES

1. To assess the interpersonal relationship among the mentally ill clients.
2. To evaluate the effectiveness of activity based group therapy among the mentally ill clients.
3. To associate the mentally ill clients with selected demographic variables.

ASSUMPTIONS

1. Clients may have impaired communication with others.
2. Administration of activity based group therapy may increase the social interaction of the mentally ill clients.

Hypothesis

H_1: There will be a significant difference in the pre and post test level of interpersonal relationship of mentally ill clients.

H_2: There will be a significant association of the post test level of interpersonal relationship with selected demographic variables among the care givers of mentally ill clients.

RESEARCH DESIGN

The research design selected for this study is pre experimental design, one group pre test–post test design. Here the test acts as a measurement tool for the evaluation effect on post test.[8]

Variables:

Independent Variable: Activity based group therapy

Dependant Variable: Level of interpersonal relationship among the mentally ill clients.

Setting: The study was conducted in Cheshire home, Peelamedu, Coimbatore.

Population: The study population comprises of mentally ill clients Cheshire home, Peelamedu, Coimbatore.

Samples: Mentally ill clients who stayed in Cheshire home, who fulfills the inclusive criteria.

Sample Size: Sample size of the study is 15 mentally ill clients

Sampling Technique: Non probability convenient sampling technique.

Sampling Criteria

Inclusive Criteria

1. Mentally ill clients who are willing to participate in the study.
2. The clients who can understand Tamil and English.

Exclusive Criteria: The clients who are deaf and dumb and handicapped

Score interpretation

Good - >75%

Satisfactory - 50-75%

Poor - <50%

Development and Description of the Tool: The tool constructed in this study consists of 2 parts.

Section A: Demographic data

Section B: Interpersonal Relationship Communication scale. The tool has 4 sections with thirteen items, which is converted into 4 dimensions. It covers almost all dimension of interpersonal relationship communication.

1. Establishing rapport (3)
2. Effective communication (3)
3. Critical thinking (3)
4. Problem solving (4)

Each item is scored as below:

Positive Items	Negative Items
Poor-1	Poor–5
Fair-2	Fair–4
Good-3	Good-3
Very Good-4	Very Good-2
Excellent-5	Excellent-1

The total score for Section B is 65. To interpret the interpersonal relationship communication, the scores were interpreted as follows:

Score Interpretation:

Good = >75%, Satisfactory = 50-75%, Poor = <50

Intervention:

Activity Based Group Therapy: Activity Based Group Therapy involves the clients in group games wind-up games, group session and wind-down games. Wind-up games are musical chair, ball throw. Main games are those which can be completed in 60 seconds which includes tower building and marble games. Wind-down games are clapping and obtaining feedback.

FINDINGS

Table 1: Frequency and percentage distribution of level of pre and post test level of interpersonal relationship communication

n = 15

Interpersonal relationship communication	Pre test			Post test		
	Poor <50%	Satisfactory 50-75%	Good >75%	Poor <50%	Satisfactory 50-75%	Good >75%
Establishing rapport	5	9	1	0	5	10
Effective communication	12	3	0	0	9	6
Critical thinking	10	5	0	0	9	6
Problem solving	8	7	0	0	11	4

Table 2: Comparison of level of interpersonal relationship communication

(n = 15)

Interpersonal Relationship Communication	Pre Test		Post Test		t test
	Mean	SD	Mean	SD	
Establishing rapport	11.8	4.68	20.8	4.81	5.19*
Effective communication	3.8	1.37	12.53	1.77	15.1*
Critical thinking	3.8	1.37	4.63	0.88	11.7*
Problem solving	12.67	4.58	17.07	3.53	11.7*
Overall	24.27	7.44	63.2	10.82	11.4*

*p<0.05level significant

CONCLUSION

The study findings conclude that the post-test interpersonal relationship of mentally ill client score was higher than the pre-test score after administration of activity based therapy. Thus this study proves that "Activity based therapy was effective in improving interpersonal relationship of mentally ill client".

ACKNOWLEDGMENT

The study was conducted in Chesire Home in Coimbatore after obtaining formal permission from the Chesire Home. Ethical clearance obtained from PSG IMS&R Institutional Human Ethics Committee. My heartfelt thanks to my research group students B. Sc Nursing IV Year Ms. Saravanakala. S, Mr. Sasikumar. S, Ms. Seethalakshmi. N, Ms. Sheharin nelopher.S, Ms. Sherin ann Mathew, Ms. Sherin farhana.S, Ms. Steffie jose.P for their support. This study is submitted in 2010 Batch partial fulfillment of the requirement for the degree of Bachelor of Science in Nursing from The Tamil Nadu Dr. M.G.R Medical University, Chennai.

Conflict of Interest: Nil

Source of Funding: Self funded

REFERENCES

1. Mary C. Townsend. Essentials of psychiatric mental health nursing : concepts of care in evidence-based practice. 6th ed. Philadelphia : F.A. Davis Co; 2014.
2. Carless D, Douglas K. Social support for and through exercise and sport in a sample of men with serious mental illness. Issues Ment Health Nurs. 2008 November; 29(11): p. 1179-99.
3. Daumit GL, Goldberg RW, Anthony C, Dickerson F, Brown CH, Kreyenbuhl J. Physical activity patterns in adults with severe mental illness. J Nerv Ment Dis. 2005 October; 193(10): p. 641-6.

4. Meredith Newlin, Martin Webber, David Morris, Sharon Howarth. Social Participation Interventions for Adults with Mental Health Problems: A Review and Narrative Synthesis. Social Work Research. 2015 September; 39(3): p. 167-180.

5. Damiano Fiorillo, Giuseppe Lubrano Lavadera, Nunzia Nappo. Social participation and self-rated psychological health: A longitudinal study on BHPS. SSM - Population Health. 2017 December; 3: p. 266-274.

6. Ikiugu MN, Nissen RM, Bellar C, Maassen A, Van Peursem K. Effectiveness of Occupational Therapy in Mental Health: A Meta-Analysis. Am J Occup Ther. 2017 Sep/Oct; 71(5).

7. Barbato A, Agnetti G, D'Avanzo B, Frova M, Guerrini A, Tettamanti M. Outcome of community-based rehabilitation program for people with mental illness who are considered difficult to treat. J Rehabil Res Dev. 2007; 44(6): p. 775-83.

8. Denise F Polit, Cheryl Tatano Beck. Essentials of nursing research : appraising evidence for nursing practice. 9th ed. edition I, editor. Philadelphia : Wolters Kluwer; 2017.

DOI Number: 10.5958/2395-180X.2019.00009.4

Impact of Psoriasis on Psychological Well-being–Screening by GHQ-12

Padmavathi Nagarajan

Assistant Professor, College of Nursing, JIPMER (Jawaharlal Institute of Post Graduate Medical Education and Research), Pudhucherry

ABSTRACT

Background: Psoriasis is a chronic, inflammatory, relapsing dermatological condition with a complex etiopathogenesis. It can cause significant physical and psychological morbidity in those whom it affects.

Aim: The aim of the study is to investigate the impact of psoriasis on psychological health among patients with psoriasis and to identify the association of psychological well being with the selected demographic variables.

Method and Materials: A cross-sectional descriptive study was conducted that included 200 patients diagnosed with various types of psoriasis who attended Dermatologic Out-Patient Department of a tertiary care hospital. 12-items General Health Questionnaire (GHQ-12) was used to assess the psychological well being.

Results: Psychological distress was reported by 64 (32%) subjects and 48 (24%) subjects reported severe psychological distress and more psychological problems.

Conclusion: The study results indicate that psychological problems are common among patients with psoriasis and a simple screening instrument like GHQ-12 may be used to detect the problems for subsequent evaluation and management.

Keywords*: Psoriasis, Psychological well being, General Health Questionnaire (GHQ-12)*

INTRODUCTION

Psoriasis is a chronic skin disease that includes unpredictable periods of remission and relapse requiring long-term therapy. Many patients with psoriasis are frightened and embarrassed by psoriasis, experiences discrimination from others because of visibility of skin lesions. The social and psychological impact of psoriasis has been explored in many studies and stresses the importance of measuring and planning clinical interventions to reduce the distress associated with the disease. Some of the studies have proved that the better understanding and positive attitude towards the disease reduces the severity of the symptoms.[1]

Psoriasis can profoundly influence a patient's self-image, self-esteem, and sense of well-being. Studies have indicated that persons with a cutaneous disease experience a heightened level of distress, as measured by the General Health Questionnaire-12 (GHQ-12).[2]

Life stresses had been found as both a cause of psoriasis and as an aggravating factor in the disease. In different large epidemiological studies, up to 79% patients of psoriasis had a negative impact on their lives, and psoriasis was reported to be associated with a stressful life event in 10-90%, depression in 24-51%, felt shame and embarrassment over their appearance in 89%, lack of confidence in 42%, family friction in 26%, wish to be dead to active suicidal ideation in 9.7-5.5%, addiction and alcoholism in 18% and also significant impact upon sexual function.[3]

A recent study conducted by Golpour et al revealed that patients with psoriasis reported significantly higher degrees of depression and anxiety.[4] Further, Schmitt and Ford investigated the role of depression in psoriasis. Among two hundred and sixty five adults with psoriasis, thirty-two percent of all participants screened positive for depression. Both dissatisfaction with anti-psoriatic treatment and illness-related stress were highly associated

with depression.[5] Hence, the study was aimed to assess the psychological well being of patients with psoriasis by using 12-items General Health Questionnaire (GHQ-12).

MATERIALS & METHOD

A cross-sectional descriptive study was carried out among 200 patients diagnosed with psoriasis among those who attended Dermatologic Out-Patient Department of a tertiary care hospital. Participants were selected by convenience sampling according to the inclusion criteria. Subjects of both sex and who belonged to the age group of 18 to 65 years were included in the study. In addition to the socio-demographic data sheet, General Health Questionnaire-12 (GHQ-12 by Goldberg**)** [6] was used to assess the psychological well being**.** The GHQ-12 has high validity and it is not influenced by gender, age or level of education. The statements given in the scale are used to find out whether the respondent has experienced a particular symptom or behaviour recently. Each item is rated on a four-point scale (less than usual, no more than usual, rather more than usual, or much more than usual) with the respective scoring of 0-1-2 and 3. The score ranges from 0-36 and a score greater than 15 is being taken as evidence of psychological distress.

RESULTS

The responses of the subjects to each of the items of GHQ-12 are shown in **Table 1.** Out of 200 subjects, 125 (62.5%) subjects said that they thought themselves as worthful person; 96 (48%) subjects complained that their sleep was disturbed since they were worried; 115 (57.5%) subjects expressed that they were constantly under strain. 121 (60.5%) said that they were unhappy and depressed than usual whereas 116 (58%) subjects reported that they were unhappy, all things considered.

Further, the overall responses obtained from GHQ-12 which indicates the level of psychological distress reported by the subjects are presented in **table 2.** It showed that 46 (23%) subjects had not experienced any distress. Psychological distress concerned with their general well being was reported by 64 (32%) subjects and 48 (24%) of the subjects reported severe psychological distress and more psychological problems. There was no significant association between psychological well being with the socio demographic variables.

Table 1: Distribution of responses to each of the items of GHQ-12

(N = 200)

Sl. No.	Question	0		1		2		3	
		No.	%	No.	%	No.	%	No.	%
1.	Been able to concentrate on what you're doing	9	4.5	115	57.5	60	30	16	8
2.	Lost much sleep over worry	71	35.5	19	9.5	96	48	14	7
3.	Felt you were playing a useful part in things	3	1.5	144	72	35	17.5	18	9
4.	Felt capable of making decisions about things	7	3.5	116	58	59	29.5	18	9
5.	Felt constantly under strain	36	18	17	8.5	115	57.5	32	16
6.	Felt you couldn't overcome your difficulties	57	28.5	30	15	94	47	19	9.5
7.	Been able to enjoy your normal day-to-day activities	1	0.5	102	51	85	42.5	12	6
8.	Been able to face up to your problems	3	1.5	134	67	56	28	7	3.5
9.	Been feeling unhappy and depressed	44	22	25	12.5	121	60.5	10	5
10.	Been losing confidence in yourself	87	43.5	64	32	39	19.5	10	5
11.	Been thinking of yourself as a worthless person.	125	62.5	12	6	41	20.5	22	11
12.	Been feeling reasonably happy, all things considered	12	6	61	30.5	116	58	11	5.5

Table 2: Psychological distress based on GHQ-12

(N = 200)

GHQ-12 score (Score range: 0-36)	Number of subjects	Percentage (%)
0-10 (No stress)	46	23
11-12 (Typical)	20	10
13-14 (Mild stress)	22	11
15-20 (Evidence of distress)	64	32
21-36 (Severe psychological stress)	48	24

DISCUSSION

Psoriasis is one of the most "stress sensitive" skin diseases. Basavaraj et al stated that stress is a well-known trigger factor in the appearance or exacerbation of psoriasis.[7] Psychosocial factors have been implicated in the onset and exacerbation of psoriasis in 40% to 80% of patients. [8] The effect of psoriasis on quality of life (QoL) and the resulting psychosocial disability is usually greater than physical disability. [9] Further, psoriasis is associated with a variety of psychological constructs including stigmatization, poor self esteem, suicidal ideation, stress and sexual dysfunction.

The responses obtained from General Health Questionnaire indicated that the psychological distress concerned with general well being was experienced by 53 (26.5%) of study subjects while severe psychological problems were reported by 47 (23.5%) subjects. This result is similar to the result reported by Colombo et al who found psychological distress in 46% of their patients. [10] Similarly, Fried et al found that half of their patients were found to have moderate to extreme levels of anxiety, depression, and anger. [11]

In a recent study conducted by Panebianco et al among dermatological patients including psoriasis demonstrated that out of 508 (78%) subjects who completed the GHQ-12, 35.2% subjects were suggested for psychological consultation and 15.7% subjects were recommended for psychological consultation. The authors concluded that a simple instrument like GHQ-12 may be useful to detect patients at risk of psychological problems and to refer them subsequently for psychological consultation. [12]

Madrid Alvarez et al assessed the psychological state of patients with psoriasis receiving systemic treatment in a psoriasis unit, especially those with mild or no disease involvement. Findings indicated that it is necessary to assess the psychological state of patients with psoriasis, because psychological effects persisted even in cases where the disease was almost totally controlled. [13]

In addition, a study conducted by Nagarajan and Thappa revealed that psychological interventions improve the quality of life of people with psoriasis. [14] Many other studies have also stressed the importance of evaluation and management of psychological factors associated with the treatment aspects of psoriasis. [15]

CONCLUSION

Psoriasis is a complex, multifaceted skin condition which affects the physical, psychological, emotional, social and spiritual health of an individual who suffers from this chronic disease. Multidimensional approach is needed for the successful treatment outcome for this group of patients. GHQ-12 is a simple and useful screening instrument to evaluate psychological distress among these patients.

Ethical Clearance: Ethical approval was obtained from Institute Ethics Committee (Humans), JIPMER, Pudhucherry.

ACKNOWLEDGMENT

I sincerely thank Dr. Karalene Karunagari, Principal, Rani Meyyammai College of Nursing, Annamalai University and Dr. D.M. Thappa, Director, NEIGRIMS, Shillong, Meghalaya for their valuable guidance and support in conducting the study.

Sources of Funding: Nil

Conflict of Interest: Nil.

REFERENCES

1. McHenry PM, Doherty VR. Psoriasis: an audit of patients' views on the disease and its treatment. Br J Dermatol,1992;127:13-7.
2. Hughes J, Barraclough B, Hamblin L, et al. Psychiatric symptoms in dermatology patients. Br J Psychiatry 1983;143:51-4.
3. Rabin F, Bhuiyan SI, Islam T, Haque MA, Islam MA. Psychiatric and psychological comorbidities in patients with psoriasis- a review. Mymensingh Medical Journal 2012;21:780-6.
4. Golpour M, Hosseini SH, Khademloo M, Ghasemi M, Ebadi A, Koohkan F, et al. Depression and Anxiety Disorders among Patients with Psoriasis: A Hospital-Based Case-Control Study. Dermatol Res Pract 2012; 2012:381905. Published online 2012 Jul 16. doi: 10.1155/2012/381905. PMCID: PMC3403219
5. Schmitt JM, Ford DE. Work limitations and productivity loss are associated with health-related quality of life but not with clinical severity in patients with psoriasis. Dermatology, 2006;213:102-10.

6. Goldberg D, Blackwell B. Psychiatric illness in general practice. A detailed study using a new method of case identification. BMJ, 1970;1:439-43.

7. Basavaraj KH, Navya MA, Rashmi R. Stress and quality of life in psoriasis: an update. Int J Dermatol, 2011;50:783-92.

8. Gupta MA, Gupta AK. (1997). Psoriasis and sex: a study of moderately to severely affected patients. Int J Dermatol, 1997;36:259-62.

9. Finlay AY, Coles EC. The effect of severe psoriasis on the quality of life of 369 patients. Br J Dermatol, 1995;132:236-44.

10. Colombo D, et al. Evolution of and risk factors for psychological distress in patients with psoriasis: the PSYCHAE study. Int J Immunopathol Pharmacol, 2010;23:297-306.

11. Fried RG, et al. Trivial or terrible? The psychosocial impact of psoriasis. Int J Dermatol, 1995;34:101-5.

12. Panebianco A et al. A screening programme for dermatologists as a guide to request psychological consultation in routine clinical practice. Eur J Dermatol. 2018;28:326-331

13. Madrid Álvarez MB, Carretero Hernández G, González Quesada A, González Martín JM. Measurement of the Psychological Impact of Psoriasis on Patients Receiving Systemic Treatment. Actas Dermosifiliogr. 2018;109:733-740.

14. Nagarajan P, Thappa DM. Effect of an educational and psychological intervention on knowledge and quality of life among patients with psoriasis. Indian Dermatol Online J 2018;9:27-32.

15. Root S, Kent G, AI-Abadie M. the relationship between disease severity, disability and psychological distress in patients undergoing PUVA treatment for psoriasis. Dermatology 1994;189:234-7.

DOI Number: 10.5958/2395-180X.2019.00010.0

Comparison of Level of Expressed Emotion between Family Caregivers of Patients with Mania and Schizophrenia

Pheba Ann Chacko[1], Sreeja I[2]

[1]2nd year MSc Nursing Student, [2]Professor, College of Nursing, Ananthapuri Hospitals and Research Institute, Chackai, Trivandrum

ABSTRACT

The burden of mental disorders continues to grow with significant impacts on health, social, human rights and economic consequences in all countries of the world. The objectives of the study were to assess and compare the level of expressed emotion among caregivers of patients with Mania and Schizophrenia. Quantitative descriptive approach was used for the study. The population under study were family caregivers of patients with Mania and Schizophrenia. Study was conducted among 20 subjects selected by purposive sampling technique. Level of expressed emotion scale was used to assess the expressed emotion of caregivers. The level of expressed emotion were compared by Mann Whitney U test and showed significant difference between the groups with $p<0.05$. Result revealed that the level of expressed emotion is seen more in family caregivers of patients with Schizophrenia than family caregivers of patients with Mania. The presence of significant increase in the amount of expressed emotion point out to the need for psychosocial support to the family members for the reduction in expressed emotion, which in turn reduce the relapse rates and helps the family caregivers to effectively cope and manage the ill family member.

Keywords*: Mania, Schizophrenia, expressed emotion, family caregivers.*

INTRODUCTION

Mental illnesses are health conditions involving changes in thinking, emotion or behaviour (or a combination of these).[1]The prevalence rate of schizophrenia is 1 percent internationally. The incidence is about 1.5 per 10,000 people.[2]An estimated 4.3 to 8.7 million people in India suffer from Schizophrenia.[3] And 3.2 lakh people in Kerala suffer from Schizophrenia.[4] Most of the studies report on mania as part of bipolar disorder. The prevalence of mania in patients aged 50 and above is approximately 6% globally.[5] The United States has the highest lifetime rate of bipolar disorder at 4.4% and India has the lowest with 0.1%.[6] The prevalence rate of major psychiatric disorders in Kerala is 14.57 per 1000.[7]The burden of mental disorders has significant impacts on health, social, human rights and economic consequences all over the world. The emotional climate within the family is referred to as Expressed Emotion (EE). Specifically "high EE", refers to critical, hostile, or over involvement attitudes expressed by a family member towards an ill person. Expressed emotion may vary according to the illness.[8]The negative family atmosphere causes not only relapse of symptoms and rehospitalisation, but also has a significant effect on the course of illness.[9]

MATERIALS AND METHOD

The objectives of the study were to

1. Assess the level of expressed emotion among family caregivers of patients with mania
2. Assess the level of expressed emotion among family caregivers of patients with schizophrenia.
3. Compare the level of expressed emotion between family caregivers of patients with Mania and Schizophrenia.

Assumption: There may be a significant difference in the level of expressed emotion between family caregivers of patients with mania and schizophrenia.

METHODOLOGY

Research approach: Quantitative research approach.

Research design: Descriptive research design.

Setting: A selected hospital in Trivandrum.

Population: Caregivers of patients with mania and schizophrenia in Trivandrum.

Sample: Caregivers of patients with mania and schizophrenia in a selected hospital, Trivandrum.

Inclusion Criteria:

- Caregivers who actively involved in the care of patients for at least 2 years.
- Caregivers who can read and write Malayalam.

Exclusion Criteria: The following caregivers will be excluded from the study.

- Those who are not willing to participate.
- Caregivers who are not available at the time of data collection.
- Caregivers who are mentally ill.

Sample size: 20

Tool and technique: The technique used was purposive sampling technique.

Tool 1: Demographic Proforma of caregivers

Tool 2: Level of Expressed Emotion scale

Tool 1: Demographic Proforma of caregivers consisting of 11 questions which includes age, gender, education, marital status, job, type of family, family income, relationship with patient, duration of stay with the patient and the bearer of treatment expenditure.

Tool 2: Level of Expressed Emotion scale

The Level of expressed emotion scale is a standardized self-report instrument developed by Cole J D and Kazarian in 1988. It consists of 60 items having the domains such as lack of emotional support, criticism, intrusiveness and irritability. Each item is marked with a 4-point likert scale response format which includes true, more or less true, more or less untrue, and not true. Score of positive items are 4,3,2,1 and negative items are 1,2,3,4. The maximum score for the tool is 240. The Cronbach alpha coefficient of level of expressed emotion scale is 0.86-0.95, $p<0.001$.[10]

RESULTS

The present study was undertaken to compare the level of expressed emotion between family caregivers of patients with Mania and Schizophrenia.

Table 1: Demographic characteristics of caregivers of patients with Mania and Schizophrenia

N = 20

Sl. No.	Sample Characteristics	Mania (10)		Schizophrenia (10)	
		f	%	f	%
1.	**Age**				
	20-30	4	40	4	40
	31-40	0	0	1	10
	41-50	2	20	2	20
	51-60	4	40	2	20
	61-70	0	0	1	10
	Mean age (SD)	41.3 (14.3)		40.3 (14.2)	
2.	**Gender**				
	Male	3	30	6	60
	Female	7	70	4	40
3.	**Education**				
	Illiterate	1	10	0	0
	Primary education	6	60	5	50
	Secondary education	1	10	0	0
	Pre-degree	1	10	5	50
	Professional	1	10	0	0
4.	**Marital status**				
	Married	5	50	7	70
	Unmarried	3	30	3	30
	Widow/widower	2	20	0	0
5.	**Family**				
	Nuclear family	8	80	7	70
	Joint family	2	20	3	30
6.	**Relationship**				
	Father/Mother	5	50	5	50
	Husband/Wife	1	10	0	0
	Son/Daughter	0	0	0	0
	Brother/sister	3	30	5	50
	Grandfather/ Grandmother	1	10	0	0

Conted…

7.	**Family income**				
	≤ ₹ 3000	3	30	1	10
	≥ ₹ 3001	7	70	9	90

As shown in table 1, majority of the caregivers of patients with Mania were in the age group 20-30 and 51-60 (40% each). Mean age of caregivers was 41.3, whereas in Schizophrenia majority (40%) were in the age group of 20-30 and mean age of caregivers was 40.3. Seventy (70) % of the caregivers of Mania patients were females, whereas in Schizophrenia 60% were males. Majority of caregivers of Mania patients were educated up to primary level. In Schizophrenia patients 50% caregivers were educated up to primary level and 50 % caregivers were educated up to pre-degree. 50% caregivers of Mania patients were married, whereas 70% in caregivers of Schizophrenia patients. Majority were from nuclear family in both groups. 70% caregivers of Mania patients and 90% caregivers of Schizophrenia patients had family income ₹ above 3000. Half of the caregivers were parents in Mania group, whereas in Schizophrenia majority were parents and siblings (50% each).

Table 2: Mean, standard deviation of level of expressed emotion among caregivers of patients with mania

(n = 10)

Subscales of Expressed emotion	Mean	Standard deviation	Mean %
Lack of emotional support	54.1	6.32	52.01%
Criticism	14.5	3.47	60.41%
Intrusiveness	35.8	5.84	59.66%
Irritability	28.6	4.67	55%
Total	133.2	14.627	55.5%

As shown in table 2,the criticism (60.41%) was more in caregivers of patients with Mania when compared to other subscales of expressed emotion.

Table 3: Mean, standard deviation of level of expressed emotion among caregivers of patients with Schizophrenia

(n = 10)

Subscales of Expressed emotion	Mean	Standard deviation	Mean %
Lack of emotional support	58.5	2.63	56.25%
Criticism	15.8	3.11	65.83%
Intrusiveness	38.3	3.33	63.83%
Irritability	31.6	2.17	60.76%
Total	144.2	5.28	60.08%

As shown in table 3, among the subscales the criticism (65.83%) was more in caregivers of patients with Schizophrenia when compared to other subscales of expressed emotion.

Table 4: Comparison of level of expressed emotion between care givers of patients with Mania and Schizophrenia by using Mann Whitney u test

n = 20

	Sum of ranks	Mean of ranks	U- Value	P value
Mania	76	7.6	21*	0.028
Schizophrenia	134	13.4		

*significant at p <0.05

As shown in table 4, the mean rank of caregivers of patients with Schizophrenia (13.4) are having more expressed emotion than Mania. It can be concluded that the expressed emotion of family caregivers of patients with Schizophrenia was statistically significantly higher than the expressed emotion of family caregivers of patients with Mania (U=21, p=<0.05).

Table 5: Subscale comparison of level of expressed emotion between caregivers of patients with mania and schizophrenia by using Mann Whitney U test

n = 20

	Group	Mean rank	Sum of ranks	U value p value
Lack of emotional support	Mania	7.9	79	24*0.048
	Schizophrenia	13.1	131	
Intrusiveness	Mania	9.4	94	39 0.403
	Schizophrenia	11.6	116	
Irritability	Mania	7.6	76	21* 0.027
	Schizophrenia	13.4	134	
Criticism	Mania	9.1	91	36 0.282
	Schizophrenia	11.9	119	

*significant at 0.05 level.

As shown in table 5, the mean rank of all the subscales of expressed emotion were foundto be more in family caregivers of patients with Schizophrenia than with Mania. Whereas lack of emotional support and irritability were found to be more in family care givers of patients with Schizophrenia with mean rank 13.1 and 13.4 respectively. U value of lack of emotional support is 24 and irritability is 21, which are significant at 0.05 level. Hence it is revealed that, there is significant difference in lack of emotional support and irritability between the family caregivers of patients with Mania and Schizophrenia.

DISCUSSION

The present study assessed the level of expressed emotion between the caregivers of patients with mania and schizophrenia. The major findings of the study are discussed in relation to the findings of other research studies.

The first objective of the study was to assess the level of expressed emotion among caregivers of patients with mania. In the present study, majority of the caregivers of patient with mania is having high level of criticism that is 60.41%, than other subscales of expressed emotion such as lack of expressed emotion, intrusiveness and irritability. The mean score for overall subscales of expressed emotion was 133 and standard deviation 20.3. There have been a few studies that suggests a positive association between EE and relapse of mental illness. A cohort study by Miklowitz et al., to investigate the association between the course of bipolar disorder and EE among 24 patients found a positive association between the families EE and relapse.[11] Over 90% of patients with BPAD experience recurrence during their lifetime, often within 2 years of the initial episode.[12]

A study to assess the family factors and course of bipolar affective disorder shows that expressed emotion and interactional behaviours have been found to predict relapse in bipolar disorder. The predictive relationship observed were independent of patient medication compliance, treatment regimen, baseline symptoms, demographics and illness history. Results suggest that the emotional atmosphere of the family during the post discharge period may be an important predictor of the clinical course of bipolar disorder.[13]

The second objective of the study was to assess the level of expressed emotion among caregivers of patients with schizophrenia. In the present study, the caregivers show more criticism compared to other subscales of expressed emotion. In a study conducted on expressed emotion and psychiatric relapse showed high level of EEs in the form of criticism in patients with

Schizophrenia.[14]Another study conducted on expressed emotion in schizophrenia found that prolonged contact of patients with the critical caregivers determines the relapse in schizophrenia. It was established that high family levels of EE are consistently associated with higher rates of relapse in patients with schizophrenia.[12]

The third objective was to compare the level of EE between caregivers of patients with mania and schizophrenia. In the present study, there is difference in the level of expressed emotion between family caregivers of patients with mania and schizophrenia. In a comparative study conducted to assess the burden in caregivers of schizophrenia and bipolar affective disorder patients showed that there is considerable burden of care in caregivers of schizophrenia patients. In contrast to the present study emotional over-involvement was significantly more in patients with BPAD compared to patients with schizophrenia.[12]An another study on the impact of expressed emotion on the course of schizophrenia found that Schizophrenia sufferers who are exposed to family environments characterized by a high level of criticism, hostility and emotional over-involvement demonstrate a higher rate of relapse. Successful treatment and favourable outcome of schizophrenia depend on the quality of relationship between the patient and family members. High level of expressed emotion is one of the risk factors for relapse in schizophrenia.[15]

Implications: It helps to plan and provide interventions for reducing the high EE among caregivers of patients with Schizophrenia and Mania. The interventions for reducing the high EE among caregivers of patients with Schizophrenia and Mania may indirectly help to reduce the relapse.

Limitations of the study

- Sampling technique used in this study was non probability purposive sampling which limits generalizability of the study.
- Limited to single hospital.
- Sample size is only 20.

Recommendations

- A follow up study can be done after giving the interventions for reducing the expressed emotion among caregivers.
- Similar study can be conducted by probability sampling method and with larger sample.
- A similar study can be carried out with different methods and tools.

CONCLUSION

The present study concluded that there is no much significant difference in the level of expressed emotion between family caregivers of patients with mania and schizophrenia. But the presence of significant increase in the amount of expressed emotion point out to the need for psychological interventions to the family members for the reduction in expressed emotion, which in turn reduce the relapse rates and helps the family caregivers to effectively cope and manage the ill family member.

ACKNOWLEDGMENT

Study participants

Conflict of Interest: None declared

Source of Funding: Self

Ethical Clearance: After obtaining the institutional ethical clearance, permission was obtained from concerned hospital and informed consent from the participants. Data were collected by using the demographic Proforma, level of Expressed Emotion scale. Structured self-administered questionnaire was given to all caregivers for assessing their expressed emotion.

REFERENCES

1. Whatis mental illness? [Internet].Psychiatry. org.2018.Availablefrom:https://www.psychiatry.org/patients-families/what-is-mental-illness.
2. Fischer B, Buchanan R. Schizophrenia in adults: Epidemiology and pathogenesis. UpToDate. Retrieved online at http://www. uptodate. com/contents/schizophrenia-in-adultsepidemiology-andpathogenesis. 2017.
3. Schizophrenia Facts and Statistics [Internet]. Schizophrenia.com. 2018. Available from: http://www.schizophrenia.com/szfacts.htm.
4. Paper T. `Schizophrenia most common psychotic illness in State' [Internet]. The Hindu. 2018.

Availablefrom:http://www.thehindu.com/todays-paper/tp-national/tp-kerala/schizophrenia-most-common-psychotic-illness-in-state/article3137644.ece

5. Dols A, Kupka RW, Van Lammeren A, Beekman AT, Sajatovic M, Stek ML. The prevalence of late-life mania: a review. Bipolar disorders. 2014 Mar;16(2):113-8.
6. AnanyaMandal M. Prevalence of bipolar disorder [Internet]. News-Medical.net. 2018. Availablefrom:https://www.newsmedical.net/news/20110307/Prevalence-of-bipolar-disorder.aspx
7. Shaji S, Verghese A, Promodu K, George B, Shibu V. Prevalence of priority psychiatric disorders in a rural area in kerala. [Internet]. PubMed Central (PMC). 2018. Available from: http://europepmc.org/articles/pmc2971473
8. Peris TS, Miklowitz DJ. Parental expressed emotion and youth psychopathology: New directions for an old construct. Child Psychiatry & Human Development. 2015 Dec 1;46(6):863-73.
9. Haobam M, Lenin RK, Ningombam H, Mohanty R. Expressed emotion as a precipitant of relapse in schizophrenia and bipolar disorder. International Journal of Science and Research (IJSR). 2013;4:477-81.
10. Chien WT, Chan SW. Testing the psychometric properties of a Chinese version of the Level of Expressed Emotion Scale. Research in nursing & health. 2009 Feb 1;32(1):59-70.
11. Miklowitz DJ, Goldstein MJ, Nuechterlein KH, Snyder KS, Mintz J. Family factors and the course of bipolar affective disorder. Arch Gen Psychiatry 1988;45:225-31.
12. Parija S, Yadav AK, Sreeraj VS, Patel AK, Yadav J. Burden and Expressed Emotion in Caregivers of Schizophrenia and Bipolar Affective Disorder Patients: A Comparative Study. MAMC Journal of Medical Sciences. 2018 May 1;4(2):68.
13. Nirmala BP, Vranda MN, Reddy S. Expressed emotion and caregiver burden in patients with schizophrenia. Indian journal of psychological medicine. 2011 Jul;33(2):119.
14. Butzlaff RL, Hooley JM. Expressed emotion and psychiatric relapse. A meta-analysis. Arch Gen Psychiatry.1998 jun;55(6):547-52.
15. Bogojevic G, Ziravac L, Zigmund D. Impact of expressed emotion on the course of schizophrenia. European Psychiatry. 2015 Mar 28;30:390.

DOI Number: 10.5958/2395-180X.2019.00011.2

Impact of Stress on Quality of Life of Caregiver's of Alzheimer's Patient in Ernakulam Dist., Kerala

Manju Cherian[1], Preeti Mathew[2]

[1]IInd MSc (N), [2]Assoc. Professor, Mar Baselios College of Nursing, Kothamangalam

ABSTRACT

Introduction: A quantitative study with a descriptive correlational design he present study was conducted in selected ARDSI society, Kerala.

Aim: to assess the stress and quality of life of caregivers of Alzheimer's patients.

Materials and Method: 100 caregivers of Alzheimer's patients were selected through purposive sampling technique. The study was conducted in ARDSI society for a period of 4 weeks. Modified Caregiver Stress Self-Assessment Questionnaire and Modified Caregiver Quality of life Scale was used to assess the stress and quality of life of caregivers. Data were analysed using descriptive and inferential statistics.

Results: Revealed majority (99%) of caregivers had moderate stress with 85% of caregivers leading average quality of life. On correlating stress and quality of life of caregivers a negative correlation (-0.09) was found. It was statistically not significant at 0.05 level of significance.

Based on the findings it was concluded care givers involved in caring for Alzheimer's patients at home undergo a significant amount of stress; which has a negative impact on their quality of life. Therefore, measures to reduce the stress of care givers and improve their quality of life should be taken which in turn will enhance the quality of life of patients.

Keywords*: Caregiver, Stress, Quality of life, Alzheimer's patients.*

INTRODUCTION

Alzheimer's disease poses real challenges for both the person diagnosed with AD and to those who assume caregiving responsibilities. It is estimated that 8.9 million caregivers provide care to someone fifty years or older with AD or a related dementia. Seventy percent of people with Alzheimer disease (AD) live at home and are cared for by family and friends.

Alzheimer's disease (AD) has a major impact on everyday living of families, placing an emotional burden on the whole family unit. AD can cause changes in family structure and roles: Children become caregivers of their ill parents, looking after them and taking on the duties of carer - a situation which may create conflict if not handled properly. With the progression of disease, patients become progressively more dependent on caregivers.[1]

For the successful treatment and care of the patient, family assistance is extremely valuable and often of major importance as family members are the primary source of care and support for people with Alzheimer's.[2]

Caregivers must provide various levels of care for the person with Alzheimer's disease. At the beginning of the disease, responsibilities frequently include shopping, meal preparation, transportation, oversight of medication, and assistance with financial and legal affairs. With progression of the disease, the person with Alzheimer's disease may require assistance with activities of daily living including bathing, feeding, dressing, and toileting. As AD progresses, caregivers watch their loved ones deteriorate at the same time as they are called upon to perform an increasing range of tasks that ultimately include helping loved ones with basic activities.

Being a family caregiver, is a situation that demands daily responsibility and transforms individuals' life. It demands time, energy, work, affection, effort and good will. Gradual cognitive losses, behavioural and emotional changes, and even changes in the patients' personality require great capacity to adapt with a view to living together satisfactorily. Numerous daily arrangements are necessary to meet progressive and irreversible patient demands.[3]

The changes that take place in the life of caregivers, such as: lack of time, reduction of intimacy, deterioration in social life, a sense of loss of control over their own lives, may cause physical and emotional burden (anxiety, stress, and depression), acute and chronic diseases, as well as financial deterioration, affecting all activities.[4]

Studies of caregivers, caring for persons with chronic illnesses suggest that the experience of care giving can affect their physical and mental health. Physical health outcomes as suggested in various studies of caregivers caring for person with chronic illness include a decrease in immune system response, increased risk of cardiovascular disease, high blood pressure and interruption in sleep. The psychological health of the family caregiver is negatively affected by providing care. Higher levels of stress, anxiety, depression and other mental health effects are common among family members who care for an older relative or friend, often leading to a poor quality of life.[5]

Several studies demonstrate that caregiving has a strong impact on caregiver's physical and mental health and well-being, due to many factors. The major life impact of AD on the family means that care giving can be a very difficult and physically demanding activity that encompasses all of the caregiver's life. Caregivers not only lose their relationship, spare time, have problems with their job, but experience depression, anxiety, and social isolation, leading to poor health impact as a caregiver of AD.[6]

Alzheimer's disease is a family disease, because the chronic stress of watching a loved one slowly decline affects everyone. An effective treatment will address the needs of the entire family. If the needs of family caregivers can be addressed, caregivers can more effectively look after care recipients and prevent hospitalization or placement in long-term care facilities. Emotional and practical support, counselling, resource information and educational programs about Alzheimer's disease will help a caregiver provide the best possible care for a loved one.[7]

Although the care of the caregiver is always considered very important by keeping a balance of attention for both patient and caregiver, evaluation of burden and possible emotional problems of caregivers is not routinely carried out by health professionals. Nurses, while recognizing families having specific needs, often do not have the knowledge or skills necessary to provide the appropriate assistance. A gap does exist between what families of the Alzheimer patient need to lower stress and improve coping skills and what nurses can provide.

Based on the above facts and conclusion drawn from the observations made during clinical practice, the researcher felt hat primary caregivers were enveloped, with various unspoken burden involved in caring the patient resulting in a poor quality of life.

OBJECTIVES OF THE STUDY

1. Assess the level of stress among caregivers of patients with Alzheimer's disease.
2. Assess the level of quality of life among caregivers of patients with Alzheimer's disease.
3. Find the relation between stress and quality of life of caregivers of patient with Alzheimer's disease.
4. Find the association between stress and quality of life of caregivers with selected demographic variables.

Hypotheses: At <0.05 level of significance.

H_1: There will be a significant correlation between overall stress and quality of life scores of caregivers of Alzheimer's patient.

H_2: There will be a significant association between overall stress score and selected demographic variables.

H_3: There will be a significant association between overall quality of life score and selected demographic variables.

METHODOLOGY

Research approach: In view of the nature of the problem selected for the study and the objectives to be accomplished, a quantitative research approach was considered.

Research design: A non- experimental descriptive correlation design.

Setting of the study: Care Centre Ernakulam, Respite Care Centre, Guruvayoor and Dementia Day Care Centre Aluva, were selected as setting for the present study.

Population: In the present study, the population comprised of all the Caregivers of Alzheimer's patients attending the ARDSI centres.

Sample and sampling technique

100 caregivers, who met Selection criteria, were selected, using purposive sampling technique.

Inclusion criteria

Caregivers:

- Of patient diagnosed with Alzheimer's disease and other related disorders.
- Willing to participate in the study.
- Caring for Alzheimer's patients at home.
- Providing more than 6 months of care.

Exclusion criteria

Caregivers:

- Who were occasional caregivers.
- Suffering from mental illness.
- Of patients with mental illness.

Tools/instruments: The tool consisted of 3 sections as:

Part A: Socio demographic profile: Socio demographic profile consisted of 20 items aimed at collecting demographic data of caregivers and Alzheimer patient.

Part B - Modified Caregiver Stress Self-Assessment Questionnaire: The modified version of Stress Self-Assessment Questionnaire was developed .Modified scale consisted of 25 items

Scoring and Interpretation: Score ranged from 0 to 4 per item, thus for the 25 items, a minimum score was 0 and maximum score was 100.

00	No stress
<33	Mild stress
33-67	Moderate stress
>67	Severe stress

Part C: Caregivers Quality of life Scale: A self-report questionnaire on Caregiver's QOL is a 20 –item instrument that measures the overall QOL of caregivers.

Scoring and interpretation: With 3 response alternatives the score ranged from 1-3 for each item, thus the minimum score was 20 and the maximum score 60.

20-33 Low Quality of Life

34-47 Average Quality of Life

47-60 High Quality of Life

FINDINGS

Table 1: Assessment of Overall Level of Stress of Caregivers

(n = 100)

Level of Stress	Range of Score	f	%
No Stress	00	00	00
Mild Stress	< 33	01	01
Moderate Stress	33-67	99	99
Severe Stress	>67	00	00

The level of stress of caregivers ranged from mild to moderate stress. Majority of the caregivers (99%) were having moderate stress.

Table 2: Assessment of quality of life of caregivers'

(n = 100)

Level of quality of life	Range of Score	f	%
Low quality of life	20-33	15	15
Average quality of life	34-47	85	85
High quality of life	47-60	10	10

Majority of caregivers (85%) were having average quality of life and only 15% were having low quality of life.

Table 3: Correlation between stress and quality of life scores among caregivers of Alzheimer's patient

(n = 100)

Variables	Mean ± SD	r value	p-value
Caregiver stress	61.60 ± 5.94	-0.09	0.40
Quality of life	37.00 ± 3.09		

The computed r value (-0.09) indicates a negative correlation existing between Stress score and Quality of life score. Based on the findings, it can be inferred that with an increase in stress, the quality of life of caregiver decreases.

On associating stress of caregivers and quality of life with selected socio-demographic characteristics of caregivers of Alzheimer's patient using ANOVA and 't' test. It is found that there was no statistically significant association between stress score and quality of life and selected variables of caregivers at 0.05 level of significance. Hence the null Hypothesis H02: "There

is no significant association between stress, quality of life and selected demographic variables at 0.05 level of significance" is accepted.

DISCUSSION

Most of the primary caregivers are unprepared to provide physical care, meet emotional demands of the patients, as they possess inadequate knowledge and resources and get very little guidance. Providing care to a disabled elderly friend or relative can have profound effects on the caregivers physical and emotional health. Caregivers are much more likely than non-caregivers to suffer from stress overload, depression, and other health problems resulting in a poor quality of life. Because being a caregiver is so hard, some doctors think of caregivers as "hidden patients."

Assessment of stress of caregivers: In the present study it was seen that majority of caregivers (99%) were having moderate stress. None of the caregivers reported severe stress. The overall mean score was found to be 61.60 ± 5.94 (61.60%). Similar findings were reported by Vellone E, Piras G, Sansoni J.34 where 54% of subjects reported stress.[8]

Assessment of quality of life of caregivers: Majority of caregivers (85%) were having average quality of life and 15 % were having low quality of life. However, none of the caregivers reported high quality of life. Overall mean score was 37.00±3.09 (80.43%).

In a study by Vellone E, Piras G, Talucci C, Cohen MZ. factors that caregivers said improved their quality of life were good health of the patient, independence from the patient, and more help in caregiving. But worries about the future and progression of the patient's illness and stress worsened caregivers' quality of life.[8]

Correlation between stress and quality of life scores among caregivers of Alzheimer's patient: On correlating stress and quality of life scores among caregivers of Alzheimer's patient, a negative correlation was seen. Similar findings were reported by Divya CP [9] where the burden negatively correlated with the quality of life of caregivers. In another study by MA Mahesh a poor quality of life was reported in relation to psychological distress.[10]

CONCLUSION

Based on the findings it was concluded that AD is a disease that involves not only the patient, but also affects the whole family. The continuous commitment in caring also causes stress on the caregiver resulting in negative repercussions in the family.

Keeping this in mind, Support to caregivers through meetings, lectures and home visits with the help of multi-professional team will contribute towards reinforcing family and community bonds, encouraging caregivers to accept their limitations and to seek help which will reduce the stress imposed on the caregivers.

Nursing Implications: In this section, based on the researcher's experience during the study, some specific implications have been highlighted for nursing in different dimensions:

Nursing education

- Create awareness among the nurses about the magnitude of AD in India, especially in Kerala.
- Educate nurses to gain in depth knowledge regarding identification of stress, anxiety, depression and its prevention.

Nursing Practice

- Provide counselling services to the caregiver.
- Provide support to families through tailored strategies aimed to reshape the dysfunctional coping styles.
- Teach stress management techniques to the caregiver.
- Emphasis to alleviate the burden among caregivers and measures to improve quality of life.

Nursing Administration

- Establishing a network of community services to alleviate the burden on families.
- Adequate resources like information booklet/ brochures/pamphlets to create awareness in them.
- Organizing and conducting caregivers meeting.

Nursing Research: Nurses can play a vital role in undertaking research to expand their body of knowledge.

- Future research should be done to investigate the potential benefits of early intervention and education among caregivers.
- Need for development of follow up package to enhance the quality of life and reduce stress among caregivers.

Limitations

- Results cannot be generalized to the wider population.
- Sample size was small.
- Setting was limited to ARDSI society.

Recommendations

- Researchers should also investigate whether different types of caregivers (spouse, adult child and friend) have different needs or problems.
- Longitudinal studies for understanding the stress and quality of life in caregivers over a period.
- Effective intervention strategies to reduce the stress and improve the quality of life among caregivers.

Conflict of Interest: Nil

Source of Funding: Self-Funded

Ethical Clearance: Ethical clearance was obtained from Institutional Human Ethics Committee at Mar Baselios Mission Hospital, Kothamangalam.

REFERENCES

1. [11]Martin M, Rebeca LR, Anyolina N P, Natacha RC. Burden, anxiety and depression in caregivers of Alzheimer patients in the Dominican Republic. Dement Neuropsychol [Internet] 2014 December [cited 2015 May5]; 8(4):384-388. Available from: http://www.scielo.br/pdf/dn/v8n4/1980-5764-dn-08-04-00384.pdf.
2. Sansoni J, Anderson KH , Varona LM , Varela G. Caregivers of Alzheimer's patients and factors influencing institutionalization of loved ones: some considerations on existing literature. Ann Ig [Internet] 2013[cited 2014 Dec 31]; 25: 235-246. Available from:http://www.seu-roma.it/riviste/ annaliigiene/open_access/articoli/0c3f2676640af498e8434c85928b9def.pdf.
3. Inouye K, Pedrazzani ES, Pavarini SC, Toyoda CY. Perceived quality of life of elderly patients with dementia and family caregivers: evaluation and correlation. Rev Lat Am Enfermagem [Internet] 2009 Mar-Apr[cited 2015 April 5];17(2):187-93. Available from: http://www.ncbi.nlm.nih.gov/pubmed/19551271.
4. Martin M, Rebeca LR, Anyolina N P, Natacha RC. Burden, anxiety and depression in caregivers of Alzheimer patients in the Dominican Republic. Dement Neuropsychol [Internet] 2014 December [cited 2015 May5]; 8(4):384-388. Available from: http://www.scielo.br/pdf/dn/v8n4/1980-5764-dn-08-04-00384.pdf.
5. Caregiver Health [Family Caregiver Alliance: National centre on caregiving] No date [cited 2014 Dec 21]. Available from: https://caregiver.org/caregiver-health.
6. Alzheimer's disease and Caregiving [Family Caregiving Alliance: National Centre on caregiving].No date [cited 2014 Dec 31]. Available from: https://caregiver.org/alzheimers-disease-caregiving.
7. Quang TT. The Quality of life and Caregiving burden among caregivers of people with Dementia in Hanoi, Bac ninh and Hai phong, Vietnam. [PhD thesis].Australia: Queensland University of Technology;2015 [cited 2015 April 24]. Available from: http://eprints.qut.edu. au/82287/1/Quang%20 Trung_Truong_Thesis.pdf.
8. Vellone E, Piras G, Talucci C, Cohen MZ. Quality of life for caregivers of people with Alzheimer's disease. J Adv Nurs.[Internet] 2008 Jan [cited 2015April 5];61(2):222-31. Available from http://www.ncbi.nlm. nih.gov/pubmed/18186913.
9. Divya CP. A quality of life of Elderly with dementia and their primary caregivers.[M.Sc Thesis]. Bangalore: NIMHANS Deemed University; 2012.
10. Mahesh MA. A study of quality of life and burden in caregivers of elderly with dementia and other psychiatric disorders. [M.Sc Thesis].Bangalore: NIMHANS;2010.

DOI Number: 10.5958/2395-180X.2019.00012.4

Death Anxiety and Death Depression among Elderly

Renu Bala[1], S K Maheshwari[2]

[1]Lieutenant, Military Hospital, Barely cant, U.P.; [2]Associate Professor, University College of Nursing, BFUHS, Faridkot (Pb), India

ABSTRACT

Background: Death is the only certainty of the life. Elderly people have a significant death anxiety and death depression which causes negative effect on their health and creates low self esteem, lack of purpose in life, negativity and poor mental well being.

Aim: Present study aimed to assess the death anxiety and death depression among elderly and their relationship with socio-demographic variable.

Method: Descriptive, cross-sectional survey was done to assess the death anxiety and death depression among 100 elderly who were age of more than 60 years.

Results: Majority (94.0%) of elderly people had moderate death anxiety whereas (3.0%) had severe death anxiety. Majority (72%) elderly people had moderate death depression whereas (15%) had severe death depression. A significant moderate positive correlation was found between death anxiety and death depression (r=0.477 and p=<0.001).

Conclusion: Elderly people had moderate death anxiety and death depression and both are positively correlated.

Recommendation: There is an urgent need to initiate some interventional strategies to reduce death anxiety and death depression among elderly so that their physical and mental health can be improved.

Keywords*: Death, anxiety, depression, elderly people*

INTRODUCTION

Old age in human beings is the final stage of the normal life span. Old age is frequently defined as 60 years of age or older. The elderly population with age of 60 years and above is increasing around the world, as due to decline in their mortality rate life expectancy has been increased.[1] Today the number of elderly is estimated to be 605 million in the world [2] and a rise to this segment of population is estimated to 2 billion by 2050.[3] This growing old age population is showing the most difficult challenges for both the developed and developing countries. Pakistani society, where traditionally the elders are supposed to be respected and their care is still seemed as a family responsibility, is also facing issues as time has changed.[4]

Ageing is a natural process. In the words of Seneca; "Old age is an incurable disease", but more recently, Sir James Sterling Ross commented; "You do not heal old age. You protect it; you promote it; you extend it." These are in the fact the basic principles of preventive medicine. Old age should be regarded as a normal, inevitable biological phenomenon.[1]

Ageing is an irreversible biological process which starts from conception and ends after death. Also old people have limited regenerative abilities and are more prone to disease, syndromes, and sickness as compared to other adults.[5] Average life expectancy throughout the world is increasing year by year leading to an overall increase of geriatric population. These trends are appearing

Corresponding Author:
S K Maheshwari
Associate Professor, University College of Nursing, BFUHS, Faridkot (Pb), India
Email: skmbfuhs@gmail.com

in all countries where medical and social services are well developed and standard of living is high.[6]

Death is only certainty of the life. There is no reversal, no remedy, no more tomorrow. Everyone has to face it and death signifies the centre of all hope with respect to this world. Death is inevitable. Various study conducted to know death anxiety and death depression among elderly. These studies show elderly participants in assisted living facility have higher level of fear of dying process. Also this fear of dying was due to unsatisfactory lifestyle which creates low self-esteem, little purpose in life, negativity and poor mental well being.

In addition to it many studies reported that there was a significant death anxiety and death depression among elderly, which is causing many negative effect related to health of elderly.[6-7] In Indian setting, very few studies have been conducted with small sample, so to explore death anxiety and death depression in elderly is the objective of study.

It gave awareness to the community people current status of elderly in Punjab, so that they will look forward and have positive attitude. It will clear out the old to make way for new generation

MATERIALS AND METHOD

A quantitative, non-experimental, descriptive research approach was used to assess death anxiety and death depression among elderly. The present study was conducted in two setting i.e. community rural area of village Bazakhana, Faridkot (Punjab) and old age homes (under Red Cross Society), in Faridkot city. The old age home were selected on the basis of expected availability of old age people, giving permission to conduct the study and convenience in terms of distance. The population under study was elderly people residing in old age home of Faridkot city. Sample consisted of elderly people of old age home, those meeting the inclusion criteria were selected by the researcher for the study. A sample of 100 elderly people was taken conveniently for study. The tools used for the study were Socio demographic Data Sheet, Death Anxiety Scale and Death depression scale.

1. **Socio-demographic data sheet:** It is self developed questionnaire and used in this study to measure socio-demographic profile of the elderly people. It includes items related to age, gender, educational status, religion, residence, occupational status, marital status, self income per month type of family, practicing in any prayer on regular basis and practicing any yoga or exercises.
2. **Death Anxiety Scale (DAS)[8]:** It is standardized five point likert scale and used in this study to measure anxiety related to death among elderly. It includes 15 items in which are 1, 4, 8, 9, 10, 11, 12, 13, 14 are positive statements where as 2, 3, 5, 6, 15 are negative statements. Options vary from strongly disagree to strongly agree. Positive items are scored from 1 to 5 where as negative items were scored 5 to 1, respectively. Higher score indicates that subject perceived themselves as being more anxious. Tool administration time is approximately 5-10 minutes. Score between 15-35 is considered as low death anxiety, score between 36-55 is considered as moderate death anxiety, and score between 56-75 considered as severe death anxiety. It has acceptably high validation and reliability scores. The scale has relatively high internal consistency and stability. The reliability was established for the present study through test retest method (r =0.84).
3. **Death Depression Scale (DDS)[9]:** It is standardized five point likert scale and used in this study to measure depression related to death among elderly. It includes 17 statements out of which 11 and 12 are negatively stated and rest are positive statements. All items are scored on five point likert scale ranging from strongly disagree to strongly agree. Positive items are scored from 1 to 5 where as negative items were scored 5 to 1, respectively. Higher score indicate that subject perceived themselves as being more depressed. Score between 15-39 is considered low death depression, score between 40-62 is considered moderate death depression, and score between 63-85 is considered as severe death depression. Administration time is approximately 5-10 minutes. It has acceptably high validation and reliability scores. The scale has relatively high internal consistency and stability. The reliability was established for the present study through test retest method (r =0.77).

The tools were translated into Punjabi language under the guidance of language experts and amendments were made according to suggestions. Back translation in English was done to ensure the content and meaning.

Try out of the tool was done to ensure the reliability and understanding of the tool. Pilot study was conducted and the study was found to be feasible.

Prior to administration to tools, a participant information sheet explaining the purpose of the study was readout and handed over to the subject. All the questions and queries were discussed and sort out before actual data collection. An informed written consent form was signed by the each subject before data collection. All the subjects were ensured that confidentiality and anonymity was maintained throughout the study. Permission was obtained from Institutional Ethical Committee to carry out the study. Written permission was also obtained from various Incharges or Sarpanch of the Bajakhana village before data collection.

The data was analyzed by Statistical Package for Social Sciences (SPSS) version 21. The $p<0.05$ level was established as a criterion of statistical significance for all the statistical procedures performed. Appropriate descriptive and inferential statistics were employed to analyze data as per objectives of the study. Frequency and %age distribution of sample characteristics was computed.

RESULTS

Table 1: Distribution of elderly as per Socio-demographic variables

(N = 100)

Variables	Categories	f	%
Age	60-70	55	55.0%
	71-80	38	38.0%
	81-90	7	7.0%
Gender	Male	73	73.0%
	Female	27	27.0%
Education	Illiterate	27	27.0%
	Up to Matric	42	42.0%
	Higher secondary	4	4.0%
	Graduate	12	12.0%
	Postgraduate	15	15.0%
Religion	Sikh	76	76.0%
	Hindu	23	23.0%
	Muslim	1	1.0%
Residence	Institutional	50	50.0%
	Non-institutional	50	50.0%
Occupation	Retired from Govt job	36	36.0%
	Private job	16	16.0%
	Farmer	18	18.0%
	Any others	30	30.0%
Marital status	Married	86	86.0%
	Widow/widower	14	14.0%
Self Income (Per Month)	Less than 10,000	62	62.0%
	10,001 to 20,000	9	9.0%
	20,001 to 30,000	9	9.0%
	Above 30,000	20	20.0%
Type of family	Nuclear Family	54	54.0%
	Joint Family	45	45.0%
	Extended Family	1	1.0%
Worship/ Spiritual participation	Yes	85	85.0%
	No	15	15.0%
Yoga and Exercise	Yes	67	67.0%
	No	33	33.0%

As shown in table 1, the mean age of the subject was 71.38 (SD-7.67) years and little over half (55.0%) was in the 60-70 years age group category. Maximum of the subjects were male (73%), educated up to matriculation (42%), and belongs to Sikh religion (76%). Majority (86%) of the subjects were married and one third of the subjects (36%) were retired from Govt. job. Mean monthly income of subject (62%) was < 10,000 Rs. and maximum subjects (54%) were from nuclear family. Majority of subjects (85%) were doing worship/spiritual activities and majority of subjects (67%) were doing yoga and exercises.

Table 2: Mean (SD) of death anxiety and death depression among elderly

(N = 100)

Variables	Min.	Max.	Mean ± SD
Death anxiety	26	58	44.73 ± 5.4
Death depression	31	74	50.65 ± 9.5

As shown in table 2, mean ± SD score of death anxiety of the subjects was 44.73 ± 5.4. Similarly, mean ± SD score of death depression of the subjects was 50.65 ± 9.5. Hence, it can be concluded that elderly people has considerable death anxiety and death depression.

Table 3: Level of death anxiety and death depression among elderly

(N = 100)

Level	Anxiety f (%)	Depression f (%)
Mild	3 (3%)	13 (13%)
Moderate	94 (94%)	72 (72%)
Severe	3 (3%)	15 (15%)

As shown in table 3, majority of the subjects had moderate (94%) level of death anxiety where as 3% of the subjects had severe death anxiety. Similarly, maximum (72%) elderly people had moderate death depression followed by severe (15%) death depression.

As shown in figure 1, a significant moderate positive correlation was found between death anxiety and death depression (r=0.477 and p=<0.001). Hence, it can be concluded that increase in death anxiety results in high death depression among elderly.

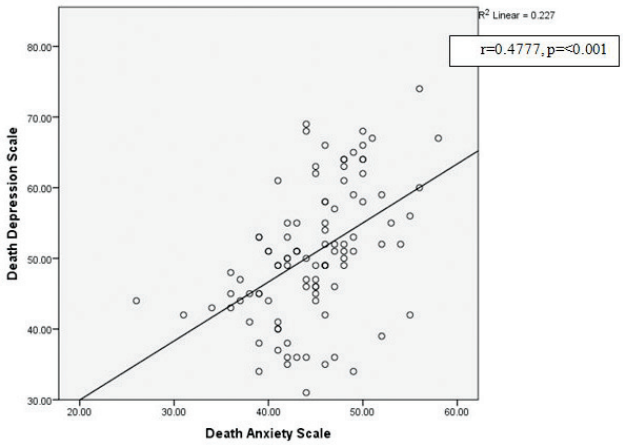


Figure 1: Relationship of death anxiety with death depression among elder

Association of death anxiety and death depression with socio-demographic variables was established with chi-square test. It was found that age, occupation and family type is significantly associated with death anxiety where as rest of the variables (gender, educational status, religion, residence, marital status, self income, spiritual organization & worship yoga and exercise) had no association. Similarly, age, gender, occupation and marital status had significant association with death depression where as rest of the socio-demographic variables had no association.

DISCUSSION

The present study is an attempt to understand the relationship of death anxiety and death depression among elderly. Result revealed that there is moderate positive significant relationship between death anxiety and death depression among elderly. High level of death anxiety results in high depression in old age people. Similar results were reported by **Manjus John et al (2016)**[10] who found that elderly people have severe (40%) death anxiety score, followed by 36 (60.0%) subjects have moderate death anxiety. A significant association was found between knowledge with demographic variable such as age, type of family, income and source of information. **Mathew (2009)**[11] conducted a study among 32 residents of three skilled nursing homes showed that majority of them were (81%) women and 85 years or older (41%). **Naik NA (2007**)[12] reported that maximum (90%) of the senior citizens from old age home were under borderline emotional well-being, 05% of them under negative emotional well-being. Those senior citizens who were staying with family had positive emotional well-being (92%). **Goyal A et al (2014)**[13] assessed depressive symptoms among Indian elderly and found that maximum of them were mildly depressed. 13% were suffering from severe depression. **Doaa A. Almostadi (2010)**[14] revealed statistically significant correlation between death anxiety and death depression. Study also reported a significant difference in gender with death anxiety and death depression.

CONCLUSION

Study concluded that majority of the elderly people had death anxiety and death depression. To ensure a healthy elderly population, improving the nutrition is one of the most important approaches. Death could act as a powerful risk for anxiety and depression in elderly population that it should detected early. The results are expected to help in designing policies and making plans regarding health care provision for the elderly. Elderly people should be regularly assessed for their anxiety, depression and coping.

IMPLICATIONS AND RECOMMENDATIONS

Nurses are the primary health care workers for the early detection of death anxiety and death depression among elderly population. Therefore the nurses should use screening tools for early detection of sign and symptoms. Nurses can motivate the people for regular screening. The community health nurse should have strong emphasis on making the community aware of death anxiety and death depression, its prevention, early

detection and treatment. A Mental health nurse should take the benefit of each and every encounter with the people. Study recommend that nurse administrators may arrange awareness campaigns on anxiety and depression in the hospital and community people and should also assess the effectiveness of such programmes thereafter.

LIMITATIONS

Lack of large sample size may result in lack of representativeness and generalizability to the whole population; however data were collected from old age home of Punjab. The data in the present study may subject to selection bias as the elderly were conveniently selected. In order to make findings generalizable, a large geographical area based study based on random sampling technique is recommended.

Financial and Material Support: This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Conflicts of Interest: The authors declare that they have no conflict of interests with any organization regarding the materials discussed in this manuscript.

REFERENCES

1. Shoaib, M., Khan, S., & Khan, H. M. Family support and health status of elderly people: A case study of district Gujrat, Pakistan. Middle East Journal of Scientific Research, (2011). 10(4), 519-525; http://idosi.org/mejsr/mejsr10(4)11/17.
2. Dawane, J., Pandit, V., Rajopadhye, B. Functional assessment of elderly in Pune, India: Preliminary study. Journal of Gerontol Geriatric Research, (2014). 3(3), 155-156. doi:10.4172/2167-7182.1000155
3. Perna, L., Mielck, A., Lacruz, E. M., Emeny, T. R., Holle, R., Breitfelder, A.Ladwig, H. K. Socioeconomic position, resilience, and health behaviour among elderly. Public Health, (2012). 57, 341-349. doi: 10.1007/s000 3801102940http: //www. jofamericanscience.org
4. Gulzar, F., Zafar, I. M., Ahmad, A., & Ali, T. Socioeconomic problems of senior citizens and their adjustment in Punjab, Pakistan. Pakistan Journal of Agricultural, Sciences, (2008). 45(1), 138-144. http://pakjas.com.pk/upload/75355.
5. Hankey,C. & Leslie,W. Nutritional issues and potential interventions in older people. Journal of Clinical Gerontology. 2011; 21: 286.
6. Situation Analysis of The Elderly in India. Central Statistics Office Ministry of Statistics & Programme Implementation Government of India. June 2011: 4-9
7. Barker, H. 1996. Nutrition and Dietetics For health care. 9th edition. USA. 3-137. Malnutrition is condition…..http://www.nlm.nih.gov/medlineplus/ency/article, accessed on 4th May, 2015 at 3:00 pm.
8. Templer, DI. The construction and validation of a Death Anxiety Scale. The Journal of General Psychology, 82, (1970): 165-177. doi:10.1080/00221309.1970.99206
9. Templer, DI et al. The measurement of Death depression. The Journal of clinical Psychology, 46, (1990): 834-9.
10. Manju John, Binoy Susan, Reddy J Venkat, Passyavula Satish Kumar, Reddy V Parameshwar ;International Journal of Medical and Health Research ISSN: 2454-9142, Impact Factor: (RJIF 5.54) www.medicalsjournals.com Volume 2; Issue 5; May 2016; Page No. 23-24
11. Mathew MA. Stress, coping strategies and quality of life of institutionalised and non-institutionalized elderly. Indian Journal of Gerontology: 2009;Aug23[01]; Pg79-87
12. Naik N: Labeling life events and psychological wellbeing, Psychosocial Nursing: Mar 2007; 20(3); Pg no 635-646
13. Goyal A. and Kajal K.S. Prevalence of Depression in Elderly Population in the Southern Part of Punjab. Journal of Family Medicine and Primary Care. 2014 Oct- Dec; 3(4): 359-361
14. Doaa A Almostadi. "Relationship between Death Depression and Death Anxiety among Cancer Patients in Saudi Arabia" (2012). h5p://scholarcommons.usf.edu/etd/3947.

DOI Number: 10.5958/2395-180X.2019.00013.6

Effect of Self Structured Emotional Intelligence Module on Emotional Intelligence and Self-Compassion among Nursing Students of Selected Nursing Schools in Bhubaneswar

Sanjukta Dixit[1], K Jayakrishnan[2], Neethu Maria Joseph[2]

[1]Tutor, Kalinga Institute of Nursing sciences, KIIT University,Bhubaneswar, Odisha, India;
[2]Assistant Professor, SUM Nursing College, Siksha O Anusandhan University, Bhubaneswar, Odisha, India

ABSTRACT

A quasi experimental study to examine the effect of self structured emotional intelligence module on emotional intelligence and self compassion of 1st year general nursing and midwifery students of randomly selected private nursing schools of Bhubaneswar was conducted and 62 students meeting the inclusion criteria were purposively selected , out of which 27 were from experimental group and 35 from control group. Tools used were modified Genos emotional intelligence inventory and Neff's Self compassion scale with a reliability of 0.91 &0.73 respectively . Self structured emotional intelligence module was delivered to the experimental group for 7 days in two sessions. Descriptive and inferential statistics were used for data analysis. Maximum samples in both experimental and control were within 20-22 yrs and females. A significant difference between the pre test and post test scores of emotional intelligence (124.96 ± 19.20 to 177.07 ±29.92, t= 16.61 and p <0.01) as well as self compassion(2.13 ±0.47 to 3± 0.43 ,t= 8.63 and p<0.01) was evidenced in experimental group only . No statistically significant relation was found between emotional intelligence and self compassion (r= -0.036, p=0.77) and the study concluded that self structured emotional intelligence module was effective in improving emotional intelligence and self compassion of nursing students.

Keywords*: Emotional intelligence , self compassion, Emotional intelligence module*

INTRODUCTION

Emotion, a term used, in day to day speech ,is any relatively short conscious experience characterized by intense mental activity and a high degree of pleasure or displeasure. It is derived from the word "emover" which means to move or excite. Emotions refer to the feelings of love ,hate , attraction ,anger , aggression, jealousy and disappointment.[1]

Intellect is objective-oriented, and persons with greater IQ can achieve success over certain parameters very effectively. But, a leader need may not be an all rounder with capabilities to handle a wide array of complex situations involving different types of people and getting the things done perfectly.

By the end of 20th century a remarkable concept came to limelight which revealed that 80% of success at workplace depends on ones ability to handle people while technical competence counts for 20%. The science of emotional intelligence which encompasses abilities to handle people is of great significance to mankind , as it governs our success or failure.[2]

Peter Salovey and John D. Mayer defined emotional intelligence as, "the subset of social intelligence that involves the ability to monitor one's own and others' feelings and emotions, to discriminate among them and to use this information to guide one's thinking and actions".[3]

Daniel Goleman revealed that for ages what has been universally regarded as ıntellıgence is merely one type of Cognitive intelligence, and is not as important as another type of Intelligence i.e. Emotional Intelligence.[4.]

Corresponding Author:
Mrs. Sanjukta Dixit
Tutor, Kalinga Institute of Nursing sciences,
KIIT University, Bhubaneswar, Odisha
Email: sanjuktadixit@gmail.com

Goleman (1998) has suggested an EI framework that consists of four clusters:

1. *Self awareness* – being aware of own emotions and its significance; having realistic knowledge of strengths and weaknesses; having self confidence.
2. *Self management* – having control over emotions; mobilising emotions for success; being honest , flexible and dedicated.
3. *Social awareness* – being empathetic ; recognizing and perceiving other's emotions, thoughts and points of view.
4. *Relationship management* – anger control, conflict resolution, effective leadership and excellent interpersonal communication skills[2].

The smartest people are not always the most successful or the most cherised and accepted people in life. Sometimes we see that academically brilliant people become unsuccessful at work or in their personal and social life whereas people with average IQ lead a happy,prosperous and productive personal as well as social life . Intellectual intelligence or IQ isn't enough on its own to be successful in life. It is the emotional intelligence which can help us to manage in both social and personal relationships and to acquire success in life along with the other important aspects.[5]

Many psychologists have proposed a wide variety of different concepts for human beings as how to develop healthy attitudes towards self, maintain own mental health, cope up with stress and establish healthy relationships out of which self-esteem, self-efficacy, personal character and self-compassion are few to be practiced and studied. [6]

Self compassion is the ability to be warm and compassionate towards self at the time of experiencing harsh and painful emotions . According to Neff, self-compassion is all about acknowledging and accepting one's feeling that cause suffering and hardship, approaching self with concern and warmth, being sensible and non-judgmental towards self in times of insufficiency and failure and accepting negative experiences to be a part of human living.[7]

In other words, self-compassion is the unique quality to handle sufferings related to emotions tenderly, with great interest ,consciousness and wit .[8] Self-compassion has three dimensions i.e. self-kindness, mindfulness and common humanity.[9.]

Self-kindness is the unconditional acceptance of self. It relates to be kind, compassionate ,sympathethic and non judgemental towards self during adverse situations.[10]

Mindfulness is the discernment that aids an individual in accepting the hardest and saddening emotions of life without letting oneself be carried away by the exaggerated storyline of distress. Common humanity is recognizing the common human features i.e. man is to err, nobody is a perfectionist and one's happy or distressful experiences are not solely distinct to oneself rather others also have similar experiences.

Nursing relies on a trusting relationship .It focuses on meeting the physical, social and emotional needs of individuals, families and society. In health care, nurses directly communicate with patients and try to empathize with them, give care under emotionally intense conditions where the individual undergoes pain and distress

Nurses need to be in contact with the patients, be open towards their emotions, be supportive while accepting their emotions, be affectionate and approach the mistakes and lapses without prejudice during the time when they provide care. Studies have shown that such type of dealings by nurses increases their tension, frustration, depression, decreases job satisfaction and causes psychosocial problems as they lack in the abilities of handling and mobilizing emotions of self and others.[11]

Students being the future and backbone of a nation need to be emotionally mature and congruent enough to fight with all the odd situations , to bring prosperity and development for their country while maintaining a warm and compassionate attitude towards self at the time of experiencing painful emotions. Studies conducted to find out the role of perceived emotional intelligence (PEI) measured by the Trait Meta-Mood Scale, in the use of stress-coping strategies, quantity and quality of social support and in the mental health of nursing students have shown that emotional intelligence minimizes the negative stress consequences.[12]

Although both self-compassion and emotional intelligence are important parameters of nursing but, very little is known about them to the nursing students.

A descriptive corelational study was conducted by H Ibrahim, W Elgzar, R Mohamed and G Salem in 2016 to assess the relationship between Nursing Students

Emotional Intelligence and their Clinical Performance during Obstetrics and Gynaecologic Nursing Practical Training in, Benha University of Egypt . A convenience sample of allthird year female students (N=98) were taken and tools used for data collection were the SchutteSelf Reported Emotional Intelligence scale and clinical performance evaluation scale . Descriptive statistics, correlation coefficient and t- test were calculated . Results showed that 70.40% of students had moderate level of emotional intelligence whereas, 2% had low level of emotional intelligence and the total EI mean score was 110.5±17.46. The mean score of students' clinical/procedural skills was (15.25±3.77). A positive correlation was found between students total clinical performance skills with their total EI as well as utilization of emotions score ($r= 0.22$, $p<0.05$ $ $r=0.20$, $p<0.05$) respectively, as well as between total supportive clinical skills and total EI and utilization of emotions score ($r= 0.23$, $p<0.05$, $r=0.22$, $p<0.05$) respectively .[13]

F Sharif et al in 2013 conducted a randomized clinical trial on 52 intensive care unit nurses working in a hospital affiliated to Shiraz University of Medical Sciences. Samples were recruited through purposeful convenience sampling and then randomly categorized into two groups and emotional intelligence training was given to the intervention group members. Bar-on emotional intelligence and Goldberg's general health questionnaires were administered to each participant before, immediately after, and one month after the intervention. The mean score of general health for the experimental group decreased from 25.4 pre-intervention, to 18.1 post intervention and to 14.6 one month later but, for the control group, it increased from 22.0, to 24.2 and to 26.5, respectively ($p<0.001$). Teaching emotional intelligence improved the general health of intensive care unit nurses.[14]

MATERIALS AND METHOD

Experimental research approach with Quasi experimental study design was used . Settings for the study were randomly selected and 2 private nursing schools each for experimental and control group were selected by lottery method.

The setting for the experimental group was Neelachal Institute of medical sciences Bhubaneswar and Lord Jagganath missions college and school of nursing Bhubaneswar and for the control group was Hi-tech school of nursing Bhubaneswar and Sum nursing college Bhubaneswar.

A total of 62 1st year GNM students were selected by purposive sampling and meeting the sampling criteria participated in the study out of which 27 were from experimental group and 35 were from control group.

Tools used in the study were socio demographic proforma, Modified Genos Emotional intelligence inventory and Self compassion scale.

The self structured emotional intelligence module was administered to the experimental group in 2 sessions for 7 days i.e. from 11th to 12th and then from 16th to 20th January daily for 1 hour ,(11-12 a.m at Lord Jagganath missions School of nursing and 3-4 at NIMS School of nursing).

FINDINGS

Distribution of study samples into various levels of emotional intelligence and self compassion , according to the pre test and post test scores in terms of percentage.

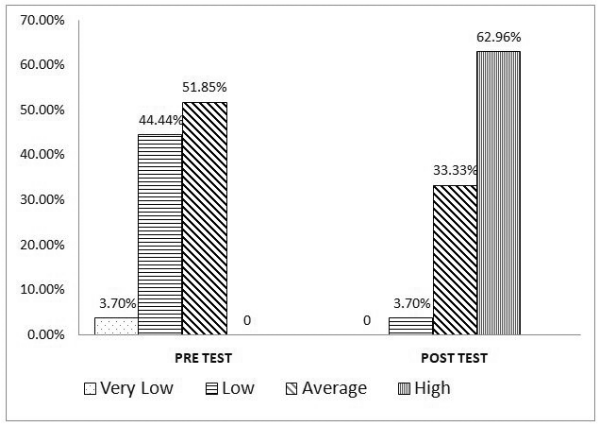


Figure 1: Bar diagram showing percentage distribution of pre test and post test scores of experimental group according to the levels of emotional intelligence

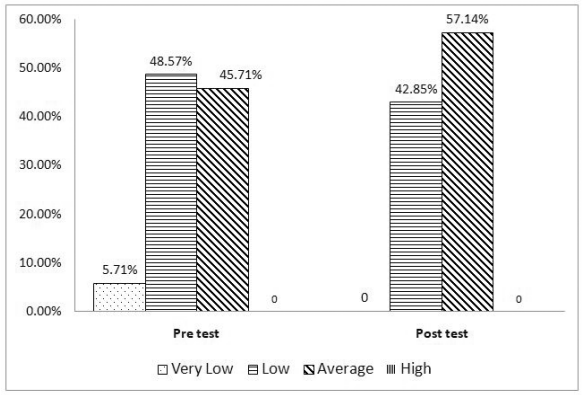


Figure 2: Bar diagram showing percentage distribution of pre test and post test scores of control group according to the levels of emotional intelligence

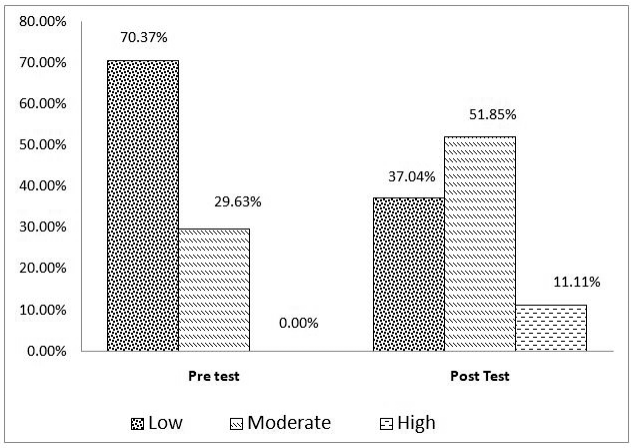


Figure 3: Bar diagram showing percentage distribution of pre test and post test scores of experimental group , according to the levels of self compassion

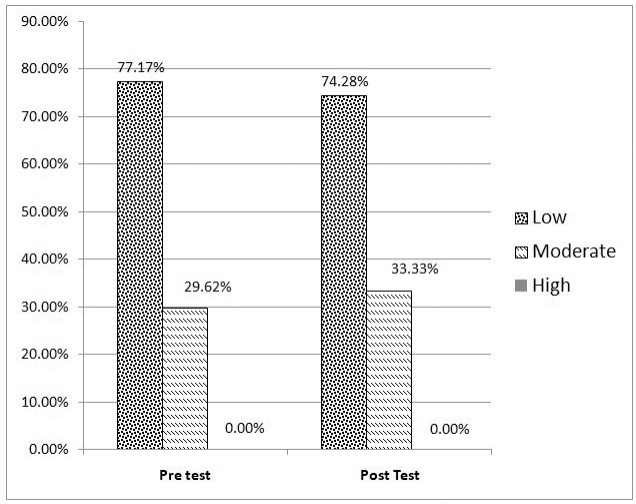


Figure 4: Bar diagram showing percentage distribution of pre test and post test scores of control group according to the levels of self compassion

Figure-1, depicts that in experimental group 51.85% samples had average level of emotional intelligence in pre test but, in post test 62.96% had high and33.33% had average level of emotional intelligence.

Figure -2, states that in control group 48.57% samples had low and 45.71% had average level of emotional intelligence in pre test but, in post test 57.14% had average and 42.85% had low level of emotional intelligence.

Figure -3, demonstrates that in experimental group 70.37% had low and 29.63% had moderate level of self compassion in pre test but, 51.85% had moderate and 11.11% and high level of self compassion.

Figure-4, depicts that in control group 77.17% had low level of self compassion in pre test and 74.28% also had low level of self compassion in post test.

Effect of self structured emotional intelligence module on emotional intelligence and self compassion

Table 1: Comparison of pre test and post test scores of emotional intelligence and self compassion of experimental group (n1) and control group (n2).

$N=n_1(27)+n_2(35)=62$

Groups	Items	Mean Value	SD	Paired t-	Df	P-Value
Experimental	Emotional Intelligence	52.11	16.3	16.61	26	<0.01**
	Self Compassion	0.8	0.48	8.63	26	<0.01*
Control	Emotional Intelligence	5.88	20.05	1.73	34	0.091
	Self Compassion	0.03	0.35	0.52	34	0.605

*P≤ 0.05

Table no.1 reveals that in experimental group the pretest and post test scores of emotional intelligence and self compassion are statistically significant as p<0.05 whereas in control group the pre test and post test scores of emotional intelligence and self compassion are statistically insignificant as p>0.05.

Table 2: Correlation between pre test scores of emotional intelligence and self compassion

N=n1(27)+n2(35)=62

Variables	r-Value	p-Value
Emotional Intelligence	-0.0362	0.778
Self compassion		

Table no.2 States that Pearson's correlation coefficient value between the pre test scores of emotional intelligence and self compassion was -0.032 and p=0.778 which indicated that emotional intelligence and self compassion had no relation with each other as the pre test values were statistically insignificant.

MAJOR FINDINGS AND DISCUSSION

The present study revealed that the overall emotional intelligence score of experimental group demonstrated a significant hike from 124.96 ± 19.20 to 177.07± 29.92 with paired t-value 16.61 and p <0.01 . This finding is supported by the study of Claire Rene who conducted a dissertation in 2015 to assess the effect of emotional intelligence training on emerging staff and student leaders in a collegiate setting at the Abraham S. Fischler college of education . 30 participants were randomly divided into 2 groups (15 experimental and 15 control) and Bar-On EQ-I was used to assess the EI level. The trained group was given EI training video module. Results indicated that total EI score of the trained participants before the training was 113.40, and after the training was 115.00. The untrained participants total EI score remained unchanged i.e. 109.33 pretest and 109.33 posttest.[15]

Significant difference between the self compassion scores of pre test (2.13± 0.47) and post test (3± 0.43) with a t- value of 8.63 and p-value <0.01 was found in experimental group .

This is supported by the study of Archontia Mantelou and Eirini Karakasidou who conducted a study on the effectiveness of a Brief Self-Compassion Intervention Program on Self-Compassion, Positive and Negative Affect and Life Satisfaction ,in 2017 on 42 students recruited by opportunity sampling . participants were randomly divided into two groups, the self-compassion intervention group (N = 20) and the control group (N = 22). Intervention was given to the experimental group whereas the control group didn't receive anything. Results revealed that there was significant increase in the self compassion scores of the participants of intervention group (paired t-value= -4.42, p<0.001) whereas no statistically significant difference was marked between the pre test and post test scores of control group (paired t- value=−1.46, p = 0.159].[16]

The present study found that there exists no relation between emotional intelligence and self compassion i.e. ,r= -0.036, p=0.77 which is contrary to the findings of the following study.

E.Senyuva et al. conducted a descriptive correlational study to analyse the relationship between self compassion and emotional intelligence among nursing students in Turkey by taking 571 undergraduate students . findings yielded that a fair level of significant positive correlation was present between the self compassion and emotional intelligence of nursing students (r=0.400,p<0.01)[17]

CONCLUSION

The present study concludes that nursing students possess low-average level of emotional intelligence and low- moderate level of self compassion in general .Self structured emotional intelligence module was very much effective in increasing emotional intelligence as well as self compassion level of nursing students.

Conflict of Interest: None

Source of Support: Self

Ethical Clearance: Taken from Institutional Ethical committee.

REFERENCES

1. Cabanac Michel , What is emotion , Behavioral processes ,2002, 60(2), 69-83 .
2. Sharma A. R. K Intelligence (the Vivekananda way) 1st edition , Vijayawada , Sri Sarada Book House, 2013. Emotional, 15-20
3. Yi Yi Mo & Andrew R.J. (2007) Measuring and Enhancing the Emotional Intelligence of Construction Management Students: An Empirical Investigation, Journal for Education in the Built Environment, 2:1, 110-129
4. Goleman Daniel, Emotionalintelligence Why it can matter more than IQ, 1st ed. New Delhi, Thompson press India ltd, 2013 , ix.
5. Bradberry Travis & Greaves Jean , Emotional Intelligence 2. 0, 1st edition ,,San Diego ,Talent Smart , 2009, 5-10.
6. BennetGoleman T. Emotional Alchemy: How the Mind Can Heal the Heart. New York: Three Rivers Press, 2001.

7. Neff KD. Development and validation of a scale to measureself-compassion. Self and Identity 2003; 2: 223–250.

8. Neff KD, McGehee P. Self-compassion and psychological resilience among adolescents and young adults. Self and Identity 2010; 9: 225–240.

9. Neff KD, Vonk R. Self-compassion versus global selfesteem: Two different ways of relating to oneself. Journalof Personality 2009; 77: 23–50.

10. Neff KD. Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. Self and Identity 2003; 2: 85–102.

11. Martin JR. Mindfulness: A proposed common factor. Journal of Psychotherapy Integration 1997; 7: 291–312.

12. Montes-Berges B, Augusto JM. Exploring the relationship between perceived emotional intelligence, coping, social support and mental health in nursing students.2007 April[cited2016june14];14(2):163-71.Available from:URL:http://www.ncbi.nlm.nih.gov/pubmed/17352779#

13. Ibrahim H, Elgzar W, Mohamed R and Salem G: Relationship Between Nursing Students' Emotional Intelligence and Their Clinical Performance During Obstetrics and Gynaecologic Nursing Practical Training ; American Journal of Nursing Science ; 2016; 5(6): 240-250.

14. Sharif f, Rezaie s , Keshavarzi s ,Mansoori p ,Ghadakpoo s , Teaching emotional intelligence to ICU nurses and their general health ; a RCT , International Journal of Occupational and Environmental Medicine 2013 , 4(3):141-8 ·

15. Claire Rene. 2015. Effects of Emotional Intelligence Training on Emerging Staff and Student Leaders in a Collegiate Setting. Doctoral dissertation. Nova Southeastern University. Retrieved from NSUWorks, Abraham S. Fischler College of Education. (31) http://nsuworks.nova.edu/fse_etd/31

16. Mantelou Archontia and Karakasidou Eirini, The Effectiveness of a Brief Self-Compassion Intervention Program on Self-Compassion, Positive and Negative Affect and Life Satisfaction, 2017, Psychology, 8, 590-610. https://doi.org/10.4236/psych.2017.84038 .

17. Senyuva Emine, Kaya Hulya, Isik Barcin, Bodur Gonul, Relationship between selfcompassion and emotional intelligence in nursing students ; International Journal of nursing practice ;2014 ; 20 (1) ,588-596.

DOI Number: 10.5958/2395-180X.2019.00014.8

Assess the Level of Attitude on Nursing and Nursing Education among Final Year B.Sc. Nursing Students in Seleced Nursing College, Salem

M.D. Santhi[1], Manjula B[2], Mohanraj S.[3], S. Sandhiya[4]

[1]Professor cum HOD, [2]Lecturer, [3]Tutor, [4]M.Sc (N) I Year student, Sri Gokulam College of Nursing, Salem

ABSTRACT

Nursing is unique among the health care professional in the whole world in that it has multiple educational pathways leading to an entry level licence to practice. The aim is to assess the level of attitude on Education & nursing education among final year B.sc nursing students. Descriptive research design was adopted and selected 51 samples through non probability purposive sampling technique. The tool consists of two parts demographic variables and attitude questionnaires regarding attitude on nursing and nursing education. The data was collected and analyzed by descriptive statistics. The result of the study includes most of the (60.7%) students belongs to 19-20 years of age, pertaining to gender (74.5%) students are females. Regarding the level of attitude towards nursing shows, majority of (70.58%) them chosen in the area of nursing as their life time career and nearly half of them (49.1%) expressed that nursing as a noble profession. In the area of Nursing present strength and weakness shows maximum (60.78%) of them said still need to join in nursing profession and in the area of Social Stigma for nursing 41 percentage of them said sometimes and Majority (47.17%) of them expressed that reason for choosing the nursing profession is due to service to community. Regarding the level of attitude towards nursing education shows, majority (86.27%) of them responded that nursing education prepares them to be an independent nurse and maximum (58.83%) were responded faculties play an encouraging and excellent role in clinical posting, highest percentage (74.50%) of them preferred mixed method of teaching and Half of them (50.98%) were preferred bedside clinic for clinical teaching and Maximum (43.13%) of them opted to be a bedside nurse after their graduation.

Keywords*: Attitude on education & nursing education, Nursing students*

INTRODUCTION

Nursing is unique among the health care professional in the whole world in that it has multiple educational pathways leading to an entry level licence to practice. Every nursing curriculum process aims at programs which provide the student with clinical experience and classroom instruction as regulated by national and international nursing regulatory bodies.[1]

Corresponding Author:
Dr. M. D. Santhi
Professor & HOD,
Sri Gokulam College of Nursing,
No. 3/836, Periyakalam, Neikkarapatti, Salem-636010
Email: santhi_pooja@yahoo.co.in

The image of both nurses and nursing as a profession are vital in the successful recruitment and retention of staff in the health care industry.[2] Waters believes that nurses are the backbone of the healthcare sector and are fundamental in the delivery of quality care for all the inhabitants of a country.[3]

An understanding of student's perception and its evolvement during the course of the study can assist nurse education in evaluating the educational program's strengths and weaknesses. This understanding can enhance curricular development towards a caring and holistic paradigm of nursing. Moreover, it will add to the body of knowledge of nursing education, especially in relation to admission processes, by examining specific personal factors that influence students' perceptions.[4]

An exploratory survey was carried out to find out the perception of outgoing B.SC nursing students towards

nursing profession and carrier plans in selected colleges of Tirupathi. Perception and future life orientation is important in judging the students. Data was collected from 100 randomly selected outgoing fourth year B.SC (N) students. Findings of the study were most of the students (71%) were self-motivated to pursue nursing and (84%) preferred to go for higher education. More than three thirds (84%) felt it is an opportunity to get government. 50% of students expressed their desire to change profession, Almost all of the students felt nursing profession gives opportunity to serve humanity but majority it is not equal to other professions. Less than half prefer to be employed at bedside and nursing administration. Nursing administration and professional associations need to create opportunities for higher education in nursing. Financial incentives and, promotional opportunities have to be provided to nursing professionals to create interest to retain themselves in nursing profession. It is further recommended that nursing educators can play an important role in providing guidance and counselling to nursing students regarding career prospects.[5]

The profession of nursing is a respectable occupation where one toils day and night for the common people, which existed as a crude form in the times of Florence Nightingale. The nurses at that time were not having good social status & often those nurses were belonging to lower class of the society. But at present, the conditions have changed a lot. It has now got a better status in the society. But the standard of candidates coming to the profession especially in Bangalore has declined from past two years.[6]

STATEMENT OF THE PROBLEM

A study to assess the level of Attitude on Nursing and Nursing Education among Final year B.SC nursing Students in selected Nursing College, Salem.

OBJECTIVES

1. To assess the level of attitude on Nursing among final year B.Sc nursing students.
2. To assess the level of attitude on Nursing Education among final year B.Sc nursing students.
3. To associate the level of attitude on nursing and nursing education scores with the demographic variables of nursing students.

Assumption: Attitude regarding nursing and nursing education among individual may vary from individual to individual.

Hypotheses:

H_1: There is a significant association between level of attitude on nursing and nursing education scores with the demographic variables among nursing students at $p \leq 0.05$ level.

Conceptual Framework: The investigator adopted Modified Imogene King Goal Attainment Theory which is aimed to assess the Attitude on Nursing and Nursing Education among Final year B.SC nursing Students.

MATERIALS & METHOD

In quantitative Research Approach, a descriptive research design was used for this study. The study was conducted in Sri Gokulam College of Nursing, Salem. chosen to assess the Attitude on Nursing and Nursing education among final year B.SC Nursing Students at selected college, Salem. Non probability purposive sampling technique was adopted and selected 51 students of B.SC nursing final year who full fill inclusive criteria. Written permission was obtained from the Managing Director of Sri Gokulam college of Nursing, Salem and written consent was obtained from the B.Sc Nursing final year students those who are willing to participate in the study. Student's demographic variables were collected. Structured Attitude Questionnaire was used to assess the Attitude towards on Nursing and Nursing education. The data will be analysed by using both descriptive and inferential statistics.

RESULTS & DISCUSSION

Distribution of final year B.Sc Nursing Students according to their selected demographic variables: Percentage wise distribution of age shows that, 31(60.7%) final year B.Sc nursing students belong to 19-20 years of age, 20 (39.2%) final year B.Sc nursing students belong to 21-22 years of age and none of them belong to 23-24 years of age.

Percentage distribution of sex shows that, 38(74.5%) final year B.Sc nursing students are females and 13(25.4%) final year B.Sc nursing students are males.

Distribution of the final year B.Sc nursing students according to their attitudes towards nursing

Table 1: Frequency and percentage distribution of final year B.Sc nursing students according to their attitude towards nursing

n = 51

Sl. No.	Questionnaire	Frequency (f)	Percentage (%)
1.	**Is nursing your life time career**		
	Yes	36	70.58
	No	3	5.88
	Not sure	12	2.35
2.	**Attitude towards nursing**		
	Good profession	23	45.09
	Profession like any other	3	5.88
	Noble profession	25	49.01
3.	**Knowing your present strength and weakness**		
	Enter other professional college	2	3.92
	Still join nursing	31	60.78
	Other	18	35.29
4.	**Is there lack of recognition for nursing service**		
	Yes	2	3.92
	Sometimes	19	37.25
	No	19	37.25
5.	**Is there social stigma for nursing**		
	Yes	18	35.29
	Sometimes	21	41.17
	No	12	23.52
6.	**Reason for choosing nursing**		
	Earning money	12	23.52
	Service community	24	47.17
	Good status	6	11.76
	Other reasons	9	17.64

Regarding the level of attitude towards nursing shows, majority of (70.58%) them have chosen in the area of nursing as their life time career, whereas only few (2.35%) of them expressed they have not sure about nursing as their life time career. Nearly half of the students (49.1%) expressed that nursing as a noble profession but only least of them (5.88%) expressed nursing is just like other profession. In the area of Nursing present strength and weakness shows maximum (60.78%) of them said still need to join in nursing profession and very minimum (3.92%) expressed they choose other professional course. In the area of lack of recognition of nursing services shows the same percentage (37.25%) of the students expressed that both sometimes and also no lack of recognition of nursing services. In the area of Social Stigma for nursing, 41 percentage of them said sometimes and 23 percentage of them said no stigmatised. Majority (47.17%) of them expressed that reason for choosing the nursing profession is due to service to community whereas only few (11.76%) were chosen to improve their status.

Distribution of final year B.SC nursing students according to their Attitude towards nursing education

Table 2: Frequency and percentage distribution of final B.SC nursing students according to their attitude towards nursing education

n = 51

Sl. No.	Questionnaire	Frequency (f)	Percentage (%)
1.	**Nursing education prepares independent nurse**		
	Yes	44	86.27
	No	7	13.73
2.	**Role played by faculty during posting**		
	Satisfactory	4	39.21
	unsatisfactory	0	0
	Discouraging	1	1.96
	Encouraging and excellent	30	58.83
3.	**Most preferred method of teaching**		
	Lecture	4	7.85
	Practical examination	1	17.65
	All of the above	30	74.50
4.	**Most preferred classroom evaluation**		
	Surprise test	20	39.21
	Unit test	13	25.49
	Sessional exams	7	13.72
	Modal exams & Assignment	3	21.28
5.	**Preferred method of clinical teaching**		
	Bedside clinic	26	50.98
	Clinical presentation by students	11	21.56
	Clinical teaching by faculty	8	15.68
	Nursing rounds	4	7.84
	Others	2	3.92

Conted…

6.	**Preferred of work after graduation**		
	Remain in bedside nursing	22	43.13
	Take other collaborative roles	7	13.72
	Join another less demanding job	1	1.96
	Be a nurse manager	8	15.68
	To teach in nursing college	3	25.49
7.	**Would you prefer to pursue higher studies?**		
	Yes	41	80.39
	No	15	19.60
8.	**A V aids preferred**		
	Films	4	7.84
	Power point presentation	15	29.41
	Video assisted practical demonstration	9	17.64
	Multiple methods	23	45.09

Regarding the level of attitude towards nursing education shows, majority (86.27%) of them were responded that nursing education prepares them to be an independent nurse but only 13 percentage of them were not accepted this aspect, maximum (58.83%) were responded that their faculties play an encouraging and excellent role in clinical posting, only minimum 1percentage were responded discouraging role in faculty and none of them said the faculty role was unsatisfactory. Highest percentage (74.50%) of them preferred mixed method of teaching, least percentage (7.85%) of them preferred lecture method and none of them preferred seminar method. 39.21 percentage of them expressed that surprise test was most preferred classroom evaluation method, only less (5.88%) of them preferred model exams for classroom evaluation. Half of them (50.98%) were preferred bedside clinic for clinical teaching and 3.9 percentage of students preferred other method of clinical teaching. Maximum (43.13%) of them opted to be a bedside nurse after their graduation and only very less 1.96 percentage of them opted less demanding job after their graduation. Majority (80.39%) of them preferred to pursue their higher education and 19.6 percentage were not pursuing their higher studies. Nearly half of them (45.09%) responded that multiple methods of A.V aids using for teaching, only 7.8 percentage were preferred teaching methods can be used through films and none of them preferred models for using teaching methods.

There was no significant association found between level of attitude on nursing and nursing education and their demographic variables. Hence H_1 is rejected at $p>0.05$ level.

CONCLUSION

Majority (60.7%) of final year B.SC nursing students belong to 19-20 years of age highest percentage (74.5%) final year B.SC nursing students are females. Maximum (70.58%) have chosen nursing as their life time career**.** All most (86.27%) responded that nursing education prepares them to be an independent nurse. There was no significant association found between level of attitude on nursing and nursing education and their demographic variables

Implications:

Nursing services:

- Evaluative study can be used to evaluate the attitude of nursing and nursing education by using different evaluative methods.
- In nursing service evidence based practice is encouraged

Nursing education:

- Follow traditional and creative method of teaching to improve the attitude of nursing and nursing education.
- To improve positive attitude towards nursing and nursing education consider physical and emotional status of the students.
- Critical evaluative techniques are practiced in formative and summative manner.
- Allow the students to use online and offline sources to upgrade the nursing knowledge in nursing education.

Nursing Administration:

- The nursing administration can organize in-service education programme regarding the steps

to improve positive attitude towards nursing and nursing education.

- Provide scholarship to the students to fulfil the final needs in nursing education.

Nursing research:

- There is need to explore the challenges faced by nursing students in clinical areas.
- Nursing researcher can emphasis on practice of evidence based practice to improve practical skills.

Recommendations:

- A comparative study can be conduct to assess the knowledge and attitude regarding nursing and nursing education.
- Co-relational study can be conduct to correlate the attitude towards nursing and nursing education.
- Experimental study can be done to assess the pre-test, post-test knowledge and attitude towards nursing and nursing education.
- A cohort study on impact of nursing curriculum implementation on student attitude towards nursing can be done at the end of each year during their course of study.

Conflict of Interest: Nil

Source of Support: Self Funded

Ethical Clearance: Obtained from Institutional ethical board.

REFERENCES

1. Susan.B.Bastable, "*Nurse as Educator", Principles of the Teaching and learning for nursing practice,* 2nd edition, Jones and Bartlett Publishers, Newyork, London, 2015.
2. Mable Catherine john, et al., The public's image of nursing as described to Baccalaureate prenursing Students. "*Journals of Professionl Nursing",* 2008.
3. Lakhveer Kaur, Kanika and Ajesh Kumar., The experience of choosing nursing as a career. *Journal of Nursing education.* 2016; 39:320-322.
4. Rheaume A, Swarna . S, Why students choose nursing. *Journal of Canadian Nurse.* 2003; 99: 25-29.
5. Ibrahim Ali Tawfiq Al Jarrah, Nursing students perception towards nursing profession, American journal of Nursing, January 2013, 2
6. Matheka, et al., Attitude of first and final year B.Sc Nursing students on Nursing, "*American journal of Nursing",* June 2012, 6 (9).

DOI Number: 10.5958/2395-180X.2019.00015.X

A Study to Assess the Level of Knowledge on Polycystic Ovarian Syndrome among Nursing Students at Selected Nursing College, Salem

M.D. Santhi[1], Manjula B[2], Kanaga Durga M[3], Sathya J.[4], S. Sandhiya[5]

[1]Professor cum HOD, [2]Lecturer, [3]Asst. Professor, [4]Lecturer, [5]M.Sc (N) I year & DGNM III year 2014-2017 Batch students, Sri Gokulam College of Nursing, Salem

ABSTRACT

About one in five women has polycystic ovaries, and approximately one in 10 has PCOS to some degree. Polycystic ovary syndrome (PCOS) is a condition in which women typically have a number of small cysts around the edge of their ovaries. The aim of the study is to assess the level of knowledge on polycystic ovarian syndrome among nursing students. The Descriptive research design was used. Selected 44 girls of nursing students through non-probability convenient sampling technique. The tool used was structured questionnaire consists of demographic variables, tool for diagnosis of PCOS and structured questionnaire on polycystic ovarian syndrome. The data were analyzed by using descriptive and inferential statistics. Majority of the nursing students 37(84.09%) had moderately adequate knowledge. The overall mean score was 14.2±3.173; the mean percentage was 46.6%.There was no significant association found between the level of knowledge on poly cystic ovarian syndrome among nursing students with their demographic variables. As a nurse midwife, we have to promote knowledge about sign& symptoms of PCOS and thus helping the Nursing students to have future in peaceful.

***Keywords**: Polycystic ovary syndrome, Knowledge, Nursing students*

INTRODUCTION

Typically, polycystic ovarian syndrome first appears in adolescence, normally around the state of menstruation. Occasionally, some women do not develop polycystic ovary syndrome symptoms until their early to mid-20s. One of the most common symptoms of poly cystic ovarian syndrome is irregular periods. Polycystic ovarian syndrome (PCOs) becomes symptomatic during adolescence and affects at least 5% of reproductive-age women. Poly cystic ovarian syndrome is a heterogeneous syndrome of unexplained chronic hyperandrogenism and oligo-anovulation, with a polycystic ovary being an alternative diagnostic criterion.[1]

Corresponding Author:
Dr. M. D. Santhi
Professor & HOD, Sri Gokulam College of Nursing,
No. 3/836, Periyakalam, Neikkarapatti, Salem-636010
Email: santhi_pooja@yahoo.co.in

The prevalence of Poly cystic ovarian syndrome in increasing rapidly but the females doesn't have adequate knowledge about this syndrome. The prevalence of overweight and obese (BMI 30kg/m2) is significantly contributing to the overall burden of Poly cystic ovarian syndrome worldwide. The Poly cystic ovarian syndrome is reported to be a growing problem with adolescent girls. Adolescent may experience the full range of symptoms irregular (or) complete absent of menstruation. Research has proved that Poly cystic ovarian syndrome predisposes the women including adolescent girls to additional health problems. Polycystic ovarian syndrome accounts for 90 of women with oligomenorrhoea 30 of women with amenorrhoea and over 70 of women with anovulation.[2]

Conducted a study to assess prevalence and knowledge of PCOS among female science students of different public universities at Quetta, pakistan.A mixed methodology apporoach was conducted in different public universities of quetta which focuses on questionnaire based on assessment as well as providing education. The data from 451 female students of age

range between 18-26 years was collected by using stratified convenient sampling technique from January to September 2016. The finding of the study revealed that 374(72.5%) respondents were not aware of PCOS and get knowledge through brochure. while 407(90.2%) subjects were having adequate knowledge about PCOS after educational intervention. It was obtained in the study that 79(17.5%) participants were suspected with PCOS and 16(3.5%) were diagnosed with PCOS on the basis of signs and symptoms and 25(5.5%) were already diagnosed with PCOS. It was also obtained that 35(7.8%) participants were overweight and 13(2.9%) respondents were obese.[3]

A cross - sectional analytical study was conducted in Qassim University Clinic, in the year of 2007 -2009. They concluded that obesity plays an important role in the genesis and maintenance of polycystic ovarian disease. Poly cystic ovarian disease is the leading cause of anovultory infertility in females and affects 1 in 10 women of reproductive age. Poly cystic ovarian disease is strongly associated with obesity.[4]

Conducted a prospective longitudinal study concluded that there is a significant risk mood disorders in women with polycystic ovarian syndrome. The persistent high rate of depression and other mood disorders are presents in young women with Poly cystic ovarian disease.[5]

Conducted a cross - sectional, regarding quality of life in women with polycystic ovarian syndrome. The results of this study indicate that women with polycystic ovarian syndrome have the greatest concern in the area of weight, followed by menstrual problems and infertility. These concerns are directly reflected in their objective life experiences. Women with polycystic ovarian syndrome clearly need education and support regarding the effect of their quality of life.[6]

Statement of the Problem: A study to assess the level of knowledge on polycystic ovarian syndrome among nursing students at selected nursing college, Salem.

OBJECTIVES

- To assess the prevalence of polycystic ovarian syndrome among nursing students.
- To assess the level of knowledge on polycystic ovarian syndrome among nursing students.
- To associate the level of knowledge on Polycystic ovarian syndrome with their demographic variables.

Hypothesis

H_1: There is a significant association between the level of knowledge of Polycysti ovarian syndrome among nursing students with their demographic variables at $p \leq 0.05$ level

Conceptual Framework: The conceptual framework of this study is based on Pender's health promotion model (2002). Health promotion is directed at increasing a client level of well being. This model focuses on the following three areas Individual characteristics and experience, Behavior specific knowledge and effect and Behavior outcomes.

MATERIALS AND METHOD

The non-experimental descriptive research design was used for this study. The study was conducted in Sri Gokulam College of Nursing, Salem. The non probability convenient sampling technique was adopted and selected 44 girls from IV year B.Sc(N) and III year DGNM students as a study samples. The tool consists of three sections. It Section I consists of 10 demographic variables, Section II consists of Modified Clinical tool for diagnosing the prevalence of polycystic ovarian syndrome & Section III consists of Structured questionnaire to assess the knowledge of polycystic ovarian syndrome. Data analysis was done by using both descriptive and inferential statistics.

RESULT AND DISCUSSION

Age wise distribution shows that highest percentage 20(45%) of students were in the age group between 20 years and most of the students 38(86.3%) were Hindus, only 1(2.2%) belongs to Muslim. Course of study wise distribution shows that 34(77.2%) were IV year B.Sc(N) students and 10(22.7) were III year DGNM students. Dietary pattern wise distribution shows that most of student 37(84.0%) were non-vegetarian, and majority of nursing students 29(65.9%) consume weekly once. According to consuming of junk food 25(56.8%) of them like junk foods and majority of the nursing students 30(68.1%) drink only 500-1000ml of water per day. According to regularity of menstrual cycle majority of nursing students 36(81.8%) have regular menstrual cycle and 27(61.3%) of the nursing students having ideal weight and none of them were obese.

Distribution of nursing students according to the prevalence of polycystic ovarian syndrome

Table 1: Frequency and Percentage wise distribution of nursing students according to the prevalence of polycystic ovarian syndrome

n = 44

Scores	Frequency	Percentage
Mo More than and equal to 2, C consistent with diagnosis of Poly cystic ovarian Syndrome.	3	6.8
M More than 2, not consistent diagnosis of Poly cystic ovarian syndrome	41	93.18

Distribution of nursing students according to their prevalence of poly cystic ovarian syndrome 3(6.8%) were consistent with diagnosis of Polycystic ovarian syndrome and 41(93.18) were not consistent with diagnosis of Polycystic ovarian syndrome.

Distribution of nursing students according to their level of knowledge on polycystic ovarian syndrome

Table 2: Frequency and Percentage wise distribution of nursing students according to their level of knowledge on polycystic ovarian syndrome

n = 44

Level of knowledge	Frequency	Percentage
Adequate knowledge	1	2.27
Mo Moderately adequate knowledge	37	84.09
In Inadequate knowledge	6	13.63

Distribution of nursing students according to their level of knowledge shows that 1(2.27%) of students had adequate knowledge, 37(84.09%) of students had moderately adequate knowledge and only 6(13.63%) of students had inadequate knowledge on poly cystic syndrome.

Mean, standard deviation and mean percentage of knowledge scores among nursing students

Table 3: Distribution of Mean, standard deviation and mean percentage level of knowledge of poly cystic ovarian syndrome

n = 44

Variable	Maximum score	Mean	S.D	Mean %
Knowledge	30	14.02	3.173	46.6

Distribution of Mean, Standard Deviation and Mean percentage on knowledge scores on poly cystic ovarian syndrome shows that the overall mean score was 14.2±3.173; the mean percentage was 46.6%. It shows that nursing students had moderately adequate knowledge on poly cystic ovarian syndrome.

Association between knowledge scores of poly cystic ovarian syndrome with their demographic variables

H_1: There will be a significant association between the level of knowledge poly cystic ovarian syndrome with their selected demographic variables at $P \leq 0.05$ level.

Table 4: Association between the knowledge scores with their demographic variables among nursing students

n = 44

Sl. No.	Demographical variables	Df	Table Value	$\chi 2$
1.	Ag Age in years	3	7.82	2.893
2	Rel Religion	3	7.82	2.359
3.	Co Course of study	1	3.84	0.925

Conted…

4.	Die Dietary pattern	1	3.84	0.722
5.	H Habit of consuming non-veg	2	5.99	1.031
6.	Do Do you like junk food	1	3.84	1.212
7.	Am Amount of water intake per day	2	5.99	1.168
8.	Re Regularity of menstrual cycle	1	3.84	1.485
9.	Me Menstruation disorder	1	3.84	0.589
10.	So Source of information	5	11.07	2.099
11.	BMI	3	7.82	0.981

* Not Significant at P<0.05 level.

No significant association was found between the level of knowledge scores on poly cystic ovarian syndrome among nursing students with their demographic variables like age of the student, religion, course of study, dietary pattern, habit of consuming non veg, do you like junk food, amount of water intake per day, regularity of menstrual cycle, menstruation disorder, source of information and source of previous knowledge at P< 0.05 level. Hence the research hypothesis was rejected.

CONCLUSION

The study was done to assess the level of knowledge on poly cystic ovarian syndrome among nursing students at selected Nursing College, Salem. The findings revealed that 84.09% of the nursing students had moderately adequate knowledge on poly cystic ovarian syndrome.

IMPLICATIONS

Nursing Research:

- Findings of this study will act as catalyst to carry out more extensive research on the largest samples in different settings.
- Nurses have expanded and extended role of promotive, preventive, curative and rehabilitative services of individual, family and community level.
- Nurses can provide centralized approach regarding obesity and Poly cystic ovarian syndrome by taking action to impart knowledge to the community people.

Nursing Education:

- Nursing curriculum provide clinical experience regarding conduction of VAT programme about obesity and Poly cystic ovarian syndrome in various settings.
- Various in- service education and appropriate teaching materials need to be prepared and made available to the students and staffs regarding Polycystic ovarian syndrome.
- In order to educate the patients, it is essential that nurses should be competent and should have sound knowledge to improve the level of understanding on obesity and Polycystic ovarian syndrome and an improved level of understanding can be reflected to public through education.

Nursing Administration:

- Nurses have to play multidimensional role and their skills have to be combined with the specialised knowledge to ensure prevention of complications of obesity and Polycystic ovarian syndrome.
- The nurse should participate in public awareness programs, through mass media and administration should take initiatives to organize educational program for health personnel regarding obesity and Polycystic ovarian syndrome.

Nursing Services:

- Nurses play an important role in promotive, curative and preventive aspects of health care system. The nurses should provide teaching programme for obesity and Polycystic ovarian syndrome in hospital and community.
- The nurses working in hospitals should themselves provide health education to clients; they should do teaching programme rather than incidental teaching.

RECOMMENDATIONS

- The study needs to replicate on a large sample to validate and generalize its findings.
- A similar study can be conducted in community health centres to assess the knowledge regarding obesity and Poly cystic ovarian syndrome.
- A longitudinal study can be conducted to assess the correlation between obese and overweight adolescent girls with the symptoms of polycystic ovarian syndrome.
- A similar study can be conducted to assess the knowledge regarding obesity and Poly cystic ovarian syndrome among staff nurses, other college girls, reproductive age bearing women, and all other females who are having obesity and hormonal imbalances
- Learning modules with pictorial should be given to public regarding obesity and Poly cystic ovarian syndrome.

Conflict of Interest: Nil

Source of Support: Self Funded

Ethical Clearance: Obtained from Institutional ethical board.

REFERENCES

1. Azziz R, Marin C, "Health care-related economic burden of the polycystic ovary syndrome during the reproductive life span". J Clin Endocrinol Metab. 2005 Aug;90(8):4650-8.
2. Bronstein J, et al., Retrospective chart review and systematic review of the literature among 58 girls (age ≤ 18 yrs) with a diagnosis of PCOS based on the Rotterdamcriteria. JPediatrAdolescGynecol.2011,Feb;24(1):1520.
3. Chakrabarti J. Correlational study on serum leptin level in women with polycystic ovary syndrome .Ann Med Health Sci Res. 2013 Apr;3(2):191-6.
4. Creatsas G, Deligeoroglou E. Polycystic ovarian syndrome in adolescents.Abstract of Curr Opin Obstet Gynecol. 2007 Oct;19(5):420-6.
5. Ene-ObongH1 et al., Prevalence of overweight, obesity, and thinness among urban school-aged children and adolescents in southern Nigeria. Food Nutr Bull.2012Dec;33(4):24250.
6. Guo X1 et al., Prevalence and risk factors of being overweight or obese among children and adolescents in northeast China.PediatrRes.2013 Oct; 74(4):443-9.

DOI Number: 10.5958/2395-180X.2019.00016.1

Effectiveness of Play Therapy for Improvement of Fine Motor Skills and Attention Span in Children with Cerebral Palsy

Rajashree Das[1], Sinmayee Kumari Devi[2]

[1]Lecturer, Dept. of Paediatric Nursing, [2]Vice Principal, Dept of Obstetrics and Gynaecological Nursing, Lord Jagannath Mission's College of Nursing, Bhubaneswar, Odisha

ABSTRACT

Cerebral palsy (CP) is the most common motor disability in childhood. It's important for children who have cerebral palsy to engage in activities. These activities can be essential in helping the child enjoy the highest quality of life and to improve their muscular and skeletal development. "Play therapy is a medium to develop other skills and abilities." Through play children at a very early age engage and interact in the world around them. A True experimental research study where experimental and control group pre-test–post-test only design was used to assess the effectiveness of video assisted teaching module on knowledge among mothers regarding play therapy for improvement of fine motor skills and attention span in children with cerebral palsy. The data were collected from 60 mothers of children with Cerebral Palsy by simple random sampling technique for experimental group and control group by using close ended knowledge questionnaire. **'t'** test and **chi square** test has been done. In experimental group the Findings revealed that the pre-test scores was 14.73±3.19 which shows 36.82% of the total mean score, where as in post-test the total mean score was 32.6±4.19 which reveals 81.5% of total mean score. In the control group the pre-test scores of mother of children with CP was 15.33±2.79 which reveals 38.32% of the total mean score, where in the post test the total mean score was 14.07 ±3.8 which shows 35.15%. From the findings of the present study it was concluded that VATM regarding play therapy for improvement of fine motor skills and attention span in children with cerebral palsy children was effective to increase the level of knowledge among mothers of CP children.

Keywords*: Cerebral Palsy (CP), Video Assisted Teaching Module (VATM).*

INTRODUCTION

Every moment of womb time is taken up by growing, developing, learning, and changing and that's just before making his or her way down the birth canal and out into the world.[1] Cerebral palsy is the most common cause of physical disability. Cerebral means brain, and palsy is defined as a loss of control or weakness in movement. Cerebral palsy affects the motor area of the brain. [2]

Population-based studies from around the world report prevalence estimates of CP ranging from 1.5 to more than 4 per 1,000 live births or children of a defined age range. [3] The world-wise incidence of CP is 2-2.5/1000 live birth CP is a life lasting disability and is one of the most expansive health conditions. [4] Cerebral palsy is a life-long physical disability due to damage of the developing brain. In most cases, brain injury leading to cerebral palsy during pregnancy.[5] Early treatment for children with cerebral palsy is important because the developing brain and body are more resilient. There are more opportunities to correct or improve. Children with cerebral palsy can improve their motor skills with the help of play therapy and other treatments. [6] "play therapy is a medium to develop other skills and abilities." [7]

Play allows children to use their creativity while developing their imagination, physical, cognitive, and emotional strength. Through play children at a very early age engage and interact in the world around them. [8] Mother is the primary caretaker of the child and attached emotionally compared to father. Mother should have adequate knowledge about play because play is an essential part of every child's life and is vital for the enjoyment of childhood.[9] Through play, child lays the foundation. [10] It is very clear that the knowledge regarding play therapy for improvement of fine motor skills and attention span is very important for CP

children mother. So for the improvement of knowledge as a researcher I felt to administer play therapy through VATM for both psychological and physiological improvement of the child.

Statement of Problem: "Effectiveness of video assisted teaching module on knowledge among mothers regarding play therapy for improvement of fine motor skills and attention span in children with cerebral palsy in selected rehabilitation centres of Odisha."

OBJECTIVES OF THE STUDY

- To assess the level of knowledge among mothers before intervention both experimental and control group.
- To administer video assisted teaching module among mothers regarding play therapy for improvement of fine motor skills in children with cerebral palsy.
- To find out the effectiveness of VATM among mothers regarding play therapy for improvement of fine motor skills in children with cerebral palsy.
- To find out the association between the post-tests levels of knowledge selected demographic variables.

Hypotheses: All Hypotheses were tested at 0.05 level of significance.

H_1: There will be significant difference between the level of knowledge among mother regarding play therapy for improvement of fine motor skills and attention span with CP children.

H_2: There will be significant association between post-test level of knowledge of mothers with their selected demographic variables

Delimitation: The study will be limited to mothers of-

- Children with Cerebral palsy.
- Children age between 2 to 14 years.

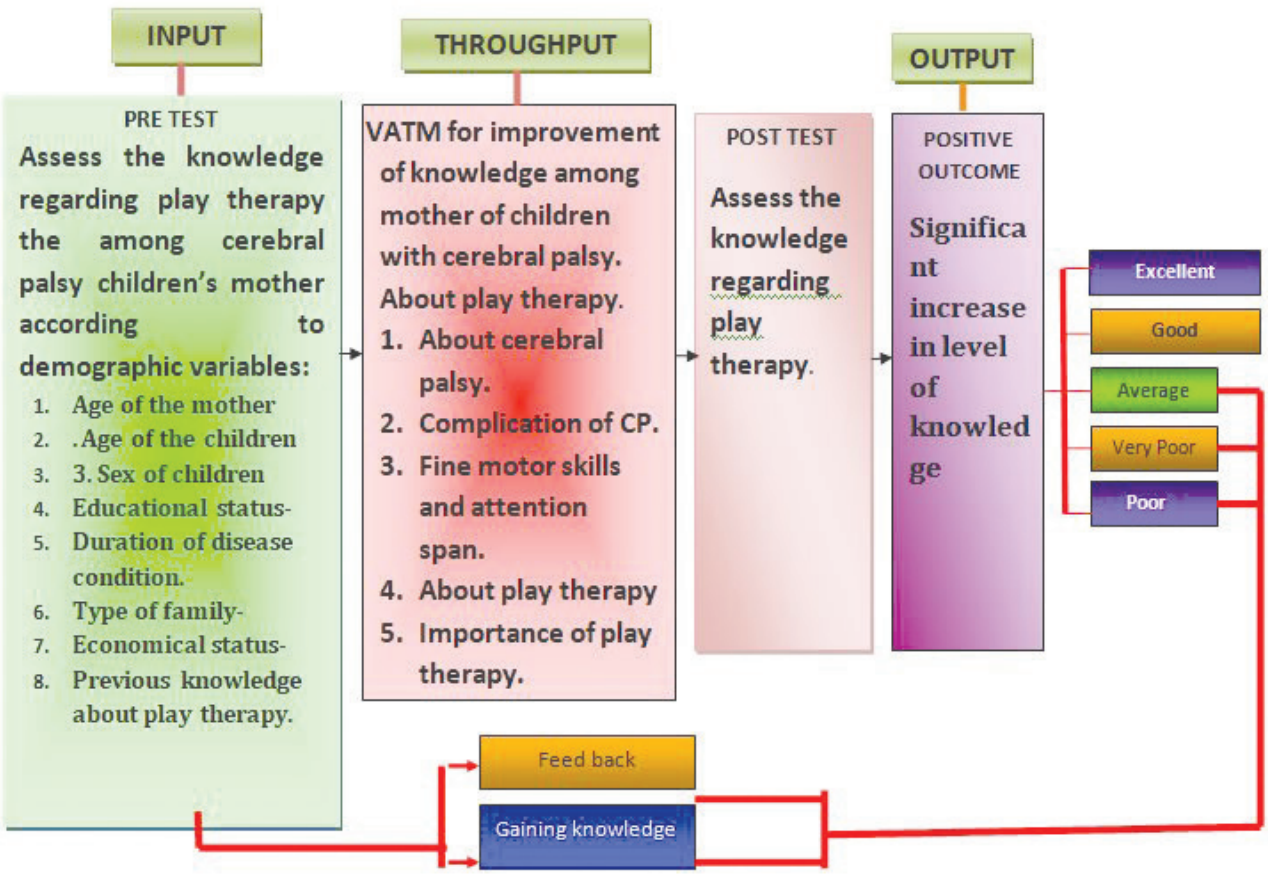


Fig. No. 1: Theoretical framework based on J.W. Kenny's open system model (1990)

MATERIAL AND METHOD

A True experimental research study where experimental and control group pre-test – post-test only design was used to assess the effectiveness of VATM on knowledge among mothers regarding play therapy for improvement of fine motor skills and attention span in children with cerebral palsy in Swami Vivekananda National Institute of Rehabilitation Training and Research (SVNIRTAR), Olatpur, Cuttack, Odisha for experimental group. The study was conducted at Physiocare and research centre, Plot No: 98 jail road, Jharpada, near Flyover Bridge, Bhubaneswar, Odisha for control group. The data were collected from 60 mothers of children with CP by simple random sampling technique for experimental group and control group by using close ended knowledge questionnaire. The tool consists of two sections:

Section A: It includes Demographic variables of the mothers of CP children.

Section B: It consists of Close ended Structured Questionnaire & VATM.

Permission was obtained from the director of SVNIRTAR, Olatpur, Cuttack, Odisha for experimental group and the director of Physiocare and research centre, Bhubaneswar, Odisha for control group. Pre-test was conducted by using closed ended questionnaires followed by implementation of VATM. After 7 days post-test was done. Descriptive and inferential statistics was used for data analysis.

FINDINGS

Table 1: Frequency and percentage wise Distribution demographic variables in both experimental and control group

Age of Mother (in Years)	Experimental Group		Control Group	
	Frequency	Percentage	Frequency	Percentage
20-25	10	34%	13	44%
26-31	13	43%	10	33%
32-36	7	23%	6	20%
>36	0	0%	0	3%
Age of Children (In Years)				
2-5	10	33%	9	30%
6-9	11	37%	14	47%
10-12	8	27%	5	16%
>12	1	3%	2	7%
Sex the Children				
Male	13	43%	16	53%
Female	17	57%	14	47%
Educational Status				
Primary	11	37%	11	37%
Secondary	12	40%	17	57%
Graduate or above	7	23%	2	6 %
Duration of Disease Condition				
<2 yrs.	1	3%	3	10%
2-3yrs	8	27%	7	24%
4-5yrs	8	27%	10	33%
>5yrs	13	43%	10	33%

Conted…

Type of Family				
Nuclear family	14	47%	12	40%
Extended family	8	27%	10	33%
Joint family	7	23%	8	27%
Single parent family	1	3%	0	0%
Economical Status				
>5000	8	27%	12	40%
5000-10000	9	30%	10	33%
10001-20000	13	43%	8	27%
<20000	0	0%	0	0%
Previous Information				
Electronic media	15	50%	15	50%
Public media	15	50%	15	50%

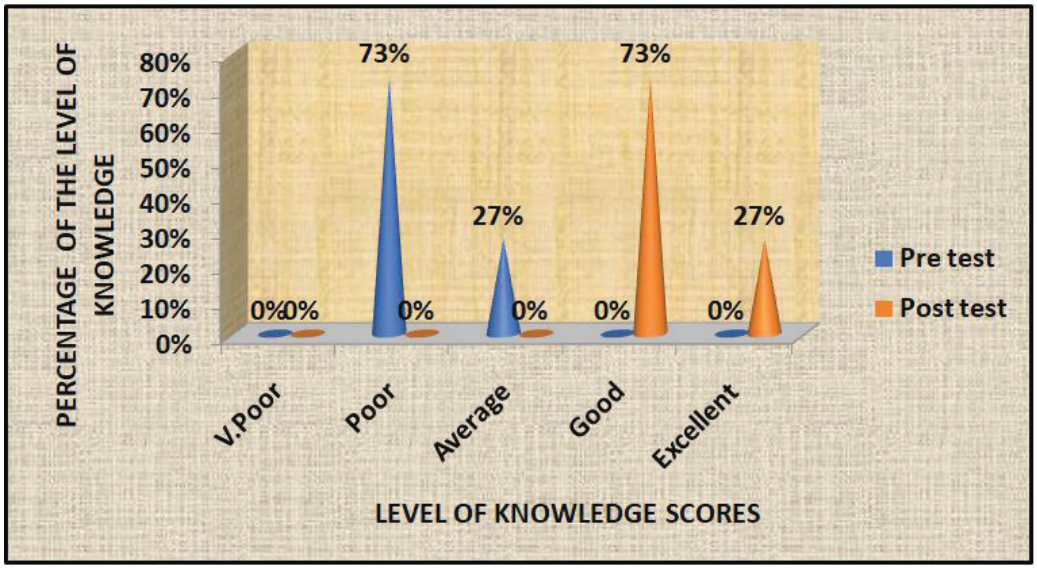
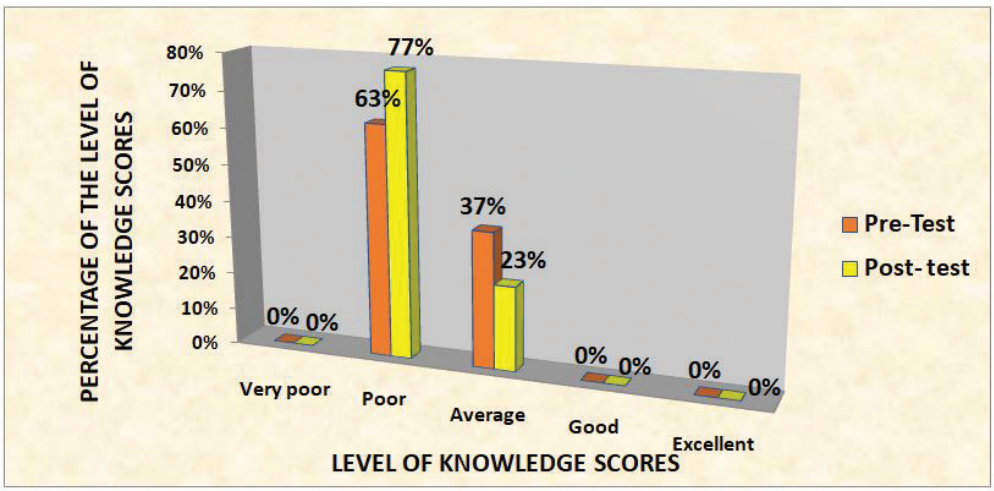


Figure 2: Pyramid diagram representing the overall comparison of pre-test and post-test level of knowledge scores among CP children's mother regarding play therapy in experimental group



Figur.3: Bar diagram representing the overall comparison of pre-test and post-test level of knowledge scores among CP children's mother regarding play therapy in control group

Figure 2 and Figure 3: Shows that in experimental group maximum percentage (73%) of the mothers of children with CP had **POOR** knowledge in pre-test and other side in post-test 73% had **EXCELLENT** knowledge. Whereas in control group more or less similar percentage (63% and 77%) of the mothers of children with CP had **POOR** knowledge score in pre-test and post-test.

Table 2: Comparison of mean, SD and mean (%) percentage of pre and post-test level of knowledge score among mother of children with CP for improvement of fine motor skills and attention span of CP children both in experimental and control group

Area	Experimental Group							Control Group						
	Pre test			Post test			Difference in mean % (y-x)	Pre test			Post test			Difference in mean % (y-x)
	Mean	SD	Mean %(x)	Mean	SD	Mean % (y)		Mean	SD	Mean % (x)	Mean	SD	Mean % (y)	
Cerebral Palsy	3.8	1.19	48	6.77	0.76	85	37	3.53	1.08	44.3	3.57	1.2	44.62	.49
Play therapy	4.37	1.35	36	9.53	1.33	79	43	3.2	1.4	26.67	1.67	.69	41.75	15.08
Non directed play	1.53	0.55	38	3.37	0.79	84	46	2.2	0.75	55	3.2	1.49	26.67	28.33
Directed play	1.86	0.83	31	4.73	0.85	79	48	2.73	1.74	45.5	2.43	0.88	40.5	5
Prescribed play	0.3	0.38	30	0.8	0.18	80	50	0.13	0.33	13	0.17	1.13	17	4
Importance of play therapy	3.27	1.1	36	7.13	1.38	79	43	3.27	1.34	36.33	3	1.29	33.33	3
Over all	15.13	3.19	37.83	32.33	4.19	80.82	42.99	15.33	2.79	38.32	14.07	3.88	35.17	3.15

Tabe 2: Depicts that in experimental group the highest post-tests mean score was (3.8±1.19) which is 85% for the area "cerebral palsy" and the effectiveness was ranges from 43% to 50%, which shows the effectiveness of VATM. Whereas in control group there is not much changes in knowledge score in pre and post test.

H_1: There will be significant difference between the level of scores in pre-test & post- test of mother of children with CP with regard to improve the knowledge level after administering play therapy for improvement of fine motor skills and attention span in children with CP in experimental group.

Table 3: Area wise Comparison between difference of pre-test and post-test level of knowledge score among mothers of children with CP by using closed ended knowledge questionnaire on selected sections of Play Therapy

Area	't' value	Level of Significance
Cerebral palsy	11.42	Highly Significant
Play Therapy	14.74	Highly Significant
Non directed Play	10.22	Highly Significant
Directed Play	13.05	Highly Significant
Prescribed Play	6.25	Highly Significant
Importance of Play Therapy	12.06	Highly Significant

(df=29), (Table Value= 2.05), ($P \leq 0.05$)

Unpaired 't' test was 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 null hypothesis was rejected **($P \leq 0.05$)** and statistical hypothesis was accepted.

H_2: There will be significant association between post- test knowledge levels with their selected demographic variables among mother of children with Cerebral Palsy.

Table 4: Association between post-test knowledge scores among mothers regarding play therapy for improvement of fine motor skills and attention span in children with cerebral palsy with their selected demographic variables

Demographic variables	Chi square value ($\chi 2$)	Df	Table value	Level of significance
Age of the mother	.66	12	21.03	Not significant
Age of the children	1.7	12	21.03	Not significant
Sex of children	.52	4	9.49	Not significant
Educational status	1.06	8	15.51	Not significant
Duration of disease condition	5.74	12	21.03	Not Significant
Type of family	0.7	12	21.03	Not significant
Economical status	6.73	12	21.03	Not Significant
Previous knowledge Play therapy	7.56	12	21.03	Not Significant

($P \leq 0.05$)

Table 4: Reveals that Chi square was calculated to find out the association between post-test knowledge scores of the mother of children with CP with their selected demographic variables. It found that there was no significant association between post test scores among mothers regarding play therapy for improvement of fine motor skills and attention span in children with cerebral palsy when compared with age of the mother, age of the children, sex of children, educational status of mother, duration of disease condition of the children, type of family, Economical status, previous knowledge about play therapy. It was find that in some demographic variables null hypothesis was rejected and alternative hypothesis was accepted.

CONCLUSION

From the findings of the present study it was concluded that video assisted teaching module regarding play therapy for improvement of fine motor skills and attention span in children with cerebral palsy children was effective to increase the level of knowledge among mothers of children with Cerebral Palsy children.

RECOMMENDATIONS

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

- A similar study can be conducted with a very large sample size for wide generalization.
- A similar study can be conducted for longitudinal duration to find out the more effectiveness.
- A similar study can be undertaken in other setting like residential institution and psychiatric centres specially designed for the mentally challenged children.
- A similar study can be conducted among care takers, family members, and paediatric nurses.

Conflict of Interest: None

Source of Funding: Self

Ethical Clearance: Permission was obtained from the Director of Swami Vivekananda National Institute of Rehabilitation Training and Research (SVNIRTAR), Olatpur, Cuttack, Odisha and informed consent was taken from the respondent.

REFERENCES

1. 7 amazing thing babies do in the womb: available from thestir.cafemom.com/pregnancy/157203/7_amazing_things_babies_do Jun 21, 2013.
2. A closer look at Cerebral Palsy (TARE) - DFPS Home: available from https://www.dfps.state.tx.us/Adoption_and...Our.../cerebral_palsy.asp
3. By centre of disease control and prevention, Data & Statistics for Cerebral Palsy Data and Statistics | Cerebral Palsy | NCBDDD | CD: available from www.cdc.gov/ncbddd/cp/data.html.
4. Shashtika Shali Pinda Sweda *and* Samvardhana Ghrita, Virendra Kumar Kori, S. Rajagopala, and Kalpana S. Pate: Etiopathological study on

cerebral palsy and its management by available from www.ncbi.nlm.nih.gov › NCBI › Literature › PubMed Central(PMC).

5. Children with Disabilities - In Schoolallinschool. org/wp- content/uploads/.../OOSC-2014-Children-with-Disabilities- final.pd...
6. Cerebral Palsy - Learn Causes, Diagnosis and Treatment https://www.cerebralpalsyguide.com/cerebral-palsy.
7. Play Therapy: Cerebral Palsy: OriginsOfCerebralPalsy.com www.originsofcerebralpalsy.com/05-treatment/06-playtheraphy.html.
8. The Importance of Play in Promoting Healthy Child Development and... pediatrics.aappublications.org/content/119/1/182.
9. Rajakumari P.Reddy and Uma Hirisave Indian J Psychol Med. Child' Play: Therapist's Narrative, 2014 Apr-Jun; 36(2): Pp204–207.Doi: 10.4103/0253-7176.130998.
10. Play Therapy | Play with Purpose | CerebralPalsy.orgCerebralPalsy.org www.cerebralpalsy.org/about-cerebralpalsy/treatment/therapy/play-therapy.

DOI Number: 10.5958/2395-180X.2019.00017.3

"Assessment of Burden and Coping Strategies among Caregivers of Stroke Survivors in a Teaching Hospital in Ernakulam, Kerala"

Sona Anto[1], Susan Mathai[2], Sheela Shenai NA[3]

[1]MSN (Med Surg), [2]Associate Professor, [3]Principal, College of Nursing, MOSC Medical College Hospital, Kolenchery, Ernakulam, Kerala

ABSTRACT

Objectives: to assess the burden among caregivers of stroke survivors, to identify the coping strategies among caregivers of stroke survivors, to find the association between burden and coping strategies among caregivers of stroke.

Method: A quantitative approach was used with descriptive cross-sectional survey design; 155 caregivers of stroke survivors were selected as study subjects by purposive sampling technique. Data was collected by self report method using demographic profile, burden assessment schedule and coping checklist.

Results: Results of the study revealed that 66% of the subjects have moderate burden, 24% of subjects have no burden and 10% of subjects have severe burden. Majority of the subjects adopted the coping strategy in the domain of emotional focused coping (24.89 ± 4.08). There is significant association between level of burden and different domains of coping strategies. It is revealed that burden has significant influence on different coping strategies.

Conclusion: Study concluded that caregivers experienced higher degree of burden. Burden was significantly associated with coping strategies. The study felt, the need of development of psycho educational program to assist caregivers to cope successfully with burden resulting from the care of stroke survivors.

Keywords*: Burden, Coping strategies, Caregiver, Stroke survivors*

INTRODUCTION

Neurological damage accounts for approximately 40% of cases of severe disability (in which individuals require daily help) and for the majority of cases of complex disability resulting from combinations of physical, cognitive and behavioural impairments. The disability related to neurological diseases is higher than Ischemic heart diseases, malignancies or HIV. Stroke being the 3rd most common cause of death is related to more than half of the death and disability in these diseases. Because of the changing lifestyles and urbanization of the population, including an increase in risk factors like smoking, obesity, physical inactivity, high blood pressure and cholesterol, the burden of stroke rather than decreasing like in the Western countries has increased in the South Asian countries. WHO defines stroke as 'a clinical syndrome consisting of rapidly developed signs of focal (or global) disturbances of cerebral functions, lasting more than 24 hours. It can be ischemic (50-80%) or hemorrhagic (8-34%). Worldwide prevalence of stroke was 33 million, 600000 people have first occurrence and stroke kills nearly 140000 people in a year. Stroke, one of the public health concerns, is a leading cause of long term disability[1].

Comprehensive stroke care or holistic cares need the very effective caregivers; the caregivers play an important role for post stroke rehabilitation. A caregiver

Corresponding Author:
Sona Anto
MSN (Med Surg)
College of Nursing, MOSC Medical College Hospital,
Kolenchery, Ernakulam, Kerala
Mob: 9645370543
Email: sonuzenalphons@gmail.com

has responsibilities to not only look after the disabled individual but also to make adjustments to his/her life. Need of a stroke survivor may vary from being physical (help walking, carrying from bed to toilet), in communication (verbal and nonverbal cues to other family members), nursing (feeding, personal hygiene), emotional support (handling disruptive behaviour) along with an overwhelming financial responsibility. Additionally, hospitalization exerts a burden on caregivers of patient as well. Caregivers of patient with neurological disease have been found to have higher risk of social isolation, emotional burden and a reduction in quality of life. Caregivers across the world are often unrecognized and under supported, are deeply and personally impacted by the care they provide. When individual face a traumatic event, they must use a variety of strategies to cope with negative experience and stress. Hence caregiver burden, particularly that of closely involved family members such as parents, spouse, is important as an outcome measure in health care, to assess and reduce it for the well-being of both the survivors and caregivers[8]. Caregiver burden and coping has not been adequately addressed in the care of neurological patients where it has a significant impact on the health and functioning of the individual. Indeed, the measurement of caregiver burden has been shown to enhance worker and administrator awareness of the need to reduce such burden in health care field in general. The objectives of this study were to assess the burden and coping strategies among caregivers of stroke survivors and to find the association between burden and coping strategies.

MATERIALS AND METHOD

A cross sectional survey design of caregivers of stroke survivors was used in this study. A quantitative non experimental approach was used to assess the burden and coping strategies among 155 caregivers of stroke survivors in a teaching hospital in Ernakulam Kerala. Purposive sampling technique was used in this study. Population was care givers of stroke survivors. Sample was 155 caregivers of stroke survivors attending neurology OPD at MOSC MCH, Kolenchery. The burden and coping strategies were measured by using self report method. It consists of two standardised tool Burden Assessment Schedule (BAS) developed by Thara et al (1998) and The Coping Checklist (CCL) developed by R Kiran et al (2003). Burden Assessment Schedule (BAS) consists of 40 items on burden with 3-point Likert scale scaled not at all, to some extent, very much. The score range from 40-120. Higher scores indicate greater burden range from 0 - 40 indicates no burden, 41-80 moderate burden, 81-120 severe burden[2]. The coping checklist (CCL) has 70 items describing a broad range of behavioral, cognitive and emotional coping responses that an individual might use to handle stress. The responses are scored dichotomously in a yes/no format, indicating whether a coping behavior is present or not[3]. Socio-demographic characteristics were determined by a structured questionnaire. The study protocol was approved by the Institutional Ethics Committee, and written informed consent was obtained from all participants. Burden and coping strategies were computed by frequency, percentage, mean, and standard deviation. The association between burden and coping strategies was analyzed using one way ANOVA. Chi-square, fisher's exact, independent sample t test and one way ANOVA was used to compute the association between burden and coping strategies with selected demographic variables.

FINDINGS

The study results revealed that 52.9% of care givers were in the age group of 41-50 years and 50.3% of caregivers were females. Majority of the caregivers (47.1%) had primary education and 63.2% of caregivers were unemployed. Most of the caregivers (81.9%) were married, 68.4% of caregivers had monthly family income below Rs.5000, 74.8% of caregivers belong to nuclear family and 85.81% of caregivers were spouses. The majority of caregivers (69.68%) were providing around the clock care, 51.61% caregivers were providing care more than 1 year and above, 81.94% of caregivers had their children for helping them, 70.97% stroke patients were partially dependent on caregivers, 34.84% stroke patients had duration of illness 1-5 years, and 60.65% of stroke patients have thinking and memory problems. The study findings showed that 66% of caregivers had moderate burden, 24% had no burden and 10% had severe burden. Mean coping strategy score revealed that the subjects had higher mean score in the domain of emotion focused coping (24.89 ± 4.08), and lower mean scores in the domain of social support (4.17 ± 0.66). One way ANOVA test scores showed that there is significant association between level of burden and different domains of coping strategies (p=0.000). It revealed that burden has significant influence on coping strategies. On

computing the association between selected variables, it is found that there is an association between burden and coping strategies with gender, duration of care, type of disability and duration of illness($p<0.05$).

Table 1: Distribution of subjects according to their level of burden

(n = 155)

Sl. No.	Level of Burden	Frequency	Percentage
1.	No Burden	15	10%
2.	Moderate Burden	38	24%
3.	Severe Burden	102	66%

Table 2: Coping strategies among caregivers of stroke survivors

(n = 155)

Sl. No.	Coping Strategies	Mean	SD
1.	Problem focused coping	19.98	5.11
	Problem solving	8.03	1.15
	Distraction positive	7.88	3.57
	Distraction negative	4.07	1.02
2.	**Emotion focused coping**	**24.89**	**4.08**
	Acceptance	9.73	1.58
	Religion	6.51	1.66
	Denial blaming	8.65	1.15
3.	**Social support**	**4.17**	**0.66**

Table 3: Statistical association between Burden and Coping strategies

(n = 155)

Sl. No.	Domains of coping		No burden	Moderate burden	Severe burden	One way ANOVA (F)	P value
1.	Problem focused coping	Mean	28.05	18.14	12.00	1100.32	$p < 0.001$
		SD	0.98	0.95	3.07		
2.	Emotional focused coping	Mean	28.89	25.03	13.73	2039.80	$p < 0.001$
		SD	0.72	0.62	1.53		
3.	Social Support	Mean	5.05	4.00	3.06	215.30	$p < 0.001$
		SD	0.51	0.22	0.45		

$p < 0.05$ is significant

DISCUSSION

The present study revealed that 65.8% of the caregivers have moderate burden, 24.5% of caregivers have no burden and 9.7% of caregivers have severe burden. So, from this study researcher could be said that most of the caregivers faced moderate level of burden. However, few studies have been observed higher level of burden among caregiver of stroke survivor. A cross sectional study was conducted by Salma Begum in 2013 to assess the level of burden among caregivers of stroke survivors at CRP in Bangladesh, among 151 participants who were selected from occupational therapy outdoor and stroke rehab unit reported that most of the caregivers (78.8%) of stroke survivors faced with moderate level of burden, in terms of domain most of the caregiver faced with moderate burden about general strain (58.9%), isolation (63.6%), higher burden about disappointment (60.3%), lower burden about emotional involvement (59.6%) and environment (78.8%)[4].

Female caregivers who were housewives, wife and daughter in relationship with stroke survivors giving long duration of care exhibit higher burden. It is clear that informal caregivers have played a significant social and economic role in the care and treatment of individuals diagnosed with stroke. Informal caregivers may become frustrated, depressed, and feel demoralized because they are not adequately prepared to perform the care giving responsibilities or have an outlet for voicing their concerns.

Present study revealed that most of the caregivers were used emotion focused coping, a few of the subjects used problem focused coping and social support. Similar study done by Sukhpal Kuar et al in 2014 reported that problem focused coping (68.50%) is most commonly used coping strategies followed by mix of problem and emotion focused (72.33%) and least one emotion focused coping (46.48%) by caregivers of stroke survivors. The most coping strategies used by caregivers were acceptance, getting social support, problem solving and seeking help of religious things[5]. However, denial and distracting negatively were used as least common coping strategies by caregivers.

It is clear that, there are no standards for coping strategies, they vary depending on, and are influenced by socio-cultural factors. People can adopt new coping mechanisms on the basis of lessons learned in the past and these mechanisms can consolidate in what we call culture. Emotion-focused coping changes a person's emotional response to the stressor and are focused on reducing the negative emotional responses that the caregiver experience because of stressors. Problem-focused coping is about trying to deal with the stressor itself so as to avoid the stress response it is causing and a practical way to deal with stressful situations. People are more likely to adopt emotion-focused coping when they don't think their actions can affect the stressor itself, so they alter their response to the stressor. Talking to other people about the situation or engaging in other activities may help to deal with the emotional stress of that encounter.

The study revealed that there is significant association between level of burden and different domains of coping strategies. It showed that burden has significant influence on different coping strategies. Another study done by Carod et al. reported that a statistical positive significant relationship between denial as a coping styles and different sphere of burden among caregivers[6]. Similar study conducted by Beische D et al. on caregivers, reported that increasing burden leads to more use of denial or start blaming others for present problems[7]. It interpreted that caregivers start blaming others for existing problem as the level of burden increased while caring for the patient. However, use of emotional focused coping also showed as statistically significant association with burden. Coping is understood as the process of managing external or internal demands that are considered as taxing or exceeding the resources of the person. These are understood as adaptive versus maladaptive and problem focuses versus emotion-focused. Findings suggest that caregivers of patients with stroke uses mixed type of coping mechanisms to deal with the stress of care giving.

CONCLUSION

Stroke is a major non-communicable disease. It is the most common cause of mortality and a significant cause of adult disability. Stroke may also compromise cognitive, mood, functional abilities and quality-of-life. It also results in caregiver burden and economic stress at individual, familial and national level. Stroke creates a burden on the whole family due to joint family system in India, where parents, spouse and children and other in laws live together under one roof. Caregivers face many obstacles as they balance care giving with other demands, including child rearing, career, and relationships. They are at increased risk for burden, stress, depression, and a variety of other health complications. The effects on caregivers are diverse and complex, and there are many other factors that may exacerbate or ameliorate how caregivers react and feel as a result of their role.

This study discovered that there is a possibility to have higher burden on caregiver in the future. When individual face a different level of burden, they must use a variety of strategies to cope with negative experience and stress. This study suggests the health professional to focus on the care giving situation to provide a better support to them and suggested that it will be advisable to provide equivalent services for caregivers and their families as provided to the stroke survivors. Caregivers must be adopted varied types of coping strategies to overcome burden and maintain a balance between different spheres of life. Health care worker should be aware about the hidden stress and burden being faced by

caregivers of stroke survivors and must act as counsellors to the caregivers by helping them ventilate their feelings, provide emotional support to them and help them in adopting positive coping strategies. They must also refer the caregivers to appropriate support services if they feel that expert help is needed. Strategic home based rehabilitation programs needed to assist caregivers to cope successfully with burden resulting from the care of the stroke patients. Since the incidence of stroke is increasing day by day and care giving task become more stressful now a days, more research studies should be encouraged to address this problem. Experimental studies should be promoted to develop new strategies to deal with burden among caregivers and their families.

Source of Support: Nil

Conflict of Interest: None declared

Ethical Clearance: Ethical clearance was obtained from appropriately constituted ethics committee in MOSC Medical College Hospital, Kolenchery, Ernakulam. A letter explaining the purpose of the study was handed out to subjects. Consent forms were signed before participating in the study.

REFERENCES

1. User S. World Stroke Organization - World Stroke Campaign [Internet]. World-stroke.org. 2015 [cited 28 December 2015]. Available from: http://www.world-stroke.org/advocacy/world-stroke-campaign
2. R Thara e. Burden assessment schedule [Internet]. www.scarfindia.org/wp-content/uploads/BAS0001c.pdf. 1998 [cited 19 March 2016]. Available from: http://www.scarfindia.org/wp-content/uploads/BAS0001c.pdf
3. Rao K, Subbakrishna DK, Prabhu GG. Development of a coping checklist—a preminary report. Indian Journal of psychiatry. 1989 Apr;31(2):128.
4. Begum S. Level of caregiver burden: a study on caregivers of stroke survivors at CRP in Bangladesh (Doctoral dissertation, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI)), 2014.
5. Kumar R, Kaur S e. Burden and coping strategies in caregivers of stroke survivors [internet]. imedpub.com. 2015 [cited 6 January 2016]. available from: http://www.imedpub.com
6. Carod-Artal FJ. Determining quality of life in stroke survivors. Expert review of pharmacoeconomic & outcomes research. 2012 Apr 1; 12(2):199-211.
7. Beische D, Hautzinger M, Becker C, Pfeiffer K. Problem-solving counselling for caregivers of stroke survivors-an analysis of the addressed topics. Psychotherapie, Psychosomatik, medizinische Psychologie. 2011 Dec;62(9-10):3
8. Folkman S, Lazarus RS. The relationship between coping and emotion: Implications for theory and research. Social science & medicine. 1988 Jan 1;26(3):309-17. 75-82.

DOI Number: 10.5958/2395-180X.2019.00018.5

The Art of Aromatherapy in Nursing Practice

Mary Sebastian

Professor, KIMS College of Nursing ,Secunderabad, Telangana

ABSTRACT

Aromatherapy is the fastest growing of all complementary therapies among nurses in the United States and the UK. Aromatherapy has been used by the public for recreation for thousands of years and by the nurses throughout the world during the last 15years.This article explores the potential role of aromatherapy in nursing, and suggests practical ways that nurses can begin using this gentle therapy.

***Keywords**: Aromatherapy, essential oils*
***Common Names:** Aromatherapy, Holistic Aromatherapy, Aromatic Medicine*
***Scientific/Medical Name(s):** None*

INTRODUCTION

'Aromatherapy' is a compound word. The two parts are: Aroma~ meaning fragrance or smell and Therapy~ meaning treatment, therefore aromatherapy is the process of caring for the body using smell. Aromatherapy is the controlled, therapeutic use of essential oils. Essential oils are the volatile, organic constituents of fragrant plant matter that are extracted by steam distillation or expression. When essential oils are used to target specific conditions and the outcomes are measured, aromatherapy becomes clinical. Aromatherapy is now one of the largest growing alternatives to chemical medicine. It is widely used in homes, hospitals and clinics such as pain relief.[1]

Historical Background: Although the renaissance of Aromatherapy occurred only about fifty years ago in France, the use of aromatic, perfumed oils dates back thousands of years to ancient Egypt, China and India. In Egypt, such oils were used after bathing and for embalming mummies. Thousands of years ago the Chinese compiled an encyclopedia of information on plants, herbs, and the wood. In ancient India, Aromatic massage was part of Ayurvedic medicine. The Greeks and Romans used fragrant oils both for medicinal and cosmetic purposes. Until the dawn of the pharmaceutical era, plants were the only medicines available. However, it was the medicinal physician Avicenna who first extracted these oils from plants.[2]

Rene Maurice Gattefosse, a French chemist, originated modern aromatherapy, and even the term itself. After burning his hand in a laboratory accident, he used lavender oil to soothe the pain. His hand healed quickly with no scar, and he attributed this outcome to the lavender oil. Herbal medicine is still responsible for 80% of the world's health care.[1]

Type, Indication and Method of Use of Essential Oils:

Type	Indication	Method of use
Eucalyptus, Peppermint	Depression, insomnia, sinusitis and upper respiratory tract infection.	Inhale directly from tissue or float two drops on a steaming bowl of water.
Frankincense, lavender, Melaleuca, Melissa and sandalwood diluted with carrier oils such as Cassia, Cinnamon, Clove, Oregano and Thyme	Contusions, skin complaints, muscle strain, and scar tissue	Compress, bathe and massage using the 'm' technique (structured stroking sequences in a set pattern at a set pressure.
Essential oils high in alcohol such as Tree, Rosemary and Thyme	Yeast infections or cystitis	Dilute in carrier oil or tampon

Inhaled aromas have the fastest effect, about 5 minutes although compounds absorbed through massage can be detected in the blood with 20 minutes. It seems that the effects of inhaled aromas do not last long as the effects of topically applied aromas do not last as long as the effects of topically applied aromas. It is difficult, however, to analyze exactly what impact touch has had. Essential oils always must be diluted before use on the skin.[3]

FINDINGS

Aromatherapy in nursing care: For the past 20 years, clinical aromatherapy has been used by nurses as an enhancement of nursing care in many parts of the Western World. Aromatherapy is a complementary therapy and is accepted as one of the tools of holistic nursing. In the United Kingdom aromatherapy is accepted (and expected) as part of nursing care. The Royal College of Nursing, the largest nursing union in the world, insures nurses to the use aromatherapy to enhance nursing care.

Aromatherapy is a useful tool for other nursing interventions. Often, clinical aromatherapy uses a nursing diagnosis such as alteration of pain perception. In this instance, a nurse chooses an essential oil with an analgesics action such as Mentha piperita (peppermint) or Cymbopogan citrates(West Indian lemongrass). Outcomes can be simply measured by using a Visual Analog Scale(0-10) or a Likert Scale. Similarly depression, anxiety and stress all can be measured. By quantifying outcomes, it is possible to carry out statistical analysis, thereby translating the therapeutic effects of aromatherapy into the language of science and modern Western medicine.

Aromatherapy used as a part of nursing care requires clinical training to add a few drops of synthetic aromatic mix to a bath of a healthy adult purely for pleasure is clearly not the same as using two drops of pure and powerful essential oils to reduce the nausea of radiation for a cancer survivor.

Medical conditions: Although case studies show the use of essential oils in treating neurological, oncological, respiratory, dermatological, digestive and critical care conditions there is no evidence based practice to support these.

Peppermint oil and eucalyptus oil have been shown to have muscle relaxing and analgesic effects for relief of headaches. [4] Both oils have the ability to improve cognitive functioning. Although essential oils have contradicting response in seizure control it is found to assist in coping with the social and emotional aspects of such a condition.[5]

Essential oils particularly eucalyptus oil have been shown to have broncholytic, antispasmodic and secretolytic properties.[6] However there is some controversy about their actual effectiveness as bronchodilators, decongestants and antitussives. There is also concern at the number of accidental poisonings associated with eucalyptus oil.[7]

Data suggests that peppermint may be useful as a digestive antispasmodic and in reducing colonic spasm during colonoscopy. As these involve internal applications, they are beyond the scope of nursing and aromatherapy practice.[8]

A randomized clinical trial of patients with bald patches on their scalp or skin showed aromatherapy to be safe and effective for hair loss resulting from alopecia areata, a condition in which damage to the hair follicles is caused by the patient's own immune system. However it is not evaluated as a treatment option.[1] In two well designed trials, several different essential oils have been found to have effect on head lice, especially when used in conjunction with a vinegar rinse. [9]

The use of essential oils in the management of eczema and psoriasis has been explored by various authors, but the case studies and small trials involved all used different essential oils applied with massage had inconclusive results.[10,11]

Various essential oils have been explored as possible alternatives in treating some side effects associated with cancer, it cannot be used as an alternative to conventional therapy. It can also help cancer patients cope with anxiety and fear associated with high doses of steroids and poor outcomes.[12] In Britain, there are reports of successful use of aromatherapy massage as a complementary treatment for people with cancer to reduce anxiety, depression, tension and pain. There are also reports that inhaled peppermint, ginger & cardamom oils seem to relieve the nausea caused by chemotherapy. [1]

Clinical aromatherapy uses pure essential oils that frequently are applied topically as in the case of a burn, contusion or pressure area sore.

During a study on the effects of aromatherapy in a critical care unit in the United Kingdom, patients were asked to comment on the treatment they had received. One of the comments was "you were the first person who did not hurt me."[1]

Maternal and child health: Aromatherapy may help with some minor symptoms in pregnancy such as morning sickness, stretch marks, varicose veins, heartburn, haemorrhoids, backache and exhaustion. No empirical evidence suggests this. Whether massage as an intervention also contributes to the reduction of the symptoms and eases labour pain is debatable.[13]

Many studies, however, recently have been published on relaxation, pain, ease of labour, sleep pattern, and infection, and many more are in the process of peer review.[1]

Aromatherapy in mental health: Several human trials in mental health settings have indicated that there are positive emotional effects of using aromatherapy and, given that at least 60% of visits to doctors are stress related, there is great potential in this area; several mental health services already incorporate aromatherapy into patient care.[14]

Inhaled essential oils may increase alertness and reduce anxiety as well as having positive effects on physical parameters of the autonomic nervous system, enhancing relaxation.[15]

Studies have suggested that inhaling chamomile oil has a positive effect on mood when compared with a placebo. Inhaling lavender or Melissa essential oils has also been found to reduce some symptoms associated with dementia, especially restlessness. Several dementia care units have reported regular use of various aromatherapy measures.

Studies have shown that the depression of an elderly person was reduced with the aromas of fruit and flowers.[7]

In another clinical trial, inhaling the vapours from black pepper extract reduced the craving for tobacco and improved participant's mood.[16]

DISCUSSION

Although essential oils have been in the public domain for thousands of years and were used by nurses as part of nursing care before the advent synthetic drugs, research into the therapeutic effects of essential oils on human studies is in its infancy.

Toxicological studies published in the Food and Toxicology Journals between the period of 1973 to 1978 indicate that most essential oils also have thousands of years of anecdotal evidence of therapeutic use. It is strange that synthetic aromas that have no history of long-term use and few studies are used often instead of real essential oils.[7]

The popularity of aromatherapy needs to be balanced against the potential risks related to allergies, safety and inappropriate use by inexperienced users. Many studies have been hampered by small sample sizes, imprecise measuring tools, difficulties in blinding participants and researchers to treatments, incorrect or absent statistical analysis, and varied doses or methods of application of the essential oil. However, these studies do provide valuable information for future researchers.

There is clear indication that the scientific community is taking serious interest in the potential healing properties of essential oils, and this will further add to the information-base from which nurses can draw. Whether the findings of the studies conducted by scientific community will be incorporated into holistic aromatherapy, or into pharmacotherapy, is only conjecture at this stage.

CONCLUSIONS

There is great potential for more collaborative research by nurses to explore the clinical applications in greater detail and to move beyond the low dose paradigm of application of essential oils. While there is inconclusive evidence about whether the addition of essential oils at 25% or lower improves the physiological effects of massage, aromatherapy has been shown to, aromatherapy has shown to be helpful in mental health in improving anxiety, agitation and stress-related symptoms particularly in dementia. Cineole-rich essential oils, such as eucalyptus, have the potential to assist with a number of minor respiratory conditions through their expectorant and anti-tussive properties. There is also some evidence that the internal use of essential oils has great potential within certain clinical areas; however, this requires considerably more research before if can be incorporated into nursing practice.

Nurses should at least have a basic understanding of the few common essential oils, if they plan to use it in nursing practice. They can consider undergoing formal education as aromatherapists as per the professional and legislative requirements of the registering body in their state or country.

Conflict of Interest: Nil

Source of Funding: Self

Ethical Clearance: NA

REFERENCES

1. Buckle .J. The Role of Aromatherapy in Nursing Care. The Nursing Clinics of North America. 2001; 36(1): 57-72
2. Esposito E.R, Bystrek M.V, Klein J.S. An elective course in aromatherapy science. Am J Pharm Educ. 2014; 78(4): 79
3. Buckle .J. Literature review: should nursing take aromatherapy more seriously? Br J Nur. 2007; 16:116-120
4. Gobel H., Schmidt G. & Soyka D. Effect of peppermint and eucalyptus oil preparations on neurophysiological and experimental algesimetric headache parameters. Cephalgia 1994; 14(3): 228–234.
5. Asjes E. Managing epilepsy. The International Journal of Aromatherapy. 1993; 5(3):16–19.
6. Schafer D. & Schafer W. Pharmacological studies with an ointment containing menthol, camphene and essential oils for broncholytic and secretolytic effects [abstract].Arznei-mittelforschung.1981; 31(1): 82–86.
7. Tibballs J. & James A. Eucalyptus oil: medicinal therapy or folk remedy? Australian Journal of Hospital Pharmacy. 1995; 25(6): 516–519.
8. Asao T., Mochiki E., Suzuki H., Nakamura J., Hirayama I., Mori-naga N., Shoji H., Shitara T. & Kuwano H. An easymethod for the intraluminal administration of peppermint oil be-fore colonoscopy and its effectiveness in reducing colonic spasm. Gastrointestinal Endoscopy. 2001; 53 (2): 172–177.
9. Veal L. The potential effectiveness of essential oils as a treatment for head lice, Pediculus humanus capitis. Complementary Therapies in Nursing and Midwifery.1996 ; 2: 97–101.
10. Walsh D. Using aromatherapy in the management of psoriasis. Nursing Standard 11 (13/14) ;1996 :53–56.
11. Weaver J. Chronic psoriasis. The International Journal of Aromatherapy .1991; 3(1) :20–21.
12. Lampic C., Wennberg A., Schill J-E., Brodin O., Glimelius B. & Sjoden P-O. Anxiety and cancer related worry of cancer patients at routine follow-up visits. Acta Oncologica . 1994; 33(2): 119–125.
13. Labrecque M., Nouwen A., Bergeron M. & Rancourt J.F. A randomized controlled trial of nonpharmacologic approaches for relief of pain during labour. Journal of Family Practice. 1999;48(4): 259–263.
14. Henry J. Dementia aroma groups improve the quality of life in Alzheimer's disease. International Journal of Aromatherapy.1993; 5(1):27–29.
15. Morris N., Birtwistle S. & Toms M. Anxiety reduction. The International Journal of Aromatherapy. 1995;7(2): 33–37.
16. Roberts A. & Williams J.M. The effect of olfactory stimulation on fluency, vividness of imagery and associated mood: a preliminary study.British Journal of Medical Psychology.1992; 65(pt 2):197–199.

Call for Papers/Article Submission

Article Submission Fee

- Please note that we charge manuscript handling charges for all publications. Charges can be enquired by sending mail.
- In case of urgent publication required by author, he/she should write to editor for discretion.
- Fast tracking charges are applicable in urgent publication.
- Please not that we charge only after article has been accepted for publication, not at the time of submission.
- Authors have right to with withdraw article if they do not wish to pay the charges.

Article Submission Guidelines:

Please submit paper in following format as far as possible–

- Title.
- Names of authors.
- Your Affiliation (Designations with college address).
- Corresponding Author: Name, Designations, Address, E-mail ID.
- Abstract with Keywords
- Introduction or background
- Material and Method
- Findings
- Discussion/Conclusion
- Conflict of Interest
- Source of Funding
- Ethical Clearance
- References in Vancouver style.
- Please quote references in text by superscripting
- Word limit 2500-3000 words, MSWORD Format, single file.

All articles should be sent to: **editor.ijpn@gmail.com**

Our Contact Info:

Institute of Medico-Legal Publications

Logix Office Tower, Unit No. 1704, Logix City Centre Mall, Sector-32, Noida-201 301 (Uttar Pradesh)
Mob.: 09971888542, E-mail: editor.ijpn@gmail.com
Website: www.ijpn.co

International Journal of Psychiatric Nursing

CALL FOR SUBSCRIPTIONS

About the Journal

Print-ISSN: 2394-9465 **Electronic-ISSN:** 2395-180X

International Journal of Psyxhiatric Nursing is a double blind peer reviewed international Journal which has commencedits publication from January 2015. The frequency is half yearly in frequency. The Journal covers all aspects of Psychiatric Nursing.

Subscription Information

Journal Title	Print Only
International Journal of Psychiatric Nursing	**₹ 6,000/=**

Note for Subscribers

- Advance payment required by cheque/demand draft/bank Transfer in the name of "Institute of Medico-Legal Publications" payable at New Delhi.
- Cancellation not allowed except for duplicate payment.
- Claim must be made within six months from issue date.
- A free copy can be forwarded on request.

Bank Details

Name of Account: Institute of Medico-Legal Publications Pvt Ltd

Bank: HDFC Bank

Branch: Sector-50, Noida-201 301

Account Number: 09307630000146

Type of Account: Current Account

MICR Code: 110240113

RTGS/NEFT code: HDFC0000728

Our Contact Info:
Institute of Medico-Legal Publications
Logix Office Tower, Unit No. 1704, Logix City Centre Mall, Sector- 32, Noida-201 301 (Uttar Pradesh)
Phone: +91 120 429 4015; Mobile: +91 997 188 8542
Email: editor.ijpn@gmail.com | Website: www.www.ijpn.co

Published, Printed and Owned: Dr. R. K. Sharma
Printed: Printpack Electrostat, G-2, Eros Apartment, 56-Nehru Place, New Delhi-110019
Published at: Institute of Medico-Legal Publications, Logix Office Tower, Unit No. 1704, Logix City Centre Mall Sector-32, Noida-201 301 (Uttar Pradesh)
Editor: Dr. R. K. Sharma, Mobile: +91 997 188 8542