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Assessment of Aggression, Exposure to Violence and Abuse among Street Children in Selected Shelter Homes of Hyderabad

Disney Sabatina[1] Anumol Joseph[2], Sister Mary Rappai[3]

Abstract

Introduction: Street children are often subjected to abuse and exploitation and they release their aggression through direct and indirect means. The investigators explored aggression, exposure to violence and abuse among street children residing in shelter homes. *Methodology:* A quantitative approach non-experimental descriptive research design was selected. The sample consisted of 60 street children residing in shelter homes. The data was collected by structured interview. A structured tool was developed by the investigator to assess aggression, exposure to violence and abuse. *Results:* 87% of street children were found to have severe aggression, 60% of street children had moderate exposure to violence and 86.6% of street children reportedly were victims of severe abuse. *Conclusion:* Street children should be counselled intermittently and provided opportunity to ventilate their pent up feelings so that prevention can be done at primordial level to prevent further complications.

Keywords: Street Children; Aggression; Abuse; Violence.

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Introduction

Street children are minors who live and survive on the streets. They often grow up in public land field, train stations, or under the bridges of the world's major cities because of conflicts with their families. These children do not want to, or cannot return home. Homeless children are often called street kids, the definition is contestable, but many practitioners and policy makers use UNICEF concept of boys and girls, aged under 18 years, for whom "the street" (including unoccupied dwellings and wasteland) has become home and or their source of livelihood, and who are inadequately protected or supervised [1].

Street children are also called Gamines, a term used for either street children of either gender. Some street children, notably in more developed nations, are part of a subcategory called thrown away children who are children that have been forced to leave home. Thrown away children are more likely to come from single-parent homes. Street children are often subject to abuse, neglect, exploitation, or, in extreme cases, murder by "clean-up squads" that have been hired by local businesses or police. In Western societies, such children are treated as homeless children rather than criminals or beggars [2]. 'Street children' is a catch-all term but covers children in wide variety of circumstances and with a wide variety of characteristics. Policymakers and service providers struggle to describe and assist such a sub-population. Individual girls and boys of all ages are found living and working in public spaces and are visible in the great majority of the world's urban centers [2].

UNICEF in the year 2013, analyzed 364 studies and 6,000 articles and reported the child maltreatment in

Author Affiliation
[1]M.Sc Nursing Student [2]Assistant Professor, [3]Associate Professor, Vijaymarie College of Nursing, Hyderabad, Telangana 500016, India.

Corresponding Author
Anumol Joseph, Assistant Professor, Vijaymarie College of Nursing, Hyderabad, Telangana 500016, India.
E-mail: anujoseph14@hotmail.com

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the region of East Asia and Pacific region [3]. World Health Organization in the year 2013, identified violence against children as a growing public health issue with a global magnitude. Findings suggest that the confluence of risk factors such as poverty, poor legal protections, illiteracy, large family size, unemployment create an enabling environment for violence against children [4].

Kiellgren, Svedin & Nilsson in 2013 conducted a study on child physical abuse among the parents and the children in 16 sessions of programme and revealed that 76% of the children are abused at the age of 12-13 years [5]. Mathur in 2009 carried out a study on street children with aim to map the socio-economic realities of street children in Jaipur in India. The field scenario indicated that majority of street children were boys (71%) and in 8-12 years age group. Smoking, Drug abuse, gambling, watching television, robbery were common modes of entertainment for these children [6].

Methodology

Quantitative research approach, with non-experimental descriptive research design was adopted. The study was conducted in selected shelter homes of Hyderabad. The sample was selected through purposive sampling technique. 60 street children under the age group of 06-14 years of age were selected.The data was collected through a structured interview method. The reliability obtained was 1 indicating that tool was statistically reliable. The structured tool for the present study consisted of two sections, i.e., Section-A and Section-B. Section-A consisted of sample characteristics which gave baseline data information of street children such as age, gender, religion, education and schooling, parents, siblings and type of shelter home. Section-B consistedof items to assess the aggression, exposure to violence and abuse. There were 21 questions to assess under four domains, namely verbal aggression, physical aggression, indirect aggression and direct aggression with five-point Likert scale. The scores were organized in three categories:

01-35: Mild Aggression

36-70: Moderate Aggression

70-105: Severe Aggression

The exposure to violence checklist consisted of 16 questions and the scoring was done as follows:

0-4: No Exposure to Violence

5-8: Mild Exposure to Violence

9-12: Moderate Exposure to Violence

11-16: Severe Exposure to Violence

The abuse checklist consisted of 22 questions under four domains namely sexual abuse, physical abuse, verbal abuse and emotional abuse and the scores are organized in three categories namely:

0-7: No Abuse

8-14: Exposed to Abuse Frequently

15-22: Severe victimization to Abuse

Ethical clearance and permission to conduct the study was obtained from the authorities of the shelter homes.The purpose and the other details of the studys were explained to the subjects. Assurance was given to the subjects about the anonymity and confidentiality of the data collected from the subjects.

Results

Table 1: Frequency and percentage of subjects by sample characteristics (n = 60)

S.No.	Demographic Variables	Frequency	Percentage
1	**Age**		
	a) 06 – 08 Years	12	20%
	b) 09 – 11 Years	30	50%
	c) 12 – 14 Years	18	30%
2	**Gender**		
	a) Boys	35	58.3%
	b) Girls	25	41.6%
3	**Religion**		
	a) Hindu	24	40%
	b) Muslim	08	13.3%
	c) Christian	26	43.3%
	d) Others	02	3.3%
4	**Education**		
	a) Primary (01-05th)	22	36.6%
	b) Secondary (06-10th)	38	63.3%
5	**Type of shelter home**		
	a) Day	11	18.3%
	b) Night	49	81.6%
6	**Number of parents**		
	a) Single parent	21	35%
	b) Divorced	14	23.3%
	c) Both parents alive	07	11.6%
	d) None alive	18	30%
7	**Number of siblings**		
	a) 1 Sibling	07	11.6%
	b) 2 Siblings	16	26.6%
	c) More Than 2	19	31.6%
	d) None	18	30%

Table 1 depicts that the 30 (50%) children were under the age group of 09-11 years and 18 (30%) were from the age group of 12-14 years. 35 (58.3%) were boys and 25 (41.6%) girls. 26 (43.3%) were Christians, 24 (40%) were Muslims. 38 (63.3%) children were pursuing Secondary Education (6th-10 thstandard) and 22 (36.6%) were pursuing Primary Education (1st-5th standard). 49 (81.6%) children were in night shelter homes and only 11 (18.3%) were in day shelter homes. 21 (35%) were having single parent (alive) and 18 (30%) were orphan. 19 (31.6%) were having more than 2 siblings followed by no siblings 18 (30%).

Table 2: Level of aggression. (n=60)

S.No.	Aggression	Frequency	Percentage
1	Mild Aggression (01-35)	01	2%
2	Moderate Aggression (36-70)	07	11.66%
3	Severe Aggression (71-105)	52	87%

The table 2 shows that a larger proportion of street children reportedly had severe aggression, 87%, followed by 07 (11.66%) with moderate aggression, and only 1 (2%) child had mild aggression.

Table 3: Domain wise aggression mean scores and rank order of street children (n=60)

S. No.	Domains	Mean	Modified Mean	Rank Order
1	Verbal Aggression	21.2	4.2	2
2	Physical Aggression	23.75	3.39	4
3	Direct Aggression	17.05	3.41	3
4	Indirect Aggression	19.66	4.91	1

Table 3 shows the mean scores of aggression in each domain and further rank order of aggression levels. The highest reported aggression was indirect aggression with modified mean of 4.91, followed by verbal aggression with modified mean of 4.2, direct aggression with modified mean 3.41, and physical aggression with modified mean of 3.39 was the least reported aggression.

Table 4: Levels of exposure to violence (n=60)

S. No.	Exposure To Violence	Frequency	Percentage
1	No Exposure to Violence (0-04)	0	0%
2	Mild Exposure to Violence (05-08)	02	3.3%
3	Moderate Exposure to Violence (09-12)	36	60%
4	Severe Exposure to Violence (13-16)	22	36.6%

Table 4 shows that 36 (60%) children were exposed to moderate violence, 22 (36.6%) street children were exposed to severe violent behavior. Only a small proportion of subjects, thatis 2 (3.3%) were exposed to mild violence and surprisingly no street children reported no exposure to violent behavior. From the above findings, it can be inferred that street children were vulnerable to violence.

Table 5: Levels of Abuse. (n=60)

S. No.	Abuse	Frequency	Percentage
1	No Abuse (0-07)	01	1.67%
2	Exposed to Abuse Frequently (08-14)	07	11.66%
3	Severe Victimization to Abuse (15-22)	52	86.66%

Table 5 shows that more than half children, that is 52 (86.66%) had been victims of severe abuse, followed by 07 (11.66%) street children who were exposed to abuse frequently and only one child reported of being not abused. The above findings highlighted that children vulnerable to be exploited by others posing a threat to their psychological health and all round development.

Table 6: Domain wise abuse scores rank order of street children (n=60)

S.No.	Domains	Mean	Modified Mean	Rank Order
1	Sexual abuse	3.01	0.75	3
2	Physical abuse	2.91	0.72	4
3	Verbal abuse	4.61	0.92	1
4	Emotional abuse	7.1	0.78	2

Table 7: Vulnerability of Aggression, Exposure to Violence and Abuse among Street Children. n = 60

S. No.	Categories	Possibile Range of Score	Range of Obtained Score	Mean	Median	Mode	Standard Deviation
1	Vulnerability to Aggression	01-105	34-105	81.67	83	3	13.10
2	Exposure to Violence	01-16	08-16	11.95	12	12	1.97
3	Vulnerability to Abuse	01-22	05-22	17.64	18	18	2.92

Table 6 shows the mean scores of various types of abuse in each domains and further rank order of abuse levels. Children reported to be more verbally abusedwith modified mean of 0.92, followed by emotional abuse with modified mean of 0.78, sexual abuse with modified mean of 0.75 and physical Abuse with modified mean 0.72 being the least reported abuse.

Table 7 shows, no significant association was found of aggression, exposure to violence and abuse with the selected demographic variables like age, gender and number of parents as all the calculated Chi-square values were less than the table value.

Discussion

The present study is congruent with a study done by Kaur on anger, aggression and violence among adolescents in a selected school of Delhi [7]. The study revealed that majority of the male samples that is 58.33% belonged to age group of 14-18 years. In the present study both the genders participated 58.3% males and 41.6% females respectively.In the former study the findings revealed that majority of the children, that is, 75% reported mild vulnerability to aggression and violence [16]. The present study highlighted that 87% of street children had severe aggression, followed by 07 (11.66%) who had moderate aggression, and one 01 (2%) reported mild aggression. Another study conducted in Norway [8] on 'Suspected Child Sexual Abuse as Context for Parenting' by Softestad and Toverud showed that sometimes it is the parent who is abusing the child and hence precautions are to taken by providing interventions to the child on the basis of schooling, recovery and behavioral building pattern with changes in parent-child relationship. However, the present study has not used any preventive and parenting strategies. The street children reported to be abused verbally more than any other type of abuse, such as emotional, sexual and physical.

Conclusion

The children who are ill-treated and neglected are the ones who turn out to be juvenile delinquents and criminals.Street children, orphans are most vulnerable to abuse, exploitation and violence. Hence, these children need counselling for their emotional and psychological health. The children who are aggressive, exposed to violence and abused are violent and angry towards the society. Hence, they should be reformed in children homes and rehabilitated in society.

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Original Article

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A Study to Assess the Knowledge Regarding Homecare Management among Primary Caregivers of Depressive Patients in Selected Hospitals, Gujarat

Patel Hinabahen B.

Abstract

Depression is the oldest and most common psychiatric illness. A study to assess the effectiveness of the Planned Teaching Programme related to depression in selected mental health hospitals of Gujarat state. *Aims:* To assess the level of knowledge regarding depression and its homecare management among primary caregivers of patients admitted with depression before and after administration of planned teaching programme, To assess the effectiveness of Planned teaching programme regarding depression and its homecare management, To find out association of pre-test knowledge score regarding depression and its homecare management with selected demographic variables. *Method:* Pre-experimental research approach was used with one group pre-test post-test design, samples consisted of 40 and non probability purposive sampling technique for selecting 40 samples. A structured knowledge questionnaire was prepared to assess the knowledge of the samples. *Result:* The mean pre-test knowledge score of samples about primary caregivers of patients admitted with depression was 10.2 where as post-test knowledge score was 22.45. The mean post test knowledge score is significantly higher than the mean pre test knowledge score with the mean difference of 12.28 and the calculated 't' value (t = 22.22) was greater than tablulated 't' value (t =2.02) which was statistically proved at 0.05 level of significance. The findings of the study reveal that there is no significant association with pre-test knowledge scores and selected demographic variables of the samples except religion of primary caregivers regarding homecare management of depression. *Conclusion:* The result of the study reveals that the primary caregivers of patients had poor knowledge before administration of Planned Teaching Programme. After administration of planned teaching programme, the knowledge had been improved. Hence, it can be seen that the Planned Teaching Programme was effective in enhancing knowledge of primary caregivers of depressive patients.

Keywords: Home care management; Depressive patients; Primary caregivers; Planned Teaching Programm.

How to cite this article:

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Introduction

Depression is the common cold of mental disorders-most people will be affected by depression in their lives either directly or indirect through a friend or family member with a prevalence of 10-15% in general population 7-12% in men and 20-25% in women Overall 30-70% of depression has attributed to heritable factors Monozygotic twins have two folds greater concordance rates (50-70-%) for major depressive disorder than the dizygotic twins (20-25%) [2].

Depression is a different from feeling down. There are also the types of depression. Major depression, Persistent psychotic depression, Premenstrual dysphoric depression, Post partum depression, Seasonal depression, that people may experience [4] Depression is characterized by a number of common symptoms like Appetite and/ or weight loss or overeating and weight gain may be symptoms of depression in some people. Many

Author Affiliation

Lecturer (M.Sc Nursing in psychiatric Nursing) Apollo Institute of Nursing, Gandhi Nagar, Gujarat, India.

Corresponding Author

Patel Hinabahen B., Lecturer (M.Sc Nursing in psychiatric Nursing) Apollo Institute of Nursing, Gandhi Nagar, Gujarat, India.

E-mail: Heenapatel0044@gmail.com

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others experience decreased energy, fatigue, and a constant feeling of being slowed down. Thoughts of death or suicide are not uncommon in those suffering from severe depression. Restlessness and irritability are also found among depression patients [1,3].

Materials and Methods

The study was conducted in government mental health hospitals of Gujarat, India. Samples were taken from primary caregivers of patients admitted with depression. The sample consisted of 40 samples. Pre experimental one group pre test and post test design was used. Samples were selected using non probability purposive sampling techniques. The subjects were given structure knowledge questionnaires which consisted of 30 questions.

Results

Part I: Findings related to sample characteristics

The table 1 shows that out of 40 samples, 14 (35%) were in age group 41- 50 years. 21 (52.5%) samples were female, 22 (55%) were Hindu, 13 (32.5%) were studied primary, 17 (42.5%) had monthly income of as rupees10,001 to15,000.

Table 1: Frequency and percentage distribution of samples based on demographic Variables [n=40]

Sr No.	Demographic Variables	Frequency (F)	Percentage (%)
.1	**Age (in years)**		
	1. 21-30years	8	20%
	2. 31-40 years	13	32.5%
	3. 41-50 years	14	35%
	4. >50 years	5	12.5%
2	**Gender**		
	1. Male	19	47.5%
	2. Female	21	52.5%
3	**Religion**		
	1. Hindu	22	55%
	2. Muslim	10	25%
	3. Christian	5	12.5%
	4 Others	3	7.5%
4	**Education Status**		
	1. Illiterate	8	20%
	2. Primary	13	32.5%
	3. Higher secondary	11	27.5%
	4. Graduate or above	8	20%
5	**Occupation**		
	1. Service	11	27.5%
	2. Business	12	30%
	3. Labor	3	7.5%
	4. None of above	14	35%
6	**Income per month (In Rupees)**		
	1. <5000	4	10%
	2. 5001 to 10,000	12	30%
	3. 10,001 to 15,000	17	42.5%
	4. >15,000	7	17.5%

Part II: Findings related to mean pre and post test score of samples

Table 2 shows the percentage gain in the area related to introduction was 26.67%, in the area related to types was 20%, in the area related to causes was 18%, in the area related to sign and symptoms was 19%, in the area related to depression and suicidal risk 32.5% and in the area of risk factor was 33%, in the area related treatment was 45%, in the area related homecare management was 51.52%. So the investigator concluded that there was marked increase in the mean post test knowledge score as compared to mean pre test knowledge score of samples after the administration of a Planned Teaching Programme regarding homecare management.

Table 2: Area wise mean, mean percentage and percentage gain of pre-test and post test knowledge of the samples. [n=40]

Sr No	Area of content	Max score	Pre-test knowledge score		Post-test knowledge score		Percentage (%) gain	Mean difference
			Mean score	Mean (%)	Mean score	Mean (%)		
1	Introduction	3	1.1	36.66%	1.9	63.33%	26.67%	0.8
2	Types	2	0.7	35%	1.1	55%	20%	0.4
3	Causes	1	0.35	35%	0.53	53%	18%	0.18
4	Sign and Symptoms	2	0.9	45%	1.28	64%	19%	0.38
5	Depression and suicidal risk	2	0.65	32.5%	1.3	65%	32.5%	0.65
6	Risk factor	1	0.4	40%	0.73	73%	33%	0.33
7	Treatment	2	0.6	30%	1.5	75%	45%	0.9
8	Homecare management	17	5.4	32%	14.2	83.52%	51.52%	8.8
	Total	30	10.2	34 %	22.48	75%	41 %	12.28

Part III: Findings related to effectiveness of planned teaching programme.

Table 3 Shows that 24 (60%) samples had poor, 15 (37.5%) samples had average, 1 (2.5%) had a good knowledge as per their pre- test knowledge scores where as 11 (27.5%)samples had average, 29 (72.5%) samples had good knowledge as per their post- test knowledge scores.

Table 4: Mean, Mean Difference, Standard Deviation (SD) and 't' test value of the Pre-test and Post-test Knowledge scores of samples. [n=40]

Knowledge Test	Mean	Mean difference	SD	Calculated 't'value
Pre- test	10.20	12.28	2.68	22.22
Post-test	22.48		2.97	

Df (39) 0.05 level t value = 2.02.

Table 3: Analysis and interpretation of the data related to knowledge to assess the effectiveness of planned teaching programme regarding home care management. [n=40]

Level of Knowledge	Pre Test		Post Test	
	Frequency	Percentage%	Frequency	Percentage%
Poor (1-10)	24	60%	0	0
Average (11-20)	15	37.5%	11	27.5%
Good (21-30)	1	2.5%	29	72.5%
Total	40	100%	40	100%

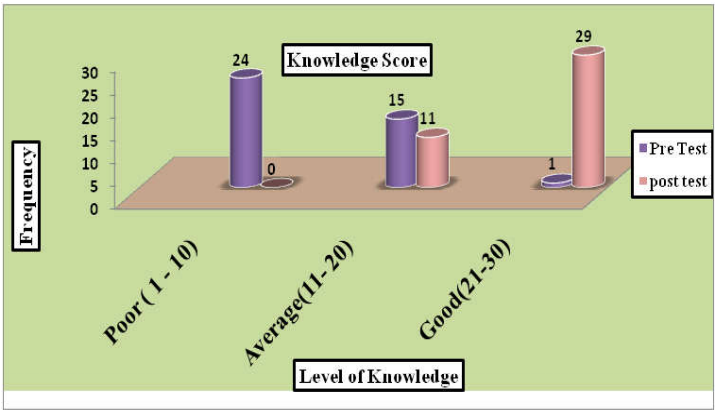

Fig. 1: Bar Graph Showing the Comparison of Pre Test and Post Test Knowledge Frequency of Samples regarding homecare management among primary caregivers of patients admitted with depression.

Part IV: Findings related to mean, mean difference, standard deviation, and t test.

Table 4 shows the comparison between pre-test and post-test knowledge scores obtained by the respondents regarding homecare management among primary caregivers of patients admitted with depression. The mean Pre-test score was 10.20 and the mean post test score was 22.48. The mean difference between pre-test and post-test knowledge score was 12.28. The table 4 also shows that the standard deviation of pre-test score of knowledge was 2.68 and Standard deviation of post test score of knowledge was 2.97. The calculated 't' was 22.22 and the tabulated 't' was 2.02 at 0.05 level of significance at for 39 df Above table reveals that the mean post-test knowledge score was significantly higher than the mean pre-test knowledge.

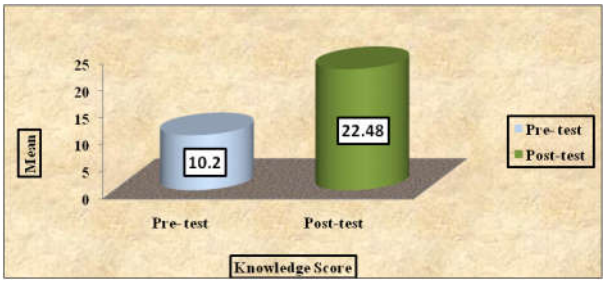

Fig. 2: Bar Graph Showing the Comparison of Mean Pre Test and Mean Post Test Knowledge Scores of Samples regarding depression and its homecare management

Part V: Findings related to association of pre test knowledge score with demographic variables.

Table 5 shows that regarding, religion of the samples with the pre test knowledge scores, the calculated value of chi square (χ^2) was 13.532 is greater than table value of (χ^2) 12.59 at 6 degree of freedom and 0.05 levels of significant. Hence, it has significant association with the knowledge of the samples.

Table 5: Analysis and interpretation of the data related to association of pre-test knowledge score with selected demographic variables [n = 40]

Sr. No.	Demographic variables	Frequency (f)	χ^2		Df	Significance
			Calculated value	Table value		
1	**Age (in year)**					
	1. 21-30 years	8	9.627	12.59	6	Non significant
	2. 31-40 years	13				
	3. 41-50 years	14				
	4. >50 years	5				
2	**Gender**					
	1. Male	21	1.136	5.99	2	Non significant
	2. Female	19				
3	**Religion**					
	1. Hindu	22	13.532	12.59	6	Significant
	2. Muslim	10				
	3. Christian	5				
	4. Others	3				
4	**Education Status**					
	1. Illiterate	8	5.902	12.59	6	Non significant
	2. Primary	13				
	3. Higher secondary	11				
	4. Graduate or above	8				
5	**Occupation**					
	1. Service	11	6.212	12.59	6	Non significant
	2. Business	12				
	3. Labor	3				
	4. None of above	14				
6	**Income per month (in Rupees)**					
	1. <5000	4	2.802	12.59	6	Non significant
	2. 5001 to 10,000	12				
	3. 10,001 to 15,000	17				
	4. >15,000	7				

Discussion

The present study was conducted to assess the effectiveness of Planned Teaching Programme regarding homecare management among primary caregivers of patients admitted with depression in selected mental health hospitals of Gujarat. In order to achieve the objective of the study, pre experimental one group pre test post test was adopted. The data was collected from 40 primary caregivers of depressive patients by using structured knowledge questionnaire. The post test score (mean 22.48) was higher than that of pre test score (mean 10.20) and which was statistically proved and it revealed that Planned Teaching Programme was effective in terms of knowledge among the primary caregivers of patients admitted with depression [9].

Conclusion

From the above finding the conclusion can be drawn that care givers were aware about depression and its homecare management, and the planned teaching programme was found effective in enhancing the knowledge of the primary caregivers of depressive patients. There was statistically significant association of pre test knowledge score with selected demographic variable such as religion.

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Original Article

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Effectiveness of Sleep Promotion Education Regarding Quality of Sleep among Adolescents in Selected Schools of Doiwala Block, Dehradun, Uttarakhand

Meenakshi Rana[1], Grace M. Singh[2], Shobha Masih[3]

Abstract

Background of the study: Adolescents is the stage in which an individual grow and develop physically and psychologically from puberty to legal adulthood. The study aimed to assess the effectiveness of sleep promotion education regarding quality of sleep among adolescents in selected schools of Doiwala Block, Uttarakhand.

Method: Quantitative research approach was adopted for present study. Total 260 adolescents were selected through total enumerative sampling technique. Data was collected by administering tool to the participants. Tool consists of socio- demographic Performa, Pittsburgh Sleep Quality Index. The data was analyzed by using descriptive and inferential statistics.

Results: This study showed that sleep promotion education improved significant improvement in sleep quality from baseline mean 7.22 to 4.81; $p< 0.001$ post interventions as measured by Pittsburgh sleep quality index. The results showed that mean score is decreasing from pre interventions to the third week of post interventions which means that sleep promotion education was effective in improving the sleep quality of adolescents. There was no significant association between pre-test quality of sleep scores among adolescents regarding sleep promotion education with selected demographic variables tested at 0.05 level of significance.

Conclusion: The study concluded that the adolescents had inappropriate sleep quality for which sleep promotion education was given to the adolescents. Sleep promotion education improved the sleep quality of adolescents significantly after three weeks of education.

Keywords: Effectiveness; Sleep Quality; Adolescents; Sleep Promotion Education.

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Introduction

Adolescents is the stage in which an individual grow and develop physically and psychologically from puberty to legal adulthood. There are various changes from childhood period to adolescence results in sleep loss during adolescence. Along with the pubertal changes the requirement of attending school early affects the sleep-wake schedule and quality of sleep. A study conducted by National sleep Foundation found that over 45% of adolescents obtain inadequate sleep. Maximum delay occurs in girls than boys [1]. Sleep problems are frequent in adolescents Worldwide, the prevalence of sleep problems among adolescents was 11% aged 13 to 16 years and 17% of the adolescents aged between 12-18 years. In Indian Scenario, the prevalence of sleep problems is 42.7% among adolescents. In Uttarakhand, the prevalence of sleep problems is 10-11% [2]. Sleep plays a major role in regulating daytime brain functioning and various biological processes of the body. Sleep also maintain cognitive

Author Affiliation
[1]M.Sc. Nursing Student [2]Assistant Professor Dept. of Mental Health Nursing, [3]Nursing Tutor, Himalayan College of Nursing, Dehradun, Uttarakhand 248140, India.

Corresponding Author
Grace M. Singh, Assistant Professor, Dept. of Mental Health Nursing, Himalayan College of Nursing, Dehradun, Uttarakhand 248140, India.

E-mail: meenakshirana36@gmail.com

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and psychological processes such as learning and memory consolidation[3].

Need for the Study

Health is the state in which various aspects such as physical, mental, social and spiritual are included. Mental health is the psychological state in which emotional and behavioral adjustment occurs at satisfactory level. Mental health can be maintained through maintaining sleep hygiene and prevent mental disorders through psycho-education, early treatment and public health measures. Sleep is the basic requirement of health and well being. Sleep health is the maintenance of average normal sleep pattern in order to prevent sleep disorders. A community based School survey conducted by Gupta R. et al. [4] among 1920 adolescents at Delhi which revealed that adolescents were suffering from sleep deficit of one hour per day and this progressed with higher grades. The results showed that adolescents with higher standard had taken less sleep that is a student studying in higher class is more sleep deprived than that of student studying in lower class in the school [4]. Quality of sleep among adolescents is affected by various factors. Although not much published data is available from India but the studies conducted in other countries show similar results. Adolescent is the period in which sleep problems arise so education regarding sleep help in dealing with sleep problems among adolescents promotes more effective changes in student's sleep pattern.

So the current study was taken up to assess the effectiveness of sleep promotion education regarding quality of sleep among adolescents in selected schools of Doiwala Block, Uttarakhand. Objectives of the Study were to assess the sleep quality among adolescents, to find out the effectiveness of sleep promotion education on sleep quality score among adolescents at selected schools of Doiwala block Uttarakhand and to find out the association between pre-test quality of sleep scores among adolescents regarding sleep promotion education with selected demographic variables.

Material and Methods

In the present study quantitative approach with quasi experimental design (Time- series design) was used. 260 adolescents were selected through total enumerative sampling technique from Govt. Inter college Bullawala, Dehradun, Uttrakhand Sleep Quality was measured using self reported inventory that is Pittsburgh Sleep quality Index and demographic details were obtained using baseline data.

Results

Table 1: Frequency and percentage distribution of adolescents according to their selected demographic variables n=260

Variables	Subject characteristics	Frequency (f)	Percentage (%)
Age in years	12-13	49	19
	14-15	131	50
	16-18	80	31
Gender	Male	148	57
	Female	112	43
Family style	Nuclear	157	60
	Joint	99	38
	Extended	4	02
Family income	2000-5000	167	64
	5001-8000	93	36
Use of drinks before sleep	Yes	142	55
	No	118	45
Use of items before sleep	Laptop	25	10
	Mobile phone	43	16
	Television	147	57
	videogame	45	17
Environment during sleep	Calm	167	64
	Dark	80	31
	Light	13	05
During last one month family problems	Never affected	55	21
	Affected a little bit	119	46
	Affected sometimes	81	31
	Affected frequently	2	01
	Affected always	3	01

Data presented in table 1 illustrate that the half of participants were in age group of 16-18 years i.e 50% and 19% of the participants were of age 12-13 years. Out of 260 participants, 57% were males, 60 % belonged to nuclear family. Two third of the participants i.e 64% having family income between 2000-5000. More than half of the participants i.e. 55% took drinks before sleep such as milk, tea, coffee. More than half of the participants i.e 57% used laptop and television before sleep. Two third of the participants i.e. 64% maintained calm environment during sleep and 5% of the participants maintained light environment. Less than half of the participants i.e 46%, suffered from family problems during last one month which affected their quality of sleep and 1% of the participants reported family problems

that affected quality of sleep frequently during last one month.

Table 2: Effectiveness of sleep promotion education on quality of sleep scores n=260

S.N.	Levels	M±SD	F value	P value
1.	Pre test (Day 1)	7.22±2.17	468.25	0.001*
2.	Post test (After one week)	6.28±1.88		
3.	Post test (After two week)	5.47±1.54		
4.	Post test (After three week)	4.81±1.12		

F- repeated measures ANOVA

Hypothesis tested at 0.05 level of significance

* Significant

Table 2 depicts the mean and standard deviation of sleep quality scores of study participants at pre intervention, one week, two weeks and three weeks after intervention. The mean sleep quality score was statistically significant (F(1.800,466.08) = 468.25, p<0.001). This concluded that the mean post test score was decreased from pre test score which showed that the interventions which were given to the participants were beneficial.

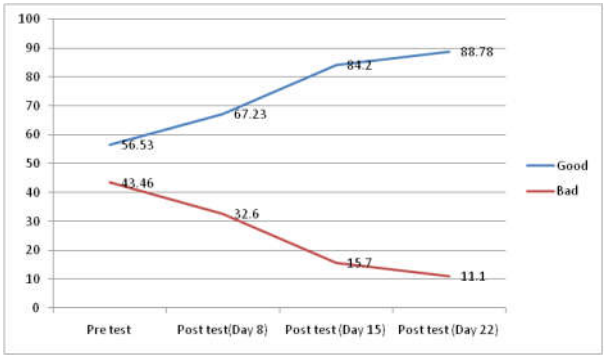

Fig. 1: percentage distribution of change in sleep quality scores before and after interventions.

The sleep quality scores was graded into two levels i.e. Good and poor sleep quality according to the interpretation of PSQI scale. The change in the frequency of participants having good quality and poor quality of sleep from pre interventions to post interventions is illustrated in Figure 1. The number of the participants having poor quality of sleep declined from 43.46% to 11.10% at baseline to the day 22nd after interventions. In contrast there was increase in number of participants with high sleep quality score from 56.53% to 88.78% at day 22nd after interventions. This suggested that the sleep quality scores of the participants were improved from baseline to post interventions.

Table 3: Association between sleep quality scores among adolescents with their socio- demographic variables n=260

S.N.	Variables	Below median<7	Above and at ≤ 7	X^2	df	p value
1.	**Age (in years)**					
	12-13	45	74			
	14-15	41	61	3.181	2	0.220
	16-18	21	18			
2.	**Gender**					
	Male	44	80	3.147	1	0.079
	Female	63	73			
3.	**Family style**					
	Nuclear	67	86	3.106	2	0.184
	Joint	40	63			
	Extended	0	4			
4.	**Family income**					
	2000-5000	72	96	0.569	1	0.510
	6000-8000	35	57			
5.	**Use of drinks before sleep**					
	Yes	51	64	0.869	1	0.376
	No	56	89			
6.	**Use of items before sleep**					
	Laptop/mobile phone	19	25	0.118	2	0.971
	Television	82	120			
	Videogame	6	8			
7.	**Environment during sleep**					
	Calm	77	95	3.345	2	0.206

	Dark	25	44			
	Light	5	14			
8.	**Family problems in the past month**					
	Never	23	35			
	Little	49	70	2.302	4	0.732
	Sometimes	33	45			
	Frequently	2	1			
	Always	0	2			

Data depicted in table 3 illustrates that 'there was no statistically significant association between sleep quality scores among adolescents with their socio-demographic variables at 0.05 level of significance.

Discussion

The study findings illustrated that the mean sleep quality score of adolescents in pre test was 7.22 with standard deviation 2.17, after seven days of interventions the mean sleep quality score of adolescents was 6.28 with standard deviation 1.88, after 14 days of interventions the mean sleep quality scores of adolescents was 5.47 with standard deviation 1.54, after twenty one days of interventions the mean sleep quality scores of adolescents was 4.81 with standard deviation 1.12. The study findings were interpreted on the basis of Pittsburgh Sleep Quality scores which showed higher the sleep quality score, lesser will be the sleep quality and lower the sleep quality score, higher will be the sleep quality. The mean post intervention scores of sleep quality following one week (6.28±1.88), two weeks (5.47±1.54) and three weeks (4.81±1.12) of sleep promotion education was lower than the mean pre interventions score(7.22 ±2.17) of sleep quality. Findings showed that the post interventions sleep scores were decreasing from pre interventions scores which meant sleep promotion education improved the sleep quality of adolescents. The findings also showed that there was no significant association between sleep quality scores among adolescents with their socio-demographic variables at the level of 0.05 level of significance.

Conclusion

The study concluded that the adolescents had inappropriate sleep quality for which sleep promotion education was given to the adolescents. Sleep promotion education improved the sleep quality of adolescents significantly after three weeks of education. This suggests that the sleep quality scores of the participants were improved from baseline to post interventions.

Aknowledgement

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Effectiveness of Planned Teaching Programme on Alcoholism among the Adolescents at Government School Gurugram, Haryana

Sonia[1], Sarika Yadav[2], Arti Attri[3]

Abstract

Background: Alcoholism is considered as a serious public health issue in India and at large in the world. Adolescence is a period of the life cycle when individuals are managing multiple and complex development tasks. They have less self-control, emotional stability and more likely to smoke, drink, use drugs, and get in to trouble with the law. *Objectives:* 1. To assess the pre-test knowledge regarding alcoholism among adolescents. 2. To assess the post-test knowledge regarding alcoholism among adolescents. 3. To find out the association between post-test knowledge scores regarding alcoholism and selected demographic variables. *Material and Methods:* A pre-experimental study-one group pre-test and post-test design was selected for the study. The study was conducted at Government Senior Secondary school, Gurugram, Haryana. Data was collected from 30 students using structured knowledge questionnaire. *Results:* The study findings revealed that the mean knowledge score of students on alcoholism during pre-test (10.87±2.62) was lower than mean knowledge score of students on alcoholism during post-test (13±2.12). The difference in mean pre-test and post-test knowledge scores was found to be significant. *Conclusion:* The result of present study clearly showed that the structured teaching programme regarding alcoholism had significant impact on knowledge of senior secondary school students.

Keywords: Alcoholism; Structured Teaching Programme; Adolescents; Effectiveness.

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Introduction

Alcohol is a liquid form substance which contains ethyl alcohol (also known formally as ethanol) that can cause harm and even damage to a person's DNA. Alcohol consumption is recognized worldwide as a leading risk factor for disease, disability, death and is rated as the most used and abused substance by adolescents [1].

Author Affiliation
[1,2]Assistant Professor [3]Lecturer, SGT University, Gurugram, Haryana 122505, India.
Corresponding Author
Sarika Yadav, Assistant Professor, SGT University, Gurugram, Haryana 122505, India.
E-mail: soniav2387@gmail.com
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Adolescence is a transitional stage of physical and psychological changes,usually a time in a person life in which they go through puberty [2]. Alcoholism is the most severe form of alcohol abuse and involves the inability to manage drinking habits. It is also commonly referred to as alcohol use disorder. Alcohol use disorder is organized into three categories: mild, moderate and severe. Each category has various symptoms and can cause harmful side effects. If left untreated, any type of alcohol abuse can spiral out of control. Individuals struggling with alcoholism often feel as though they cannot function normally without alcohol [3].

Studies find that drinking alcohol often starts at very young ages. Moreover, studies indicate that the younger children and adolescents are more likely to engage in behaviors that can harm themselves and others. Those who start to drink before age 13 years, are nine times more likely to binge drink frequently than those who begin drinking later.

Data from recent surveys show that

approximately 10% of 9 to 10year-olds have already started drinking; nearly one third of youth begin drinking before age 13, and more than one in four 14 year old report drinking within the past year [4].

There is global concern about drinking trends among young people. Alcohol consumption is an important risk factor for morbidity, mortality and social harm worldwide leading to 2.5 million deaths each year. It is responsible for approximately 4% of the global burden of disease [5,6].

Alcohol consumption has been identified as a risk factor for many health, social and economic problems of communities. The recent traditional societies are gradually adopting modern lifestyles giving rise to new problems. World Health Organization (WHO) report identified alcohol as being responsible for nearly 60 types of disorders and injuries (WHO, 2000). Alcohol consumption has been recognized as the fifth leading risk factor, next only to underweight, unsafe sex, blood pressure and tobacco usage (WHO, 2002). Traditionally, the adverse effects of alcohol use have been linked only to the acute immediate effects (states of drunkenness) and long-term effects of alcohol dependence (resulting from habitual, compulsive and long-term heavy drinking). Numerous other common and frequent public health effects as well as the social and economic aspects have not been recognized by health professionals and policymakers. Further, alcohol has been a known risk factor for increasing crime, work absenteeism, loss of productivity, damage to property and the physical and emotional abuse of women and children [7,8].

People are most likely to begin abusing drugs, including tobacco, alcohol, and illegal and prescription drugs—during adolescence and young adulthood.

By the time they are seniors, almost 70 percent of high school students will have tried alcohol, half will have taken an illegal drug, nearly 40 percent will have smoked a cigarette, and more than 20 percent will have used a prescription drug for a nonmedical purpose [9].

There are many reasons adolescents use these substances, including the desire for new experiences, an attempt to deal with problems or perform better in school, and simple peer pressure [10]. Adolescents are "biologically wired" to seek new experiences and take risks, as well as to carve out their own identity. Trying drugs may fulfill all of these normal developmental drives, but in an unhealthy way that can have very serious long-term consequences [11]. Some children and adolescents start using alcohol at a very early age and are at a risk of developing physical and psychological problems earlier.

The World Health Organization estimates that as of 2010, there were 208 million people with alcoholism worldwide (4.1% of the population over 15 years of age). In the United States, about 17 million (7%) of adults and 0.7 million (2.8%) of those age 12 to 17 years of age are affected [12,13]. In November 2011, ASSOCHAM survey found a 100% rise in drinking among the 15-18 age groups in the last 10 years. The greater problem these days is not alcoholism but drinking problem, which affects 60 percent of users and makes them aggressive, said Dr. BK Rao, Chairman of ASSOCHAM. Usage of alcohol has also resulted in deliberate self-harm, high-risk sexual behavior, HIV infection, tuberculosis, esophageal cancer, liver disease, duodenal Ulcer and many more [14].

In 2014, the World Health Organization reported that alcohol contributed to more than 200 diseases and injury-related health conditions, most notably DSM–IV alcohol dependence (see sidebar), liver cirrhosis, cancers, and injuries. In 2012, 5.1 percent of the burden of disease and injury worldwide (139 million disability-adjusted life-years) was attributable to alcohol consumption [15].

According to the 2015 NSDUH (National survey on Drug use and Health), 33.1 percent of 15-year-olds reported that they had had at least 1 drink in their lives. Research indicates that alcohol use during the teenage years could interfere with normal adolescent brain development and increase the risk of developing AUD. In addition, underage drinking contributes to a range of acute consequences, including injuries, sexual assaults, and even deaths—including those from car crashes [16,17].

Methodology

For the present study, quantitative approach and pre-experimental one group pre-test and post-test design was used. The study was conducted at a selected Government Senior Secondary school, Gurugram, Haryana.

Administrative permission was taken to conduct the study. An informed consent was taken from each subject individually to participate in the study. Convenient sampling technique was used to select 30 students. The data were collected using structured questionnaire which was divided into

three sections. Section I consisted of items related to demographic data including 6 items such as age, gender, education, type of family, family income, & residence. Section II consisted of 20 items to assess the level of knowledge among students and Section III consisted of structured teaching program on Prevention of Alcoholism. Content validity of the tool was established by experts from Nursing, Psychiatric Nursing, Psychology, and Psychiatry. The collected data was analyzed by using descriptive and inferential statistics.

Results

Table 1: Frequency and Percentage distribution of subjects by their sample characteristics n = 30

S.No.	Characteristics	N	Percentage
1	**AGE (in years)**		
	15 to 16	12	40%
	17 to 18	18	60%
2	**Gender**		
	Male	23	76.66%
	Female	7	23.34%
3	**Educational Status**		
	11th class	23	76.66%
	12th class	7	23.34%
4	**Type of Family**		
	Nuclear	18	60%
	Joint	12	40%
5	**Family Income**		
	1000 to 5000	26	86.67%
	5000 to 10,000	4	13.33%
6	**Residence**		
	Rural	23	76.66%
	Urban	7	23.34%

The data presented in the table 1 indicates that the 40% students were in the age group of 15 to16 years were 40%, and 60% were in 17 to 18 years age group. According to gender, 76.66% students were male and 23.34% students were female. According to educational status, 76.66% students were in 11th class, 23.34% students were in 12th class. According to family, 60% students belonged to nuclear family and 40% students belonged to joint family.

According to family income, 86.67% students had family income Rs.1000 to 5000 and 13.33% students had family income of Rs. 5000 to 10,000. According to residence, 76.66% students belonged to the rural area, 23.34% students belonged to urban area.

The data presented in table 2 indicated that the mean knowledge score of students on alcoholism in pre-test (10.87±2.62) was lower than mean knowledge score of students on alcoholism in post-test (13±2.12). t-test was applied to find the significance of mean difference of pre-test and post-test knowledge scores. The calculated t-value of 4.326 was found to be higher than the table value (2.04) at 0.05 level of significance which indicated that the PTP on alcoholism was effective in increasing the knowledge of adolescents on alcoholism.

Findings in Table 3, Indicated that subjects 1 (3.33%) subject had poor level of knowledge, 23 subjects 76.67% were having average level of knowledge and 6 (20%) subjects were having good level of knowledge. No subject had excellent knowledge during pre-test. In the post-test, no subjects was found to have poor knowledge, 14 (46.67%) subjects were having average level of knowledge and 16 (53.33%) subjects were having good level of knowledge. No subjects was found to haveexcellent knowledge during post-test.

Chi-square test was applied to find association of knowledge scores of the adolescents on alcoholism with age, gender, educational status, type of family, family income and place of residence.

Table 2: Range, Mean,Standard Deviation and significance of mean difference of Pre-Test and Post-Test Knowledge scores regarding alcoholism among Adolescents. n=30

S no.		Range	Mean	Standard Deviation	t- test	Table Value
1.	Pre-test	7-13	10.87	± 2.62	4.326	2.04
2.	Post-test	14-20	13	± 2.12		

Table 3: Frequency and percentage distribution of adolescents by their pre-test and post-test knowledge scores regarding alcoholism.

n=30

S No.	Level of knowledge	Range of scores	Pre-test Frequency	%	Post-test Frequency	%
1	Poor	0-6	1	3.33%	0	0%
2	Average	7-13	23	76.67%	14	46.67%
3	Good	14-20	6	20%	16	53.33%
4	Excellent	21-28	0	0%	0	0%

The findings depicted that the knowledge of the adolescents about alcoholism was dependent on age, gender, educational status, type of family but knowledge of adolescents on alcoholism was independent of family income and place of residence.

Discussion

The present study showed that 76.66% adolescent boys and 23.34% adolescent girls who consumed alcohol. A similar study conducted by Tur, Puig and Benito[18] showed that about 60% of adolescents, 53% of boys and 65%of girls, reported alcohol consumption, which increased with age in boys [91% when they were 18 years old], but remained constant in girls.

In the present study, 3.33% subjects were having poor level of knowledge, 23 (76.67%) subjects were having average level of knowledge and 6 (20%) subjects were having good knowledge on alcoholism.In the post-test, 14 (46.67%) subjects were having average level of knowledge and 16 (53.33%) subjects were having good level of knowledge.

These findings were consistent with the study conducted by Gopi D, S Deepa [19] who found that school students in general lacked knowledge about alcohol abuse and its adverse effects before the education programme.

The findings of this study support the need for conducting educational programme to increase the knowledge about alcohol abuse.The study shows that knowledge of adolescents regarding alcohol abuse significantly increased after attending teaching programme on alcohol abuse.

The findings of the present study showed that the mean knowledge score of students on alcoholism in pre-test (10.87±2.62) was lower than mean knowledge score of students on alcoholism in post-test (13±2.12).

A similar study conducted byR Snehalatha*, M Bhagyalakshmi and S Hemalatha [20] also revealed the same results, i.e.,pretest mean value and standard deviation of knowledge scores was 15.40+2.499 and the posttest mean value and standard deviation of knowledge scores on alcoholism was higher at 24.08+2.499.

The above results revealed that there was a significant difference between pre-test and post-test scores among high school children after structured teaching programme.

Conclusion

Alcoholism has been found to be a serious health problem. There is need to generate adequate awareness and plan educational interventions. There is also a need to identify vulnerable groups, for example children and adolescents. Children and adolescents need to be educated on alcohol addiction and its ill-effects. Schools should have adequate resources, such as well-informed teachers, school health nurse and counselor for early recognition and management of alcoholism in school children.

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Original Article

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The Missing Tile Syndrome

Vandana S. Thangavel

Abstract

Human beings can never be perfect instead they should enjoy their imperfections and celebrate them because there is nothing like a perfect life. The Missing Tile Syndrome is a term coined by Dennis Prager. It means focusing on the things that one does not have and in the process, robbing ones happiness. Life is a beautiful gift of god and we should always keep this in mind.

Keywords: Missing; Lacking; Unsatisfied; Syndrome.

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Concept of Missing Tile

Dennis Prager gave the concept of missing tile. Imagine yourself sitting in a newly constructed room. You looked up and you see such a perfect tile ceiling. However, while you are admiring the ceiling, you notice one tile is missing. From then on, no matter how beautiful the ceiling is, you can't fully enjoy its beauty just because of one single missing tile. So you finally called the maintenance and have the missing tile replaced. After that, you now have the perfect ceiling once again.

If we shift our concentration on our lives, all of us have something that we desire for but do not possess. Those are the missing tiles in our lives. However, there are some tiles, that no matter how hard we try,can never be replaced or fixed. The missing tile in the ceiling can be replaced and once again make the ceiling look perfect. But sadly, there is no such thing as 'a perfect life'.

There is a big danger when we concentrate on the missing tiles in our life. It makes us dissatisfied, ungrateful, remorseful, and unhappy. At this point in time, we might be suffering from the Missing Tile Syndrome.

Signs of Missing Tile Syndrome

- Feeling of despair
- Feeling helpless
- Feeling of dissatisfaction

Possible solutions to deal with Missing Tile Syndrome

- *Clarify* - this simply means thatyou have to clarify within yourself what you perceive to be the missing item in your life, what you think may be troubling you.
- *Decide*- Decide with or without. Decide if this missing item is central to your happiness or whether you can be happy without it. From here, you can either 'get it', 'forget it', or 'replace it'.
- *Analyze power*- If the item is within your power

Author Affiliation
Assitant Professor, HOD Mental Health Dept., MKSSS, Sitabai Nargundkar College of Nursing, HIngna, Nagpur, Maharashtra 441110, India.

Corresponding Author
Vandana S. Thangavel, Assitant Professor, HOD Mental Health Dept., MKSSS, Sitabai Nargundkar College of Nursing, HIngna, Nagpur, Maharashtra 441110, India.
E-mail: vandanaswaran@gmail.com

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to obtain, and it is central to your happiness; focus on how you might get it. Examples might include finding a mate, having another child, spending more time with your spouse, or moving to another state, changing job etc.

- *Have it or leave it*- If the item is not within your power, do your best to forget it or at least try not to think about it as much. If you can't change the thing just accept the way it is. It will give you peace.
- *Replace*- Replace your missing item with something else. Example can be of the star athletes who are injured and who go on to have successful, inspiring careers in another field. Focusing on the inability to play football would only increase unhappiness, while creating a new dream helps bring fulfillment.

Ways to avoid Missing Tile Syndrome

1. Avoid covetousness- This means a strong desire to acquire the same thing which belongs to others. This feeling is so strong that we always think about it. This feeling damages one's life because these desires can never be satisfied.Finally, covetousness can lead to other deviant behavior such as stealing, lying, adultery, murder, etc.

2. Be thankful- . Being thankful is a wonderful attribute. It prevents us from being bitter towards what other people have and helps us concentrate on the things that we are blessed with.In this life, we may never have everything, but we always have something.

3. Be content- Contentment is the assurance that in whatever situation we may be in, situation is in our control. Contentment helps us to avoid looking at what is missing in our life, but rather focusing on the things that you have

Conclusion

All of us have only one life to lead. If we go to the grave with a list of grievances, all it means that we did not try. Why talk about fate, chance, breaks, and many other factors, when we ourselves are responsible for what happens in life. Margus Aurellus said that a man's life is what his thoughts make of it. Start right where you stand andbecome the master of yourself, start now,and banish the old self, as you have lived with it enough. Recognize and embrace the other self which can give you everything your heart carves. Remember that it is profoundly significant that the only thing over which you have complete control is your own mental attitude, use your potential and reach the target with excitement and jubilation.

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Review Article

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Schizophrenia: Unlock Strategies to Prevent a Relapse

Jyothi Sunandha

Abstract

Schizophrenia is a chronic illness with a relapsing nature. It is of paramount importance to avert a recurrance for the following reasons 1. The symptoms of a relapse are more severe than the previous episode 2. Burden to the family and society is humungous 3. It is imperative that a schizophrenic patient leads a normal life. Therfore, this article gives information on ways to monitor one's mental health and prevent a relapse.

Keywords: Prevent; Relapse; Schizophrenia.

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Introduction

Relapse in schizophrenia may be clinically defined as the emergence of psychotic symptoms to the point that crisis intervention or hospitalization is required. Understanding the relapse and remitting course is central to relapse prevention [1].

Why prevention of relapse is important in Schizophrenia?

Schizophrenia is a mental illness that demands vigilance. The sooner the symptoms of schizophrenia are recognized, the greater the likelihood is of regaining control [2]. Unfortunately, psychotic relapse is common, with up to 40% of all patients suffering a relapse within a year of being hospitalised. Relapse can cause significant personal distress, interfere with rehabilitation efforts, and result in psychiatric hospitalization [3,4].

Author Affiliation

Lecturer, Dept. of Nursing, College of Health Sciences, Mizan Tepi University, Ethiopia.

Corresponding Author

Jyothi S. Sunandha, Lecturer, Dept. of Nursing, College of Health Sciences, Mizan Tepi University, Ethiopia.

E-mail: jyothi.daffs@gmail.com

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Events that trigger a relapse

Special phenomenon that may trigger relapses may include the following:

- Particular times of the year, week or day
- Anniversaries of becoming ill, of losses such as bereavements (including significant events in a client's life namely birthdays etc.)
- Change in medications
- Watching a film/TV programme or listening to music (May be a reminder or a trigger)
- Use of alcoholism or drugs [5].
- Loss or grief
- Poor adherence to treatment plan (such as not taking prescribed medications)
- Other stressful events
- An unpleasant event such as perceived failure, disappointment or criticism [6].

Strategies to prevent relapse

Access to supports:

Identifying and managing one's own health needs are primary concerns for everyone, but this is a particular challenge for clients with schizophrenia because their health needs can be complex and their ability to manage them can be impaired. Providing

facts about schizophrenia, identifying the early warning signs of relapse and teaching health practices to promote physical and psychological well-being are important [7]. Support networks including mental health services, friends, family members and medications need to be available along with a readiness to use such access [5].

Availability and flexibility are the cornerstones of relapse prevention. Patients and their support persons should be able to reach clinicians easily, particularly during evenings and weekends. Whenever possible, patients with schizophrenia who may be relapsing should be evaluated within 24 to 48 hours. Family members and supportive others can become the 'eyes and ears' of the treatment team in detecting the onset of relapse. They can also have a protective effect by helping patients manage stressful situations and by supporting adherence to treatment [1].

Recognising and responding to early warning signs:

Some people have unique, rather than common, early warning signs of relapse. The patient and family members are in the best position to recognise these signs. A relapse "signature" (an individualised pattern) can include a change in sleep pattern (especially a reduction in amount) tiredness, anxiety and depression and/or the re-emergence of psychotic symptoms. 'A touch of schizophrenia's coming on' or 'the fear of going mad' has been described as a frequent initial symptom preceding relapse [5].

The primary goal of monitoring early warning signs is to be able to act quickly to prevent relapses. The earlier you take preventive steps, the more likely that a relapse can be averted. Even if a relapse does occur, early intervention can decrease the severity of the episode and avoid hospitalisation. Even if hospitalisation is necessary, recognising and responding quickly to the early warning signs of relapse results in a briefer stay.

Providing additional medication during the first few days or weeks after early warning signs have been detected is a powerful strategy for preventing relapses and hospitalization [8].

Be Compliant to Medications:

Non-compliance with long term antipsychotic medications is very high. An estimated 40 to 50% of patients become non-compliant to medications within 1 or 2 years. It is generally recommended that patients with multiple episodes receive maintenance treatment for at least 5 years and many experts recommend pharmacotherapy on an indefinite basis [9].

Clients may have practical barriers to medication compliance such as inadequate funds to obtain expensive medications, lack of transportation or knowledge about how to obtain prescriptions or inability to plan ahead to get new prescriptions before current supplies runout. Clients usually can overcome all these obstacles once they have been identified. Sometimes clients decide to decrease or discontinue their medications because he/she dislikes taking them or believes he/she does not need them. The client may have been willing to take the medications when experiencing psychotic symptoms but may believe that medication is unnecessary when he/she feels well. By refusing to take the medications, the client may be denying the existence or severity of schizophrenia. These issues of noncompliance are much more difficult to resolve [7].

Pharmacotherapy can be optimized by simplifying drug regimens, by considering the use of atypical and decanoate antipsychotic medications, and by minimizing drug side effects [11,12]. Side effects are a major cause of medication non adherence among schizophrenic patients. Since novel 'atypical' antipsychotic medications produce noticeable fewer EPS than standard antipsychotic medications, they have the potential to improve adherence and help prevent relapse. Recent studies have suggested that atypical antipsychotic medications are superior to standard medications in preventing psychotic relapse1.

Learn Coping Skills:

An essential component of building healthy coping skills is a healthy life style which includes eating well, exercising regularly and getting enough sleep. Learning specific relaxation skills like meditation, mindfulness, deep breathing exercises, progressive muscle relaxation, yoga or cognitive-behavioural therapy skills can help a person calm down. Other activities like music, art or writing may also be helpful [6].

Mind-body relaxation plays a number of roles in recovery [12]. First, stress and tension are common triggers of relapse. Second, mind-body relaxation helps individuals let go of negative thinking such as dwelling on the past or worrying about the future, which are triggers for relapse. Third, mind-body relaxation is a way of being kind to oneself. The practice of self-care during mind-body relaxation

translates into self-care in the rest of life. Part of creating a new life in recovery is finding time to relax [13].

Conclusion

Primarily, there are two sides to prevention of relapse in schizophrenia namely identifying the early prodromal signs and indulging in healthy life style. Further, phenomenon that act as triggers and strategies to avoid a relapse was reviewed. To conclude, this article will empower one with skills needed for recovery from disabling schizophrenia.

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