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Contents

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A study to Assess the Occurrence, Pattern and Impact of Bullying Behaviour and to Identify Preventive Strategies Adopted by the school Children to Curb bullying in a Selected School of Hyderabad

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Abstract

Introduction : Bullying in schools is an issue that continues to receive attention from researchers, educators, parents, and students. Despite the common assumption that bullying is a normal part of childhood and encompasses minor teasing and harassment, researchers increasingly find that bullying is a problem that can be detrimental to students' well-being. This report focuses not only on the prevalence of bullying, but also on those subsets of students who reported being the victims of direct, and indirect bullying, and both of them.

Objectives :

- To assess the impact of bullying behaviour among school children in a selected school
- To identify the preventive strategies used by the school children to curb bullying in selected school

Methodology : A Quantitative research approach was adopted for the present study .Research design selected for the present study was non experimental descriptive research design. A structured questionnaire consisted of Part A with seven demographic variables and Part B comprising of 21 questions on impact of bullying on a 3 point likert scale,also separate section on patterns was also studied. A structured checklist was used to collect the data.The sample size was 100 and sampling technique was purposive sampling.

Results: The findings revealed that that 55% of children were having mildly impacted by bullying, 18%of children were having moderate impact on bullying, 5%children were having severe impact on bullying and 22% of children had no impact on bullying. It was reported by maximum school children that is 27 to be bullied in washrooms. Regarding the time of bullying, it was observed relational bullying to be predominant affecting .In terms of prevention strategies adoption, majority of the children that is 65% adopted a neutral approach towards bullying prevention. The researcher in future would devise a protocol to curb bullying in schools and to develop assertive attitude towards bullying.

Conclusion: Bullying is an unwanted , aggressive behaviour among school children that involves real or perceived power imbalance .It can be performed in various ways based on the child background .The bullying activity will lead to some impacts on the victims and can make them mentally weak later on .

Keywords*: bullying behaviour ,school children,impact, preventive strategies.*

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Introduction

World Health Organization defines bullying as a threat or physical use of force, aiming at the individual, another person, a specific community or group which can result in injury, death, physical damage, some

development disorders or deficiency. The concept of bullying at school is not new; however it has been increasing in recent years. There is a crucial increase in studies conducted and the number of news on bullying at school in mass media. Different types of bullying may affect different groups of students, occur in different types of schools, or affect student behaviour in different ways. These distinctions allow readers to differentiate between students who were either physically (directly) or socially (indirectly) bullied, and also to identify those students who were bullied both physically and socially.[1]

Bullying in schools is an issue that continues to receive attention from researchers, educators, parents, and students. Despite the common assumption that bullying is a normal part of childhood and encompasses minor teasing and harassment, researchers increasingly find that bullying is a problem that can be detrimental to students' well-being. This report focuses not only on the prevalence of bullying, but also on those subsets of students who reported being the victims of direct, and indirect bullying, and both of them.[2]

Bullying can be also defined as negative physical, verbal, or relational actions that (a) have hostile intent, (b) cause distress to the victim, (c) are repeated and (d) involve a power imbalance between perpetrators and victims. This definition underlines the key elements that differentiate bullying from other common expressions of aggression among peers, such as fighting, where the imbalance of power is irrelevant, as well as from playful acts based on friendly motives that are part of normal patterns of socialization among youths.[3]

Methodology

Research approach adopted for the present study was quantitative research approach. The research design adopted was non-experimental descriptive research design.The study was conducted in selected school of Hyderabad that is Zilla Parishad High School ,Jinnaram ,Sangareddy .The sample consisted of 7th and 8th class children .The data collection was carried from 1/3/2019-3/4/2019.Sample size is of 100 school children .The technique adopted for the study was purposive sampling technique. A Structured questionnaire to assess the occurrence ,pattern and impact of bullying behaviour and a structured checklist to identify preventive strategies adopted by the school children to curb bullying .data analysis was carried out by descriptive and inferential statistics .

The scoring and interpretation of the impact of the bullying was done in the following way:

1-7:Mild impact of bullying

8-14:Moderate impact of bullying

15-21: Severe impact of bullying

No impact of bullying was given 0 score. Part C consisted of a structured checklist with 18 items. The scoring and interpretation of the prevention strategies on bullying was done in the following way:

1-6:Non assertive

7-12:Neutral

13-18:Assertive

Results

Table:1 Frequency and Percentage of places of bullying in the school (n =100)

Si No	Places Of Bullying	Frequency	Percentage
1	Before And After Going /Coming Back From School a)School bus b)Bus stop c)On the way to and fro the school	 0 2 8	 0 2 8

Cont... **Table:1 Frequency and Percentage of places of bullying in the school (n =100)**

2	In The School a)Play ground b)Class room c)School verandas d)Wash rooms e)Laboratory f)Parking area i)Stair case j)Auditorium	 3 7 5 27 0 0 5 1	 3 7 5 27 0 0 5 1
3	Other Places a)home b)tuition center c)cyber space	 3 3 10	 3 3 10
4	a)None of the above	26	26

Table1:represents that .27 %were bullied in the wash rooms ,10 % of them were bullied in the cyber space ,7% of them were bullied in the class room and 5% of them were bullied in the in the school verandas . 8 %of the children were bullied on the way to school. Majority of the children had not reported any specific places, it could be elicited that bullying could have taken place in any other area which was not mentioned in the options .This can be informed that students have reported any place in an around the school premises .There could be a higher possibility that the students could be bullied by a relative ,neighbours ,strangers, parents ,friends which were difficult for parents to trace and often goes unreported.

Table2: Findings related to Frequency and Percentage of types of bullying (n =100)

Si No	**Types Of Bullying**	**Frequency**	**Percentage**
1	Verbal bullying	77	77
2	Physical bullying	18	18
3	Relational bullying	50	50
4	Damaging Of property	27	27
5	Cyber bullying	16	16

Table2: shows that larger proportion of school children report verbal bullying i.e. 77%, followed by 50% experienced relational bullying, 27%of school children were faced the problems like damaging of their property by others (eg: stealing of money and stationary items),16%of them were reported with cyber bullying surprisingly only 18%of students suffered with physical bullying .

Table 3:Domain wise mean of bullying scores and rank order of school children (n =100)

Si No	Types Of Bullying	Mean	Modified Mean	Rank Order
1	Relational Bullying	1.68	0.336	1
2	Verbal Bullying	0.23	0.115	2
3	Damaging Of Property	0.72	0.36	3
4	Physical Bullying	0.28	0.28	4
5	Cyber Bullying	0.24	0.048	5

Table 3: shows the mean scores of types of bullying and further rank order based on the types of bullying .The highest modified mean score was found to be in relational bullying domain (0.36) whereas least modified mean was found in cyber bullying .The descending order of types of bullying domain wise order was cyber bullying(0.048),physical bullying(0.115),damaging of property (0.28),verbal bullying(0.336) and relational bullying (0.36) .

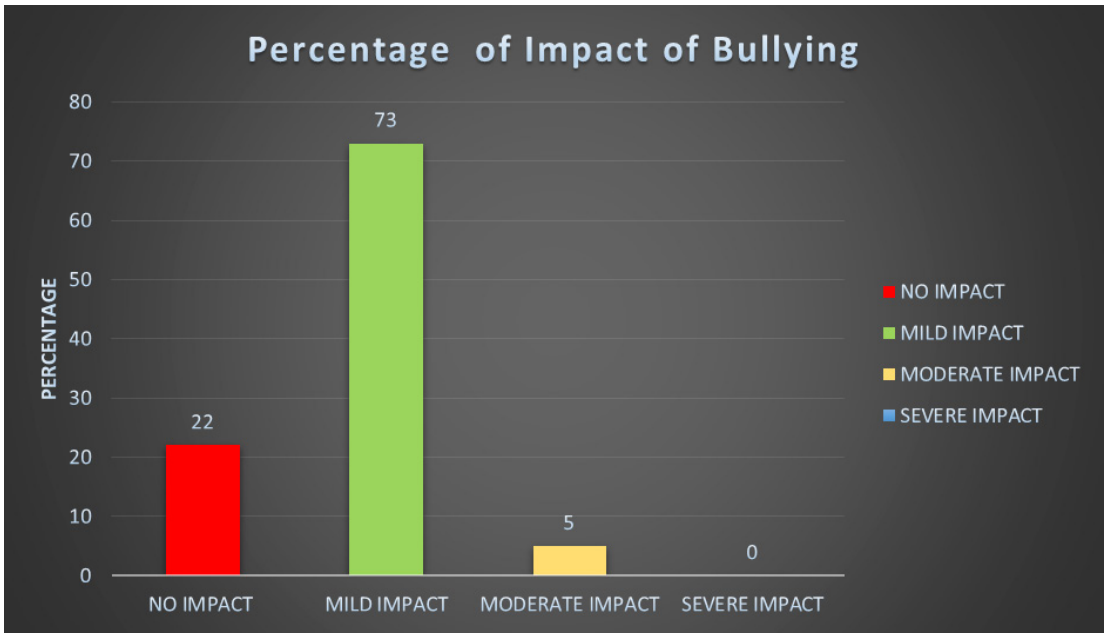

Figure 1: Percentage of Impact on Bullying in Children

Figure 1 represents that 55% of children were having mild impact on bullying, 18%of children were having moderate impact on bullying,5%children were having severe impact on bullying and 22% of children had no impact on bullying.

Table 4: Mean, Median, Mode, Standard deviation and possible range of score and range of obtained score of impact of bullying scores

(n =1)

GROUP	POSSIBLE RANGE OF SCORES	OBTAINED RANGE OF SCORES	MEAN	MEDIAN	MODE	STANDARD DEVIATION
VII &VIII CLASS STUDENTS	0-18	0-8	2.16	4	3	8.40

Table 4 highlights that the mean, median, mode, possible range of scores, obtained range of sores and standard deviation. The investigator found the possible range of scores as 01-18, obtained range of score obtained is 0-8 with average mean score of 2.16, median is 4, mode is 3 and standard deviation is 8.40.

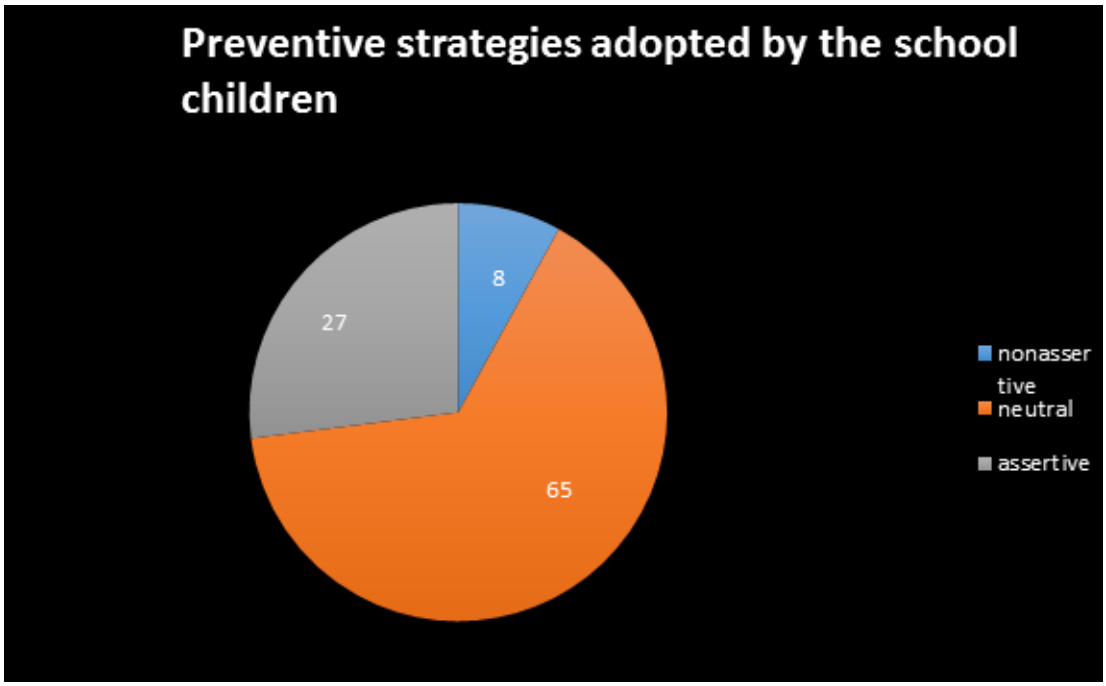

Figure 2 :Pie diagram on preventive strategies in the school

Figure 2 illustrates that majority of the children (65%)chose to be neutral towards bullying ,27%of the children were assertive and vocal about bullying behaviour on bullying prevention strategies and 8% of them were non-assertive, in other words were passive on confronting with bullying .

Table 5 :Item analysis on preventive strategies of bullying among school children (n=100)

Si No	Item /Statements	Response	
		Yes	No
1	INDIVIDUAL STATERGIES The teachers scolded and punished the bully for his misbehaviour	39	61
2	I will report any acts of bullying to my parents	67	33
3	I will not suffer in silence or become a silent bystander when I witness an incident of bullying	63	37
4	I will talk to my parents regularly and openly about bullying and find ways to overcome it .	80	20
5	On witnessing bullying I will bring it into the notice of authorities .	74	26
6	SCHOOL ENVIRONMENT Do you feel free to share your problems with bullying in the class.	28	72
7	Do you feel that if needed you will get support from your parents and teachers?	75	25
8	Do you feel that your school has a positive environment ?	84	16
9	When bullying is reported in your school ,is appropriate action taken	75	25
10	Does your school have an environment to make foster nurturing relationship and friendship pattern.	98	2

As per table no 5 the findings reveal that 98% children reported that their school has an environment that foster nurturing relationship and friendly environment .86% of the children felt safe in school which facilitated conducive environment .

However surprisingly 77%of them had not reported the incident of bullying to their teachers and 72% of them reported that their teachers have not taken any initiation to identify the bully for further actions and the students were not feeling free to share their problems related to bullying in the class.68% of the children were not assertive, that is the children were not reactive towards the incidence of bullying.

Table 6: Association between Impact on bullying and selected demographic variables n =100

si no	Demographic variables	Chi square	Degree of freedom	Table value	Level of significance
1	Age	3.221	6	12.59	NS
2	Gender	1.509	2	5.99	NS
3	Class	8.19	2	5.99	significant
4	Education of the father	4.76	6	12.59	NS
5	Education of the mother	8.59	6	12.59	NS
6	Number of good friends	6.96	4	9.49	NS
7	interest towards school	0	2	5.99	NS

Table 6 shows that there is a significant association between impact on bullying and the class of students which they are studying and there is no significant association between impact on bullying and the selected demographic variables like age ,gender, education of the father and mother ,number of good friends and interest of the child towards school

Discussion

A study conducted by **Veena sharma, etal**[4] on assessing the pattern and impact of bullying behaviour among school children and the results shows that 74 % of subjects had been called names (mota,moti,kala,kali etc),66%had been made fun of ,62%had been pushed or shoved ,58%had been slapped .it was highlighted 82%children had mild impact of bullying such as feeling sick, not wanting to go to school ,bed wetting , having no friends and feeling frightened when alone ,feeling bad ,having difficulty in sleeping ,low self-esteem ,decrease appetite, not talking to any one becoming irritable ,having nightmares while 10%had moderate impact on bullying and 8%had severe impact on bullying .The children reported that they had informed about the bullying incidents to their school teachers and parent.[4]However in the present study was conducted on school children and found that 77 % of children were verbally bullied like made fun of ,called by nick names ,shown inappropriate gestures ,50%of children were reported relational bullying that is spreading the rumours 27 % of the children reported that their personal properties are damaged by the bullies .When we see the impact on bullying , 55%of children were having mild impact on bullying ,18%of children were having moderate impact on bullying ,5%children were having severe impact on bullying and 22% of children had no impact on bullying .

Similarly a study carried out by **Chapell, et** [5] saying that 119 undergraduates from an eastern university and discovered students who were bullies or were a bully-victim in elementary and/or high school were also bullies or bully-victims in college. This study found there is more bullying in elementary schools than in high schools. At the elementary school level the bullying rate is at 14% and by the end of high school that rate drops down to 2%. According to the study those students who were bullied in elementary and high school experienced more verbal bullying than social bullying or physical bullying [5]However the present study conducted only on 7th and 8th class students and the result shows that larger proportion of school children report verbal bullying.55%of children were having mild impact on bullying ,18%of children were having moderate impact on bullying ,5%children were having severe impact on bullying and 22% of children had no impact on bullying .

School children become silent victims of bullying and it may affect their academic performance and mental health .It is important that teachers and parents should carefully deal with the students so that they can be free to share their feeling. This will help us to know about the child more deeply. This present study also attempted to assess the different types of bullying behaviour seen in children and how it affects victim in the school .Many of the victimized children were from the 7th class than from the 8th class. Most of the children were assertive which indicates that they can empower themselves and others.

Conclusion

Bullying is an unwanted ,aggressive behaviour among school children that involves real or perceived power imbalance .It can be performed in various ways based on the child background .The bullying activity will lead to some impacts on the victims and can make them mentally weak later on .As Herber Hoover says “children are our most valuable resources,every child is important”[5].So we should make sure that all the preventive measures against bullying activity are provided in the school which helps the child to be free from the difficulties .This helps the child to mould the proper behaviour so that he or she can be a good resources in the future

Ethical Clearance: The ethical clearance obtained from our institute

Conflicts of Interest : None

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

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Assess the Effectiveness of Bibliotherapy on Exam Anxiety Reduction amongB.Sc. Nursing Students

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Abstract

Background: Bibliotherapy is the best and effective way of managing exam anxiety because it allows the reader to assess with a character and realize that he or she is not the only person with a particular problem. As the character works through a problem, the reader is emotionally involved in the issue and primarily achieves insight of his or her own situation. It allows interaction among the participants who share common needs or interests. Objectives: To assess the pre test level of exam anxiety among first year Nursing students. To assess the effectiveness of bibliotherapy on exam anxiety among first year nursing students. To associate the pre-test level of exam anxiety with selected demographic variables among first year Nursing students.Methodology: A pre-experimental study with one group pre test- post test design was used in this study. The population of the study, 30first year nursing students with exam anxiety was selected by purposive sampling. To assess the level of exam with Sarason‘s exam Anxiety Scale. After assessing the level of exam anxiety administered bibliotherapy for 15 days followed that post-test after 7 days.Results: The mean pre-test level of exam anxiety was 18.37±3 and the post-test level of test anxiety was 8.33±3 The effectiveness of bibliotherapy was tested in terms of reduction in exam anxiety in post-test at 0.05 level of significance. The mean pre-test and post-test level of test anxiety was analysed and the findings were significant at 0.05 level. The associations of pre-test level of test anxiety were found to be significant with age, family income and residential area at 0.05 level of significance. Conclusion: This study has shown that bibliotherapy plays a major role in reducing the level of exam anxiety among the first year nursing students. It would help the students to acquire better coping solutions in order to face a future carrier examinations. Keywords: Effectiveness; Bibliotherapy; exam anxiety; Nursing students

Introduction

Stress isn‘t always bad. In small doses, it can help the individual to perform under pressure and motivate him to do the best. But when the individual constantly running in emergency mode, the mind and body pay the price.[1] In stressful situations, such as before and during an exam, the body releases a hormone called adrenaline. This helps to prepare the body to deal with what is about to happen and is commonly referred to as the “fight-or-flight” response. Essentially, this response prepares the person to either stay and deal with the stress or escape the situation entirely. In a lot of cases, this adrenaline rush is actually a good thing. It helps prepare the person to deal effectively with stressful situations, ensuringthose people are alert and read.[2]

Nursing colleges are highly stressful. Two stressors related to nursing institutes may be stress of examinations and high threshold of standards that they implement in their programs; many programs require that students achieve certain percentages on every examination in order to progress. Thus, testing has high consequences and this may exacerbate any anxiety associated with testing. Exam anxiety is the result of many interrelated beliefs and experiences. Ineffective study methods can lead to anxiety and a lowered self-image.[3]

Bibliotherapy is effective because it allows the reader to identify with a character and realize that he or she is not the only person with a particular problem. As the character works through a problem, the reader is emotionally involved in the struggle and ultimately achieves insight of his or her own situation. Bibliotherapy allows interaction among the participants who share common needs or interests, provides security to students who feel uncomfortable if singled out for attention, allows for sharing of experiences which serves to lessen anxieties, promote feelings of belonging, and

improve self-concept, lead students to appreciate others who are in some way different, thus aiding in social development.[4]

According to the results of a descriptive study conducted in India among 159 high school students, 39.7% of boys and 40.4% of girls who belongs to 10th grade experienced high level of test anxiety. The study concluded that high level of test anxiety were evident in high school students who are preparing for the examination.[5]

A study was conducted in Kolkata, India to understand better anxiety among adolescents. Data was collected from 460 adolescents of 13-17years of age by using State-Trait Anxiety Inventory. Study results shown that 20.1% of boys and 17.9% of girls found to be suffering from high anxiety. Adolescents from Bengali medium schools were more anxious than adolescents from English medium schools. Adolescents belonging to middle socio-economic group suffered more of anxiety than those from both high and low socio-economic groups. Adolescents with working mothers were found to be more anxious.[6]

Problem Statement

A study to assess the effectiveness of bibliotherapy on examanxiety reduction among first year nursing students in selected nursing colleges at Coimbatore.

Objectives of the study

- To assess the pre test level of exam anxiety among first year nursing students.
- To assess the effectiveness of bibliotherapy on exam anxiety among first year nursing students.
- To associate the pre-test level of exam anxiety with selected demographic variables among first year Nursing students

Hypotheses: H_1: There will be a significant difference between the mean pre-test level of exam anxiety and mean post-test level of exam anxiety among first year nursing students. H_2: There will be significant association between pre-test level of exam anxiety with selected demographic variables among first year nursing students

Methodology

Evaluative approach was used in the present study. A pre-experimental design that is, one group pre-test - post-test design because the study was intended to assess the 30 nursing students at Sree Abirami College Of Nursing. Purposivesampling usedfor selecting samples Data were collected from the subjects by using Sarason‘s exam Anxiety Scale and demographic proforma.

Results

Table 1: Frequency and percentage distribution of students according to Demographic Variables

n = 30

S.no	Sample Characteristics	Category	F	%
1	Age	17 Yrs	14	46.7
		18 Yrs	16	53.3
2	Residence	Rural	26	86.6
		Urban	4	13.3
3	Education Father	Secondary	20	67
		Graduate	10	33
4	Education Mother	Secondary	28	93
		Graduate	2	7
5	Occupation Mother	Service	3	10
		Non Service	27	90
6	Occupation Father	Self Employed	14	46.7
		Government	3	10
		Daily Wages	13	43
7	Family Income	Below 10,000	15	50
		10,000-20,000	15	50

Demographic Characteristics Category Students Frequency (f) Percentage (%) Age group 17 years 14 (46.7%) 18 years 16 (53.3%) Residential area Rural 26 (86.6%) Urban 4 (13.3%) Educational status of Father Secondary 20 (67%) Graduate 10 (33%) Educational status of Mother Secondary 28 (93.35) Graduate 2 (7%) Occupation of Father Government 3 (10%) daily wages 13 (43%) Self employed 14 (46.7%) Occupation of Mother Service 3 (10%) Housewife 27 (90%) Family income / month Below Rs.10, 000, 15 (50 %) Rs.10000-20,000, 15 (50%).

Table 2:Pre-test level of exam anxiety among first year nursing students

Level	Category	f	%
Low	1-10	0	0
Moderate	11-20	22	73
High	21-30	8	17

Table 3: Mean, Standard Deviation and Mean percentage of pre-test level of test anxiety among first year nursing students n = 30

Pre test	Mean	SD	Mean %
	18.37	3	61.2

The findings of the study revealed that majority (61.2%) of the nursing students experienced moderate to high range level of exam anxiety. Pre-test score of exam anxiety ranged from 14- 28.The mean pre- test score of the group was 18.37±3. This indicates that the subjects had anxiety related to exam.

TABLE 4: Area wise pre test mean exam anxiety scores.

S.no	Areas	scores	Mean	SD	Mean %
1	General exam taking anxiety	15	8.63	1.8	58
2	Expression of bodily symptoms	7	4.27	1.5	61
3	Thought distribution	8	5.47	1.4	68

It reveals that 57.6% of the students had experienced general test taking anxiety and 61.0% had experienced bodily symptoms related to a test whereas more people (68.3%) experienced thought disruption when taking a test.

The effectiveness of bibliotherapy on exam anxiety among first year nursing students

Low level anxiety f(22) 73.3% ,moderate f (8) 17%,high f (0) 0%.post-test level of test anxiety among the nursing students had reduced. The percentage of students with moderate level of test anxiety was reduced to 16.7% and no students were in the category of high range of test anxiety

Mean, Standard Deviation and Mean percentage of post –test level of test anxiety among students:

The average level of test anxiety in posttest is 8.33±3, with mean percentage of 27.8%.

Figure 1 Pre-test and Post-test Mean scores of students on Test Anxiety Reduction among first year B.Sc. nursing students

Significant at 5% levelt(0.05,29df=2.045)

Paired ‗t'test ($t = 13.96, p \leq 0.05$). The obtained result is greater than that of table value thus, the hypothesis H_1 is accepted that is there is a significant difference in the mean pre-test level of test anxiety and the mean post-test level of test anxiety. It indicates that bibliotherapy was effective in reducing test anxiety among first year B.Sc. nursing students.

Association of the pre-test level of exam anxiety with selected demographic variables of first year nursing students:

The finding conveys that the association between pre-test level of test anxiety with age, residential area and family income of the students was statistically significant at 0.05 level. There was no association between test anxiety and variables such as occupational and educational status of parents. Hence, the hypothesis H_2 was accepted in relation to the variables age, residential area and family income that is, there was significant association between the demographic variables and pre-test level of exam anxiety.

Discussion

The study findings proved that even though the students have prior experience in writing exam they all were experiencing moderate to high range of anxiety when they have to face the exam. The mean post-test level of test anxiety was 18.37±3 and the post-test level of test anxiety was 8.33±3. The effectiveness of bibliotherapy was tested in terms of reduction in exam anxiety in post-test at 0.05 level of significance. The mean pre-test and post-test level of exam anxiety was analyzed and the findings were statistically significant at 0.05 level.

Conclusion

There is an emergency need to deal with the issues of the students associated with writing an exam. Most of the students had moderate to high range of exam anxiety. It also helped a great deal to explore and improve the knowledge of the area as well as to minimize the level of exam anxiety of the students. The constant encouragement, timely corrections and guidance, cooperation and interest of students will reduce the exam anxiety.,

Conflict of Interest: There was no such issue

Source of funding: Funding was by self-finance

Ethical Clearance

- Permission taken from Principal of Sree Abirami College Of Nursing.
- Written consent was taken from all the participants.

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Investigating of the Relationship among Identity Styles and Attachment Styles in Online Addictions

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Abstract

Objective: The purpose of this study was to study the predictive role of attachment styles and identity styles in technological addictions between students of Islamic Azad University, Borujerd Branch, Iran.

Methods: The present study is a cross-sectional and descriptive-correlational study conducted by survey method. 200 students were selected by random sampling were studied.

Results: among the three Internet addicts surveyed, mobile virtual internet networks had the highest average and standard deviation (23.25 ± 62.31). Findings also show that among the identity styles and attachment styles, the informational style (7.42 ± 7.38) and the avoidance style (0.66 ± 1.22) have a mean and standard deviation higher than the other style They were.

Conclusions: The results confirmed the predictive role of attachment and identity styles in Internet addiction.

Key Word: *Technological addiction, identity styles, attachment styles*

Introduction

From the beginning of the 21st century and the third millennium, connections, Technology and the Internet have been an integral part of human life[1] and the development of digital technologies and the compression of time and space are features of this era[2].

Over the past two decades, Internet addiction is considered to be a term that covers a wide range of online problematic activities for individuals (including online gambling, online gambling, online sexual activity, social networking, etc.)[3]. Although modern online technologies have a positive impacts on different aspects of life Like its roundabout availability, Easy and quick search of subjects, Speedy and anonymity, But, as numerous studies have shown, overuse of these technologies can be problematic, and today there are growing concerns about the effects of this technology on various aspects of human life, including the Change in lifestyle, the existence of suicidal thoughts, hyperactivity, social phobia, aggression, violence and anti-social behaviors, lack of attention to their health, social isolation and educational problems[4], and therefore researchers are interested in examining factors Individual and / or social enhancement of Internet addiction.[5]

The American Psychiatric Association regards internet addiction as a pattern of Internet usage that causes functional disorders and is associated with unpleasant internal states over a two-month period and offers seven criteria (at least three in two months) for its diagnosis: Tolerance; withdrawal symptoms; the use of the Internet is longer than the one initially intended; Continuous tendency to control behavior; significant time spent on the Internet; reduction of social, occupational and recreational activities due to the use of the Internet and continued use of it, given the awareness of its negative effects[6].

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Due to the increasing use of the Internet, the addiction statistics are on an upward trend and among young people it is more than any other age group. The results of studies in Iran indicate that the prevalence of Internet addiction among Iranian students ranged from 5.7 to 67.1%[1].

According to the report of the World Internet Statistics Web site, Iran ranked thirteenth in the world in terms of number of Internet users, and ranked first in the Middle East and it's one of the twenty countries that have many Internet users (2017).

Computer games have gained so much development over the past several decades, which has become a major commercial, artistic, and cultural Fields. Despite the benefits of computer games, like all other phenomena in human civilization, this technology can be dangerous and even deadly due to improper, inaccurate, and excessive use, and it has a great deal of psychological, educational, physical, and social damages in a way that Many researchers consider the effects of physical, psychological, and social injuries on these games to be far greater than their benefits. Internet gaming disorder (IGD) has recently been included in the Section III ("Emerging measures and models") of the latest (fifth) edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association [APA] 2013)[7].

Empirical studies indicate the interactions of individual components with personality and demographic characteristics; Among these factors, identity features can play a role as a protective or risk factor[8]. People vary in how to evaluate, use, and modify their identity. In Berzonsky's style identity models, there are three distinct identity styles, which are: informational; normative and avoidant confusion styles, which these styles result from problem solving strategies or coping mechanisms[9]. Findings of the research show that normative and avoidant confusion styles accordingly, they have protective and adaptive effects in relation to Internet addiction and social networks While the informational style has ambiguous effects, it can have both roles[10,11,7].

Another important factor in predicting Internet addiction is attachment styles, studies show that anxious and avoidant insecure attachment styles can be prone to online addiction. Learned attachment style can affect the behavior of individuals in adulthood[12]. This pattern can be safe, insecure, ambivalent and avoidant. In this context, some researchers have widely considered the relationship between online addiction and attachment style[9,10].

With regard to the content on internet addiction, On the other hand, the abundance and complications of it in different fields in Iran, also, the importance of having enough knowledge about its predisposing factors to prevent and reduce this dependence, research in this regard is a necessity in our present society; Therefore, the present study was conducted to study the relationship between identity styles and attachment styles with online addiction, internet games and use of virtual social networks among students of Islamic Azad University, Boroujerd Branch.

The present study investigates the variables of attachment styles and identity styles as a predictor variable and the variable of technological addiction consists of internet addiction, internet games and virtual social networks as a criterion variable. the research hypotheses are:

- Attachment styles predict the online Internet addictions.

- Identity styles predict the online Internet addictions.

Research methodology

The present study is a cross-sectional and descriptive-correlational study conducted by survey method. The statistical population of the study was all students of Borujerd Islamic Azad University in the academic year of 2017- 2018. The sampling method was multi-stage cluster sampling and 200 people were willing to participate in the study. After the sampling, incomplete questionnaires were excluded from the study. Finally, 191 questionnaires were collected. The data were analyzed using SPSS software version 22 and descriptive and inferential statistics indexes including:

Mean, standard deviation, independent t-test, to examine the effects of age and sex variables on dependent variables (Internet addiction, social networks and Internet games), Pearson correlation coefficient to examine the communication pattern between variables, bivariate correlation coefficient to investigate the relationship between gender and dependent variables and multivariate hierarchical regression for prediction

Beams depends on the independent variables were used. In the first stage, age and gender variables were considered as independent variables. In the second stage, three identity styles were added and in the third stage, three attachment styles were enveloped.

The criteria for entering the study were:

A) complete satisfaction of the student to enter the study and complete the questionnaire

B) Student being educated at Borujerd Islamic Azad University in different educational levels

C) lack of clear mental illness

Demographic information included age, gender, field, grade, and study group. The study method

was conducted in accordance with the Helsinki Declaration and the licenses for the study were obtained by the university respective assistants. In order to do sampling, firstly, the students were given explanations regarding the research goals, their rights and responsibilities, with emphasis on the confidentiality of information and how to complete the questionnaires. After obtaining oral satisfaction, tools used in the research were presented to them:

1. Yang Internet addiction inventory

2. The Berzonsky Identity Style Questionnaire

3. Hazan and Shaver style attachment style questionnaire

4. Mobile Social Networking Questionnaire, designed by Polladi et al. (1395)[13].

5. Questionnaire for short form of Internet Game Disorder Question 9 (IGDS-SF9)[14]

Findings

Table 1 shows the mean and standard deviation of the research variables. According to the findings of Table (1), the mean age of subjects was 24/60 with a standard deviation of 6/34.

Independent t-test was used to compare the mean of technological addiction in both male and female students. As the results of Table 2 show, there is no significant difference between the girls and boys in terms of the score of using the Internet and social networks. In the game component, there was a significant difference between the two groups ($p < 0.05$)

Table (3) represents the relationship between different variables with types of online addictions. The findings indicated a positive relationship between the three types of addiction. Among the identity styles, informational style with Internet addiction and normative style had a negative relationship with all three types of addiction and the confused / avoidant style had a positive relationship with all three types of addiction. Also, among attachment styles, safe style with all three types of addiction has a negative relationship with anxious / social and ambivalent styles of the positive relationship with the types of addictions studied.

Table (1). Mean and standard deviations of study variables (technological addiction scores, identity styles, and attachment styles)

Total sample (N =191)	**Mean (SD)**
Technological addictions	
IAT	49.49 ± 18.83
IGD9-SF	14.64 ± 7.32
SNA	62.40 ± 23.25
Identity styles	
Informational	38.35 ± 7.42
Normative	30.62 ± 7.15
Diffuse / avoidant	29.83 ± 7.30
Attachment styles	
secure	1.67 ± 0.75
Avoidance	2.12 ± 0.66
Ambivalent	1.62 ± 0.88
Age	24.60 ± 6.34

Table (2). Comparison of three types of technological addiction in male and female students

Variables	mean	value of t	F	average difference	meaningful
IAT	m: 49.25 f: 49.73	- 0.177	1.17	-0.48	0.86
IGD9-SF	m: 16.73 f: 12.49	4.198	61.77	4.23	0.00
SNA	m: 60.02 f: 64.84	-1.436	0.002	-4.82	0.15

Table (3). Pearson correlation coefficient between various variables and technological addictions

	IAT	IGD9-SF	SNA
Sociodemographic			
Age	0.09	0.085	0.008
Technological addictions			
IAT	-	0.328**	0.747**
IGD9-SF	0.328**	-	0.224**
SNA	0.747**	0.224**	-
Identity styles			
Informational	-0.315**	-0.54	-0.140
Normative	-0.517**	-0.149*	-0.313**
Diffuse / avoidant	0.179*	0.315**	0.260**
Attachment styles			
secure	-0.290**	-0.323**	-0. 250**
Avoidance	0.528**	0.258**	0.437**
Ambivalent	0.300**	0.169*	0.195**

Table (4). Regression coefficients between addiction scores (internet use, internet gaming and social networking), identity styles and attachment styles

	IAT	IGD9-SF	SNA
	R R2 B SE β Sig	R R2 B SE β Sig	R R2 B SE β Sig
Identity styles			
Informational	0.73 0.53 0.48 0.19 0.19 0.012		
Normative	0.62 0.39 -1.41 0.19 -0.53 0.000	0.58 0.34 0.77 0.28 0.24 0.006	0.56 0.31 -1.24 0.28 -0.38 0.000
Diffuse/avoidant	0.72 0.52 0.43 1.46 0.16 0.003	0.46 0.21 0.24 0.007 0.21 0.001	0.52 0.27 0.67 0.21 0.20 0.002
Attachment styles			
secure	0.67 0.46 -4.75 0.1.31 -0.18 0.00	0.32 0.10 -3.07 0.65 -0.25 0.000	0.49 0.24 -5.30 1.91 -0.17 0.006
Avoidance	0.7 0.49 5.34 1.46 0.18 0.000		
Ambivalent	0.52 0.27 7.39 1.23 0.34 0.000	0.4 0.16 2.06 0.54 0.22 0.001	0.43 0.19 9.74 1.78 0.36 0.000

Conclusion

The purpose of this study was to examine the relationship between demographic characteristics, identity styles and attachment styles, with technological addictions (online addiction, online games, and the use of virtual social networks). In general, in our study, sex of students affected on internet addictions. but age did not have an effect, which could be due to the presence of all subjects in their young age and their dispersion. The findings show that there is a positive correlation between addiction to the Internet, addiction to internet games and social media addiction, and this correlation between the Internet addiction and the stronger social networks, which is consistent with the results of Monacis et al. (2017) and empirically confirms that Internet addiction includes a wide range of online activities, such as communicating through social networking sites and Internet games[7].

Concerning the correlation between identity styles and Internet addiction, the results indicate that these styles play an important role in predicting these addictions, which are consistent with the findings of previous research[3,7,11,15]. In the present study, among the identified identity styles, the informational style is only with addiction There is a negative correlation between the Internet and the normative style with all three types of addiction, while the diffuse style has positive and low correlations with the Internet addicts. normative style has a more significant reverse relationship with Internet addiction compared to other identity styles, while the information identity style was expected to have the most negative correlation with Internet addiction. According to the results of numerous researches, the informational identity style should have the most protective effect on the use of online addictions, but in some studies, we see an unexpected positive relationship between this style and online addictions, such as Monacis et al.'s research[7].

One of the influential factors in Internet addiction is attachment styles. Research indicates that there is an insecure attachment style in people with the internet addiction[9,16]. In this study, among attachment styles, secure style with three types of online addiction, negative and low relationship, and anxious and ambivalent / avoidant insecure styles have a positive and low correlation with Internet addictions, that of course this relationship between anxious insecure style and the Internet and social networks addictions are more than other attachment styles, which can be due to the feeling of insecurity, anxiety and distrust that these people have towards themselves and others. and because of them failure in communicating with others, they are isolated more and more and they are more interested in Internet activities. In general, the results of this research section are in line with the findings of previous research and support the existence of a causal relationship between these structures. In particular, the role of predictor and negative correlation of secure attachment with three types of Internet addiction[16,22]. The current study has some limitations that are: Low sample size in order to increase the generalizability of the features, it is suggested that the number of higher samples should be investigated in future studies. Using self-reporting questionnaires and considering their number of questions, they can be applied to their response and their accuracy, and therefore, it has negative effects on the ability to generalize the findings. for this reason, it is recommended that more effective methods of collecting information, such as face-to-face interviews, are recommended. Longitudinal plans can also be used to evaluate the causal relationships between the variables in question.

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Conflict of Interests: The authors declare that they have no conflict of interests.

Source of Funding- self

Ethical Clearance: i) The study subjects provided a verbal consent. ii)The right was kept for respondents to refuse study participation in all of the research time, iii) Subject's identification was not revealed, iv) The data were kept strictly confidential, v) Acknowledgment of each participants and all of dears who helped us in this study.

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Is There any Burden or Impaired Quality of Life of Caregivers of Patients with HIV/AIDS?

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Abstract

Introduction: HIV has become a chronic illness like Diabetes and Chronic Kidney disease. Chronic diseases not only affect the lives of those suffering from the illness but also affect the lives of family members who take care for them.

Objectives:

(i) To assess burden of caregivers of patients with HIV/AIDS

(ii) To assess quality of life of caregivers of patients with HIV/AIDS

(iii) To associate burden with quality of life of caregivers

Methodology: A sample of 100 caregivers was selected using convenient sampling method. Research variables under study were burden and quality of life of caregiver. The tool used for data collection consisted of semi-structured questionnaire for socio-demographic characteristics of patient and caregiver and standardized tools namely, Zarit Burden Interview and WHO Quality of Life – BREF scale.

Results: Majority (35%) of the caregivers reported to have mild to moderate burden. The mean burden score was 37.37±14.61SD. In quality of life, social domain showed a maximum score of 61.08±15.41SD and psychological domain a minimum score of 55.39±14.21SD.

There was significant strong negative correlation between mean burden score and the scores of four domains of quality of life. The result indicated that the caregivers who reported higher degree of burden had reduced quality of life.

Conclusion: The study revealed that there is significant strong negative correlation between burden and quality of life of the caregivers. Care giving role can be enhanced through formal education programme on HIV/AIDS care giving and home service.

Keywords: *HIV/AIDS, caregiver, burden, quality of life.*

Introduction

Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity [WHO] [1]. Many factors combine together to affect the health of individuals and communities.

The appearance of a disease in a family member entails countless changes in the family structure. Chronic diseases not only affect the lives of those suffering from the illness but also affect the lives of family members who take care for them.[2] When the disease is HIV/AIDS, the situation gets worse, as this is a stigmatized illness the population fears, due to the suffering it causes to

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patients and relatives.

The caregivers of HIV/AIDS patients experience multiple physical, emotional, social and financial stresses and these factors can seriously affect their quality of life. Caregivers can get personal satisfaction by helping to reduce the suffering of their relatives. The negative aspects of care giving have been described as caregiver burden or stress.[3] So, more focus should be placed on providing moral and social support to improve the caregivers' quality of life.

Need for the Study

It is felt by the investigator that there is a need to conduct a study on the caregiver burden and related quality of life of the primary caregivers of patients with HIV/AIDS. This study aims to elicit the caregiver burden and quality of life of the primary caregivers of the HIV/AIDS patients undergoing treatment.

Family caregivers, especially those who share same house with an ailing family member, providing 24 hours care a day adding on to their own problems. Their leisure activities are also curtailed by the daily tasks and stressors of caring for loved ones. The family caregiver's identity, coping strategies, self-care efforts and social network may be disrupted. Decrease of pleasurable and meaningful activities also add to the perceived burden of the caregivers.

Aim

The aim of the study is to assess burden and quality of life of caregivers of patients with HIV/AIDS undergoing treatment in a selected tertiary care hospital."

Objectives of the study

- To assess burden of caregivers of patients with HIV/AIDS undergoing treatment in a selected tertiary care hospital.
- To assess quality of life of caregivers of patients with HIV/AIDS undergoing treatment in a selected tertiary care hospital.
- To associate burden with quality of life of caregivers of patients with HIV/AIDS undergoing treatment in a selected tertiary care hospital.

Hypotheses

H0: There is no association between burden and quality of life of caregivers of patients with HIV/AIDS undergoing treatment in a selected tertiary care hospital.

H1: There is association between burden and quality of life of caregivers of patients with HIV/AIDS undergoing treatment in a selected tertiary care hospital.

Material and Methods

Study design: Facility based cross-sectional study

Setting: Anti-retroviral Therapy (ART) centre of a tertiary care hospital of Pune.

Sample size: Calculated on prevalence rate as 62.2% based on previous study[5], considering absolute precision as 10% and 95% confidence interval. Sample size was calculated to be 91. The researcher chose sample size as 100.

Sampling technique:

Non probability convenient sampling.

Population:

Caregivers (spouse, parent, grandparent or children) in the age group of 18–65 years who provided care to the HIV/AIDS patient for least 6 months of duration were included.

Data collection:

Written informed consent was obtained from the study subjects. Data was collected using a semi-structured questionnaire which included socio demographic and clinical details of the care givers and patients. Caregiver burden was assessed using the Zarit Burden scale and the WHOQOL-BREF Questionnaire was used to assess the QOL of caregivers. The scoring was done in accordance with the guidelines given in the respective instruments.

Zarit burden scale was used to score caregiver's burden. It consists of 22 questions. Items were answered on a 5-point likert scale (never, rarely, sometimes, quite frequently, or nearly always). Using these scores, the level of burden was categorized into little (0–20), mild to moderate (21–40), moderate to severe (41–60) or severe (61–88) burden.

WHO's QOL scale (WHOQOL-BREF) was used to assess quality of life in this study. The WHOQOL-

BREF questionnaire contains 26 items including two items (global scores) i.e. overall QOL and general Health and 24 items of satisfaction that are divided into four domains: physical health, psychological health, social relationships and environmental health. Each item is rated on a 5-point Likert scale. The four domains have a score range of 4–20 that was transformed to 0–100 scale.

Statistical Analysis

Data collected was analysed using SPSS Version 17 statistical software. For socio demographic data and burden, frequency distribution and percentage were calculated, while for level of care burden and quality of life, we calculated the mean and standard deviation.

Correlation between caregivers' burden score and quality of life was established using Karl Pearson's Correlation Coefficient. The p-value <0.05 was considered to be significant.

Findings

Socio demographic characteristics of caregivers

A total of 100 caregivers participated in the study. The maximum number (39%) was of the age group ranging from 20 – 30 years. Majority (65%) of them were married and were female caregivers . Nearly half (44%) of the caregivers provided care for 1-5 years duration. More than half (67%) of the caregivers got support from their family members in providing care to the HIV/AIDS patients [Table 1].

Table 1: Socio demographic characteristics of caregivers

n=100

Sample Characteristics	Category	Frequency (f)	Percentage (%)
Age (Yrs)	**20 – 30**	**39**	**39**
	31 – 40	23	23
	41 – 50	26	26
	51 – 60	12	12
Gender	Male	31	31
	Female	**69**	**69**
	Transgender	0	0
Marital status	**Married**	**65**	**65**
	Widowed	6	6
	Unmarried	27	27
	Divorced	2	2
	Separated	0	0
Educational status	Illiterate	6	6
	Primary	24	24
	Secondary	25	25
	Higher secondary	**27**	**27**
	Graduate & above	18	18
Relation with patient	**Husband/wife**	**45**	**45**
	Parent	17	17
	Grand parent	9	9
	Children	29	29
Type of family	**Nuclear**	**53**	**53**
	Joint	47	47
Occupation	Employed	28	28
	Unemployed	**43**	**43**
	Self employed	29	29

Cont... **Table 1: Socio demographic characteristics of caregivers**

Monthly family income (Rs)	≤10000	26	26
	10001 – 25000	**44**	**44**
	25001 – 50000	30	30
	>50000	0	0
Duration of care provided (Yrs)	6mth – 1	22	22
	1 – 5	**44**	**44**
	5 – 10	19	19
	>10	15	15
HIV status	Positive	42	42
	Negative	**58**	**58**
	Not known	0	0
Illness other than HIV/AIDS	Yes	23	23
	No	**77**	**77**
Get support from other family member in care giving	**Yes**	**67**	**67**
	No	33	33

Socio demographic characteristics of HIV/AIDS patients

More than half (64%) belonged to the age group of 26 – 50 years and around 55% of the subjects were female. Almost an equal number of subjects (46% and 44%) were in Stage II and Stage III. [Table 2].

Table 2: Socio demographic characteristics of HIV/AIDS patients

Characteristics	**Category**	**Frequency (f)**	**Percentage (%)**
Age (Yrs)	≤25	19	19
	26 – 50	**64**	**64**
	≥50	17	17
Gender	Male	45	45
	Female	**55**	**55**
	Transgender	0	0
Stages of HIV/AIDS	**Stage II**	**46**	**46**
	Stage III	44	44
	Stage IV	10	10

n=100

Caregiver Burden and Quality of Life

The mean Burden score was 37.37±14.61SD. Majority (35%) of caregivers reported mild to moderate burden. Only 9% subjects reported severe burden [Table 3].

Table 3: Distribution of caregivers as per burden score n= 100

Characteristic	Category	Frequency (f)	Percentage (%)
Burden	Little or No Burden (0-20)	25	25
	Mild to Moderate Burden (21-40)	35	35
	Moderate To Severe Burden (41-60)	31	31
	Severe Burden (61-88)	9	9

The social domain of quality of life showed a maximum score of 61.08+15.41SD and psychological domain showed the minimum score of 55.39+14.21SD.[Table 4]

Table 4: Mean scores of QOL domains n= 100

Characteristics	Category	QOL score	
		Mean	SD
Quality of life	Physical domain	56.49	13.68
	Psychological domain	55.39	14.21
	Social domain	61.08	15.41
	Environmental domain	55.84	14.03

The QOL scores among caregivers had a negative correlation with caregiver burden and the finding was statistically significant in all the four domains ($p< 0.0001$). [Table 5]

Table 5: Correlation between mean burden and domains of QOL of caregivers n=100

Correlation between burden score and domains of QOL	r Value	P Value
QOL (Physical domain)	-0.55	<0.0001
QOL (Psychological domain)	-0.60	<0.0001
QOL (Social domain)	-0.66	<0.0001
QOL (Environmental domain)	-0.59	<0.0001

Discussion

In a study done on 360 caregivers in Mangalore, 37.8% of study samples had little or no burden. Severe burden was reported by 10% of the caregivers.[3] Another study[4] on caregiver burden among 409 caregivers in Thailand using Zarit scale, 53% of caregivers experience moderate to severe burden and 13.4% had severe burden. Inverse association was observed between caregiver burden and quality of life ($p=0.004$) and depression and quality of life ($p<0.0001$). Social support had direct positive association with caregiver's quality of life ($r= 0.48$, $p<0.0001$).

In the Mangalore study done WHOQOL-BREF scale was used to assess the Quality of life. Physical domain of QOL showed maximum score of 60.28±13.08, while a minimum score of 51.88±14.20 was seen in social domain. This is in contrast to our finding. Caregiver burden was compared with each domain of QOL using

ANOVA with $p<0.05$. It was found to be statistically significant with a p-value <0.001.

A similar study[6] on quality of life of caregivers in Taiwan revealed that they felt most stressful on disclosure and stigma issues and most worried about patients' interpersonal relationships and had poor quality of life.

Limitation

Our study had some limitations. Our study design was cross sectional; therefore, causal interpretations cannot be established. It was a single centre study so the results may not be generalized.

Recommendations

For future research work following recommendations are made:

- A qualitative study can be undertaken highlighting the experiences of the caregivers of HIV/AIDS patients.

- A study to assess the comparison of caregiver burden among HIV/AIDS and other chronic diseases can be conducted.

Conclusion

The present study adopted descriptive survey approach to assess the burden and quality of life among the caregivers of HIV/AIDS patients undergoing treatment in a tertiary care hospital. It revealed that there is significant strong negative correlation between the burden and quality of life among caregivers in all the four domains ($p< 0.0001$). The association of caregiver burden and stages of HIV/AIDS was found statistically significant ($p = 0.037$). The caregivers of HIV/AIDS patients experience severe burden of physical, psychological and social forms.

Ethical Clearance: Taken from Institutional Ethical Committee (IEC) and written informed consent taken from individual.

Source of Funding: The study is self funded.

Conflict of Interest: Nil

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Is there any Burden or Impaired Quality of Life of Caregivers of Patients with HIV/AIDS?

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Abstract

Introduction: HIV has become a chronic illness like Diabetes and Chronic Kidney disease. Chronic diseases not only affect the lives of those suffering from the illness but also affect the lives of family members who take care for them.

Objectives:

(iv) To assess burden of caregivers of patients with HIV/AIDS

(v) To assess quality of life of caregivers of patients with HIV/AIDS

(vi) To associate burden with quality of life of caregivers

Methodology: A sample of 100 caregivers was selected using convenient sampling method. Research variables under study were burden and quality of life of caregiver. The tool used for data collection consisted of semi-structured questionnaire for socio-demographic characteristics of patient and caregiver and standardized tools namely, Zarit Burden Interview and WHO Quality of Life – BREF scale.

Results: Majority (35%) of the caregivers reported to have mild to moderate burden. The mean burden score was 37.37±14.61SD. In quality of life, social domain showed a maximum score of 61.08±15.41SD and psychological domain a minimum score of 55.39±14.21SD.

There was significant strong negative correlation between mean burden score and the scores of four domains of quality of life. The result indicated that the caregivers who reported higher degree of burden had reduced quality of life.

Conclusion: The study revealed that there is significant strong negative correlation between burden and quality of life of the caregivers. Care giving role can be enhanced through formal education programme on HIV/AIDS care giving and home service.

Keywords: *HIV/AIDS, caregiver, burden, quality of life.*

Introduction

Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity [WHO] [1]. Many factors combine together to affect the health of individuals and communities.

The appearance of a disease in a family member entails countless changes in the family structure. Chronic diseases not only affect the lives of those suffering from the illness but also affect the lives of family members who take care for them.[2] When the disease is HIV/AIDS, the situation gets worse, as this is a stigmatized illness the population fears, due to the suffering it causes to

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patients and relatives.

The caregivers of HIV/AIDS patients experience multiple physical, emotional, social and financial stresses and these factors can seriously affect their quality of life. Caregivers can get personal satisfaction by helping to reduce the suffering of their relatives. The negative aspects of care giving have been described as caregiver burden or stress.[3] So, more focus should be placed on providing moral and social support to improve the caregivers' quality of life.

Need for the Study

It is felt by the investigator that there is a need to conduct a study on the caregiver burden and related quality of life of the primary caregivers of patients with HIV/AIDS. This study aims to elicit the caregiver burden and quality of life of the primary caregivers of the HIV/AIDS patients undergoing treatment.

Family caregivers, especially those who share same house with an ailing family member, providing 24 hours care a day adding on to their own problems. Their leisure activities are also curtailed by the daily tasks and stressors of caring for loved ones. The family caregiver's identity, coping strategies, self-care efforts and social network may be disrupted. Decrease of pleasurable and meaningful activities also add to the perceived burden of the caregivers.

Aim

The aim of the study is to assess burden and quality of life of caregivers of patients with HIV/AIDS undergoing treatment in a selected tertiary care hospital."

Objectives of the Study

- To assess burden of caregivers of patients with HIV/AIDS undergoing treatment in a selected tertiary care hospital.
- To assess quality of life of caregivers of patients with HIV/AIDS undergoing treatment in a selected tertiary care hospital.
- To associate burden with quality of life of caregivers of patients with HIV/AIDS undergoing treatment in a selected tertiary care hospital.

Hypotheses

H0: There is no association between burden and quality of life of caregivers of patients with HIV/AIDS undergoing treatment in a selected tertiary care hospital.

H1: There is association between burden and quality of life of caregivers of patients with HIV/AIDS undergoing treatment in a selected tertiary care hospital.

Material and Method

Study design: Facility based cross-sectional study

Setting: Anti-retroviral Therapy (ART) centre of a tertiary care hospital of Pune.

Sample size: Calculated on prevalence rate as 62.2% based on previous study[5], considering absolute precision as 10% and 95% confidence interval. Sample size was calculated to be 91. The researcher chose sample size as 100.

Sampling technique:

Non probability convenient sampling.

Population:

Caregivers (spouse, parent, grandparent or children) in the age group of 18–65 years who provided care to the HIV/AIDS patient for least 6 months of duration were included.

Data collection:

Data was collected using a semi-structured questionnaire which included socio demographic and clinical details of the care givers and patients. Caregiver burden was assessed using the Zarit Burden scale and the WHOQOL-BREF Questionnaire was used to assess the QOL of caregivers. The scoring was done in accordance with the guidelines given in the respective instruments.

Zarit burden scale was used to score caregiver's burden. It consists of 22 questions. Items were answered on a 5-point likert scale (never, rarely, sometimes, quite frequently, or nearly always). Using these scores, the level of burden was categorized into little (0–20), mild to moderate (21–40), moderate to severe (41–60) or severe (61–88) burden.

WHO's QOL scale (WHOQOL-BREF) was used to assess quality of life in this study. The WHOQOL-BREF questionnaire contains 26 items including two items (global scores) i.e. overall QOL and general Health and 24 items of satisfaction that are divided into four

domains: physical health, psychological health, social relationships and environmental health. Each item is rated on a 5-point Likert scale. The four domains have a score range of 4–20 that was transformed to 0–100 scale.

Statistical Analysis

Data collected was analysed using SPSS Version 17 statistical software. For socio demographic data and burden, frequency distribution and percentage were calculated, while for level of care burden and quality of life, we calculated the mean and standard deviation.

Correlation between caregivers' burden score and quality of life was established using Karl Pearson's Correlation Coefficient. The p-value <0.05 was considered to be significant.

Findings

Socio demographic characteristics of caregivers

A total of 100 caregivers participated in the study. The maximum number (39%) was of the age group ranging from 20 – 30 years. Majority (65%) of them were married and were female caregivers . Nearly half (44%) of the caregivers provided care for 1-5 years duration. More than half (67%) of the caregivers got support from their family members in providing care to the HIV/AIDS patients [Table 1].

Table 1: Socio demographic characteristics of caregivers n=100

Sample Characteristics	Category	Frequency (f)	Percentage (%)
Age (Yrs)	**20 – 30**	**39**	**39**
	31 – 40	23	23
	41 – 50	26	26
	51 – 60	12	12
Gender	Male	31	31
	Female	**69**	**69**
	Transgender	0	0
Marital status	**Married**	**65**	**65**
	Widowed	6	6
	Unmarried	27	27
	Divorced	2	2
	Separated	0	0
Educational status	Illiterate	6	6
	Primary	24	24
	Secondary	25	25
	Higher secondary	**27**	**27**
	Graduate & above	18	18
Relation with patient	**Husband/wife**	**45**	**45**
	Parent	17	17
	Grand parent	9	9
	Children	29	29
Type of family	**Nuclear**	**53**	**53**
	Joint	47	47
Occupation	Employed	28	28
	Unemployed	**43**	**43**
	Self employed	29	29
Monthly family income (Rs)	≤10000	26	26
	10001 – 25000	44	44
	25001 – 50000	30	30
	>50000	0	0

Cont... **Table 1: Socio demographic characteristics of caregivers n=100**

Duration of care provided (Yrs)	6mth – 1	22	22
	1 – 5	44	44
	5 – 10	19	19
	>10	15	15
HIV status	Positive	42	42
	Negative	58	58
	Not known	0	0
Illness other than HIV/AIDS	Yes	23	23
	No	77	77
Get support from other family member in care giving	Yes	67	67
	No	33	33

Socio demographic characteristics of HIV/AIDS patients

More than half (64%) belonged to the age group of 26 – 50 years and around 55% of the subjects were female. Almost an equal number of subjects (46% and 44%) were in Stage II and Stage III. [Table 2].

Table 2: Socio demographic characteristics of HIV/AIDS patients

Characteristics	Category	Frequency (f)	Percentage (%)
Age (Yrs)	≤25	19	19
	26 – 50	**64**	**64**
	≥50	17	17
Gender	Male	45	45
	Female	**55**	**55**
	Transgender	0	0
Stages of HIV/AIDS	**Stage II**	**46**	**46**
	Stage III	44	44
	Stage IV	10	10

n=100

Caregiver Burden and Quality of Life

The mean Burden score was 37.37±14.61SD. Majority (35%) of caregivers reported mild to moderate burden. Only 9% subjects reported severe burden [Table 3].

Table 3: Distribution of caregivers as per burden score n= 100

Characteristic	Category	Frequency (f)	Percentage (%)
Burden	Little or No Burden (0-20)	25	25
	Mild to Moderate Burden (21-40)	35	35
	Moderate To Severe Burden (41-60)	31	31
	Severe Burden (61-88)	9	9

The social domain of quality of life showed a maximum score of 61.08+15.41SD and psychological domain showed the minimum score of 55.39+14.21SD.[Table 4]

Table 4: Mean scores of QOL domains **n= 100**

Characteristics	Category	QOL score	
		Mean	SD
Quality of life	Physical domain	56.49	13.68
	Psychological domain	55.39	14.21
	Social domain	61.08	15.41
	Environmental domain	55.84	14.03

The QOL scores among caregivers had a negative correlation with caregiver burden and the finding was statistically significant in all the four domains (p< 0.0001). [Table 5]

Table 5: Correlation between mean burden and domains of QOL of caregivers **n=100**

Correlation between burden score and domains of QOL	r Value	P Value
QOL (Physical domain)	-0.55	<0.0001
QOL (Psychological domain)	-0.60	<0.0001
QOL (Social domain)	-0.66	<0.0001
QOL (Environmental domain)	-0.59	<0.0001

Discussion

In a study done on 360 caregivers in Mangalore, 37.8% of study samples had little or no burden. Severe burden was reported by 10% of the caregivers.[3] Another study[4] on caregiver burden among 409 caregivers in Thailand using Zarit scale, 53% of caregivers experience moderate to severe burden and 13.4% had severe burden. Inverse association was observed between caregiver burden and quality of life (p=0.004) and depression and quality of life (p<0.0001). Social support had direct positive association with caregiver's quality of life (r= 0.48, p<0.0001).

In the Mangalore study done WHOQOL-BREF scale was used to assess the Quality of life. Physical domain of QOL showed maximum score of 60.28±13.08, while a minimum score of 51.88±14.20 was seen in social domain. This is in contrast to our finding. Caregiver burden was compared with each domain of QOL using ANOVA with p<0.05. It was found to be statistically significant with a p-value <0.001.

A similar study[6] on quality of life of caregivers in Taiwan revealed that they felt most stressful on disclosure and stigma issues and most worried about patients' interpersonal relationships and had poor quality of life.

Limitation

Our study had some limitations. Our study design was cross sectional; therefore, causal interpretations cannot be established. It was a single centre study so the results may not be generalized.

Recommendations

For future research work following recommendations are made:

- A qualitative study can be undertaken highlighting the experiences of the caregivers of HIV/AIDS patients.

- A study to assess the comparison of caregiver burden among HIV/AIDS and other chronic diseases can be conducted.

Conclusion

The present study adopted descriptive survey approach to assess the burden and quality of life among

the caregivers of HIV/AIDS patients undergoing treatment in a tertiary care hospital. It revealed that there is significant strong negative correlation between the burden and quality of life among caregivers in all the four domains ($p < 0.0001$). The association of caregiver burden and stages of HIV/AIDS was found statistically significant ($p = 0.037$). The caregivers of HIV/AIDS patients experience severe burden of physical, psychological and social forms.

Conflict of Interest: Nil

Source of Funding; Self

Ethical Clearance: Permission was taken from Institutional Ethical Committee. Written informed consent was obtained from the study subjects.

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Self-Directed Learning Readiness among Nursing Students: A Cross Sectional Study

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Abstract

Learning brings about changes in the way we act, think and feel. The changes in method in learning, changes the quality of learning. It may be positive or negative, as in how we adopt it. A descriptive study was conducted on readiness towards self-directed learning among nursing students, in Sree Gokulam Nursing College, Venjaramoodu with the objectives; to assess the readiness towards self-directed learning among nursing students, to compare SDLR score across various streams in nursing and to determine the association between readiness towards self-directed learning and selected socio demographic variables. The study used a quantitative approach and was conducted among 200 subjects recruited by total enumeration sampling technique. Data was collected using a socio demographic proforma and Fisher's self-directed learning readiness scale with reliability of 0.8, after concerning the ethical considerations. The results show that majority (72.5%) had high SDLR score and 55(27.5) had low SDLR score, there was significant association between readiness towards self-directed learning and previous exposure to self-directed learning enhancement program (p=0.010).

Key words: *Readiness, self-directed learning, nursing students, SDLR*

Introduction

Learning is the act of acquiring new or modifying and reinforcing existing knowledge, behaviors, skills, values, or preferences which may lead to potential change in synthesizing information, depth of knowledge, attitude or behavior relative to the type and range of experience.[1] The ability to learn is possessed by humans, animals, plants, some machines. Progress over time tends to follow learning curve. Learning does not happen all at once, but it builds upon and is shaped by previous knowledge. To that end, learning may be viewed as a process, rather than a collection of factual and procedural knowledge. Learning produces changes in the organism and the changes produced are relatively permanent.[2]

The factors involved in academic failure can be classified in three categories of;

1. Individual factors (components like having a goal, motivation, anxiety, *studying method*, intelligence, attention),

2. Internal organizational factors (professional characteristics of instructors, space and proper facilities and equipment)

3. External organizational factors (parents' education level and their dealing with students' academic failure, socioeconomic status of families and unclear and uncertain occupational prospects)

Self-Directed Learning, in its broadest meaning, describes a process in which individuals take the initiative with or without the help of others, in diagnosing their learning needs, formulating learning goals, identifying resources for learning, choosing and implementing learning strategies and evaluating learning outcomes[3].

The literature on SDL asserts that self-directed learners demonstrate a greater awareness of their responsibility in making learning meaningful and monitoring them. They are curious and willing to try new things (Taylor, 1995). Taylor also found them to be motivated and persistent, independent, self-disciplined, self-confident and goal oriented[4].

Self-directed learning allows learners to be more effective learners and social beings. And it is the ability to search for information in multiple texts, employ different strategies to achieve goals, and to represent

ideas in different forms (drawing and writing). With proper planning and implementation, self-directed learning can encourage students to develop their own rules and leadership patterns[4].

A cross sectional descriptive study on readiness towards self- directed learning was conducted at the college of nursing at one of the largest Governmental University in Saudi Arabia. The data collected from 230 students by using self -directed learning readiness scale. The participant self- control recorded the highest mean score (56.72+ 9.17) followed by the self- management (45.90+ 9.17) subscale, with desire or learning readiness. The lowest mean score is (45.04+ 7.32). the current study, the subscale of self- control, self- management and desire to learn, as well as the general sore SDLR, were likely lower than those reported in a previous study conducted at Agiuf University. The study found that the nursing students were autonomous learners and those most demonstrated a strong desired to learn[5].

Self-directed learning has become a focus for nursing education in the past few decades due to the complexity and changes in nursing profession development. Many medical and non-medical professional education systems has inculcated SDL as a learning method, this study explores students readiness towards SDL as a learning method supplementing their traditional learning methods.

Materials and Method

This study used a quantitative research approach using a descriptive research design. Objectives were to assess readiness towards self-directed learning among nursing students and to find out association between readiness towards SDL and selected socio personal variables. All nursing students in selected nursing college will be the sample, recruited using total enumeration sampling technique. 200 subjects were recruited for this study from the selected setting.

Tools and techniques

- **Socio demographic data**

This section collects baseline data regarding subjects, such as; age ,sex, year of study ,previous pattern of education ,medium of previous pattern of education, Educational level of father ,educational level of mother .

- **Fisher's Self Directed Learning Readiness Scale (SDLRS)**

It is a standardized 40 item 5 point likert scale ranging from 'strongly agree to strongly disagree', with three domains – self management, desire for learning and self-control. Reliability of SDLRS is 0.87. The total score ranges from 40-200, scores above 150 denotes a higher SDLR and below 150 indicates lower SDLR[6].

Data collection procedure

1. Clearance from the institutional ethical committee

2. Formal permission from the head of institution from selected nursing college

3. Selected sample through Total Enumeration Technique

4. Brief introduction of the study objectives

5. Informed consent was obtained after ensuring confidentiality of the data

6. Administered tools:

- Socio demographic data
- Fisher's self-directed learning readiness scale

Data was analyzed using SPSS V20.0. Descriptive (frequency, percentage, mean and standard deviation) and inferential statistical techniques (Chi square and Kruskall wallis Anova) was used to analyze data in order to meet the objectives.

Results

a. Socio demographic characteristics

Majority of nursing students i.e. 64%were the group of 18-20, and 92% belongs to females. Most of the students are (82%) BSC nursing and 90.5% students studied state syllabus. In the education patter of father, majority (44%) belongs to SSLC and below category and among them 48.5% belongs to self-employment category. In the education patter of mother, majority (38.5%) belongs to SSLC and below and among them 69.5% belongs to unemployment.

b. Distribution of subjects based on readiness towards Self Directed Learning (SDLR)

Table 1: Frequency and percentage distribution, mean self-directed readiness score of subjects (n=200)

SDLR	Frequency(f)	Percentage (%)	Mean SDLR score	Standard deviation
Low SDLR	55	27.5	160.54	± 15.598
High SDLR	145	72.5		
Total	200	100.0		

Table 1 reveals that 145(72.5%) subjects had high SDLR score and 55(27.5%) had low SDLR score.

c. Association between readiness towards self-directed learning and selected socio personal variables

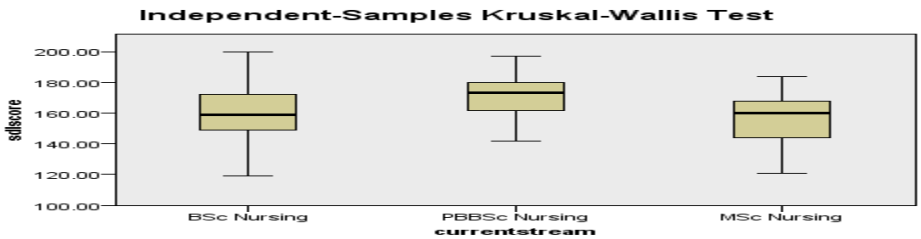
Table 2: Chi square value, degrees of freedom and P value (n=200)

SI. no	Variables	Chi square value	df	P value
1	Age	5.418	2	0.067
2	Gender	0.123	1	0.726
3	Current stream of study	3.917	2	0.141
4	Previous pattern of education	2.351	2	0.309
5	Education of father	1.223	3	0.747
6	Occupation of father	3.180	3	0.365
7	Education of mother	4.920	3	0.178
8	Occupation of mother	1.395	3	0.707
9	Previous exposure to SDL enhancement program	6.657	1	0.010**

***Significant at P value less than 0.01 level**

Chi square test was used to analyze association between readiness towards self-directed learning and selected socio demographic variables. There was statistically significant association between readiness towards self-directed learning and previous exposure to previous learning enhancement programs p value <0.05 (p=0.010).

d. Distribution of SDLR scores across streams of nursing



Total N	201
Test Statistic	10.250
Degrees of Freedom	2
Asymptotic Sig. (2-sided test)	.006

1. The test statistic is adjusted for ties.

Figure 1: Independent sample Kruskal wallis ANOVA with grouping variable current stream of nursing

The distribution of self-directed learning readiness score is the same across categories of current stream of study in nursing at P value <0.05 level.

Discussion

The study revealed that 145(72.5%) subjects had high SDLR score and 55(27.5%) had low SDLR score. Many studies published across world revealed congruent findings as noted below.

A cross sectional descriptive study was conducted at Peshawar, Pakistan in 2010 to examine the self-directed learning readiness among nursing students of four nursing institutes. Fisher's self-directed learning readiness scale (SDLRS) for nursing education was used to collect data from 91 nursing students who were recruited conveniently for the study. The findings from the study showed 60% of students have positive attitude towards self-directed learning, i.e. having a score above 150 in SDLRS[7].

A descriptive correlational study was conducted in school of nursing, Fujian Medical University , China in 2014 to determine the relationship with SDLR and nursing competency. 519 undergraduate nursing students were recruited for this study and assessed using SDRL scale and nursing competency inventory. The results revealed that the mean score was 148.55 with SD 18.46 indicating and intermediate SDLR and also a strong positive correlation with nursing competency[8].

Implications

- Nurses should able to identify the learning skills and learning difficulties
- Nurses should act as role models to empower their students to become independent learners by modeling their own self-directed learning and applying a number of techniques in supporting their students in becoming ready for self-directed learning
- Further experimental studies on effect of self-directed learning among nursing student.
- More research should be conducted on various psychological and nursing interventions for the management of learning difficulties among students
- Improve facilities for identification and supportive management of patients with leaning difficulties.
- Provide opportunities for nurses to attend learning enhancement programs

Ethical Considerations: 1. Ethical clearance was attained from institutional ethical committee of Sree Gokulam Medical College and Research Foundation.

2. Setting permission from the head of the institution.

3. Written informed consent was obtained from the study participants prior to the study after explaining objectives of our study and ensuring the confidentiality of the data collected..

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Conflict of Interest- Nil

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Investigating of the Relationship among Identity Styles and Attachment Styles in Online Addictions

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Abstract

Objective: The purpose of this study was to study the predictive role of attachment styles and identity styles in technological addictions between students of Islamic Azad University, Borujerd Branch, Iran.

Method: The present study is a cross-sectional and descriptive-correlational study conducted by survey method. 200 students were selected by random sampling were studied.

Results: among the three Internet addicts surveyed, mobile virtual internet networks had the highest average and standard deviation (23.25 ± 62.31). Findings also show that among the identity styles and attachment styles, the informational style (7.42 ± 7.38) and the avoidance style (0.66 ± 1.22) have a mean and standard deviation higher than the other style They were.

Conclusions: The results confirmed the predictive role of attachment and identity styles in Internet addiction.

Key Word: *Technological addiction, identity styles, attachment styles*

Introduction

From the beginning of the 21st century and the third millennium, connections, Technology and the Internet have been an integral part of human life[1] and the development of digital technologies and the compression of time and space are features of this era[2].

Over the past two decades, Internet addiction is considered to be a term that covers a wide range of online problematic activities for individuals (including online gambling, online gambling, online sexual activity, social networking, etc.)[3]. Although modern online technologies have a positive impacts on different aspects of life Like its roundabout availability, Easy and quick search of subjects, Speedy and anonymity, But, as numerous studies have shown, overuse of these technologies can be problematic, and today there are growing concerns about the effects of this technology on various aspects of human life, including the Change in lifestyle, the existence of suicidal thoughts, hyperactivity, social phobia, aggression, violence and anti-social behaviors, lack of attention to their health, social isolation and educational problems[4], and therefore researchers are interested in examining factors Individual and / or social enhancement of Internet addiction.[5]

The American Psychiatric Association regards internet addiction as a pattern of Internet usage that causes functional disorders and is associated with unpleasant internal states over a two-month period and offers seven criteria (at least three in two months) for its diagnosis: Tolerance; withdrawal symptoms; the use of the Internet is longer than the one initially intended; Continuous tendency to control behavior; significant time spent on the Internet; reduction of social, occupational and recreational activities due to the use of the Internet and continued use of it, given the awareness of its negative effects[6].

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Due to the increasing use of the Internet, the addiction statistics are on an upward trend and among young people it is more than any other age group. The results of studies in Iran indicate that the prevalence of Internet addiction among Iranian students ranged from 5.7 to 67.1%[1].

Computer games have gained so much development over the past several decades, which has become a major commercial, artistic, and cultural Fields. Despite the benefits of computer games, like all other phenomena in human civilization, this technology can be dangerous and even deadly due to improper, inaccurate, and excessive use, and it has a great deal of psychological, educational, physical, and social damages in a way that Many researchers consider the effects of physical, psychological, and social injuries on these games to be far greater than their benefits. Internet gaming disorder (IGD) has recently been included in the Section III ("Emerging measures and models") of the latest (fifth) edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association [APA] 2013)[7].

Empirical studies indicate the interactions of individual components with personality and demographic characteristics; Among these factors, identity features can play a role as a protective or risk factor[8]. People vary in how to evaluate, use, and modify their identity. In Berzonsky's style identity models, there are three distinct identity styles, which are: informational; normative and avoidant confusion styles[9]. Findings of the research show that normative and avoidant confusion styles accordingly, they have protective and adaptive effects in relation to Internet addiction and social networks While the informational style has ambiguous effects, it can have both roles[10,11,7].

Another important factor in predicting Internet addiction is attachment styles, studies show that anxious and avoidant insecure attachment styles can be prone to online addiction. Learned attachment style can affect the behavior of individuals in adulthood[12]. This pattern can be safe, insecure, ambivalent and avoidant. In this context, some researchers have widely considered the relationship between online addiction and attachment style[9,10].

With regard to the abundance and complications of it in different fields in Iran, also, the importance of having enough knowledge about its predisposing factors to prevent and reduce this dependence, research in this regard is a necessity in our present society; Therefore, the present study was conducted to study the relationship between identity styles and attachment styles with online addiction, internet games and use of virtual social networks among students of Islamic Azad University, Boroujerd Branch. The research hypotheses are:

- Attachment styles predict the online Internet addictions.

- Identity styles predict the online Internet addictions.

Research methodology

The present study is a cross-sectional and descriptive-correlational study conducted by survey method. The statistical population of the study was all students of Borujerd Islamic Azad University in the academic year of 2017- 2018. The sampling method was multi-stage cluster sampling and 200 people were willing to participate in the study. After the sampling, incomplete questionnaires were excluded from the study. Finally, 191 questionnaires were collected. The data were analyzed using SPSS software version 22 and descriptive and inferential statistics indexes including:

Mean, standard deviation, independent t-test, to examine the effects of age and sex variables on dependent variables (Internet addiction, social networks and Internet games), Pearson correlation coefficient to examine the communication pattern between variables, bivariate correlation coefficient to investigate the relationship between gender and dependent variables and multivariate hierarchical regression for prediction Beams depends on the independent variables were used. In the first stage, age and gender variables were considered as independent variables. In the second stage, three identity styles were added and in the third stage, three attachment styles were enveloped.

The criteria for entering the study were:

A) complete satisfaction of the student to enter the study and complete the questionnaire

B) Student being educated at Borujerd Islamic Azad University in different educational levels

C) lack of clear mental illness

The study method was conducted in accordance

with the Helsinki Declaration and the licenses for the study were obtained by the university respective assistants. In order to do sampling, firstly, the students were given explanations regarding the research goals, their rights and responsibilities, with emphasis on the confidentiality of information and how to complete the questionnaires. After obtaining oral satisfaction, tools used in the research were presented to them:

1. Yang Internet addiction inventory

2. The Berzonsky Identity Style Questionnaire

3. Hazan and Shaver style attachment style questionnaire

4. Mobile Social Networking Questionnaire, designed by Polladi et al. (1395)[13].

5. Questionnaire for short form of Internet Game Disorder Question 9 (IGDS-SF9)[14]

Findings

Table 1 shows the mean and standard deviation of the research variables. According to the findings of Table (1), the mean age of subjects was 24/60 with a standard deviation of 6/34.

Independent t-test was used to compare the mean of technological addiction in both male and female students. As the results of Table 2 show, there is no significant difference between the girls and boys in terms of the score of using the Internet and social networks. In the game component, there was a significant difference between the two groups ($p < 0.05$)

Table (3) represents the relationship between different variables with types of online addictions. The findings indicated a positive relationship between the three types of addiction. Among the identity styles, informational style with Internet addiction and normative style had a negative relationship with all three types of addiction and the confused / avoidant style had a positive relationship with all three types of addiction. Also, among attachment styles, safe style with all three types of addiction has a negative relationship with anxious / social and ambivalent styles of the positive relationship with the types of addictions studied.

Table (1). Mean and standard deviations of study variables (technological addiction scores, identity styles, and attachment styles)

Total sample (N =191)	**Mean (SD)**
Technological addictions	
IAT	49.49 ± 18.83
IGD9-SF	14.64 ± 7.32
SNA	62.40 ± 23.25
Identity styles	
Informational	38.35 ± 7.42
Normative	30.62 ± 7.15
Diffuse / avoidant	29.83 ± 7.30
Attachment styles	
secure	1.67 ± 0.75
Avoidance	2.12 ± 0.66
Ambivalent	1.62 ± 0.88
Age	24.60 ± 6.34

Table (2). Comparison of three types of technological addiction in male and female students

Variables	mean	value of t	F	average difference	meaningful
IAT	m: 49.25 f: 49.73	- 0.177	1.17	-0.48	0.86
IGD9-SF	m: 16.73 f: 12.49	4.198	61.77	4.23	0.00
SNA	m: 60.02 f: 64.84	-1.436	0.002	-4.82	0.15

Table (3). Pearson correlation coefficient between various variables and technological addictions

	IAT	IGD9-SF	SNA
Sociodemographic			
Age	0.09	0.085	0.008
Technological addictions			
IAT	-	0.328**	0.747**
IGD9-SF	0.328**	-	0.224**
SNA	0.747**	0.224**	-
Identity styles			
Informational	-0.315**	-0.54	-0.140
Normative	-0.517**	-0.149*	-0.313**
Diffuse / avoidant	0.179*	0.315**	0.260**
Attachment styles			
secure	-0.290**	-0.323**	-0. 250**
Avoidance	0.528**	0.258**	0.437**
Ambivalent	0.300**	0.169*	0.195**

Table (4). Regression coefficients between addiction scores (internet use, internet gaming and social networking), identity styles and attachment styles

	IAT	IGD9-SF	SNA
	R R2 B SE β Sig	R R2 B SE β Sig	R R2 B SE β Sig
Identity styles			
Informational	0.73 0.53 0.48 0.19 0.19 0.012		
Normative	0.62 0.39 -1.41 0.19 -0.53 0.000	0.58 0.34 0.77 0.28 0.24 0.006	0.56 0.31 -1.24 0.28 -0.38 0.000
Diffuse/avoidant	0.72 0.52 0.43 1.46 0.16 0.003	0.46 0.21 0.24 0.007 0.21 0.001	0.52 0.27 0.67 0.21 0.20 0.002
Attachment styles			
secure	0.67 0.46 -4.75 0.1.31 -0.18 0.00	0.32 0.10 -3.07 0.65 -0.25 0.000	0.49 0.24 -5.30 1.91 -0.17 0.006
Avoidance	0.7 0.49 5.34 1.46 0.18 0.000		
Ambivalent	0.52 0.27 7.39 1.23 0.34 0.000	0.4 0.16 2.06 0.54 0.22 0.001	0.43 0.19 9.74 1.78 0.36 0.000

Conclusion

The purpose of this study was to examine the relationship between demographic characteristics, identity styles and attachment styles, with technological addictions (online addiction, online games, and the use of virtual social networks). In general, in our study, sex of students affected on internet addictions. but age did not have an effect, which could be due to the presence of all subjects in their young age and their dispersion. The findings show that there is a positive correlation between addiction to the Internet, addiction to internet games and social media addiction, and this correlation between the Internet addiction and the stronger social networks, which is consistent with the results of Monacis et al. (2017) and empirically confirms that Internet addiction includes a wide range of online activities, such as communicating through social networking sites and Internet games[7].

Concerning the correlation between identity styles and Internet addiction, the results indicate that these styles play an important role in predicting these addictions, which are consistent with the findings of previous research[3,7,11,15]. In the present study, among the identified identity styles, the informational style is only with addiction There is a negative correlation between the Internet and the normative style with all three types of addiction, while the diffuse style has positive and low correlations with the Internet addicts. normative style has a more significant reverse relationship with Internet addiction compared to other identity styles, while the information identity style was expected to have the most negative correlation with Internet addiction. According to the results of numerous researches, the informational identity style should have the most protective effect on the use of online addictions, but in some studies, we see an unexpected positive relationship between this style and online addictions, such as Monacis et al.'s research[7].

One of the influential factors in Internet addiction is attachment styles. Research indicates that there is an insecure attachment style in people with the internet addiction[9,16]. In this study, among attachment styles, secure style with three types of online addiction, negative and low relationship, and anxious and ambivalent / avoidant insecure styles have a positive and low correlation with Internet addictions, that of course this relationship between anxious insecure style and the Internet and social networks addictions are more than other attachment styles, which can be due to the feeling of insecurity, anxiety and distrust that these people have towards themselves and others. and because of them failure in communicating with others, they are isolated more and more and they are more interested in Internet activities. In general, the results of this research section are in line with the findings of previous research and support the existence of a causal relationship between these structures. In particular, the role of predictor and negative correlation of secure attachment with three types of Internet addiction[16,22]. The current study has some limitations that are: Low sample size in order to increase the generalizability of the features, it is suggested that the number of higher samples should be investigated in future studies. Using self-reporting questionnaires and considering their number of questions, they can be applied to their response and their accuracy, and therefore, it has negative effects on the ability to generalize the findings. for this reason, it is recommended that more effective methods of collecting information, such as face-to-face interviews, are recommended. Longitudinal plans can also be used to evaluate the causal relationships between the variables in question.

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Conflict of Interests: The authors declare that they have no conflict of interests.

Source of Funding- self

Ethical Clearance:

i) The study subjects provided a verbal consent. ii)The right was kept for respondents to refuse study participation in all of the research time, iii) Subject's identification was not revealed, iv) The data were kept strictly confidential, v) Acknowledgment of each participants and all of dears who helped us in this study.

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Level of Stigma Towards Mental Illness among the Caregivers of Clients With Mental Illness and Other Chronic Medical Illness

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Abstract

Background: Mental illness is considered to be associated with high level of stigma. The stigmatizing experience is not only limited to the patients but is also experienced by their close relatives. Due to the stigma, people often avoid the use of mental health services because of the fear of being labeled as a "mentally ill patient" and thus avoid the negative consequences connected with the stigma of mental illness.

Aim: The aim of the study was to compare the level of stigma towards mental illness between the caregivers of clients with mental illness and other chronic illness.

Methods and Materials: A cross-sectional descriptive study was conducted that included 200 subjects of which 100 from group I (caregivers of clients with mental illness) and 100 from group II (caregivers of clients with other chronic illness). Convenient sampling method was used. Fear and Behavioural Intention scale was used to assess the level of stigma.

Results: Group I had positive attitude towards mental illness with the mean score of 37.21±7.13 whereas Group II had less positive attitude towards mental illness with the mean score of 27.48±7.98.

Conclusion: The study results indicate that caregivers who have their family member under treatment for mental illness were more likely to have behaviourally favourable attitude towards mental illness when comparing with the caregivers who do not have a family member with mental illness. Educating the public on mental illness may reduce the stigma associated with mental illness.

Key words: *Caregivers, mental illness, fear and behavioural intention scale (FABI)*

Introduction

The World Health Organization (WHO) reported in 2001 that about 450 million people worldwide suffer from some form of mental disorder and in India, it is almost 60 to 70 million. Four of the ten leading causes of disability worldwide are neuropsychiatric disorders, accounting for 30.8% of total disability and 12.3% of the total burden of disease. The burden of these disorders is expected to rise to 15% by the year 2020.[1] An epidemiological review of prevalence studies of psychiatric disorders from 1960 to 2009 found that the prevalence of mental illness falls in the range of 9.5–370 persons per 1000.[2]

It is well known that lack of awareness regarding mental illness in general population leads to stigmatization attitudes towards people with mental illness. Stigma may be regarded as, "a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid and discriminate against people with mental illness. For the mentally ill, stigma acts as a barrier that separates them from society. Nearly, two third of people with mental disorders do not seek treatment due to the stigma related to mental illness.

Stigma related to mental illness not only has the negative impact on the sufferers but also has the impact on the lives of their family members or caregivers.

Research suggests that stigma negatively impacts self-esteem and also affects the variables related to recovery from mental illness, including social relationships; treatment adherence and willingness to seek help.[3] Fear of stigma by patients or other family members may become a major obstacle to help seeking and treatment adherence. Patients and their family members often report that the diagnosis of a mental illness is followed by increasing isolation as family and friends withdraw. Patients feel rejected and feared by others and their families are blamed by others for having mental illness. [4]

In his theory of human attribution, Weiner (1995) argued that blaming someone for a negative life condition such as mental illness leads to anger and social avoidance ("I don't want that weak-willed person around me!"). Hence, educating the public about the biological roots of mental illness—for example, comparing people with mental illness to those with other chronic disorders such as diabetes—may decrease the blame for psychiatric illness. Ranjithkumar et al studied the attitudes of people towards mental illness. The study compared the attitudes people between the caregivers of mental illness and the lay public. The findings highlighted that caregivers of mentally ill individuals had more positive attitude than the lay public. In addition, the authors concluded that knowledge of the prevailing attitudes of people towards mental illness helps in adopting methods to make these attitudes more positive, which helps in better outcome & recovery.[5]

Hence, the present study was aimed to compare the level of stigma towards mental illness between the caregivers of clients with mental illness (Schizophrenia, Bipolar disorders and major depression) and other chronic illnesses such as diabetes, hypertension and certain dermatological disorders.

Materials & Method

A cross-sectional descriptive study was carried out among 200 caregivers of patients of which 100 from group I (caregivers of clients with mental illness) and 100 from group II (caregivers of clients with chronic medical illness) and those who attended Medical, Dermatological and Psychiatric Out-Patient Department of a tertiary care hospital. Participants were selected by convenience sampling according to the inclusion criteria. Subjects of both sex and who belonged to the age group of 18 to 65 years, caregivers of clients having mental illness for two years and above were included in the study. Also, the caregivers who had cared the patients for more than two years and who was also a close relative were included in the study. The same criteria were followed for the caregivers attending Medical, and Dermatological Out-Patient Departments. Caregivers with mental illness or having any other acute illness were excluded from the study. In addition to the socio-demographic data sheet, Fear and behavioural intentions towards mentally ill (FABI) was used to collect the data. FABI is a simple, ten item self rated scale that assesses the fear and likely behavior towards mentally ill. Each item is rated on five point Likert scale.

Results

The socio-demographic profile of the study participants

Out of 200 subjects, one hundred subjects belonged to the Group I (caregivers of clients with mental illness) and Group II (caregivers of clients with chronic medical illness) also had the same number. In Group I, majority of the subjects (52%) were between the age group of 26-50 years. Similarly, group II also had the majority of subjects (68%) belonged to the age group of 26-50 years. Males outnumbered in group I (52%) where as females (62%) were outnumbered in Group II. In both the group, majority of the subjects (83% each) were married. Concerning with residential area, 46% subjects from Group I, belonged to the urban area and the remaining 54% were hailed from rural area, In group most of the subjects (63%) were hailed from rural area. In group I, 71% of caregivers reported that they gained information regarding mental illness through their personal experience and the remaining 29% gained information through media. In group II, 64% of caregivers reported that they gained information regarding mental illness through their personal experience and the remaining 36% gained information through media. The duration of psychiatric illness varied from two years to 25 years. In group I, most of the caregivers (95%) belonged to the category of first degree relatives.

The comparison of demographic variables between group I and II is shown in table 1. The results showed that variables such as age, gender and educational status were found to be statistically significant between the two groups where as other variables such as marital status, occupation and income were not found to be statistically significant.

Further, comparison of group I & II based on responses for fear and behavioral intention towards mentally ill (FABI) is shown in table 2. All the items in FABI were found to be statistically significant regarding the attitudes towards mentally ill between group I & II. For statements like "Would you object to having mentally ill people living in your neighborhood?" and "Would you avoid conversations with neighbors who had suffered from mental illness?", higher proportion of caregivers with mental illness expressed positive attitude towards mentally ill by answering very unlikely or unlikely. Among those respondents who do not have a relative under treatment for mental illness expressed significantly more negative attitude towards the mentally ill.

For statements "Would you be willing to work with somebody with a mental illness and "Would you invite somebody into your home if you knew they suffered from mental illness?" higher proportion of caregivers with mental illness expressed significantly favorable attitude towards mentally ill.

For statement like "Would you be worried about visiting somebody with a mental illness?" significantly higher proportion of caregivers with mental illness expressed favorable attitude.

For statements from FABI, like "If somebody had been a former psychiatric patient, would you have them as a friend?", "If somebody who had been a former psychiatric patient came to live next door to you, would you greet them occasionally?", "Would you have casual conversations with neighbors who had suffered from mental illness?", Significantly higher proportion of caregivers with mental illness expressed favorable attitude towards mentally ill, while those without having mentally ill relative expressed more negative attitude towards mentally ill when these issues were posed.

Table - 1: Comparison of demographic profile of the subjects between Group I & II ((N=200)

Variables	**Categories**	**Group I** (caregivers of clients with mental illness n=100)	**Group II** (caregivers of clients with chronic medical illness n=100)	χ^2**(df)**	**P value (two tailed)**
Age in years	18-25	19%	16%	6.146 (2)	**0.046***
	26-50	52%	68%		
	51-60	29%	16%		
Gender	Male	52%	38%	3.96 (1)	**0.046***
	Female	48%	62%		
Marital Status	Married	83%	83%	1.025 (2)	0.599
	Unmarried	17%	17%		
Place of Residence	Urban	46%	37%	1.668 (1)	0.196
	Rural	54%	63%		
Educational status	Illiterate	27%	20%	8.877(3)	**0.030***
	Primary	19%	38%		
	Secondary	32%	25%		
	Graduates	22%	17%		
Occupational status	Labour	47%	53%	3.753 (3)	0.289
	Skilled	08%	08%		
	Semi-skilled	17%	08%		
	Unemployed	28%	31%		

Cont... **Table - 1: Comparison of demographic profile of the subjects between Group I & II ((N=200)**

Income in rupees	Below 1000	20%	14%	5.43 (4)	0.246
	1001- 5000	38%	36%		
	5001- 10,000	04%	12%		
	10,001 and above	09%	07%		
	No income	29%	31%		

* Significant at p<0.05 level for a two tailed test

Table 2: Comparison of group I & II based on responses for fear and behavioral intention towards mentally ill (FABI) questionnairre

FABI items	Categories	Group I N=100	Group II N =100	χ2(df)	P two tailed
I am afraid of people with mental illness	Strongly Agree	28	17	12.92(4)	0.011*
	Agree	21	14		
	Neutral	02	09		
	disagree	23	18		
	Strongly disagree	26	42		
"Would you object to having mentally ill people living in your neighborhood?"	Very likely	13	34	28.37(4)	0.000***
	Likely	09	09		
	Uncertain	02	11		
	Unlikely	36	32		
	Very Unlikely	40	14		
"Would you avoid conversations with neighbors who had suffered from mental illness?"	Very likely	09	30	29.31(4)	0.000***
	Likely	10	21		
	Uncertain	09	09		
	Unlikely	34	28		
	Very unlikely	38	12		
"Would you be willing to work with somebody with a mental illness?"	Very likely	36	12	43.05(4)	0.000***
	Likely	34	19		
	Uncertain	08	05		
	unlikely	12	15		
	Very unlikely	10	49		
"Would you invite somebody into your home if you knew they suffered from mental illness?"	Very likely	32	08	36.73(4)	0.000***
	Likely	32	18		
	Uncertain	10	12		
	unlikely	14	19		
	Very unlikely	12	43		
"Would you be worried about visiting somebody with a mental illness?"	Very likely	13	31	15.21(4)	0.004**
	likely	10	16		
	Uncertain	05	06		
	unlikely	31	25		
	Very Unlikely	41	22		

Cont... **Table 2: Comparison of group I & II based on responses for fear and behavioral intention towards mentally ill (FABI) questionnairre**

"If somebody had been a former psychiatric patient, would you have them as a friend?"	Very likely	52	28	24.65(4)	0.000***
	likely	27	21		
	Uncertain	06	06		
	unlikely	09	17		
	Very unlikely	06	28		
"If somebody who had been a former psychiatric patient came to live next door to you, would you greet them occasionally?"	Very likely	38	11	56.59(4)	0.000***
	likely	37	11		
	Uncertain	02	09		
	unlikely	11	37		
	Very unlikely	12	32		
"Would you have casual conversations with neighbors who had suffered from mental illness?"	very likely	36	14	33.69(4)	0.000***
	likely	36	19		
	Uncertain	08	10		
	unlikely	08	16		
	Very unlikely	12	41		
"If somebody who had been a former psychiatric patient came to live next door to you, would you visit them?"	Very likely	42	22	14.81(4)	0.005**
	likely	30	27		
	Uncertain	09	11		
	unlikely	09	14		
	Very unlikely	10	26		

* Significant at $p<0.05$ level

** Significant at $p<0.01$ level

*** Significant at $p<0.001$ level

Discussion

The present study assessed the level of stigma towards mental illness among caregivers of clients with mental illness and compared with the caregivers of chronic medical illness. The results, as discussed earlier are consistent with the study done by Kvistet al, who assessed the attitudes towards mental illness by student nurses with previous contact with mentally disordered persons prior to education in psychiatric nursing. The result revealed that student nurses who had experienced some type of contact with mental illness prior to education in psychiatric nursing exhibited a positive attitude, than those lacking contact, towards mental illness.[6]

Another study by Vibha et al assessed the attitudes of psychiatric ward attendants towards mental illness. Results revealed that psychiatric ward attendants had more positive attitudes than general attendants towards psychiatric illness.[7] Similarly, Crabb et al conducted a study to assess the level of stigma of the caregivers towards mental illness. The findings suggested that those individual attending non-mental health clinics had higher level of stigma towards mental illness than those attending mental health clinics.

Barke et al conducted a study to assess the attitude of the urban population towards mental illness. The results revealed that a higher level of education was associated with more positive attitude towards mentally ill people.[8] Bener et al reported that men had a better attitude towards mental illness than women. Women were more afraid than men to talk to the mentally ill. Authors insisted that knowledge of common mental illnesses was generally poor, and it seemed to be lower among women.[9] A study conducted by Linden et al which assessed the attitudes of qualified versus student mental health nurses towards individuals diagnosed with schizophrenia, revealed that nurses employed in a community setting held more positive attitudes.

Conclusion

The study results indicated that those subjects having a family member under treatment for mental illness (Group I) were more likely to show behaviorally

positive intentions towards mentally ill and the mean score was 37.21±7.13. Subjects who did not have any family member taking treatment for mental illness (Group II) expressed unfavorable attitude towards mentally ill and the mean score was 27.48±7.98. This could be due to lack of awareness about mental illness among general public and there is a need to educate the people regarding the nature of mental illness. This in turn will reduce the stigma towards mentally ill and their caregivers.

Ethical Clearance for this study was obtained from Institute Ethics committee (Human studies) from JIPMER, Puducherry.

Conflicts of Interest: Nil

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The Missing Tile Syndrome

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Abstract

When you are sitting in nice ambiance hotel, & you find that the tile in the corner of a wall is missing, u continuously start observing the same tile & think about the same instead of enjoying the great ambience. When a lady hoping for a baby, trying to conceive but unable to do so, sees all pregnant ladies everywhere she goes & thinks about the missing baby in her life. If you see one of your friends achieving a higher position in his professional life, instead of trying hard for the same you may think & become sad about your present condition. All these situations depict the missing tile or tiles in your life.

Keywords: *missing tile, syndrome, thankful, happiness*

Introduction

"The Missing Tile Syndrome" is a term given by Dennis Prager. It simply means focusing on the things that we don't have and in the process, robbing ourselves of happiness.[1]

A man with baldness may always see all people with hair & become sad for not having hair as others. A obese lady may always see slim ladies wearing nice dresses & wish to have same body. Dennis Prager, an American author and radio talk show host, calls this as the missing tile syndrome. He describes that as human beings, we tend to focus on the thing that is missing or has gone wrong frequently than what is okay. It may affect our quality of life, Maybe you are having a wonderful life full of joy but you focus only in the thing that you don't have. [2]

This is typical for most of us in our lives – there's always a tile or two missing – either in our personal lives or professional ones, we try to define ourselves by what we don't have.

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Signs of missing tile syndrome

1) Feeling of despair
2) Feeling of dissatisfaction
3) Feeling of insecurity
4) Feeling of hopeless & helpless
5) Feeling of untrustworthy
6) Feeling of disrespect

Possible solutions to fix missing tile syndrome

1) Clarify: clarify if the missing tile is really bothering you? Does it really affect you?

2) Decide: decide if you really need the missing tile in your life?

3) Power analyzing: identify if you can change the situation? Weather the situation change is in your hand?

4) Have it or leave it: if you can get the things changes then go do it, have it otherwise just let it go.

5) Replace: sometime you can find alternative for what you miss and even it can be better. [3]

Measures to avoid Missing Tile Syndrome

1) Count your blessings: just with the open mind see the many other things you have in your life. See your family, friends, relatives, job, assets etc. you have many

of them when the other may not have any. Learn to count your blessings.

2) Avoid covetousness: It is the strong will to acquire something that belongs to other people. It starts with the mind. Though some people might not see your thought, the desire to have something can become too strong, that you've always been thinking about it, that your words and action made it obvious. It is also damaging to one's life because of its unsatisfactory wishes.

3) Think positive thoughts.

4) Be thankful: Being thankful is very important. It prevents you from being bitter to other people and helps you concentrate on the things that you want in life. Choose to be thankful and enjoy the warm and happy feeling from it.

5) Volunteer to help the less fortunate.

6) Be content: Contentment is the insight that we don't actually own anything & everything in this world. Contentment helps you to avoid looking at what's missing in your life, but rather focusing on the things that you have. Contentment does not mean that you should not seek to improve yourself. It doesn't mean that you should be content with just being a burden to others while knowing very well that you could have done better.

7) Stop comparing yourself to other people.

8) Explore new things you had never done or you were scared to do.[4]

Conclusion

The Missing Tile Syndrome is a biggest obstacle towards happiness & satisfied life. But accepting your situation, being thankful and content are the great ways to deal with the Missing Tile Syndrome. Do not let it steal your happiness. Be thankful for the many great tiles in your life & learn to avoid the other missing things in your life after all it's about the games of mind.

Source of fFunding- Self

Conflict of Interest - nil.

Ethical Clearance- Taken from institutional committee

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A Study to Assess Level of Anxiety and to Identify the Factors Contributing to Anxiety among Adolescents

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Abstract

There are about 1.2 billion adolescents with the age group of 10-19 years, which comprises sixteen percent of world's population. Studies have shown that excessive stress during the teen years can have a negative impact upon both physical and mental health later in life. Putting undue pressure on children for performance in class leads to development of anxiety and granting autonomy was associated in decreasing anxietyamong children.

Objectives:-i) to assess prevalence of anxiety among adolescents, ii) to analyze the level of anxiety among adolescents and iii) to identify factors contributing to anxiety among adolescents.

Method:- A Quantitative Research Approach with Descriptive Exploratory Research Design was used to conduct the study. The study was conducted in two phases. In phase I total enumeration sampling was used to assess the prevalence and level of anxiety among 1447 study subjects using standardized tool i.e. State Trait Anxiety Inventory (STAI). In phase II, study subjects who were having high to extremely high state anxiety scores were selected by Purposive Sampling Technique to find out factors contributing to anxiety.

Results : Finding revealed that in phase I majority 51.14% study subjects had average state anxiety followed by 20.73% with high state anxiety as measured by STAI. Regarding contributory factors the main factor contributing to anxiety among study subjects included parental pressure for good academic performance with a frequency 58.43% followed by frustration in life 40.98%.

Conclusion: The present study confirms the prevalence of anxiety among adolescents and highlights the need for immediate attention towards strategies in reducing the magnitude of the problem. Their Parents need to be counseled about avoiding to put extra pressure for academic performance on their adolescents. Teachers can play a vital role in early identification of anxious adolescents and helping them in promotion of their psychological functioning.

Key Words: *Adolescents; Anxiety; Contributory Factors;*

Introduction

"*There is no such thing as pure pleasure; some anxiety always goes with it*"

(*Anonymous*)

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In absolute numbers, South Asia is having more adolescents (around 340 million) than any other region, followed by East Asia and the Pacific with around 277 million of adolescents. (UNICEF 2016)[1]

Unfortunately the modern youth is in perpetual state of anxiety, unhappiness and is withdrawn because he is not able to achieve a well-balanced placement in his present circumstances and situations.(Joshi D, Dutta I 2014)[2]

The academic achievement of adolescents who had low anxiety is better than the adolescents with high anxiety. Severalother researchers have reported that

school students with higher level of anxiety have lower academic performance. (Mohd P, Mohd S (2014)[3]

No meaningful relationship between academic anxiety and academic performance. This is very interesting to note that females are securing better marks in comparison than their male counterparts in almost all the examinations. This cannot be attributed to a single factor, but is the outcome of a number of factors such as intelligence, study habits, creativity, aptitude, interests, socio economic factors etc. S H Baversad N (2008)[4]

Along with these, gender of the students also plays an influencing factor on academic achievement. A close perusal of literature on the effects of anxiety on the academic achievement of students revealed that academic anxiety hampers the academic achievements of adolescents negatively. There are numerous studies comparing the anxiety of male and female adolescents and comparing the academic achievement of male and female students. (Karthigeya K, Nirmala K 2012)[5]

Materials and Method

Methods

The study has been conducted in BCM Arya Model Senior Secondary School, Ludhiana, Punjab. A quantitative research approach has been adopted to accomplish the objectives of the present study and was conducted in two phases Phase-I and Phase II. In phase–I Prevalence of anxiety was assessed using Descriptive Exploratory Research Design and in phase II in phase II identification of factors contributing to anxiety among adolescents was done who were having high to extremely high level of anxiety.

Hypothesis for this study were-

H_1:-There is a significant difference in the level of anxiety among male and female adolescents as measured by STAI at $p< 0.05$ level.

H_{01}:-There is no significant difference in the level of anxiety among male and female adolescents as measured by STAI at $p< 0.05$ level.

Sample and Sampling Technique

The present study is carried out in two phases.

In Phase I of the study, sample consisted of 1447 adolescents studying in 9th, 10th, 11th, and 12th class for assessment of anxiety. Total enumeration sampling was used to select the sample for assessment of prevalence of anxiety.

In phase II of the study, sample consisted of 344 adolescents selected by Purposive sampling technique who were having high to extremely high level of anxiety out of all adolescents assigned in phase I.

Tools

- **Tool I**-State Trait Anxiety Inventory (STAI) a standardized tool for assessment of anxiety among adolescents.

- **Tool II-**includedQuestionnaire for identifying factors contributing to anxiety. Structured questionnaire was constructed to identify the factors contributing to anxiety among adolescents. This tool is divided into six major headingssuch as Biological, Psychological, Social, Environmental, Situational and Interpersonal factors. It consisted of total 51 items.

Reliability of the tools

STAI is a standardized tool. Reliability of Tool II (Questionnaire for contributory factors of Anxiety) was computed in form of Stability. The reliability of Tool II was found to be 0.86, hence this tool was reliable.

Validity of the Tool

Concurrent validity and construct validity of the Tool I (STAI) have already been established as it is a standardized tool.

Validity of Tool II (Questionnaire for factors contributing to anxiety) was established by submitting the tool to experts in the field of Psychiatry, Psychiatric Nursing and Clinical Psychology.

Data Collection Process

Out of 1502 adolescents studying in classes 9th, 10th, 11th and 12th, 1447 adolescents who were meeting the inclusion criteria were selected and instructions regarding filling of Tool I were given. Tool I i.e. STAI was administered to assess occurrence of anxiety among them.Out ofthe 1447 adolescents, 344 were found to be having high to extremely high Anxiety scores on STAI. All these adolescents were enrolled for the study and Tool II (Questionnaire for factors contributing to anxiety) was administered to them. It took approximately 40 minutes to complete the tool.

Ethical Consideration

Formal written permission was taken from the Principal of the school. Informed written consent was also taken from the selected adolescents and their parents for participation.

Results

Table 1: Sample Characteristic

N= 1447

Characteristics	n	%age
Age (in years)		
14	371	25.63
15	340	23.49
16	347	23.98
17 and above	389	26.88
Class		
9th	378	26.12
10th	345	23.84
11th	368	25.43
12th	356	24.61
Gender		
Male	732	50.58
Female	715	49.41
Academic Performance (Percentage in previous class)		
< 60	31	2.14
61 – 70	312	21.56
71 – 80	601	41.53
≥81	503	34.76
Family income/ month		
<₹30,000	224	15.48
₹30,001-₹60,000	485	33.51
>₹60,000	738	51
Type of family		
Nuclear	1111	76.77
Joint	336	23.22
Father's Occupation		
Government job	410	28.33
Private job	423	29.23
Business	554	38.28
Others	60	4.14
Mother's occupation		
Home maker	862	59.57
Government job	214	14.78
Private job	210	14.51
Business	161	11.12

Table 1 deals with Demographic profile, According to Age, majority 25.63% of study subjects belonged to the age group of 14 years, followed by 23.49% in age group of 15 years.

With respect to Class, maximum 26.12% of study subjects were in 9th class followedby 10th class i.e. 23.84%.

As per Gender 50.58% of study subjects were male and remaining 49.41% were female.

As per Academic Performance in previous class maximum 41.53% of the study subjects scored 71-80% in their previous class followed by 34.76% who scored 81% and above.

With regard to Family income/month, majority 51% of study subjects had family income of >₹60,000 followed by 33.51% who had ₹30,001-₹60,000.

According to Type of family majority, 76.77% of study subjects belonged to nuclear family followed by 23.22% who belonged to joint family.

With respect to Father's occupation, fathers of 28.33% of study subjects were in government job, 29.23%.

With regard to Mother's occupation, mothers of majority of study subjects (59.57%) were home maker.

Table 2: Level of State Anxiety among Study subjects N=1447

Level of Anxiety	State Anxiety				Trait Anxiety			
	n	n%	Mean	Rank	n	n%	Mean	Rank
Extremely High	44	3.04	62.6	5	59	4.07	61.9	5
High	300	20.73	55.3	2	85	5.87	55.9	4
Average	740	51.14	49.6	1	394	27.22	46.3	2
Low	284	19.62	38.6	3	818	56.53	34.6	1
Extremely Low	79	5.45	18.2	4	91	6.28	17.1	3

Table 2 depicts the Level of Anxiety among Study subjects. Findings revealed that majority 51.14% of study subjects (mean 49.6) had average state anxiety

(rank 1st) followed by 20.73% with rank 2nd (mean 55.3) high state anxiety, 19.62% with rank 3rd (mean 38.6) low state anxiety and 5.45% with rank 4th (mean 18.2) extremely low state anxiety. Least number of study subjects 3.04% with rank 5th had extremely high state anxiety (mean 62.6). Hence it was inferred that anxiety was prevalent among study subjects.

Table 3: Factors contributing to anxiety among Study Subjects N=344

S.N.	Contributory Factors	f	f%	Rank
A	Biological Factors			
	I feel anxious because……			
1	I have family history of anxiety	32	9.30	2
2	of unfulfilment of the basic needs	67	19.47	1
B	Psychological Factors			
	I feel anxious because……			
1	I am frustrated in my life	141	40.98	1
2	I am unable to solve my problems	91	26.45	3
3	of unmet need of love and affection	111	32.26	2
C	Social Factors			
	I feel anxious because…….			
1	I belong to low socio-economic status	46	13.37	3
2	I have suffered from verbal abuse	87	25.29	2
3	I have suffered from Physical abuse	98	28.48	1
D	Environmental Factors			
	I feel anxious because ……..			
1	My parents are unemployed	12	3.4	4
2	I stay at over crowed area.	22	6.3	3
3	I live in a noise polluted area (like: -Loud Noise)	28	8.13	2
4	I don't have privacy	105	30.52	1
E	Situational Factors			
	I feel anxious when.....			

Cont... **Table 3: Factors contributing to anxiety among Study Subjects N=344**

S.N.	Contributory Factors	f	f%	Rank
1	I participate in competitive activities	61	17.73	1
	I feel anxious because.....			
2	I have lost my loved ones.	41	11.91	2
3	People always Scold me	24	6.97	3
F	Interpersonal Factors			
	I feel anxious because.....			
1	I am usually Punished bymy parents	89	25.87	2
2	My parents pressurize me for good academic performance	201	58.43	1
3	My ideas/suggestions/thoughts/opinions are not accepted	75	21.80	3

As per Table 3, Findings revealed that with respect to Biological factors, unfulfilment of basic needs was the most frequent contributory factor (19.47%) of anxiety among study subjects followed by family history of anxiety (9.30%). With regard to Psychological factors most of the study subjects reported frustration in life was most contributing to their anxiety (40.98%) followed by unmet needs of love and affection (32.26%). With respect to Social factors, the most frequent factor contributing to anxiety among study subjects was "I feel anxious because I have suffered from physical abuse (28.48%) followed by "I feel anxious because I suffered from verbal abuse (25.29%). As per findings of Environmental factors, "I feel anxious because I don't have privacy was found to be most frequent factor contributing to anxiety among study subjects (30.52%) followed by "I live in a noise polluted area (8.13%). With regard to Situational factors, most of the study subjects 17.73% found participation in competitive activity as a factor contributing to anxiety followed by "I feel anxious because I have lost my loved ones (11.91%) and "I feel anxious because people always scold me (6.97%). With regard to Interpersonal factors, Parental pressure for good academic performance was most frequent contributing factor of anxiety among study subjects (58.43%) followed by "I feel anxious because I am usually punished by my parents (25.87%) and "I feel anxious because I am neglected in my family was expressed by 17.73% of study subjects.

Hence it can be interpreted that contributory factors definitely have a role in developing anxiety among study subjects.

Discussion

In present study the prevalence of high state anxiety among adolescents was 20.73% and average anxiety was 51.14%. Similar prevalence 48.9 was reported by Khalid S Al-Galban (2007)[6]. These high prevalence rates for anxiety and stress among adolescents can be attributed to increased stresses on families undergoing social and cultural transformations. Findings of the present study are in consistent with the findings of Hess Jessica (2014)[7] which revealed that high school students often suffer from anxiety.

Bernstein A G, Garfinkd B D, Hoberman H M(1989)[8] also reported similar finding in general population of adolescents with 51.7% had high anxiety and 30.5% had low anxiety. A study conducted by Cohen I C, Magai C, Yaffee R, Brown L(2006)[9] revealed that prevalence of anxiety among adolescents was reported as lower as 14%. They further added that prevalence of anxiety among adolescents is under reported, this may be due to under reporting of the symptoms. They further added that anxious and non-anxious adolescents have substantial differences in psychological and physical health related variables.

In consistent with the present study findings Boyd C., Kostanski M, Gullone E, Ollendick T, Shek D (2000)[10] reported that the prevalence rates of anxiety among adolescent's ranges from 4.0% to 25.0% with an average rate of 8.0%. So it can be concluded that anxiety is prevalent among adolescents population though it is in varied degree.

In the present study with regard to contributory factors the main factor contributing to anxiety among study subjects included parental pressure for good academic performance with a frequency 58.43% followed by frustration in life 40.98%, and 17.73% found participation in competitive activity as factor contributing to anxiety.

Similar findings were reported by Jeffrey J W, Bryce D McLeod, Marian Sigman, Wei-Chin H, Brian C(2003)[11] they stated that putting undue pressure on children for performance in class leads to development of anxiety and granting autonomy was associated in decreasing anxietyamong children. Ollendick H T, Yule W, Ollier K (1991)[12] also reported that genetic and temperamental factors, parental influences, conditioning events, are associated with the onset of social anxiety disorder among children.

Waite P, Whittington L C (2014)[13] also reported after a systematic review that there is an association between anxiety in adolescents and perceived parental control.

Diana R L (2012)[14] reported that constant pressure from parents to perform well as the major theme in her qualitative study The Lived Experience of Anxiety among Adolescents during High School. She also concluded that the areas of improvement for the healthcare and school systems.

Conclusion

The present study confirms that state anxiety is prevalent among adolescents. Male adolescents were more anxious than female adolescents. With respect to contributory factors present study revealed that unfulfilment of basic needs, frustration in life, physical abuse, privacy issues, too much competitive activities and parental pressure for good academic performance are most reported factors leading to anxiety among them.

Conflict of Interest: No conflict of interest is involved in above research

Source of Funding: -Self

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Self-Medication Practices among Health Care Workers at Tertiary Hospital at Puducherry

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Abstract

The purpose of the study was to assess the self- medication practices among healthcare workers in south India famous hospital JIPMER, Puducherry. Study had the aim to assess the self- medication practices among health care workers , to know the common drugs used for self –medication and potential reasons contributing to self-medication practices among health care workers

The population included all staff nurses, pharmacists, radiology technicians, anaesthetists, laboratory technicians, health assistants and social workers who are working at different units of JIPMER Hospital, Puducherry. Proportionate sampling technique was used to select the sample for the present study. Sample consists of 296 health care workers in JIPMER hospital Puducherry. After getting permission from Nursing Research Monitoring Committee (NRMC) and Institute Ethical Committee (IEC), the healthcare workers of JIPMER were contacted to collect data. They were approached after the working hours, explanation about the study has been given to the healthcare workers and written informed consent has been obtained from them. Structured self-report questionnaire has been used to collect data. Each participant approximately took 30 minutes to answer the questionnaire. The findings of the study revealed that 88% of healthcare workers practicing self-medication and 12% were not practicing any form of self-medication. Majority of participant took medications like analgesics 246 (34.7) antipyretic 146 (20.3) antibiotic 78(10.8) antacid 66 (9.7).

Key words: *self-medication, Analgesics, health care worker*

Introduction

"One of the first duties of the physician is to educate the masses when not to take medicines".

-William Osler

Any alteration in health it is called a disease, every individual will experience even a mild infirmity in their life. The most effective method used to cure or prevent diseases will be medications. Medications are a drug or other form of preparations that is used to treat or prevent disease. Medications contribute to millions of untold healthcare success stories ever year- healing, ameliorating pain and symptoms, and sustaining life.

Self-medication(SM) is an issue with serious global implications[1]. Although over the counter drugs are meant for self-medication and are of proven efficacy and safety, improper use or abuse may lead to serious consequences, especially in paediatrics, geriatrics, pregnancy and lactation[2]

The World Health Organization (WHO) also has pointed out that responsible SM can help to prevent and treat ailments that don't require medical consultation and can provide a cheaper alternative for treating common illnesses. However, it is also recognized that responsible SM must be accompanied by appropriate health information[3] The practice of SM must be based on authentic medical information to avoid irrational use of drugs which, in turn can cause wastage of resources, increased resistance of pathogens and can lead to serious health hazards like prolonged sufferings, drug reaction and drug dependence[4].

Developing country like India[12], self-medication is commonly practiced as it is less expensive and due to availability of many drugs without prescription from a registered medical practitioner. The prevalence of self-medication is high all over the world with a rate of 68% in European countries and much higher in the developing countries with up to 59% in Nepal, 76% in India and 92% in Kuwait[5]. A study conducted on 307

health science students in Mekelle University. Moreover there were statistically significant differences between respondents who reported practicing self-medication based on gender, specific field of study and study year[9].

A cross-sectional observational survey was carried out among medical, pharmacy and nursing students of a tertiary care hospital, Pune. Out of 318 health science students, 88.0% were practicing self-medication whereas, 12.0% denied for taking medications on their own

A study conducted to assess the Self-medication patterns among medical students in South India as a sample of 200 students. Of the medical students surveyed, self-medication was reported among 92%. Of the respondents, 33% were unaware of the adverse effects of the medication and 5% had experienced adverse reactions. The majority (64%) of students advised medications to others, more often to family and friends[10].A two-period comparative cross-sectional study conducted to assess the Self-medication practice and factors influencing it among medical and paramedical students concluded that a significant increase was observed in number of students who took complete course of oral antibiotics[11].

Materials and method

Quantitative research approach this cross sectional study was conducted at JIPMER, Puducherry during the year 2017-2018, aimed to assess the self- medication practices and potential reasons contributing to self-medication & common drugs used for self-medication among the health care workers of JIPMER Hospital , Puducherry and to identify the socio demographic and clinical factors associated with the self-medication in health care workers. Inclusion criteria were person who has involved in health care work and aged between 18 to 60years. Health care workers who know to read English were included. Health care workers who are on regular follow-up for any illness were ecxluded from study. Sample size was estimated using the Epi data software for estimating a population with relative precision. The expected proportion of self-medication practice among health care professionals P=0.7(77.6%)[5] (Ali et al) and the sample size was estimated at 5% level of significance and 10% relative precision. The total required sample size was 295.

Propotionate sampling technique was used to select the subjects during data collection period investigator approached the participants with a brief introduction after getting due permission. The instrument used for the present study consisted of two parts which was prepared by researcher for the study consisted of 2 parts.

PART 1 was the proforma to collect the background variables. It includes the background variables of the healthcare workers which includes age, gender, educational qualification, area of work, health care experiences.

PART 2 consists of self –reported questionnaire which seek the information about practice of taking medication among health care workers which was developed by the investigators for research purpose.

Content validity was obtained from the experts from Psychiatric department , medicine department and from faculty of Nursing. Reliability also checked using test retest and split half method. After getting permission from Nursing Research Monitoring Committee (NRMC) and Institute Ethical Committee (IEC), the healthcare workers of JIPMER are contacted to collect data. They were approached after the working hours, and explanations about the study have given to the healthcare workers and written informed consent has been obtained from them. Structured self-report questionnaire have been used to collect data. Each participant approximately took 30 minutes to answer the questionnaire.

Data analysis was done using SPSS21. All statistical analyses carried out at 5% level of significance and p-value <0.05 will be considered as significant

Results

Totally 295 participants participated in the study. The findings reveal that majority of the participants are females 171(58%) and the males are 124(42%). Most of the participants have educational qualification of NURSING 130(44.1) and MBBS 99(33.6).Majority of participants are from clinical area of work 280(95).The mean age of the participants are 30 years.

Table 1: Frequency and percentage distribution of self-medication practice among health care workers n=295

Self-Medication Practice	Frequency (N)	Percentage (%)
YES	260	88
NO	35	12

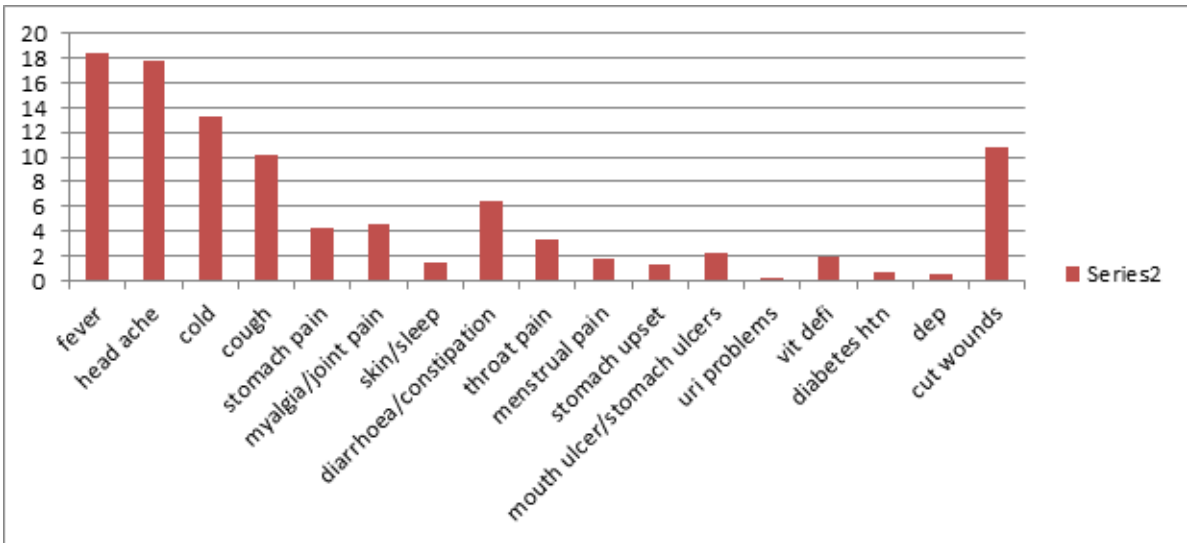

Fig1: Frequency and percentage distribution of the disease for self-medication n=295

Total responses=1255

Table 3: Frequency and percentage distribution of system wise ailments for self-medication practices

n=295

Total response=1246

Ailments	Frequency	Percentage (%)
respiratory ailments	335	27
gastro intestinal ailments	180	14.4
general ailments	691	55.4
Genitourinary ailments	25	2.0
diagnosed ailments	15	1.2

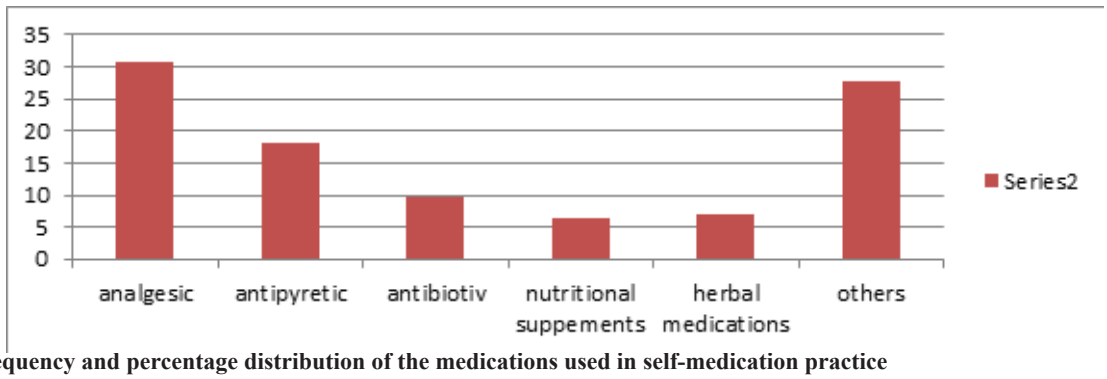

Fig 2:Frequency and percentage distribution of the medications used in self-medication practice

n=296

Total responses=801

Table 3: Frequency and percentage distribution for source of information in self-medication practice

Total response =335

Source of information	Frequency	Percentage (%)
Self-decision	182	54.3
Family members	14	4.1
Media(mass)	16	4.7
Pharmacist	38	11.3
Physician	60	17.9
Herbalist	9	2.6
Paramedical staffs	16	4.7

Above table shows the percentage and frequency distribution of source of information from which the participant have self-medication practice. Majority of participant gather information for self-medication by self-decision 182 (54.3) followed by physician 60 (17.9) pharmacist 38 (11.3)

Table 4: Frequency and percentage distribution for reason of self-medication practices n=295

Total responses=366

Reason For Taking Medication	Frequency	Percentage (%)
High cost for medications	27	7.4
not enough time to go to hospital	44	12.0
Fear of medical check-ups	8	2.9
Lack of trust in doctor	4	1.1
Pharmacist advice	10	2.7
Doctors old prescription	19	5.1
Advice from non-medical colleagues	1	0.2
Long distance to go to hospital	9	2.5
Long wait to see doctors	20	5.5
Advice from medical colleagues	104	28.4
Reluctant to consult for minor ailments	118	32.2
Can't stop medication	2	0.6
High cost for medication prescribed by doctors	27	7.4

Table 5: Association of Demographic variables with reason of self-medication as reluctant to consult doctor for minor ailments. n=295

Demographic variables	Reluctant to consult doctor for minor ailments Yes No		Chi square	P value
Sex Male Female	 77 113	 46 59	0.816	0.665
Educational qualification B pharm /Bsc/DMLT/MLT MBBS Medicine Nursing	 19 32 20 119	 4 67 23 11	109	0.000
Chronic illness Yes No	 21 169	 8 97	0.899	0.343
Area of work Clinical Non clinical	 179 11	 101 4	9.85	0.007

Discussion

A total of 295 healthcare workers were selected for the study using proportionate sampling method. The first objective of the study was to assess the self- medication practices among health care workers. The findings of the study revealed that 88% of healthcare workers practicing self-medication and 12% not practicing self-medication. The study conducted to evaluate and analyse the prevalence of self-medication practice among healthcare professionals in a private university, Malaysia. Among respondents, 77.6% were practicing self-medication supports the current study findings.[5]

The second objective of the study was to assess the common drugs used for self-medication among healthcare workers. The study findings showed that Majority of participant takes medications like analgesics 246 (34.7) antipyretic 146 (20.3) antibiotic 78(10.8) antacid 66 (9.7).This finding was supported by a study conducted at turkey[13] to assess the pattern of self-medication practices and drug use habits of among university students. The most common medicines that the students had consumed without prescription were analgesics by 39.5%, antibiotics by 36.9% and cold remedies by 24.0%.the rate of students who declared that they were familiar with rational use of antibiotics (RUA) was 45.9%[1]. Similar study findings showed that the participants used self-medications mainly for fever, headache, followed by spasmodic abdominal [symptoms11-12]

The third objective of the study was to assess the potential reasons contributing to self-medication practices among health care workers. The study findings showed that majority of participant has reasons of reluctant to consult for minor ailments 118 (32.2) advice from medical colleagues 104 (28.4) not enough time to go to hospital 44 (12) high cost of medication prescribed by doctors 27(7.4) high cost of medications 27 (7.4). A cross sectional study conducted to assess the self-medication practices among medical and pharmacy students at Jordan [17]. Compared to the general population rate of 42.5%, self-medication practice was reported by the students. Reasons for self-medication included previous disease experience (55.7%); minor ailments (55.3%); and having enough medical knowledge (32.1%). Medicines were used according to instructions obtained mainly from the leaflet (28.8%); pharmacist (20.7%); and university courses (19.7%)[9]

The fourth objective of the study was to find any association between the self -medication practices with selected demographic Variables. Areas of work and educational qualification associated with self medication

practice especially reluctant to see doctor. The study conducted about Prevalence of self-medication practices and its associated factors in Urban Puducherry, India results showed that sex, occupation, and age factors were found to be associated with self-medication[12].

Conclusion

On the basis of the findings of the present study it is recommended that similar study can be undertaken in a multi-centre level. A study can be conducted on awareness to the health care workers about self –medications problems and its consequences and importance of consulting doctors instead of taking self-medication

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The Perceived Benefit and Perceived Barriers: Against the Family Behavior in Supporting the Adherence in Consuming Drugs on Patients with Paranoid Schizophrenia

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Abstract

Paranoid schizophrenia is a type of schizophrenia that most occurs. The use of antipsychotic drugs is still being the main choice for the treatment of schizophrenia. Non-adherence in consuming drug is a common thing for patients, because the patients need to consume the drugs for a long time. The role of family is very important for the patients' treatment, but there are still many family behaviors which are less supportive against the treatment of patients with paranoid schizophrenia. There are several factors related to family behavior based on the Health Belief Model which are perceived benefits and perceived barriers.

This study was observational analytic with cross sectional approach. The samples were 182 people of families who had a family member with paranoid schizophrenia who visited the Mental Hospital of Dr. Radjiman Wediodiningrat Lawang, which selected by purposive sampling technique. Collecting data using questionnaires. Data were analyzed by univariate and bivariate. Bivariate data analysis used chi square test.

The bivariate test results showed a significant correlation between perceived benefits and perceived barriers by family behavior in supporting the adherence in consuming drug, with p-value and OR value respectively (p=0.014, OR=2.096), (p=0.015, OR=0.481).

The conclusion of this study stated that the family behavior in supporting the adherence in consuming drug could be improved with the perceived benefits and perceived barriers of family.

Keywords: *Family behavior, Perceived benefits, Perceived barriers, Adherence in consuming drugs on patients with paranoid schizophrenia*

Background

Schizophrenia is a mental disorder types that most occurs. There are different types of schizophrenia but the most common is paranoid schizophrenia[(1)]. The sufferer of paranoid schizophrenias show typical symptoms, such as auditory hallucinations and delusions that accompanied by affective disorder[(2)]. Pharmacological therapy in the form of the antipsychotic drug use is still the main choice for the treatment of schizophrenia[(3)]. Patients need to take antipsychotic medication for a long time even to the rest of their life[(4)]. This makes the patient needs to take medication regularly because in case of withdrawal would lead to a recurrence[(5)].

Non-adherence in consuming the drug is a common thing for patients with paranoid schizophrenia, they need to take drugs for a long time. In 2006, the Federation of Mental Health conducted a survey on 982 families who have family members with mental disorders, and obtained approximately 51% of patients relapse due to mental disorder stop consuming the drug and 49% relapse due to change drug dosage[(6)]. Data od non-adherence in consuming the drugs from Riskesdas showed that 84.9% of schizophrenia patients have treatment, and approximately 51.1% do not taking their medicine regularly[(7)].

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Treatments are performed in accordance with the rules will help to reduce the symptoms of psychosis, relapse prevention and may help patients return to their social environment in a faster time[8]. The role of the family is very important in the treatment of patients. Families help patients access care, including making sure patients take their medications through reminders and encouragement as well as helping the patient to make decisions about the care they need[9].

In fact there are many families that are less supportive behavior treatment of paranoid schizophrenia patients. This is because knowledge of poor families to treatment of paranoid schizophrenia patients. Lack of family support for the patient's medication adherence occur due to lack of family's understanding against drug usage instructions. The behavior of families who do not always remind and motivate patients to take medication, and lack of oversight in patients taking the drug also caused non-adherence[10].

Rosenstock introduced the Health Belief Model in the 1950s. This model describes the behavior of the family against disease prevention and treatment measures. Aspects of Health Belief Model can improve health behaviors for the better based on their perception related to the perceived benefits and perceived barriers[11].

Aspects of perceived benefits, in this aspect of the patient more compliant because the perceived benefits of treatment and the family also believes in the benefits of treatment are carried out, so that families help motivate patients to follow recommended treatment rules[12]. In addition, the benefits of treatment are considered highly effecting change for the better conditions will also strengthen the individual to serve targeted action in avoiding the gravity of the disease.

Aspects of perceived barriers, this aspect leads to a subjective assessment which includes the individual's perception of obstacles to behavioral change[13]. It is also perceived barriers help explain how perceptions of family-related obstacles that contribute to the undertaking of compliance. This can happen because they feel better to do unhealth behaviors instead of going through the perceived barriers[14].

Preliminary studies were conducted at the Poly of Mental Hospital of Dr. Radjiman Wediodiningrat Lawang in 10 families of patients through direct interviews found that all families (100%) benefit from treatment which is performed for the patients became calmer and not a tantrum, 8 families (80%) stated that the distance of residence to health services and fees transportation is quite expensive and side effects of drugs to be barriers to the family to take control and take medication the patient to the hospital. The purpose of this study is to determine the relationship between the perceived benefits and perceived barriers to family behavior support medication adherence paranoid schizophrenia patients at the Mental Hospital of Dr. Radjiman Wediodiningrat Lawang.

Methodology

The research design used in this study was observational analytic with cross sectional approach. The study population was families who had a family member with paranoid schizophrenia who visited the Mental Hospital of Dr. Radjiman Wediodiningrat Lawang. The sample used for the study were 182 people who were selected by purposive sampling and met the appropriate inclusion criteria which were the families who had family members who were already suffering from paranoid schizophrenia and outpatients at least 6 months and getting oral drug therapy, aged 30-60 years old, living at home with the patient, a family member of the patient, is able to read, write and communicate well, willing to become respondents. Collecting data using questionnaires. Belief on Medication Questionnaire (BMQ) was used to measure aspects of the perceived benefits, Urrutia's Questionnaire used to measure aspects of the perceived barriers, as well as questionnaires Morisky Medication Adherence Scale (MMAS) and questionnaire of Family Support Behaviors was used to measure the behavior of families in supporting the adherence. The data was processed and analyzed with univariate and bivariate analysis.

Result

1. Univariate analysis results

The results of the univariate analysis of demographic data of respondents were showed in Table 1 and univariate data of variables showed in Table 2.

Table 1. Univariate result of demographic data of respondents.

Characteristics of Respondents	Frequency (n)	Percentage (%)
Gender		
Male	85	46.7
Female	97	53.3
Education		
Not completed in primary school	8	4.4
Elementary School	43	23.6
Junior High School	24	13.2
Senior High School	71	39.0
Bachelor's degree	34	18.7
Master's degree	2	1.1
Occupation		
Work	127	69.8
Does not work	55	30.2
Relationships with patients		
Father	17	9.3
Mother	35	19.2
Children	21	11.5
Husband	17	9.3
Wife	12	6.6
Older brother	55	30.2
Younger brother	17	9.3
Etc	8	4.4

Table 1 showed that most of the respondents were female. Last Education level of respondents mostly was senior high school. Most of the respondents worked. The most relationship of respondents with the patient was older brother.

Table 2. Univariate result of the study variables

Variables	Category	Frequency (n)	Percentage (%)
Perceived benefits	High	99	54.4
	Low	83	45.6
Perceived barriers	High	96	52.7
	Low	86	47.3
Family behavior in supporting the adherence in consuming drug	Support	97	53.3
	Not support	85	46.7

Table 2 showed that most of respondents feel the high benefits, most of respondents felt high barriers and mostly family gave the support the adherence in consuming drug on patients with paranoid schizophrenia.

2. Bivariate Analysis Results

The results of the bivariate analysis were showed in Table 3.

Table 3. The results of bivariate analysis

Not support		Family behavior		Total	OR	p
		Support				
Perceived benefits	Low	47	36	83	2.096	0.014
	High	38	61	99		
Perceived barriers	Low	32	54	86	0.481	0.015
	High	53	43	96		

Table 3 showed that the perceived benefits and perceived barriers related to family behavior in supporting the adherence in consuming drug.

Discussion

1. Correlation the perceived benefits against family behavior in supporting the adherence in consuming the drug.

The results showed that there is a significant correlation between the perceived benefits to family behavior support medication adherence paranoid schizophrenia patients. The perceived benefits of an individual assessment related to the effectiveness of doing a healthy behavior to reduce the risk of experiencing a health problem[13]. When the family feel that the health measures undertaken have a positive impact for the condition of their family members who are sick then he will retain up to improve health behaviors.

The results also indicate that families feel the benefits of a high makes them more likely to support the treatment is done by bringing the control patients on a regular basis and support the patient's medication adherence. The benefits of the treatment is not only felt by the patient himself but felt also by the family. Pelealu, Bidjuni and Wowiling in their research stated that,

when patients feel the benefits of adherence in taking medication then the family will also feel the benefit due to changes in the patient's condition becomes better. The benefits are felt by the family will make families more support and motivate patients in taking medications, one of which is through medication adherence[15].

Assessment of the effectiveness of the drugs proven to have positive impact on self-management behaviors. Behavioral family support medication adherence in patients affected by the highest perception of the family about the effectiveness or benefit of taking the medication. Perceived positive impact on treatment outcomes can improve the perception of the family about health behavior targeted[16].

Other studies have also explained that the condition may be influenced by the respondents' level of awareness about the usefulness or effectiveness of health actions that may affect the extent to which they are an incentive to take action. If there is no confidence on the benefits of recommended, then people tend to avoid such action[17].

2. Correlation perceived barriers against the family behavior in supporting the adherence in consuming the drug.

The results showed that there is a significant correlation between perceived barriers to family behavior support medication adherence paranoid schizophrenia patients. Perceived barierr is one of the factors that influence non-adherence to treatment. Someone could not take action even though confidence in the benefits of taking such action as caused by resistance. Barriers refer to the specific characteristics of the measurement of a countermeasure as expensive, inconvenient, unpleasant or painful. These characteristics can make the individual avoid any action that would like to do[18].

The problem that most felt the distance of residence to the hospital and the high transport cost is required. The perceived problems sometimes make family too late to bring the patient to control and take drugs. These results correspond to the research conducted by Shameena, who explained that the distance from health facilities with shelter greatly affect health care seeking behavior and compliance with taking medications on a regular basis[19].

Other studies have also explained that the perceived barriers that affect the decision to take a particular action. Perceived barriers including phobic reactions, physical and psychological obstacles, cost and accessibility factors. When people realize that they have the capacity to overcome these barriers then they will only take the necessary action alone[20].

Perceived barriers also be an important predictor one which led to non-adherence to treatment is because when people feel a greater barierr than the benefits obtained treatment it will make them think twice to do so[21].

The results also show that although the family feel of a high barierr, but they are still trying to bring the patient to control every month because it has a good knowledge about the benefits of treatment. Good understanding about the benefits of treatment makes family is able to overcome perceived barriers because they do not want patients had a relapse.

This happens because the medication adherence is more likely to occur if people feel the benefits outweigh the barriers that must be experienced. On the positive expectations of the family of the efficacy of the drug will affect their confidence in treatment do so will increase support for treatment adherence committed by family members who are sick[22].

Conclusion

The conclusion of this study was the perceived benefits and perceived barriers that affected the perception of family in shaping the family behavior thus it supported the adherence of in consuming drug in patients with paranoid schizophrenia.

Conflict of Interest : None.

Source of Funding: This study used private funds of researcher.

Etichal Clearance : This study had been declared eligible by the Ethics Committee of University of Brawijaya and Health Research Ethics Commission in Mental Hospital of Dr. Radjiman Wediodiningrat Lawang.

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