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A Comparative Study to assess the Myths, Beliefs and Perceptions about Mental Disorders among the General Population in Selected Rural and Urban Areas at Gonda District, U.P. in the View to Develop an Information Booklet

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Abstract

The objective of the study is to compare the assessment of the myths, beliefs and perceptions about mental disorder in general population among urban areas. The conceptual framework used in this study was based on Rosenstock's and Becker's health Belief Model (1974). The study was used non-experimental descriptive and comparative study design. The sample comprised of general population Bhadhva Tarhar (Rural area) 300 + Pantnagar (Urban area) 300). Non-Probability convenient sampling technique was used to select the sample. Data was collected using Sociodemographic variables and likert Scale to assess the Myths, belief and perception among general population. The result presented that there was a significant difference in the rural and urban mean score and the findings were statistically significant at 0.05 level of significance. In rural 45.3% had bad level, 37.7% had poor level and 17.0% had good level of myths, beliefs and perceptions about mental disorder, where as in urban 18.3% of the samples had bad level, 48.7% showed poor and 33.0% of the samples remained with good level of myths, beliefs and perceptions about mental disorder. The investigator is grateful for the experience gained through this study.

Keywords: Myths; beliefs; Perception; General Population; Urban Area and Rural Area.

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INTRODUCTION

Mental and behavioral disorders are existing about 11% of the adult population all over the world. The mental disorders are highest among young adults, the most productive section of the people. Neuropsychiatry conditions together reason for 12% of the global problem of disease as measured by disability adjusted life years (DALYs). Plans estimation by the year 2020, neuropsychiatric conditions will account for 15%

of disabilities worldwide, with unipolar depression alone responsible for 6% of DALYs and will stand second in top 10 leading causes of in capacity.[1] *(WHO, 2019).*

In India, the occurrence of mental disorders are from 11 to 380 per 1000 population in different parts of the nation. The median conservative estimate of 65 per 1000 population has been given by Gururaj *et al.* (2015). The rates are high in females by 21-25%. As far as causation of mental illness is concerned, there are many issues similar to any other world community, but delayed health seeking behavior, cultural, illiteracy and geographic distribution of people are distinct for India.[2] *(Reddy & Chandrashekar, 2018).*

Access to adequate mental health care always falls short of both implicit and explicit needs. This can be explained in part by the fact that mental illness is still not well understood, often unnoticed, and considered an offensive. The mentally ill, their families and relatives, as well as specialists providing particular care, are still the thing of marked stigmatization. These attitudes are intensely entrenched in society. The idea of mental illness is often related with fear of potential threat of patients with such diseases. Adverse, fear, attitude and ignorance of mental illness can result in an in adequate focus on a patient's physical fitness needs. The belief that mental illness is incurable or self-inflicted can also be damaging, leading to patients not being referred for suitable mental health care.[3] *(Kishore, 2014).*

Need For the Study

Mental diseases have an effect on everybody in a way. Somebody World Health Organization has intimate with a mental illness at some purpose. However, there are still several hurtful attitudes around mental diseases that fuel stigma and discrimination and create it tougher to succeed in out for facilitate. the subsequent are the myths concerning mental state. Mental diseases aren't real diseases, mental diseases are simply associate degree excuse for poor behavior, unhealthy parenting causes mental diseases, folks with mental diseases are violent and dangerous, folks don't get over mental diseases, those who expertise mental diseases are weak and can't handle stress, those who expertise mental diseases can't work, youngsters can't have a mental state like depression and those are adult problems; everybody gets depressed as they age. It's simply a part of the aging method.[4]

Changing attitudes and behaviors takes time, and it would seem to be one person can't presumably build a distinction. Actually, everybody will realize tiny ways in which to assist. First, place confidence in wherever our info comes from. Thinking critically regarding wherever our info comes from will facilitate U.S. Separate sensational stories from balanced points of view. Second, all folks will support laws and practices in our communities that stop discrimination against people with mental diseases and promote inclusion. Third, all peoples will pay time with those that expertise mental diseases to share and learn from one another. This is often best once most are in associate degree equal position of power. Volunteering with a community organization could be a good way to attach with others.[5] *(Canadian Mental Health Association, 2017).*

A cross-sectional study was administered with a sample of 436 subjects (360 subjects from urban and rural communities of Delhi and 76 medical professionals working in numerous organizations in Delhi). A pre-tested form consisting things on perceptions, myths, and beliefs regarding causes, treatment, and health seeking behavior for mental disorders was used. The mental disorders were thought to be owing to loss of semen or vaginal secretion (33.9% rural, 8.6% urban, 1.3% professionals), less sexual desire (23.7% rural, 18% urban), excessive masturbation (15.3% rural, 9.8% urban), God's social control for his or her past sins (39.6% rural, 20.7% urban, 5.2% professionals), and impure air (51.5% rural, 11.5% urban, 5.2% professionals). A lot of individuals in rural areas than in geographical area thought that keeping fasting or a religion expert will cure them from mental diseases, where as 11.8% of medical professionals believed the same. Most of the individuals rumored that they likable to travel to somebody close who might hear their issues, after they were unhappy and anxious. Only 15.6% of urban and 34.4% of the agricultural population rumored that they might prefer to head to a medical specialist after they or their relations are stricken by psychopathy. This study concluded that the myths and misconceptions are considerably a lot of prevailing in rural areas than in urban areas and also the individuals ought to be communicated to vary their behavior and develop a positive angle toward mental disorders so health seeking behavior will improve.[6] *(Jugal, Avni, Ram, & Patrick, 2011).*

From the above study the researcher came to know there is lot of myths, beliefs and perception surveying in the society in bad level. It makes the people to away from psychiatric treatments. Therefore, it is necessary to find the level of myths, beliefs and perception on mental illness in

different places, for that the researcher chose this comparative study, so that we can increase the awareness on mental illness mental health, reduce the bad level of myths, beliefs and perception on mental illness.

Problem Statement

A comparative study to assess the myths, beliefs and perceptions about mental disorders among general population in selected rural and urban areas at Gonda district, U.P. in the view to develop an information booklet.

Objectives of the Study

1. To assess the myths, beliefs and perceptions about mental disorder in general population among rural areas at Gonda District, U.P.
2. To assess the myths, beliefs and perceptions about mental disorder in general population among urban areas at Gonda District, U.P.
3. To compare the values of myths, beliefs and perceptions about mental disorder between the general population among selected rural and urban areas at Gonda district, U.P.
4. To associate the values of myths, beliefs and perceptions about mental disorder of rural and urban with their demographic values.
5. To develop an information booklet regarding myths, beliefs and perceptions about mental disorder.

Hypothesis

H_1: There will be a significant association between the values of myths, beliefs and perceptions about mental disorder of rural and urban with their demographic values.

H_2: There will be a significant difference between the values of myths, beliefs and perceptions about mental disorder of rural and urban area population.

Operational Definitions

Comparative Study: In this study it refers that comparative study is a research methodology that aims to make comparisons between population among selected rural and urban areas at Gonda district, U.P. to assess the myths, beliefs and perceptions about mental disorders.

Assess: In this study it refers that the evaluation or estimation of myths, beliefs and perceptions about mental disorders in general population among selected rural and urban areas at Gonda district, U.P. in the view to develop an information booklet.

Myths: In this study it refers, a widely held but false belief or idea that explaining a natural or social phenomenon, and typically involving supernatural beings or events in the cases of mental disorders.

Beliefs: An acceptance that something exists or is true, especially one without proof in the attitude towards mental illness.

Perceptions: In this study it refers, the ability to become aware of the nature of mental disorder.

Mental disorders: A mental disorder, also called a mental illness or psychiatric disorder, is a behavioral or mental pattern that causes significant distress or impairment of personal functioning. Such features may be persistent, relapsing and remitting, or occur as a single episode.

Information booklet: A small, thin book with paper covers, typically giving information on amyths, beliefs and perceptions about mental disorders in general population.

Assumptions

1. The information booklet helps an individual to get the knowledge about mental illness.
2. Myths, belief and perceptions are more common in rural areas.
3. There will be a little different in values of myths, beliefs and perceptions about mental disorder of rural and urban area population.
4. Information book let help to improve the awareness among rural and urban area population.

Delimitations

The study will be limited to:

1. 600 (300 from rural area+300 from urban area) general population from Bhadhva Tarhar (Rural Area) & Pantnagar (Urban Area).
2. This study only involves the general population from selected area from Gonda district, Uttar pardesh only.

Review of Literature

Review of literature related to prevalence of mental disorder.

Ganguli (2015) conducted a study, during these fifteen epidemiological studies on psychiatric morbidity in India are analyzed. National all India prevalence rates for 'all mental disorders' and 5 specific disorders are discovered the national prevalence rates for 'all mental disorders' found out are 71 (Rural), 73 (Urban) and 73 (Rural + Urban) per 1000 population. Prevalence of schizophrenia

is 2.5/1000 and this looks to be the sole disorder whose prevalence is consistent across cultures and over time. Rates for depression, neurosis, hysteria and stupidity are provided. Urban morbidity in India is 4% over the rural rate, however rural urban variations aren't consistent for various malady classes. In Hindi speaking north India, mental morbidity amongst factory staff is 2 and half times that of the non-industrial urban inhabitants and 5 times the rural morbidity. This information is anticipated to function baseline rates for mental health planners and for psychiatrists curious about epidemiological studies.[7]

Review of Literature related to Myths, Beliefs and Perception about Mental Disorder

Jugal, Avni, Ram, & Patrick, (2011) conducted a cross-sectional study. They administered with a sample of 436 subjects there in 360 subjects from urban and rural communities of city and 76 medical professionals working in several organizations in Delhi. A pre-tested questionnaire consisting things on perceptions, myths, and beliefs regarding causes, treatment, and health-seeking behavior for mental disorders was used. The collected knowledge was statistically analyzed exploitation laptop software system package Epi-info. The result shows that the mental disorders were thought to be owing to loss of humor or channel secretion (33.9% rural, 8.6% urban, 1.3% professionals), less physical attraction (23.7% rural, 18% urban), excessive masturbation (15.3% rural, 9.8% urban), God's penalty for his or her past sins (39.6% rural, 20.7% urban, 5.2% professionals), and impure air (51.5% rural, 11.5% urban, 5.2% professionals). A lot of individuals (37.7%) living in joint families than in nuclear families (26.5%) believed that unhappiness and unhappiness cause mental disorders. 34.8% of the agricultural subjects and 18 of the urban subjects believed that youngsters don't get mental disorders, which suggests they need conception of adult oriented mental disorders. 40.2% in rural areas, 34% in urban areas, and 8% professionals believed that mental diseases are untreatable. Only 15.6% of urban and 34.4% of the rural population according that they might wish to attend a psychiatrist once they or their members of the family are stricken by mental illness.[8]

MATERIALS AND METHODS

Research Approach: Research approach could be a arrange and procedure that consists of the steps of broad assumptions to elaborate technique of information collection, analysis and interpretation. it's thus, supported the character of the analysis drawback being self-addressed. The research approach selected for this study is quantitative approach.

Research Design: The research design refers to "the researcher's overall plan for obtaining answer to the research question and it spells out strategies that the researcher adopted to develop information that is accurate, objective and interpretable."[9]

It helps the researcher in selection of subjects, comparison of two groups. In this study the non-experimental descriptive and comparative study design was done. This design helps the researcher to compare two groups to find the different between the variations among samples.

Variables under the study

Study Variable: The study variable in this study is general populations' level of myths, beliefs and perception about mental illness.

Socio Demographic Variables: It consists of gender, age in years, type of family, family income per month, education, religion, occupation and experienced mental disorder in family.

Setting of the Study: Setting is a physical location and condition in which data collection takes place. The investigator selected two areas Bhadhva Tarhar (Rural area) & Pantnagar (Urban area) in Gonda district for the present study.

Population: Bhadhva Tarhar (Rural area) compresses the population of approximate 4930 and Pantnagar (Urban area) compresses the population of approximate 3500.

Sample: In this study the samples are from Bhadhva Tarhar (Rural area) 300 + Pantnagar (Urban area) 300.

Sample Size: In this study the sample size is 600. 300 from Bhadhva Tarhar (Rural area) and another 300 from Pantnagar (Urban Area).

Sampling Technique: For selection of the sample the Non-Probability convenient sampling technique was used.

Sampling Criteria: The sample was selected with the following predetermined set criteria during the period of study.

Inclusive Criteria:

1. Those who are interested to participate in this study.
2. Those who are available on the day of data

collection.

3. Those who can speak Hindi Language.
4. Those who are aged more than 14 years.

Exclusion criteria:

1. Those who are not able to understand the concept of the research study.
2. Those who don't know Hindi language.
3. Those who are aged less than 15 years.

Description of the Research Tool

Section A: Demographic variable which include gender, age in years, type of family, family income per month, education, religion, occupation and experienced mental disorder in family.

Section B: It consists of likert Scale to assess the Myths, belief and perception among general population. It has 30 questions. Each question has 5 likert scale options such as strongly agree, mildly agree, neutral, mildly disagree and strongly disagree.

Maximum Mark per items = 4; Minimum Mark per item = 0; Maximum mark for the questionnaire = 120; Minimum mark for the questionnaire = 0.

For Positive Questions: Strongly agree = 4; Mildly Agree = 3; Neutral = 2; Mildly Disagree = 1; Strongly Disagree = 0.

For Negative Questions: Strongly agree = 0; Mildly Agree = 1; Neutral = 2; Mildly Disagree = 3; Strongly Disagree = 4.

Pilot Study: Pilot study was conducted from 28-11-2018 to 16-12-2018 in Bhadhva Tarhar (Rural area) & Pantnagar (Urban area). The pilot study was conducted to check the clarity, reliability and feasibility of the research tool. 60 samples who fulfilled the inclusion criteria were selected by Non-Probability convenient sampling technique. 30 from rural area and 30 from urban area.

RESULTS

Table 1: Percentage and frequency distribution of respondents by gender, age in years, type of family and family income per month

N = 300+300=600

Demographic Variable	Rural Area		Urban Area	
	Frequency	Percentage	Frequency	Percentage
Gender				
Male	150	50	150	50
Female	150	50	150	50
Age in years				
15-25	42	14	44	15
26-35	80	27	55	18
36-45	90	30	121	40
46-55	61	20	51	17
56 and above	27	9	29	10
Type of family				
Nuclear family	94	31	155	52
Joint family	206	69	145	48
Family income per month (in Rupees)				
Below 10000	81	27	55	18
10000 to 20000	189	63	163	54
Above 20000	30	10	82	27

The above table 1 implies that in rural and urban area maximum 150 (50.0%) respondents are males. In rural area maximum 90 (30.0%) respondents were 36-45 years old. In urban area maximum 121 (40.3%) respondents were aged between 36-45 years old. In rural area maximum 206 (68.7%) respondents were belongs to joint family In urban area maximum 155 (51.7%) respondents were from nuclear family. In rural area maximum 189 (63.0%) respondents family income per month was Rs. 10000 to Rs. 20000. In urban area maximum 163 (54.3%) respondents family income per month was Rs. 10000 to Rs. 20000.

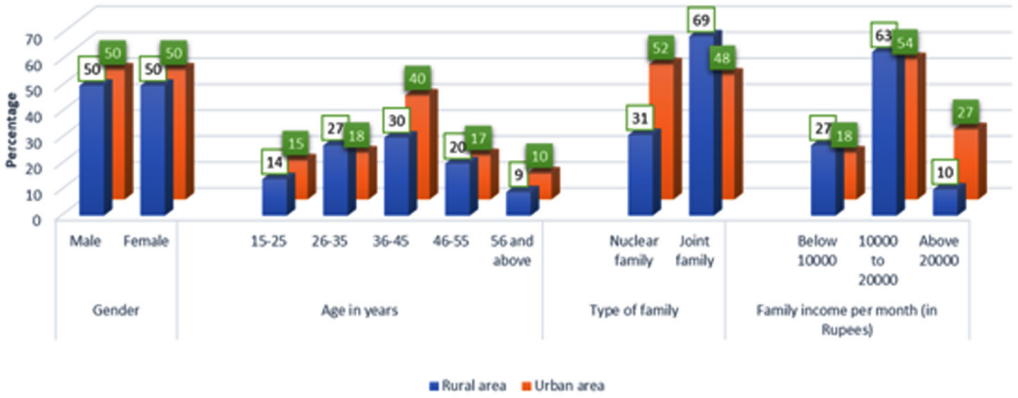

Fig. 1: Percentage distribution of gender, age in years, type of family and family income per month

Table 2: Percentage and frequency distribution of respondents by education, religion, occupation and experience of mental disorders in family.

N = 300+300=600

Demographic Variable	Rural Area		Urban Area	
	Frequency	Percentage	Frequency	Percentage
Education				
Illiterate	191	64	22	7
Primary Education	49	16	116	39
Graduate	31	10	100	33
Postgraduate	29	10	62	21
Religion				
Hindu	182	61	150	50
Muslim	69	23	96	32
Christian	27	9	28	9
Other religion	22	7	26	9
Occupation				
Unemployed	21	7	15	5
Private job	59	20	99	33
Government job	42	14	56	19
Business	32	11	63	21
Coolie	76	25	42	14
Agriculture	70	23	25	8
Experience of mental disorders in family				
Yes	61	20	70	23
No	239	80	230	77

The above table 2 implies that in rural area maximum 191 (63.7%) respondents were illiterate. In urban area maximum 138 (46.0%) respondents' maximum education was primary education. In rural area maximum 182 (60.7%) respondents and in urban area 133 (44.3%) respondents were Hindu. In rural area maximum 76 (25.3%) respondents are coolie workers. In urban area maximum 99 (33.0%) respondents were in private job. In rural area maximum 239 (79.7%) respondents and in urban area 230 (76.7%) respondents were not experienced mental disorder in their family.

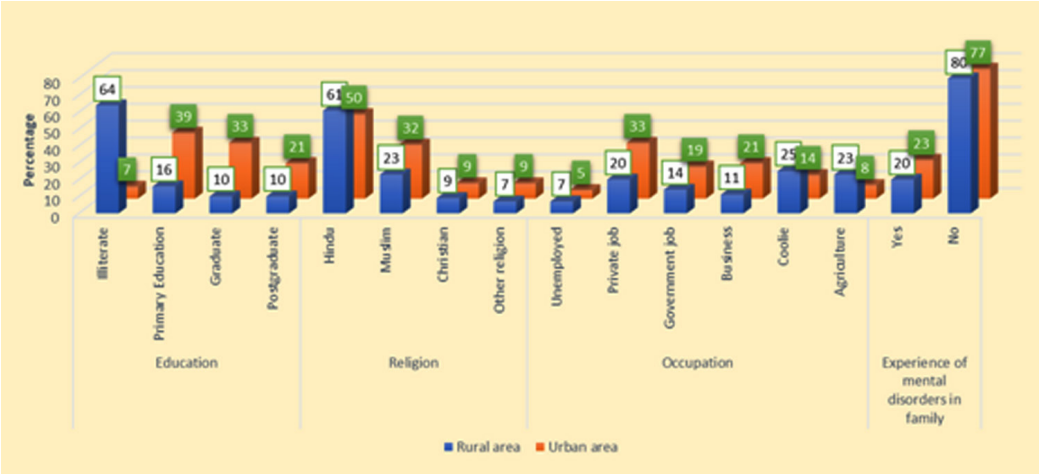

Fig. 2: Percentage distribution of education, religion, occupation and experience of mental disorders in family

Table 3: Compare the level of myths, beliefs and perceptions about mental disorder between the general population among selected rural and urban areas

N=300

Level	Rural Area		Urban Area	
	Frequency	Percentage	Frequency	Percentage
Bad	136	45%	55	18%
Poor	113	38%	146	49%
Good	51	17%	99	33%

Above table 3 compares the rural and urban area samples level of myths, beliefs and perceptions about mental disorder. In rural 45.3% had bad level 37.7% had poor level and 17.0% had good level of myths, beliefs and perceptions about mental disorder, where as in urban 18.3% of the samples had bad level, 48.7% showed poor and 33.0% of the samples remained with good level of myths, beliefs and perceptions about mental disorder.

Table 4: Find the significant difference between rural and urban area general populations' level of myths, beliefs and perceptions about mental disorders

N=300+300=600

S. no.	Area	Mean	Mean %	SD	SE	'z' value	'p' value
1	Rural	60.39	50.3	29.637	2.18	9.3	0.05
2	Urban	81.00	67.50	23.390			

The above table 4 shows that the calculated z value is more than the tabulated value 2.0 at 0.05 level of significance, therefore the hypothesis H2 was accepted. It shows that there is a significant difference between the rural and urban area general populations level of myths, beliefs and perceptions about mental disorder.

Table 5: Associate the values of myths, beliefs and perceptions about mental disorder of rural area with their demographic values.

N=300

Demographic variables	Level		N	df	$\chi 2$	P-value	P<0.05
	Below Median	>= Median					
Gender							
Male	78	72	150	1	0.05	3.84	NS
Female	76	74	150				

table cont.....

Age in years							
15-25	20	22	42				
26-35	44	36	80				
36-45	37	53	90	4	10.20	9.49	S
46-55	33	28	61				
56 and above	20	7	27				
Type of family							
Nuclear family	40	54	94	1	4.22	3.84	S
Joint family	114	92	206				
Family income per month							
Below 10000	47	34	81				
10000 to 20000	88	101	189	2	4.90	5.99	NS
Above 20000	19	11	30				
Education							
Illiterate	87	104	191				
Primary Education	42	7	49	3	34.89	7.82	S
Graduate	18	13	31				
Postgraduate	7	22	29				
Religion							
Hindu	87	95	182				
Muslim	42	27	69	3	9.31	7.82	S
Christian	18	9	27				
Other religion	7	15	22				
Occupation							
Unemployed	12	9	21				
Private job	29	30	59				
Government job	27	15	42	5	14.79	11.07	S
Business	15	17	32				
Coolie	27	49	76				
Agriculture	44	26	70				
Anybody experienced mental disorder in the family?							
a) Yes	22	39	61	1	7.14	3.84	S
b) No	132	107	239				

S=Significant; NS=Non-Significant

The above chi-square Table 5 shows the following that there is a significant association between myths, beliefs and perceptions score and age in years, type of family, family income per month, education, religion, occupation and experienced mental disorder in family as the chi-square value 10.20 is higher than the tabulated value 9.49. Therefore, the H1 is accepted.

Table 6: Associate the values of myths, beliefs and perceptions about mental disorder of urban area with their demographic values.

N=300

Demographic variables	Level		N	df	$\chi 2$	P-value	P<0.05
	Below Median	>= Median					
Gender							
Male	82	68	150	1	0.34	3.84	NS
Female	87	63	150				

table cont.....

Age in years							
15-25	24	20	44	4	9.65	9.49	S
26-35	40	15	55				
36-45	64	57	121				
46-55	23	28	51				
56 and above	18	11	29				
Type of family							
Nuclear family	81	74	155	1	2.17	3.84	NS
Joint family	88	57	145				
Family income per month							
Below 10000	30	25	55				
10000 to 20000	94	69	163	2	0.26	5.99	NS
Above 20000	45	37	82				
Education							
Illiterate	11	11	22	3	7.93	7.82	S
Primary Education	73	43	116				
Graduate	59	41	100				
Postgraduate	26	36	62				
Religion							
Hindu	80	70	150				
Muslim	57	39	96	3	9.91	7.82	S
Christian	22	6	28				
Other religion	10	16	26				
Occupation							
Unemployed	8	7	15				
Private job	54	45	99				
Government job	38	18	56	5	6.46	11.07	NS
Business	29	34	63				
Coolie	26	16	42				
Agriculture	14	11	25				
Anybody experienced mental disorder in the family?							
Yes	47	23	70	1	4.34	3.84	S
No	122	108	230				

S=Significant; NS=Non-Significant

The above chi-square Table 6 shows that there is a significant association between myths, beliefs and perceptions score and age in years, education, religion, and experience of mental disorder in family as the chi-square value 9.65 is higher than the tabulated value 9.49. Therefore, the H1 is accepted.

DISCUSSION

In this study the comparison of the rural and urban area general population's level of myths, beliefs and perceptions about mental disorder says that in rural area 45.3% had bad level 37.7 % had poor level and 17.0% had good level of myths, beliefs and perceptions about mental disorder, where as in urban area 18.3% of the samples had bad level, 48.7% showed poor and 33.0% of the samples remained with good level of myths, beliefs and perceptions about mental disorder.

A similar study result was observed by (Jugal, Avni, Ram, & Patrick, 2011) they said 74.4% of rural subjects, 37.1% of urban subjects had bad level of myths, beliefs and perception about mental illness. They conducted a cross sectional study with a sample of 436 subjects from urban and rural community in Delhi, India.

CONCLUSION

The finding of the study shown that there was a

poor or bad level of myths, beliefs and perceptions. This need to be changed therefore, based on this study different measures can be taken at various levels to improve their understanding and performance towards mental disorder. The findings of the study have implications for nursing practice, education, administration and research.

Summary

The investigator felt a deep sense of satisfaction for having undertaken this study. The investigator has drawn many conclusions based on the study findings. The expert opinions and directions from the guide and the experience during the study helped to give suggestions and recommendations for further studies. This chapter suggested ways and means that could be adopted in future to improve the general population knowledge on mental illness. The direction, support and encouragement given by the guide were appreciable and made the experience fruitful and highly rewarding.

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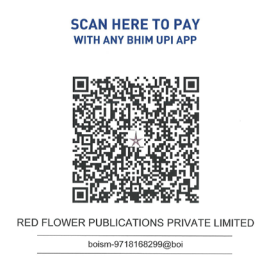

Original Article

Journal of Psychiatric Nursing
Volume 12 Number 3 September – December 2023
DOI: http://dx.doi.org/10.21088/jpn.2277.9035.12323.2

A Quasi Experimental Study to Evaluate the Effectiveness of Pranayama on the Level of Stress and Coping among Care givers of Mentally Ill Clients in Selected Hospitals

K. Vara Prasath Babu

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Abstract

The research approach used in this study is quantitative approach. Their research design adopted for the study was quasi experimental non equivalent control group design Setting of the study was Rathna institute of mental health & Rammental hospital. The sample size was 60, in which 30 belongs to experimental and 30 belongs to control group. Samples were recognized based on the inclusion criteria and selected by non-probability purposive sampling technique.

Keywords: Stress; Coping; Family Care Givers; Mentally Ill Clients; Psychiatric Nurses.

INTRODUCTION

Family[1] caregivers experiencing extreme stress have been shown to age prematurely. The level of stress can take as much as 10 years off a family care giver's life.

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MATERIALS AND METHODS

The research approach used in this study is quantitative approach. Their research design adopted for[2] the study was quasi experimental non equivalent control group design. The sample size was 60, in which 30 belongs to experimental and 30 belongs to control group. Samples were recognized based on the inclusion criteria and selected by non-probability purposive sampling technique.

RESULTS

Level of stress among care givers of mentally ill clients: [3,4]In control group 7 (23%) had severe stress, 18 (60%) had moderate stress & 5 (17%) had mild stress & none in little stress at pre-test & 7 (23%) had severe stress, 18 (60%) had moderate stress & 5 (17%)had mild stress, remaining 0 (0%) was moved from little

stress to little stress In experimental group 3 (10%) had severe stress 20 (67%) moderate stress 7 (23%) had mild stress & none in little stress at pre-test & none in severe stress & moderate stress 18 (60%) moved from moderate stress to mild stress & 12 (40%) had little stress in post-test. In control group 28 (90%) of care givers had low level of coping & 2 (10%) had high level of coping at pre-test & 27 (85%) had low level of coping & 3 (15%) had high level of coping at post-test. In experimental group 20, (60%) of care givers had low level of coping & 10, (40%) at high level of coping in pre-test and 0 (0%).

Comparison of the Level of Stress and Coping among Care givers of Mentally Ill Clients

The pre-test and post-test level of stress and coping levels in control group revealed.

That[5] the 't' value of stress is 0.23 and 't' value of coping was 0.34.

Effectiveness of pranayama on stress and coping

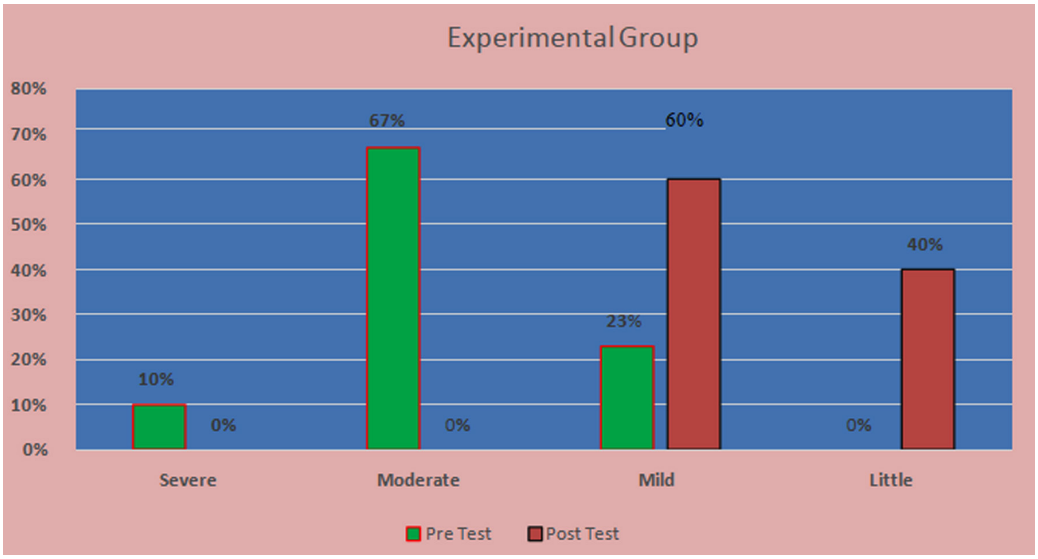

Fig. 1 a: Frequency and percentage distribution of the pre-test and post-test level of stress scores among care givers of mentally ill clients in experimental group

The mean post test score was lower in experimental group than

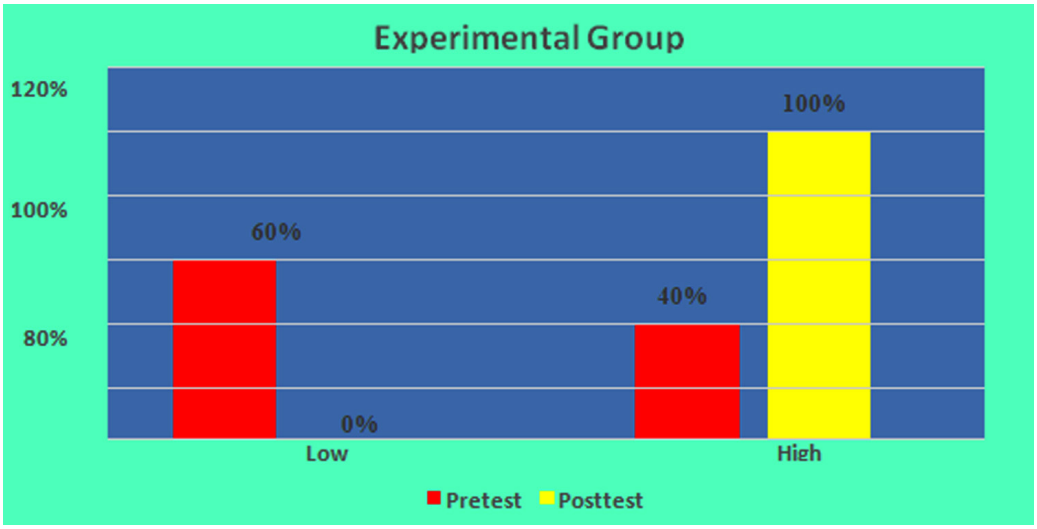

Fig. 1b: Frequency and percentage distribution of the pre-test and post-test level coping of care givers of mentally ill clients in experimental group

The mean post test score was higher in experimental group

among care givers of mentally ill clients by comparing the post test scores of experimental groups

Correlation between the Stress and Coping among care Givers of Mentally ill Clients

The study shows the correlation between stress among care givers. The obtained pre-test mean score was 49.6 with a SD of 9.94 & obtained level of coping mean score was 22 with SD of 8.04 The 'r' value was -0.3 which shows a negative correlation which is significant at 0.05 level.

DISCUSSION

When the stress is increases the level of coping decreases among the care givers & when the level of coping increases, the level of stress decreases.

Association between level of stress and coping among care givers of mentally ill clients with selected demographic variable

There was a significant association found with number of admission ($p<0.02^*$) in pre-test level of coping among care givers of mentally ill clients in experimental group at $p<0.0001$

CONCLUSION

The main study findings show that the existing level of coping was low and stress level was high among care givers of mentally ill clients, So the researcher planned for administering pranayama to reduce the level of stress and improve coping. The results revealed after the pranayama there was a significant increase in the level of coping and decreased level of stress among care givers of mentally ill clients.

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Original Article

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Assess the Effectiveness of Structured Teaching Programme on Prevention of Hepatitis-B among Bsc Nursing 1St Year Students at Selected Nursing College, Badrachalam

B. Rajesh

How to cite this article:
B. Rajesh/Assess the Effectiveness of Structured Teaching Programme on Prevention of Hepatitis-B among Bsc Nursing 1St Year Students at Selected Nursing College, Badrachalam/J Psychiatr Nurs. 2023;12(3):105–108.

Abstract

The study aimed to assess the knowledge of Nursing students before administering a structured teaching program on the prevention of Hepatitis-B and to Administer a structured steaching program on the prevention of Hepatitis-B.

In this study, a descriptive research approach was used with, one group pre-test post-test quasi-experimental research design. Non-probability purposive sampling technique was used to select the participants (n=60). A self-structured questionnaire was administered as a tool and the collected data was analyzed. The study result has shown that among 60 students, in the pre-test knowledge score, 12 (20%) were having in adequate knowledge, 43 (71.7%) were having moderate knowledge, and only 5 (8.3%) students were having adequate knowledge. Where as in post-test majority i.e. 38 (63.4%) were having adequate knowledge, 20 (33.3%) were having moderate and only 2 (3.3%) students were having inadequate knowledge. This indicates that the post-test knowledge score is greater than the pre-test knowledge score Hence the difference between the pre-test and post-test overall knowledge score was 57.46%. So the results of the study show the difference between the pre-test and post-test knowledge scores of the students regarding the prevention of Hepatitis-B.

Keywords: Assess; Effectiveness; Hepatitis-B; Nursing; Social Media; Health Education.

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INTRODUCTION

Hepatitis Bis a systemic infection of the liver and is affected by the Hepatitis-B virus & transmitted by mainly the parental route. Hepatitis-B infection can cause progressive liver diseases like chronic Hepatitis & Hepatocellular carcinoma. More than 2 billion people worldwide have evidence of past or current Hepatitis-B virus infection and 350 million are chronic carriers of

the virus, which is harbored in the liver, the virus causes 60-80% of all primary liver cancer, it is one of the three top causes of cancer death in East and South-East African Region, the Pacific Basin and Sub-Saharan Africa. Approximately 2 billion people are affected by Hepatitis B worldwide, of whom more than 350 million are chronically infected.

Hepatitis B has become a major public health problem. From 1979-1989 occurrence of acute Hepatitis-B increased by 37% and probable 1 million persons with chronic Hepatitis-B virus infection are potentially infectious toot hers. Keeping in view the changing epidemiological profile of Hepatitis B in rural populations and there is a need for educating the target group. The investigator planned to construct a structured teaching program that will be administered to the adults and test its effectiveness in achieving the desired goal.

MATERIALS AND METHODS

The objectives of the study were to assess the knowledge of prevention of Hepatitis-B among 1st year Nursing Students. A descriptive research approach with a Non-experimental research design was adopted for this study. Non-probability purposive sampling technique was used to select the participants (n=60). Nursing students from Maruthi College of Nursing were selected. The tool used for the study is a self-structured questionnaire, it is organized as Section-I Socio-demographic data, Section-II Questionnaire on Prevention of Hepatitis-B. All the items were prepared by the researcher based on reviews, previous studies, journals, magazines, and research articles on Hepatitis-B. Ten experts constituting of three psychiatrists, two psychologists, and six mental health nursing personnel validated the Tool. The reliability was assessed by using Karl Pearson's Correlation co-efficient. The obtained reliability was 0.93 which indicates that the tool which is taken by the researcher is reliable, valid, and predictable of the desired objective. The data were analyzed by using descriptive and inferential statistics.

RESULTS

Table 1: Analysis of pre-test and post-test knowledge scores on prevention of Hepatitis-B among 1st year nursing students.

N=60

Knowledge Level	Pre Test		Post Test	
	Knowledge	%	Knowledge	%
In Adequate	12	20%	2	3.3%
Moderate	43	71.7%	20	33.3%
Adequate	05	8.3%	38	63.4%
Total	60	100%	60	100%

The study result has shown that among 60 students, in the pre-test knowledge score, 12 (20%) were having inadequate knowledge, 43 (71.7%)were having moderate knowledge, and only 5 (8.3%) students were having adequate knowledge.Where as in post-test majority i.e. 38 (63.4%) were having adequate knowledge, 20 (33.3%) were having moderate and only 2 (3.3%) students were having inadequate knowledge. adolescents, 31 (51.67%) had Inadequate knowledge, 28 (46.67%) had moderate knowledge and 1 (1.67%) had adequate knowledge regarding Internet addiction.

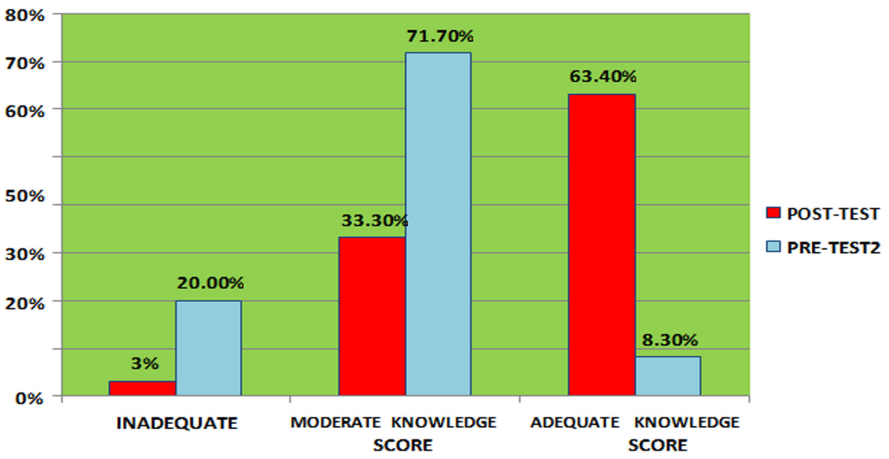

Fig. 1: Bar diagram representing the knowledge score of pre-test and post-test

Table 2: Mean and standard deviation value of knowledge on Hepatitis-B among students.

N=60

	Mean	S.D	Mean Difference	Paired 't' Test
Pre-test	9.7	3.06	4.1	t=57.56
Post-test	13.8	2.91		

Table 2 shows that in Pre-test the Mean value of the knowledge on Hepatitis-B among students was 9.7 and the Standard deviation was 3.06. Where as in Post-test mean value is 13.8 and Standard deviation was 2.91. The mean difference is 4.1 and t value is 57.56. This indicates that there is significant difference between pre-test and post-test knowledge score. Hence H1 is accepted. Therefore, it is establish that the structured teaching programe regarding prevention of Hepatitis-B was effective in enhancing the knowledge score of 1st year nursing students.

Chi square is computed to determine the significance association between revention of Hepatitis-B with demographic variables. From that significant association is found between prevention of Hepatitis-B with gender. And non-significant association with age, parental education, parental occupation, family income, and source of information.

DISCUSSION

Among 60 students, in the pre-test knowledge score, 12 (20%) were having in adequate knowledge, 43 (71.7%) were having moderate knowledge, and only 5 (8.3%) students were having adequate knowledge. Where as in post-test majority i.e. 38 (63.4%) were having adequate knowledge, 20 (33.3%) were having moderate and only 2 (3.3%) students were having inadequate knowledge. ado-lescents, 31 (51.67%) had Inadequate knowledge, 28 (46.67%) had moderate knowledge and 1 (1.67%) had adequate knowledge regarding Internet addiction. The mean difference is 4.1 and t value is 57.56. This indicates that there is significant difference between pre-test and post-test knowledge score. Hence H1 is accepted. Therefore, it is establish that the structured teaching programe regarding prevention of Hepatitis-B was effective in enhancing the knowledge score of 1st year nursing students.

The implications have been drawn from the present study were of vital concern to students and Teachers should take an active part in giving accurate and correct information regarding prevention of Hepatitis-B. Teacher themselves should under go training in the area regarding prevention of Hepatitis-B so that they have adequate knowledge, which can be imparted to the students.

The professional nurses must be aware of Hepatitis-B, its symptoms, causes, complications, management and its prevention etc. They should be able to educate the 1st year nursing students regarding Hepatitis-B and its prevention. Nurse must beaware of preventive measures which should use at the time handling Hepatitis positive patient and make them understand the benefit and practice of new method. Since the nursing students are consider as the vulnerable group, special care and concern to be given to them to prevent from getting Hepatitis infection.

Nurses as a administrator should take the initiative in organizing continuing education programme on prevention of Hepatitis-B for the nursing personal in the hospital and community setting with modern technological vedio-aid to gain adequate knowledge regarding prevention of Hepatitis-B and to reduce the incidence of Hepatitis-B.

There is need for extensive and intensive research in the aspect of prevention of Hepatitis-B.

Nursing students should actively conduct research in this so as to become aware with latest issues. Disseminate the findings of the study through conferences, seminars and publishing in nursing journals, public mass media will promote the utilization of research finding in the prevention of Hepatitis-B.

CONCLUSION

The implications have been drawn from the present study were of a vital concern to the students in order to improve their knowledge as they are directly dealing the patients in their day to day practices. Nurses should import the knowledge to public through Awareness programs.

There is a need for the provision of Health education program. The findings of the study have implications in various areas like nursing service, nursing education, nursing administration

and nursing research. It is recommended to do same study at different areas like large sample in different settings can be conducted.

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A Study to assess Attitude Regarding E-Health among Nursing Students

Yashpreet Kaur[1], Jatinder Kaur[2]

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Abstract

Background: Today technology covers all work sectors through out the world, including health sector. E-Health is a broad term, defined by WHO as the use of Information and Communication Technology (ICT) for health. It may involve communication between healthcare providers forsuch activities as online referrals, electronic prescribing and sharing of electronic health records. It can also provide access to information database, knowledge resources and decision support tool to guide service delivery. E-Health has the potential to not only improve health, but also decrease healthcare costs, enhance scientific understanding of health issues, increasing equity of healthcare and improve communication between and amongst healthcare providers. In a more philosophical sense it has been suggested E-Health is 'a commitment for networked, global thinking, to improve healthcare locally, globally and worldwide by using information and communication technology.

Problem Statement: A Descriptive study to assess attitude regarding E-Health among B.Sc. Nursing 1st Year students of Selected College of Nursing, Amritsar, Punjab.

Objectives: 1. To assess attitude regarding E-Health among B.Sc.Nursing 1st year students.

2. To as certain association of attitude regarding E-Health among B.Sc. Nursing 1st year students with selected socio-demographic variables.

Material and Method: A descriptive study was conducted to assess the attitude regarding E-Health among 65 B.Sc nursing 1st year students, who were selected by using convenient sampling technique. The knowledge regarding E-Health was assessed using attitude scale. *Results:* Results revealed that all (100%) the students had positive regarding E-Health.

Conclusion: The result of the studydemonstrates that all of the students had positive attitude regarding E-Health.

Keywords: E-Health; Attitude; Nursing Students.

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INTRODUCTION

The year 2014 is a watershed in the history of Indian Republic. This is significant as said year has heralded the beginning of new era. This is era of 'Digital India'. The Digital India program

is a initiative of honorable Prime Minister' Mr. Narendra Modi'will emerge new progressions in every sector and generates innovative endeavors.

This programme has been envisaged by Department of Electronics and Information Technology (Deity) and will impact ministry of communication and IT ministry of health and others. This programme will also benefit all states and Union territories. The motive behind the concept is to build participative, transparent and responsive system. Digital India is a large umbrella National programme that focuses at providing universal accessibility to all digital resources for citizens. Digital infrastructure will focus on providing high speed secure internet. Governance and services across departments and making services available in real time for both online and mobile platforms.[1]

The vision of Digital India is Digital empowerment of citizens creation of digital in frastructure and delivery of governance and services on demand. E-Health is the single most important revolution in health care since the advent of modern medicine, vaccine or even public health measures like sanitation and clean water. The term E-Health has been in use since the year 2000. E-Health encompasses much of medical information but tend to prioritize the delivery of clinical information, care and services rather than the function of technologies.[2]

The World Health organization (WHO) has estimated that the proportion of people over 60 years of age will double in 22% in 2050 from 11% in 2000. Thus over 2 Billion will require additional medical support even assisted living as they will be prone to health related issues E-Health services provide timely health care and quality of care. However as the technology becomes more prevalent and number of users increases, then programmes may offer an efficient alternative to meet escalating demands of a rapidly changing health care environment. Because it is an area of rapid change, the research method used must be able to anticipate the impact of new innovative web technologies that are just emerging and will emerge in future.[3]

E-Health facilitation of chronic disease management has potential to add to program components, increase engagement and effectiveness and extend access forunder served groups. System have been developed for specific chronic condition, particularly diabetes but generic chronic disease management systems are also needed to structure overall cases, especially for the majority of patient who have morbidities. mIf we want a vehicle for reaching the undiscovered with interventions from health and other sectors of the economy mobile phone is the technology of choice.[4]

A study was conducted to assess the awareness, knowledge and attitude among Health Professional Faculty Working in Teaching Hospitals. A total of 120 teaching faculties and practitioners were selected from selected teaching hospital of puducherry, India. A self structured knowledge questionnaire was used for the survey. The knowledge level of the respondents was found to be good with 41% of the respondents, 35% possess fair knowledge and 24% don't have adequate knowledge of telemedicine. With regard to the attitude towards telemedicine 39% of the respondents possess high attitude, 31% possess moderate attitude and 30% possess low level of attitude.[5]

Problem Statement

A Descriptive study to assess attitude regarding E-Health among B.Sc. Nursing 1st Year students of Selected College of Nursing, Amritsar, Punjab.

Objectives

- To assess attitude regarding E-Health among B.Sc. Nursing 1st year students.
- To as certain association of attitude regarding E-Health among B.Sc. Nursing 1st year students with selected socio-demographic variables.

MATERIAL AND METHODS

A quantitative research approach and descriptive research design was used in the study. Nursing college of Amritsar was selected for present study. Written permission was taken fromthe principal of the college. Total 65 B.Sc nursing 1st year students were selected using convenient sampling technique for the study. The attitude towards E-Health was assessed by using self-structured 5 point attitude scale consists of 12 statements was used i.e.containing mixture of positive and negative declarative statements. Attitude scale was divided into 2 categories i.e. positive (>50) and negative (<50), item number 1,2,3,4,5,6,7,8,9,10 were considered as positive and 11, 12 as negative items. Before administration the tool was validated by experts in the field of various nursing specialties. Written consent was taken from each participant individually.

RESULTS

Objective 1: To assess attitude regarding E-Health among B.Sc. Nursing 1st year students.

Table 1: Frequency and percentage distribution of B.Sc. Nursing 1st year students according to their attitude regarding E-Health

N=65

Attitude	n	(%)
Positive (>30)	57	87.7
Negative (<30)	08	12.3

Maximum Score = 60, Minimum Score = 12

Table 1 represents the frequency and percentage distribution of B.Sc. Nursing1st year students according to attitude of students regarding E-Health. It shows that, 57 (87.7%) students had positive attitude while 8 (12.3%) students had negative attitude regarding E-Health.

Objective 2: To ascertain association of attitude regarding E-Health among B.Sc. Nursing 1st year students with selected socio-demographic variables.

In present study, the analysis of data revealed that there was significant association of attitude that there was significant association of knowledge regarding E-Health among B.Sc. Nursing 1st Year students with Age, Education of Father, Place of living, device for surfing.

DISCUSSION

The present study, "A descriptive study to assess the knowledge and attitude regarding E-Health among B.Sc. Nursing 1st year students of Khalsa College of Nursing Amritsar, Punjab." was conducted at Khalsa College of Nursing Amritsar, Punjab. The total sample used was 65 B.Sc. Nursing 1st year students. Convenient sampling technique was used to collect the sample. Before collecting data researcher gave a brief introduction about self, purpose of the study and gain confidence of the subjects.

Objective 1: To assessattitude regarding health among B.Sc. Nursing 1st year students.

In present study the analysis of data revealed that majority (87.7%) of students had positive attitude while (12.3%) students had negative attitude regarding E-Health. A similar study was conducted by Rechana Parv in BPT, MPH, MdS hahjahan, MCPS, MD to assess knowledge, attitude and practice of E-Health among doctors working at selected private Hospitals in Dhaka, Bangladesh. The result showed that doctors were considered to have a favourable attitude (78%), moderately favourable attitude (22%) with no unfavourable attitudes present towards E-Health.[6]

Objective 2: To as certain association of attitude regarding E-Health among B.Sc. Nursing 1st year students with selected socio-demographic variables.

In present study, the analysis of data revealed that there was significant association of attitude that there was significant association of knowledge regarding E-Health among B.Sc. Nursing 1st Year students with Age, Education of Father, Place of living, device for surfing. A similar study was conducetd by Tamannah Sharma to assess the awareness, knowledge, attitude and skills of telemedicine among the health professionals working in various private and government teaching hospitals in Jhansi district of Uttar Pradesh, India. A cross-sectional survey was conducted among 110 healthcare professionals, the results revealed that residential area and knowledge had significant association with attitude regarding E-Health.[7]

CONCLUSION

Utilization of health services are key to improvement of health outcome in low income countries. In these countries, knowledge of access to and utilization of health services is important in planning for health resources allocation to different level of health system and monitoring the achievement of Universal Health Coverage (UHC), which the World Health Organization (WHO) advocates as a means to ensuring equity in use of health services. Further more, knowledge of barriers to health services utilization among poor and marginalized people is essential in informing the design of interventions aimed at increasing coverage of services.

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Assess the Quality of Sleep and Level of Stress among Nurses Engaged in Shift Duties in Selected Hospitals of Pune City

Donit John[1], Erin Jacob[2], Rajshri Kokate[3]

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Abstract

A descriptive study conducted to assess the quality of sleep and level of stress among 100 nurses engaged in shift duties in selected hospitals of Pune city by using questionnaires Demographic data, Pittsburgh sleep quality index, Nursing stress scale Proportionate stratified random sampling techniques is used.

Result: 51% of poor and 49% of good quality of sleep, 46% of severe, 40% of moderate, 8% of very severe and 6% of mild level of stress, and also correlation seen that the nurses having more stress are prone to have poor quality of sleep. Demographic variables marital status, were found to have significant association with quality of sleep and level of stress, number of children and salary were found to have significant association with quality of sleep, Work experience and Working hours in a day/night were found to have significant association with level of stress.it is suggested that nurses having stress are prone to have poor quality of sleep.

Keywords: Sleep Quality: Stress Level; Nurse; Shift Work.

INTRODUCTION

Nursing is a highly stressful occupation.[1] Nurses are particularly at risk for stress related problems, with high rates of turnover, absenteeism, and burnout.[2,3] Stress and sleep can be described as counterparts that interact and affect each other in various ways. Sleep is suggested to be an important "anti stress" mediator that counteracts the wear and tear of stress on individuals.[4] According to World Health Organization 87.4% of nurses from Delhi reported occupational stress. This study proves that nurses are the high risk group to undergo stress and related problems.[5] Shift work is generally defined as work hours that are scheduled outside of day light. Shift work disrupts the synchronous relationship between the body's internal clock and environment. This disruption often results in problems such as sleep disturbances.[6] Occupational stress is a possible risk factor for insomnia and changes in the sleep

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patterns.[7] Stress can have both positive and negative aspects; when it is positive it can act as a motivating force for growth and change, but when negative it can cause a wide variety of illness, ranging from sleeplessness to degenerative diseases.[8] As nursing is the most stressful profession investigator is interested to assess the correlation between stress and sleep quality among nurses and this study would help to understand the present status of nurse's sleep quality and stress rate.

Objectives

1. To assess the quality of sleep among nurses engaged in shift duties.
2. To assess the level of stress among nurses engaged in shift duties.
3. To determine the correlation between the quality of sleep and level of stress among nurses engaged in shift duties.
4. To assess the association between quality of sleep with selected demographic variables.
5. To assess the association between stress with selected demographic variables.

Hypothesis

- H_0: There is no correlation between the quality of sleep and level of stress among nurses engaged in shift duties.
- H_1: There is a significant correlation between the quality of sleep and level of stress among nurses engaged in shift duties.

Operational Definitions

- *Description:* In this study it refers the description of strength the relationship between quality of sleep and level of stress.
- *Assess:* In this study, it is the organized systematic continuous process of collecting data from nurses regarding their quality of sleep and level of stress.
- *Sleep Quality:* In this study the term 'sleep quality' refers the normal sound sleep.
- *Stress Level:* In this study it is a state of emotional strain level among study participants during the time of their working hours.
- *Shift Work:* In this study it refers to the work system in which nurses work in different timings, that is, morning, evening and night shift.
- *Selected Hospitals:* In this study it refers to the hospital were the nurses working in all three shifts in all specialty area.

Tool:

Section A: Demographic Data

Section B: Pittsburgh Sleep Quality Index

Section C: Nursing Stress Scale

Section A: Demographic Data

1. Present working department: _____
2. Age (in years): _____
3. Gender: Male/Female
4. Marital Status: Single/Married/Divorced/ separated/Widow/widower
5. Type of family: Nuclear/Joint/Extended / Single parent family.
6. Number of family members:_____
7. Number of children:_____
8. Total gross salary:_____
9. Educational qualification: ANM/GNM/B. SC/M.Sc.
10. Total number of years of work experience:__
11. Working hours in a day/night:_____

Section: Pittsburgh Sleep Quality Index

During the past month,

1. When have you usually gone to bed?_____
2. How long (in minutes) has it taken you to fall asleep each night?_____
3. When have you usually gotten up in the morning? _____
4. How many hours of actual sleep do you get at night? (This may be different than the number of hours you spend in bed) _____

5. During the past month, how often have you had trouble sleeping because you…	**Not during the past month (0)**	**Less than once a week (1)**	**Once or twice a week (2)**	**Three or more times a week (3)**
a. Cannot get to sleep within 30 minutes				
b. Wake up in the middle of the night or early morning				

table cont.....

c. Have to get up to use the bathroom

d. Cannot breathe comfortably

e. Cough or snore loudly

f. Feel too cold

g. Feel too hot

h. Have bad dreams

i. Have pain

j. Other reason (s), please describe, including how often you have had trouble sleeping because of this reason(s):

6. During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?

7. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?

8. During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?

9. During the past month, how would you rate your sleep quality overall?

Component 1 #9 Score . . . . . .C1_____

Component 2 #2 Score (²15min=0; 16-30 min=1; 31-60 min=2, >60 min=3) + #5a Score

(if sum is equal 0=0; 1-2=1; 3-4=2; 5-6=3) . . . . . C2_____

Component 3 #4 Score (>7=0; 6-7=1; 5-6=2; <5=3) . . . . . .C3_____

Component 4 (total # of hours asleep)/(total # of hours in bed) x 100

>85%=0, 75%-84%=1, 65%-74%=2, <65%=3 . . . . . .C4_____

Component 5 Sum of Scores #5b to #5j (0=0; 1-9=1; 10-18=2; 19-27=3). . . . . .C5_____

Component 6 #6 Score . . . . . .C6_____

Component 7 #7 Score + #8 Score (0=0; 1-2=1; 3-4=2; 5-6=3) .. . . . . .C7_____

Add the seven component scores together _____ Global PSQI Score _____

≤ 5 associated with good sleep quality

> 5 associated with poor sleep quality

Section C: Nursing Stress Scale

This questionnaire is designed to collect relevant data from the nurses working in a selected hospital to assess their level of stress.

The tool comprised of 30 items and 3 sections.

Section 1: stress related to physical manifestations, consists of six questions.

Section 2: stress related to psychological manifestations, consists of eight questions.

Section 3: Stress related to interpersonal or social manifestations, consists of sixteen questions.

Instructions:

- In each statements, there are levels of response. kindly indicate how frequently you experience, by placing a (√) in the space provided for the answer you think is appropriate.
- Read every item carefully.
- Please answer all questions.

It is 5 point scale with following dimensions.

Items	score
Always	4
Some times	3
Once a while	2
Rarely	1
Never	0

Statements	Always (4)	Sometimes (3)	Once a while (2)	Rarely (1)	Never (0)
Physical Manifestiations					
I feel exhausted after the duty.					
I experience appetite disturbances.					
I experience physical problems (head ache, leg pain etc.) because of heavy duty schedule.					
I found difficulty in my sleeping pattern.					
My concentration level decreased.					
I am not punctual in arriving to duty.					
Psychological Manifestations					
I experienced tension due to heavy work load.					
I feel worried when I didn't have enough time to complete a task.					
I feel my self-esteem is lowered when a doctor/health team members criticizes me.					
It's annoying when am been assigned to many non-nursing jobs. (ex: collecting the items from other department)					
It's distressing to perform a risky procedure. ex: administering injection to HIV infected patient.					
I have fear of making a mistake when caring a patient.					
Lack of experience makes me nervous in handling a ward without seniors supervision.					
I feel anxious, when asked to handle and operate a specialized instrument, which I don't know.					
Interpersonal or Social Manifestations					
Argument with a doctor/health team members makes me upset.					
Working with an unfamiliar colleagues makes me uncomfortable.					
Lack of support from the nursing supervisor disappoints me.					
I get disturbed when ward in charge fails to provide necessary support.					
Criticism by a ward in charge makes me tensed.					
Malfunctioning equipment's makes me stressed.					
Shortage of essential drugs and equipment's irritates me.					
Lack of essential services in ward (water, electricity etc.) for providing patient care gets irritates me.					
Shortage of staffs in shift duty over burdens for me.					
I feel annoyed when there is inadequate cooperation with paramedical staff.					
When patients family members makes extra demands, it irritates me.					
I feel dissatisfied even with personal accomplishment (getting the desired jobs).					
I am unable to communicate work frustrations with family, friends and colleagues.					
I neglect my family obligations like caring of children, festival celebrations ets.					
I neglect social obligations like attending marriages, birthday parties etc.					
There are conflict with in my family/friends due to work stress.					

Scoring

Mild level of stress 0-30

Moderate level of stress 30-60

Severe level of stress 60-90

Very severe level of stress 90-120

METHODOLOGY

Non experimental descriptive research design is adopted for the present study. The study was conducted in various wards, OPDs, ICUs at selected hospitals of Pune city on 100 shift duty working nurses, proportionate stratified random sampling technique was used.The tool used by researcher is *Section A:* Demographic data *Section B:* Pittsburgh sleep quality index [Reliability (test retest method) = 0.87], *Section C:* Nursing stress scale [reliability (Split half method)= 08]. Study was conducted from 9th march 2014 to 23rd march 2014 at two different hospitals of Pune city.

RESULT

Section I: *Analysis of data related to personal characteristics of samples (nurses engaged in shift duties) in terms of frequency and percentages.*

Table 1: Distribution of samples according to their personal characteristics (N=100)

Demographic variable	Frequency	Percentage %
Present working department		
Casualty	14	14%
ICU	22	22%
Medicine ward	19	19%
Ortho ward	9	9%
Private ward	15	15%
Surgical ward	21	21%
Age		
21-25 years	33	33%
26-30 years	48	48%
31-35 years	16	16%
36-40 years	3	3%
Gender		
Female	75	75%
Male	25	25%
Marital status		
Married	46	46%
Single	51	51%
Widow	3	3%
Type of family		
Extended	1	1%
Joint	29	29%
Nuclear	70	70%
Number of family members		
Up to 5	77	77%
6 to 10	20	20%
More than 10	3	3%
Number of children		
0	55	55%
1	21	21%
2	21	21%
3	3	3%
Total gross salary		
Rs. 5001-10000	48	48%
Rs. 10001-15000	29	48%
Rs. 15001-20000	18	48%
Rs. 20001-25000	1	47%
Rs. 25001-30000	4	5%
Educational qualification		
ANM	18	18%
B.Sc.	26	26%
GNM	56	56%
Total years of work experience		
Up to 5 years	68	68%
6 to 10 years	23	23%
11 to 15 years	7	7%
More than 15 years	2	2%
Working hours in a day/night		
6 hours	14	14%
7hours	6	6%
8 hours	72	72%
9 hours	3	3%
10 hours	1	1%
12 hours	4	4%

Section II: *Analysis of data related to assessment of quality of sleep among nurses engaged in shift duties*

51% of the nurses had poor quality of sleep (Score >5) and 49% of them had good quality of sleep (Score <=5). (N=100)

Section III: *Analysis of data related to assessment of level of stress among nurses engaged in shift duties*

46% of the nurses engaged in shift duties had severe stress (Score 60-90), 40% of them had moderate stress (Score 30-60), 8% of them had very severe stress (Score 90-120) and 6% of them had

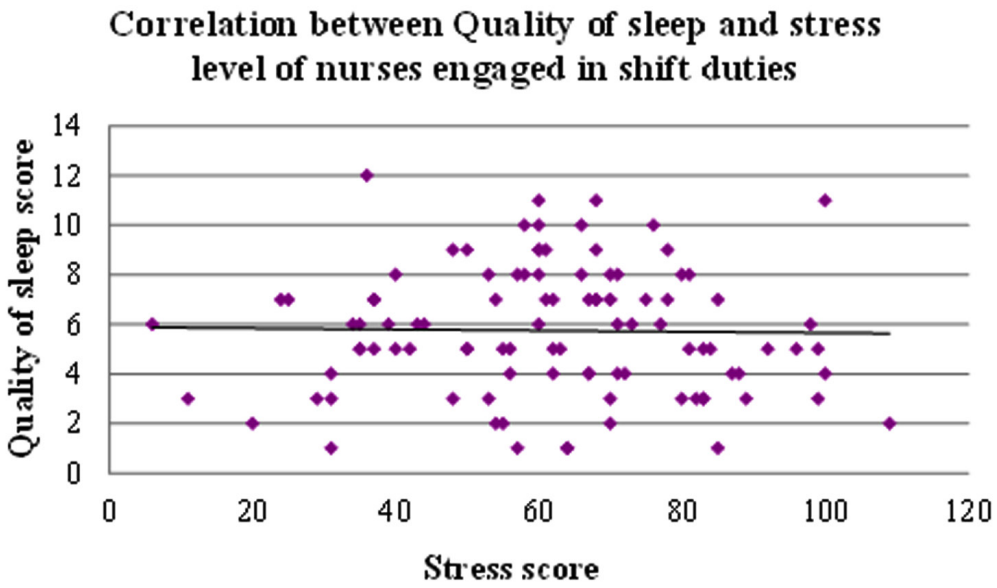
mild stress (Score 0-30).(N=100)

Section IV: *Analysis of data related to correlation between the quality of sleep and level of stress among nurses engaged in shift duties*

Table 2: Correlation between the quality of sleep and level of stress among nurses engaged in shift duties (N=100)

Statistic	Value
Pearson's correlation coefficient	-0.02
t	-0.19
p-value	0.577

Pearson's correlation coefficient was found to be -0.02. This indicates that there is a slight negative correlation between sleep quality and stress. This means that the nurses having more stress, are prone to have poor quality of sleep. The strength of this relationship was tested using t-test for testing the correlation coefficient. The T-value was found to be 0.19. The corresponding p-value was found to be 0.577. Since p-value is large, we fail to reject the null hypothesis. The correlation between the quality of sleep and level of stress though found negative is not statistically significant. Following the scatter plot shows the visual display of this relationship.



Section V: *Analysis of data related to association between quality of sleep with selected demographic variables*

This assessment was done using Fisher's exact test. The summary of the results of Fisher's exact test is tabulated below (N=100):

Demographic variable		Sleep Quality		p-value
		Poor	Good	
Marital Status	M	12	13	0.014
	Married	19	27	
	Single	32	19	
	Widow	0	3	
Number of children	6 to 10	10	10	0.006
	More than 10	0	3	
	0	33	22	
	1	13	8	
	2	5	16	
	3	0	3	

table cont.....

Salary	Rs. 5001-10000	22	7	
	Rs. 10001-15000	9	9	
	Rs. 15001-20000	1	0	0.005
	Rs. 20001-25000	1	3	
	Rs. 25001-30000	18	10	

Since p-values corresponding to marital status, number of children and salary are small (less than 0.05), the null hypothesis is rejected. Demographic variables marital status, number of children and salary were found to have significant association with quality of sleep among nurses engaged in shift duties.

Section VI: *Analysis of data related to association between quality of sleep with selected demographic variables*

Table 6: Association between stresses with selected demographic variables

Demographic Variable		Stress				p-value
		Mild	Moderate	Severe	Very Severe	
Marital Status	Married	6	16	19	5	0.044
	Single	0	24	24	3	
	Widow	0	0	3	0	
Number of Children	0	0	26	28	1	0
	1	5	4	11	1	
	2	1	10	7	3	
	3	0	0	0	3	
Salary	Rs. 5001-10000	1	16	27	4	0.048
	Rs. 10001-15000	2	11	14	2	
	Rs. 15001-20000	3	9	5	1	
	Rs. 20001-25000	0	0	0	1	
	Rs. 25001-30000	0	4	0	0	
Work Experience	Up to 5 years	1	29	36	2	0.001
	6 to 10 years	4	9	6	4	
	11 to 15 years	1	1	4	1	
	More than 15 years	0	1	0	1	
Working hours in a Day/Night	6 hours	2	9	3	0	0.009
	7 hours	0	3	2	1	
	8 hours	4	27	37	4	
	9 hours	0	0	3	0	
	10 hours	0	0	1	0	
	12 hours	0	1	0	3	

Since p-values corresponding to marital status, number of children, Work experience, salary and Working hours in a day/night are small (less than 0.05), the null hypothesis is rejected. Demographic variables marital status, number of children, Work experience, salary and Working hours in a day/night were found to have significant association with quality of sleep among nurses engaged in shift duties.

DISCUSSION

The finding of present study has been discussed with reference to the objectives and hypothesis. The finding of the study shows that the nurses having more stress are prone to have poor quality of sleep.

A cross sectional study conducted by B. Pikó on Work related stress among nurses: a challenge for health care institutions. The participants of the survey were female nurses (n=218). The result showed that nurses with only primary education had the highest stress levels, while those with baccalaureate level education had the lowest stress level. Furthermore, nurses aged 51-60 years and those on rotating night shift proved to be

vulnerable to stress the most frequently. However, no significant differences were found between nurses working in-theatre and those non-theatres; nor were job satisfaction found to have a significant impact on the levels of stress experienced. In this present study result shows that GNM nurses have severe stress than B.Sc. and ANMs. Furthermore, in this study the most of the participants are comes under 26-30 yrs of age so the stress level more in this age group. However, nurses working in ICU have severe stress than other ward/departments. 76 A study to determine if different types of work strain experienced by nurses, particularly those of an essentially psychological nature, such as emotional demand, mental effort and problems with peers and/or supervisors, have a differential impact on sleep quality and overall recovery from work strain, compared with physical work strains, and lead to higher maladaptive chronic fatigue outcomes conducted by Peter C. Winwood, Kurt Lushington. A large sample (n = 760) of Australian nurses working in a large metropolitan hospital completed questionnaires on their work demands, sleep quality, fatigue, and recovery between shifts Result shown that a high work pace exacerbates the psychological rather than the physical strain demands of nursing. Psychological strain affects sleep quality and impairs recovery from overall work strain between shifts. Similarly in this present study researcher found that nurses having more stress are prone to have poor quality of sleep. 77A cross-sectional study design to investigate behavioural and psychological factors that influence neurophysiological regulation of sleep in shift workers by Chung, Min-Huey; et al. with a sample of 338 female nurses working rotating shifts at an urban regional hospital. The Pittsburgh Sleep Quality Index (PSQI) measured participant's self-reported sleep quality. The results revealed that sleep hygiene practices and mood states mediated the effects of morningness eveningness and menstrual distress on sleep quality.[78] However in this present study also researcher used Pittsburgh Sleep Quality Index (PSQI) to measure sleep quality of nurses it was found that 51% of nurses are prone to poor sleep quality and 46% of nurses are prone to severe stress level.

So it is important that nurses working consistently either in the morning, evening or at night shifts having more stress ad prone to have poor quality of sleep. Further studies are still needed to develop interventions that improve sleep quality and decrease burnout in nurses working shifts.

CONCLUSION

From the above study, it can be concluded that that the nurses having more stress are prone to have poor quality of sleep. The result was found that there is slight negative correlation between sleep quality and stress level.

Recommendations

- The similar study can be replicated in different setting and large sample size and on interns, doctors and other health care personnel to strengthen the findings.
- A study to assess the knowledge and attitude towards the coping strategy regards to level of stress and quality of sleep among nurses engaged on shift duty.
- Same study can be conducted by giving interventions like yoga, meditation, behavioral therapy etc.

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