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Effectiveness of Structured Teaching Programme Regarding the Knowledge of Life Skills Training Program among Inmates of a Selected Rehabilitation Center of Hyderabad

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ABSTRACT

Introduction: Skills are the learned capacity which helps us to do a task effectively. Skills are abilities to use know-how to complete tasks.

Aim: `To assess the knowledge of life skills training program among inmates of a selected rehabilitation center.

Methodolody: Quantitative approach was adopted for the study. The research design was pre experimental one group pre test post test design. Thirty inmates were selected from a Rehabilitation Center in Hyderabad, Telangana through convenient sampling. A structured questionnaire was administered to collect the data from the subjects.The reliability was computed by split half method and found to be 1 which indicated perfect reliability.

Results: It was found during pre test that 36.6% inmates had poor knowledge and 63.3% inmates had average knowledge in pretest. However,after life skills training (post-test) there was significant improvement in the knowledge as 80% of inmates had good knowledge and only 20% of inmates had average knowledge which indicated that structured teaching improved the level of knowledge.

Conclusion: Life skills training can promote interactive, decision-making, problem - solving, critical thinking and stress management skills and lead to more social acceptability, which in turn reduce the risk for mental illness. It is recommended to plan and perform constant life skills training workshops as effective tools for development of psychosocial skills.

Keywords: *Life Skill Training; Inmates; Rehabilitation Center.*

INTRODUCTION

Skills are the learned capacity which helps us to do a task effectively. Skills are abilities to use know how to complete tasks. They are acquired through practice and patience. A skilled person uses less time, energy and resources to do a job and produces quality results. Skills are gained through school/college, work experiences, hobbies, books, elders, peers etc. They can be improved if we could identify, analyze and practice them.(1)

World Health Organization estimates indicate a prevalence level of about 22% of the individuals developing one or more mental or behavioral disorders in their lifetime in India. Mental disorders afflict 5 crores of the Indian population and need special care.(2)

Initiatives to develop and implement life skills education in schools have been undertaken in many countries around the world. The need for life skills education is highlighted, directly and indirectly in the Convention of the Rights of the Child and a number of international recommendations. Life skills education is aimed at facilitating the development of psychosocial skills that are required to deal with the demands and

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challenges of everyday life. It includes the application of life skills in the context of specific risk situations and in situations where children and adolescents and adults need to be empowered to promote and protect their rights.[3]

"Life Skills are abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life (WHO) Adaptive means that a person should have the flexibility to adjust according to the situation. For positive behavior, a person needs to have positive thinking and look at opportunities even in difficult situations, in order to cope with the situation". [4]

UNICEF defines Life Skills as "a positive behavior or behavior development approach designed to address a balance of three areas: knowledge, attitude and skills". Life Skills, are essentially those abilities that help to promote physical, mental and emotional well-being and competence to face the realities of life.[5] Some of the important life skills identified through Delphi Method by WHO are: [6]

- Decision making
- Problem solving
- Creative thinking/lateral thinking
- Critical thinking/perspicacity
- Effective communication
- Interpersonal relationships
- Self-awareness/mindfulness
- Assertiveness
- Empathy
- Equanimity
- Coping with stress, trauma and loss
- Resilience

Life skills training is helpful to improve thinking process. It is based on three areas of change. First area is knowledge. Other two area are attitude and skills. A life skill enables to transform knowledge, skill, attitudes and morals into actual abilities that is what to do and how to do the work, given the scope and opportunity to do so. Present study used power-point presentation to improve the skills of the inmates. We have many online life skills training programmes available by which courses are provided with evidenced based practice and testimonies.[7]

METHODOLOGY

Quantitative approach was adopted for the study. The research design was pre experimental one group pre test post test design. 30 inmates were selected from a Rehabilitation Center in Hyderabad, Telangana through convenient sampling. A structured questionnaire was administered to collect the data from the subjects. The reliability was computed by split half method and found to be 1 which indicated perfect reliability. Data was then analyzed using descriptive and inferential statistics.

Table 1: Findings related to sample characteristics n = 30

S. No.	Demographic Variables	Frequency	Percentage
1.	**Age**		
	Young Adults (18-29yrs)	12	40 %
	Middle Age (30-49yrs)	16	53.3 %
	Senior Citizens(50-65+Yrs)	02	6.6 %
2.	**Gender**		
	Male	13	43.3 %
	Female	17	56.6 %
3.	**Duration of Hospital Stay**		
	1month-3yrs	14	46.6 %
	4-6yrs	09	30 %
	7-9yrs	05	16.6 %
	More Than 10yrs	02	6.6 %

Conted…

4.	**No. of Hospitalization**		
	Once	13	43.3 %
	2-5 Times	08	26.6 %
	6-9 Times	09	30 %
	More Than 10 Times	01	3.3 %
5.	**Diagnosis**		
	Schizophrenia	15	50 %
	BPAD	10	33.3 %
	Psychosis	02	6.6 %
	Personality Disorder	03	10 %

The above table majority of the samples were of middle aged that is 16(53.3%), males 13(43.3%) and females were 17(56.6%) participated in the study. Most of them were hospitalized for the duration of 1 month-3yrs 14(46.6%) and only 13(43.3%) were once admitted for the mental illness in the rehab center with majority of them were diagnosed with Schizophrenia 15(50%).

Table 2: Mean, mean difference, standard deviation effectiveness of structured teaching program (n = 30)

S. No.	Tests	Mean	Mean Difference	S D
1.	Pre test	5.83	6.34	2.00
2.	Post test	12.17		1.60

The above table shows that pretest and the post test scores revealed that the mean of pretest is 5.83 with SD 2.00 and Post test score revealed mean of 12.17 with SD 1.60.

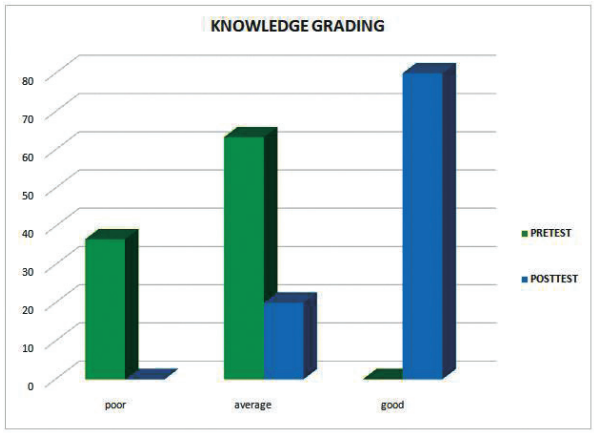

Figure 1: Grading of knowledge scores

The above figure demonstrates that the pre test knowledge scores was average knowledge 63.3% and poor knowledge 36.6% whereas post test scores showed increase in the level of knowledge with majority of the subjects having good knowledge 24(80%) and average knowledge was 20%.

Table 3: Effectiveness of Structured Teaching Programme on the knowledge of life skills training program (n = 30)

Pre test Mean	Post test Mean	Paired 't' Test	Df	Table t value	P value
5.83	12.17	31.28	29	2.05	0.05

$p < 0.05$

The above table shows mean s pretest scores were 5.83 and mean posttest scores were 12.17, Paired 't' Test value is 31.28 and table value is 2.05 at 0.05 at df is 29.

Table 4: Findings related to Association between post test and selected demographic variables. N = 30

S. No.	Demographic Variable	Chi Square	Degree of Freedom	Table Value	Test of Significance
1.	Age	1.42	4	9.49	Not Significant
2.	Gender	0.12	2	5.99	Not Significant
3.	Diagnosis	1.66	6	12.59	Not Significant

$P < 0.05$

The above table: 4 shows that there is no significant association between post test and selected demographic variables like Age, Gender and Diagnosis.

DISCUSSION

Today, despite the deep cultural changes and the changes in the way of life, many people do not have the basic and required skills in dealing with life' problems, and that's why, they have been vulnerable in the face of their problems and requirements of life. Meanwhile, some programs have been designed for preventing and avoiding these problems, which one of the most effective kind of them is the life skills education program that has been designed by World Health Organization (WHO).

Dr.Javad Khalatbari conducted a study on Psychological Explanation and Importance of life skills training programmes, applications and challenges facing to it revealed that to determine the importance of implementation and training of these skills through psychological orientation, and paid a brief overview on the applications and the challenges facing it in today's world. Life skills are simply a set of capabilities that provide field of adjustment and positive and helpful behavior. Numerous and extensive research have shown the positive effect of life skills in reducing drug abuse, preventing violent behaviors, strengthening self-reliance, increasing skills to deal with pressures and stresses, establishing positive and effective social relationships. [8] The findings of the present study revealed that in pre test 36.6% subjects had poor knowledge and 63.3% subjects had average knowledge in pretest. After life skills training (post-test) there was significant improvement in the knowledge with 80% good knowledge and 20% average knowledge.

Tungpunkom et al., 2012 conducted a study on effectiveness of life skills on chronic mental illnesses with a total of 483 participants. All participants were people with a chronic mental illness, mostly with schizophrenia and schizophrenia-like disorders. The life skills for the chronic mentally ill patients was effective and showed good results in both the genders.[10]The present study is congruent with the study findings of Tungpunkom et al where the investigators would found significant improvement in the knowledge scores.The findings of the present study revealed that in pre test 36.6% subjects had poor knowledge and 63.3% subjects had average knowledge in pretest. After life skills training (post-test) there was significant improvement in the knowledge with 80% good knowledge and 20% average knowledge.

CONCLUSION

Studies have shown that if we provide individuals in the rehabilitation center with the necessary knowledge and information and create situations in which they can practically experience the knowledge they have acquired, this knowledge as well as the value and attitude will be turned into actualized abilities. Life skills training can promote interactive, decision-making, problem - solving, critical thinking and stress management skills and lead to more social acceptability, which in turn reduce the risk for mental illness. It is recommended to plan and perform constant LST workshops as effective tools for inmates in rehabilitation center.

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

Source of Funding: No funding was required

Conflict of Interest: Nil

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Awareness and Practices on Toy Safety among Mothers of Preschool Children

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ABSTRACT

Poor parental knowledge and attitudes often contribute to inappropriate management and practices of child care. This baseline study aimed to assess the awareness and practice of parents of preschool children regarding toy safety in a selected children's hospital at Kanyakumari District, Tamil Nadu. Using a descriptive research design, 60 mothers of preschool children were selected by convenience sampling technique. Structured questionnaire was distributed to assess the awareness and practice on toy safety. The finding showed that 93% of mothers had inadequate awareness and 48% had moderately adequate practice on toy safety. There was a statistically significant association between level of awareness with maternal age (p=0.0004), maternal occupation (p=0.0001), fathers occupation (p=0.0014) and monthly income (p=0.0305). The study suggests that parents need to be taught on toy safety guidelines and practices so that toy related injuries could be avoided among children.

Keywords: *awareness, practice, toy safety, preschooler, mothers.*

INTRODUCTION

Play is the key centre of a healthy child's life. Play provides the opportunities to be free, creative and expressive. Toys are meant to provide enjoyment and education for children of all ages, however they can also provide a great deal of danger. Toy safety is the practice of ensuring that toys, especially those made for children, are safe, usually through the application of set safety standards[1]**.** Parents are constantly looking for ways that they can keep their children safe when they are playing. One of the best things that they can do to make sure that their children are safe is by making sure that the toys that they purchase for their children are safe options for them to enjoy. In order to choose the best toys, parents must take into consideration the age that their children currently are and buy accordingly. Parents also should have better awareness and attitude for better practice of toy safety in order to prevent toys related accidents[2].

BACKGROUND

Purchasing safe toys is something that all parents should focus on when they are buying a toy for their child. That is the best way to make sure that their child will enjoy the toy and will be able to safely play with it. A survey done in US (1999 -2010) on toy related injuries showed that 3, 278, 073 children <18 years old were treated in emergency departments for toy-related injuries. The number and rate of injuries peaked at age 2 years; 63.4% were male children and 80.3% of toy related injuries were occurred at home. Riding toys including non motorized scooters and small toy balls were associated with most of the death. Most of these deaths were associated with airway obstruction from small toys, drowning and motor vehicle accidents during play. Most of the injuries were lacerations, contusion and abrasions, the head and faces were the frequently affected areas[3]. To prevent such incidents the patents should have adequate awareness on toy safety practices. Comparing to western literature very less information was found and wide gap was identified in Indian setting, hence the present study was conducted.

METHODOLOGY

Using a descriptive research design, present was conducted among 60 mothers of preschool children in a selected children's hospital at Kanya kumari District,

by convenience sampling technique. Data was obtained after getting approval from institutional research committee, hospital authority and consent from the mothers. To meet the study objectives the material used were structured questionnaire on awareness, structured practice questionnaire on toy safety. Descriptive (frequency and percentage) and inferential statistics (Chi square test) was used to analysis the collected data.

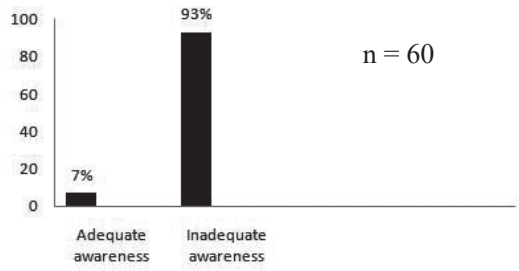

Figure 1: Awareness on toy safety among mothers of Preschool children

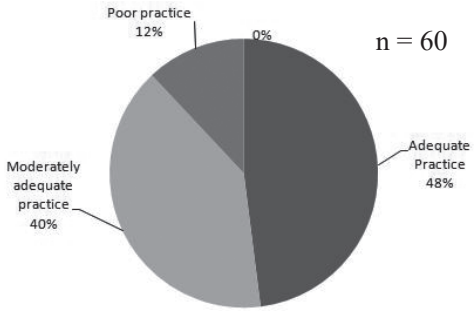

Figure 2: Practice on toy safety among mothers of Preschool children

RESULTS

Regarding the demographic parameters, nearly half (47%) of the mothers were aged more than 30 years, more than half of them (51.4%) were from nuclear type of family, nearly three fourth of them (70%) were residing in rural area, less than half (42%) of the mother's had attended secondary school as their educational qualification, majority of the mother's were housewives and most of them had mentioned as their monthly family income as less than Rs.7500/-

Table 1: Association between awareness and selected socio-demographic variables, n = 60

Sl. No.	Demographic variables	Chi-square value	Degree of freedom	P value
1.	Mother's age	18.3	3	0.0004***
2	Gender of the child	0.019	1	0.8904
3	Religion	1.08	2	0.5827
4	Type of family	0.48	1	0.4884
5	Number of children	2.04	2	0.36.6
6	Area of living	0.05	1	0.8231
7	Mother's education	1.03	4	0.9052
8	Mother's occupation	26.32	3	0.0001***
9	Father's age	1.35	3	0.7173
10	Father's education	6.16	4	0.1875
11	Father's occupation	15.58	3	0.0014**
12	Monthly income	8.91	3	0.0305*
13	Perception of role of play in child's growth	0.73	1	0.3929

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

DISCUSSION

In the present study it was identified that a large majority (93%) of the mother's had inadequate awareness and nearly half (48%) of them had moderately adequate toy safety practices. There was a statistically significant association between level of awareness with maternal age (p=0.0004), maternal occupation (p=0.0001), fathers occupation (p=0.0014) and monthly income (p=0.0305). This finding is consistent with the study findings of Inbaraj et al that they identified that mothers had a poor perception of household injury and age, education, and literacy ($p< 0.05$) were found to be significant predictors of perception of risk and hazard of injuries. They also suggested that education and awareness programme will improve mother's awareness[4]. Bharadwaj R, Sorte DY,

George U also found that pretest knowledge score and practice scores (14.37, 28.00) was less than mean posttest knowledge score and practice scores (20.74, 32.46) among mothers of under five children on management of minor ailments which was statistically significant (at $p<0.05$)[5].

CONCLUSION

The study has found that the mothers of preschool children had inadequate awareness and moderately adequate toy safety practices. These findings emphasize the importance of educating mothers on importance of toy safety which helps to enhance the toy safety practices so that toy related injuries could be prevented among children. To protect the child from any injury or hazard from toys, parents must follow toy safety guidelines. Parents should avoid buying non-branded toys, plastic toys, toys on internet, and brightly colored toys as they contain higher content of lead. Also, parents should carefully read the instructions given on the toys or its manual; preferably buy toys made up of cloths or wooden.

Ethical Clearance: Taken from "The Salvation Army Catherine Booth College of Nursing Ethical Research Committee"

Source of Funding: Self

Conflict of Interest: Nil

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Maternal Awareness and Perception on Phototherapy for Neonates with Hyperbilirubinemia

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ABSTRACT

Phototherapy is the safest treatment modality for neonatal jaundice and it consists of the application of fluorescent light to the infants exposed skin. The present study was aimed to assess maternal awareness and perceptions regarding phototherapy among 110 mothers of neonates received phototherapy from OBG wards. Data were obtained by self report method from the mothers on perception and awareness. The results showed that more than half of the mothers (61.8%) had average perception and 53.6% of mothers had moderately adequate awareness regarding phototherapy**.** There was a significant association between maternal perception on phototherapy and type of family (p = 0.020), information received regarding phototherapy (p = 0.015). There was a significant association between awareness of mother and information received regarding phototherapy (p = 0.001). There was a significant weak positive correlation (r = 0.373, p = 0.000) between maternal perception and awareness regarding phototherapy. The study emphasizes the importance of educating the mothers on neonatal jaundice, phototherapy to enhance their awareness and perception.

Keywords: *maternal perception; awareness; phototherapy; neonate*

INTRODUCTION

Infants between birth and first 28 days of life are called newborns or neonates. Globally 130 million babies are born every year. Every year about 27 million babies (20% of global births) are born in India. Neonatal jaundice is a common condition that pediatricians encounter in their practice. It is also a significant cause of neonatal morbidity world-wide and is estimated to be present in 60% of term neonates and 80% of preterm babies. Interventions to prevent progression of neonatal jaundice significantly reduce the morbidity and mortality rate of neonate and one among the management is phototherapy[1]

BACKGROUND

Normally neonate's body is able to maintain a balance between the destruction of RBCs and the use or excretion of by- products. However, when developmental limitations or a pathologic process interferes with this balance, bilirubin accumulates in the tissues to produce jaundice. If the bilirubin level is greatly elevated, symptoms may include yellowing of the skin and the sclera, poor feeding and lethargy[2] Managing neonatal jaundice is by pharmacological (Phenobarbitone, Intravenous Immunoglobulins, Metalloporphyrins) and non pharmacological (phototherapy and exchange transfusion) way. Phototherapy consists of the application of fluorescent light to the neonates exposed skin. Light promotes bilirubin excretion by photoisomerization, which alters the structure of bilirubin to a soluble form (Lumirubin) for easier excretion. Studies indicate that blue fluorescent light is more effective in reducing bilirubin.[3]

A cross-sectional study was conducted to identify level of knowledge, belief and attitude on neonatal jaundice among 150 Malay pregnant mothers who live in Seberang Perai Utara state and identified that, about 50% of the respondent had inadequate general awareness on neonatal jaundice, especially the knowledge on complications and identifying the best method of jaundice detection[4] Since it is the mother who is wholly and solely responsible for caring the neonate it is necessary for her to have adequate awareness on the treatment or procedure the baby undergoes / receives. In the first week of life, 50% of neonates have clinically detectable jaundice and mothers are the primary care givers who

will present with the neonate all the time. Hence, it is essential for the mothers to have adequate awareness regarding neonatal jaundice and phototherapy, for which their hyperbilrubinated neonates were diagnosed.

METHODOLOGY

Quantitative approach with descriptive design was adopted to achieve the objectives of the present study. Data were collected from 110 mothers of their neonates received phototherapy for hyperbilirubinemia in a tertiary care hospital at Kerala through consecutive sampling technique. Information on awareness and perception towards phototherapy was collected through structured knowledge questionnaire and 3 point likert scale respectively. Content validity was established by submitting the tool to subject expert and test- retest method was used to assess reliability and the tool was found to be reliable (r = 0.80). After getting institutional ethical clearance, permission to conduct the study was obtained from the hospital authority and informed consent was obtained from the mothers. Collected data were entered into SPSS-20, analysis was done by using descriptive and inferential statistics.

RESULTS

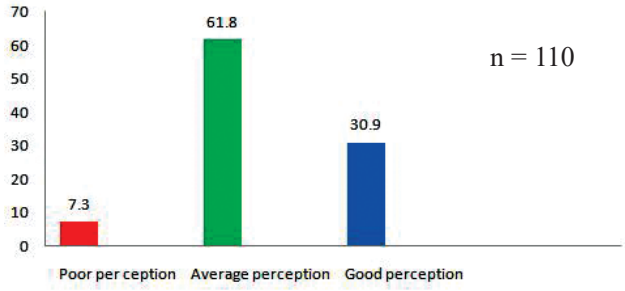

Figure 1: Maternal perception regarding phototherapy

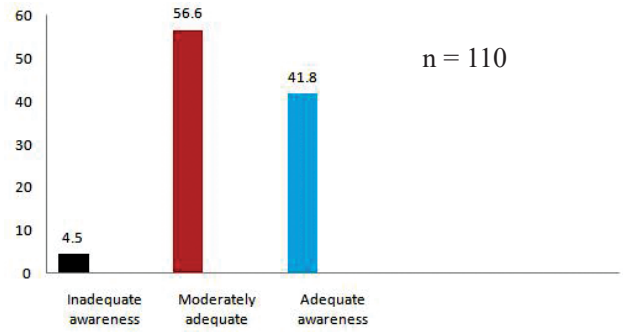

Figure 2: Maternal awareness regarding phototherapy

Table 1: Association between awareness of mothers and selected socio–personal variables n = 110

Socio personal variables of the mother		df	Chi square	p value
1.	Age (in yrs)	2	3.200	0.202
2.	Educational status	1	0.048	0.827
3.	Occupation	1	2.024	0.155
4.	Religion	2	0.851	0.653
5.	Type of family	2	0.358	0.836
6.	Place of living	1	0.054	0.816
7.	Parity	1	1.255	0.263
8.	Information regarding phototherapy	1	11.013**	0.001

**Significant at p < 0.01 level.

Table 2: Association between perception of mothers and selected socio – personal variables n = 110

Socio personal variables of mother		Df	Chi square	p value
1.	Age (in yrs)	2	1.373	0.503
2.	Educational status	1	0.8040	0.772
3.	Occupation	1	1.337	0.247
4.	Religion	2	1.875	0.392
5.	Type of family	2	7.863*	0.020
6.	Place of living	1	0.352	0.552
7.	Parity	1	0.236	0.627
8.	Information regarding phototherapy	1	5.959*	0.015

*Significant at p < 0.05 level.

Table 3: Correlation between maternal awareness and perceptions regarding phototherapy (n = 110)

Variables	Correlation coefficient (r)	p value
Maternal knowledge		
Maternal perception	0.373	0.000***

***Significant at p < 0.001 level.

DISCUSSION

More than half of the mothers were between the age group of 21 – 25 years (53.6%). This finding is consistent with finding from a study showed that 65.6% of mothers were in the age group of 21–25 years[5]. More than half of the mothers (52.7%) were graduates or postgraduates. A large majority of the mothers (80%) were housewives. Nearly three fourth

of the mothers (66.4%) were primi. More than half (59.5%) of the multi parity mothers mentioned that their previous child had history of receiving phototherapy. The present study found that more than half of mothers (53.6%) had moderately adequate awareness regarding phototherapy and there was a significant association between awareness of mothers and information received regarding phototherapy ($p = 0.001$). This finding is consistent with the finding by Khalesi et al and they found that knowledge had a significant association with history of neonatal jaundice ($p = 0.033$), mother's age ($p < 0.001$), and child's birth order ($p = 0.001$)[6]. The present study found that more than half of mothers (61.8%) had average perception regarding phototherapy and that there was a significant association between perception of mother and type of family ($p = 0.020$), information received regarding phototherapy ($p = 0.015$)**.** This findings are inconsistent with the findings by Khalesi et al and found that there was a significant association between mother's attitude and their educational level ($p < 0.001$)[6] An ethnographic study from the USA showed that 27 mothers (57%) perceived neonatal jaundice to be a serious condition.[7]

The present study found that there was a significant weak positive correlation ($r = 0.373$) between maternal perception and awareness regarding phototherapy ($p = 0.000$). The study finding is consistent with the finding by Khalesi et al showed that there was a direct correlation between knowledge, attitude and behavior ($p < 0.001$)[6]. The study finding is consistent with finding from Rodrigo NR showed that there was a significant correlation between mothers' attitude and behavior scores with the knowledge scores[8].

CONCLUSION

The study has found that the maternal perception was average and had moderately adequate awareness regarding phototherapy. Maternal perception and awareness had a significant association between selected socio - personal variables. The findings of the study emphasize the importance of educating the mothers on neonatal jaundice, phototherapy to enhance their awareness and perception.

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Effectiveness of Pelvic Girdle Exercise on Pelvic Girdle Pain and Specific Activities among Primigravida Mothers Attending Antenatal OPD at Selected Hospitals, Salem

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ABSTRACT

Introduction: Pregnancy is a precious period and memorable moment for every woman who faces physical, physiological and psychological changes resulting some sorts of ailment.. One among that is Pelvic Girdle Pain.Women with Pelvic Girdle Pain or symphysis pubis dysfunction during pregnancy has functional difficulties that significantly affecting quality of life**.**

Objectives: Assess the Effectiveness of Pelvic Girdle Exercise on Pelvic Girdle Pain and Specific Activities among Primigravida Mothers

Design: Quasi experimental research design (pre-test and post-test control group design)

Setting: Sri Gokulam Hospital, Salem and Salem Poly Clinic Hospital.

Samples: 60 primi gravida mothers (30 in experimental group and 30 in control group).

Measurements and Tools: Modified Pelvic Girdle Questionnaire and Patient Specific Functional Scale. Descriptive and Inferential statistics were used.

Findings: In pre-test score in experimental group, 66% of mothers had moderate pain whereas in post-test I & II (66% & 97%) of mothers had mild pain respectively. In pre-test the experimental group mothers had mean specific activities score of 3.02 ± 1.15 whereas in post-test I & II the mean score was 4.36 ± 0.90 and 6.30 ± 0.78. Hence, it shows that there was reduction in Pelvic Girdle Pain and improvement in specific activities. Comparison of post test scores and 't' value on Pelvic Girdle Pain and specific activities among experimental and control group shows that the mean score was 12.83 ± 5.33, 37.40 ± 12.46 and 6.30 ± 0.78, 3.38 ± 0.97 respectively. There was no significant association with demographic variables and negative correlation between post test scores of Pelvic Girdle Pain and specific activities among experimental group mothers.

Conclusion: Pelvic girdle exercise reduces Pelvic Girdle Pain and improves specific activities of the mother. This exercise is easy to follow, simple to do, has no risk and effective to reduce Pelvic Girdle Pain.

Keywords: *Pelvic girdle exercise, Pelvic girdle pain, Specific activities, Primigravida mothers*

INTRODUCTION

All over the world Pelvic Girdle Pain is a significant problem for pregnant women. Studies have revealed that Pregnancy related Pelvic Girdle Pain is a common symptom among pregnant women in European population and in many studies the average reported prevalence of Pregnancy related Low Back Pain and Pelvic Girdle Pain is 45.3%.[2]

Majority (62.5%) of women having pelvic pain get relieved within 1 month after delivery but 8.6% continued to experience Pelvic Girdle Pain even two years after delivery in developing countries.[2]

In 2005, the National Centre for Health Statistics reported that the prevalence rate of PGP is 72% in India.[5]

A study conducted on 'Prevalence of Pregnancy related Pelvic Girdle Pain in Indian primigravida mother' at New Delhi in India Concluded that 1 in every 2 primigravida mothers suffered by Pregnancy related Pelvic Girdle Pain and lumbo pelvic pain also she reported that high prevalence of Pelvic Girdle Pain observed at 16 and 36 weeks of gestation.[1]

PGP was observed 74% in first pregnancy it shows the frequency of pain increases as the pregnancy advances, that is 12% in the first trimester, 34% in the second trimester and 52% in the third trimester.[3]

Most of the mothers not having adequate knowledge regarding Pelvic Girdle Pain hence not seeking any treatment for it. So many research article shown that the untreated Pregnancy related Pelvic Girdle Pain sustains in postpartum period and for some women it continues as a lifelong problem which is affecting their daily activities.[6]

Pelvic Girdle exercise is simple exercise able to follow by the mothers easily and helps to improve the stability of pelvic and back thereby reduces pain and improves specific activities. Comparatively with other modalities, Pelvic girdle exercise is simple, easy to follow and effective for Pelvic Girdle Pain.[4]

OBJECTIVES

1. To identify the primigravida mothers with Pelvic Girdle Pain of both experimental and control group.
2. To assess the level of Pelvic Girdle Pain among primigravida mothers of both experimental and control group before and after implementation of Pelvic girdle exercise.
3. To assess the specific activities among primigravida mothers of both experimental and control group before and after implementation of pelvic girdle exercise.
4. To associate the Pelvic Girdle Pain and specific activities scores with selected demographic variables among primigravida mothers of both experimental and control group.
5. To correlate post test scores of Pelvic Girdle Pain and specific activities among primigravida mothers of both experimental and control group.

HYPOTHESES

1. **H_1:** There is a significant difference between pre and post test scores on Pelvic Girdle Pain among primigravida mothers of Experimental and control group at $p \leq 0.05$ level.
2. **H_2:** There is a significant difference between pre and post test scores of specific activities among primigravida mothers of Experimental and control group at $p \leq 0.05$ level.
3. **H_3:** There is a significant difference between post -test score on Pelvic Girdle Pain and specific activities among primi gravida mothers of experimental and control group at $p \leq 0.05$ level.
4. **H_4:** There is a significant association between pre test scores of Pelvic Girdle Pain and specific activities with demographic variables among primigravida mothers of both experimental and control groupat $p \leq 0.05$ level.
5. **H_5:** There is a significant association between post test scores of Pelvic Girdle Pain and specific activities with demographic variables among primigravida mothers of both experimental and control groupat $p \leq 0.05$ level.
6. **H_6:** There is a significant correlation between post test scores of Pelvic Girdle Pain and specific activities of both experimental and control group mothers at $p \leq 0.05$ level.

Theoritical Framework: Theoretical framework selected for this study was based on Modified Widenbach's Prescriptive Theory-A helping art of clinical nursing.

MATERIALS AND METHOD

A Quasi experimental research design (pre-test and post-test control group design) was used in this study.

Exp. Group pre test treatment post test$_1$ post test$_2$

No randomization ----------

Con. Group pre test ---------- post test1 post test 2

The study population includes the primigravida mothers at 36 weeks of gestation attending antenatal OPD. Written permission was obtained from the Managing Director of Sri Gokulam Hospital and Salem Polyclinic, Salem and written consent was obtained from primigravida mothers. Modified Pelvic Girdle Questionnaire was used to assess the level of Pelvic Girdle Pain and Patient Specific Functional Scale was used to assess the specific activities for both experimental and control group mothers. After pre test, demonstrated the Pelvic girdle exercise for 3-5 primigravida mothers of experimental group for 30 minutes. After demonstration the mothers were instructed to redemonstrate the exercise and the investigator checked their performance, and also insisted to perform this exercise program 2 times daily for a period of 2 weeks and a logbook was given

to record the exercise were performed in their home. At the end of 1st and 2nd week of their antenatal visit the post test was conducted by using same tools. The collected data was organized, tabulated and analyzed by using both descriptive and inferential statistics.

FINDINGS

In experimental group 30% of mothers were in the age group of 26-30 years whereas in control group 20% of mothers belongs to the age group of 26-30 years. In both experimental and control group majority of (64%), (70%) mothers were housewives. Almost all the mothers (84%) were moderate workers in both experimental and control group. In both experimental and control group highest percentage (53%,70%) of mothers were belongs to the family income of Rs.10001-20000 . Highest percentage of mothers in both experimental and control group (94%, 97%) were not practicing any antenatal exercises regularly.

In pretest majority of mothers had moderate pain in both experimental and control group (66% & 73%) respectively.

Majority of the experimental group mothers had mild pain in both post test-I (66%) and post test–II (97%), whereas majority of the control group mothers had moderate pain (66%) in both post test – I and post test–II respectively.

Comparison of Mean, SD and Mean percentage of Pre and Post test scores on Pelvic Girdle Pain among primigravida mothers in both experimental and control group shows that in experimental group the pretest mean score was 35.30 ± 12.33 and mean percentage was 47.06 where as in post test-I it was 22.33 ± 7.31 and 29.77 in post test-II it was 12.83 ± 5.33 and 17.10. The difference in mean score from pre test to post test it was 12.97 in post test-I & 22.47 in post test-II respectively which shows that reduction in level of Pelvic Girdle Pain in post test.

In control group the pretest mean score was 34.03 ± 12.62 and mean percentage was 45.37 where as in post test-I it was 35.53 ± 12.33 and 47.37 and post test-II it was 37.4 ± 12.46 and 49.86. The difference in mean score from pre test to post test it was 1.5 in post test-I & 3.37 in post test-II respectively, which shows that no significant difference in the level of Pelvic Girdle Pain from pre test to post test-I & post test-II. Hence it reveals that the primigravida mothers in experimental group had reduction in Pelvic Girdle Pain compare to control group after implementation of Pelvic girdle exercise.

Table 1: Comparison of Mean, standard deviation and 't' value on level of Pelvic Girdle Pain among primigravida mothers in experimental and control group $n_1 = 30$, $n_2 = 30$

Primigravida Mothers	Pre test		Post test–I			Post test–II		
	Mean	SD	Mean	SD	't' Value	Mean	SD	't' Value
Experimental Group (n_1=30)	35.30	12.13	22.33	7.31	11.98*	12.83	5.33	12.08*
Control Group (n_2=30)	34.03	12.62	35.53	12.33	2.47	37.4	12.46	2.15

*Significant at $p \leq 0.05$ level; table value = 2.045; df = 29

In pretest the experimental group mothers had mean score of 35.30 ± 12.13 where as in post test I & II mean score was 22.33 ± 7.31 & 12.83 ± 5.33. The calculated 't' values were 11.98 in post test –I & 12.08 in post test-II which was highly significant at $p \leq 0.05$ level.

In control group the pretest mean score was 34.03 ± 12.62, where as in post test I & II mean score was 35.53 ± 12.33 & 37.4 ± 12.46. The calculated 't' values were 2.47 in post test-I &2.15 in post test-II which was not significant at $p \leq 0.05$ level. Hence it concludes that H_1 was retained at $P \leq 0.05$ level.

Table 2: Correlation between post test scores of Pelvic Girdle Pain and specific activities of both experimental and control group mothers

Variable	Experimental Group ($n_1 = 30$)			Control Group ($n_2 = 30$)		
	Mean	SD	'r' Value	Mean	SD	'r' Value
Pelvic Girdle Pain	12.83	5.33	-0.6	37.40	12.46	1.70
Functional Ability	6.30	0.78		3.38	0.97	

* Significant at $p \leq 0.05$ level

There was negative correlation seen in experimental group and the calculated 'r' value was -0.6 which was significant at $p \leq 0.05$ level. In control group there was positive correlation and the calculated 'r ' value was 1.70 which was significant at $p \leq 0.05$ level. Hence H_6 was retained.

CONCLUSION

The result of this study showed that, the pre-test score in experimental group, 66% of mothers had moderate pain whereas in post-test I & II (66% & 97%) of mothers had mild pain respectively. In pre-test the experimental group mothers had mean specific activities score of 3.02 ± 1.15 whereas in post-test I & II the mean score was 4.36 ± 0.90 and 6.30 ± 0.78. Hence, it shows that there was reduction in Pelvic Girdle Pain and improvement in specific activities. Comparison of post test scores and 't' value on Pelvic Girdle Pain and specific activities among experimental and control group shows that the mean score was 12.83 ± 5.33, 37.40 ± 12.46 and 6.30 ± 0.78 , 3.38 ± 0.97 respectively. Hence, it shows that there was reduction in Pelvic Girdle Pain and improvement in specific activities among experimental group mothers. Pelvic girdle exercise reduces Pelvic Girdle Pain and improves specific activities of the mother. This exercise is easy to follow, simple to do, has no risk and

IMPLICATIONS

Nursing Education:

- Educational programme on Pelvic Girdle Pain and Pelvic girdle exercise can be included in subject content.
- Alternative pain relief management can be included in nursing curriculum.

Nursing practice:

- Pelvic girdle exercise could be adopted in hospitals and maternity centre.
- Staff development programme can be arranged for staffs working in the hospitals and maternity centre.

Recommendations for further research:

- A comparative study can be done to determine the effectiveness of Pelvic girdle exercise among primi and multi gravida mothers.
- A longitudinal study can be done to determine the effectiveness of pelvic girdle exercise.

Conflict of Interest: Nil

Source of Funding: Self

Ethical Clearance: Taken from the Institutional Ethical Committee.

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Stress and Coping between the Intensive Care Unit and General Ward Nurses in Selected Hospital, Coimbatore

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ABSTRACT

Nurses stress is defined as the emotional and physical reactions resulting from the interactions between the nurse and her/his work environment where the demands of the job exceed capabilities and resources. Nurse stress is one of the current problems which affect the nurses and the quality of patient care.

Objectives:

- To compare the level of stress and coping between Intensive Care Unit and General Ward nurses.

Material and Method: The research design adopted for this study was comparative descriptive. The study was conducted in PSG Hospital, Coimbatore. Desired sample of 150 were selected according to the inclusion and exclusion criteria. Demographic data and the stress of the nurses is assessed using a standardized questionnaire developed by Chaudhury et al., 2004 and coping is assessed by a standardized rating scale developed by McElfatrick et al., 2000. The data was analyzed by inferential & descriptive statistics.

Results: The stress level of intensive care unit nurses is significantly more than the general ward nurses which have been proved by the value of Z test (10.98) which is greater than the table value 1.64. The coping level of intensive care unit nurses is significantly less than the general ward nurses which have been proved by the value of Z test (15.22) which is greater than the table value 1.64. The correlation coefficient 'r' = 0.425 revealed that, there was a moderate level of significance at $p<0.01$ level.

Conclusion: This study shows that the intensive care unit nurses were more stressed than the general ward nurses and general ward nurses have more coping than the intensive care unit nurses. It was strongly recommended that a regular assessment of stress and stress reduction programme can be arranged to reduce the stress of intensive care unit nurses which helps to improve the quality of care for patients.

Keywords: *Stress, Coping, Intensive care unit, General ward, Nurses.*

INTRODUCTION

Nursing is the profession of caring the sick. Nurses take care of patient and co - ordinate all the services in the health care setting. Nursing care therefore demands continuous exercise of critical thinking, creative imagination, independent judgment in problem solving and decision making.

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Nurse's stress is defined as the emotional and physical reactions resulting from the interactions between the nurse and his/her work environment where the demands of the job exceed capabilities and.

Need for the Study: A moderate level of stress or "Eustress" is an important motivating factor and is considered normal and necessary. If stress is intense, continuous, and repeated, it becomes a negative phenomenon or "Distress," which can lead to physical illness and psychological disorders and thus make life very miserable.[1]

Stress experienced by workers at work is called job stress. It may be due to a number of factors such as

poor working condition excessive work load, shift work, long hours of work, role ambiguity, role conflicts, poor relationships with boss, colleagues or subordinates.[2] A survey conducted among Registered nurses of America showed that 59% of Registered nurses reported that their job as so stressful and they felt burned out.[3]

REVIEW OF LITERATURE

Research studies related to Stress and Coping Strategies Adopted by the Staff Nurses: A descriptive comparative design was conducted compare the level of stress and coping strategies adopted by the staff nurses working in various patient care settings. The 240 staff nurses were selected by stratified random sampling. Data were collected by self-report method using socio demographic performa, Perceived Stress scale and coping scale. The result showed among staff nurses working in general wards, private wards and ICU, severe stress was experienced by ICU staff (42%) while majority of the staff nurses in general wards and private wards were experiencing moderate level of stress. There was no significant difference between the coping strategies adopted by staff nurses working in general wards, private wards and ICU. The present study concludes that if there were effective management of stress among ICU and novice nurses, the work place errors can be minimized; productivity can be increased to maximum and ultimately can enhance quality patient care.[4]

A cross-sectional study was conducted to compare stress level and job stressors operating in two different units, i.e. intensive care units (ICU) and general wards of a tertiary care hospital of North India. Convenient sample technique were used to selected 285 nurses (general wards = 176; ICU = 109). The study revealed moderate to high stress level among general wards and ICU nurses with young female nurses experiencing more stress. Further, workload, role ambiguity and lesser social support accounted for significant amount stress among nurses working on both the units while external factors, such as physical environment and resources hardly contributed to stress. It was also found that the ICU nurses experienced stress more in the form of exhaustion (11.9%); irritation (11.9%) and reduced self-confidence (0.9%) that those working in general wards. However, the nurses on both the units use distraction, positive coping, problem-solving and religious strategies to manage and handle their stress. The findings of the study give insight into stress and stressors related to job which can be buffered using various stress management strategies by the nurse managers.[5]

A descriptive comparative design study was conducted on perceived stress among nurses in Jordan. 310 were selected from various hospitals. Nurses answered the Arabic Version of Perceived Stress Scale 10-Items Questionnaire (PSS10) and a Characteristic Checklist. This study results showed that nurses working in psychiatric departments perceived the highest stress levels followed by oncology nurses (ONs), ICU/CCU, and ER nurses respectively. Medical and surgical nurses reported the lowest level of stress. This study concluded that psychiatric nurses have the highest levels of stress among all participated nurses. This might lead to dissatisfaction with the work and high rates of burn out and turn over. All these factors can easily affect patients care and safety issue, especially psychiatric patients. It is highly recommended that nurse managers and policy makers pay a particular attention to this phenomenon and looking for causes of such high level of stress is important.[6]

Statement of the Problem: A comparative study to assess the stress and coping between the intensive care unit and general ward nurses in selected hospital, Coimbatore

Objectives:

- To assess the stress and coping between Intensive Care Unit and general ward nurses.
- To compare the level of stress and coping between Intensive Care Unit and General Ward nurses.
- To correlate the level of stress and coping between Intensive Care Unit and General Ward nurses.

Assumptions:

- The nurses working in intensive care unit may have more stress than the nurses working in general ward.

Hypothesis:

- There will be a difference in level of stress and coping between nurses of intensive care unit and general ward.
- There will a significant correlation between levels of stress and coping strategies among nurses of intensive care unit and general ward.

Operational Definitions: Stress: Stress is considered to result from an imbalance between the demands of the workplace and the nurse's ability to cope.

Coping Strategies: Coping strategies are the efforts taken by the nurses to manage the external and the internal demands perceived by them.

Research Design: The research design selected for present study is comparative descriptive design.

Setting of the Study: The study was conducted among the nurses who are working in PSG hospital critical care units and general ward. The PSG Hospital is a multispecialty 910 bedded hospital and is well equipped with adequate facilities.

Population: The study population includes nurses who were working in PSG Hospital critical care units and general ward.

Samples: Staff Nurses.

Sample Size:

Sample size of the study was 150 samples were selected (intensive care unit, n = 75 and general ward n = 75) total samples were 150.

Sampling Technique: Non-probability convenient sampling technique

Instruments and Tools for Data Collection: A questionnaire for assessing the level of stress and a rating scale was used to assess the coping level among the nurses.

Section I: Section I deals with the demographic data of the samples. The demographic profile included age, sex, educational qualification, family profile, individual income, family income, place of domicile, distance to work place, mode of travel, time of travel, experience of nurses and hobbies.

Section II: Section II includes a standardized questionnaire developed by Chaudhury et al., in the year 2004.The questionnaire includes 17 items focused on stress. Each question has five possible responses like not at all, a little, average, a lot, and extremely and carries scores as 0,1,2,3 and 4 respectively. The total score is then calculated and depending on score stress is classified into mild, moderate or severe.

Section III: Section III consist of a standardized rating scale for coping strategy developed by Mc Elfatrick et al., in the year 2000.The rating scale includes 33 items focused on coping skills of nurses. Each question has five possible responses like Never, Rarely, Occasionally, Often, All the time and carries scores as 1,2,3,4 and 5 respectively. The total score is then calculated and depending on score coping is classified as adequate, moderately adequate or inadequate.

Scoring: The scores are interpreted as follows

Level of stress

>50% - Mild stress

50-75% - Moderate stress

<75% - Severe stress

Level of coping

>50% - Inadequate coping

50-75% - Moderately adequate coping

<75% - Adequate coping

FINDINGS

Table 1: Assessment of Level of Stress between the intensive care unit and general ward nurses

N = 150

Sl. No.	Level of stress	Intensive care unit n = 75	Percentage (%)	General ward n = 75	Percentage (%)
1.	Mild (>50%)	5	6.6	42	56
2.	Moderate (50-75%)	21	28	28	37
3.	Severe (<75%)	49	65	5	6.6

Table 1 shows the assessment of Level of Stress between the intensive care unit and general ward nurses.

Stress level of nurses working in intensive care unit was assessed and it was observed that among 75 nurses working in intensive care unit 5 nurses have mild stress, 21 nurses have moderate stress and 49 nurses have severe stress.

Stress level of nurses working in general ward was assessed and it was observed that among 75 nurses working in general ward 2 nurses have mild stress, 28 nurses have moderate stress and 5 nurses have severe stress.

Table 2: Assessment of Level of coping between the intensive care unit and general ward nurses

N = 150

Sl. No.	Level of stress	Intensive care unit n = 75	Percentage (%)	General ward n = 75	Percentage (%)
1.	Inadequate (>50%)	53	70	7	9.33
2.	Moderately adequate (50-75%)	17	22.66	28	37.33
3.	Adequate (<75%)	5	6.66	40	53.33

Table 2 depicts the assessment of Level of coping between the intensive care unit and general ward nurses

Coping strategies of nurses working in intensive care unit was assessed and it was observed that among 75 nurses 53 nurses have inadequate coping, 17 nurses have moderate coping and 5 nurses have adequate coping.

Coping strategies of nurses working in general ward was assessed and it was observed that among 75 nurses 7 nurses have inadequate coping, 28 nurses have moderately adequate coping and 40 nurses have adequate coping.

Table 3: Comparison of Level of stress between the intensive care unit and general ward nurses

N = 150

Sl. No.	Variable Level of stress	Intensive Care Unit n = 75		General Ward n = 75		'Z' value	Table value (p>0.05)
		Mean	SD	Mean	SD		
1.	Level of stress	66.41	12.62	44	13.41	10.98	1.64

Table 3 shows the **c**omparison of stress between the intensive care unit and general ward nurses.

Stress among nurses working in intensive care unit and general ward was compared and it was observed that the nurses working in intensive care unit have more stress with the mean value of 66.41 comparing with the mean value of 44 of general ward nurses.

Table 4: Comparison of Level of coping between the intensive care unit and general ward nurses

N = 150

Sl. No.	Variable Level of coping	Intensive Care Unit n = 75		General Ward n = 75		'Z' value	Table value (p>0.05)
		Mean	SD	Mean	SD		
1.	Level of coping	74.9	15.71	112.99	22.17	15.22	1.64

Table 4 depicts the comparison of level of coping between the intensive care unit and general ward nurses**.**

Coping strategies among nurses working in intensive care unit and general ward was compared and it was observed that nurses working in intensive care unit have less coping with the mean value of 74.90 than the nurses of general ward with the mean value of 112.99

Table 5: Correlate the level of stress and coping between Intensive Care Unit and General Ward nurses

n = 150

Variables	Intensive Care Unit		General Ward		'r' value
	Mean	Standard Deviation	Mean	Standard Deviation	
Stress	66.41	12.62	44	13.41	0.425** (S)
Coping	74.9	15.71	112.99	22.17	

**p<0.01, S – Significant

Table 5 reveals the correlation the level of stress and coping between intensive care unit and general ward nurses.

The means score of intensive care unit nurses level of stress was 66.41 with the standard deviation of 12.62 and the mean score of General Ward nurses level of stress was 44 with the standard deviation of 33.41. The means score of intensive care unit nurses level of coping was 74.9 with the standard deviation of 15.71 and the mean score of General Ward nurses level of stress was 112.99 with the standard deviation of 22.17. The correlation coefficient 'r' = 0.425 revealed that, there was a moderate level of significance at $p<0.01$ level.

DISCUSSION

Assessment of Stress of Nurses Working in Intensive Care Unit it was observed that majority of nurses (49) among 75 nurses working in ICU is experiencing severe stress and only 5 nurses reported mild stress. A similar study which has been conducted to identify the stress of intensive care unit nurses showed that 50% of the nurses have severe form of stress in the work environment.[7]

Assessment of Stress of Nurses Working In General Ward it was observed that stress level was comparatively less. Among 75 nurses 42 nurses had mild stress, 28 nurses had moderate stress and 5 nurses had severe stress. This finding was supported by another study conducted among general ward nurses saying that the stress level will be less for nurses working in general wards.[8]

Comparison of Stress among Nurses Working In Intensive Care Unit and General Ward it was observed that the nurses working in intensive care unit have more stress with the mean value of 66.41 comparing with the general ward nurses mean stress value of 44. A similar study has been conducted to compare the stress level of nurses working in ICU and general ward and it has been found that the intensive care unit nurses experiences more stress than general ward nurses.[9]

IMPLICATIONS

Nursing practice: The level of stress assessment can be done for nurses and proper management can be given, which can improve their potency to perform well.

Recommendations: Periodic stress assessment should be done for the nurses and necessary management measures like regular relaxation classes can be arranged.

CONCLUSION

Stress of nurses working in hospitals is a worldwide problem. This study has been done to find the stress and coping level of the nurses in intensive care unit and in general ward, and it was found that most of intensive care unit nurses has more stress comparing to general ward nurses and proper intervention is needed to reduce the stress level.

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Effectiveness of Video Teaching Programme on Self-Help Techniques of Osteoarthritis among Elderly in Selected Old Age Homes, Coimbatore

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ABSTRACT

Introduction: Osteoarthritis is a disease in which the cartilage which acts as a cushion in between bones in joints begins to overstress, resulting in swelling and pain in joints which affects negatively. It could be also called as degenerative arthritis or degenerative joint disease.

Objectives: Assess the effectiveness of video teaching programme on Self-Help techniques of Osteoarthritis among Elderly for improving their knowledge and practice.

Design: Quasi experimental time series design

Setting: Old age homes, Coimbatore

Participants: 272 osteoarthritis clients.

Measurements and tools: Osteoarthritis identification tool, Modified WOMAC Index tool, structured interview schedule, observational checklist and video teaching programme on self-help techniques of Osteoarthritis. Both descriptive and Inferential statistics were used.

Findings: Distribution of osteoarthritis clients according to their severity level of osteoarthritis shows that, in pre-test, 97 percentage of clients had severe level of osteoarthritis, in post test 74 percentage of clients in mild level of severity through fully adaptation of self-help technique. Significant association formed between the knowledge and practice of OA clients when compared to the demographic variables. Difference between the pre and post-test knowledge and practice of self-help techniques of osteoarthritis shows highly significant difference. Karl Pearson's co-relation co-efficient analysis between knowledge and practice score of the post-test shows significant positive relationship ($r = 0.882$). Paired't' test was calculated to analyze the severity of osteoarthritis, shows that in pre and post-test there was a significant difference in WOMAC index. Difference in severity of osteoarthritis in pre and post assessment by using one way repeated measure ANOVA shows there was a significant improvement in the observation of reduction in severity of osteoarthritis.

Conclusion: After implementation of video teaching programme on self-help technique of osteoarthritis shows the clients had excellent knowledge and fully adoptive practice of self-care management as well as reduced the severity of osteoarthritis gradually and significantly.

Keywords: *Video teaching programme, Osteoarthritis, Elderly, Self-help techniques*

INTRODUCTION

Osteoarthritis is a common disorder occurring in all population, and overall prevalence is the same in men and women. It is seen that there is a more rapid age related increase in the prevalence of generalized osteoarthritis in women more than men. By the age 40, 90 percentage of all persons can have such changes in their weight bearing joints, though clinical symptoms are generally absent. Under age of 45 years, prevalence was greater among men, whereas after the age of 55 prevalence was more in women than in men. Moderate to severe grades of osteoarthritis was seen to a larger extent in women compared to men. Obesity has a close association with development of knee osteoarthritis.[1]

In U.S. there are around 20 million of people with arthritis, which may grow up to 40 million by 2020.[2]

There is a remarkable increase in the number of the old age population. In India, 5.3 percentage of males and 4.8 percentage of female were aged who are more than 65 years. The proportionate percentage of old age people in developing countries is less but in developed countries the absolute number is high.[3]

Demographic changes in India estimated that the population of person above 60 years was around 76.62 million in 2001, which can rise up to 179 million by 2031. Dependency ratio in 1991 was around 12.26 and it may rise up to 14.12 by 2016 and there were around 1, 50,000 centenarians in India in 1991 which will grow to nearly 2, 00,000 by 2016.[4]

The major relationship between diet and arthritis is weight. Excess of body weight does not hold good for joint health. Losing some body weight helps in reducing the strain of knees, hips, feet and lower back, thus improving overall physical health and mobility. Many researchers have also shown that in combination with regular exercise, weight loss helps in reducing pain in joint and stiffness related to osteoarthritis. Other serious medical conditions are commonly seen in people who are obese. So, reducing excess weight not only helps to manage but prevent this disease conditions.[5]

The osteoarthritis usually affects the knee, hip and hand. Osteoarthritis becomes more common with age after 50 years and women are affected more than men. Also said that the age and sex-standardised incidence of osteoarthritis of the hand is 100 per 1, 00,000 persons per year, for the hip is 88 per 1, 00,000 persons per year, and that of knee is 240 per 1, 00,000 persons per year.[6]

OBJECTIVES

1. To identify the clients affected with Osteoarthritis among elderly.
2. To assess the self-care among elderly with Osteoarthritis.
3. To implement the Video Teaching Programme to clients with osteoarthritis on Self-Help Techniques of Osteoarthritis
4. To assess the effectiveness of Video Teaching Programme on Self-Help Techniques of Osteoarthritis.
5. To associate the self-care knowledge and practice with demographic variables of clients with osteoarthritis.
6. To compare the self-care practice in relation to knowledge of the clients with osteoarthritis.

HYPOTHESIS

H_1: There is a significant association between pre-test self-care knowledge and demographic variables of the clients with osteoarthritis.

H_2: There is a significant association between pre-test self-care practice and demographic variables of the clients with osteoarthritis.

H_3: There is a significant difference between pre and post-test self-care knowledge of clients with osteoarthritis.

H_4: There is a significant difference between pre and post-test self-care practice of clients with osteoarthritis.

H_5: There is a significant relation between the post-test self-care knowledge and practice of clients with osteoarthritis.

H_6: There is a significant difference between the pre and post assessment on severity of Osteoarthritis.

Theoritical Framework: Theoretical framework chosen and modified for this study, was General System's theory by Alabwig Von Bertanlanffy (2010).7

MATERIAL AND METHOD

Quasi experimental time series design was adopted for this study.

Experimental Group:

O_1 X O_2 X O_3 X O_4

The sample size was 272 osteoarthritis clients from old age homes, Coimbatore. Purposive sampling technique was adopted in this study. Clients more than 50 years of age and of both the sexes were included for the study. The tool used for data collection were osteoarthritis identification tool, modified WOMAC Index tool to assess the severity of osteoarthritis, structured interview schedule in tamil to assess the self-care knowledge on osteoarthritis, observational checklist to assess the self-care abilities and video teaching programme on self-help techniques of Osteoarthritis.

Permission was obtained from the Head of the person in old age home. Identified the elderly with Osteoarthritis by using Osteoarthritis identification tool. Severity level of Osteoarthritis was assessed by using modified WOMAC Index. Structured interview schedule in tamil was used to assess the self-care knowledge of elderly with Osteoarthritis and concealed and non concealed observation was adopted to assess the self-care abilities of elderly with Osteoarthritis by using observational checklist as pre-test. Implemented the video teaching programme on self-help techniques of Osteoarthritis for 25 minutes. Post-test was conducted after 15 days of interval with same pre-test instruments. Severity of Osteoarthritis was assessed for 3 times with every 15 days of intervals by using modified WOMAC tool. The collected data were organized, tabulated and analyzed by using descriptive statistics like frequency, percentage, mean and standard deviation. The Inferential statistics like Chi-square, Correlation co-efficient, paired 't' and one way repeated measure ANOVA was used.

FINDINGS

Highest percentage (31%) of clients aged between 66 -70 years and majorities (54%) of them were female. Highest percentage (27%) of clients had secondary education and majority (39%) of them was semi manual workers. 67 percentage of clients were non vegetarians and highest percentage (45%) of clients under the BMI classification of obese. 56 percentages of clients were not had any chronic illness. 78 percentages of clients had history of joint pain more than 5 years and only 13 percentages of clients were adopted the assistive devices for mobilization.

Area-wise distribution of osteoarthritis clients according to their level of knowledge regarding self-care shows that, overall highest percentage (37%) of clients had poor knowledge in pre-test and 62 percentage of clients had excellent knowledge in post-test.

Area-wise mean, SD and mean percentage of pre and post-test knowledge scores of osteoarthritis clients shows that in pre-test, out of 34 maximum obtainable scores the mean score was 15.785±4.594 which is around 52.502 percentage of the total score revealing, average knowledge of clients on self-help techniques of osteoarthritis. Where as in post-test the mean score was 28.281±3.822, which is around 87.129 percentage of the total score revealing excellent knowledge of clients on self-help techniques of osteoarthritis.

Table 1: Area-wise mean, SD and mean percentage of pre and post-test knowledge scores of clients with osteoarthritis n = 272

S. No.	Self-help technique areas	Max. Score	Knowledge Score						Difference in Mean %
			Pre-test			Post-test			
			Mean	S.D	Mean %	Mean	S.D	Mean %	
1.	Basics about Osteoarthritis	6	2.813	0.837	46.883	4.805	0.720	80.083	33.200
2.	Activities of Daily Living	2	1.647	0.477	82.350	2	0	100	17.650
3.	Exercise	5	2.423	0.563	48.460	4.287	0.522	85.740	37.280
4.	Diet	3	1.449	0.545	48.300	2.783	0.412	92.767	44.467
5.	Weight Control	3	2.162	0.472	72.067	2.949	0.126	98.300	26.233
6.	Non drug pain relief measures	8	2.629	0..672	32.863	5.813	1.043	72.663	39.800
7.	Rest and relief from the stress on joint	5	1.467	0.541	29.340	3.824	0.614	76.480	47.140
8.	Socialization	2	1.195	0.487	59.750	1.820	0.385	91	31.250
	Over all	34	15.785	4.594	52.502	28.281	3.822	87.129	34.628

Area-wise distribution of osteoarthritis clients based on their level of self-care practice shows that, overall highest percentage (62%) of clients had partially adoptive practice in pre-test. Where as in post-test, 97 percentage of clients had fully adoptive practice it reveals the effectiveness of video teaching programme on self-help techniques of osteoarthritis.

Assessment of self-care practice of the clients with osteoarthritis

Table 2: Area-wise distribution of osteoarthritis clients according to their level of self-care practice n = 272

S. No	Self-help technique areas	Level of Practice											
		Not Adoptive Practice				Partially Adoptive Practice				Fully Adoptive Practice			
		Pre-test		Post-test		Pre-test		Post-test		Pre-test		Post-test	
		No	%	No	%	No	%	No	%	No	%	No	%
1.	Activities of Daily Living	0	0	0	0	268	99	0	0	4	1	272	100
2.	Exercise	272	100	0	0	0	0	40	15	0	0	232	85
3.	Diet	0	0	0	0	174	64	6	2	98	36	266	98
4.	Non drug pain relief measures	191	70	0	0	81	30	7	3	0	0	265	97
5.	Rest and relief from the stress on joint	0	0	0	0	260	96	4	1	12	4	268	99
6.	Socialization	0	0	0	0	226	83	0	0	46	17	272	100
	Over all	71	28	0	0	168	62	9	3	27	10	263	97

Area-wise mean, SD and mean percentage of pre and post-test practice of osteoarthritis clients shows that in pre-test, out of 64 maximum obtainable scores the mean score was 27.08±4.607 which is around 44.368 percentage of the total score, revealing clients had partially adoptive practice on self-help techniques of osteoarthritis. Whereas the means score was in post-test, 54.519±5.031 which is around 85.019 percentage of the total score, revealing fully adoptive practice of client on self-help techniques of osteoarthritis.

Table 3: Area-wise mean, SD and mean percentage of pre and post-test practice scores of clients with osteoarthritis n = 272

S. No	Self-help technique areas	Max. Score	Practice Score						Difference in Mean %
			Pre-test			Post-test			
			Mean	S.D	Mean%	Mean	S.D	Mean %	
1.	Activities of Daily Living	14	7	1.170	50	12.912	0.976	92.229	42.229
2.	Exercise	10	1.702	0.455	17.020	7.478	0.903	74.780	57.760
3.	Diet	10	6.180	0.929	61.800	8.224	0.773	82.240	20.440
4.	Non drug pain relief measures	18	6.077	0.849	33.761	15.496	1.313	86.089	52.328
5.	Rest and relief from the stress on joint	8	3.952	0.829	49.400	6.596	0.675	82.450	33.050
6.	Socialization	4	2.169	0.375	54.225	3.813	0.386	92.325	41.100
	Over all	64	27.08	4.607	44.368	54.519	5.031	85.019	41.151

Distribution of osteoarthritis clients according to their severity level of osteoarthritis shows that, in pre-test, 97 percentage of clients were had severe level of osteoarthritis and only 3 percentage had moderate level. Where as in post-test 74 percentage of clients (202 nos.) came to mild level of severity through fully adaptation of self-help techniques and only 5 percentage were still in severe level of osteoarthritis.

There was a significant association between the clients knowledge and practice when compared to the demographic variables like age, sex, educational status, type of previous occupation, body mass index, history of chronic illness and usage of any assistive devices.

To evaluate the difference in pre and post-test knowledge and practice scores paired ‘t’ test was

calculated on different aspects of self-help techniques of osteoarthritis shows the highly significant difference. Hence it can be concluded that video teaching programme on self- help techniques of osteoarthritis is highly effective as well as it influenced their knowledge and practice.

Table 4: Difference between pre and post-test self-care knowledge of clients with osteoarthritis

S. No.	Area-wise knowledge items	't' Value
1.	Basics about Osteoarthritis	61.417*
2.	Activities of Daily Living	12.154*
3.	Exercise	59.104*
4.	Diet	42.413*
5.	Weight Control	29.166*
6.	Non drug pain relief measures	77.148*
7.	Rest and relief from the stress on joint	61.024*
8.	Socialization	21.185*

df = 271, *p < 0.05 – Significant

Table 5: Difference between pre and post-test self-care practice of clients with osteoarthritis

S. No.	Area-wise practice items	't' Value
1.	Activities of daily living	134.114*
2.	Exercise	131.390*
3.	Diet	53.003*
4.	Non drug pain relief measures	128.698*
5.	Rest and relief from the stress on joint	80.246*
6.	Socialization	52.922*

df = 271, *p < 0.05 – Significant

Karl Pearson's co-relation co-efficient analysis done between knowledge and practice score of the post-test shows the significant highly positive relationship between knowledge and practice (r= 0.882).

Paired't' test was calculated to analyse the severity of osteoarthritis, shows that there was an increasing significant difference between pre and 1st post-test of WOMAC index, pre and 2nd post-test of WOMAC index as well as pre and 3rd post-test of WOMAC index. Hence it can be concluded that there is a highly significant difference between the pre and post severity level of osteoarthritis and the hypothesis is accepted. However the practice of self-help technique reduced the severity of osteoarthritis gradually and significantly.

Identified the difference in severity of osteoarthritis in pre and post assessment by using one way repeated measure ANOVA shows that, there is a significant improvement in the observation on severity of osteoarthritis after implementation of video teaching programme on self-help techniques of osteoarthritis by the researcher and by the persistent practice of the clients.

Table 6: Significant difference in severity of osteoarthritis in pre and post assessment

S. No.	Variables	't'-Value
1.	Pre-test and 1st post-test of WOMAC Index	139.643*
2.	Pre-test and 2nd post-test of WOMAC Index	142.713*
3.	Pre-test and 3rd post-test of WOMAC Index	208.123*

df = 271, p < 0.05 – Significant*

CONCLUSION

Osteoarthritis is a common disorder in all population and overall prevalence is same in men and women. Osteoarthritis cannot be cured but it can be controlled. The primary responsibility of nurse is to create awareness and explain about self-care management of disease, which will develop positive attitude and learn to practice according to the standard level. In this study majority of the clients had inadequate level of knowledge about the self-care management of osteoarthritis. After implementation of video teaching programme on self-help technique of osteoarthritis, majority of the clients had excellent knowledge and fully adoptive practice of self-care management as well as reduced the severity of osteoarthritis gradually and significantly.

IMPLICATIONS

Nursing practice

- The findings of the study may help the nursing personnel's working in hospital and community

knowing about the self-help techniques of Osteoarthritis and helps in planning and implementation of health teaching.

- Nurses need to update their knowledge on various treatment options available for osteoarthritis to care the osteoarthritis clients effectively.
- Nurses need to focus on the prevention of obesity through weight control especially those with knee osteoarthritis could be benefitted from weight reduction.

Nursing Research: This study helps the nurse researchers to develop insight into the development of intervention module for osteoarthritis clients towards promotion of quality of life and prevention of osteoarthritis related problems.

Recommendations

- A comparative study on pharmacological and non pharmacological pain management of osteoarthritis can be studied.
- A study can be undertaken in hospital settings.
- Longitudinal study can be undertaken for identifying the associate factors of osteoarthritis.
- A comparative study can be conducted between clients with osteoarthritis and rheumatoid arthritis about the effectiveness of self-help technique.

Conflict of Interest: Nil

Source of Funding: Self Funded

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Effectiveness of Video Teaching Programme on Neonatal Care among Primigravida Mothers Admitted in Urban Health Maternity Centres, Coimbatore

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ABSTRACT

Introduction: Birth of a healthy newborn is one of the finest gifts of nature. The process of birth takes only a few hours but it is the most hazardous period of life since it is associated with largest number of deaths as compared to any other phase of life.

Objectives: assess the effectiveness of video teaching programme on Neonatal care among Primigravida mothers for improving knowledge and practice.

Design: True experimental design pre and post-test control group design

Setting: 6 urban health maternity centres, Coimbatore.

Participants: 266 (147 experimental group and 119 control group) primigravida mothers adopted by Simple random sampling technique.

Measurements and tools: Structured interview schedule, Observational checklist and video teaching programme on neonatal care. Both descriptive and inferential statistics were used.

Findings: In experimental group the pre-test the mean was 10.163 ± 4.783, in post-test it was 48.38±6.103, revealing excellent knowledge of mothers on the components of neonatal care. In control group pre-test mean score was 9.656 ± 3.497 whereas in post-test, the mean score was 9.656 ± 3.825 revealing very poor knowledge of primigravida mothers. In practice of neonatal care shows that, in experimental group the mean score was 56.412 ± 3.272, revealing fully adoptive practice. And in control group, the mean score was 27.547 ± 1.815, revealing mothers had partially adoptive practice. There was highly significant difference in post-test knowledge and practice scores. Positive relationship was found between knowledge and practice of experimental group primigravida mothers (r = 0.79) and no significant relation found between knowledge and practice of control group (r= 0.14).

Conclusion: Majority of the experimental and control group mothers had inadequate knowledge on neonatal care in pre-test. After implementation of video teaching programme primigravida mothers from experimental group had excellent knowledge and fully adoptive practice of neonatal care.

Keywords: *Video teaching programme, Neonatal care, Primigravida mothers, Experimental and control group*

INTRODUCTION

World's one of the neglected health problem is neonatal mortality. Globally 3.9 million neonatal deaths constitute 36 percentage of under-five deaths. In India every year nearly 1.2 million neonatal deaths occurred. Nearly half of the under five deaths occurs in neonatal period. The World Health Organization guidelines on essential newborn care consists cleanliness, thermoregulation, early suctioning, early breast feeding initiation and exclusive, eye care, immunization, minor illness management, and low birth weight neonatal care. And emphasized education to the mother and her family regarding preparation, birth choice, thermal care, breast feeding and preparation of danger signs.[1]

The under-5 child mortality rate in global shows decreased continuously from 13.5 million in the year 1980, to 7.7 to 8.8 million in 2008. The neonatal deaths also decreased from 4.6 million in the year 1990 to 3.1

to 3.6 million in 2009. When comparing these two data the neonatal deaths had declined only at a lower rate.[2]

Nearly 1.2 million die during the neonatal period out of 26 million infants, before completing 4 weeks of life. Global under five including infant mortality rates were reduced to past four decades, whereas neonatal mortality rates was very high and remains relatively unchanged.[3]

In 2008 Newborn Indicators Technical Working Group (TWG) was developed by the Saving Newborn Lives program at Save the Children to improve the indicators and arranging standard tools to measure the newborn care interventions. The newborn care indicators like drying, delayed bathing, umbilical cord cutting with sterile instruments, kangaroo mother care and identifying the evidenced based interventions.[4]

In India among 26 million newborn babies, 1.2 million were dying before completing their newborn life every year. Approximately one fifth of Indian population lives in slums, with higher mortality rate. According to Survey Registration System 2009, India's birth rate of 22.22 per 1000 population and Infant mortality rate was 53 per 1000 live births. The higher rates recorded in slum and resettlement colonies. Therefore neonatal health to be imposes among poor communities, which is a national priority. The interventions like tetanus toxoid vaccination, clean delivery, breast feeding, care of low birth weight babies and managing neonatal infections. These measures may reduce the neonatal deaths up to 72 percentage.[5]

OBJECTIVES

1. To assess the level of knowledge on neonatal care among experimental and control group primigravida mothers before implementation of video teaching programme.
2. To implement the video teaching programme on neonatal care among experimental group primigravida mothers.
3. To evaluate the effectiveness of video teaching programme on neonatal care among primigravida mothers.
4. To associate the post-test scores with selected demographic variables of both experimental and control group primigravida mothers.
5. To correlate the post-test knowledge with practice of both experimental and control group primigravida mothers.

HYPOTHESIS

H_1: There is a significant association between post-test knowledge and demographic variables of experimental and control group primigravida mothers

H_2: There is a significant association between post-test practice and demographic variables of experimental and control group primigravida mothers.

H_3: There is a significant difference between pre and post-test knowledge of experimental and control group primigravida mothers on neonatal care.

H_4: There is a significant difference between post-test knowledge of experimental and control group primigravida mothers on neonatal care.

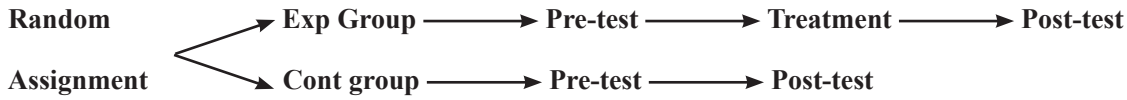
H_5: There is a significant difference between post-test practice of neonatal care among experimental and control group primigravida mothers.

H_6: There is a significant relation between the knowledge and practice of experimental and control group primigravida mothers regarding neonatal care.

Theoritical Framework: Theoretical framework chosen and modified for this study, was General System's theory by Alabwig Von Bertanlanffy (2010).[6]

MATERIAL AND METHOD

True experimental pre and post test - control group research design was adopted for this study.



By used the simple random sampling the sample size for this study was 266 primigravida mothers out of which 147 were from experimental centre and 119 were from controlled centre. Structured interview schedule in tamil was used to identify the knowledge on neonatal care to primigravida mothers during their 37th week of gestation of both the groups. Immediately after pre-test video teaching programme on neonatal care was implemented for 25 minutes only to mothers from experimental group. Then using the same pre-test tool the post-test was conducted in her 38th week of gestation for both groups. Once after delivery observation was made on care of neonatal practice by using observation checklist among primigravida mothers in both groups for 2-3 days. The collected data were organized, tabulated and analyzed by using descriptive statistics like frequency, percentage, mean and standard deviation. The Inferential statistics like Chi-square, Correlation co-efficient, paired 't' and unpired 't' test was used.

FINDINGS

Highest percentage of (50% & 49%) for experimental and control group mothers were from 21-25 years of age. 46 percentage of experimental and 41 percentage of control group mothers had secondary education. Majority of the primigravida mothers from experimental group (39%) and control group (43%) were daily waged. 49 percentage of mothers from experimental and 61 percentage from control group were getting family monthly income of Rs. 3,001 to 5,000. Maximum 65 percentage of experimental group and 73 percentage of control group were belonged to nuclear family.

67 percentage of experimental and 72 percentage of control group newborns had Apgar score of 10 at 5 minutes. Distribution of newborn babies according to their mean auxillary temperature in 1st day control group newborns had 35.4^0C and experimental group had 36.6^0C, whereas in 3rd day the control group newborns had 35.8^0C and experimental group had 37.4^0C. Distribution of newborn babies according to their mean weight shows, in 1st day control group newborns had mean weight of 3.025 gm and experimental group had 3.016 gms, where as in 3rd day the control group newborns had mean weight 2.815 gms and experimental group had 3.096 gms.

Area-wise mean, standard deviation and mean percentage of pre and post-test knowledge of experimental group mothers shows that, in pre-test, the mean score was 10.163 ± 4.783, which is around 18.366 percentage of the total score revealing mothers had very poor knowledge. Whereas in post-test it was 48.38 ± 6.103, which is around 89.26 percentage revealing excellent knowledge of neonatal care.

Table 1: Area-wise Mean, Standard Deviation and Mean percentage of experimental group primigravida mothers knowledge on neonatal care in pre and post-test n = 147

S. No.	Areas of neonatal care	Max. Marks	Experimental group Knowledge score						Difference Mean %
			Pre-test			Post-test			
			Mean	SD	Mean %	Mean	SD	Mean %	
1.	Meaning and components of neonatal care	5	0.87	0.654	17.4	3.76	0.811	75.2	57.8
2.	Breast feeding	14	2.524	1.108	18.03	12.728	1.032	90.9	72.9
3.	Physical care	19	4.136	1.729	21.8	17.905	0.985	94.2	72.4
4.	Thermoregulation	7	0.932	0.591	13.3	6.279	2.607	89.7	76.4
5.	Immunization	8	1.701	0.701	21.3	7.707	0.668	96.3	75
Over all		53	10.163	4.783	18.366	48.38	6.103	89.26	70.9

In control group mothers shows that in pre-test the overall mean score was 9.656 ± 3.497 which is around 17.98 percentage of the total score revealing mothers had very poor knowledge on the components of neonatal care. Whereas in post-test, the mean score was 9.656 ± 3.825 which is around 18.102 percentage of the total score revealing very poor knowledge of primigravida mothers.

Area-wise Mean, Standard deviation and Mean percentage practice of neonatal care shows that, in experimental group out of 60 maximum obtainable scores the mean score was 56.412±3.272, which is around 93.3 percentage revealing fully adoptive practice. And in control group, the mean score was 27.547±1.815, which is 45.72 percentage revealing mothers had partially adoptive practice.

Table 2: Area-wise distribution of primigravida mothers of both the groups based on their level of neonatal care practice
Experimental group n = 147
Control group n = 119

S. No.	Areas of neonatal care	Not Adoptive Practice				Partially Adoptive Practice				Fully Adoptive Practice			
		Exp. Group		Control Group		Exp. Group		Control Group		Exp. Group		Control Group	
		No	%	No	%	No	%	No	%	No	%	No	%
1.	Breast feeding	-	-	1	1	6	4	118	99	141	96	-	-
2.	Physical Care	-	-	-	-	9	6	118	99	138	94	1	1
3.	Thermoregulation	-	-	19	16	13	9	100	84	134	91	-	-
Over all		**-**	**-**	**7**	**6**	**9**	**65**	**112**	**94**	**138**	**94**	**-**	**-**

There was no significant association found between experimental and control group mother's knowledge and practice, when compared with the demographic variables.

There was a significant difference between pre and post-test knowledge scores of experimental & control group primigravida mothers.

Table 3: Difference between pre-test and post-test knowledge of primigravida mothers from experimental group and control group on neonatal care

S. No.	Areas of neonatal care	Exp. Group	Control Group
		't' Value	't' Value
1.	Meaning and components of neonatal care	38.93*	2.672*
2.	Breast feeding	90.3*	2.705*
3.	Physical care	100.48*	2.909*
4.	Thermoregulation	59.07*	1.562*
5.	Immunization	87.72*	1.56*

Experimental group – df. = 146,

*p < 0.001 – Significant difference

Control group – df. = 118,

*p > 0.05 – Not Significant difference

There was highly significant difference in post-test knowledge on all the components of neonatal care among primigravida mothers of experimental and control group shows the video teaching programme was effective on various aspects of neonatal care.

Table 4: Difference between experimental group and control group primigravida mothers knowledge on neonatal care in post-test.

S. No.	Areas of Neonatal Care	Unpaired 't' value
1.	Meaning and components of neonatal care	31.423*
2.	Breast feeding	91.085*
3.	Physical care	108.902*
4.	Thermoregulation	21.055*
5.	Immunization	63.691*

df – 264 (n-2), *p < 0.01 – Significant

There was significantly high difference found in various aspects of neonatal care practices such as breast feeding, physical care and thermoregulation. It shows that the video teaching programme was effective on various aspects of neonatal care practice.

Table 5: Difference between experimental group and control group primigravida mothers neonatal care practice

S. No.	Areas of neonatal care	Unpaired 't' value
1.	Breast feeding	106.14*
2.	Physical care	90.608*
3.	Thermoregulation	50.618*

df – 264 (n-2) *p < 0.01 Significant

There was a positive relationship between knowledge and practice of experimental group primigravida mothers (r = 0.79). There was no significant relation between knowledge and practice of control group (r = 0.14).

CONCLUSION

Among under 5 children, the neonatal period life is 1/60, but contributes 38 percentage of the neonatal mortality contributes under-five deaths in every year. In each year estimated Neonatal Mortality Rate occurs four million and almost completely present in low income countries. The World Health Organization recommends by improving neonatal care practices can reduce the neonatal morbidity and mortality rates. It described as essential neonatal care (ENC) practices which includes sterile cord care, thermoregulation and breast feeding within the half an hour after birth. This essential neonatal care training improves midwives' skill and knowledge according to the standard level in order to reduce early (7-day) neonatal mortality.

IMPLICATIONS

Nursing practice

- The findings of the study may help the nursing personnel's working in hospital and community knowing about the neonatal care practice and helps in planning and implementation of health teaching.
- Nurses need to update their knowledge on various aspects available in neonatal care practice to educate the primigravida mothers.

Nursing Research

- This study helps the nurse researchers to develop insight into the development of intervention module for neonatal care to primigravida mothers towards promotion of quality of life and prevention of neonatal morbidity problems.

RECOMMENDATIONS

- Interventional study can be done based on disease progression and mothers need, could help the mothers as well as healthcare providers to develop an individualized treatment plan.
- Longitudinal study can be undertaken for identifying the associate factors related to neonatal care.
- A comparative study can be conducted between primigravida and multigravida on neonatal care.

Conflict of Interest: Nil

Source of Support: Self Funded

Ethical Clearance: Ethical clearance was obtained from Institutional Human Ethics Committee in PSG Institute of Medical Sciences and Research (PSG IMS&R), Coimbatore.

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Factors Influencing Clinical Learning Environment among Nursing Students: A Cross Sectional Study

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ABSTRACT

Clinical learning is the essence of nursing education. Many factors have been demonstrated to influence students' development of clinical competence. A non-experimental descriptive study was conducted aiming to assess the factors influencing clinical learning environment, to prioritize those factors and to compare with degree and diploma nursing. The study was conducted among student nurses in a selected nursing college in Thiruvananthapuram district of Kerala. 100 student nurses including fifty B.Sc. nursing and fifty General nursing students were recruited using stratified and simple random sampling technique after obtaining institutional ethical committee clearance. Data was collected from samples after getting informed consent; the tools used were: Section A- Performa to collect demographic characteristics of subjects and Section B- Assessment of factors influencing CLE which was a three point likert scale and it included factors like; Supervision -10 items, Clinical facilities -5 items, Organization -5 items, Inter personal relationship -5 items and Student related factors - 5 items. Descriptive statistical measures such as frequency, percentage and mean were used for analyze data. The collected data was analyzed using statistical package for social sciences version 20. The mean score of distribution of factors affecting CLE was found as supervision (24.59), clinical facilities (10.74), organization (10.60), IPR (11.68) and student related factors (11.33). On prioritizing the factors highest mean percentage was obtained for supervision (81.97) and the lowest for organization (70.67).

Keywords: *Clinical learning, nursing education, clinical competence*

INTRODUCTION

Clinical practice is a vital component of the nursing curriculum and has been acknowledged as being central to nursing education[1]. Based on this general premise, there is agreement that nursing curriculum should be directed towards improvement of clinical competencies of nursing students[2]. During clinical learning, nursing students frequently feel anxious and even vulnerable in the clinical environment[3]. There have been numerous studies[4,5,6] examining the effects of clinical experience on student learning and the problems students encounter at clinics. These studies also shown stressors associated with going out into the clinical field for the first time, the fear of making mistakes, anxiety over possible criticisms from peers, being able to communicate with health personnel and patients, providing care for the seriously ill or terminal patients, having the necessary technical skills for procedures, attitudes towards and expectations of staff of students[7,8,9]

In addition to above mentioned factors, it has been shown that the attitudes, experiences and knowledge of mentors influence student learning. By contrast, an effective mentor who tries to enables students to put their knowledge into practice by creating learning opportunities helps students the best. Research also indicates that mentors should make use of supportive strategies to facilitate learning in the clinical setting. For example, in a study[10] found that students learned better by assuming responsibilities, having opportunities to implement new interventions and receiving feedback

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about their performance. In another study, found that students reported that having opportunities to discuss clinical problems and being prepared to give the best nursing care were among the most important factors in effective clinical learning. Only a few studies in clinical education were directed towards determining problems frequently encountered in clinical practices[11,12,13].

A descriptive cross sectional study found that about 56% of the students indicated that mentors did not show much interest in their learning[14]. In another study, with the first year students showed that students were worried that mentors and staff might have harbored negative attitude towards them. Research, in general, suggests that further studies are needed to identify the facilitating factors in clinical learning. Therefore, the aim of this study is to investigate the factors which facilitate to nursing students' clinical learning.

MATERIALS AND METHOD

This non experimental descriptive study adopted a quantitative approach to assess the factors influencing clinical learning environment, to prioritize those factors and to compare with degree and diploma nursing. The study was conducted among student nurses in a selected nursing college in Thiruvananthapuram district of Kerala. 100 student nurses including fifty B.Sc. nursing and fifty General nursing students were recruited using stratified and simple random sampling technique after obtaining institutional ethical committee clearance. Data was collected from samples after getting informed consent; the tools used were: Section A- Performa to collect demographic characteristics of subjects and Section B- Assessment of factors influencing CLE which was a three point likert scale and it included factors like; Supervision -10 items, Clinical facilities -5 items, Organization -5 items, Inter personal relationship -5 items and Student related factors - 5 items. Descriptive statistical measures such as frequency, percentage and mean were used for analyze data. The collected data was analyzed using statistical package for social sciences version 20.

RESULTS

(a) Socio demographic characteristic's: Majority of the subjects (56%) belonged to the age group 18-21 years and 44% subjects belonged to 22-24 years, 50% subjects were from BSc nursing course and 50% students from general nursing course. Regarding the educational background majority (76%) had their previous pattern of education in English medium and from state syllabus (68%). In concern with the reason for selection of nursing as profession majority of subjects (49%) reported compulsion from parents as reason, (27%) thinks nursing as a service to humanity.

(b) Factors influencing clinical learning environment

Table 1: Mean score of distribution of factors which affect CLE (n = 100)

Factors	Total Score	Mean
Supervision	2459	24.59
Clinical facilities	1074	10.74
Organization	1060	10.60
IPR	1168	11.68
Student Related Factors	1133	11.33

Prioritization of Factors

Table 2: Mean percentage of factors influencing CLE (n = 100)

Factors	Mean	Mean Percentage
Supervision	24.59	81.97
IPR	11.68	77.87
Student Related Factors	11.33	75.53
Clinical facilities	10.74	71.60
Organization	10.60	70.67

DISCUSSION

Our findings highlight that the clinical learning of nursing students of various groups has been influenced and associated with mainly presence of supervision, interpersonal relationship, student factors, availability of clinical facilities and organizational factors. A qualitative study with a phenomenological approach[15] shows the importance that students attribute to clinical placement in order to achieve good clinical learning experiences. Moreover, they point out that the health professionals have a big influence on the student, who needs to receive recognition and support from the different members of the team, apart from his/her preceptor. Other studies

also confirm that the relationship between students and clinical nurses has a significant influence on the learning experiences in clinical placement[16]. Other authors[17] have noted that communication and cooperation are the basis of adequate supervisory relationships. Further, concluded that having meaningful learning situations was a relevant aspect highlighted by students. These results are consistent with those obtained in the present study, where the elements that were best perceived by students focused on the good supervision and interpersonal relationship either with the team or with the preceptor and on the motivation to learn, has been on the positive side[18].

Conflict of Interest: Nil

Source of Funding: Self

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Helping Art of Clinical Nursing: Application of Theory in Enhancing the Quality of Life of Patients with Psoriasis

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ABSTRACT

Psoriasis is a chronic inflammatory hyper proliferative disease of the skin and affects people of all ages. In addition to the skin and joint manifestations, psoriasis impairs many aspects of individual well-being, including emotional, physical, sexual, and financial status. The cosmetic disfigurement of psoriasis has a negative impact on quality of life by causing psychological stress, disruption of social relationships and difficulties in daily life. Helping the patients with psoriasis to learn to live with their condition is a challenging and important role of nurses as health professionals. Nursing practice should be theory based and it enables the researcher to link the findings to nursing's body of knowledge. In this article, the author explains the application of Wiedenbach's "Helping art of clinical nursing theory" in developing and administering an intervention to enhance the quality of life of patients with psoriasis.

Keywords: *Nursing theory, Psoriasis, Quality of life*

INTRODUCTION

Healthy skin is an essential part of patient wellbeing. Skin problems are common in the general population and comprise a wide variety of diagnoses ranging from pure cosmetic conditions to tumors, genetic disturbances, autoimmune diseases and inflammatory skin diseases.[1] Many of the diseases seen in dermatology are chronic and life-long. Due to the visible aspect of skin lesions and their potentially high psychological impact, the evaluation of quality of life in psoriasis is a very useful complement to clinical studies.

Magin et al [2] found that embarrassment, shame, impaired self-image, low self-esteem, self-consciousness and stigmatization were more prominent among patients with psoriasis. Many of the difficulties experienced by patients with psoriasis make demands that outstrip the coping measures of patient and their family or social network. They need sufficient education and support from healthcare providers to manage their condition effectively. Today, dermatologic treatment of psoriasis has become increasingly effective, can alleviate physical symptoms but not cure the disease. A challenge to the patients is therefore to cope with psoriasis in everyday life.

The World Health Organization (WHO) defines quality of life as "individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns". According to WHO, health-related quality of life (HRQoL) is a broad-ranging concept affected in a complex way by a person's physical health, psychological state, level of independence, social relationships, personal beliefs, and their relationship with salient features of their environment (WHOQoL Group, 1995).[3]

Nurses are in unique position to address the multidimensional impact of psoriasis on quality of life with patients by allowing them to verbalize fears and concerns, meeting with significant others, teaching patients about the disease process and assisting patients to participate in their activities of daily living. Hence, it is essential to develop appropriate nursing strategies to bring positive patient outcomes on quality of life (QoL) among patients with psoriasis.

Generally, theories are used to explain the events that occur in people's life and in their environment. For example, we consider stress theory as the explanation for the tensed and impatient behaviours of the traffic police men because of their continued and uncomfortable working situations. Similarly, nurses use theories to explain their activities significance to nursing. A sound

theoretical or conceptual framework strengthens the quality of a research study and provides the foundation on which the research has been carried out. One of the most common theory which has relevance and significance to nursing practice is, Wiedenbach's "Helping Art of Clinical Nursing Theory".[4]

CONCEPTS OF THE THEORY

Wiedenbach proposes a prescriptive theory for nursing that directs action towards an explicit goal. It consists of three factors such as the central purpose, prescription and realities.

(i) The central purpose refers to what the nurse researcher wants to accomplish towards the patient's benefits or wellness.

(ii) The prescription refers to the plan of care for subjects suffering from psoriasis. It specifies the nature of action that will fulfill the nurse's central purpose and the rationale for that action to achieve the central purpose.

(iii) Realities; It refers to the factors that come into play in a situation involving nursing action. The five realities are agent, recipient, goal, means and framework.

The nurse researcher as an agent interacts with patients diagnosed to have psoriasis as recipients with a goal to identify the need for help and devises means to achieve the help within the framework of nursing practice.[4]

Application of "Helping Art of Clinical Nursing Theory": According to this nursing theory, nursing practice focuses on identifying a patient's need for help who has been diagnosed with psoriasis, ministering the needed help and validating that the needed help was met. The researcher identified a psoriasis sufferer's need for help using the pretest which assessed their knowledge, attitude and quality of life. The central purpose was to reduce the negative effects of psoriasis on affected patients and achieving a better quality of life.

Based on the central purpose, the nurse researcher prescribed the needed help i.e. administered structured teaching programme and progressive muscle relaxation along with deep breathing exercises. Thus, the researcher helped the patients with psoriasis to understand their disease process and reduced the stress associated with daily life which promoted a better quality of life.

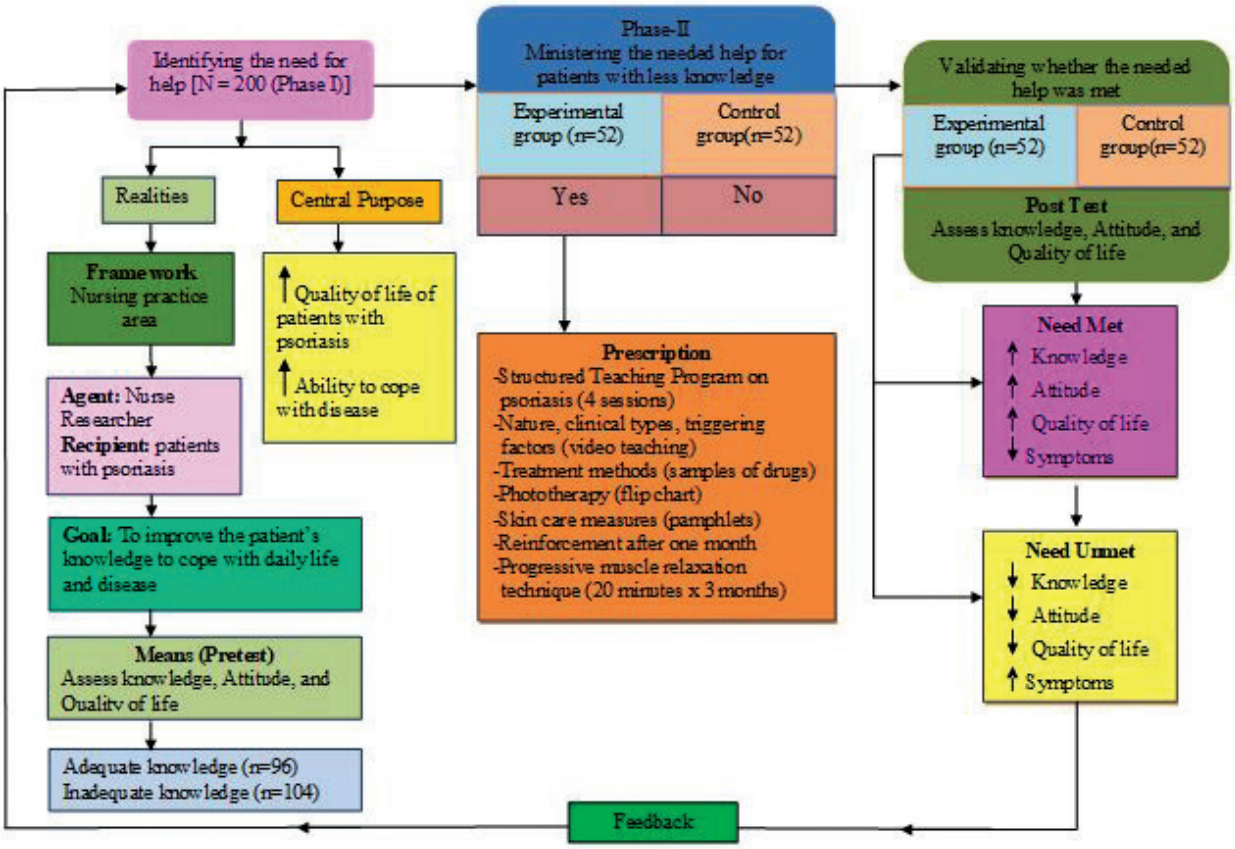
After administering the prescription, the researcher validated whether the quality of life was improved through a post test. When the quality of life was improved, the patients experienced better control over their disease and they were able to cope up with daily life. If not, their need for help had to be identified to take further action in order to strengthen their ability to cope up with their disease till they achieved a better quality of life.

Clients with psoriasis were assessed before the introduction of nursing strategies regarding their knowledge and attitude towards their disease. Further, the disability experienced in the day to day activities of their life and stress experienced by them because of their illness were also studied. A structured teaching programme on psoriasis was taught to them with the help of video, pamphlets, charts and other necessary medications and ointments for a period of three months along with simple relaxation techniques. They were assessed at different time intervals (at the end of one month, two months and three months after the interventions) to assess the changes that might have occurred during the study period. Based on the outcome measures, the researcher was able to assess the effectiveness of her strategies.[5-8]

The findings had showed a significant difference in knowledge, attitude and quality of life after three months of intervention in the experimental group when compared to the control group. The findings also revealed that the implementation of nursing strategies were effective in improving the quality of life of patients with psoriasis.

CONCLUSION

Psoriasis is a chronic skin disease which has an impact on health-related quality of life (QoL). It is a disease with profound impact on the psychological and social aspect of the patient, particularly because of its visibility. In the health team, nurses play a vital role in educating, training and providing various psychosocial therapies. The nurses should be aware of the stress associated with psoriasis among the affected individuals. By using various nursing strategies that reduce the psychosocial burden and stress associated with the disease, nurses can help the patients to lead an independent and productive life. The theoretical framework which was based on Wiedenbach's "Helping Art of Clinical Nursing" was useful to determine the effectiveness of nursing strategies on quality of life among patients with psoriasis.



Conceptual Frame Work based on modified Wiedenbach's Helping Art of Clinical Nursing

Conflicts of Interest: Nil

Sources of Funding: Self

Ethical Clearance: Taken from Institute Ethics Committee for human studies, JIPMER (Jawaharlal Institute of Post- Graduate Medical Education and Research), Pudhucherry-06.

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A Study to Assess the Effectiveness of Structured Teaching Programme on Knowledge Regarding Premenstrual Syndrome among Adolescent Girls Studying in a Selected English Medium High School at Bagalkot.

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ABSTRACT

A one group pre-test post-test experimental design has been used in this study . The sample for the present study composed of 50 adolescent girls attending the selected English medium high school of Bagalkot. The result concluded that with Comparison of level of knowledge of Adolescent girls in pretest and posttest reveals that majority 66 % of adolescent girls had poor knowledge, 22 % of them had average knowledge, 12 % of them had very poor knowledge and there were no adolescent girls had good and excellent knowledge. Where as in posttest 64 % of adolescent girls had excellent Knowledge and 36 % of them had good knowledge.

Keywords: *adolescent girls, knowledge, premenstrual syndrome STP.*

INTRODUCTION

Adolescence is the most common time of life for psychiatric illness to emerge. The behaviors observed during adolescence represent a non-linear change that can be distinguished from childhood to adulthood, as evidenced by the national center for the health statistics on adolescent behavior and mortality. Adolescence represents a period of intensive growth and change in nearly all aspects of the child's physical, mental, social and emotional life. Adolescents are very prone to emotional maladjustment. The most frequently observed problem during this period are psychological disorders like anxiety & depression, violent behavior, eating disorders, substance abuse, sexually transmitted diseases, premenstrual syndrome[1].

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Premenstrual syndrome can be defined as any mood change, physical or behavioral symptoms that appear in the luteal phase of the menstrual cycle and disappear shortly after the onset of next menstruation. Menstruation is the shedding of the uterine lining through the vagina[2].

Premenstrual syndrome (PMS) is a symptom complex recognized primarily by cyclical changes associated with ovulatory cycles. It occurs 7 – 14 days prior to menstruation and spontaneously resolves after menstruation.[2] PMS is a common cause of sickness absenteeism from schools and interferes with the daily routine activities of adolescent girls. It is a common adolescent health problem with high prevalence and suffering, leading to loss of academic achievements[3].

Most common emotional PMS symptoms are Irritability, anger, depression, crying, over sensitivity, feeling nervous and anxious, alternating sadness and rage. These mood / emotional disturbance are thought to be connected to rise and fall of hormones specifically estrogen throughout the menstrual cycle. Estrogen level begins to rise slowly just after period ends and it peaks two weeks later. Then estrogen levels drop like a rock and begin rising slowly before dropping again just before menstruation starts. These hormonal

peaks and valleys are thought to cause mood swings and other menstrual symptoms. Stressful situations cannot cause PMS but they can make it worse. Some research suggests that female hormones interact with the brain chemicals and effect mood in those with PMS. Reduced levels of estrogen during the luteal phase of the cycle could possibly cause a drop in serotonin. Lower serotonin levels are associated with depression, irritability and carbohydrate cravings, all of which can be PMS symptoms[4].

The Research problem statement: A study to assess the effectiveness of structured teaching programme on knowledge regarding premenstrual syndrome among adolescent girls studying in a selected English medium high school at Bagalkot

OBJECTIVES

- To assess the knowledge of adolescent girls regarding premenstrual syndrome.
- To assess the effectiveness of STP among adolescent girls regarding premenstrual syndrome.
- To associate the knowledge of adolescent girls regarding premenstrual syndrome with their selected demographic variables such as age, education.

Hypothesis

H1: There will be significant difference between pre-test and post-test knowledge scores of adolescent girls regarding premenstrual syndrome and its management.

H2: There will be significant association between pre-test knowledge scores of Adolescent girls regarding premenstrual syndrome and its management with their selected socio-demographic variables.

Delimitations

1. Study is limited to adolescent girls in the age group (13-16) years.
2. Adolescent girls available during the period of study.
3. Adolescent girls who are studying in selected English medium high school at Bagalkot.
4. Study is limited to adolescent girls who have attained menarche.

Conceptual Framework: The conceptual framework used for this the study is based on Systems Model (Von Ludwig Bertalanffy).

METHODOLOGY

Research approach: An evaluative approach using pre-test (O_1) and post-test (O_2) without a control group was adopted for this study

Research design: A one group pre-test post-test experimental design has been used in this study.

Experimental Group	Pre-test	Intervention	Post-test
R	O_1	X	O_2

Table no 1 A one group pre-test post-test experimental design has been used in this study

Setting of the Study: The present study was conducted at St Anne's Lions School, Bagalkot.

Population: The target population of the study is adolescent girls attending selected English medium high school at Bagalkot

Sample and Sample size: The sample for the present study composed of 50 adolescent girls attending the selected English medium high school of Bagalkot.

Sampling Technique: Simple random sampling technique was used to select the school and convenience sampling technique method was adopted to select the samples for the present study

Development and Description of the Tool: The data collection tool was structured knowledge questionnaire for knowledge assessment. Keeping this in mind structured questionnaire was selected and developed on knowledge of adolescent girls regarding premenstrual syndrome. The tool was prepared on the basis of objectives of the study. The following steps were adopted in the development of tool.

- The need to educate the adolescent girls regarding premenstrual syndrome.
- Related review of literature.
- Consultation with experts in the relevant field.
- Discussion and consultation with the statistician.
- The final tool was prepared with the guidance and suggestions of the guide.

Description of the final Tool: After a thorough review of literature related to the topic and considering the suggestions of experts a structured questionnaire was developed.

The structured questionnaire comprised of two parts.

Part I: Consists of items seeking information regarding socio-demographic characteristics of adolescent girls such as age, education, occupation of parents, type of family, monthly income in rupees, sources of information.

Part II: Consists of 40 knowledge items related to premenstrual syndrome.

Validity and Reliability: The constructed tool was given to 3 experts of related fields for content validity. They were from the departments of Child Health Nursing, community health nursing, and mental health nursing. The tool was modified according to the suggestions of the experts.

The reliability of the tool was established by using split half method. 4 subjects were selected from English medium high school, Bagalkot. Karl Pearson's coefficient correlation 'r' was computed for finding out the reliability. The obtained value of 'r'' was 0.85, indicating that the tool was highly reliable for knowledge.

RESULTS

Part I: Description of socio-demographic characteristics of sample.

Out of 50 sample distribution of adolescent girls according to their age in years shows that Most 64% of the adolescent girls were 15–17 years old, and 36 % of adolescent girls were 13–15 years old. major adolescent girls according to their Religion shows that Majority of adolescents 90% were belonging to Hindu religion, 6% of them were Muslims and 4 % of them were belonging to Christian religion. Adolescents girls mothers educational status reveals that Majority 46.00% of mothers had degree and above, 28.00 percent of them had secondary education,14.00% them had PUC, 10.00% them had primary education, and remaining 2.00% mothers' of adolescent girls were illiterate. adolescent girls according to their age of attained menarche shows that Most 76% of the adolescent girls were 13–14 years old, and 22% of adolescent girls were 10 – 12 years old, and remaining 2 percent of adolescent girls were 15 – 16 years.

Part II:

Section A: Assessment of pre-test knowledge of the adolescent girls regarding pre menstrual syndrome and its management.

Level of knowledge	Range of scores	Number of respondents	Percentage (%)
Excellent	33 - 40	0	0
Good	25 - 32	0	0
Average	17 – 24	11	22
Poor	9 - 16	33	66
Very poor	0 - 8	6	12
Total	40	50	100

Table no 2 Assessment of pre-test knowledge of the adolescent girls regarding pre menstrual syndrome and its management

Section B: Area wise mean, SD and mean percentage of pre-test knowledge scores of Adolescent girls.

Knowledge Area	Max. Score	Mean	SD	Mean %
Disease aspect of premenstrual syndrome	23	7.6	2.041	33.04
Management of premenstrual syndrome.	17	6.12	2.33	36
Total	40	13.72	3.31	34.3

Table 3: Comparison of level of knowledge of adolescent girls in pre-test and post-test. N = 50

Level of knowledge	Pre–test		Post Test	
	No. of respondents	Percentage	No. of respondents	Percentage
Excellent	O	0.0	32	64.0
Good	0	0.0	18	36.0
Average	11	22.0	0	0.0
Poor	33	66	0	0.0
Very poor	6	12	0	0.0
Total	50	100	50	100

Comparison of level of knowledge of Adolescent girls in pretest and posttest reveals that majority 66 % of adolescent girls had poor knowledge, 22 % of them had average knowledge, 12 % of them had very poor knowledge and there were no adolescent girls had good and excellent knowledge. Where as in posttest 64 % of adolescent girls had excellent Knowledge and 36 % of them had good knowledge.

Section B: Area- wise effectiveness of the STP on disease aspect of pre menstrual syndrome and its management.

Table 4: Area- wise effectiveness of the STP on disease aspect of pre menstrual syndrome and its management

Knowledge area	Max. score	Pre-test (O_1)		Post-test (O_2)		Effectiveness (O_2-O_1)	
		Mean ± SD	Mean %	Mean ± SD	Mean %	Mean ± SD	Mean %
Disease aspect of pre menstrual syndrome	23	7.6 ± 2.04	33.04	18.88 ± 1.34	82.09	11.28 ± 2.2	49.04
Management of pre menstrual syndrome.	17	6.1 ± 2.33	36	14.98 ± 1.37	83.06	8.02 ± 2.70	47.18
Total	40	13.72 ± 3.31	34.3	33 ± 2.02	82.5	19.28 ± 3.9	48.2

Comparison of mean percentage of the knowledge scores of the pre-test and post-test reveals an increase of 48.2 percent in the mean knowledge score of the adolescent girls after STP. Comparison of area wise mean and SD of the knowledge scores in the area of 'disease aspect of premenstrual syndrome' shows that the pre-test mean percentage of knowledge score was 33.04percent with mean and SD 7.6±2.04where as post-test mean percentage of knowledge score was 82.09% with mean percent with mean and SD 18.88±1.34. This shows an increase of 49.04 % in the mean percentage of knowledge scores of the adolescent girls.

Section C: Testing of Hypothesis: The calculated values were much higher than table value (1.96). Hence the H_1 stated is accepted. Findings reveal that the difference between mean pre-test (13.72 ± 3.31) and post-test (33 ± 2.02) knowledge scores of adolescent girls found to be statistically significant at 0.05 level of significance [t = 33.91, p < 0.05].

Similarly the area wise difference between pre-test and post-test knowledge scores on premenstrual syndrome and its management were highly significant. Mean of post-test knowledge scores in the area 'disease aspect of premenstrual syndrome' (18.88 ± 1.33) is significantly higher than the mean of pre-test knowledge scores (6.12 ± 2.33) at 0.05 level of significance (t = 35.17, p < 0.05). Similarly Mean of post-test knowledge scores in the area 'management of premenstrual syndrome' (14.98 ± 1.37) is significantly higher than the mean of pre-test knowledge scores (6.12 ± 2.33) at 0.05 level of significance (t = 20.8, p < 0.05).

Findings reveal that there is significant association between post-test knowledge scores of the adolescent girls and socio demographic variables such as mothers educational status [x^2 = 8.33, P, 0.05] and year of study [x^2 = 4.22, P < 0.05]. There is no significant association between post-test knowledge scores of the adolescent girls and socio demographic variables such as age, religion, type of family, father's occupation, and mothers' occupation monthly income of family, age of attained menarche and source of health information. Thus H_2 state disaccepted for demographic variables such as mothers educational status and year of study and rejected for their other variables.

Implications of the Study: The findings of the study can be used in the following areas of nursing profession.

1. **Nursing Practice:** Health education is an important tool of healthcare agency. It is one of the most cost effective interventions. It is concerned with promoting health as well as reducing stress. The extended and expanded roles of professional nurse have emphasized more about the preventive and primitive aspects of the health.
2. **Nursing Education:** The curriculum is responsible for preparing the future nurses. There it should emphasize on preventive and promotive health practices. The learning experience of the students should give more emphasis on teaching the population who are at risk. Workshops, seminars and conferences can be conducted to educate the student nurses regarding pre

menstrual syndrome and its management so that they could disseminate their knowledge to the adolescent girls. The student nurses should be given opportunities during his/her training to plan and conduct health education for adolescents studying in different colleges regarding problem solving techniques and coping skills to meet the challenges of the transitional age.

3. **Nursing Administration:** The nursing administrator can take part in developing protocols, standing orders related to designing the health education programmes and strategies for school going adolescent girls regarding pre menstrual syndrome and its management.

The nursing administrator can mobilize the available resource personnel towards the health education of school going girls regarding pre menstrual syndrome and its management.

Nursing Research: This study helps nurse researchers to develop appropriate health education tools for educating the school going girls regarding pre menstrual syndrome according to their demographic, socio-economic and cultural characteristics.

Nurses should come forward to take up unsolved questions in the field of pre menstrual syndrome and its management to carryout studies and publish them for the benefit of youth, public and nursing fraternity. The public and private agencies should also encourage research in this field through materials and funds.

Limitations of the Study

- The study is limited to the adolescent girls between the age group of 13-16 years studying in English medium high school at Bagalkot.
- The study did not use a control group. The investigator had no control over the events that took place between pretest and post test.
- Only a single domain that is knowledge is considered in the present study.
- The sample for the study was limited to 50 adolescent girls. This was only a small sample for generalization.
- The researcher could not get a standardized tool to assess the knowledge of adolescent girls. The researcher himself developed the tool.
- The content of STP was limited to cover within 45 minutes.

RECOMMENDATIONS

Based on the findings of the study the following recommendations are stated;

- A similar study can be undertaken with a large stratified sample including adolescent girls from selected English medium high school to generalize the findings.
- A similar study can be undertaken with a control group design.
- A study can be conducted to find out the prevalence of pre menstrual syndrome among adolescent girls.

Suggestions

- Health professionals can conduct health education programme on premenstrual syndrome and its management among adolescent girls at schools and colleges.
- Structured teaching programme can be conducted in a group including adolescent girls and their parents, teachers, administrators and community members.

CONCLUSION

On the basis of the findings of the study, the following conclusions are drawn:

- Assessment of the level of pre test knowledge of the adolescent girls reveals that majority 66% of the adolescent girls had poor knowledge, 12 percent of them had very poor knowledge and there were no adolescent girls who had good and excellent knowledge regarding pre menstrual syndrome.
- A significant difference was found between the post-test and pre-test knowledge scores of adolescent girls. The study showed that the STP was highly effective in improving the knowledge of adolescent girls on pre menstrual syndrome.
- There is significant association between post-test knowledge scores of the adolescent girls and socio demographic variables such as mothers' educational status and year of study. There is no significant

association between post-test knowledge scores of the adolescent girls andsocio demographic variables such as age, religion, type of family, father's occupation, mothers' occupation monthly income of family, age of attained menarche and source of health information.

Ethical Clearance: Taken from Shri B V V S Sajjalashree Institute Of Nursing Sciences Navanagar Ethical clearance-committee

Source of Funding: Self

Conflict of Interest: Nil

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Family Focused Nursing Intervention for Functional Improvement of BPAD Clients- A Pilot Study Report

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ABSTRACT

Introduction: Bipolar affective disorder is a chronic, episodic illness that can create problems and disruptions in social, occupational, and family functioning of a client. Current study aimed to assess Family Focused Nursing Interventions (FFNI) on functional improvement on sample of symptomatic Bipolar disorder clients.

Method: In view of checking the feasibility of Randomized controlled trial involving 208 samples, as a Pilot testing of 46 clients with bipolar affective disorders has been selected for this study. Study had equal number of control and study group participants 23 in each group. Control group received routine treatment, study group received FFNI in 7 sessions. The primary outcome is functional level of client, was assessed using Functional Assessment Short Test -FAST Score. The collected data was analysed using SPSS 20, Independent sample t-test, ANOVA and Pearson correlation used as different statistical methods. P value less than .05 was considered as statistically significant result.,

Results: At the end of pilot study 45 patients completed the treatment and follow-up. After the random assignment to control and study group, the pre-test evaluation of functioning then repeated evaluation at discharge, after a month and at 2 month follow-up. Results showed that both group were comparable at baseline and there was a significant improvement in the functional level after FFNI .Study was feasible to conduct.

Conclusion: Adjuvant to routine treatment family focused nurse led interventions will improve the functional ability of the client.

Keywords: *family focused, Bipolar illness, nursing intervention.*

INTRODUCTION

Bipolar illnesses tend to recur and cause functional impairment during the relapse and in remission period. Bipolar illness is severe in nature and mood changes from depression to mania. During active illness period, clients' functional ability is becoming aggressive to nil activity. This is affecting patients' social, occupational, recreational, relationship and family functioning. The bipolar illness affects nearly 1% of world population. Bipolar disorder is associated with impulsive and self-destructive behavior[1]. Not surprisingly, families are frequently most affected by their bipolar member, and themselves experience a range of deeply felt emotions, not the least of which is a sense of helplessness to fix bipolar symptoms. With appropriate drug treatment, about 40 percent of recovered patients will suffer relapses (NIMH, 2005).

Mood stabilizers, ECT and psychotherapy are the treatment modalities for bipolar disorder. The Prevalence Rate for bipolar disorder is approximately 1.1% of the population over the age of 18 or, in other words, at any one time as many as 51 million people worldwide suffer from bipolar disorder, 8.7 million people in India. The United States had the highest prevalence rate of bipolar spectrum (4.4 percent), while India had the lowest rate (0.1 percent). More than half of those with bipolar disorder in adulthood note that their illness began in their adolescent years[2].

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Bipolar disorder has traditionally been associated with a better outcome than schizophrenia because of a presumed absence of cognitive impairment and seemingly normal functioning between episodes[3]. Thus, generally little attention has been given to psychosocial outcomes in patients with bipolar disorder[4]. However, in contrast to early studies3-4, recent studies point to a significant degree of psychosocial dysfunction even when patients are euthymic[5,6].Functioning is a complex concept since it involves the capacity to work, study, live independently and engage in recreation and romantic life[4]. Functional recovery has been described as the ability to achieve the level of functioning prior to the most recent episode[5]

Miklowitz and colleagues have pioneered family-focused[8-12] psychoeducational treatments for bipolar disorder (2000, 2003and 2008). Their family-focused treatment involves all available immediate family members in 21 one-hour sessions delivered over 9 months (12 weekly, then 6 fortnightly, then 3 monthly). It comprises three consecutive modules:

Psychoeducation focusing on the signs and symptoms of bipolar disorder, the etiology of bipolar episodes according to a stress-vulnerability model and the development of strategies to prevent relapses; communication enhancement training sessions using role-play and between-session rehearsal to teach skills for active listening, ways to deliver positive and negative feedback and constructive ways to request changes in behaviour; Problem-solving skills training sessions in which participants learn to identify specific family problems that might contribute to relapse and develop skills for finding acceptable solutions to these problems. The current study is expected to assess the functional impairment of bipolar affective disorder clients and the effect of family-focused nursing intervention on functional improvement of clients with bipolar disorder. This study is expected to determine the effect of family-focused nursing intervention and can be incorporated to practice as a way to help the family and clients with bipolar disorder.

To check the feasibility of the main study with 46 subjects pilot study has been conducted.

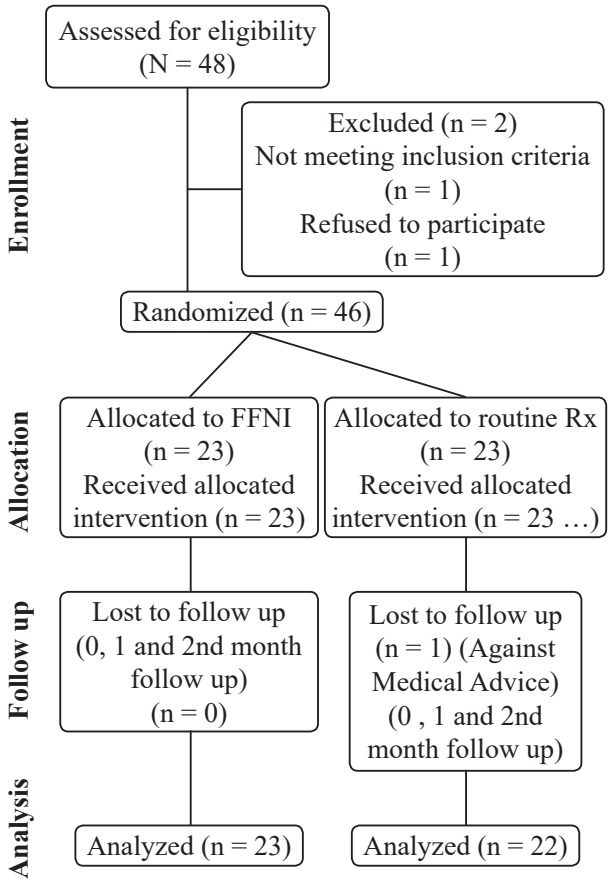
METHOD AND MATERIALS

This study aimed to a to assess the feasibility and effect of family focused nursing intervention (FFNI) on functional improvement among the client with BD With the above objectives, bipolar clients who have admitted to the psychiatric ward at JIPMER were recruited with following inclusion criteria such as patient has at least one primary caregiver a blood relative or a person whom client stays with more than a year and who is willing to participate. A client who had ICD 10 diagnosis of the bipolar affective disorder has been included. Patients enrolled for any other psychological therapy, Primary caregiver with mental illness and Patient has a co-morbid major mental illness (alcohol dependence /another psychiatric diagnosis) were excluded from the study. The experimental group received routine psychiatric treatment along with Family-Focused Nursing Intervention. Control group received routine psychiatric treatment. Consecutive sampling technique was used to select the study participants. The clients with Bipolar Affective Disorders admitted in a psychiatric ward who fulfilled the inclusion criteria was selected along with their family member after written informed concern. This study was approved by Institute ethics committee, JIPMER and registered under CTRI. (CTRI/2017/09/009860)

The calculated sample size was 208 (n=101 in each arm) for the main study. But for feasibility checking only 46 clients included. Block randomization with varying block size used to randomize the clients into study arms. The block randomization with varying blocks was generated using a computer program.

Socio demographic variables such as Age, Gender, Marital status, Religion, education, Occupation, monthly Family Income, type family: number of siblings, personal habits, number of hospitalization, duration of illness in months, Total duration of ill period in the last year in days, Level of functioning assessed by FAST (Functional Assessment Short Test) Adriane R Rosa et al 2007[18] Data were collected from patients admitted to the inpatient department of JIPMER hospital who satisfy the inclusion criteria after written informed consent.

They randomly assigned to control group and study group. Clients and primary caregiver interviewed for collecting demographic profile and pre-test assessment clients function using FAST Scale, then Family-focused nursing intervention was given in 7 sessions to client and family member the primary caregiver in an inpatient setting. At discharge, after one month and at 2-month assessment done to see the functional improvement of clients at outpatient setting



Consort diagram: Family focused nursing intervention for functional improvement of BPAD clients–A pilot study report

RESULTS

Table 1: Demographic details of the client with Bipolar disorders N = 45

Variable	Frequency (%) Study group n = 23	Frequency (%) Control group n = 22	Sig*
Sex			
Male	12(52.2)	13(59)	P = .644
Female	11 (47.8)	9 (40.9)	
Marital status			
Single	12 (52.2)	11(50)	P = .887
Married	11 (47.8)	11 (50)	
Religion			
Hindu	19 (82.6)	21(95.4)	P = .163
Others	4 (17.4)	1(4.5)	
Education			
Primary	4 (17.4)	5 (22.7)	P = .028
Secondary	9 (39.1)	6 (27.3)	
Higher secondary & Above	10 (43.5)	11(50)	
Employment			
Employed	12 (52.2)	13 (59.1)	P = .029
Un employed	7 (30.4)	5 (22.7)	
Student	4 (17.4)	4 (18.2)	
Income			
< 2500	16 (69.6)	16 (72.7)	P = .001
2501-10000	4 (17.4)	5 (22.7)	
10001 -above	3 (13)	1 (4.5)	
Family type			
Nuclear	19 (82.6)	18 (81.8)	P = .001
Joint	4 (17.4)	4 (18.2)	
Habits (Alcohol, smoking)			
Yes	6 (26.1)	10 (45.5)	P = .001
No	17 (73.9)	54.5)	

*Chi-square test used

Table I shows that majority of the participants details were comparable. Mean age of the participants were 31.4±8.6.

Table 2: frequency and percentage distribution of Clinical factor of clients N = 45

Variable	Study n = 23 Frequency (%)	Control n = 22 Frequency (%)
Family history		
No	14(60.8)	14(63.6)
Yes	9 (39.1)	8 (36.4)
Current episode		
Mania	19(82.6)	20(90.9)
Others	4 (17.4)	2 (9)
Anti – psychotics	22(95.7)	21(95.5)
Anti- manic	12(52.2)	12(54.5)
Anti anxiety	18(78.3)	16(72.6)

Conted…

Medication	2-3	2-3
Previous admission	2.61	2.82
Total duration	5-10years	5-10 years
Illdays	23.1	13.82
Manic episode	2	2

Majority of the clients has no family history of bipolar illness. But considerable number had family history of BD. In BD, Mania was the major subtype for the client admitted in hospital. Majority of the clients received anti psychotics and anti- anxiety drug, half of the client received even mood stabilizers.

Duration of illness, no of medications was comparable in both groups.

Table 3: Frequency distribution of care givers of clients with BPAD N = 45

Variable	Study n = 23	Control n = 22	Sig
Education			
Primary	7 (30.4)	17 (77.2)	P = .001
Secondary	11 (47.8)	2 (9.1)	
Above	5 (21.7)	3 (13.6)	
Occupation			
Working	19 (82.6)	17 (77.3)	P = .001
Not working	4 (17.4)	5 (22.7)	
Marital status			
Married	21 (91.3)	17 (77.3)	P = .28
Single	2 (8.7)	5 (22.7)	
Relation			
Parents	13 (56.5)	16 (72.7)	P = .128
Siblings &others	9 (39.2)	5 (22.7)	
Spouse	1 (4.3)	1 (4.5)	

*chi square test

In the study group majority of the care givers had secondary education, in control group primary to secondary education. In both the group majority of the family members were working, and married. Many clients the primary care givers were parents even though the clients marital status was married.

Table 4: Correlation of FAST score with age of client, care giver and illness days n = 45

Variable	Mean ± SD	FAST score	Sig*
Age of the patient	31.4 ± 8.6	56.6 ± 9.4	P = .578
Age of the care giver	48.9 ± 14.2		P = .139
Illness days in previous year	18.58 ± 26		P = .528

*Pearson correlation test

In the above table shows that mean age of the clients were 31.4 ± 8.6. Mean age of the care giver were 48.9 ± 14.2. Mean illness days in previous year were 18.58. None were correlated with Functional level

Table 5: Comparison of improvement of functional level of bipolar clients from admission to follow-up

	Experimental group n = 23	Control group n = 22	Sig
Fast score at baseline	61.3 ± 9.1	61.1 ± 7.7	P = .083
Fast 1	44.6 ± 11.5	58.2 ± 9.48	P = .001*
Fast 2	31.6 ± 9.4	40.8 ± 12	P = .01*
Fast 3	18.4 ± 8.3	29.9 ± 12	P = .003*

*significant–Kruskal wallis test

Base line scores were comparable. There is a significant change in the mean score of the clients from admission to follow-up in both the groups. The mean score at the end of the study between study group and control group had significant difference with p =.003. This shows FFNI was Effective.

DISCUSSIONS

Bipolar illness are episodic and considered to be better outcome, but current study found that functional outcome is bad and impairment is evident. Functional improvement among treated Bipolar disorders is less than the syndromal and symptomatic recovery. Like previous studies current study also found mania is major sub type in BD in Indian population[18]unlike western countries[3, 18].

Mean FAST score level also was high which explains higher disability during acute period, similar findings have been reported in south India as well as study conducted in Australia[18-20].

Poorer over all functions in BD have been reported in the previous study conducted in Massachusetts [19] which supports current study findings. But study conducted in China had contrast findings than present study that patients with schizophrenia have more significant deficits in everyday functioning skills than healthy individuals and, in some domains, patients with affective disorders[20]. Primary care givers were mostly parent's even though the client had his own family.

Main objective of the study was to check the feasibility; it's feasible to conduct the study. From the base line functional impairment, client had improved functional level significantly at the end of the study which was statistically significant. The current findings were supported by previous studies, that reported Intensive psychosocial treatment enhances relationship functioning and life satisfaction among patients with bipolar disorder[16,17].

Limitations of the study was follow-up period attrition was un avoidable. 2 follow up only was possible. Since it's a pilot study associations between variables were not established.

CONCLUSION

Psychiatric nurse should assess the function of the client not only during admission even during remission period and plan for rehabilitation services. Since function is a complex and taxing task. But it's very important to bring back the client to his fullest possible level to normal life by planning effective psychoeducation about illness, communication training and teaching problem solving skills to client and family. Current study suggests that functional assessment and nursing intervention can help patient to come back to near normal functional level not only during or inter episode euthymic period but also during relapse period.

Conflict of Interest: Nil

Ethical Clearance: Institute Ethics Committee approved

Source of Funding: Self

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Stress, Anxiety and coping among Engineering Students at Selected College of Pokhara, Kaski, Nepal

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ABSTRACT

Background: Stress has been identified as a 20th century disease and has been viewed as a complex and dynamic transaction between individual and their environments. Stress can be regarded as a psychological threat, in which the individual perceives a situation as a potential threat.

Objectives: To assess the level of stress, anxiety and coping among engineering students at Pokhara University, Pokhara, Kaski, Nepal and to assess the association between demographic variables with level of stress and level of anxiety respectively and correlation between level of stress and level of anxiety.

Methodology: The descriptive survey approach was adopted for present study and conducted at Pokhara University, Pokhara, Kaski, Nepal. Purposive sampling technique was used to select samples and sample size was 182. The tool consisted of socio demographic proforma, Perceived Stress Scale , Zung Self Anxiety Rating Scale and Brief Cope Scale. Data was collected by self administered questionnaire. Data analysis and interpretation was done using SPSS for Windows Version 16.0.

Results: Majority of students have moderate level of stress and most of students experienced mild level anxiety. Most of the students use "planning" category of coping. There is significant association between level of stress and type of family, reason for choosing engineering and non significant association between age, sex, level of education, sources of income and residence and there is significance association between level of anxiety and reason for choosing engineering and non significant association between level of anxiety and are, sex, level of education, type of family, sources of income, residence and reason for choosing engineering. There is positive correlation between level of stress and level of anxiety at 0.05 level of significance($r = 0.171$).

Conclusion: The present study concludes that majority of students have moderate level of stress .Most of the students use "planning" category of coping. There is no significant association between socio demographic variables and level of stress and there is significant association between level of anxiety and socio demographic variables. There is significant correlation between stress and anxiety at 0.05 level of significance ($r = 0.171$).

Keywords: *Stress, anxiety, coping, engineering students.*

INTRODUCTION

Stress is the "non-specific response of the body to any kind of demand made upon it". Stress has been identified as a 20th century disease and has been viewed as a complex and dynamic transaction between individuals and their environments. Stress can be regarded as a psychological threat, in which the individual perceives a situation as a potential threat.[1]

Epidemiological studies have shown more than 50% of college students suffer from stress and anxiety worldwide and 70-80% of the diseases are related to stress. Studies show that more than 18% of college students in US are experiencing stress and among which 30% of the stress is due to the academic pressure. According to American Institute of stress 8 in 10 college students say they frequently experience stress in their daily basis. 13% of the students in UK are experiencing stress each year.[2]

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Stress has become an important topic in academic circle as well as in our society. Many scholars in the field of behavioral science have carried out extensive research on stress and its outcomes and concluded that the topic needed more attention. Since there is very few research on stress and anxiety among engineering student in Nepal and increasing incidence. So, researcher felt need for research in this topic.

RESEARCH METHODOLOGY

Descriptive study design was adopted for the study. The study was conducted at Pokhara University, Pokhara, Kaski, Nepal. Study population for study comprise of all semester engineering students, studying in Pokhara University, Pokhara, Kaski, Nepal. Sample was 182 engineering students from first year to fourth year studying Engineering at Pokhara University. Inclusion criteria was engineering students from Pokhara University, Pokhara, Kaski, Nepal and Engineering students who were willing to participate. Exclusion criteria were engineering students who were not available during the time of data collection.Non-probability purposive sampling technique was used to conduct the study. Data was collected through Self administered questionnaire with Socio-demographic Tool, Perceived stress scale, Zung self anxiety rating scale and Brief cope scale.Pretest was performed on 10% of total sample size at Western Regional Campus (WRC), Pokhara, Kaski, Nepal: Data was checked for completeness and consistency. The collected data was organized, coded and entered in SPSS. The data was analyzed by descriptive and inferential statistics. The study was conducted after approval from the ethical committees of Pokhara University. All the ethical norms were considered prior to the data collection.

RESULTS

Table 1: Description of sample characteristics (n = 182)

Sample Characteristics	F	%
Age (yrs)		
18-20	110	60.4 %
21-23	61	33.5 %
24-26	11	6.0 %
Sex		
Male	141	77.5%
Female	41	22.5%

Conted…

Level of education		
First year	48	26.4%
Second year	48	26.4%
Third year	37	20.3%
Fourth year	49	26.9%
Type of family		
Nuclear	143	78.6%
joint	38	20.9%
Sources of income		
Unemployed	3	1.6%
Unskilled worker	11	6.0%
Semi skilled worker	15	8.2%
Skilled worker	31	17.0%
Clerical, shop owner, farmer	46	25.3%
Semi professional	50	27.5%
Professional	26	14.3%
Residence		
Rural	58	31%
Urban	124	68.1%
Reason for choosing engineering		
Own choice	150	82.4%
Parental pressure	7	3.8%
Friends	2	1.1%
Abroad	6	3.3%
Job security	17	9.3%

Data presented on Table 1 shows that most of the participants (60.4%) were from age group 18-20, majority of the participants (77.5%) were male and were studying in fourth year (26.9%). Most of participants (78.6%) were from nuclear family. Most of the sources of income (27.5%) was through semi professional work. Majority of participants (68.1%) belong to urban area. Majority of participants choose engineering as a profession because of their own choice.

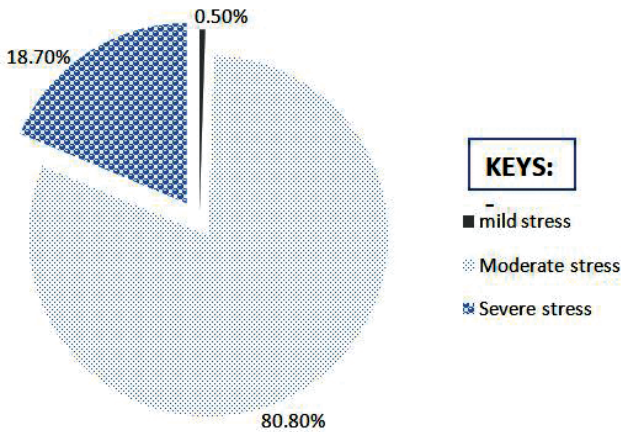

Figure 1: level of stress among engineering students

Data represented from fig 1 indicate majority (80.8%) of engineering students had moderate stress, 18.7% have severe stress and very less i.e (0.5%) of engineering students have mild stress.

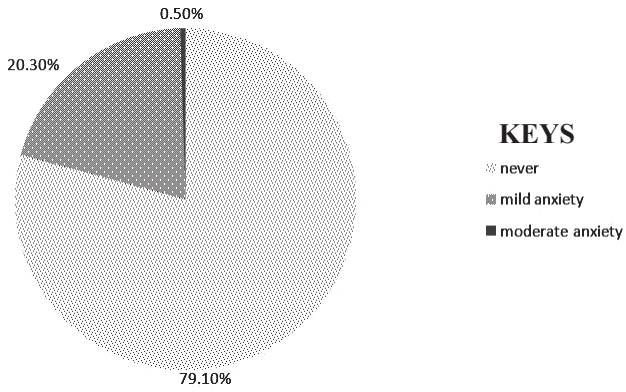

Figure 2: level of anxiety among engineering students

Data represented from fig 2 indicate majority (79.1%) of engineering students never experience anxiety, (20.3%) experience mild level of anxiety,(0.5%) of engineering students experience anxiety in moderate amount.

Table 2: table showing frequency and percentage of Coping (n = 182)

Items	Never N (%)	Little bit N (%)	Moderate Amount N (%)	A lot N (%)
Self distraction				
turning to work or other activities	24 (13.2)	62 (34.1)	57 (31.3)	39 (21.4)
doing something to think about it less.	11 (6.0)	50 (27.5)	73 (40.1)	48 (26.4)
Active coping				
concentrating my efforts on doing something	6 (3.3)	47 (25.8)	64 (35.2)	65 (35.7)
taking action to try to make the situation better	8 (4.4)	27 (14.8)	68 (37.4)	79 (43.4)
Denial				
saying to myself "this isn't real."	44 (24.2)	70 (38.5)	48 (26.4)	20 (11.0)
refusing to believe that it has happened.	47 (25.8)	63 (34.6)	51 (28.0)	21 (11.5)
Substance abuse				
using alcohol or other drugs to make myself feel better.	119 (65.4)	25 (13.7)	18 (9.9)	20 (11.0)
using alcohol or other drugs to help me get through it	112 (67.0)	28 (15.4)	21 (11.5)	11 (6.0)
Emotional support				
getting emotional support from others	27 (14.8)	62 (34.1)	47 (25.8)	46 (25.3)
getting comfort and understanding from someone	20 (11.0)	51 (28.0)	66 (36.3)	45 (24.7)
Instrumental support				
getting help and advice from other people	17 (9.3)	48 (26.4)	64 (35.2)	53 (29.1)
trying to get advice or help from other people about what to do.	11 (6.0)	52 (28.6)	62 (34.1)	57 (31.3)
Behavioral disengagement				
giving up trying to deal with it.	66 (36.3)	47 (25.8)	45 (24.7)	24 (13.2)
giving up the attempt to cope.	68 (37.4)	49 (26.9)	50 (27.5)	15 (8.2)

Conted…

Venting				
saying things to let my unpleasant feelings escape	46 (25.3)	71 (39.0)	44 (24.2)	21 (11.5)
expressing my negative feelings.	59 (32.4)	69 (37.9)	35 (19.2)	19 (10.45)
Positive reframing				
trying to see it in a different light, to make it seem more positive.	18 (9.9)	40 (22.0)	68 (37.4)	56 (30.8)
looking for something good in what is happening	4 (2.25)	25 (13.7)	69 (37.95)	84 (46.25)
Planning				
trying to come up with a strategy about what to do.	10 (5.5)	35 (19.25)	62 (34.1)	74 (40.7)
thinking hard about what steps to take.	12 (6.6)	29 (15.9)	63 (34.6)	78 (42.9)
Humor				
I've been making jokes about it.	51 (28.0)	58 (31.9)	35 (19.2)	38 (20.9)
I've been making fun of the situation.	41 (22.5)	52 (28.6)	43 (23.6)	46 (25.3)
Acceptance				
accepting the reality of the fact that it has happened.	18 (9.9)	30 (16.5)	67 (36.8)	67 (36.8)
learning to live with it.	10 (5.5)	30 (16.5)	73 (40.1)	69 (37.9)

Data presented in table 2 shows that 40.1% of participants do something to think about the stress less, such as going to movies, watching TV, reading, day dreaming, sleeping or shopping in moderate amount. Majority 43.4% of the participants takes an action to try to make the situation better as an active coping method. 38.5% of the participants sometimes says that the situation is not real as a denial method of coping. Majority 67.0% of the participants never use alcohol or other drugs to help get through the stressful situation. 34.1% of the participants gets emotional support from others to cope up with the stressful situation .35.2% of the participants get help and advice from other people to cope and very few 6.0% of the participants never try to get advice or help from other people about what to do. 37.4% of the participants never give up the attempt to cope and very few 13.2% give up trying to deal with the situation most of the time. 39.0% of the participants most of the time looks for something good in happening and 9.9% never try to see the things in different light to make it seem more positive. 42.9% of the participants do planning and think hard about further steps to take most of the time and 5.5% of the participants never do planning up with a strategy about what to do. 31.9% of the participants sometimes have been making jokes about the situation to cope. 40.1% of the participants often accepts the situation and learn to live with it and 9.9% of the participants never accept the reality of the fact that has happened.31.9% of the participants most of the times try to find comfort in their religion or spiritual beliefs and 17.6% never try to find comfort in their religion or spiritual beliefs. 37.4% of the participants never criticize themselves for the stressful situation and 15.4% most of the time blame themselves for things that happened.

Table 3: Association between level of stress and selected socio demographic variables (n = 182)

Socio-demographic variables	Level of stress			Chi-square		df	Significance
	Mild stress	Moderate Stress	Severe stress	Calculated value	Tabulated value		
Type of family							
Nuclear	0	120	23	6.099	5.99	2	S
Joint	1	27	10				
Reason for choosing engineering							
Own choice	0	124	26	15.705	15.51	8	S
Parental pressure	0	4	3				
Friends	0	1	1				
Abroad	0	6	0				
Job security	1	12	4				

At $p < 0.05$, NS = Non significant, S = Significant

Table 3 reveals that there is significant association between level of stress and type of family, reason for choosing engineering and non significant association between age, sex, level of education, sources of income and residence.

Table 4: Association between level of anxiety and selected socio demographic variables n = 182

Socio-demographic variables	Level of anxiety				Chi-square		df	Significance
	Normal	Mild to moderate	Moderate to Severe	Extreme	Calculated value	Tabulated value		
Reason of choosing engineering								
Own choice	117	33	0	0	28.770	15.51	8	S
Parental pressure	5	1	1	0				
Friends	1	1	0	0				
Abroad	5	1	0	0				
Job security	16	1	0	0				

P < 0.05, S = Significance, NS = Not significant

Table 4 reveals that there is significance association between level of anxiety and reason for choosing engineering and non significant association between level of anxiety and are, sex, level of education, type of family, sources of income, residence and reason for choosing engineering.

Table 5: Co-relation between level of stress and level of anxiety (n = 182)

Variables	Correlation coefficient (r)	P value	Significance
Level of stress	0.171	0.021	Significance
Level of anxiety			

Table 5 shows that correlation between level of stress and level of anxiety was found to be positive at significant level of 0.05. Therefore, the researcher rejects the null hypothesis and accepts the alternative hypothesis which can be concluded that there is significant relationship between level of stress and level of anxiety.

DISCUSSION

A comparative research study was conducted by Kumar.S and Bhukar.j.p among engineering students in India showed that stress level was high among girls[3]. This study supports the present study as (22.20%) girls had severe stress as compared to boys.

A descriptive study was conducted by Lisa Schneider at Cornell University College of engineering showed that perceived stress level varied significantly by gender.[4] This study supports the present study as level of perceived stress difference among male and female and severe stress is high among female.

A Cross-sectional study was conducted by Waghachavare.V.B in Sangi district of western Maharashtra India showed that there was no statistical significant between stress and environmental factors.[5] Which is consistent with present study where there is no significant correlation between stress and environmental factors such as residence.

A Co relational study conducted by Aziah.A, Norzaidi.M, Choy Chong.S and et.all at Malaysia to examine the relationship between stress factors and the level of perceived stress at three different periods of semester and their impact on the academic performance of Diploma Engineering students. Study showed that in an overall students expressed moderate level of stress[6]. This study supports the present study where majority of the students experiences moderate level of stress.

CONCLUSION

The present study concludes that the majority of students have moderate level of stress and most of students experienced mild level of anxiety. Most of the students use “planning” category of coping. There is significant association between level of stress and

type of family, reason for choosing engineering and non significant association between age, sex, level of education, sources of income and residence and there is significance association between level of anxiety and reason for choosing engineering and non significant association between level of anxiety and are, sex, level of education, type of family, sources of income, residence and reason for choosing engineering. There is positive correlation between level of stress and level of anxiety at 0.05 level of significance (r = o.017, p = 0.02).

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Effectiveness of Structured Teaching Programme on Level of Knowledge Regarding Safe Motherhood among Antenatal Mothers at Maternity Centre, Salem

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ABSTRACT

The world health organization estimated that 150 million pregnancies occur annually. pregnancy related complications die nearly 6, 00,000 each year; of these 99% of death occurs in developing countries. Quantitative experimental research approach was adopted for this study. 60 samples were selected (n=60) at gestational weeks of 28-34 weeks based on inclusion criteria by using purposive sampling technique. Pre-test was conducted with the help of structured interview schedule. Structured teaching programme on safe motherhood was given and post test was conducted after 15 days. The study findings showed that Majority of the mothers (53%) were between 33-34 weeks of gestation. In pretest 88% of mothers had inadequate knowledge, whereas in post test 68% of mothers had moderately adequate knowledge. The mean pretest score was 11.79±6.07 whereas in post test mean score was 32.66± 6.47. The calculated't' value was 26.14 which was highly significant at $p \leq 0.05$ level. Hence it was proved that the structured teaching programme on knowledge regarding safe motherhood was effective**.** There was no significant association between pre and post test knowledge scores with demographic variables.

Keywords: *Safe Motherhood, Pregnancy,Structured teaching programme*

INTRODUCTION

The Safe Motherhood Initiative was launched by the World Health Organization (WHO) and other international agency includes UNICEF, UNFPA, World Bank, Population Council and IPPF in 1987 and was immediately supported by ICM. At that time the number of women suffering maternal deaths worldwide was estimated to be at least 600,000 each year with 99% of deaths occurring in the developing world. The most common direct causes of such deaths are known to be severe bleeding infection leading to sepsis the effects of unsafe abortion, eclampsia, hypertension, obstructed labour, anaemia and malnutrition.[1]

Almost 35% of women in developing countries receive no antenatal care during pregnancy; in some countries antenatal coverage is as low as 26%. Millions of women do not have access to good quality of health services during pregnancy and childbirth, especially, women who are poor, uneducated or who live in rural areas (UNFPA 1996). [2]

The goal of Safe Motherhood Initiative is to cut maternal mortality by half by the year 2010, global experience has shown that pregnancy related deaths are preventable and a significant body of research on strategies for reducing maternal mortality has been generated. It is addressed to governments, policy makers, program managers and each of the respective agencies personnel and is intended to guide their decision making to ensure safer pregnancy and childbirth.[3]

The primary focus of modern obstetrical nursing is on preventive care of pregnant women. The main aim of which is to help the mothers to have a safe and natural childbirth. Successful antenatal care and education can better prepare women and families to care for themselves. As a result, it reduces to one maternal death in a village of 1000 population and it takes 9-10 years to see it.[4]

Developments and trends of safe motherhood initiative since 1987, has identified, Essential steps needed to reduce maternal mortality, early diagnosed and now emphasizes making skilled care available for each birth. Countries that provide skilled birth attendants and access to emergency obstetric care have cut their maternal deaths. Tunisia reduced its maternal mortality rate by 80% in 23 years with such a comprehensive

strategy and Sri Lanka reduced its maternal mortality rate from more than 1,500 per 100,000 live births in the 1960 and 30 today. [5]

The world health organization estimated that 150 million pregnancies occur annually. Among these women who die of pregnancy related complications, nearly 6,00,000 women die each year; of these 99% of death occurs in developing countries.[6]

India has a high mortality rate. In India, in every 5 minutes 1 women dies from complications related to pregnancy and child birth. This adds upto total of 1,21,000 women per year. Maternal mortality rate in 1938 was 20 per 1000 live birth in 1954. In 1990 maternal mortality rate in India was per 1,00,000 live birth. The trend as not changed in last 5 years. This means more than 1,00,000 women die each year due to pregnancy related to causes.[7]

According to sample registration survey estimates 1.1% of all deaths in the country in 1991 were due to maternal causes. An estimate 82,93,770 deaths occured of which 91,231 were related to pregnancy and childbirth. Unless appropriate measures are taken its may reach its peak and endanger the life of mother's. Studies also indicate that it is more with the illiterate or for those who have poor knowledge regarding safe motherhood.[8]

Statement of the Problem: A study to evaluate the Effectiveness of STP on level of knowledge regarding safe motherhood among antenatal mothers at Maternity Centre, Salem.

OBJECTIVES

1. To assess the level of knowledge on safe motherhood among antenatal mothers before implementation of structured teaching programme.
2. To assess the effectiveness of structured teaching programme on safe motherhood.
3. To associate the pre and post test scores with selected demographic variables among antenatal mothers.

Hypotheses:

- **H_1:** There is a significant difference between pre and post test knowledge scores on safe motherhood among antenatal mothers at $p \leq 0.05$ level.
- **H_2:** There is a significant association between pre and post test knowledge scores with selected demographic variable among antenatal mothers at $p \leq 0.05$ level.

Conceptual Framework: The investigator adopted Modified Widenbach's Prescriptive Theory -A helping art of Clinical Nursing(1964) theory as a basis of conceptual framework, which is aimed to assess the effectiveness of Structured Teaching Programme on Safe motherhood among antenatal mothers.

MATERIALS & METHOD

Quasi experimental one group pre-test and post-test research design was used for this study. The study was conducted in Anna Maternity Centre, Salem. Purposive Sampling technique was adopted and selected 60 Antenatal mothers for this study. The inclusion criteria were Mothers of both primi and multigravida and also have 28-34 weeks of gestation. Structured Interview Schedule and structured Teaching Programme were used to assess the pre test and post test knowledge score. The researcher obtained permission from the Medical Officer of Anna Maternity Centre. Pre-test was conducted by structured interview schedule. Structured teaching programme on safe motherhood was given and post test was conducted after 15 days by using same Structured Interview Schedule. Descriptive statistics were used to assess the level of knowledge regarding safe motherhood. Inferential statistics such as paired't' test was used to assess the pre and post test scores on knowledge. Chi-square test was used to associate the pre and post test scores with their demographic variables.

RESULTS &DISCUSSION

The highest percentage (63%) of mothers in the age group were 21-25 years. The maximum percentage (35%) of mothers was completed secondary education and Majority of the them (32%) were daily wages. Maximum half of the mothers (49%) belongs to nuclear family and have the family income of less than Rs.3000 (44%). Majority of the mothers (53%) were between 33-34 weeks of gestation, and more or less similar percentage of mothers were between 28-30 weeks (27%) and 31-32 weeks of gestation (20%). The maximum percentage (62%) of mothers were primi and (38%) of mothers were multigravida mothers. Most of the mothers (40%) received information regarding safe motherhood through their family members and more or less similar percentage of mothers obtained information through Radio and Television (12%) and books and newspaper (15%) respectively.

Distribution of mothers according to their pre and post test level of knowledge on safe motherhood

Table1: Distribution of mothers according to their pre and post test level of knowledge on safe motherhood N = 60

Level of knowledge	Pre test		Post test	
	f	%	f	%
Inadequate knowledge	53	88	-	-
Moderately adequate knowledge	7	12	41	68
Adequate knowledge	-	-	19	32

Distribution of mothers according to their pre and post test level of knowledge on safe motherhood shows that in pre test 88% of mothers had inadequate knowledge and 12% of mothers had moderately adequate knowledge. Whereas in post test 68% of mothers had moderately adequate knowledge and 32% of mothers had adequate knowledge.

Area wise comparison of Mean, Standard deviation and mean percentage of pre and post test knowledge scores.

Table 2: Area wise comparison of Mean, Standard deviation and mean percentage of pre and post test knowledge scores on safe motherhood among antenatal mothers

S. No.	Area of knowledge	Max score	Pre-test			Post-test			Difference in mean %
			Mean	SD	Mean %	Mean	SD	Mean %	
1.	Antenatal care	14	4.0	2.0	29	11.44	2.53	82	53
2.	Intranatal care	8	2.44	1.56	30	6.36	1.56	80	50
3.	Postnatal care	12	4.44	1.56	37	10.5	1.28	88	51
4.	Newborn care	6	0.91	0.95	15	4.3	1.10	72	57
Total		40	11.79	6.07	27.5	32.6	6.47	80	211

In pre test the highest mean knowledge score was 4.44 ± 1.56, which is 37% in the area of post natal care and the lowest mean score was 0.91 ± 0.95 which is 15% for the area of newborn care. Whereas in post-test the highest mean knowledge score was 11.44 ± 2.53 which is 82% in the area of Antenatal care and the lowest mean score was 4.3 ± 1.10 which is 72% for the area of newborn care. However the highest difference in mean percentage between pre and post test score was 53% for the area of antenatal care and the lowest mean percentage (50%) for the area of intranatal care. Hence it shows that STP was effective on safe motherhood among antenatal mothers.

Hypotheses testing

H_1: There is a significant difference between pre and post test knowledge scores on safe motherhood at P≤ 0.05 level.

Table 3: Assess the difference between mean, SD and't' value of pre and post test knowledge scores on safe motherhood n = 60

S. No.	Knowledge	Maximum score	Mean	SD	't' value
1.	Pre-test	40	11.79	6.07	26.14*
2.	Post-test		32.6	6.47	

Significant at P ≤ 0.05 level; Table value = 2.021, df = 59

Comparison of mean, standard deviation and 't' value on safe motherhood reveals that in pretest the antenatal mothers had mean score of 11.79±6.07 where as in post test mean score was 32.66± 6.47.The calculated 't' value was 26.14 which was highly significant at p≤0.05 level. Hence it can be interpreted that the difference in the pretest and posttest mean score value of knowledge regarding safe motherhood is true difference and hypothesis H_1 is retained. This reveals the planned teaching programme on knowledge regarding safe motherhood was effective.

H_2: There will be a significant association between the effect of STP on pre and post test knowledge scores on safe motherhood and their demographic variables.

Table 4: Association between pre and post test knowledge scores on safe motherhood with their demographic variables n = 60

S. No.	Demographic variables	Pre Test			Post Test		
		df	Table value	χ^2	df	Table Value	χ^2
1.	Age in Years	3	7.81	0.14	3	7.81	0.68
2.	Educational status	2	5.99	0.64	2	5.99	0.86
3.	Occupation	1	3.84	0.96	1	3.84	0.12
4.	Type of family	2	5.99	0.55	2	16.27	5.99
5.	Monthly income	2	5.99	0.75	2	5.99	0.81
6.	Gestational age	1	3.84	0.56	1	3.84	0.52
7.	Obstetrical score	1	3.84	0.879	1	3.84	0.59
8.	Source of information	4	9.49	0.38	4	9.49	0.30

*Significance at $p < 0.05$ level

The above table shows that there was no significant association found between pre and post test knowledge scores on safe motherhood and their demographic variables. Hence H_1 is rejected at $p>0.05$ level.

CONCLUSION

In pre test 88% of mothers had inadequate knowledge and 12% of mothers had moderately adequate knowledge. Whereas in post test 68% of mothers had moderately adequate knowledge and 32% of mothers had adequate knowledge. In pre test the antenatal mothers had mean score of 11.79±6.07 where as in post test mean score was 32.66± 6.47.The calculated t' value was 26.14 which were highly significant at $p\leq0.05$ level. There was no significant association found between pre and post test knowledge scores on safe motherhood and their demographic variables at $p>0.05$ level.

IMPLICATIONS

Nursing research:

- The finding of the study can be disseminated through publication and presentation in conferences and seminars.
- Educational institutions and service organizations can motivate researcher for implementing the teaching programmes to the mother related to safe motherhood.

Nursing practice:

- Midwives working in the maternity hospitals and centers can teach the antenatal mothers regarding safe motherhood and improve their knowledge.
- Nurses and other health team members can motivate mothers to practice safe motherhood.

Nursing Administration:

- Nurse administrator can organize educational programme regarding safe motherhood for mothers attending antenatal OPD.
- Nurse administrators can organize workshop or seminars for the nurses working in the community set up regarding newer technique of safe motherhood.

Recommendation:

- A comparative study can be done to assess the knowledge of mothers in urban and rural area on safe motherhood.
- A study can be done to identify the practice of antenatal mothers regarding safe motherhood in the community.
- A study can be done to assess the knowledge on safe motherhood among nursing students.

Conflict of Interest: Nil

Source of Funding: Self Funded

Ethical Clearance: Obtained from Institutional ethical board.

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A Study to Compare the Effects of Music Therapy and Laughter Therapy on Reducing Level of Depression among Old Age People Old Age Homes

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ABSTRACT

The Researcher aims to compare the effects of music therapy and laughter therapy on reducing level of depression among old age people in selected old age homes. Review of literature shows that depression is most common psychological problems among old age group. Music and laughter therapy is a effective non pharmacological, non invasive therapy to reduce the level of depression among elderly people in old age homes.

Keywords: *Music therapy, Laughter therapy, Level of depression, Old age people*

INTRODUCTION

The world's population is rapidly aging and developing countries are more involved with such issue. According to the United Nations' estimates, elderly population is predicted to increase from almost 10.5% of the total population in 2007 to 28.8% by 2050. [1] Aging is a worldwide issue in our society, Elderly people living in old age homes may suffer from sadness, pain and isolation. Numerous studies have documented a high prevalence of depressed mood and other depressive symptoms in elderly Persons living in the community.[2] The National Institute of Mental Health's epidemiologic catchment Area (ECA)program found that one of the most common mental disorders of elderly are depressive disorders.[3] Music therapy minimizes the pain and enhances sleep. Music therapy has been recognized as an effective method in helping the elderly improve both their physical and mental health.[4]Laughter therapy has been also used to reduce depression among elderly people. Laughter therapy is a unique concept which uses laughter as a group exercise, as it is a physically oriented technique. Laughter therapy is the only technique that allows adults to achieve sustained laughter without involving in cognitive thought.[5]

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MATERIAL METHODS AND FINDINGS

The study is to compare the effects of music therapy and laughter therapy on level of depression among old age people in old age homes.

REVIEW OF LITERATURE

1. Haejinko and Changho youn conducted study to investigate the effects of laughter therapy on depression, cognitive function, quality of life, and sleep of the elderly in a community. Between July and September 2007, the total study sample consisted of 109 subjects aged over 65 divided into two groups; 48 subjects in the laughter therapy group and 61 subjects in the control group. The subjects in the laughter therapy group underwent laughter therapy four times over 1 month. Study

compared Geriatric Depression Scale (GDS), Mini-Mental State Examination (MMSE), Short-Form Health Survey-36 (SF-36), Insomnia Severity Index (ISI) and Pittsburgh Sleep Quality Index (PSQI) between the two groups before and after laughter therapy. There were no significant differences in baseline characteristics between the two groups. Laughter therapy is considered to be useful, cost-effective and easily-accessible intervention that has positive effects on depression, insomnia, and sleep quality in the elderly.[6]

2. A randomised controlled study was conducted by Moon Fai Chan, Zi Yang Wong, Hideaki Onishi and Naidu Vellasamy Thayala, from July 2009–June 2010 at participants' home in Singapore. In total, 50 older adults (24using music and 26 control) completed the study after being recruited. Participants listened to their choice of music for30 minutes per week for eight weeks. Depression scores were collected once a week for eight weeks. Depression levels reduced weekly in the music group, indicating a cumulative dose effect, and a statistically significant reduction in depression levels was found over time in the music group compared with non-music group. So Listening to music can help older people to reduce their depression level. Music is a non-invasive, simple and inexpensive therapeutic method of improving life quality in community-dwelling older people.[7]

3. J korean conducted study to investigate the effects of visiting laughter therapy on depression and insomnia in the vulnerable elderly. A quasi-experimental non equivalent control group pre tests-post test design was used for this study. The participants were 87 elderly who were registered in the Tailored Visiting Health Program of public health centers. Data were collected from September to November 2010.The experimental group received 10~15 min of laughter therapy once a week for 8 weeks. The instruments included Geriatric Depression Scale and Insomnia Severity Index to measure depression and sleep problems before and after the laughter therapy. The results showed that visiting laughter therapy was effective in decreasing depression and insomnia among the vulnerable elderly. These findings indicate that laughter therapy may be an effective nursing intervention to improve depression and insomnia.[8]

4. JaakkoErkkila¨, Marko Punkanen, Jo¨rgFachner, EsaAla-Ruona, Inga Po¨ ntio¨ , Mari Tervaniemi, MaunoVanhalaand Christian Gold et al, conducted study to determine the efficacy of music therapy added to standard care compared with standard care only in the treatment of depression among working-age people in 2011.Participants (n = 79) with an ICD–10 diagnosis of depression were randomised to receive individual music therapy plus standard care (20 bi-weekly sessions) or standard care only, and followed up at baseline, at 3 months (after intervention) and at 6 months. The response rate was significantly higher for the music therapy plus standard care group than for the standard care only group (odds ratio 2.96, 95% CI 1.01 to 9.02). Individual music therapy combined with standard care is effective for depression among working-age people with depression.[9]

5. Jinliangwang, Haizhenwang, and Dajunzhang conducted study to examine the effects of group music therapy on depression and mental health among college students in 2011. The balance group pre-test and post-test experimental design was used. The college students with the score of self-rating depression scale, greater than 40 and score of depression factors of SCL-90, the symptom checklist, greater than 2.18 are selected as the participants.80 students participated in this study, with 40 assigned to control group and other 40 assigned to experimental group. The results showed that after the group music therapy, for the experimental group, the depression scores have reduced significantly and the mental health scores have improved, while for the control group, no significant difference was obtained on the depression and mental health scores. This indicates that group music therapy can effectively reduce depression and improve mental health.[10]

6. Ravikumar conducted study to aseess the effectiveness of music therapy on level of depression among elderly people residing in selected old age home in Pune in 2012.Quasi Experimental study with pre-test and post-test design was used. 60 samples (30 experimental and 30 controls) were selected as per the inclusion criteria using Non-Probability Purposive Sampling. In pre -test 76.7% of elderly people of experimental Group were having moderate

depression score (11-15). In pre -test 73.3% of elderly people of control Group were having moderate depression score (11-15). In post test, in the experimental group, 50% of the people had mild depression score (6-10). In post-test, in the control group, 80% of the people had moderate depression score (11-15), which indicates that the music therapy is effective in reducing the depression of the elderly people residing in old age home.[11]

7. Jaya rani George and Vineetha Jacob conducted study to assess the effectiveness of laughter therapy on depression among elderly people in selected old age homes at Mangalore in 2014. The study design was two group pre-test post-test design. Purposive sampling technique was used for selecting 60 samples above the age of 60 years. The tool used for the study were demographic proforma and modified Geriatric Depression Scale. There was a significant difference between pre-test depression score and the post-test depression scores ($t = 37.696$, $p < 0.05$).The findings of the study shows that the intervention programme was effective in reducing the depression among elderly people.[12]

8. The experimental study was conducted by Elham Mohamad Esmail and Taiebe Ahromi Boshehri to compare the effects of laughter therapy and play therapy on reduction of depression symptoms in primary school girls. 36 sample of Tehran's primary school girls were selected by purposive sampling and randomly assigned in three groups Play therapy, laughter therapy and the control group in the academic year 2014/15. Research tool was CSI-4 questionnaire. Eight therapy sessions were considered for every experimental group. Then the post-test was administered. The results of one-way ANOVA indicated laughter therapy and play therapy reduced depressive symptoms. According to findings, laughter therapy and play therapy techniques, recommended to psychotherapists in order to reduce the symptoms of depression in children.[13]

9. The pre experimental study was conducted by Shine George Joseph and Riaz K.M. to assessing the effect of laughter therapy on depression among 30 elderly between the age group of 60-80 years residing in selected old age homes of kerala in 2015. Semi structured interview schedule was used to collect socio demographic data; Modified Beck Depression Inventory was used to assess the level of depression of elderly. The laughter therapy given to elderly residing in an old age home has significantly reduced their level of depression (P0.05). The study reveals that there was no significant association between level of depression and selected demographic variables (P>0.05).Laughter therapy may be an innovative option to promote a healthy environment for individuals in family and in other community settings.[5]

10. Pre-experimental one group pre-test post test study was conducted by Srinivasan to evaluate the effectiveness of music therapy on quality of life with 40 elderly inmates in Old age home (InbaIllam), Pasumalai at Madurai in 2015.Total enumerative sampling was used and the data was collected by WHO QOL old BREF scale with interview technique before and after music therapy. Study subjects were given with Music therapy in open mode technique to all samples daily for 30 minutes for the period of 24 days. There was a significant difference in the mean score of quality of life before and after music therapy and it was statistically significant at 0.05 level. Further there was a significant association between the level quality of life and education at 0.05 level. Thus, study finding concludes that music therapy was significantly effective to improve quality of life among elderly.[4]

11. Padmapriya, Prabavathy , and Renukha conducted study to assess the effectiveness of Music Therapy on level of depression among elderly in Volontariat Home, Oupalam, Puducherry in 2015. A Quantitative Quasi Experimental study (Pre-experimental- one group pre and post test design) done among 40 elderly people with Depression. Data were collected using Hamilton Depression Scale. Data analysis was done using inferential and descriptive statistics. Majority of the samples had Normal and Mild level of Depression. The mean pre test values of Depression score had significant difference during post test measurement of mean Depression score which proved that there was significant reduction in the level of Depression among Elderly due to Music therapy. This study

it was proven that Music therapy reduces the level of Depression among Elderly suffering from Depression.[14]

12. The pre–experimental study was conducted by Gangadghar Rao Kalapala to investigate the effective of music therapy on depression among elderly people staying in the old age home in Hyderabad IN 2017.The study employs the pre-test and post–test for assessing the level of depression among the elderly persons in the old age homes , and with respect to the demographic variables which are used for assessing the levels of depression among both males and females from the study. Findings clearly showed that there was mild level of depression among elderly people before the intervention and the level of depression was decrease after the intervention. Overall 63.3% of samples 38 have mild depression and 20% of the samples 12 have severe depression and remaining are normal in pre-test. The music therapy plays a crucial role in reducing depression among the elderly persons who are residing at the old age homes.[2]

CONCLUSION

Researcher felt that Music and laughter therapy can be effective non pharmacological, non invasive therapy. So that the present study to compare the effectiveness of therapy to reduce the level of depression among elderly people in old age homes is planned to assess more effective means to reduce depression among old age people.

Conflict of Interest: None

Source of Funding: No separate funding was received for this study.

Ethical Clearance: The ethical clearance obtained from our institute.

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Knowledge and Attitude Regarding Inclusive Education among School Teachers

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ABSTRACT

Inclusive education means the process of placing students with disabilities or special needs in classrooms with children who do not have such disabilities or needs. The present study aimed to assess the school teacher's knowledge and attitude regarding inclusive education. The main objective of the study was to assess the knowledge and attitude regarding inclusive education among school teachers.The research approach was quantitative and descriptive design was used for the study. The setting of the study was selected schools in Venganoor Panchayath Trivandrum. Sample consisted of 50 teachers selected by multistage sampling technique. In the first stage, 2 schools (1 from Government and 1 from private) in Venganoorpanchayath were selected. In the second stage, 25 teachers working in each school were selected randomly by lottery method. Structured self- administered questionnaire was used to assess the knowledge and rating scale was used to assess the attitude regarding inclusive education among school teachers. Data were collected by self- report method after getting informed consent from the study participants. Results revealed that majority of the teachers 66 % were having average knowledge regarding inclusive education, 10% were having low knowledge and 24% were having high knowledge. The mean score for overall knowledge was 6.4 and standard deviation was 1.54. Out of the 50 subjects, 80%had positive attitude towards inclusive education and18% had a neutral attitude. The mean score for overall attitude was 58.4 and standard deviation was 6.53. There was significant association between knowledge of teachers and educational status. Selected socio-demographic variable such as gender and educational qualification was found to have significant association with attitude. It can be concluded that school teachers lack appropriate knowledge even though they had positive attitude regarding inclusive education. There is a need for schools to provide more special educational needs training, for implementing the special educational needs (SEN) strategies in the classrooms as well as offering teachers new strategies onimproving their knowledge and attitude towards inclusive education.

Keywords: *Knowledge, Attitude, Inclusive education, School teachers*

INTRODUCTION

Education is the most powerful and effective instrument for including radical changes in the behavior of students.It is reported that ten percent of our school aged children show evidences of specific learning disabilities and they can be considered as children with special needs. Children with special needs are those who deviate mentally, socially, educationally, physically or culturally from normal children. Such children need special educational care and their learning problems are to be tackled in a special manner. Educating these differently abled children is a challenging task in human resource development. Until the late18th and early 19th centuries no attempts were made to treat disadvantaged individuals in a human fashion.[1]

UNICEF's Report on the Status of Disability in India 2000 states that there are around 30 million children in India suffering from some form of disability. The Sixth All-India Educational Survey (NCERT, 1998) reports that of India's 200 million school-aged children (6–14

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years),20 million require special needs education. While the national average for gross enrolment in school is over 90 per cent, less than five per cent of children with disabilities are in school.[2]

Inclusion in education is an approach to educating students withspecial educational needs. Children with special needs have always been segregated from their peers. Parents of those children were discriminated and humiliated.[1]The plan of action to improve education system created by the Education Commission (1964 - 66) suggested that people with disabilities should be included in mainstream and attempts should be made to bring in as many children in integrated programs. The concept of including children with disabilities in regular education environments has been identified using many labels main streaming, integration, and most currently, inclusion. Inclusion seeks to educate children with disabilities in regular education classrooms rather than in segregated settings.[2]A successful inclusive learning community fosters collaboration, problem solving, self directed and critical discourse, it also allows (a) students with extra rate (b) students who progress slower than the average to move at the best of their ability and (c) students with specific learning challenges to receive creative and effective support to maximize the success.

The movement towards inclusive education has various potential advantages not only for the child with special educational needs, but also for the child without any disability. In the case of the child without a disability, this can lead to positive changes in attitude towards disability. In addition, growing opportunities for social contact with fellow learners who are not disabled can create tolerance towards diversity and facilitate friendships.[2]

The government has recently launched the SarvaShikshaAbhiyan (SSA). This proposes to implement 'universalization of elementary education' (UEE) in a mission mode with a focus on providing quality elementary education to all children in the age group 6–14 years. Inclusive education is an integral component of SSA, and promises to make 'education for all' a reality by 2010.[2]

Survey of various studies conducted on inclusive education in India and abroad helps to understand more about inclusion and its importance today. It clearly emphasizes how important the role of school and teacher is, in dealing with inclusion, and making it successful. Methods and techniques are developed to give Special education for specific disabilities in special schools but for inclusive education few efforts about program & curricula can be listed out especially in India. Providing access to education is only the first stage in overcoming exclusion or discrimination. There is a need for a shift in perspectives and values so that diversity is appreciated and even welcomed, while teachers are given skills to provide all children, including those with different learning needs, with quality education.

Nayak (2008) focused on the attitude of parents and teachers towards inclusive education. Findings indicated significant difference between the opinions of parents of differentially abled children, parents of normal children and teachers of normal children.[3]

In the present scenario, it is seen that the previous system of education-general schools and special schools is now changing as inclusive schools. In this respect it becomes essential to assess the attitude and knowledge level of teachers. Attitude of the teachers towards inclusion is of much importance.

Teacher requires right type of awareness and attitude on various aspects of diverse abilities, causes and characteristics, identification and assessment, teaching and training methods and guidance and counseling to the children with diverse abilities, their parents and community.[4]Such an awareness and attitude will lead to better competencies in teachers. A teacher with right type of awareness, attitude and competencies is an asset to any institution offering programmes for the differently abled. By considering all these factors, investigators decided to find out the knowledge and attitude of teachers towards inclusive education.

METHODOLOGY

The present study was conducted to assess the knowledge and attitude regarding inclusive education. A prior permission was obtained from the concerned authority of the schools of Venganoor Panchayath, Thiruvananthapuram for conducting the study. Ethical clearance was obtained from the institutional ethics committee. Informed consent was obtained from the participants and data collection was done over one week among 50 teachers who met the inclusion criteria. Subjects were selected by Multistage sampling technique. Questionnaire was distributed among participants and information was collected by self report method. The subjects took about 20 – 30 minutes to answer the questions.

The objectives of the study were to:

1. Assess the knowledge regarding inclusive education among school teachers
2. Assess the attitude regarding inclusive education among school teachers
3. Determine the association between knowledge and selected socio demographic variables
4. Determine the association between attitude and selected socio demographic variables

The Quantitative approach was used and the research design was descriptive. The setting of the study was selected schools in Venganoor Panchayath. Sample size was 50. Multistage sampling was adopted for the study. In the first stage 2 schools (1 from Government and 1 from private) in Venganoor Panchayath were selected. In the second stage 25 teachers working in each school were selected randomly by lottery method.

TOOL AND TECHNIQUE

Tool was developed by the investigator. It consists of three parts

Part A: Questionnaire to assess socio-demographic and personal information

Part B: Questionnaire to assess knowledge on inclusive education consists of 10 questions related to inclusive education. Each right answer carries 1 mark.

Part C: Attitude scale to assess the attitude regarding inclusive education. It consists of 24 questions with rating as agree, neutral and disagree.

The questionnaire was pretested among study population. The reliability of the tool was done by test-retest method and reliability was found to be 0.76. Questionnaire and attitude scale was distributed among teachers and data was collected by self report method.

The statistical analysis of the data was performed using the SPSS software package (Version 16.0.). The statistical measures used were frequency distribution, percentage, meanand chi square test. The level of significance was kept at significance of 0.05 level.

RESULTS

The data collected were analyzed based on the objectives of the study. Table 1 depicts that majority of the subjects 70% (35) were females and 30% (15) were male. Majority of the subjects 48% (24) were having BE. d / Bachelors degree, 46 %(23) were having Masters degree and 6% (3) were having other certificate. majority of the subjects 18% (36) were teaching high school, 32 % (16) were teaching upper primary , 24% (12) were teaching lower primary, 2% (1) of the subjects were teaching pre primary and 6% (3) of the subjects were teaching higher secondary classes. Majority 48% of the subjects belonged to the age group 30-40.

Table 1: Demographic characteristics of teachers N = 50

Sl. No.	Variables	Frequency	Percentage
1.	**Gender**		
	Male	15	30
	Female	35	70
2.	**Age**		
	21-30	6	12
	31-40	24	48
	41-50	12	24
	51-60	8	16
3.	**Educational qualification**		
	BE.d/Bachelor degree	24	48
	Masters	23	46
	Other degrees	3	6
4.	**Class Taught**		
	Pre primary	1	2
	Lower primary	12	24
	Upper primary	16	32
	High school	18	36
	Higher secondary	3	6

Table 2: Knowledge of teachers regarding inclusive education N = 50

Knowledge	Frequency	Percentage
Low knowledge	5	10
Average knowledge	33	66
High knowledge	12	24

Mean 6.4 SD 1.54

The above table 2 shows that majority of the participants 66 % (33) had average knowledge, 10%

(5) had low knowledge and 24% (12) were having high knowledge. The mean knowledge score was 6.4 and standard deviation was 1.54.There was no significant association found between knowledge level and gender (Chi-square value is 1.42 and p value is 0.49).

Table 3: Attitude of teachers regarding inclusive education N = 50

Attitude	Frequency distribution	Percentage
Negative	1	2
Neutral	9	18
Positive	40	80

As evident from the above table 3, majority of the participants 80 % (40) had positive attitude towards inclusive education and 2% (1) had negative attitude and 18% (9) of the subjects had neutral attitude towards inclusive education. The mean score for overall attitude was 58.4 and standard deviation was 6.53.

Majority 70% of teachers opined that inclusive education gives equal importance to all children (Table 4). 88%of subjects agreed that inclusive education helps to improve functioning of children with disability.78% teachers reported that inclusive education program provides different students with opportunities for mutual communication. 76% of teachers agreed that inclusive education program promotes students to understand and accept individual diversity.78% of subjects reported that nonhandicapped children can adjust with disabled peers in his classroom

Table 4: Attitude regarding inclusive education among teachers

Sl. No.	Items	Agree	Neutral	Disagree
1.	Inclusive education gives equal importance to all children	70%	4%	26%
2.	Inclusive education is not useful for children with disability	6%	14%	80%
3.	Inclusive education helps to improve functioning of children with disability	88%	10%	2%
4.	The needs of students with disabilities can be met only in separate special settings	4%	14%	82%
5.	Inclusive education program provides different students with opportunities for mutual communication	78%	16%	6%
6.	Nonhandicapped children can adjust with disabled peers in his classroom	78%	12%	10%
7.	Inclusive education program promotes students to understand and accept individual diversity	76%	18%	6%
8.	In Inclusive education teachers should know the needs of children with disability	72%	18%	10%

Table 5: Association between level of knowledge regarding inclusive education and educational qualification N = 50

Educational qualification	Low	Average	High	Chi-square value	P value
Bachelors Degree/B.Ed	0	15	8	16.906**	0.002*
Masters Degree	3	18	3		
Inclusive education certificate Doctorate Degree Other Certificate/Diploma	2	0	1		

** Significant at 0.01 level

Table 5 shows that, knowledge and educational qualification are statistically significant at 0.01 level. It can be interpreted that there is significant association between knowledge and educational qualification.(Chi-square value 16.906,P value 0.002).

Table 6: Comparison of attitude regarding inclusive education among teachers based on gender N = 50

Gender	Mean	SD	n	t value	P value
Male	62.2	4.07	15	2.85**	0.0064
Female	56.8	6.7	25		

** Significant at 0.01 level

Table 6, reveals there is a significant difference in attitude between male and female teachers.

Table 7: Association between attitude regarding inclusive education and educational qualification N = 50

Educational qualification	Neutral	Positive	Chi-square value	P value
Bachelors Degree/B.Ed	1	22	6.522**	0.038
Masters Degree	8	16		
Doctorate Degree	1	2		

** Significant at 0.01 level

Table 7, reveals that there is significant association between attitude and educational qualification(Chi-square value 6.522** and P value 0.038).

There was no other significant association between attitude and other socio–demographics variables such as subject taught or class taught.

DISCUSSION

The present study assessed the knowledge and attitude regarding inclusive education among school teachers in Venganoor Panchayath, Thiruvananthapuram. In the present study, majority of the teachers 66 % were having average knowledge regarding inclusive education, 10% were having low knowledge and 24% were having high knowledge. The mean score for overall knowledge was 6.4 and standard deviation was 1.54. A descriptive study to assess the principals' knowledge and attitudes regarding inclusive education showed a high percentage (65.1%) of principals report a high level of knowledge about inclusive education and a child with special educational needs.[5]In a study reported from Pune reported that teachers have positive attitude and low knowledge towards inclusive education.[6]

In the present study 30 % had positive attitude towards inclusive education and 20% had a negative attitude. Another study conducted on attitude of teachers towards inclusive education reported that teachers are having favorable attitude.[7,8] There is association between knowledge regarding inclusive education and educational status of teachers.In the present study there is association between attitude and selected socio-demographic variable such as gender and education. In a study attitude of male teachers was reported to be positive compared to female teachers.[9]

Sample size was relatively smaller to generalize the findings and an intervention could not be planned for teachers. It would be valuable to ascertain the attitude of parents towards inclusive education. A qualitative study involving teachers might provide additional perspective of teacher regarding this topic.

CONCLUSION

This study was intended to assess the knowledge and attitude regarding inclusive education among school teachers. The study proved that school teachers have average knowledge regarding inclusive education even though they have positive attitude towards it.It is now widely accepted that the most effective way to improve the quality and effectiveness of education programme in inclusive setting is to reach teachers and teacher educators. The success of inclusion or organized placement of children with disabilities in mainstream classrooms largely depends on teachers' attitudes towards students with special educational needs and their knowledge on how to properly educate them.

Source of Funding: Self

Conflict of Interest: None

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Burden and Family Functioning among Caregivers of Chronic Schizophrenia

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ABSTRACT

Introduction: Schizophrenia is a chronic major psychotic disorder manifested by distorted thinking and poor emotional response. Families of patients with schizophrenia face many challenges such as care burden, fear and embarrassment about illness, signs and symptoms, uncertainty about course of the disease, lack of social support, and stigma.

Objective: 1. Assess the perceived burden of caregivers of patients having chronic schizophrenia. 2. Assess family functioning of caregivers of patients having chronic schizophrenia.3. Determine the relationship between burden and family functioning.

Methods: A descriptive design and consecutive sampling was adopted for the study. The population under study was caregivers of patients having chronic schizophrenia in Thiruvananthapuram district. One hundred and seventy seven (177) constituted study sample. Burden assessment schedule and family functioning scale was used to assess burden and family functioning. Data was collected by self report.

Results: Healthy families perceived significantly (t_{175}=3.4, $p<0.01$) more burden compared to unhealthy families. Burden subscales of family relations, physical and mental health were significantly high in healthy families.

Conclusion: This study demonstrated that the perception of burden is different for healthy and unhealthy families. Family intervention can be included as a treatment modality for patients with Schizophrenia.

Keywords: *family functioning, caregiver burden*

INTRODUCTION

Schizophrenia causes significant social and work problems to the sufferer.[1]With the advent of deinstitutionalization, the focus of care has shifted from hospital to community. In a country like India, the term community care means patients remaining outside hospitals with family members. Families of patients with schizophrenia face many challenges such as care burden, fear and embarrassment about illness, signs and symptoms, uncertainty about course of the disease, lack of social support, and stigma.[2]

Families caring for a member with a chronic severe mental illness have to cope with a lot of burden and distress. The concept of family burden illustrates the impact of mental illness on families. Objective burden includes the practical, day-to-day problems and issues related to having a family member with a mental illness, such as loss of income and disruption of household routines. Subjective burden includes the psychological and emotional impact of mental illness on family members, including feelings of grief and worry. The stress of illness exacerbations coupled with limited social and coping capabilities contribute to subjective burden. [1,3]

Family is a basic unit that is responsible in preserving the integrity of individuals, who form the unit. Families extend emotional, social, and economic support to their members. Having a relation with schizophrenia also affects the roles and interactions within the family. The lifetime emotional, social, and financial consequences experienced by individuals with schizophrenia have significant effects on their families. Findings indicate that family psychological distress and patient behavioral problems are important factors in family functioning. A high functioning family helps in maintaining the dimensions of communication, emotional and behavioral

control, and also helps in problem solving and coping behaviors of its members.[4]

There is bulk of research on burden of caregiver but the relationship of caregiver burden with family functioning is lacking. Here the investigator studied the relationship between family burden and family functioning.

MATERIAL AND METHOD

This study was aimed to assess burden and family functioning among caregivers of patients having chronic schizophrenia. A descriptive design was adopted for the present study. The population under study was caregivers of patients having chronic schizophrenia. One hundred and seventy seven (177) caregivers were recruited for the study. Consecutive sampling was adopted for the study. Subjects for the study were recruited from three hospitals in Thiruvananthapuram district, where mentally ill patients were mostly admitted. Caregivers of patients diagnosed as chronic Schizophrenia according to ICD-10 criteria and are admitted in inpatient settings of selected hospitals were included for the study. The objectives of the study were to 1. Assess the perceived burden of caregivers of patients having chronic schizophrenia 2. Assess family functioning of caregivers of patients having chronic schizophrenia. 3. Determine the relationship between burden and family functioning.

Tool consisted of a structured questionnaire to assess demographic details of patient, Burden assessment schedule to assess caregiver burden, and family assessment scale to assess family functioning of caregivers.

Burden Assessment Schedule [5] is a 40 item scale, which measures different areas of burden like financial burden of care givers, occupation, patient behavior, family relations, care giver health, and social support. Each item is rated on a three point scale (not at all, to some extent and very much).The scores range from 40 to 120, with higher scores indicating greater burden. Internal consistency, as measured by the alpha co-efficient, for the full scale is 0.81.

Family Assessment Scale[6]

It describes structural and organizational properties of the family group and the patterns of transactions among family members which have been found to distinguish between healthy and unhealthy families. The model identifies six dimensions of family functioning in 53 items rated with a 4 point likert response format. Scores range from 53 to 212, higher scores indicate better functioning. Cronbach alpha's range from 0.72 to 0.90 between subscales in various studies. The measure has a Cronbach's alpha reliability of 0.86 and a split-half coefficient of 0.9.

Based on the scores family functioning is categorized as

>112 healthy functioning

<_112 unhealthy functioning

Tool was translated to Malayalam language. The validity and reliability of the tool was established. Data was collected using self-administered questionnaire by self report. Approval to conduct the study was obtained from appropriately constituted Ethics Committee.

RESULTS

As shown in table 1, majority (31) % were in the age group of 51-60. Mean age of caregivers was 49 years. Mean duration of caregiving was 7.3 years. Sixty six (66) % of caregivers were females. Majority belonged to Hindu religion. Sixty two (62) % were married.

Table 1: Demographic characteristics of Caregivers N = 177

Sl. No.	Sample characteristics	Frequency	Percentage
1.	**Age in years**		
	21-30	22	12
	31-40	26	15
	41-50	39	22
	51-60	54	31
	61-70	36	20
	Mean age (SD)	49(13)	
2.	Mean Duration of caregiving	7.3(4.1)	
3.	**Gender**		
	Males	60	34
	Females	117	66

Conted…

4.	**Religion**		
	Hindu	113	64
	Christian	42	24
	Muslim	22	12
5.	**Marital status**		
	Unmarried	36	20
	Married	109	62
	Widow/divorcee	32	18
6.	**Educational status**		
	Primary	88	50
	High school	54	31
	Higher secondary	11	6
	Degree and above	24	13
7.	**Occupation**		
	Yes	71	40
	No	106	60
8.	**Income class**		
	Lower income	130	73
	Lower middle income	34	19
	Middle/upper middle income	13	8
9.	**Relationship with the patient**		
	Father	22	12
	Mother	68	38
	Spouse	47	27
	Sister/brother	26	15
	others	14	8

Majority of caregivers were educated upto primary level. Sixty (60) % of caregivers were not having any occupation. Majority (73) % belonged to low income class. Half of the caregivers comprised parents. Twenty seven (27) % of caregivers were spouses.

Table 2: Mean Burden perceived by the caregivers of patients having schizophrenia

Burden Subscales	Maximum score	Mean Score	SD	Mean %
Financial burden	12	9.1	1.93	75
Caregiver occupation	9	6.1	1.6	67
Patient behavior	9	6.4	1.1	71
Family relations	18	11.8	2.7	65
Physical and mental health	33	22.2	4.4	67
Marital relations	12	8.2	1.29	68
Social support	27	18.2	2.5	67
Total burden	120	76.7	7.1	

As shown in table 2, Financial Burden and burden related to patient care were high compared to other subscales of burden.

Table 3: Family functioning of caregivers of patients having schizophrenia N = 177

Family functioning subscales	Max score	mean	SD	Mean %
Family Problem solving	20	13.8	1.9	69
Role	32	15	1.9	53
Communication	24	15.2	1.9	63
Emotional response	24	14.6	2.3	60
Emotional involvement	28	14.5	1.8	60
Behavioral control	36	15.8	2.9	56
General functioning	48	25.8	3.6	53
Total	212	114.4	8.3	

As depicted in table 3, role function and general functioning was low compared to other aspects of family functioning.

Table 4: Comparison of burden score of caregivers in healthy and unhealthy family

Burden subscales	Unhealthy family N = 76		Healthy family N = 101		t value	pvalue
	Mean	SD	Mean	SD		
Financial burden	9.07	2.1	9.16	1.6	0.29	0.76
Caregiver occupation	5.8	1.6	6.2	1.5	1.8	0.07
Patient behavior	6.2	1.2	6.4	1.14	1.2	0.221
Family relations	11.15	2.2	13.01	2.3	5.2**	0.000
Physical and mental health	21.53	3.6	23.8	3.5	4.2**	0.000
Marital relations	2.9	3.9	1.7	3.4	2*	0.048
Social support	18.25	2.9	18.3	1.9	0.144	0.886
Total burden	74.6	7.1	78.3	6.7	3.4**	0.001

As shown in table 4, healthy families perceived significantly ($t175=3.4$, $p<0.01$) more burden compared to unhealthy families. Burden subscales of family relations, physical and mental health were significantly high in healthy families. It can be interpreted that the perception of burden is different for healthy and unhealthy families.

DISCUSSION

Sixty (60)% of caregivers in the present study did not have occupation. Caregivers are forced to cut down their work hours to provide care for their patient. Another study carried out by Awad and Voruganti [7]reported those family members who leave their jobs to provide care for their ill relative with schizophrenia ranged from 1.2% for the first episode and 2.5% for long-term patients. The present study findings are consistent with the previous study. The fear of leaving a schizophrenic patient alone makes the caregivers reside at home most of the time and consequently isolate themselves from the social contact or the outside world. Majority (65%) belonged to urban area. Urban sites had significantly higher incidence rates of schizophrenia than rural sites.[8]

In the present study, family role function was low compared to other domains of family functioning. Neena reported that dimensions of the family functioning is correlated to the social support perceived from the family in the schizophrenic patients.

The result highlight that there is a need for psychoeducation/intervention for family members of patients with schizophrenia. Disturbed behavior is a greater determinant of severity of burden than psychiatric diagnosis; hence appropriate treatment is the first step in reducing caregiver burden.[9]

Caregivers of schizophrenia experience enormous burden and are at risk for mental disorders. The severity of the burden is related to the level of psychopathology and medical adherence.

The relationship between caregiver-burden and family relationship appears to be a complex one. More methodologically sound investigations are required to understand this intricate area, with the hope that a better understanding will help the cause of both patients and their caregivers. Sixty six (66) % of caregivers were female caregivers, out of which 38% mainly mothers. As many other studies reported in the literature, females are predominantly involved in care giving task.[3]

Caregivers reported financial burden and patient behavior more compared to other domains of burden. These findings are in accordance with the study findings of Kareem and Aarthi Jaganathan.[10]In developing countries, quality of life is affected by the caregivers' economic burden.[9] Decreased quality of life may be associated with the caregivers' burden, lack of social support, the course of the disease and family relationship problems.

- There may be discrepancy in the perception of burden among family members. A similar study including all family members can be conducted.
- There should be more post creation of community mental health nurses who should actively work for the welfare of family of patients.

CONCLUSION

It can be concluded from the study Family caregivers of patients having schizophrenia perceive high burden. Family members' functioning are disturbed due to ill member in the family.

Source of Funding: Self

Acknowledgement: Study participants

Conflict of Interest: Nil

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

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Assess the Level of Subjective well Being and Find the Association with Socio-Demographic Variables of Farmers of Selected Villages of Dharawad Taluka, Karnataka, India

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ABSTRACT

Background: Farming is associated with unique set of stressor that include unpredictable environmental, financial and social impact are felt serious reduction in income for farmer and subjective well-being is an alternate measure of poverty and deprivation among farmers**.**

Aim: To assess the level of subjective well-being of farmers,

Method: The study used convenient sampling technique and collected data from 100 farmers, by using interviewing method. The tools used were (i) Socio-demographic data sheet (ii) Subjective wellbeing scale. The data was analyzed by using descriptive and inferential statistics.

Results: The findings shows that, 65% of the farmers had medium level of subjective wellbeing, 22% of them had low level of subjective wellbeing and 13% farmers had higher level of subjective wellbeing with the overall median score of 51.50. and there is a statistically significant association found between the level of subjective well being and socio demographic variable such as amount of debt's and crop failure at the level of $p<0.05$.

Conclusion: The study results recommended that policies in the future aimed at addressing deprivation of low subjective well-being of farmers who depend on the agricultural labour as a livelihood strategy.

Keywords: *Subjective well-being, farmers, agriculture.*

INTRODUCTION

India is a land of villages and most of the populations residing in villages are farmers. Agriculture employs more than half of the Indian population. Today almost 70% of the Indian population was living on agricultural income. The major occupation among rural residents of Karnataka is agriculture.

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In India more than two decades suicides among farmers are increased. Economic problems, psychiatric illness, and stressful life events were found to be important contributors to farmers' suicides. Important economic risk factors were procurement of debt, especially from multiple sources and for nonagricultural reasons and leasing out farms. Crop failure, interpersonal problems, medical illness, and marriage of female family member were significant stressful life events.[1]

Wellbeing is a fundamental issue. Material wealth and fulfillment of one's desires, human relationships, development of one's potentialities and one's psychological state, faith in a religion and spirituality are considered as relevant and significant in this context in the conceptualization of subjective wellbeing.[2]

A person's wellbeing is influenced by their environment and disposition, their safety and security, their physical and mental health, their relationships and social networks, their access to goods and services. Farmers are no different to other people in this regard, and these factors will affect their overall wellbeing. However, understanding the wellbeing of farmers is especially complex as, in addition to the usual factors that influence wellbeing, farming is associated with a number of occupation specific factors that can challenge wellbeing. Climatic variability such as the experience of drought, pest and disease outbreaks, rising input costs, complex government bureaucracy and geographic isolation with associated lack of access to services, and social isolation for farmers.[3]

Farmers work long hours, have physically demanding work, are often isolated socially and geographically from services, are less likely to take vacations and less likely to retire than people in other occupations, In addition, farming has suffered recent pressures in the form of; globalization, economic rationalization, pest and disease outbreaks, diminishing rural populations, drought, and climate change. Therefore farmers could be considered to be a vulnerable population and the association between work and health is particularly pertinent for their livelihood and wellbeing.[4]

Farmer's suicides have been receiving a lot of social and public policy attention. Suicides were mainly concentrated in Karnataka, Andhra Pradesh and Maharashtra. These incidents raised serious questions of economic hardships faced by farmers. The researcher had come across many farmers in hospital setting and as well at community setting, observed distress related manifestations among farmers which were association with their social status. And also the suicides among farming population have drastically increased as per the reports by various studies conducted and news papers. By observing all these factors the researcher felt the need to determine the association between the subjective well being and socio demographic variable of farmers.

MATERIALS & METHOD

Research design: Descriptive research design was adopted in this study.

Setting of the study: The study was conducted in selected villages of Dharawad Taluka, Dharwad. Karnataka. India.

Population: Target population for the present study were 100 farmers' who were actively involved in farming selected from villages of Dharawad Taluka. Dharwad.

Sampling: Convenient sampling technique was used in the present study. Inclusion criteria are Farmers aged between 18 to 60 years, who are available at the time of data collection, and who are willing to participate in the study. Farmers who are suffering with any type of chronic medical or psychiatric illnesses were excluded from the study.

Tools:

Sections i: It includes'18'items related to the socio demographic variables comprise three parts,

(a) Socio demographic characteristics

(b) Socio agro economic characteristic.

(c) Socio psychological characteristics

Sections ii: Subjective wellbeing scale: Subjective Well-Being Inventory is a self report questionnaire consisting of 40 items designed to measure an individual's mental status regarding overall feeling about life.[5]

Procedure for data collection: Prior to the study formal permission was obtained from the subjects. Structured interview schedule was adopted for the data collection and was carried out within given period of 12 weeks. Before interviewing the subjects, purpose of the study was explained with self-introduction. Privacy was maintained during the interview. Subjects were made to be comfortable and relax during interview. The data collection process for each individual took 40 - 50 minutes, 5-6 subjects were interviewed per day.

DATA ANALYSIS

After completion of the data collection, the data was coded and was analyzed in terms of the objectives of the study using descriptive and inferential statistics.

RESULTS

A. Distribution of based on frequency and percentage of socio-demographic characteristics.

(a) Socio demographic characteristics: The description of socio-demographic characteristics of farmers. Regarding age group the majority of farmers (34%) belongs to

age group of 51-60 years, Regarding religion, majority (81%) farmers are belongs. Regarding farmers income, majority 61(61%) were getting Rupees below 50,000 per annum, Regarding respondents type of family, majority 73 (73%) were Joint family**.**

(b) Socio Agro Economic characteristics: The description of farmers based on socio agro-economic characteristics. Regarding the farmers by possession of land holding, majority (48%) were having Large (above 4 acres) (28%) were having small (2 to 4 acres) and (24%) were having marginal (below 2 acres) land. Regarding the distribution of farmers land holding, majority (92%) were an Own land, Only 8 (8%) were holding land on Leased. Regarding type of crop grown, majority of (88%) were growing both. (8%) were the commercial, and (4%) were Non commercial crops grown. Regarding source of water for irrigation, majority farmers (42%) were rain fed, (32%) were both and (26%) were irrigation. Regarding farmers experienced recent failure of bore wells, majority of (49%) were not had bore wells for irrigation, (36%), were no failure of bore wells, (15%) had a failure of bore wells. Regarding recent crop failure experience of farmers, majority of (62%) were experienced no crop failure,(38%) had experienced crop failure. Regarding farmers by insured crop, majority (58%) were insured their crops, (42%) were not insured their crops. Regarding the amount of debt's, majority (64%) were an rupees above 1 lakhs, (27%) had an rupees below 50,000, and (9%) are rupees 50,000 to 1 lakhs. Regarding of Source of debts, majority (58%) were taken debts from Government banks, (39%) were not taken any debts, (2%) had from money lenders, (1%) of from Private bank (**Table-1).**

Table 1: Socio-Agro Economic characteristics N = 100

Sl. No.	Characteristics	Label	No of farmers	% of farmers
1.	Possession of land holding	Marginal(<2 acres)	24	24.
		Small(2 to 4 acres)	28	28.
		Large(>4 acres)	48	48.
2.	Details of land holding of farmers	Own land	92	92.
		Leased land	8	8.
3.	Type of crop grown	Commercial	8	8.
		Noncommercial	4	4.
		Both	88	88.
4.	Source of water for irrigation	Rain-fed	42	42.
		Irrigation	26	26.
		Both	32	32.
5.	Have you experienced recent failure of Bore wells	Yes	15	15.
		No	36	36.
		No. bore wells for irrigation	49	49.
6.	Have you experienced recent crop failure	Yes	38	38.
		No	62	62.
7.	Have you insured your crop	Yes	58	58.
		No	42	42.
8.	Amount of debt's	Rs<50,000	27	27.
		Rs50,000 to 1 lakhs	9	9.
		Rs>1 lakhs	64	64.
9.	Source of debt's	Govt. bank	58	58.
		Private bank	1	1.
		Money lenders	2	2.
		Not had debt's	39	39.

(c) Socio psychological characteristics: The description of farmer's socio psychological characteristics shows that the farmers consulted for doctor', majority (59%) were not consulted doctor for any regions, (21%) were consulted for general physical weakness,(11%) had consulted for hypertension/diabetes mellitus, (6%) had consulted for stress, and (3%) were consulted for sleeplessness. Regarding farmers quarrel/conflict, majority (85%) were not had any conflict, (6%) were had conflict with neighbors/labors, (5%) were had conflict with others and (4%) were had conflict with family problems. Regarding farmers habits, majority (52%) were having habit of smoking/ tobacco chewing, (44%) were having another habits, and (2%) are alcohol and Gambling. Regarding farmers by mental illness in the family members, majority of (87%) not having mental illness in the family, and (13%) having mental illness in the family members (Table-2).

Table 2: Socio psychological characteristics N = 100

Sl. No.	Characteristics	Label	No of farmers	% of farmers
1.	Whether farmers consulted doctors for	General physical weakness	21	21
		Sleeplessness	3	3
		Stress	6	6
		HTN/DM	11	11.
		No consulted	59	59.
2.	Quarrel/Conflict with	Family problem	4	4.
		Neighbors/Labors	6	6.
		Others	5	5.
		No conflicts	85	85
3.	Habit if any	Alcohol	46	46
		Smoking or Tobacco chewing	52	52
		Gambling	2	2.
4.	Mental illness in the family	Yes	13	13
		No	87	87

B. Distribution farmers based on the level of subjective well being: Description of farmers' based on subjective wellbeing level, among 100 farmers, majority farmers were (65%) having medium level of subjective well being, (22%) were low subjective well being and only (13%) were in higher level of subjective well being (Table-3).

Table 3: Distribution of farmers based on level of subjective wellbeing N = 100

Sl. No.	Level of well being	No of farmers	% of farmers
1.	Low well being	22	22
2.	Medium well being	65	65
3.	High wellbeing	13	13
Total		**100**	**100**

C. Association between the levels of subjective well being farmers with socio demographic characteristics of farmers: Findings shows that, there was a statistically significant association (X^2 = 11.3020, p = 0.0230,) between amount of debt with level of subjective well being among farmers. There is a significant association between crop failure with subjective wellbeing (t = 2.6754, p = 0.0087).

DISCUSSION

The findings of the study had been discussed with reference to the objectives and with findings of other related literature/studies. The findings are discussed in the following 3 sections.

Findings related to the socio-demographic characteristics: Data found regarding socio-agro characteristics of crop failure, bore well failure, debts,

and habits like tobacco and alcohol are shown majority. It indicates that majority farmers were experienced crop failure, bore well failure, having debts, these loses may be provoking the farmers to cultivate un-healthy habits like using tobacco and consuming alcohol. So, it is a warning signal that farmers mental health going to be affects and risk for mental illnesses like depressive disorders, alcohol dependence syndrome, and other substance abuse disorders and also increase the risk for farmers suicide. Many research studies supports for the same results. Farmer's suicides have been receiving a lot of social and public policy attention. Suicides were mainly concentrated in Karnataka, Andhra Pradesh and Maharashtra. A large number of suicides were reported in Karnataka in the first three years of the decade starting 2000-01, while Andhra Pradesh had maximum in 2004-05. In 2006, there was virtually a suicide epidemic in Maharashtra. These incidents raised serious questions of the state of the agrarian economy and the economic hardships faced by farmers.[6]

The earlier study reports the results of present study conducted county in Iowa. Participants aged 18 or older were asked about suicidal ideation in the past year as well as mood, alcohol use, social support, and stressful life events. About 8.2% of the sample reported suicidal ideation. Depressive symptoms, problems resulting from alcohol use, infrequent social contact and financial loss characterized the suicidal group. Depressive symptoms were the strongest correlate of suicidal ideation in this rural sample. This suggests that change in financial status rather than chronic poverty poses a risk for suicidal ideation.[7]

Level of subjective wellbeing among farmers: The level of subjective wellbeing among farmers was assessed by structured interview the results shows that subjective wellbeing with the overall median score of 51.50. The findings shows that the majority of farmers experiencing the moderate or low level of subjective wellbeing. The results of the present study supported by the study conducted in 1981to identify determinants of subjective wellbeing among farmers. The study concluded that the subjective wellbeing among farmers vary and is considerably lesser than that of other workers. The salient findings revealed that near about cent percent (98.58%) selected farmers were having high composite index of agrarian distress.[8]

Association between the levels of subjective well-being with socio- demographic variables: There is a statistically significant association found between the level of subjective well being and socio demographic variables such as Amount of debt's at the level of $p<0.05$. The results of the present study are in consistent with the study carried out and reported with the purpose of determining the effects of off-farm employment on perceptions of quality of life.[9]

The earlier study results supports the present study reports reveal that exploring the relationship between subjective wellbeing and groundwater attitudes and practices of farmers in Rural India. The results suggest a singular reliance on initiatives to improve household income is unlikely to manifest as improved individual subjective wellbeing for the Dharta and Meghraj watersheds. Correlates were tabulated into a systematic decision framework to assist the design of participatory processes at the village level, by targeting specific factors likely to jointly improve aquifer sustainability and household wellbeing.[10]

Nursing personnel especially mental health and community health nurses can contribute much for prevention and management of ill well being among farmers and nurses play an important role in prevention of serious consequences like mental health problems and even suicides among farmers through early identification and prompt intervention.

CONCLUSION

The changing values of society, globalization, urbanization, industrialization and climatically changing etc are causing general well being negative and positive effect in farmer's life. Hence it is necessary to address the farmers' need of stress management. It is anticipated that this research may help mental health nurses and community mental health personals to identify the mental health status with viewing their subjective well being and to plan effective mental health needs of farmers so that further damage or consequences of distress of farmers can be prevented by timely intervention.

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Effectiveness of Psycho Educative Intervention on Body Image and Adjustment to Cancer among Head and Neck Cancer Patients

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ABSTRACT

Background: Cancer is one of the major public health problems in India. Despite the significant advancement in cancer management, it's still a most dreadful disease that has tremendous burden on individual, family and society. Head and neck cancer patients experience considerable stress, poor quality of life and impairment of adjustment to cancer. The aim of present study was to determine effectiveness of psycho educative intervention on body image and adjustment to cancer among head and neck cancer patients.

Material and Method: An experimental study, pre and post test design was undertaken among head and neck cancer patients of Pravara Rural Hospital, Loni (Bk). A total of 60 cancer patients were selected by systematic random sampling technique who fulfills the inclusion criteria's. Pre tested structured questionnaire [a) Body Image Scale and b) Mental Adjustment to Cancer Scale] was used to collect data. Study was approved by IEC/IRC and informed consent was obtained from all the participants. After pre testing psycho educative intervention was implemented individually and post test was conducted after six sessions of intervention. The descriptive and inferential statistics were applied wherever was required.

Results: Majority of patients had partially adoptiveness to cancer disease after the intervention, and found statistically significant at $p<0.05$ level. It was earlier found to be not adoptive during pre test assessment. In relation to body image, patients did not have significant change in body image after the psycho education. It was noted that body image had significant association with demographic variables like age ($x^2 = 4.29$), gender ($x^2 = 3.58$) and site of cancer ($x^2 = 7.04$); similarly adjustment to cancer had association with age ($x^2 = 3.92$) and duration of illness ($x^2 = 6.81$) $p<0.05$ level.

Conclusion: Study outcome revealed that psycho educative intervention was found effective, and played significant role for adjustment to cancer. The planned psycho educational program helps patients and their families to cope with cancer disease as well as enables to enhance quality of life.

Keywords: *effectiveness, psycho educative intervention, body image and adjustment to cancer*

INTRODUCTION

Cancer is one of the major public health problems in India, and despite the significant advancement in cancer treatment, it's still a most dreadful disease that has tremendous burden on individual and family. Head and neck cancer is the fifth most common cancer worldwide, and males are predominantly affected. In India the prevalence rate of head and neck cancer is 23%. Cancer patients including head and neck cancer patients experience considerable stress, poor quality of life and impairment of adjustment to cancer.[1]

Cancer patients has numerous and intense symptoms which leads to poor quality of life and deterioration in health status. The life of patients with advanced head and neck cancer gets involved in abundant physical, emotional and psychological symptoms. Scholarly

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studies have found the common health problems which are pain (>85%), dysphagia (>60%), airway obstruction, fungating wound, and mucosal dryness are the alarming problems in patients with head and neck cancers[2, 3].

Head and neck cancers are the commonest cancers among males in India and around more than two third presents in advanced stage with significant burden of variety of symptoms. Majority of them have poor quality of life and emotional wellbeing as well as activities of daily living. The top four common symptoms of head and neck cancer patients are pain, insomnia, loss of appetite and fatigue[4].

Cancer and its treatment strategies usually results in major alterations of body image due to loss of body part, disfigurement, scars or skin changes. Radiotherapy cause tissue damage with insidious changes for many years, the effects of surgery are immediate and often permanent, whereas transient, reversible changes results from chemotherapy. Thus, large numbers of patients across many disease groups and treatment types can be affected.[5]

Scholarly article on QOL in cancer patients revealed that majority (81%) had a poor quality of life wherein (59%) had poor QOL because of physical pain and more than half (58%) were very dissatisfied with their health condition. A considerable proportion had dissatisfaction with themselves, dissatisfaction with their sexual life (65%) and (62%) respectively. One third (35%) of them had increased frequency of having negative feelings such as blue mood, despair, anxiety, depression.[6]

Psycho education is an effective psychosocial approach of specialized education that consists of educational and psychosocial endeavors with an aim to create terminal behavior change in patients and their families. Planned psycho educational programs assist patients and their families to cope with and adapt to the difficulties associated with the disease, enable them to develop their problem solving skills and increase their quality of life.[7]

The women participating in psycho educational program had increased levels of adjustment to cancer; the intervention group had higher levels of fighting spirit, lower levels of helplessness and hopelessness, anxious preoccupation and fatalism in comparison to the control group. It was evident that the psycho education led to a change in levels of adjustment in cancer patients.[8] Thus the present communication was undertaken to examine the effectiveness of psycho educative intervention on body image, adjustment to cancer and correlate with clinical characteristics of head and neck cancer patients.

MATERIAL AND METHOD

A quantitative research, experimental study where pre and post test design was undertaken among head and neck cancer patients admitted at Pravara Rural Hospital, Loni (Bk), Maharashtra. A total of 60 head and neck cancer patients above 18 years of age of both gender, and willing to participate were selected by systematic random sampling technique. The sample size was calculated with Openepi, version 2, open source calculator–SSP. Cancer patients who are acutely ill, has co morbid conditions and secondary metastasis was excluded from the study. Pre tested and validated structured questionnaire such as a) Body Image Scale (BIS) and b) Mental Adjustment to Cancer Scale (MAC) was used to collect data. The responses for all items of BIS are graded on four point scale (3 = Very much, 2 = Quite a bit, 1 = A little and 0 = Not at all), and the responses for MAC scale are graded on a four point scale (1 – 4, one for definitely does not applies to me and 4 for definitely applies to me). The study was approved by Institutional Ethics Committee/Institutional Research Committee (IEC / IRC) and written informed consent was obtained from all participants.

The psycho educative intervention comprised of a) basic information about head and neck cancer b) importance of nutrition c) health problems of head and neck cancer d) measures to adjust/cope with cancer and e) sources of social support and financial support. It was implemented after pre testing individually through didactic lecture and discussion (in Marathi language) for six sessions with 45 minutes of duration at each follow up visit of patients. Along with education an informative pamphlets and leaflets are supplemented for enhancement and reinforcement of awareness and compliance of treatment, and the post test was conducted after six sessions of post intervention. The collected data was coded, tabulated and analyzed by using descriptive (mean, SD) and inferential statistics (t test, chi square test) wherever required, and $p<0.05$ was considered as statistically significant.

RESULTS

Results related to socio demographic data: Majority (68%) of patients was belongs to 56 to 65 years of age, majority (70%) were male, higher percent (40%) of them educated up to primary level education. More than half (55%) of them were daily wagers and agriculture laborers, significant percent (45%) had monthly income of Rs 3001–6000, majority (62%) belongs to nuclear family and most (83%) of them under study were Hindu's.

Results related to clinical characteristics of cancer: Majority (58%) of them had cancer buccal mucosa, more than half (52%) had stage III cancer and (57%) had duration of illness more than 6 months, most (89%) did not had family history of cancer while (11%) of patients had family history of cancer, significant proportion (24%) had metastasis of cancer and majority (60%) of patients had radiation therapy as a primary cancer management.

Results related to body image and adjustment to cancer: Majority of patients under study had 'partially adoptive' to cancer disease after psycho educative intervention, and found statistically significant for the areas like 'Fighting Spirit and Helplessness – Hopelessness' at $p<0.05$ level. It was earlier found to be 'not adoptive' during pre test assessment. It highlights that the patients had higher 'Fighting Spirit' and lower level of 'Helplessness and Hopelessness' after the intervention. In relation to body image patients did not had significant change in body image after the psycho education. The mean score of body image and adjustment to cancer, and its items wise description is depicted in Table No I and II respectively.

The body image had significant association with socio demographic variables such as age ($x^2 = 4.29$), gender ($x^2 = 3.58$) and site of cancer ($x^2 = 7.04$); whereas adjustment to cancer had statistically significant association with age ($x^2 = 3.92$) and duration of illness ($x^2 = 6.81$) of patients at $p<0.05$ level.

Table No. I: Pre and post psycho educative intervention mean scores of Body Image and Adjustment to Cancer

Sl. No.	Areas	Pre test		Post test		't' value
		Mean	SD	Mean	SD	
I	Body Image	9.05	1.73	7.68	0.71	1.21
II	Adjustment to cancer					
1.	Fatalism	16.43	2.49	17.69	3.61	0.72
2.	Fighting Spirit	12.75	2.96	16.55	0.91	**4.38***
3.	Helplessness – Hopelessness	26.98	4.04	19.71	3.65	**3.91***
4.	Anxiety preoccupation	19.01	3.28	16.26	3.53	1.83
5.	Cognitive avoidance	12.93	2.32	10.71	3.18	1.96

* Significant, df – 59, $p < 0.05$

Table No. II: Item wise description of body image and adjustment to cancer during pre and post psycho educative intervention

Sl. No.		Item description	Pre test	Post test	Difference
			Definitely applies to me		
			Frequency (%)	Frequency (%)	Frequency (%)
I	**Fatalism**				
	1.	Take one day at a time	31 (52%)	43 (72%)	12 (20%)
	2.	Hands of God	45 (75%)	50 (83%)	05 (08%)
	3.	Count blessings	26 (43%)	44 (73%)	18 (30%)
	4.	Bonus	29 (48%)	45 (75%)	16 (27%)
	5.	Life is precious	60 (100%)	60 (100%)	00

Conted…

II	**Fighting Spirit**				
	6.	Illness is challenge	60 (100%)	60 (100%)	00
	7.	Fight illness	46 (77%)	58 (97%)	12 (20%)
	8.	Optimistic	39 (65%)	53 (88%)	14 (23%)
	9.	Beat disease	41 (68%)	57 (95%)	16 (27%)
III	**Helplessness–Hopelessness**				
	10.	Giving up	48 (80%)	21 (35%)	27 (50%)
	11.	At a loss	52 (87%)	29 (48%)	23 (39%)
	12.	Can't handle it	50 (83%)	19 (32%)	31 (51%)
	13.	Not very hopeful	41 (68%)	19 (32%)	22 (36%)
	14.	Nothing to help myself	35 (58%)	13 (22%)	22 (36%)
	15.	End of the world	39 (65%)	11 (18%)	28 (47%)
	16.	Life hopeless	40 (67%)	16 (27%)	24 (40%)
	17.	Can't cope	37 (61%)	14 (23%)	23 (38%)
IV	**Anxiety preoccupation**				
	18.	Angry	29 (48%)	15 (25%)	14 (23%)
	19.	Devastating feeling	37 (61%)	22 (37%)	15 (24%)
	20.	Apprehensive	34 (57%)	19 (32%)	15 (25%)
	21.	Worry cancer worse	48 (80%)	34 (57%)	14 (23%)
	22.	Upset	33 (55%)	21 (35%)	12 (20%)
	23.	Belief difficult	58 (97%)	27 (45%)	31 (52%)
V	**Cognitive avoidance**				
	24.	Distract	47 (78%)	31 (52%)	16 (26%)
	25.	Not thinking helps cope	21 (35%)	36 (60%)	15 (25%)
	26.	Positive effort not to think	40 (67%)	52 (87%)	12 (20%)
	27.	Push thoughts out of my mind	26 (43%)	45 (75%)	19 (32%)

DISCUSSION

GLOBOCAN 2012 reported that the head and neck cancer is the most common cancers among male in India. The results highlights those 56–65 years of aged are commonly affected with head and neck cancer. It envisages that advance aging was a fundamental factor for the development of cancer. This finding was uphold by Aghabarari M and colleagues (2008)[9] that significant percent (48%) of patients had cancer at 46 – 65 years of age. Our study shows that the prevalence of head and neck cancer was more among males than females. It was consistent with Chaturvedi S (2009)[10] findings, who also observed that 58% of cancer patients under study were male. Similarly these findings were parallel with the WHO facts (2008)[1] that cancer cervix uteri was the leading cancer in women while head and neck cancer is third leading cancer among both gender.

A study by Kurtz EM, Kurtz JC, Given WC and Barbara G (2007)[11] have shown that (61%) of patients had late stage (III and IV) of cancer disease. In our study (52%) had stage III cancer; similarly a study done by Dhruva A, Miaskowski C, Abrams D, Michael A, Cooper B, Goodman S et al (2012)[12] found 50% of patients had metastatic cancer whereas we had noticed one fourth of patients under study had metastasis of cancer. It was observed that the radiation therapy is the primary treatment for head and neck cancer followed by combined therapy such as surgery and radiation therapy. This finding was consistent with the study done by Gritz ER, Carmack CL, Moor CD, Meyers EG and Abemayor E (1999)[13] that approximately half of patients treated with primary radiation or surgical intervention.

The results at psycho educative intervention revealed that the head and neck cancer patients had higher levels

of 'fighting spirit', and lower levels of 'helplessness and hopelessness', 'anxious preoccupation' and 'cognitive avoidance' related to adjustment to cancer while there was no significant change in body image before and after intervention. This finding were in congruence with study carried out by Dastan NB, Buzlu S (2013)[14] that psycho education intervention was effective to improve adjustment to cancer among first – second stage cancer patients.

CONCLUSION

The results highlight that psycho educative intervention was effective and played significant role for adjustment to cancer of head and neck cancer patients. Though it did not have significant impact on body image changes, certainly the intervention helps patients and families to cope or adjustment to cancer disease, and enables to enhance the wellbeing and quality of life. In conclusion, Regular the psycho education – Better the sense of control and adjustment to cancer disease; and 'Never give up, life is worth living, there is life even after having cancer'.

Source of Funding: Self

Conflict of Interest: Nil

Ethical Clearence: The study was approved by Institutional Research Committee and Institutional Ethics Committee (IRC/IEC) of Pravara Institute of Medical Sciences – Deemed to be University, Loni (Bk), Maharashtra. The ethical guidelines for biomedical research on human participants were strictly followed.

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Issues and Challenges in Psychiatric Consultation-Liaison Nurse (PCLN)

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ABSTRACT

Mental health problems are not currently given the same importance as physical health. Nurses, particularly those working in non-psychiatric settings, report that they do not feel adequately prepared to meet the mental health needs of patients. The psychiatric consultation-liaison nursing role has arisen in part, as a response to these difficulties and aims to facilitate access to mental health nursing expertise for general hospital patients and staff.

Keywords: *Psychiatric-liaison nurse, consultation-liaison nurse.*

INTRODUCTION

The mind and the body are more than married, for they are most intimately united; and when one suffers, the other sympathizes.

—Lord Chesterfield

Consultation-Liaison Psychiatry is a service provided to patients who are admitted to a general hospital for a non-psychiatric condition, but who may exhibit symptoms of a psychiatric condition and whose case may be enhanced by the expertise of health workers with mental health care training. This service is provided either through direct consultation with the patient, or indirectly, through support, education and advice to other health professionals responsible for the care and treatment of the patient. Evidence shows that 25% of all patients admitted to hospital with a physical illness also have a mental health condition, and in most cases this is not treated whilst the patient is in hospital. In terms of long-term conditions, 25– 33% of patients with a long-term physical health problem also have a concurrent mental illness that increases the risk of physical health complications and increases the costs of treating the physical illness.[1] There is now growing evidence for the impact of liaison psychiatry services. Descriptive evidence shows a list of benefits including decreased length of stay, reduction in psychological distress, improved service user experience, improved dementia care and enhanced knowledge and skill of general hospital clinicians.[2]

In India, although the General Hospital Psychiatric units were established in 1930s, C-L Psychiatry has never been the main focus of training and research.[3] The introduction of a nursing position of a consultation-liaison psychiatric nurse is yet to take its birth in the Indian health care system, even though there is a growing body of evidence to suggest that nurses working in general hospital settings do not generally consider themselves adequately prepared, skilled or experienced to care for patients with mental health problems.[4-6] Thus the Psychiatric Consultation-Liaison Nurse (PCLN) role arises as a response to these difficulties and aims to facilitate access to mental health nursing expertise for general hospital patients and staff.

ISSUES AND CHALLENGES

The challenges associated with caring for patients who experience a mental illness in acute secondary care settings in particular are often linked with the notion that health professionals are not immune to the effects of stigma attached to mental illness; despite formal

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education in psychiatry.[7] Mental health problems are not currently given the same importance as physical health problems. In simple terms it means giving mental health equal value to physical health, for example through equal access to effective care, and equal efforts to improve the quality of care. Thus there is a need to fill the gap around the mental health needs of people with physical health problems. "The status of liaison psychiatry thus should change. It needs to be recognized as an essential ingredient of modern health care and not an optional extra which is merely nice to have."[2] This calls for the need to sensitize the stakeholders, policy makers for the growth and sustenance of PCLN. A good liaison service functions best as a discrete, specialized, fully integrated team comprising multi-professional health care staff, under single leadership and management.

Various models of psychiatric consultation are described in literature depending on the focus of consultation, function and focus of work. The models based on the focus of consultation include patient oriented approach, crisis oriented approach, consultee-oriented approach, situation oriented approach and expanded psychiatric consultation.[8] Depending on the function, the models of consultation-liaison include consultation model, liaison model, bridge model, hybrid model and autonomous psychiatric model. [9] Depending on the focus of work the different models include critical care model, biological model, Milieu model and integral model.[10] Thus the model of service need to be created which is amenable to local flexibility and close working relationships between all key stakeholders.

The alliance or liaison relationship is central to the clinical practice of a PCLN.[11] The liaison relationship between the PCLN and the staff, units and the organization as a whole underpins both the clinical and organizational consultation processes. Shefer et al[12] showed that adult nurses believe they have to defer to the MHL team, and noted that while the liaison team's presence was 'useful in many ways, it can have adverse consequences, in particular in creating a reduced sense of responsibility of emergency staff for patients they see as belonging to another team'. This illustrates the gulf that characterizes much of the interaction between mental health specialists and their colleagues. Clear communication process is a key to success. Proper description of their role will help to prevent overlap with other health professionals.[11] Hence, it is important that the PCLN role within the CL team is clearly articulated to general hospital staff. The development of skilled multidisciplinary teams emphasizing close collaborations between psychiatric and non-psychiatric personnel is essential element for the functioning of the CL team. Until recently, the general health and psychiatric sectors of the public health system has been quite separate. Culture brokering is of particular importance in bridging the gap between these artificially disparate areas of nursing. Culture brokering '... is defined as the act of bridging, linking or mediating between groups or persons of differing cultural backgrounds for the purpose of reducing conflict or producing change.'[13] The skills of mediation, negotiation and innovation are important if greater communication and a greater understanding between the general and psychiatric cultures is to be achieved.

Much attention is given to outcomes of health care, but structure and process must also receive attention as they underpin the outcome. If the structure of, and processes within a service are not well defined and articulated, then it is likely that the outcome may not be as desirable. Under 'structure', consideration of components such as the PCLN position description (responsibilities, specifications, remuneration and lines of accountability), physical structure (office, equipment, teaching aids, communication devices) and resource/ budget issues can be articulated. An important challenge is the physical environment in the general ward context of a hospital when caring for patients who have co-morbid mental illness. Patients experiencing mental disorders often require a therapeutic milieu to aid recovery, and when patients are considered as not fitting into the purpose of the environment, health professionals' attitudes can alter, frustrations increase and fears become apparent with stigmatizing and stereotyping behaviors.[14] Under 'process', the model of service delivery including the choice of theory underpinning practice, clinical supervision arrangements, policies, standards, mechanisms for documentation and evaluation need to be considered. The 'outcome' of PCLN work may include whether or not the interventions improve the psychosocial care of general hospital patients, the level of satisfaction that consultees have with the service, or whether changes in the nurses' knowledge of psychosocial nursing and in their attitudes to people with mental illness has occurred. Assessment of outcome may prove to be the most challenging as the outcome measures and key performance indicators for C-L Psychiatry are not well-developed.[15&16]

The issue of the educational preparation of the PCLN has only been given cursory attention.[17] It is strongly suggested in the literature that the PCLN is considered an advanced psychiatric nurse practitioner with a number of years experience in clinical psychiatric nursing practice. Robinson[18] indicates that it is an expectation that advanced practice as a PCLN requires a Masters-prepared psychiatric nurse who has also completed post-graduate studies in C-L psychiatry and received supervision of his/her practice by an experienced qualified preceptor. Hence this calls for judicious curriculum reframing and training to meet the specific competencies required for a PCLN.

Liaison psychiatry provision is often patchy, despite its core role in risk management and in facilitating good physical health care. Existing liaison services tend typically to be for adults with mental health needs, and not for children, young people and older adults. An important development would be to commission liaison services that are age-inclusive. "The way ahead for the long-term development of liaison psychiatry is likely to lie primarily in the expanded provision of community-facing services."[2]

CONCLUSION

The role of the Psychiatric Consultation-Liaison Nurse (PCLN) not only provides potential for the development of a Nurse Practitioner role, but it also offers psychiatric nurses an opportunity to improve the quality-of-care for the psychological and psychiatric needs of patients within the general hospital setting.[19] A robust psychiatric-liaison service to be implemented requires the above mentioned issues to be considered which will then cater to the health care needs of individuals and community holistically.[20]

The primary aim of this paper was to commence debate and discussion regarding the role of the PCLN. To this end, issues and challenges related to the PCLN essential for practice and the level of education which should be mandatory for the PCLN have been considered. It is intended that this is the beginning of a much deeper exploration, and that further examination of the model for practice and its applicability to various practice settings needs to occur.

Conflict of Interest: Nil

Ethical Clearance: Not applicable

Source of Funding: Not applicable

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A Report on Diabetes Screening among Adults

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ABSTRACT

A screening programme was conducted from 5-7th April 2016 on the occasion of World Health Day theme on "Halt the Rise Beat Diabetes", at Manipal Teaching Hospital. The objectives of the screening programme were to assess the prevalence rate, risk factors for developing Diabetes and to give awareness on Diabetes. The total participants were 325 adults age group of 20 and above years. The screening programme was conducted with prior permission from the Dean Manipal College of Medical Sciences. The result of the screening programme showed that 56% of the participants had no history of both HTN and Diabetes, 30.8% had family history of Diabetes, and 10.2% already had HTN. Out of the total participants, 47.4% of the participants had overweight, 32% had normal, 19.1% had obese, and 1.5% had below normal level. Regarding GRBS, 77.8% of the participants had normal, 11.4% had pre-diabetes, 5.5% had the chance to have Diabetes and 5.2% had below normal range.

Keywords: *Adults, Diabetes, Screening*

INTRODUCTION

Diabetes is a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces. Insulin, a hormone that regulates blood sugar, gives us the energy that we need to live. If it cannot get into the cells to be burned as energy, sugar builds up to harmful levels in the blood. Over time, high blood sugar can seriously compromise every major organ system in the body, causing heart attacks, strokes, nerve damage, kidney failure, blindness, impotence and infections that can lead to amputations[1].

BACKGROUND

WHO estimates that there will be 1328 000 cases of diabetes in Nepal by 2030. According to the 2011–2012 annual report of the department of health services, 84% of the total number of outpatient visits and 90% of the total number of inpatients discharged in Nepal were attributed to NCDs.[2]

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Diabetes is one of the major causes of premature deaths and disability, and people with diabetes are at increased risk of dying from cardiovascular disease. Exposure to diabetes-related risk factors, and limited access to early diagnosis and management of diabetes, is not only associated with micro- and macrovascular complications but also leads to catastrophic health expenditure. As diabetes is prevalent in adults of working age, it threatens to further impoverish individuals, families and the community as a whole, in a country where out-of-pocket expenditure for health remains high.[3]

People with diabetes need access to appropriate medicines and a wide range of health-care services in the course of their disease. Early diagnosis and management are key to prevention and control of diabetes. There are wide variations in the availability of diabetes care services, and their availability and utilization across different socioeconomic and geographical population groups, indicating the challenge of access and equity. Diabetes services are mainly centered in urban areas and are inaccessible to many Nepalese people. There are no government health-financing schemes for diabetes care and none of the services are funded or subsidized by the government. All services such as diagnosis, treatment, medications and laboratory tests are funded by individuals and households out of pocket. There is also a lack of awareness of diabetes and its complications among the general population. There is no nationwide robust

programme for diabetes prevention in the country. Some nongovernmental organizations support occasional mass media awareness activities and screening camps and organize national events to commemorate World Diabetes Day and World Sight Day.[4]

The global burden of diseases (GBD) study stated that diabetes-related deaths have increased by 93% in the last two decades and will be 7th leading cause of deaths by 2030. South Asia, home to a quarter of the world's population, has an increasing risk of developing diabetes with country level estimates ranging from 7 to 8.5%. However, these estimations for South Asian countries were not based on the recent data, hence the current true prevalence may be likely to be higher. In Nepal, the prevalence of diabetes ranged from 1.4% to 19% according to the published studies so far. A pooled estimate of the studies among the Nepalese populations suggested that the prevalence was 8.1% in urban areas and 1% in rural areas.[5]

METHODOLOGY

The screening programme was conducted among 325 adults (age 20 yrs and above)from 5-7th April 2016 at Manipal Teaching Hospital.The physical status of the participants such as weight, height, Blood Pressure, any family history of Diabetes, Hypertension, any others were also assessed. The Body Mass Index (BMI) was calculated by using the formula (Weight in kg/Height in m^2). The BMI level of the participants were categories as below normal (less than 18.5 kg/m^2), normal (18.5-24.9kg/m^2), overweight (25-29.9 kg/m^2), and obese (30 kg/m^2 and above) according to National Institute of Health 2000.The blood glucose level was measured by pricking the finger for a drop of blood and measured it with Glucometer method. The GRBS level was categorized as normal (< 79 mg/dl), normal (80-140 mg/dl), pre-diabetes (141 - 200 mg/dl), and chance to have Diabetes (above 200 mg/dl) according to American Diabetes Association. Those participants who had blood glucose levels 200 mg/dl & above were referred to doctors for further checkup so that they can confirm to diagnose for Diabetes.

RESULT

The finding of the Diabetes screening programme can be interpreted as follow:

Distribution of frequency percentage regarding the age and sex of the participants:

Distribution of frequency percentage regarding the age and sex of the participants showed that out of 325 participants majority 181 (55.7%) were the age group of between 35-55 years and maximum 183 (56.3%) of the participants were male respectively.

Distribution of frequency percentage regarding target population of participants who are at risk of developing Diabetes presented in Table 1.

Table 1: Distribution of frequency percentage regarding target population who are at risk of developing Diabetes: n = 325

Variable	Frequency (f)	Percentage (%)
Target population		
Existing Hypertension	33	10.2
Family history of Diabetes	100	30.8
Family history of HTN	8	2.5
History of both HTN & Diabetes	2	0.6
No history of both HTN & Diabetes	182	56

The data presented in table 1 showed that out of the total participants, 182 (56%) had no history of both HTN & Diabetes followed by history of having family history of Diabetes 100 (30.8%) and 33 (10.2%) had existing HTN respectively.

Distribution of frequency percentage regarding BMI of the participants presented in Table 2.

Table 2: Distribution of frequency percentage regarding Body Mass Index (BMI) of the participants: n = 325

Variable	Frequency (f)	Percentage (%)
Body Mass Index(BMI):		
Below normal: <18.4kg/m^2	5	1.5
Normal: 18.5-24.9kg/m^2	104	32
Overweight: 25-29.9 kg/m^2	154	47.4
Obese: 30kg/m^2 and above	62	19.1

Data presented in Table 2 showed that out of 325 participants, 154 (47.4%) had overweight, 104 (32%) had normal, 62 (19.1%) had obese, and 5 (1.5%) had below normal level.

Distribution of frequency percentage regarding GRBS of the participants presented in Table 3.

Table 3. Distribution of frequency percentage of GRBS of the participants n = 325

Variable	Frequency (f)	Percentage (%)
Glucose Random Blood Sample(GRBS):		
Below normal: 60-79 mg/dl	17	5.2
Normal: 80-140mg/dl	253	77.8
Pre-diabetes: 141-200 mg/dl	37	11.4
High risk of/chance to have diabetes: Above 200 mg/dl	18	5.5

The data in Table 3 showed that out of the total participants 253 (77.8%) had normal level, 37 (11.4%) had pre-diabetes, 18 (5.5%) had the chance to have Diabetes and 17 (5.2%) had below normal range.

CONCLUSION

From the screening it can be concluded that 5.5% of adults were found at high risk or chance to have Diabetes, 11.4% found to be Pre-Diabetes and referred to consult Doctors and confirm the diagnosis and also to take treatment and preventive measures of Diabetes. As an awareness programme, a health exhibition regarding Diabetes, its causes, early diagnosis, treatment, complication, prevention and life style modification of Diabetes Mellitus also conducted side by side during the screening. Such type of survey/screening programme can be recommended to conduct in different settings so that it will help to reduce the mortality and morbidity rate of Diabetes Mellitus in the country.

Ethical Clearance: Taken from the Dean and ethical committee of Manipal College of Medical Sciences

Source of Funding: Department of Community Medicine, MCOMS

Conflict of Interest: Nil

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A Study to Assess the Depression among Elderly Residing in Old Age Homes of Thiruvananthapuram District, South Kerala

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ABSTRACT

Introduction: Population ageing is ultimate consequence of demographic transition. Due to increased industrialization and modernization and due to the shrinkage of joint family into nuclear family many of elderly find their way to old age homes. Studies indicated that older adults are commonly subjected to depression. Old age consist of ages nearing or surpassing the average lifespan of human beings and thus the end of human life cycle.

Objective: Assess the depression among elderly residing in old age homes of Thiruvananthapuram District.

Methodology: Our present study is to assess the depression among elderly residing in old age homes of Thiruvananthapuram District. The population consisted of elderly people living in te hold age homes. The study is descriptive in nature and using semi-structured questionnaire and geriatric depression rating scale we assessed the depression among 100 elderly.

Results: The findings of our study showed that 13% of our study participants have no depression, 37% have mild depression 50% have severe depression.

Keywords: *Depression, Elderly, Old age home*

INTRODUCTION

Ageing is an inevitable change largely characterised by a decline in functional ability and decreased capability. It is time related change that occurs throughout life. Ageing involves all aspects of organism. As an individual advances from infancy old age he accumulates a wealth of impression skills and knowledge and develops his own life[1]. Define ageing in terms of the biology referring to "the regular changes that occur in mature genetically representative organism living under reprehensive environmental conditions as they advance in chronological order"[2]. As man grows, his reduced activities, income and consequent decline in the position in the family and society makes his life more vulnerable[3]. An old person begins to feel that even his children don't look upon him with that degree of respect, which he used to get some years earlier. The old person feels neglected and humiliated. This may lead to psychological shunning the company of others. Geriatric depression is a major health hazard with devastating outcomes. Depression in old age is much complex and difficult to diagnose due to medical illnesses. I create many problems in the activities of daily living. In other words there is increased dependency on others and health care systems.

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BACKGROUND

Old age is a process of unfavourable progressive changes usually correlated to the passage of time, becoming apparent after maturity and terminating invariably in death of individual[4] . Rapid growth of industry and modernisation in India, it has also affected the people in many ways. The tradition of joint family is disappearing slowly, which was based on love, affection and tradition. It has also transformed the life of family,

affected the emotion of the people. Due to these reasons number of old age homes have been increasing [4,5]. Though the belief persist that depression is synonymous with ageing and that depression in fact inevitable, there has been recent researches which dispels their psychological problem. Studies have found that age is not always significantly related to level of depression, and that the oldest of folds may even have better coping skills to deal with depression making depressive symptoms more common but not severe as in younger age [6]. India, world's populous country bloom the share of India's population ages 50 and older relatively increase tremendously. All else being equal, an older population has greater needs for health care [8]. Old age means reduced physical ability, declining mental ability, the gradual giving up of role playing in socioeconomic activities, and a shift in economic status moving from economic independence to economic dependence upon others for support[9]. Family is the main source of care giving to all its members. In a globalising world, the meaning of old age is changing across cultures and within countries and families [10]. It is important that the state, civil society and community recognises the right needs of the elderly women and make suitable policies health and security scheme for the elderly which already exists. There should be laws which ensure adequate social, physical and mental protection for the elderly[11].

NEED AND SIGNIFICANCE

The last century has witnessed a rapid increase in population in elderly people. This phenomenon is not restricted to western countries only, but many countries such as ours are now facing the impact of this transaction. India ranks 4th in place of absolute size of elderly population. The country is no adequately equipped to look after their special health needs and the changing traditional value system[12]. The traditional sense of duty and obligation of the younger generation towards the older generation is being eroded. The older generation is caught between the decline in mental and physical health in one hand and the absence of adequate social support in each other[13]. Old age homes are a need of today's lifestyle changes fast and diminishing acceptance of family responsibilities towards one's elders. Other people are in need of vital support their overall quality of life. We should thoroughly understand the concept of old age homes and the problems of elderly in old age homes[14]. According to WHO report 1999, ageing can become manifest not only physically but also mentally at almost any period of life. The care of the elderly people needs special emphasis because of their frailty and vulnerability. In India we do not have special areas or settings to take care of old. Due to rapid urbanisation and growing number of nuclear families more aged feel neglected in their families. Need foe old age home is increasing as the youth of today doesn't have time to spend with old people[15].The elderly citizen are in need of urgent attention. They no need our pity, but understanding love and care of the fellow being. It is our duty to see that they do not spend the twilight years of their life in isolation, pain and misery. Older persons are in need of vital support that will keep their important aspects of the lifestyle intact while improving their overall quality of life [16]. Along with the physical illnesses mental illness also increased in elder population due to loneliness from the near and dear [17]. Ageing is not a sin. But it seems from angles that the aged suffer a lot due to denial by the near ones. Some willingly while other find their way to old age homes. As the elderly population is shooting in these decades the number of old age homes are also increasing. But they are only mere homes from there they are not getting life satisfaction which leads to various health and mental problems. This lead to the purpose of our study or let way to our study.

Statement of the Problem: A study to assess the depression among elderly residing in old age homes of Thiruvananthapuram District, Kerala.

OBJECTIVE

Assess the depression among elderly residing in old age homes of Thiruvananthapuram District.

OPERATIONAL DEFINITION

Depression: It is defined as a feeling of sadness as manifested by hopelessness, helplessness, worthlessness.

Old age homes: It refers to an organization where elderly are residing to meet there basic needs of physical psychological and social comfort.

METHODOLOGY

Research Approach: Quantitative approach.

Design: Descriptive design-Cross sectional survey

Setting: Old age homes of Thiruvananthapuram District, Kerala

Population: Elderly aged above 60 years residing in old age homes to meet there basic needs of physical psychological and social comfort and those who are willing to give consent to participate in the study.

Sample Size: 100

Sampling Technique: Simple random Sampling

Exclusion criteria

- Mentally and physically handicapped
- Who do not know Malayalam and English.

Tool: Questionnaire and Geriatric Depression Rating Scale

- **Part A:** Performa for collecting socio demographic data.
- **Part B:** J A Yesavage Geriatric Depression Rating Scale.

ANALYSIS & RESULTS

The findings of the study were analyzed and arranged under the following sections.

Section 1: Sociodemographic data

Section 2: Depression among elderly residing in the old age home.

Table I: Sociodemographic data

Variable	Number (%)	Percentage
Gender		
Male	21	21
Female	79	79
Religion		
Hindu	64	64%
Christian	33	33%
Muslim	03	3%
Education		
Illiterate	22	22%
Primary	63	63%
Secondary	09	9%
Degree	06	06%

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Occupation		
Govt. Employee	06	6%
Semi Govt Employee	39	39%
No Job	55	55%
Place of residence		
Rural	56	56%
Urban	44	44%

Depression among elderly residing in old age homes in Thiruvananthapuram district

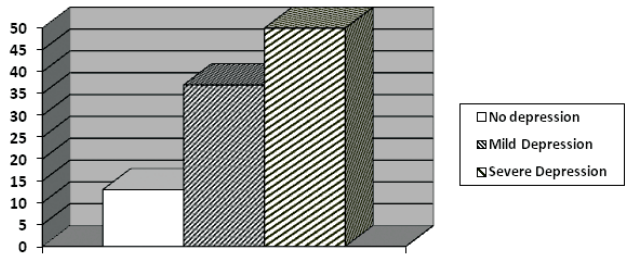

Fig. 1: Depression among elderly

Depression among elderly was assessed using Yesavage Geriatric Depression Rating Scale.

The study revealed that 13% of participants have no depression; they scored between 0-9,

37% of participants have mild depression with a score of 10-19 and 50% of participants have severe depression with higher score of 20-30 (Figure1).

DISCUSSION

A study conducted by Ngugen H and Zimmerman, Relationship between age aspects of depression in old age homes in 2006 reveals that relationship between age and depression results show a reasonable degree of stability among adults under 70 years of age and among them residing in old age home, 48% have major depression,26% have minor depression.

A study was conducted by Mildred O Hogstel published in Mosby publications that" Majority of senior citizens 71.42% living in old age homes are depressed being away from near and dear, no one to look after, absence of their children, thoughts about their past life and of no further expectations.

The present study is also consistent with the finding that depression among elderly is far higher than general population.

CONCLUSION

In our society, due to the increased industrialization, modernization and by the shrinkage of joint family most of the elderly are thrown to old age homes or they find their way to old age homes. Geriatric depression is a major health hazard with devastating outcomes. Depression in old age is much complex and difficult to diagnose due to medical illnesses. It creates many problems in activity of daily living. This study was conducted to assess the depression among elderly residing in old age homes of Thiruvananthapuram District.

Conflict of Interest: Nil

Source of Funding: Self

Ethical Clearance: The ethical clearance was taken from committee and School authorities before conducting the study

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Depression among Oral Cancer Patients Receiving Radiation Therapy in Selected Centre, Erode

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ABSTRACT

Cancer is the leading cause of disease worldwide. An estimated 12.7 million new cancer cases occurred in 2008. Cancer of the lip and oral cavity accounted for 2% of cancer cases worldwide.[1]

Objectives: The objectives of the study were to

- Assess the level of depression among oral cancer patient.
- Associate the level of depression with the selected demographic variables.

Methodology: Descriptive research design was adopted. Convenient sampling technique was used and 60 patients were selected at Erode Cancer Centre, Erode. The data was collected, organized and analyzed in terms of both descriptive and inferential statistics.

Result: The study results showed that a vast majority of them ie. 135(50%) had moderate level of Depression followed by 9(6%) of them who had mild depression, 4(2.7%) who had sever level of depression and mean 37.34 and standard deviation 18.18. Chi square test revealed there was a significant association in the level of depression of oral cancer patient receiving radiation therapy with the selected demographic variables such as age, gender, marital status, availability the family support, & educational status at $p< 0.05$ level.

Conclusion: This finding would be useful and beneficial to healthcare services which might improve in management and intervention on psychological of patient undergoing radiation therapy. Other factors that contributed to depression among cancer patient also need to be investigated.

Keywords: *Depression, Oral, Cancer, Patients, Radiation Therapy*

INTRODUCTION

Cancer is the second leading cause of death globally, and was responsible for 8.8 million deaths in 2015. Globally, nearly 1 in 6 deaths is due to cancer. Approximately 70% of deaths from cancer occur in low- and middle-income countries. Around one third of deaths from cancer are due to the 5 leading behavioral and dietary risks: high body mass index, low fruit and vegetable intake, lack of physical activity, tobacco use, and alcohol use. Tobacco use is the most important risk factor for cancer and is responsible for approximately 22% of cancer deaths.[2]

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NEED FOR THE STUDY

Cancer is the leading cause of disease worldwide. An estimated 12.7 million new cancer cases occurred in 2008. Cancer of the lip and oral cavity accounted for 2% of cancer cases worldwide.[1]

Oral mucositis can have potential serious consequences for patients. Painful lesions can compromise the patient's nutritional status and oral hygiene, and can result in local or systemic infections.

This can have a profound and debilitating effect on the patient's quality of life. The patient may suffer from malnutrition, dehydration, weight loss and have difficulty with communication. Patients with a damaged oral mucosal are at a higher risk of developing infections.

Radiotherapy is an important treatment modality for patients with cancer, but it is not without its physical and psychological side effects. Nurses have an important role is the supportive care of patients undergoing radiotherapy, whether it is radiotherapy alone or in combination with other treatment modalities such as chemotherapy. Many past supportive care practices in radiotherapy have been anecdotal and based on historical practices. This is improving; however, research of the impact of radiation treatment on an increasingly ageing population is minimal. As we progress our practice into the future, this care needs to be based on good evidence. This opens up many avenues for nurses in this speciality to engage with research to provide this evidence.[3]

REVIEW OF LITERATURE

Section–a: Studies related to depression among oral cancer patients receiving radiation therapy: A cross-sectional descriptive study was conducted at the radiation therapy Day Care Centre of North Bengal Medical College and Hospital. A total of 174 cancer patients were selected and interviewed. Brief Edinburgh Depression Scale was used to find out. The results depicts out of 174 cancer patients, 97 (55.7%) were found to be depressed. Depression was comparatively higher in patients ≥50 years; in males; those belonging to religion other than Hindus; who received higher education; had monthly family income ≥5000 rupees and were involved in moderate or heavy work. Nearly 70.6% of blood cancer patients; 64.3% of those who had been receiving chemotherapy for ≥6 months and 56.9% of those in their 4th or less cycle of radiation therapy were found to be depressed. The study revealed depression is substantially high among cancer patients undergoing radiation therapy in this area. Diagnosis and treatment of cancer patients need to be complemented by psychological support for the cancer patients.[4]

A cross-sectional and correlational design was used to collect data for this study conducted in northern Taiwan. A set of questionnaires was used to measure depression, symptom distress, performance status, social support, and demographic and disease-related information. Logistic regression was conducted to determine important factors predicting depression. The results shows that a total of 132 oral cancer patients participated in this study. Of these, 18.2% were identified as depression cases. The patient average performance status score was 90 or higher. Patients reported mild-to-moderate levels of symptom distress. The majority of social support was from families. Religious belief, alcohol use, symptom distress, and social support from family were found to be important factors predicting depression. Patients with religious belief with alcohol use reported greater symptom distress, and those with lower levels of social support from families were significantly more likely to develop depression. Conclusions of the study were clinicians should assess patient emotional status and manage symptoms in a timely manner to enhance coping abilities. Supportive care provides assurance during the acute survivor phase.[5]

Statement of the Problem: A Study to Assess the Level of Depression among Oral Cancer Patients Receiving Radiation Therapy in selected Centre, erode.

OBJECTIVES

- To assess the level of depression among oral cancer patients receiving radiation therapy.
- To associate the level of depression with selected the demographic variables.

Hypothesis

H_1: There is significant level of depression among oral cancer patient receiving radiation therapy as measured by beck depression inventory

OPERATIONAL DEFINITIONS

Assess: It is the estimation of level of depression among oral cancer patients receiving radiation therapy.

Depression: In this study it refers to a group of symptoms, feeling of sadness, loneliness, despair, low self esteem, withdrawal from inter personal contact and Physiological symptoms of insomnia, anorexia, weight loss, and loss of hair experienced by cancer patients.

Cancer: In this study it refers to the diagnosis of cancer which is confirmed by a diagnostic criteria and it includes the duration of illness, site of cancer and stages of cancer.

Radiation Therapy: The patient selected as they are receiving radiation therapy.

Assumptions: The hospitalized cancer patients have may depression in various levels of depression.

Research Design: The research design selected for present study is comparative descriptive design.

Setting of the Study: The study was conducted among the nurses who are working in PSG hospital critical care units and general ward. The PSG Hospital is a multispecialty 910 bedded hospital and is well equipped with adequate facilities.

Population: The study population includes both male and female oral cancer patient receiving radiation therapy.

Samples: Oral cancer patient.

Sample Size: The sample size was 60 cancer patients with receiving radiation therapy

Sampling Technique: Non-probability convenient sampling technique

Description of the tool: The tool consists of two parts.

Part–I: It deals with Demographic variable consists of, Age .Gender, Duration of illness, Marital status, Availability of family support, Educational status.

Part–II: Beck depression scale is the most appropriate instrument to assess the presence and level of depression symptoms which was developed by Aaron beck. This questionnaire consists of 21 of statements. The patient has to read and then one statement in each sample that best describes the way he/she has within the past 2 weeks including the day of inventory total score is 63 and it is classified as follows.

Score Interpretation:

Mild depression - <50%
Moderate depression - 50 – 75%
Severe depression - (>75%

FINDINGS

Table 1: Distribution of level of depression among oral cancer patient receiving radiation therapy

(n = 60)

Sl. No.	Level of Depression	Frequency	Percentage
1.	Mild (<50%)	20	33.3
2.	Moderate (50–75%)	30	50
3.	Severe (>75%)	10	16.6

Table 1 shows regarding the higher percentage of oral cancer patient receiving radiation therapy had moderate level of depression 30 (50%).

Table 2: Mean and standard deviation of level of depression among oral cancer patient receiving radiation therapy

(n = 60)

Sl. No.	Level of Depression	MEAN	Standard Deviation
1.	Depression	37.34	18.18

Table 2 depicts the mean 37.34 and standard deviation 18.18 of level of depression among oral cancer patient receiving radiation therapy.

Table 3: Association of demographic variables with level of depression among oral cancer patient with receiving radiation therapy

(n = 60)

Sl. No.	Demographic Variables	Mild Depression		Moderate Depression		Severe Depression		χ^2 value
		No.	%	No.	%	No.	%	
1.	**Age**							
	18-30 yrs	3	5	1	1.6	-	-	46.16 d.f = 6 (S)*
	31-40 yrs	15	25	8	13.3	-	-	
	41-50 yrs	2	3.3	18	30	2	3.3	
	Above 50 yrs	0	0	3	5	8	13.3	
2.	**Gender**							
	Male	12	20	22	36.6	9	15	6.38 d.f = 2 (N.S)
	Female	8	13.3	8	13.3	1	1.6	

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3.	**Duration of illness**							
	>6month	10	16.6	7	11.6	1	1.6	21.3 d.f = 4 (N.S)
	7-12 months	10	16.6	18	30	3	5	
	13-24 months	-	-	5	8.3	6	10	
4.	**Marital status**							
	Married	20	33.3	30	50	10	16.6	44.1 d.f = 2 (S)*
	Unmarried	-	-	-	-	-	-	
5.	**Availability the family support**							
	Yes	20	33.3	30	50	10	16.6	44.1 (S)*
	No	-	-	-	-	-	-	
6.	**Educational status**							
	No formal education	17	28.3	10	16.6	-	-	32.51 d.f = 4 (S)*
	Primary education	3	5	16	26.6	4	6.6	
	High school	-	-	4	6.6	6	10	

*(S-Significant), (N.S-Not significant)

Table 3 reveals that there showed that there was a significant association in the level of depression of oral cancer patient receiving radiation therapy with the selected demographic variables such as age, gender, marital status, availability the family support, & educational status at $p< 0.05$ level.

CONCLUSION

This finding would be useful and beneficial to healthcare services which might improve in management and intervention on psychological of patient undergoing radiation therapy. Other factors that contributed to depression among cancer patient also need to be investigated.

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Life Skills and Nursing

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ABSTRACT

Life skills are a category of soft skills that are needed to successfully navigate the challenges of daily life, both personal and professional. They include the ability to set and achieve goals, make decisions, solve problems, and effectively manage one's time. Life skills are those soft skills that largely rest in the individual. Once mastered, life skills help a person in every aspect of his life. A comprehensive literature search was performed using specific keywords. Main focus of the literature search was about life skills and its relation with nursing. Literature shows that life skills training causes significant improvement in the nurses' physical functioning, bodily pain, general health, vitality, social functioning, mental health, physical health and ultimately quality of life. Also it increases nurse's happiness.

Keywords: *life skills; nursing; self awareness.*

INTRODUCTION

If a man is hungry, don't give him fish to eat, but teach him to catch fish.

Chinese adage

Life skill is the positive behavior and ability to adjust efficiently with the needs and challenges of everyday life. The extent to which a person exposes to the desired skills and practice, determines the level of his overall development. It also helps to solve the physiological, psychological and social problems.[1]

Life skills are used every moment of our lives in various situations. Life skills are the building blocks of one's behavior and need to be learnt well to lead a healthy, meaningful and productive life.[2]

Definition:

WHO has defined life skills as, "the abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life".[3]

UNICEF defines life skills as "a behavior change or behavior development approach designed to address a balance of three areas: knowledge, attitude and skills".[4]

Life skills fall into three basic categories, which complement and reinforce each other:

Social skills	Cognitive skills	Emotional coping skills
Communication Negotiation/refusal skills Assertiveness skills Interpersonal skills Cooperation skills Empathy	Decision making/problem solving skills Understanding the consequences of actions. Determining alternative solution to problems Critical thinking skills Analyzing peer and media influences Analyzing one's perceptions of social norms & benefits Self evaluation and value clarification	Managing stress Managing feelings, including anger Skills for increasing internal locus of control (self management, self monitoring)

Core Life Skills: The Ten core Life Skills as laid down by WHO are:

1. **Self Awareness:** Self awareness is the awareness about oneself (self consciousness). It includes

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one's recognition of them, one's character, one's strengths and weaknesses, desires and dislikes. This helps the individual to understand his/her self worth and builds his/her confidence to face life boldly.

2. **Empathy:** Empathy is one's ability to understand and accept different kinds of people around them who are different in many respects. Empathy also helps to encourage nurturing behavior towards people in need of care and assistance or tolerance.
3. **Effective communication:** Effective Communication is an efficient tool for the establishment and maintenance of good social and working relationships with people. It enables an individual to express his opinions, desires and fears clearly by using both verbal communication and non-verbal expressions.
4. **Inter Personal Relationship:** Inter Personal Relations are known as survival skills which is very imperative for establishing and maintaining social relationships. Interpersonal skill is to initiate and maintain positive relationship with other individuals and de-link unconstructive relationship, with minimum disturbances to both. It teaches an individual to relate to other people in a positive manner.
5. **Creative thinking:** Creativity is the ability to generate innovative ideas and manifest them from thought into reality. It helps to respond in a flexible manner to various challenges of life. This skill helps in both problem solving and decision-making.
6. **Critical Thinking:** Critical thinking is defined as logical thinking and reasoning including skills such as comparison and classification. It also helps to recognize factors like family values, peer and media pressures that influence attitudes and behavior.
7. **Decision-making:** Decision Making is the ability to choose the best amongst the various alternatives or options in many life situations. The skill to analysis and weigh the pros and cons of alternatives and accepting responsibility for the consequences of the decision with confidence.
8. **Problem solving:** Problem solving skills enable us to deal constructively with problem that arises in our live. It enables the person to get out of the uncomfortable situation and accomplish one's need without using anger, coercion, defiance, aggressive behavior or force.
9. **Coping with emotions:** Coping with emotions helps the individual to understand feelings of them and others. This skill helps to know that it is normal to have strong feelings and that feelings are neither positive nor negative. Life skills enable the individual to learn healthy, positive and safe ways to express these feelings.
10. **Coping with Stress:** Coping with stress enable the individual to recognize the sources of stress, understanding its effects and relax without making the situation worse. This skill provides the strength to face positive or negative stressful situations.

LIFE SKILLS AND NURSING

In the last few years, reforms in public health brought significant changes to nursing. The sphere of their independent activities is expanding. The World Medical Assembly defines the main task of the nursing personnel as "maintaining health, preventing diseases, determining the patient's needs and taking actions aimed at solving these issues together with the patient".[5]

Not Everyone Can Be A Nurse A career in nursing encompasses skills that can only be found in certain types of people. Whether you're already a nurse, training to become a nurse, or simply considering nursing as a future career option, it's crucial that you cultivate the specific life-skills like stress management, communication skill, patience, compassion and selflessness, problem solving and endurance.[6]

A high priority needs to be placed on preparing nurses and midwives to meet the complexity of current and future nursing/midwifery practice. [7]

Nurses and midwives daily witness people's mourns and pains in clinical environment. Nurses' special hospital situations such as patients' sigh and their critical condition and death, nurses' insomnia, lack of assurance, and disturbances in their interpersonal communications in all levels enhance nurses' and midwives' stress, and worsen the vicious cycle of anxiety, which leads to their physical problems ultimately influencing the output of health system and the manner and quality of their care.[8]

IMPORTANCE OF LIFE SKILLS IN NURSING

- Nurses work in a variety of environments so there are always a variety of challenges and possibilities. If nurses have the skills and they are willing to invest the time and effort into a lifelong career, nursing could provide them with a fulfilling challenging profession.
- Life skills offer the nurse an opportunity to acquire self knowledge, to take a positive approach to self and to develop personal growth and enrichment. Personal growth and enrichment will support the nurse in pursuit of professional growth.
- Life skills enable the nurse to act effectively in relation to other people and to render holistic nursing care by applying life skills while supporting the patient in the pursuit and maintenance of physical, mental, and spiritual health.
- Life skills empower the nurse to develop and enhance a caring attitude in the nursing of patients. They enable the nurse to listen to beyond what the patient is saying, and to be assertive, manage conflict and make carefully considered decisions.
- Life skills develop emotional maturity, which includes honesty, openness, loyalty to people, kindness, keeping of promises and confidence.[9]
- Life skills training causes significant improvement in the nurses' physical functioning, bodily pain, general health, vitality, social functioning, mental health, physical health and ultimately quality of life.[10]
- Research study indicates that life skills education could significantly increase the happiness of nurses.[11]

Importance of Life skills for nursing students

- Nursing students need Analytical abilities, Psycho-Social-Behavioral Abilities, Physical Abilities, Sensory Abilities, and Emotional Intelligence.
- Increase the levels of emotional intelligence of the students
- Academic success
- Increased stress tolerance
- Improve self efficacy
- Reduce substance abuse

CONCLUSION

Life skills are abilities helping to behave appropriately and wisely in different situations and adaptively communicate with one's self and others. These skills assist in solving the problems with no aggression and feeling happy in life while being successful. Learning these abilities yields mental health promotion, human relations enrichment, and increased healthy behaviors.

Conflict of Interest: Nil

Ethical Clearance: Obtained from institute ethical committee

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A Study to Assess the Knowledge and Attitude towards Mental Illness among Adults at Selected Urban Community Udaipur, Rajasthan

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ABSTRACT

Background of the Study: As a worldwide phenomenon, no one is immune- mental illnesses affect people of all ages, cultures, educational and income levels. The studies conducted in developing countries have revealed that during their life time; more than 25% of individuals develop one or more mental or behavioral disorders. According to WHO report- about 450 million people were estimated to be suffering from neuropsychiatry conditions.

There have been tremendous advances in our understanding of the causes and treatment of mental illness most of these treatments can be provided effectively by a general or community health worker by having good knowledge and favorable attitude towards mental illness.

Method: A descriptive study was conducted to assess the knowledge and Attitude towards mental illness among an adult at selected urban community, Udaipur District, Rajasthan. Convenient or Purposive Sampling technique was used to collect data among 40 adults between 18-40 years of age. The data were collected using self administered structured knowledge and attitude questionnaire tools comprising of: demographic Performa, knowledge assessment questionnaire and five point attitude scale. The data was analyzed using descriptive and inferential statistics.

Results: The study findings shows that majority of an adult had good knowledge (47.5 %), excellent knowledge (42.5%), and no one had poor knowledge regarding mental illness.

92.5 % of adults had favorable attitude towards mental illness. The study revealed a positives correlation between knowledge and attitude scores. No association was found between adults knowledge and selected demographic variables.

Conclusion: The study suggests that nurses can play a vital role in educating the peoples in relation to mental health and mental illness and its prevention.

Keywords: *Knowledge, Attitude, Mental illness, Adults.*

INTRODUCTION

"The secret of National Health lies in the people with Sound Mental Health"

Mental Health concerns everyone. It affects our ability to cope with and manage change, life events and transition. The definition of 'Health' according to WHO- "State of physical, mental, social and Spiritual well being of an individual, not merely absence of any disease". It can be evident by above definition that physical aspects comprises any 25% of total health concept while other entities like Mental, Social and Spiritual have greater relevance and significance in the field of Psychiatry Nursing.

There is more good health than just a physically health body; a person should also have a healthy mind. A person with a healthy mind should be able to think clearly, solve the various problems faced in life, enjoy good relations with friends, colleagues at work and family and bring happiness to others in the community. It is these aspects of health that can be considered as mental health. Even though we talk about the mind and

body as if they were separate, in reality are like two sides of the same coin. They share a great deal with each other, but present a difference face to the world around us. if one of the two is affected in any way then the other will almost certainly also be affected. Just because we think about the mind and body separately. It does not mean that they are independent of each other. Just as the physical body can fall ill, so too can the mind. This can be called Mental Illness. Mental illness is "Any illness experienced by a person which affects their emotions, thoughts or behavior, which is out of keeping with their culture, beliefs and personality, and is producing a negative effect on their lives or the lives of their families". There have been tremendous advances in our understanding of the causes and treatment of mental illness. Most of these treatments can be provided effectively by a general or community health worker[1]. Mental illness includes a broad range of health problems. For most people mental illness is a thought of as an illness associated with severe behavioral disturbances such as violence, agitation and being sexually inappropriate. Such disturbances are usually associated with severe mental disorders. However, the vast majority of those with a mental illness behaves and looks no different from anyone else. These common mental health problems include depression, anxiety, sexual In the past and in the present also, in the field of health, our mind has been preoccupied with communicable disease because they are the biggest cause of death in the population[2].

We have been looking at health in terms of physical health, while neglecting mental health. Over the years, mental illness has increased manifold. WHO report-2017: 7.5% Indians suffer from mental disorders. Not only do 56 million Indians -- or 4.5% of India's population -- suffer from depression at this moment, another 38 million Indians suffer from anxiety disorders. Thus, according to the latest World Health Organization report on depression released, almost 7.5% of Indians suffer from major or minor mental disorders that require expert intervention[3]. Referred to the findings of the various studies: "India needs to talk about mental illness;" Every sixth Indian needs mental health help. 8% of people in Karnataka have mental illness, Mental problems more in 30–49 age group or over 60; low income linked to occurrence of mental disorders and urban areas to be most affected. The NMHS (National Mental Health Survey) is a milestone in understanding the epidemiology of mental disorders in the country. Psychiatric epidemiology has been an area of great interest among all the leading psychiatrists. The other similar area of interest is the psychiatric classifications. In both these fields, there are more "failures" than successes in the past 60 years[4]. Barriers to effective care include lack of resources, dearth of trained health-care providers, and social stigma associated with mental disorders. India, for instance, has less than 4,000 psychiatrists to treat its mentally ill people[5].

Although there has been a demographical study, psychiatrist estimates that about two percent of Indians suffers from mental illness, a staggering 20 million out of a population of 100 million. A recent survey of 500 working women in Delhi by Hamara Parivar, a family welfare programme, has found that 78% of them suffer from depression due to sociological pressure and breakdown of personal relationships[6]. Epidemiological surveys done in India as well as in many other parts of the world have amply confirmed that at any given time one to two percent of the population suffers from serious mental illness. While 10 to 15 percent suffers from so called mental disorders like anxiety, depression, somatic symptoms due to tension, alcohol and drug abuse etc. women seem to be more prone to anxiety and depression while men to alcohol and drugs more often. One to two percent of Indians suffer from manic- depressive illness alone. Nine millions people have schizophrenia in India (One out of 1000)[7].

OBJECTIVES OF THE STUDY

1. To determine the level of knowledge of adults towards mental illness.
2. To assess the attitude of adults towards mental illness.
3. To find out the co-relation between knowledge score and attitude score of adults.
4. To find out the association between knowledge score adults toward mental illness and selected demographic variables.

HYPOTHESIS

H_1: There will be significant co-relation between the knowledge score and attitude score of adults toward mental illness.

H_2: There will be significant association between knowledge of adults and selected demographic variables.

MATERIAL AND METHOD

Conceptual framework: The conceptual framework selected for the study is based on "General System theory" with the concept of input, throughout and output by Ludwig Von bertalanffy (1968)[8].

Research Approach and Design: A Non-Experimental descriptive study was conducted to assess the knowledge and Attitude towards mental illness among an adult at selected urban community, Udaipur District, Rajasthan.

Sample Size: The sample consisted of 40 adults between 18-40 years of age.

Setting of the study: Study was conducted at Hiran Magri Sec.-4 and Sec.-5, Udaipur, Rajasthan.

Sampling Technique: Convenient or Purposive Sampling technique was used to select the subjects[9].

Data Collection Instruments: Part 1: Demographic Performa: This tool was constructed to collect the background data of the study subjects.

It consisted of the six items: age, gender, education, occupation, income and marital status. The respondents were requested to place a tick mark against the appropriate boxes.

Part 2: It deals with knowledge data of an adult. It consists of 20 items on meaning of health, mental health, mental illness, causes and predisposing factor of mental illness, sign and symptoms of mental illness, treatment and preventive measure of mental illness. For this section rating scale adopted with score of (Excellent, Good, Average & Poor).Each item has four options with one correct answer with a score of one. Thus the total score is 20.

- For Excellent the score: 16-20
- For Good the score: 11-15
- For Average the score: 6-10
- For Poor the score: Below 5

Part 3: It deals with attitude of an adult towards mental illness. It contains 20 items to assess the favorable or unfavorable attitude towards mental illness. For this section five point attitude rating scale is adopted with score of Strongly Agree, Agree, Can't say, Disagree & Strongly disagree. Each question had one possible correct response. Each correct answer is assigned a score (see attitude score key).A five point attitude scale was used.

- For favorable attitude the score is 41-100.
- For unfavorable attitude the score is Below 20 -40.

VALIDITY AND RELIABILITY

To ensure the validity of the tool it was submitted to 10 experts for establishing the content validity. Among the experts, one was from the field of psychiatric medicine, two from psychiatric social work and seven were from psychiatric nursing. Reliability of the tool was established using Karl Pearson's formula. The instrument was found to be reliable with reliability. Co-efficient i.e. knowledge = 0.94 attitude = 0.96.[10]

FINDINGS

Section-I: Description of study subject by Socio demographic variables: In this section researcher analyzed and categorized the study subjects of study, into various groups based on the socio-demographic variables.

Table 1: Depicts the distribution of respondents by demographic variables

N = 40

S. No.	Variables	Frequency	Percentage (%)
1.	**Gender**		
	Male	26	65%
	Female	14	35%
2.	**Age**		
	18 – 23 years	04	10%
	24 – 29 years	20	50%
	30 – 35 years	10	25%
	36 – 40 years	06	15%
3.	**Education**		
	Secondary	04	10%
	Hr. Secondary	05	12.5%
	Graduate	19	47.5%
	Post Graduate	12	30%

Conted…

4.	**Occupation**		
	Daily Wages	05	12.5%
	Private Employee	16	40%
	Government Employee	13	32.5%
	Others	06	15 %
5.	**Income/Month**		
	< 2000 Rs.	08	20%
	2001 – 5000 Rs.	09	22.5%
	5001 – 10,000 Rs.	15	37.5%
	>10,000 Rs.	08	20%
6.	**Marital Status**		
	Married	23	57.5%
	Unmarried	12	38%
	Divorced	03	7.5%
	Widow	02	5%

Section II: Knowledge level of an adults regarding mental illness.

Table 2: shows that out of 40 samples, majority of an adult 19 had Good knowledge, no one had poor knowledge

n = 40

Knowledge Level	Respondents	
	Frequency	Percent
Excellent (16 - 20)	17	42.5%
Good (11 – 15)	19	47.5%
Average (6 – 10)	04	10%
Poor (Below 5)	0	0%
	Total = 40	100%

Maximum Score = 20

Section III: Frequency and percentage wise distribution of an attitude of an adult regarding mental illness.

Table 3: shows that maximum number of adults had favorable attitude towards mental illness

N = 40

S. No.	Attitude Score	Frequency	Percentage	Grade
1.	81–100	13	32.5%	**Favorable Attitude**
	61–80	15	37.5%	
	41–60	09	22.5%	
2.	21–40	03	7.5	**Unfavorable Attitude**
	< 20	0	0	

Maximum = 100

Section IV: Correlation between knowledge score and attitude score of an adults.

Table 4: Shows that there is a positive co-relation between knowledge score and attitude score of an adults

Sr. No.	Item	R value	Df	P value	Inference
1.	Knowledge	.85	39	>0.05	Positively Correlate
2.	Attitude				

DISCUSSION

There is correlation between knowledge and attitude as the r value is .85

It means there is significant relationship between knowledge and attitude.

A non-experimental descriptive study was conducted at urban community Udaipur Rajasthan to assess the knowledge and attitude among an adults towards mental illness. A total of 40 subjects were administered tools. Distribution of an adults knowledge towards mental illness shows that of the an adults (47.5%) had good knowledge, 42.5% adults had excellent knowledge, 10% of respondents had average knowledge while no one had poor The mean and standard deviation of knowledge score of an the mean and standard deviation scores values was 15 (mean % =75%) and standard deviation was 2.85

(14.3%). It seems that an adults had good knowledge towards mental illness. Distribution of an adults attitude towards mental illness shows that majority of the adults (92.5%) had favourable attitude towards mental illness. Mean attitude score was 70 (70%) standard deviation was 8.9%. Positive correlation was found (+0.85) between knowledge score and attitude score of an adult towards mental illness. On the basis of analysis there was no association between knowledge score and selected, because the calculated values is less that value of X2 = 3.34 ,at the 0.05 level of significance.

RECOMMENDATIONS

- Similar study can be undertaken in rural area and on a longer sample
- size to generalize the findings.
- A comparative study can be conducted on rural and urban adults.
- A study may be conducted as experimental study.
- A study may be undertaken to evaluate the effectiveness of self instructional module prepared on the topic.

CONCLUSION

The conclusion were drawn on the basis of major findings of the study were as follows.

- An adults had higher knowledge score in role of 47.5% and no one had poor knowledge towards mental illness.
- An adults had higher attitude score in role of an adults 92.5% (favorable) and 7.5% unfavorable attitude towards mental illness.
- The correlation coefficient (R) = +0.85 obtained between knowledge and attitude towards mental illness found to be positive indicating higher the knowledge better is the attitude.
- There was no significant association observed between adults knowledge with demographic variables.

Conflict of Interest: There was no conflict of interest.

Ethical Clearance: Permission has obtained from CMO, Govt. Satellite Hospital, Hiran Magri, Sec.5, Udaipur, Rajasthan and consent were taken from subjects.

Source of Funding: Self

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A Study to assess the Effectiveness of Selected Nursing Intervention on Activities of Daily Living, Self Esteem, Depression and Quality of Life among Elderly with Chronic Illness at Selected Old Age Homes in Bangalore, Karnataka

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ABSTRACT

Introduction: Elderly are the most rapidly growing segment of population. In India there are about 77 million elderly populations where as in Karnataka out of a population of 5.5 crores, 8 percent are elderly[1].

Objectives: 1.T To compare the pre and post test activities of daily living, self esteem, depression and quality of life among elderly with chronic illness between experimental and control group. 2. To correlate between activities of daily living, self esteem, depression and quality of life among elderly with chronic illness in experimental and control group.

Methodology: True experimental two group pre –post test control group design used to conduct the study. Simple random sample technique used to collect 40 elderly from selected old age home.

Results: There was statistical significant at $p<0.01$ in ADL, Self esteem, depression and QoL among elderly with chronic illness between experimental and control group. It shows positive correlation between ADL, Self esteem and QOL among elderly with chronic illness. It shows negative correlation between Depression with ADL, Self esteem and QOL among elderly with chronic illness. This indicates statistically high correlation between activities of daily living, self esteem, depression and quality of life among elderly with chronic illness in experimental Group.

Keywords: *chronic ill, elderly, old age home*

INTRODUCTION

The elderly population (aged 60 years or above) account for 7.4% of total population in 2001. For males it was marginally lower at 7.1%, while for females it was 7.8%. Both the share and size of elderly population is increasing over time. From 5.6% in 1961 it is projected to rise to 12.4% of population by the year 2026[1].

The loss of physical abilities is a common problem for the elderly in old age homes.

Physical illness can result in excess disability because of inactivity. Inactivity during physical illness can lead to a decline in skeletal muscle strength and aerobic capacity. These effects of inactivity result in excess disability[5].

Physical illness such as cardiovascular diseases, stroke, respiratory diseases, and musculoskeletal diseases may lead to a decline in skeletal muscle strength and aerobic capacity due to inactivity[6].

Consequences of excess disability

They are: 1) increased morbidity and mortality, 2) increased "true" disability, 3) increased cost, and 4) decreased quality of life[2].

About 64 per thousand elderly persons in rural areas and 55 per thousand in urban areas suffer from one or more disabilities. Most common disability among the aged persons was loco motor disability as 3% of them suffer from it.

According to the Centers for Disease Control and Prevention (CDC), chronic diseases are among the most common, costly, and preventable of all health problems. More than 2.5 – 3.0 million people die of a chronic disease each year.

Additionally, approximately 80% of older adults have at least one chronic illness, and at least 50% have at least two. Unfortunately, chronic conditions may lead to pain and disability, which may result in a lower quality of life[1].

In the population over 70 years of age, more than 50% suffer from one or more chronic conditions. The chronic illnesses usually include hypertension, coronary heart disease, and cancer.

According to Government of India statistics (2011), cardiovascular disorders account for one-third of elderly mortality. Respiratory disorders account for 10% mortality while infections including tuberculosis account for another 10%[7].

Objectives of the study

1. To assess the pre and post test level of activities of daily living, self esteem, depression and quality of life among elderly with chronic illness in experimental and control group.
2. To compare the pre and post test activities of daily living, self esteem, depression and quality of life among elderly with chronic illness between experimental and control group.
3. To correlate between activities of daily living, self esteem, depression and quality of life among elderly with chronic illness in experimental and control group.

RESEARCH HYPOTHESES

H_1: There is significant difference between the mean score pre-test and post test activities of daily living, self esteem, depression and quality of life among elderly with chronic illness between experimental group and control group.

H_2: There is a significant relationship between activities of daily living, self esteem, depression and quality of life among elderly with chronic illness in experimental and control group.

RESEARCH METHODOLOGY

Research Design: The researcher was adopted true experimental, two group-pretest-post test control group design to fulfil the objectives of the study. Subjects in the experimental group received a Self-Care Self-Efficacy Enhancement Program. Simultaneously, subjects in the control group received social visits[3].

Variables

- **Independent variable:** In this study independent variable was selected nursing intervention (SCSEEP).
- **Dependent variables:** The dependent variables are activities of daily living, self esteem, depression and quality of life among elderly with chronic illness.
- **Demographic variables:** It includes age, sex, religion, educational status, previous occupation, number of children, history of chronic illness and duration of illness.

Setting of the study: The study was conducted in Asha Seva old age homes at south Bangalore.

Sample size: Sample size was 40 (20 experimental and 20 control)

Sample technique: *Random allocation of subjects by simple random sampling* using lottery method

Criteria for selecting sample:

Inclusion criteria

- Old age home elderly ranged from 60 to 80 years.
- Those are not cognitively impaired. Cognitively intact as measured by a score of 23 or greater on the Mini-Mental State Examination (MMSE)

Exclusion criteria

- Those are bed ridden

Tools & Techniques: Researcher was used structured interview schedule after detailed review of literature and discussion with experts.

Section A: It includes baseline information of elderly

Section B: To assess Activities of Daily Living by Katz Index of independence in activities of daily living (ADL) for elderly with chronic illness.

Section C: Rosenberg Self esteem scale was used to assess self esteem

Section D: Geriatric Depression Scale (short form) was used to assess Depression level among elderly with chronic illness

Section E: WHO QOL was used to assess Quality of Life among elderly with chronic illness.

Procedure for data collection

Stage 1: The pretest was carried out in the experimental and control group using the socio demographic profile, structured interview questionnaire was used to assess the activities of daily living, self esteem, depression and quality of life among elderly with chronic illness in the experimental and control group.

Stage 2: After obtaining the responses in the pretest, the subjects in the experimental group are assembled in a group and implement the interventions that are self care self efficiency programme and social visits to subjects in the comparison group.

Stage 3: The post test was carried out with the same tools used in the experimental and control group after 6 weeks of implementing the interventional programme.

Plan for data analysis: Data collected was analyzed using both descriptive and inferential statistics.

RESULTS

Assessment of the demographic variables of elderly with chronic illness

Table 1: Frequency and percentage distribution of selected demographic variables of elderly with chronic illness

S. No.	Demographic variables		Experimental Group		Control group	
			No	%	No	%
1.	**Age in years**					
	a.	60-65	6	30	7	35
	b.	66-70	6	30	5	25
	c.	71-75	6	30	5	25
	d.	76-80	2	10	3	15
2.	**Gender**					
	a.	Male	11	55	13	65
	b.	Female	9	45	7	35

Conted…

3.	**Marital Status**					
	a.	Single	3	15	4	20
	b.	Married	11	55	12	60
	c.	Widow	6	30	4	20
4.	**Educational status**					
	a.	No formal education	2	10	2	10
	b.	Primary school	5	25	5	25
	c.	High school	6	30	7	35
	d.	Undergraduate	5	25	4	20
	e.	Post graduate	3	15	2	10
5.	**Religion**					
	a.	Hindu	13	65	13	65
	b.	Muslim	2	10	3	15
	c.	Christian	5	25	4	20
	d.	Others—(specify)	0	0	0	0
6.	**Reason for admission**					
	a.	Family members unable to care	13	65	15	75
	b.	Poor health	7	35	5	25
	c.	Others	0	0	0	0
7.	**Financial status**					
	a.	Pension	6	30	4	20
	b.	Supported by adult children	11	55	14	70
	c.	Self employment	3	15	2	10
8.	**Chronic illness**					
	a.	Hypertension	7	22.6	7	25.9
	b.	Diabetic mellitus	9	29.0	8	29.6
	c.	Respiratory problems	4	12.9	3	11.1
	d.	Arthritis problems	8	25.8	7	25.9
	e.	Cataract	3	9.7	2	7.4

Objective 1: To assess the pre and post test level of activities of daily living, self esteem, depression and quality of life among elderly with chronic illness in experimental and control group.

- With regard to ADL among elderly in experimental group, majority of elderly 16 (80%) had Dependent,

4 (20%) of them had very dependent and in control group, majority of elderly 17 (85%) had Dependent, 3 (15%) of them had very dependent.

- With regard to self esteem among elderly in experimental group, majority of elderly 15 (75%) had low self esteem, 5 (25%) of them had normal self esteem and in control group, majority of elderly 18 (90%) had low self esteem, 2 (10%) of them had normal self esteem.
- With regard to depression among elderly in experimental group, majority of elderly 13 (65%) had mild depression, 7 (35%) of them had severe depression and in control group, majority of elderly 16 (80%) had mild depression, 4 (20%) of them had severe depression.
- With regard to QOL among elderly in experimental group, majority of elderly 9.7 with 1.6 of Mean and SD in physical domain, Mean 9.6 with 0.9 SD for Environment Domain, Mean 8.4 with 0.8 SD in social relationship and Mean 7.8 with 1.4 SD in psychological domain in Quality of life.
- With regard to QOL among elderly in control group, majority of elderly 9.9 with 0.9 of Mean and SD in environment domain, Mean 8.5 with 1.3 SD for psychological Domain, Mean 8.3 with 1.2 SD in physical and Mean 7 with 1.2 SD in Social relationship domain in Quality of life.

To assess the post test level of activities of daily living among elderly with chronic illness in experimental and control group.

- With regard to ADL among elderly in experimental group, majority of elderly 17 (85%) had Dependent, 3 (15%) of them had Independent dependent. With regard to ADL among elderly in control group, majority of elderly 18 (90%) had Independent, 2 (10%) of them had very dependent.
- With regard to self esteem among elderly in experimental group, majority of elderly 19 (95%) had normal self esteem, 1 (5%) of them had low self esteem. With regard to self esteem among elderly in control group, majority of elderly 12 (60%) had low self esteem, 8 (40%) of them had normal self esteem.
- With regard to depression among elderly in experimental group, majority of elderly 16 (80%) had mild depression, 4 (20%) of them had no depression.
- With regard to depression among elderly in control group, majority of elderly 17 (85%) had mild depression, 3 (15%) of them had severe depression.
- With regard to QOL among elderly in experimental group, majority of elderly 12.8 with 1.7 of Mean and SD in psychological domain, Mean 12.6 with 1.1 SD for physical Domain, Mean 11.7 with 1.2 SD in environment domain and Mean 9.1 with 1.6 SD in social relationship domain in Quality of life.
- With regard to QOL among elderly in control group, majority of elderly 9.9 with 0.8 of Mean and SD in environment domain, Mean 9.9 with 1.2 SD for psychological Domain, Mean 9.8 with 1.6 SD in physical and Mean 7.3 with 1.6 SD in Social relationship domain in Quality of life.

Objective 2: To compare the pre and post test activities of daily living, self esteem, depression and quality of life among elderly with chronic illness between experimental and control group.

Table 2: To compare the pre and post test activities of daily living among elderly with chronic illness between experimental and control group.

N = 40

Group	Test	ADL Domain			Unpaired 't' test
		Mean	SD	Mean%	
Experimental	Pre test	3.2	0.83	53.3	0.54 N.S p<0.6
Control		3.35	0.93	55.8	
Experimental	Post test	4.8	0.8	80.0	12.7** p<0.0001
Control		3.85	0.92	64.2	

Table 2 shows that pre test comparison of experimental and control group activities of daily living with 't' value was 0.54, no statistical significant at P<0.01. In post test that comparison of experimental and control group activities of daily living shows't' value was 12.7 statistical significant at P<0.001.

Table 3: To compare the pre and post test of self esteem among elderly with chronic illness between experimental and control group

Group	Test	Self esteem			Unpaired 't' test
		Mean	SD	Mean%	
Experimental	Pre test	13.6	1.6	45.3	1.18 NS p<0.1.2
Control		13	1.6	43.3	
Experimental	Post test	18.9	3.3	63.0	6.82***p<0.0001
Control		14.2	1.7	47.3	

Table 3 shows that pre test comparison of experimental and control group of self esteem and't' value was 1.18 , not statistically significant at P<0.01. In post test comparison of self esteem between experimental group and control group. It shows't' value was 5.6 statistical significant at P<0.01.

Table 4: To compare the pre and post test of depression among elderly with chronic illness between experimental and control group

N = 40

Group	Test	Depression			Unpaired 't' test
		Mean	SD	Mean%	
Experimental	Pre test	9.75	1.7	65	0.47 NS p<0.7
Control		9.5	1.7	63.33	
Experimental	Post test	6.2	1.8	41.33	7.5***p<0.0001
Control		8.5	1.7	56.67	

Table 4 shows that pre test comparison of experimental and control group of depression and't' value was 0.47 and not statistical significant at P<0.01. In post test comparison of depression between experimental and control group shows't' value 7.5 statistical significant at P<0.01.

Table 5: To compare the pre and post test of QOL among elderly with chronic illness between experimental and control group

N = 40

Group	Test	QOL Domain			unpaired 't' test
		Mean	SD	Mean%	
Experimental	Pre test	51	4.5	44.3	0.7 N.S p<0.2
Control		52	4.5	45.2	
Experimental	Post test	71	3.9	61.7	11.4 p<0.0001
Control		57	3.9	49.2	

Table 5 shows that pre test comparison of experimental and control group of QoL and't' value was 0.7 i.e., not statistical significant at P<0.01. In post test comparison of QoL between experimental and control group, shows't' value was 11.4, statistical significant at P<0.01. So, Hypothesis H_1 was accepted.

Objective 3: To correlate between activities of daily living, self esteem, depression and quality of life among elderly with chronic illness in experimental and control group.

Table 6: To correlate between activities of daily living, self esteem, depression and quality of life among elderly with chronic illness in experimental Group for post test

N = 20

Correlation	ADL	Self esteem	Depression	QOL
ADL	---	0.21*	-0.2*	0.42*
Self esteem	0.21*	---	-0.6*	0.11*
Depression	-0.2*	-0.6*	---	-0.23*
QOL	0.42*	0.11*	-0.23*	---

* Significant at P<0.05 level

Table 6 shows that positive correlation between ADL, Self esteem and QOL among elderly with chronic illness. It shows negative correlation between Depression with ADL, Self esteem and QOL among elderly with chronic illness. So, Hypothesis H_2 was accepted.

CONCLUSION

The data was collected from 40 elderly with chronic illness (20 experimental and 20 control group) from selected old age home setting by structured interview schedule.

There was statistical significant at $p<0.01$in ADL, Self esteem, depression and QoL among elderly with chronic illness between experimental and control group.

It shows positive correlation between ADL, Self esteem and QOL among elderly with chronic illness. It shows negative correlation between Depression with ADL, Self esteem and QOL among elderly with chronic illness. This indicates statistically high correlation between activities of daily living, self esteem, depression and quality of life among elderly with chronic illness in experimental Group.

Conflict of Interest: Nil

Source of Funding: Self

Ethical Clearance: 1. The study was approved by the research committee and a formal permission was obtain from head of the institution.

2. Written consent of each of the subjects was obtain before starting data collection.

3. The subjects was assured confidentiality have maintain of information.

4. The subjects are informed that their participation is voluntary, had the freedom to with draw from the study.

5. Same intervention was given for the control group after the completion of data collection.

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Understanding Women with Infertility: Parse's and System's Theory

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ABSTRACT

Nursing develops its knowledge base from network of facts, concepts and approaches to inquiry of human experiences. Health comprises biological, psychological, social and spiritual components that follow a process of changing value priorities. The dynamic state of health requires body-mind-spirit perspective to helps man fix priorities in life. Man chooses ways of living by exploring options, his personal realities and possible outcomes. Childbearing and raising children are extremely important events in human life and are strongly associated with the ultimate goals of completeness, happiness and family integration. Infertility often pushes the women with infertility into cauldron of emotional disturbance. Nurse should provide care keeping in mind the interplay of her personal characteristics, family and the society at large. This paper attempts to integrate Parse's Human Becoming theory and Bowen's Family system theory to understand the numerous issues of women with infertility.

Keywords: *Infertility, Human Becoming, Family system*

INTRODUCTION

The most basic necessity of human race is procreation and inability to bear a child leads to devastating emotional and psychological distress. The social stigma of infertility is gender biased and impacts heavily on women. In addition to the infertility status, the high-tech reproductive technologies available brings along many associated psychological and ethical issues that the women with infertility inevitably endure. Therefore, it is important for the healthcare professionals to understand the interplay of numerous issues surrounding infertility and its treatment.

Family plays an important role in the experiences of an individual. Across cultures of the world women are subjected to varied traditional methods and religious practices, including visits to temples, abstaining from visiting a place where a woman has delivered a child, observing *tantric* rites, wearing charms, participating in rituals and visiting astrologers.[2] The stresses associated with infertility and IVF treatment had a negative impact on women's psychological health status and marital quality.[3] These findings emphasize the need to include psychological and socio-cultural considerations with any medical interventions for infertility[4].

THEORETICAL APPROACH

The complexity of human behavior is a challenge to decipher. When it is compounded with conditions that pose a severe psychosocial impact the task is overwhelming. Nurse theorists have provided theoretical frameworks to help us in the process of understanding and caring for our clients.

An individual should be considered within the context of their life situations and relationships to understand their behaviours and decisions. The domains of health that are important to an individual should be assessed to provide multidimensional treatment.[5] Nurse theorist Rosemarie Rizzo Parse iterates this view in her words, "medical model was limited as a guide for nursing practice. Why do people not follow health teaching and like some people who do, do not get well? There is a need for new perspective than the traditional view of nursing." The importance of the individual's perspective which is shaped by their lived experience (phenomenology) is the philosophical underpinning of her theory. This philosophical approach led to the development of "human becoming theory". The lived experiences are a result of interaction with the people in a particular time frame and place.

The important people who have great influence on an individual are their family members. A family is a system wherein, each member has a defined role to play and rules to respect. Members are expected to respond according to their role in a certain manner. Therefore individuals cannot be understood in isolation to one another but as an integral part of their family.[6]

Considering these perspectives, two theoretical frameworks namely, "human becoming theory" and "family system theory" has been adapted to understand infertility. A comprehensive discussion of the two theories is beyond the scope of this paper. However, the important constructs of both the theories are provided along with their application to infertility.

Human Becoming Theory: Rosemarie Rizzo Parse developed the "human becoming theory" by presenting **Totality Paradigm and Simultaneity Paradigm of Nursing**. According to totality paradigm psychological, biological and spiritual factors give identity to man, but simultaneity paradigm considers man to be a unitary being having continuous and mutual interaction with their environment.

Parse first published the theory in 1981 as the "Man-living-health" theory. Subsequent to the change in the meaning of the term 'man' as 'humankind' in the dictionary the theory was officially renamed in 1992 as "the human becoming theory". The assumptions underpinning the theory were synthesized from works by the European philosophers, Heidegger, Sartre, and Merleau-Ponty, along with works by the pioneer American nurse theorist, Martha Rogers. According to Parse humans participate in the universe in the co-creation of health and are inseparable from the universe. The human moves beyond self at all levels of the universe as dreams become realities. While providing patient care the nurses need to focus on the qualitative aspects of man and his health. Parse's theory of human becoming forms a guide for such instances[7].

Three important themes around which the theory is based are: **meaning, rhythmicity, and transcendence.**

1. **Structuring Meaning:** lived experiences give meaning to human's reality and the meaning differs with changing possibilities. The reality is based on the value (**valuing**) attached to the experience. The self realization (**imaging)** that occurs with the experience is expressed through verbal, written or action (languaging). *Meaning refers to the significance of something for a person which another cannot decide.*
2. **Rhythmicity:** Human co-exist with universe based on the meanings associated with past and interpret the present experiences. Life brings repeated patterns of paradoxes which determines what the person can share or hide (Revealing – Concealing) about oneself, weigh the opportunities and restrictions (Enabling – Limiting) to make choices and decide whether to relate or not (Connecting – Separating) with people, things and places. *Rhythmicity encompasses apparent opposite experiences that co-exist in rhythmical patterns and human interpret them based on the meanings associated with past.*
3. **Transcendence:** Change increases diversity and moves human beyond the present position. Human rise above their limits when they take control of (**powering**) situations by conscious choice of possibilities and create own identity (**originating**) as they go through the process of integrating unfamiliar ideas or activities that enables to see the familiar in a different perspective (**transforming**). *Human no longer associates the positives and negatives and live in the now without going into the past. Human change for the better and become a NEW entity*.[8]

Family system Theory: Family systems theory was developed by the late American psychiatrist Dr. Murray Bowen. It is a branch of General Systems Theory of Ludwig von Bertalanffy. A system should be viewed through its separate parts in context to their connections, dependence and relations to one another[9]. Bowen says that the individual's functioning should not be seen as a separate emotional entity but in context to his relationships. In a family the behavior and emotions of each member have impact on the others and is reciprocated or avoided or confronted. Each family has its own characteristics which are founded on its size, life stage, its member's age, temperament, health status, fertility and so on. The socio-cultural position of the family also plays an important role in establishing its uniqueness.

To carry out the daily challenges, tasks of life, and the developmental needs of its members the family organizes itself on the following concepts[10]:

Holism: The family system is the result of all individual members together and that the interaction and communication between all individual members should be studied in order to understand the system as a whole.

Hierarchies: There exists various smaller units or *subsystems* of family based on gender, generation or relationships. The primary subsystems of family are marital (couple), parental and sibling subsystems. Generally, each subsystem is comprised of members who work to accomplish the relevant tasks of the specific subsystem. Families have difficulties when there is confusion among the members or about tasks associated with each subsystem.

Boundaries: Within the hierarchies of the family its members develop boundaries to differentiate intrinsic and extrinsic matters and issues. The flow of information into and out of the family depends on the permeability of their boundaries. This permeability changes with needs of the family members.

Interdependence: Families are ***goal oriented***. The members of the family system follow certain rules and pattern of mutual interaction to cope with the daily living challenges to achieve their goals. This dynamic nature of family is maintained through ***equilibrium*** and ***feedback loops***. Equilibrium is achieved by remaining stable or permits change. The family grows or changes to new demands through positive feedbacks or remains stable with negative feedback.

Integration of "Family Systems Theory" and Parse's Theory of Human Becoming to understand women with Infertility

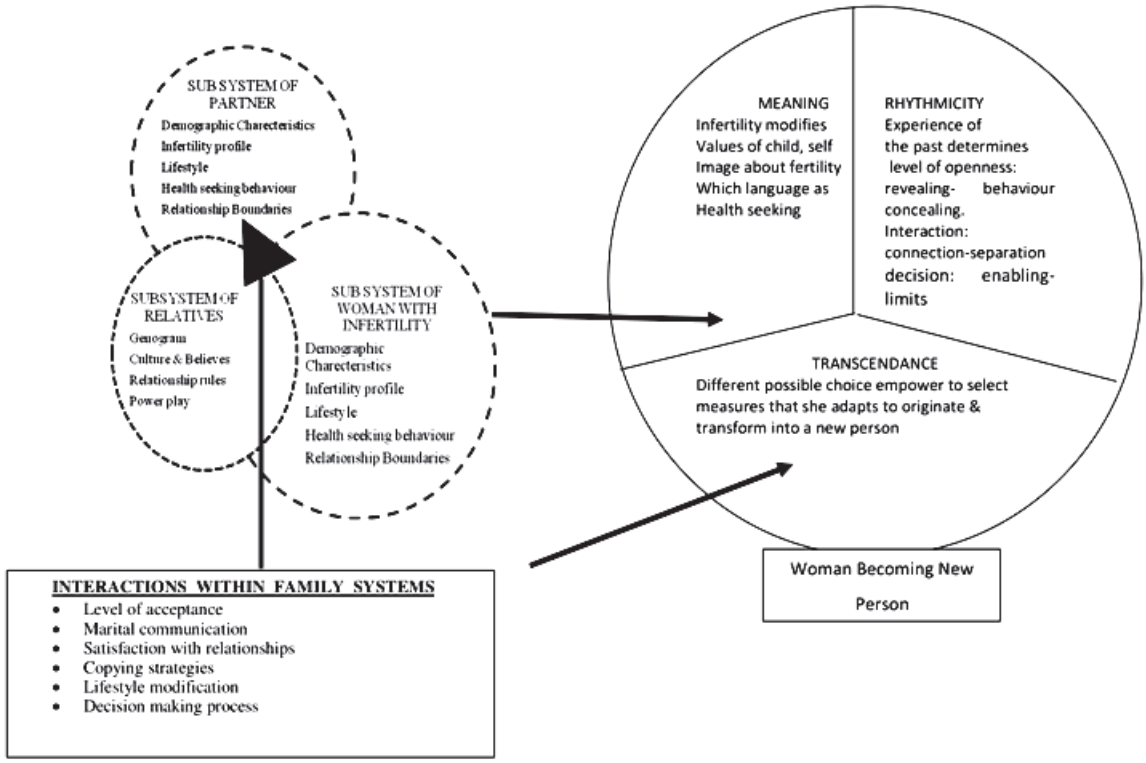

FIGURE 1: INTEGRATION OF BOWEN'S FAMILY SYSTEM THEORY AND PRASE'S HUMAN BECOMING THEORY TO UNDERSTAND WOMEN WITH INFERTILITY

The level of acceptance of infertility, congruence between the partners, the influence of significant others, quality of marital communication, satisfaction in relationships, coping strategies, ability to modify lifestyle, all of these influences the experience of infertility for each member of the system. The *value* of a child in a woman's life and *self-image* regarding her health status and capacity to procreate propels her to decide upon the type of conception she would prefer. She chooses between the possibilities of natural conception or assisted one through biological means or through donor egg or sperm. Few others may choose to adopt a child. This choice is influenced by her partner's opinion, family expectations, and available resources. The *final decision* (languaging) on treatment for infertility reflects the **meaning** or significance of a child in her life.

Once the decision is made she expresses difficulties and feasibilities in terms of oneself, family and societal constraints to the *level she deems appropriate* (revealing-concealing) so as to participate in the infertility treatment process. The interactions with the healthcare personnel will help her to realize *factors that will help or hinder* (enabling-limiting) her in the process. This realization enables (connecting-separating) her to *connect to the supporting factors* like interacting with other women with a similar problem or those who are compassionate and understanding and embracing lifestyle modification. At the same time, she also *distances herself from the stressful factors* like situations and persons who question or taunt her self-worth and practices that are detrimental to conception. The level of appropriateness, factors that help or hinder and what is supportive or stressful to the woman may follow a repetitive fashion or **rhythmicity.** These experiences finally help the woman to understand her status in light of her decision about her treatment.

This realization *empowers* (powering) her to collaborate with her significant others to make appropriate decisions on treatment modalities that will *fit her individuality* (originating). Thus she is now a *new person* (transforming) who is able to accept the situation and move forward with the necessary changes. The realization of self as being different and understanding the importance of embracing the diversities of infertility treatment is the **transcendence** seen in women with infertility.

CONCLUSION

The human behavior being complex and interwoven within their relationships necessitates nurses to recognize the client's needs in the context of their families and society at large in a comprehensive manner to provide holistic nursing care. This effort of integrating Parse's human becoming theory and Bowen's family systems theory was such an attempt to understand the numerous facets of women seeking infertility treatment.

Conflict of Interest: The author declares no conflict of interest.

Source of Support: Self

Ethical Clearance: Taken from JIPMER Institute Ethics Committee.

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A Study to Assess the Effectiveness of Self Instructional Module Regarding Reducing Academic Stress among Students of B.sc Nursing in Selected Colleges at Jaipur City Raj

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ABSTRACT

The term stress means pressure and in human life it represents an uneasy experience. It is an unpleasant psychological and physiological state caused due to some internal or external demands that go beyond our capacity. It refers to the consequence of the failure of an organism to respond adequately to mental, emotional or physical demands, either actual or imagined.

Objectives: The objectives of the study were **1)**To assess the level of academic stress among students of B.Sc. Nursing .**2**)To assess the effectiveness of self-instructional module in reducing academic stress among B.Sc. Nursing Students. **3** To find out the association between post-test stress scores and selected demographic variables.

Methodology: The research approach adopted for the study was pre-experimental research approach. The research design adopted for the study was pre-experimental research design. The data was collected through the tool which is prepared by the investigator. The sample consists of the 50 students. The tool used for the data collection was structured stress knowledge questionnaire, which has two sections:**Section A:** Items on socio-demographic variables **Section B:** Items on stress questionnares regarding , stress related to academic condition, stress related to social condition, stress related to family/environmental condition.

Results: shows that the maximum mean percentage obtained by the students is found in the aspect of stress related to social condition(52.52%) followed by stress related to general/personal condition (52.24%), stress related to family/environmental condition(49.66%) and least mean percentage obtained in the aspect of stress related to academic condition (49.60%). The overall Mean± SD of post-test level of academic stress was 46.13± 2.42 and mean percentage of 46.13%.

Conclusion: The overall findings of the study revealed that there was overall mean knowledge score obtained by the students was 46.13 and with standard deviation 2.42 and the mean percentage was 51.25%, So this indicates that level of academic stress is reduced among students

Keywords: *Assess, self instructional module,stress,academic stress,Effectiveness.*

INTRODUCTION

Education make a people easy to lead but difficult to drive, easy to govern but impossible to enslave

–Peter brougham

Psychiatric nursing is a specialized area of nursing practice, which employs theories of human behaviour. It helps the individual for the use of self in understanding the diagnosis and treatment of human responses to actual or potential mental health problems.[1]

The term stress means pressure and in human life it represents an uneasy experience. It is an unpleasant psychological and physiological state caused due to some internal or external demands that go beyond our capacity[2]. Stress is the term in psychology and biology borrowed from physics and engineering and first used in the biological context in 1930`s, which has in more recent decades become commonly used in population balance. It refers to the consequence of the failure of an organism to respond adequately to mental, emotional or physical demands, either actual or imagined.[3] academic stress is a

very important type affecting each and every student in this fast paced life running on the basis of performance in academy. Academic period is never easy, it is a time of uncertainty, insecurity and sometimes feeling of inadequacy. Life events are many like transition period from childhood to adolescence, academic stress, marital stress, occupational stress, retirement stress.[4] The reasons are separation from parents, poor infrastructure, inexperience and inadequate teachers, academic overload, new and vast subjects, language problem, presentation problem and lack of practical skills[5]. They may have difficulty adjusting to more rigorous academic expectations and the need to learn to deal with individuals of differing cultures and beliefs. Thus, stress may result from being separated from home for the first time, the transition from a personal to an impersonal academic environment, and the very structure of the academic experience at the college level[6]. Significant changes in living conditions, the novel demands of the college academic environment, and the large change in social surroundings are just a few of the potential sources of stress for a college student[7]. College students experience high stress at predictable times each semester due to academic commitments, financial pressures, and lack of time management skills. Stress results from the interaction between stressors and the individual's perception and reaction to those stressors. Other potential sources of stress for college students include excessive homework, unclear assignments, and uncomfortable classrooms. In addition to academic requirements, relations with faculty members and time pressures may also be sources of stress[8].

NEED FOR THE STUDY

According to Mental Health America's estimates, 20% of teens are clinically depressed, and the real tragedy lies with how their parents and teachers approach the subject. Because so many dismiss the symptoms of depression as mere adolescent adjustments, a disconcerting number of these teens go without the treatment they need to enjoy a healthy, happy life. Obviously, depression stems from numerous factors beyond just heightened academic pressures. But they certainly render already painful situations even worse, regardless of whether or not they exist as the root cause.

My purpose for conducting this study was to explore the undergraduate students' perception of major sources of academic stress. I wanted to know how students perceive academic stress and how they cope with it on daily basis, as they are struggling to reduce and control the negative effects on their health and their academic performance. In my opinion, it is very important for undergraduate students to learn how to manage the academic stress, even if it cannot be eliminated. In the mtv Associated Press survey for 2009, more than half of students (60%) reported that severe stress interfered with their ability to complete their schoolwork more often than once, and that this statistic reflects an increase from 2008. All India figures show that 8,046 students ended their lives last year. Maharashtra, with 1,191, reported the highest number of students taking the extreme step. Karnataka came fifth while Nagaland reported the lowest, with number of victims running in single digits for the past three years

The Spring 2013 edition of the National College Health Assessment, where the average age of those survey was 21 years, reported that almost half (46.3%) of all undergraduate students surveyed felt trauma or overwhelmed in regard to their academic responsibilities. Almost half of students surveyed reported they have more than average or extreme stress.

Problem statement: "A study to assess the effectiveness of Self Instructional Module regarding reducing academic stress among students of B.SC Nursing in selected colleges at Jaipur city".

Objectives of the study

1. To assess the level of academic stress among students of B.Sc. Nursing.
2. To assess the effectiveness of self-instructional module in reducing academic stress among B.Sc. Nursing Students.
3. To find out the association between post-test stress scores and selected demographic variables

Hypothesis

H1: There will be a difference between pre-test and post-test stress scores of students.

H2: There will be an association between post-test stress score of Bachelor of Science in Nursing students with the selected demographic variables.

Assumptions: The study assumes that

1. All the fresher students will have some sort of academic stress.
2. The knowledge of academic stress will be different among students of B.Sc. (N) 1st year according to selected demographic variables.

3. Self-instructional module will reduce the level of academic stress among students of B.Sc. (N) 1st year.

Operational Definitions

Assess: It refers to the method of evaluating knowledge regarding academic stress among students of Bachelor of science in nursing 1st year.

Self-Instruction Module: Pertaining to or constituting learning materials and conditions arrange so that students can proceed to learn on their own with little or no supervision.

Stress: In a medical or biological context stress is a physical, mental, or emotional factor that causes bodily or mental tension. Stresses can be external (from the environment, psychological, or social situations) or internal (illness, or from a medical procedure).

Academic stress is mental distress with respect to some anticipated frustration associated with academic failure or even unawareness to the possibility of such failure.

Effectiveness: The degree to which something is successful in producing desired results; success.

Delimitation

1. Study is delimited to students of B.Sc.(N) 1st year.
2. Study is delimited to 50 samples of students

RESEARCH METHODOLOGY

Research Approach: Quantitative research approach

Research Design: pre-experimental one group pre-test post-test research design

Population: Bachelor of Science in Nursing 1st year students

Sampling Technique: Non-probability convenient sampling technique

Sample Size: 50

Study Setting: Institute of Medical Technology and Nursing Education, Jaipur

Data Collection Method: structured knowledge questionnaire

RESULT

1. Level of academic stress among B.Sc. Nursing 1st year students in pre-test and post-test

Following Table: Depicts that majority 74% of the Students had moderate stress, followed by 24% had severe stress and 02% had mild stress regarding level of academic stress in the pre-test. After administration of self-instructional module 98% of the Students had moderate stress, followed by 2% had mildstress and 00% of them had severe stress

Frequency and percentage distribution of pre-test and post-test level of academic stress among B.Sc. Nursing 1st year students.

Table No. 01 (N = 50)

Level of stress	Pre test		Post test	
	Frequency	Percentage	Frequency	Percentage
Mild stress (0-50%)	01	02	01	02
Moderate stress (51-75%)	37	74	49	98
Severe stress (76-100%)	12	24	00	00
Total	**50**	**100**	**50**	**100**

2. Comparison of pre-test and post-test level of academic stress: Following table shows that it is evident that the obtained "t" value 19.57 is greater than the table value at 0.05 level of significance. Therefore, "t" value is found to be significant. It means there is decline in academic stress level of B.Sc. Nursing 1st year students. This supports that self-instructional module on reducing academic stress is effective in decreasing academic stress level of B.Sc. Nursing 1st year students.

Table No. 02 (N = 50)

	Mean	Mean Percentage (%)	SD	Decline stress	decline stress percentage (%)	df	t-value	Inference
Pretest	56.66	63%	3.59	15.74	17.54	49	19.57	S
Post test	40.92	45.46 %	2.42					

S = SIGNIFICANT, NS = NON SIGNIFICANT

DISCUSSION

1. Demographic characteristics of students.

- In the study majority 92% of the students were aged between 17-20 years & 06% of them aged between 21-24 years, 02% of them were aged above 25-29 years and 0% of them aged 29 and above.
- In the study majority 92% of the Students are males, 08% are females.
- The majority 42% of the students belongs to rural area and 32% of them belongs to urban area and remaining 26% belongs to semi-urban area.
- The majority 56% of the students are from nuclear family, 40% from joint family & 04% from extended family.
- The majority 92% of the students belongs to middle class and 06% belongs to poor class and 02% from upper class.

2. Level of academic stress among B.Sc. Nursing 1st year students in pre-test and post-test: The majority 74% of the Students had moderate stress, followed by 24% had severe stress and 02% had mild stress regarding level of academic stress in the pre-test. After administration of self-instructional module 98% of the Students had moderate stress, followed by 2% had mild stress and 00% of them had severe stress.

3. Comparison of pre-test and post-test level of academic stress: The obtained "t" value 19.57 is greater than the table value at 0.05 level of significance. Therefore, "t" value is found to be significant. It means there is decline in academic stress level of B.Sc. Nursing 1st year students. This supports that self -instructional module on reducing academic stress is effective in decreasing academic stress level of Bsc Nursing 1st year students.

4. Association of post-test stress scores of B.Sc. Nursing students with selected demographic variables: $\chi 2$ value computed between the level of academic stress and selected demographic variables. Variables such as age, area of living, type of family, income group of family, family income, education of father, education of mother were significant at 0.05 level. Variables such as gender were not significant at 0.05 level Therefore the hypothesis stated there will be an association between pre-test stress score of Bachelor of Science in Nursing students with the selected demographic variables is accepted.

RECOMMENDATIONS

On the basis of finding, the study recommendations are as follows

- A Similar study can be replicated on large sample in order to generalize the findings.
- An experimental study can be conducted with control group for the effective comparison of the results.
- A study can be conducted to evaluate the efficiency of teaching strategy like lesson plan shows on reducing academic stress among students.

CONCLUSION

The overall findings of the study revealed that there was overall mean knowledge score obtained by the students was 46.13 and with standard deviation 2.42 and the mean percentage was 51.25%, So this indicates that level of academic stress is reduced among students.

Source of Funding: Self Funding

Conflict of Interest: NIL

Ethical Clearance: Ethical Clearance Already Taken From MTIN CON Jaipur.

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A Study to Determine the Sources, Effects and Causes for Substance Use Disorders and to Develop an Informational Booklet on Prevention and Management of Substance use Disorders in Selected Drug De-Addiction and Rehabilitation Centers of Nepal

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ABSTRACT

The main objectives of the study were to determine sources, causes and effects of substance use disorders, to develop and disseminate an informational booklet on prevention and management of substance use disorders for the patients and to seek relationship between effects of substance use disorders and selected demographic variables, such as, age, marital status, family income, occupation, educational qualification.

A conceptual model of substance abuse by Clark HW was used as the conceptual framework. A descriptive survey approach with cross-sectional design was used to achieve the objectives of the study. A semi structured questionnaire, to assess the sources, causes and effects of substance use disorder was developed. The tool was validated by the experts from the field of Psychiatric Nursing, Psychology and Psychiatry. The reliability of the tool was established by using Cronbach's Alpha and the reliability coefficient was 0.87. The study was conducted at The Richmond Fellowship, Chobar, Kathmandu, Nepal. Purposive sampling technique was employed to select 60 patients attending drug de-addiction and rehabilitation centres.

Data gathered was analyzed and interpreted using both descriptive and inferential statistics. The study showed that most of the study subjects were in the age group of 15-25 years and unmarried, most of the study subjects consumed alcohol as addictive substance, most of the patients procured substances from friends and used to consume at their home. Most of the study subjects consumed substances for pleasure and also as they felt lonely. As per the severity, 75% of the study subjects had more harmful effects of the substance use disorders. Among the causes of substance use disorders, psychological causes ranked the highest. There was no significant relationship between the effect of substance use disorders and the selected variables.

Keywords: *Substance abuse, effectiveness, sources, effect, causes, prevention, management.*

INTRODUCTION

> The cause of worldwide consumption of Hasis, Opium, Wine and Tobacco lies not in the taste nor in any pleasure, recreation or mirth. They afford but simply in man's need to hide from himself the demands of conscience"
>
> –Tolstoy

People abuse substances such as alcohol, tobacco, and other drugs for varied and complicated reasons, but it is clear that our society pays a significant cost. The toll for this abuse can be seen in our hospitals and emergency departments both through direct damage to health by substance abuse and its link to physical trauma. Jails tally daily the strong connection between crime and drug dependence and abuse. Although use of some drugs such as cocaine has declined in recent years, use of other drugs such as heroin and «club drugs" has increased.[1]

Substance use is very rampant in developing countries like Nepal. Government of Nepal has included control of "substance abuse including alcohol and tobacco", as one of the main interventions in Essential Health Care Services (EHCS).[2]

According to World Health Organization (WHO) and the American Psychiatric Association (APA), drug

abuse is the illicit consumption of naturally occurring or pharmaceutical substances for the purpose of changing the way, in which a person feels, thinks or behaves, without understanding or taking into consideration the damaging, physical and mental side effects that are caused.[3]

Background of the Study: In Nepal, the drinking culture probably fits into the second model where abstinence and permissiveness towards drinking co-exists. Alcohol use is closely related with the caste system of Nepal. Many people foster the use of alcohol beverage according to their social, religious and cultural traditions. The people of Mangoloid origin used alcohol for the purpose of rituals and on religious occasions, as well as for social drinking during festivals and special occasions like birth and death. On the other hand, the Hindu society, based on the code of Manu, prohibited alcohol use among the higher caste of Brahmin and Chhetri.[4]

Nepal is a multi-ethnic, multi cultural, multi religious and multi-linguistic society with a rich repertoire of customs and traditions. It is also a geographically diverse country and a caste bound society. In the middle period, Newars adopted and followed the Trantrism- a sect of Hindusim which emphasized Matsya (fish), Mamsha (meat) and Madira (alcohol) among food items even during the rituals. The Newars made variety of alcoholic beverages from rice, fruits and millets.[4]

Need for the Study: In Nepal, drug delinquency arises due to parent related causes, the abstence of appropriate control reactive patterns of misbehavior and a lack of interpersonal relationship and communication. In order to avoid psychological terror in a family, effective and continuous guidance care and counseling should be provided to the family and people effected by the problem of drug abuse. Especially, young Nepalese addicts come from different strata of society. Research findings show they come from upper income group. They are more seriously involved in drug addiction. There are primary four ways of drug control: controlling consumption, production, processing and trafficking. Psychologically the issue of drug control is very complex. It can be solved by a multiple approach with the effort of governmental organization, NGOs and individuals. On the whole, research has shown that any kind of drug treatment is effective when they are available to drug users at a time when he or she voluntarily seeks help.[5]

METHODOLOGY

The purpose of the present study conducted at selected drug de-addiction and rehabilitation centres of Nepal, was to accomplish research objectives that were:

1. To determine sources, causes and effects of substance use disorders.
2. To develop and disseminate an informational booklet on prevention and management of substance use disorders for the patients.
3. To seek relationship between effect of substance use disorder and selected demographic variables, such as, age, marital status, family income, occupation, educational qualification.

Research Approach: As the present study is aimed to the effects of substance use disorders among the patients attending de-addiction and rehabilitation centres a quantitative (descriptive survey) approach was found to be appropriate for the study.

Setting of the Study: Permission was obtained from the administrative authority to conduct a pilot study from de-addiction center of Govindapuri, New-Delhi, and final study from drug de-addiction and rehabilitation centres of The Richmond Fellowship Nepal, Chobhar, Kathmandu, Nepal.

Criteria for Selecting Sample

The criteria for selecting sample were:

- Patients at the selected de-addiction and rehabilitation centres who were willing and available to participate in the study.
- Patients who are able to understand English or Nepali.
- Patients who were poly drug users, namely alcohol, narcotics and cannabis.

Exclusion criteria:

- Newly admitted patients at the selected drug de-addiction and rehabilitation centers of Richmond Fellowship, Chobhar, Kathmandu, Nepal.

DATA COLLECTION TOOLS AND TECHNIQUES

Based on the conceptual framework and objectives of the study, the following tool was developed to generate data:

Semi-structured questionnaire to explore the source, causes and effects of substance use disorders.

Development of Tool: In order to develop the semi-structured questionnaire to assess sources, causes and effects of substance use disorders, following steps were taken:

- Extensive review of literature to develop the need items and scoring technique for the tool.
- Formulation of the items.
- Categorization of the items under different section (personal data, sources, causes and effects of substance use disorders)

Preparation of the blue print of different questionnaires, scoring and interpretation of the scores.

Description of the Tool: The tool was divided into 4 sections.

Section 1: Consisted of questions related to demographic data such as age, gender, marital status, religion, education, father's occupation, mother's occupation, educational status of father, educational status of mother, monthly income of the family and the occupation.

Section 2: Consisted of five questions related to sources of substance use disorders.

Section 3: Consisted of one question related to causes of substance use disorders in various aspects such as biological, psychological, social, cultural and religious.

Section 4: Consisted of thirty four questions related to the effects of the substance use disorders in the various aspects such as biological, social, psychological, spiritual and financial.

Development of Information Booklet: Informational booklet was prepared on prevention and management of substance use disorders through review of research and non-research literature, discussion with peer group and experts opinion. Certain aspects were considered while preparing the booklet like simplicity of language, illustration, handy, self-pacing and independent learning. The material was developed in simple English language with help of language experts in order to facilitate independent/self learning. The booklet was translated in Hindi for pilot study and in Nepali for the main study.

The Steps Taken in Developing the Information Booklet:

- Development of Criteria Rating Scale.
- Preparation of Information Booklet.
- Content validity of Information Booklet
- Preparation of final draft of Information Booklet

Plan For Data Analysis: Plan for data analysis was chalked out by employing descriptive and inferential statistics. The following plans of analysis were developed with experts' opinions:-

- Computation of frequency and percentage distribution to describe the sample characteristics.
- Frequency and percentage distribution of the subjects by the sources, causes and effects of substance use disorders.
- Mean, median, mode, standard deviation, possible range of scores and range of obtained scores of effect of the substance use on the study subjects attending drug de-addiction and rehabilitation centres.
- Frequency and Percentage of study subjects based on severity of the Effects of the Substance Use Disorders.
- Area wise analysis of effects of the substance use in study subjects, mean modified mean and rank order of different areas of effects of substance use.
- Computation of Fisher test values to establish the relationship between selected factors and effect scores of substance use disorders.

ANALYSIS AND INTERPRETATION

Section 1: Consisted of questions related to demographic data such as age, gender, marital status, religion, education, father's occupation, mother's occupation, educational status of father, educational status of mother, monthly income of the family and the occupation.

Table No. 1: Frequency and Percentage Distribution of the Study Subjects Attending Drug De-addiction and Rehabilitation Centres by their Demographic Characteristics (Age, Sex and Marital Status)

n = 60

S. No.	Demographic Characteristics	Frequency	Percentage (%)
1.	**Age**		
	15–25 years	25	41.7
	26–35 years	20	33.3
	36–45 years	9	15
	More than 46 years	6	10

Conted…

2.	**Sex**		
	Male	50	83.3
	Female	10	16.7
3.	**Marital status**		
	Married	25	41.6
	Unmarried	31	51.6
	Divorced	1	1.6
	Separated	2	3.6
	Widow	1	1.6

Section 2: Consisted of five questions related to sources of substance use disorders.

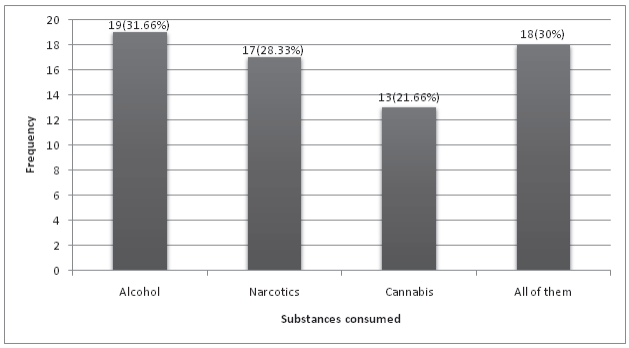

Fig. No. 1: Bar diagram showing the frequency percentage of the study subjects attending de-addiction and rehabilitation centres by the types of substance consumption

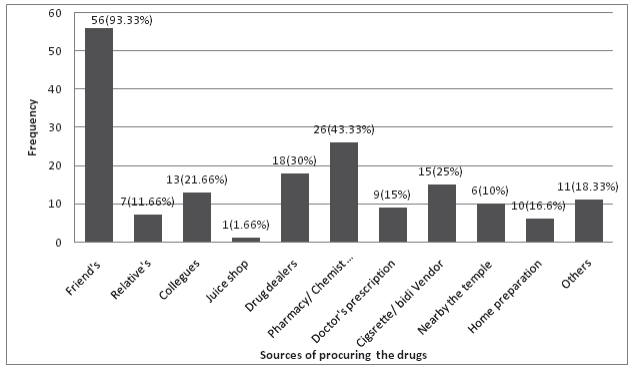

Fig. No 2: Bar diagram showing the frequency percentage of the study subjects attending de-addiction and rehabilitation centres by the sources of procuring the substances.

Section 3: Consisted of one question related to causes of substance use disorders in various aspects such as biological, psychological, social, cultural and religious.

Mean, Modified Mean and Rank Order of Different Areas of Effects of Substance Use: The highest effect of the substance use disorders was in 'psychological aspect' (1.22) and the least effect was in 'spiritual aspect' (0.90). The descending order of the effects of the substance use disorders was: psychological (1.22), social (1.09), biological (1), financial (0.9) and spiritual (0.5) respectively.

Section 4: Consisted of thirty four questions related to the effects of the substance use disorders in the various aspects such as biological, social, psychological, spiritual and financial.

Table No. 2: The Relationship between the Effect Score of the Substance Use Disorders and Age of the Study Subjects

n = 60

Group	Age (in years)	Mild Effects	Moderate Effects	Severe Effects	Fisher's Exact value	p-value
Patients attending de-addiction and rehabilitation centers	15 - 25	1	21	3	0.29	0.34
	26- 35	4	13	3		
	36- 45	2	7	0		
	Above 46	2	4	0		

Fisher's Exact value = 0.29, p>0.05, not significant at 0.05 level

Table No. 3: Relationship between the Effect Scores and Marital Status of Study Subjects

n = 60

Group	Category	Mild Effects	Moderate Effects	Severe Effects	Fisher's Exact value	p-value
Patients attending de-addiction and rehabilitation centers	Married	5	19	1	0.75	0.85
	Unmarried	4	22	5		
	Divorced	0	1	0		
	Separated	0	2	0		
	Widow	0	1	0		

Fisher's Exact value = 0.75, p>0.05, not significant at 0.05 level

Table No. 4: Relationship between the Effect Score and Total Family Incomes of the Study Subjects

n = 60

Group	Category	Mild Effects	Moderate Effects	Severe Effects	Fisher's Exact value	p-value
Patients attending at de-addiction and rehabilitation centers	Less than 20,000	3	16	1	0.87	0.79
	20,000- 50,000	10	23	4		
	More than 50,0000	1	6	1		

Fisher's Exact value = 0.87, p>0.05, not significant at 0.05 level

LIMITATIONS

1. The study was conducted on a small sample and the selected de-addiction and rehabilitation centres only, hence the broad generalization of the finding cannot be done.

Recommendations

1. A similar study may be replicated on a larger sample covering the entire population of a region or a part of a country.
2. A similar study can be conducted for assessing knowledge of the students in schools, colleges as well as street children regarding substance abuse.
3. A comparative study can be done to ascertain the prevalence, causes and effects of substance use disorder in males and females, as well as in rural and urban populations.

Conclusion drawn from the study: The study showed that most of the study subjects were in the age group of 15-25 years and unmarried, most of the study subjects consumed alcohol as addictive substance, most of the patients procured substances from friends and used to consume at their home. Most of the study subjects consumed substances for pleasure and also as they felt lonely. As per the severity, 75%of the study subjects had more harmful effects of the substance use disorders. Among the causes of substance use disorders, psychological causes ranked the highest. There was no significant relationship between the effect of substance use disorders and the selected variables.

Conflict of Interest: None

Sources of Support: Self

Ethical Clearance: The Ethical Clearance was obtained from Richmond Fellowship Nepal and Jamia Hamdard Review Board.

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Effect of Video Assisted Teaching (VAT) on Improving Primary Teacher's Knowledge Regarding Learning Disabilities: An Indian Perspective

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ABSTRACT

Objectives: Formal learning in classroom is a part and parcel of current educational system. Teachers are in a unique position to identify the children's lacunaes in the developmental learning processes. Current Study was done to assess the pre interventional knowledge of primary school teachers regarding selected learning disabilities among primary school children, evaluate the effect of Video Assisted Teaching (VAT) and to find the association between knowledge scores and selected socio-demographic variables.

Method: Pre-experimental one group Pre test- post test design was used among 60 primary school teachers selected through convenient sampling. Researcher developed structured questionnaire was administered after obtaining informed consent. Reliability and validity were established. One hour group session -Video assisted teaching (VAT) was administered for 7 days consecutive days. Theoretical and practical aspects of selected learning disabilities and its management measures were discussed. Data were assessed using descriptive and inferential statistics.

Results: Majority 33 (55%) of primary school teachers had average knowledge followed by 22 (36.6%) had poor knowledge and 5 (8.3%) had good level of knowledge score. There was a statistically significant difference in the knowledge score before and after the intervention at $p < 0.01$.

Conclusion: Teachers play a paramount role in identifying and managing learning disabilities. A well informed teacher can transform these disabilities into possibilities, which can bring out the best in the child.

Keywords: *Learning disabilities; Knowledge; Primary school teachers; Video assisted teaching.*

INTRODUCTION

"Learning Disability" is a generic term that refers to a heterogeneous group of disorders manifested by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning or mathematical abilities. These disorders are intrinsic to the individual and presumed to be due to Central Nervous System Dysfunction. Even though a learning disability may occur concomitantly with other handicapping conditions (e.g. sensory impairment, mental retardation, social and emotional disturbance) or environmental influences (e.g. cultural differences, insufficiency or inappropriate instruction, psychogenic factors) and it is not the direct result of those conditions or influences.[1]

The term Learning disability was first coined by Samuel Kirk on 1963 to describe children who have serious learning problems in schools but do not fall under other categories of handicap. The term referred to a discrepancy between a child's apparent capacity to learn and his or her level of achievement. Learning disorder is also termed as 'specific learning disorder' or 'specific academic skill disorder'.[2]

Identification of disorder prior to school age is difficult due to the instability of results obtained from formal testing procedures. Teachers are the first person to notice that the child is not learning as expected. Shaw and Mac (2005) stated that for students with a learning disorder, "Planning, monitoring, regulating

and scheduling" are difficult. These students require continuous help to adapt learning situations. Selvin (2004) in an analysis of challenging behaviours among people with learning disorder suggests that these children are a major challenge for teachers and members of caring families.[3]

Learning disability is usually identified among preschool and primary school children although it tends to progress into adulthood. Often, these children may try very hard to follow instructions, concentrate, and "be good" at home and in school. Yet, despite this effort, he or she is not mastering school tasks and falls behind.[4]

A Prevalence rate of 20-33% of psychiatric disorders in school children has been reported in India. 7% of them are developmental disorders. Among them, learning disorder constitute 1 in 10 children. In India, ever7 section of the school is likely to have around 15-25% of students, who are not able to maintain a satisfactory scholastic performance in school.[5]

Similarly a study was conducted Dalwai et al. (2010) assessed the awareness and sensitivity among parents, teachers, school management and counsellors regarding learning disability in 35 Schools of Mumbai. About the conceptual understanding of learning disabilities. Among them, 52% teachers had no awareness, 37% had minimal awareness and 11% had adequate awareness. About aetiology 72% had no awareness, 14% had minimal awareness and 14% had adequate awareness. About the types of learning disabilities 75% of teachers were not aware.[6]

A quasi-experimental study was conducted by Daniel LT, Gupta S, Sagar R (2013) at NIMHANS Bangalore, to assess the effectiveness of structured teaching programme on the level of knowledge of teacher trainees towards learning disabilities. The samples were 32 teacher trainees where, pre-test knowledge mean score was 17.75, which was improved to a post-test knowledge mean score of 28.78 significant at 0.001. The findings supports the administration of teaching programmes in improving knowledge of teachers on learning disabilities.[7]

The Indian educational perspective students are acclimatized to a rigid structured curriculum. They are owe to a plethora of academic assignments and examination. Due to inadequate knowledge and awareness, the teachers seldom give individual attention for children with disabilities. Where the existing or emerging learning difficulties are not identifying promptly, and the less academic performances further demotivates the child. Misunderstanding of the disability and negative reinforcement from teachers and parents can eventually lead to poor academic outputs and school drop outs. In this context, a structured teaching module can endorse the insight of teachers regarding learning disabilities especially in primary level. In the current research, a video assisted teaching module on selected learning disabilities was developed to evaluate the effectiveness among primary school teachers.

The study aims to assess the knowledge of primary school teachers regarding selected learning disabilities among primary school children by conducting pre-test, to assess the effectiveness of structured teaching programme on knowledge of primary school teachers regarding selected learning disabilities among primary school children by conducting post-test and to find the association between knowledge scores of primary school teachers regarding selected learning disabilities among primary school children with their selected socio-demographic variables.

METHOD

The research was conducted in one group pre-test and post-test design among 60 primary school teachers from selected Primary schools of Punjab, India using convenient sampling technique. A structured knowledge questionnaire was developed by the researcher, where the content validity of the tool was evaluated by the 5 experts. reliability was evaluated by split half method by using Karl Pearson correlation coefficient and the score obtained was 0.83. Pilot study was conducted in a selected School in Punjab. The study was approved by the Institutional Ethical Committee. Informed consent was obtained and the confidentiality and anonymity of the subjects were maintained.

Pre-test was followed by the administration of video assisted teaching sessions (1 hour per day) for the next 7 consecutive days. After 7 days a post- test was conducted by using the same questionnaire, data collected was tabulated and analysed with the help of descriptive and inferential statistics.

Table No. 1: Video Assisted Teaching (VAT) Module

Sessions	Topic discussed	Approach/Model	Duration
Day 1	Pre-test Introduction to learning disabilities	Brain storming Power point	30 minutes 1 Hour
Day 2	Etiology & identification of learning disabilities	Discussion Video Power point	1 hour
Day 3	Dyslexia (Reading Disorder)	Group discussion Video Power point	1 hour
Day 4	Dysgraphia (Writing Disorder)	Group discussion Video Power point	1 hour
Day 5	Dyscalculia (Arithmetic Disorder)	Group discussion Video Power point	1 hour
Day 6	Dyspraxia (Sensory Integration (or Processing) Disorder Expressive Language Processing disorder	Group discussion Video Power point	1 hour
Day 7	Prevention and management of selected learning disabilities. Teaching strategies and classroom handling Post test	Problem solving Video Simulation	1 hour 30 minutes

RESULTS

Socio-demographic profile of the subjects were assessed with frequency and percentage.

Table No. 2: Socio-demographic profile

Sl. No.	Variables		Frequency	Percentage
1.	Age	22- 30	15	25.0
		31-40	27	45.0
		≥41	18	30.0
2.	Gender	Male	7	11.7
		Female	53	88.3
3.	Educational Qualification	Graduation	14	23.3
		Post- graduation	46	76.7
4.	Years of Teaching experience (years)	0-2	10	16.7
		3-5	9	15.0
		6-10	23	38.3
		≥11	18	30.0
5.	Previous knowledge	Yes	16	26.7
		No	44	73.3

The table 2 depicts that, almost half of the subjects (45%) were in the age group 31-40 years, majority (88.3%) were females. Most of them (76.7%) were post-graduates, were 38.3% had 6-11 years of teaching experience. Majority (73.3%) had no previous knowledge on learning disability.

The pre-test and post-test knowledge scores were assessed and evaluated the effectiveness using paired't' test.

Table No. 3: Frequency of knowledge scores of respondents in pre-test and post-test.

Level of knowledge	Score	Pre- test		Mean score & SD	Post- test		Mean score & SD	t value	P value
		f	%		f	%			
Poor knowledge (<40%)	0-15	22	36.6	17.40 ± 4.446	-	-	28.47 ± 2.813	**15.236**	0.01*
Average knowledge (41-60%)	16-22	33	55		-	-			
Good knowledge (>61%)	≥23	5	8.4		60	100			
Total	40	60	100		60	100			

* Significant at p value<0.05

Test used- paired t test: Table 3 explains that majority 33 (55%) of primary school teachers had average knowledge followed by 22 (36.6%) had poor knowledge and 5 (8.3%) had good level of knowledge score regarding selected learning disabilities in pre-test. The mean knowledge score of primary school teachers in pre- test was 17.40 with standard deviation 4.446. The improvement had seen in knowledge level of all 60 primary school teachers (100% good knowledge) after administering structured teaching programme on selected learning disabilities where, the post- test mean knowledge score was improved to 28.47 with standard deviation 2.813.

Table No. 4: Association between knowledge scores of respondents with their selected socio- demographic variables

Demographic data		Poor	Average	Good	Chi square	Df	p value
Age (in years)	22-30	5, 22.7%	10, 30.3%	0, 0.0%	4.259	4	.372^{NS}
	31-40	8, 36.4%	16, 48.5%	3, 60.0%			
	≥41	9, 40.9%	7, 21.2%	2, 40.0%			
Sex	Male	3, 13.6%	4, 12.1%	0, 0.0%	.750	2	.687^{NS}
	Female	19, 86.4%	29, 87.9%	5, 100.0%			
Educational qualification	Graduation	6, 27.3%	8, 24.4%	0, 0.0%	1.728	2	.422^{NS}
	Post- graduation	16, 72.7%	25, 75.8%	5, 100.0%			
Years of Teaching experience	0-2	3, 13.6%	6, 18.2%	1, 20.0%	2.672	6	.849^{NS}
	3-5	5, 22.7%	4, 12.1%	0, 0.0%			
	6-10	7, 31.8%	14, 42.4%	2, 40.0%			
	≥11	7, 31.8%	9, 27.3%	2, 40.0%			
Previous knowledge	Yes	6, 27.3%	9, 27.3%	1, 20.0%	.124	2	.940^{NS}
	No	16, 72.7%	24, 72.7%	4, 80.0%			

Test used: Chisquare Test: The table no: 4 depicted that there was no statistically significant association found between knowledge scores and selected socio-demographic variables.

DISCUSSION

The present study was conducted among primary school teachers from selected schools. There are other studies which conducted on the same sample in same setting [Jabalin Mahiba (2017)[8], Maj Rajwinder Kaur & Chacko (2016)[9], Shehata et al. (2016)[10], Shari, & Vranda, (2015)[11], Pawar & Mohite (2014)[12]]. The researcher assessed 60 subjects in the current study, which is comparable with the sample size of other studies like, 60 (Pawar & Mohite , 2014)[12], 50 (Jabalin Mahiba, 2017)[8],and 42(Maj Rajwinder Kaur & Chacko 2016)[9].

The researcher used video assisted teaching as the intervention, where the other studies used different interventional modules like, self- instructional module (Pawar & Mohite 2014), structured teaching programme [Jabalin Mahiba, (2017)[8], Maj Rajwinder Kaur & Chacko (2016)[9], Shehata et al. (2016)[0], Amit Kadu, (2016)[13]].

In present study during the comparison of pre- test and post- test knowledge of primary school teachers regarding selected learning disabilities it was found that mean knowledge score of pre- test was17.40 with standard deviation 4.446and post- test mean knowledge score28.47 with standard deviation 2.813. The findings from study conducted by Pawar & Mohite (2014)[Mean pre-test knowledge score 13.48.& posttest knowledge 21.13][12] supported the results. In majority of the studies teachers reported with less or average pre test knowledge [Pawar & Mohite, (2014)[12], Jabalin Mahiba, (2017)[8], Amit Kadu, (2016)[13]].

In the current study, the difference between the pre-test and post- test mean knowledge score was statistically significant at $p<0.001$ level, which was well supported by, Daniel LT, Gupta S, Sagar R (2013) at NIMHANS, Bangalore, they found pre-test knowledge mean score as 17.75, and the post-test knowledge mean score as28.78,. The paired difference between the pre-test knowledge and post-test knowledge showed the knowledge gain and the value was 11.3 and 'p' value was significant at 0.001. This indicated that study was effective in improving knowledge of teachers on learning disabilities".[7]

There was no significant association found between the pretest knowledge and socio-demographic variables,which was contradictory to the study results by Amit Kadu, (2016) who found significant association found between the knowledge and demographic variables like age, educational qualification, and years of teaching experiences.[13]

Implications of practice: Primary teachers are to be well versed in identifying and screening children with learning disability. In service education and academic training would be conducted for the primary school teachers to develop a favourable attitude, adequate knowledge and child handling skills in concern to learning disability. Classroom management technique to handle these students coupled with easy learning techniques should be provided to the children.

RECOMMENDATIONS

Large scale study can be conducted to improve the generalizability. The same study can be done with an experimental research approach with a control group. A comparative study can be conducted on special education teachers & general education teachers. Follow up post-tests assessment can be planned in frequent intervals in order to check the retention of teacher's knowledge and application of the strategies in classrooms.

LIMITATIONS

Convenient sample technique and small sample size adopted in the current study reduced the generalizability of the findings. Extraneous variables like information given by other health professional, mass media, were not under the control of the investigator.

CONCLUSION

Teachers had inadequate knowledge before the video assisted teaching which was significantly improved after the intervention. This would definitely enhance the competency of the teachers to screen and manage the student with learning disability. The added role of primary teachers to identify and manage the learning disability is un-doubtfully accepted.

Source of Funding: Self

Conflict of Interest: Nil

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