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CONTENTS

Original Article

- The Effects of the Training of Life Skills and Positive Psychological Capital through the Art of Storytelling on Subjective Well-Being of Children with Visual Impairment** 97
Nandita, Uma Joshi

Review Articles

- Restoring Hope with Dignity through Empowering Mental Health Team: A Time for Action** 105
Divya Gigy, Anumol Joseph
- Unveiling Transcultural Psychiatry Nursing and Providing Culturally Competent Care** 111
Anumol Joseph, Sonia
- Lost Online, Then Lust Online** 117
Sujita Kumar Kar
- A Literature Review: Internet Addictions among Teens- Its Impact and Solutions** 121
Farzana Begum
- Suicide Prevention: A Brief Review** 125
Xavier Belsiyal C.
- Guidelines for Authors** 129
- Subject Index** 133
- Author Index** 135

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The Effects of the Training of Life Skills and Positive Psychological Capital through the Art of Storytelling on Subjective Well-Being of Children with Visual Impairment

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Abstract

This study discovers the effects of training of life skills (LS) and positive psychological capital (PPC) on subjective well-being (SWB) of children with visual impairment. It was an experimental, intervention study with Solomon research design. The sample of the study consisted of 160 visually impaired children (95 Boys & 65 Girls), selected from special schools for visually impaired children in Jaipur (Rajasthan). For the training of life skills and positive psychological capital, stories of Panchtantra were used. Total 28 sessions of training (20 sessions for 10 LS & 8 sessions for 4 PPC) were given. The 'Subjective well-being test' developed by Nagpal & Sell in (1992) was administered before and after training to check the status of subjective well-being of these children. Post-test scores of subjective well-being were obtained after this intervention. The result of the study revealed that the training of life skills and positive psychological capital improved subjective well-being of these children significantly. It was concluded that the method of training of life skills and positive psychological capital through the art of storytelling proved to be effective and interesting for these children. This training equipped them with psycho-social skills and positive perspective towards self, people and work to face the tough challenges of life effectively, independently. Such training paves the way to success and happiness in work place and in personal life. This study has worldwide relevance.

Keywords: Life Skills Training; Positive Psychological Capital Training; Subjective Well-Being; Storytelling; Visual Impairment.

Introduction

There are approximately 15 million visually impaired people in India and of these 26% are visually impaired children [21]. These children have limited personal resources and access to learning opportunities and growth facilities. They have to make extra efforts in comparison of normal children to come to the mainstream.

In spite of extra efforts they do not perform well in academics and their behavioral skills do not grow. This makes their journey tough and trying. The ill effects of poor subjective well-being in these children are more intense than normal children because they are vulnerable group who may get de-motivated easily. Their disabilities and life experiences force them to face repeated failures and cause anger, frustration, disappointments, anxiety and depression [2]. Their self-efficacy goes down, become pessimist in their orientation and lose hope of bright future. Self-efficacy, hope, optimism and resilience helps to reduce stress, enhance positivity, improves mental health and that in turn gives a productive, meaningful and happy life [7, 8].

Just like normal children these children have the right to have their opinions, feelings, wishes and freedom to take decisions for their own lives. They also want to develop their skills to the best of their capacity and they also expect acceptance, love and care. They want to be physically comfortable, seek love,

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care and security and want to have opportunities for physical and mental growth. These children have the capacity to become productive citizens and contribute to national development. But, they have more and difficult challenges to face their life because of their delimiting liabilities. To face the challenges of life they need special and extra training of life skills and positive prospective [12] towards life. They are marginalized and have sufficient reasons for poor mental health and low self-esteem if their liabilities are not countered by special training of life skills and positive psychological resources.

Life skills and positive psychological capital are important skills and proficiencies that enable us to face the tough challenges of life effectively. Ten life skills,[24] are namely: Self-awareness, critical thinking, creative thinking, decision making, problem solving, communication skills, interpersonal relationship, empathy, handling emotions and stress management and four positive psychological capitals by Luthans [24] are namely: Self-efficacy, hope, optimism and resilience. With the help of the training of life skills (LS) and positive psychological capital (PPC) children with visual impairment can deal with hardships of their life by facing the reality, increasing level of hope, taking risks, handling them with creativity.

Studies have shown that the training of life skills enhanced their all developmental domains such as personal, social, academic and career in children with learning disability, training of life skills and self-efficacy helped in resolving their emotion and behavioral problems and improving their skills [20]. The training of life skills changed thinking, encouraged not only hopeful thoughts but also enhanced self-compassion or empathy, positive changes in personal inter-personal relationship, life satisfaction and reduced problems in communication [22]. Life skills training improved low mood, depression and anxiety [13, 23]. Studies showed that there was a positive relation between empathy (LS), optimism (PPC) and personal achievement (components of a positive personality) that helped in reducing stress (burnout) and improving inter-personal relationships of students [9]. The training of positive psychological capital enhanced optimism and reduced stress and pessimism in students [11]. A positive and strong relationship was found between level of resilience (PPC) and problem solving abilities [3]. Another study showed that life skills improved communication skills [15]. These studies produced scientific evidences that training of life skills and positive psychological capital counters the poor behavioral skills and alters low subjective well-being

(SWB) of children with visual impairment. Hence, this emphasizes the need of the training of life skills and positive psychological capital which counter the poor behavioral skills and low subjective well-being of visually impaired children. The intensive efforts were made by the researcher to find the relevant studies that influence visually impaired children, life skills, positive psychological capital, subjective well-being and storytelling. Only some studies were found to be available especially on disability and storytelling context. This is identified as major researchable gap. Therefore, this also indicates the value and importance of current research. Thus, the present study focused on studying the effect of the training of life skills and positive psychological capital on subjective well-being of visually impaired children.

Materials and Methods

There are schools exclusively for visually challenged children in Jaipur that are run by State Government. The samples of the study comprised of 160 visually impaired children from government schools of Jaipur (Rajasthan). The age of the children aged between 13-23 years. Standardized subjective well-being test (SWB) developed by Nagpal & Sell in 1992[17] was used. Subjective well-being was assessed by positive and negative affects where a high score in positive affect and a low score on negative affect projected an index of high subjective well-being. Hindi-English-Hindi translation by the language expert was done. A Solomon research design with extra confirmatory group was used.

Pre-test	Intervention	Post-test
SWB (1)	LS Training	SWB (2)
SWB (3)	PPC Training	SWB (4)
SWB (5)	LS + PPC Training	SWB (6)
SWB (7)	No Training	SWB (8)
_ (9)	LS Training	SWB (10)
_ (11)	PPC Training	SWB (12)
_ (13)	LS + PPC Training	SWB (14)
_ (15)	No Training	SWB (16)

Due to their visual liabilities the usual methods of learning and training are not very effective with these children because they have different abilities, limitations and challenges to face. They need special instructions of learning and specially designed pedagogy to teach. Therefore, present study used the art of storytelling using Panchtantra stories as a pedagogical method. Storytelling enhances not only social skills but also develop skills in children[4]. It is

an innovative and creative method of teaching that helps to develop language and improve pronunciation and vocabulary of children [6,11]. Story-telling is an art and a skillful teaching process and an effective aid for these children which develops their social and emotional understanding [14,18] Pre-test was done. The intervention of 14 sessions or the training of life skills and positive psychological capitals through the art of storytelling using Panchtantra for 6 months where around minimum 28 sessions covering 10 life skills and 4 positive psychological capitals (two for each LS and PPC) along with some group dynamic

activities were conducted.

Results

Table 1& Figure 1& 2 reveals that the mean scores of positive subjective well-being increased after life skills training (Intervention) in terms of post-test and the mean scores of negative subjective well-being decreased after life skills training (Intervention) in terms of post-test.

Table 1

LS Training	n	Pre-test		Post-test	
		Mean (SD)	Mean (SD)	T	P
Experimental Group (Positive SWB)	20	40.80 (3.23)	47.65 (2.83)	-13.733	0.001*
Experimental Group (Negative SWB)		37.80 (1.67)	33.95 (1.95)	14.046	0.001*
Control Group No LS Training (Positive SWB)	20	40.10 (1.80)	40.00 (1.74)	.698	>.05
Control Group No LS Training (Negative SWB)		37.20 (1.70)	37.05 (1.66)	1.831	>.05
Post-test Only After LS Training (Positive SWB)	20	-	47.45 (3.08)	-21.442	0.001*
Post-test Only After LS Training (Negative SWB)		-	33.40 (1.35)	23.974	0.001*
Post-test Only No LS Training (Positive SWB)	20	-	40.25 (1.65)	-1.143	>.05
Post-test Only No LS Training (Negative SWB)		-	37.00 (1.62)	1.285	>.05

n = 80 (n = 40 ex. group & n = 40 con. group) *significant - 0.001, no significant ->.05

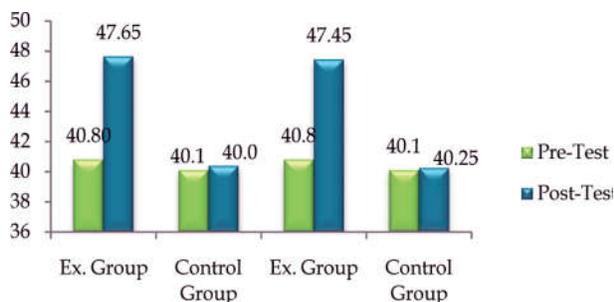


Fig. 1: Positive SWB

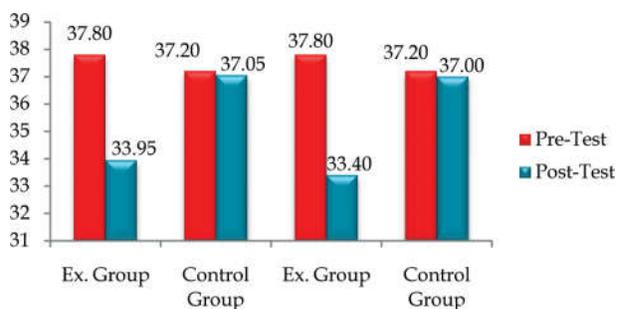


Fig. 2: Negative SWB

Table 2:

PPC Training	n	Pre-test		Post-test	
		Mean (SD)	Mean (SD)	t	P
Experimental Group (Positive SWB)	20	40.25 (2.44)	45.85 (1.92)	-16.686	0.001*
Experimental Group (Negative SWB)		37.25 (2.19)	33.10 (2.31)	11.160	0.001*
Control Group No LS Training (Positive SWB)	20	40.10 (1.80)	40.00 (1.74)	.698	>.05
Control Group No LS Training (Negative SWB)		37.20 (1.70)	37.05 (1.66)	1.831	>.05
Post-test Only After LS Training (Positive SWB)	20	-	45.60 (2.18)	-21.962	0.001*
Post-test Only After LS Training (Negative SWB)		-	33.60 (1.50)	7.396	0.001*
Post-test Only No LS Training (Positive SWB)	20	-	45.25 (1.65)	-1.143	>.05
Post-test Only No LS Training (Negative SWB)		-	37.00 (1.62)	1.285	>.05

n = 80 (n = 40 ex. group & n = 40 con. group) *significant - 0.001, not significant ->.05

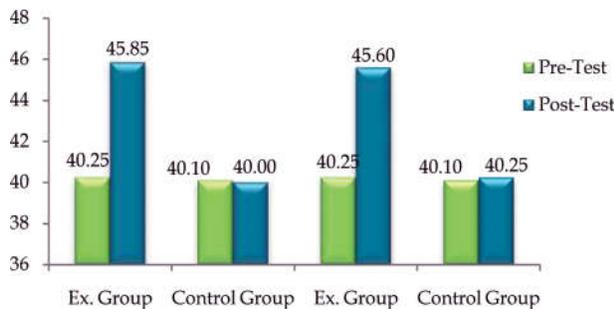


Fig. 3: Positive SWB

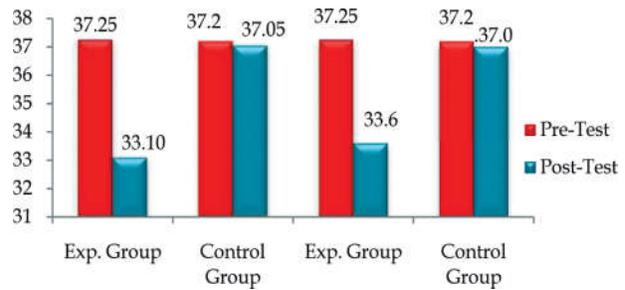


Fig. 4: Negative SWB

Table 2 & Figure 3 & 4 reveals that the mean scores of positive subjective well-being increased after positive psychological capital training in terms of post-test and the mean scores of negative subjective well-being decreased after positive psychological capital training in terms of post-test.

Figure 5 reveals that the training of life skills was more effective in enhancing positive subjective well-being whereas, there was no significant difference between life skill and positive psychological capital in reducing negative subjective well-being of children with visual impairment.

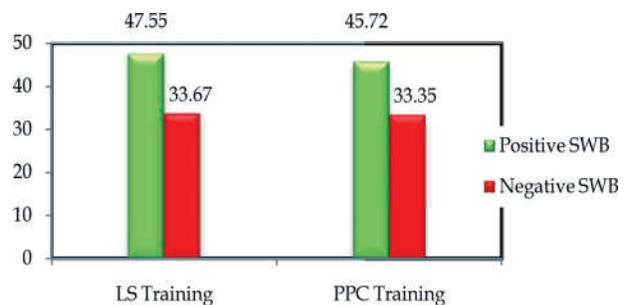


Fig. 5:

Figure 6 shows a positive and significant correlation between life skills and positive psychological capital with r and P values ($r = 0.549$ & $P 0.001^*$).

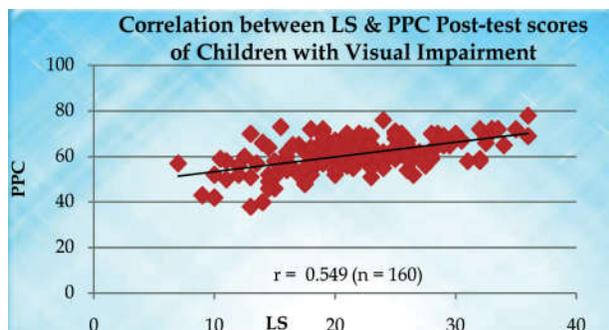


Fig 6: Correlation between Life Skills and Positive Psychological Capital Post-test scores of Children with Visual Impairment

Discussion

Children with visual impairment become very restricted in their mobility and personal resources on one hand and their exposure to the learning opportunities on the other. They are restricted in their social resources, are poorly managed, not sufficiently equipped with infrastructure and have access to limited number of special schools, learning material (books in Brail) and trained teachers. When these children confront their life with such poor facilities, they face negative experiences e.g. failures, anger, frustrations, disappointments etc. [19].

The training of life skills provides them the psychosocial weapons to face the challenges of life and fight against their self-doubts, uncertainties, in capabilities etc. As a result, they improve their subjective well-being. Using the similar intervention method and module for training of life skills on ADHD and CD children, a study reported similar results [1]. Life skills were found to be more efficient to face day to day challenges [16]. Subjective well-being is related to optimism, close-relationships, religion, spirituality, work, physical and mental health and life style [5].

The current research has shown that life skills training improves quality of life and enhances subjective well-being of children with visual impairment. Their impairment affects their efficiencies, their perception of themselves and their future adversely. This affects their mental health negatively. The training of life skills is an effective method for controlling anger that affects mental health as endorsed by Vatankhah et al. [23]. Present study findings are also in line with study by McClay et al. [13] that showed that life skills training improve low

mood, depression and anxiety. Because of absence of visual input, visually impaired children faced difficulty in expressing themselves to their family, friends and other people. Life skills education gives them the strength to express and handle their emotions, and improve inter-personal relationships. Through the training of life skills and stories of Panchtantra, children with visual impairment learned to cope with their anger and stress. They learned to regulate and handle their emotions. The training of life skills enhanced all developmental domains such as personal, social, academic and career in children with learning disability, [20] was effective in enhancing their happiness, quality of life, their life satisfaction and mental health, changed thinking, encouraged not only hopeful thoughts but also enhanced self-compassion or empathy, inculcated positive changes in personal life and inter-personal relationship, life satisfaction and reduced problems of communication, [22] The training of positive psychological capital enhanced optimism and reduced stress and pessimism in students [11]. Coskun et al. [3] showed a positive and strong relationship between level of resilience and problem solving abilities because a resilient child will absorb disturbance in his life, leap back or change and will easily recover or adjust from any situation. Norgaard et al. [15] reported that communication skills improved self-efficacy. Many of these studies in the reviews are on normal children and adolescents. When such training is so effective even in normal children, the impact of such training could be many folds. Such training not only improves the subjective well-being but enhance academic achievement, their employability and assimilation to the main stream also.

The result of study concluded that, the training of life skills and positive psychological capital through an art of storytelling improves and enhances subjective well-being of visually impaired children significantly ($t = -13.733$; $P < .001$). LS and PPC can counter their liabilities and limitations and make them efficient, successful and proactive in life. Such training also boosts their self-confidence; enrich happiness and quality of life with satisfaction. Due to their visual limitations, they need specially designed training techniques. Storytelling as a method imparting life skills and positive psychological capital proved beneficial for these children. Panchtantra stories are very appropriate for visually impaired children. Hence, it has proved that the training of LS and PPC through storytelling can bring significant and positive improvement in SWB of these children. It is recommended that training of life skills and positive psychological capital through art of storytelling should be incorporated as part of regular curriculum.

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Restoring Hope with Dignity through Empowering Mental Health Team: A Time for Action

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Abstract

Dignity is any individual's birth right. However people with mental illness are denied this basic right through stigmatizing beliefs and discrimination put forth by the societal folks. Dignity has become a great rallying cry for change in the public perception and mental health services, at national and international levels. Dignity in mental health should be brought to the forefront of not only mental health care but also general health care. Nurses should support the independence of individuals in need of support due to disability, illness or frailty. They should provide a range of services including practical assistance, personal care, and emotional support. They can provide these services in residential or nursing care settings, in the person's own home or in the community. For dignity in mental health to become universal we need to promote dignity and ethical values including social justice throughout our whole society, and create a shared understanding of what dignity in mental health looks and feels like. Making dignity happen requires delivering good care and supporting recovery for people with mental health problems and their families requires a workforce that can work in a collaborative way with patients and care.

Keywords: Dignity; Stigma; Discrimination; Autonomy.

Introduction

There is a huge disparity in physical and mental

health care even today. The workforce in health care offer services that are sub-standard. Lack of effective communication and follow up due to lack of knowledge and expertise on the part of health providers and decrepit facilities deteriorate existing health. Infinite people with mental illness are marginalized, discriminated and isolated in the societies. Consequently they become victims of physical and mental abuse.

People suffering from mental health problems, their significant care givers, and all the professional bodies need to treat people with respect, tackle discrimination, and preserve autonomy, choice, control and independence. Every member of the society needs to work together to make dignity in Mental health a reality [1].

The Indian scenario holds a different picture altogether. Medical conditions like diabetes and hypertension are given immediate attention and provided supervision. There is a great difference in the ways of treating the patient with mental illness. In some parts of India mentally ill people are considered 'special', 'blessed', 'chosen ones' and as God's creations. Altruism pours out from people and it is believed to be virtuous to help them [1]. On the contrary, in some parts of rural places they are treated badly, perceived as being under an 'ill omen', having a curse, bringing bad luck and misery, and having a negative influence on society. They are despised, discarded and neglected. In mental health institutes, there is a wide disparity concerning dignity issues in comparison to physical illnesses. Patients are not cared for very well in some situations, not given decent clothes or food, and not allowed liberty. Labeling of people because of their diagnosis, which mirrors a loss of respect, is common. Providing safety for persons with mental illness is still not a priority. Medications

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are administered to non-compliant patients, concealed in food and drinks, by family members to maintain peace at home. Autonomy is compromised at times. Persons with mental illness are not given a choice regarding their medications and interventions. Many institutes and centers do not have adequate rehabilitation services [1].

Definition of Dignity

Dignity refers to an individual's inherent value and worth and is strongly linked to respect, recognition, self-worth and the possibility to make choices. Being able to live a life with dignity stems from the respect of basic human rights including the following aspects of giving dignity [2]:



Fig. 1: Dignity required areas

Types of Dignity

As per the World Dignity Project [3], there are three main forms of dignity

1. Human Dignity-It involves physical care and respect for the individual. For instance, provision of basic amenities to sustain life like food, water and shelter and supplying bed linen and blanket should be provided in the hospital.
2. Self dignity-Feeling empowered in the treatment process. The client should participate in the decisions pertaining of his illness, treatment and prognosis.
3. Universal Dignity- It involves the perspectives of the society towards mental illness. Stigma related to mental illness can be curbed only through public awareness.

Threats to Dignity

Research evidence broadly identifies three areas as

threats to dignity in mental health care, although there is considerable overlap between them [4]:

- Stigma and discrimination
- Cute inpatient care
- Human rights violations

Stigma and Discrimination

More recently, the Stigma Shout survey, confirmed that stigma and discrimination is pervasive – 87 per cent of people with mental health problems reported that stigma had a negative impact on their lives. Two-thirds had stopped doing things because of the fear of stigma and discrimination [4]. The four categories of dignity identified by Horton are [5]:

1. being ignored or insufficiently ignored
2. being seen but only as a member of a group
3. having one's personal space transgressed involuntarily
4. Humiliation.

Acute Inpatient Care

A qualitative study findings on revealed that former patients' experiences of hospitalization, refer to the experience of inpatient care as 'a struggle for dignity in the face of discrimination and rejection [6].

Human Rights Violations

As long as professionals have the power to detain and treat someone compulsorily, practices that devalue the client's 'self-insight' and threaten their dignity will continue [4]. Furthermore, there is a view that mental health legislation in itself is discriminatory because it singles out one group of people for particular scrutiny [7]. The 'Human Rights Insight Project showed that vulnerable groups saw being treated with dignity and respect as the single most relevant factor when dealing with workers in the NHS or social services, compared with other principles of human rights. The study investigated public understanding of human rights, after a number of independent reports concluded that the potential of the Human Rights Act to improve the lives of people in the UK was yet to be realized [4].

Dignity Denied Situations-at a Glance

Frequently they are locked up in institutions where they are isolated from society and subject to inhuman and degrading treatment. Many are subjected to physical, sexual and emotional abuse and neglect not

just in hospitals and prisons, but also in the communities.

They are very often deprived of the right to make decisions for themselves. Many are systematically denied the right to make decisions about their mental health care and treatment, where they want to live, and their personal and financial affairs. They are denied access to general and mental health care. As a consequence they are more likely to die prematurely, compared with the general population. They are often deprived of access to education and employment opportunities. Stigma and misconceptions about mental health conditions means that people also face discrimination in employment and are denied opportunities to work and make a living [2].

Around one in ten children experience mental health problems. Mentally ill children are usually excluded socially and from educational opportunities. This causes discrimination and exclusion from employment opportunities in later life. These displays of discrimination can become internalized, leading to the development of self-stigma: Self-stigma can also lead to the development of the “why try” effect, whereby people believe that they are unable to recover and live normally so “why try?” They are prevented from participating fully in society. They are denied the possibility to take part in public affairs, to vote or stand for public office [8]. They are prevented from participating fully in society. They are denied the possibility to take part in public affairs, to vote or stand for public office. They are not given the opportunity to

participate in decision-making processes on issues affecting them, such as mental health policy and legislative or service reform. In addition, access to recreational and cultural activities is often denied to people with mental health conditions [2].

What the Common Man can do?

To make dignity in mental health a reality, every member of society needs to work with each other to make mental health visible and not something to be ashamed of. People need to know that mental illnesses are illnesses just like other illnesses. They need to know how to recognize mental health problems in a person and how to give them help. They do not need to be mental health practitioners to have these first aid skills. Citizens can create a more supportive and caring community for those people with mental health problems by intervening early so that the person can get good support and hasten recovery. This will contribute to advancing the cause of ‘Dignity in Mental Health’ globally [9].

In Australia, the Mental Health First Aid (MHFA) program was developed to teach people, members of the public, how to recognize and assist other people who are developing mental health problems or are in a mental health crisis situation [11]. Mental Health First Aid teaches a five-step action plan, ALGEE, for individuals to provide help to someone who may be in crisis.

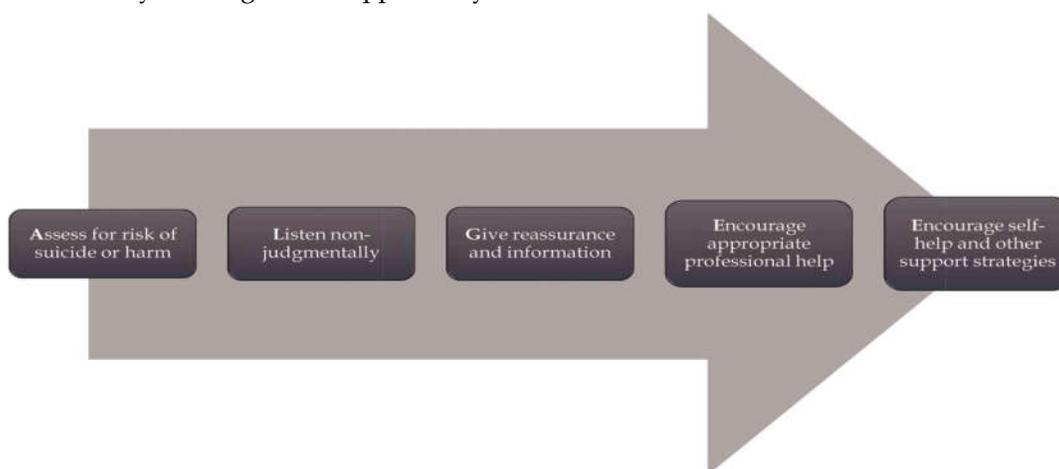


Fig. 2: Five step action plan-ALGEE developed by Mental Health First Aid Program (MHFA)

Role of Nurses in Facilitating Dignity to Populations

- Creating awareness through information, education and communication. We need to talk about mental illness on everyday basis in the media and government. We need to be open minded and welcome new ideas. In the

community and hospital settings the nurse should advocate on behalf of the patients to eliminate prejudices and discrimination pertaining to these illness. Furthermore, equity and fairness to access, accept and approach health services should be made available with any discrimination. The

nurses should see that adequate human and material resources are allocated to reduce the discrimination of disparities and inequalities [12].

- Follow up of patients should be done on a periodic basis through home visits. This will reduce stigma to a great extent. Additionally it helps to overcome non-compliance to the drug and will help to monitor the condition of the patient this can be done by community mental health nurse working at the district health programs [10].
- Strengthening of the workforce-One of the ways to improve the access to care is by using skill mix and task sharing means that new roles are developed and existing roles are redefined. Skill mix describes the range of roles and skills that people working together in a mental health team can offer each patient they see. Task sharing is when activities previously provided by a certain professional group are transferred to other people. These may include non specialists such as lay workers and family members who can use community platforms and assets such as schools and other public facilities to support the extended primary care role ,while supporting self care and working as partners in mental health care and with mental health specialists. The right mix of right workers with the right skills and attitude will understand and promote the dignity of people using mental health services [1].
- Nurses should reflect on ethical issues and be conscious of their actions, rather than blindly following ward routines like not taking the patient seriously, ignoring patients, exposing patients, physical violation of patients, asymmetrical relationships, betraying patients, and predefining patients [12].
- On giving patient centered approach good communication becomes mandatory. In some instances lack of communication skills can create a barrier in giving respect and dignity. Individual attention from healthcare staff is most valued and expected by users, and there was a significant relationship between a member of staff's ability to listen and service users feeling respected [1].
- Care should be given to prevent abuse and neglect of patients during hospital stay [1].
- The nurse should use the alternative of seclusion and restraint as last resort. Using restraint in any setting can be a dramatic indicator of unequal power in relationships. Strategies like talking down the patients, use of minor tranquilizers and sedation to deescalate anger should be practiced more.

- v Adopt a recovery approach to mental health to help people sustain their personal identity and self-respect, which are both closely associated with the concept of dignity [10].

Conclusion

Understanding the link between mental and physical illness and the importance of measures to encourage good mental health will help to reduce prejudice and fear. This understanding should extend from public policy to individual decency. Additionally, public education is necessary to eliminate the stereotypes, myths and misconceptions about mental illness. Even early education in schools can play a very useful role. Such schools cultivate social and emotional learning and tolerance, contributing to mental health promotion and even mental disorder prevention.

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Unveiling Transcultural Psychiatry Nursing and Providing Culturally Competent Care

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Abstract

Culture is the context for interpreting human experiences such as health and illness and provides direction to decisions and actions. Provision of culturally competent care requires knowledge, attitudes, and skills supportive of implementation of culturally congruent care. Cultural assessment requires a comprehensive and thorough investigation of a client's cultural values, beliefs, and practices. Transcultural psychiatry is concerned with the social and cultural determinants of psychopathology and psychosocial treatments of the range of mental and behavioural problems in individuals, families and communities. Therapeutic alliance between the nurse and patient interactions helps in sorting out social, cultural, spiritual issues of the patient. In order to provide culturally competent care five key areas should be worked upon namely cultural awareness, cultural knowledge, cultural skills, cultural encounters & cultural desire. Nevertheless during assessing the client communication, physical distance or space, social organization, time orientation, environmental control, and biologic variations should be considered. Nurses today must recognize these critical needs and be committed to provide transcultural nursing care. Nurses must be sensitive to cultural aspects and knowledgeable about factors that influence the care of clients including issues related to culture, race, gender, sexual orientation, and social and economic situation.

Keywords: Transcultural Psychiatric Nurse; Culturally Competent Care; Culture Bound Syndrome.

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Introduction

People from various cultures and subcultures are more common in today's world. These people are sensitive to the preservation of their cultural heritage and customs. The concept of transcultural nursing appeared less than 30 years ago since Madeleine Leininger first began to develop a theory of transcultural nursing as part of a doctoral study in anthropology [1]. Transcultural Nursing was developed because of the need to work with people from widely divergent cultural atmosphere [1].

Mental health nurse confronts clients with diverse cultural and ethnic background. These needs can be met by the study of transcultural psychiatric nursing [1]. Transcultural psychiatry is concerned with the social and cultural determinants of psychopathology and psychosocial treatments of the range of mental and behavioural problems in individuals, families and communities. Additionally to the clinical research methods of psychiatry, it draws from the disciplines of psychiatric epidemiology, medical anthropology and cultural psychology [1].

Definition

As per the definition by Leininger [1] transcultural psychiatry nursing is "a legitimate and formal area of study, research, and practice, focused on culturally based care, values, and practices to help cultures or subcultures maintain or regain their health and face disabilities or death in culturally congruent and beneficial caring ways".

Culturally competent nursing care means being sensitive to issues related to culture, race, gender, sexual orientation, social class, economic situation, and other factors [2].

Attributes and Attitudes Defining Cultures

As nurses living in a multicultural society, it would be unusual for us not to have come across a patient that is culturally and ethnically different from ourselves. Sometimes we can cross the barrier with ease, recognising the core values and beliefs of our patient and working with these. At other times the barrier is harder, or even impossible to cross. Communication difficulties arise-even when a translator is available, non-verbal messages may be missed by the patient, or even by the health professional.

It is important for the nurse to be aware of cultural trends keeping in mind individual preferences. Knowledge about culture comes from awareness about the same. As we know that person's illness is influenced by his culture. Some attitudes and attributes have been identified among people of different cultures. Some examples we get to see daily in clinical setting having encounters with global patients are as follows [3]:

- A Middle-Eastern patient on strict bed rest attempts to get out of bed in order to pray facing towards Mecca.
- A Chinese patient refuses pain medication after surgery (his cultural belief being that it is impolite to accept something the first time it is offered).
- The family of a newborn baby hang a knife over its crib in order to "ward off evil spirits".
- Jewish clients refusing blood transfusions.
- Dietary restrictions are adhered strictly by certain religious communities like Muslims prohibited from eating pork and Hindus do not favour beef eating practices [3].

Although we, as health professionals, constantly strive to provide sensitive, compassionate care, there is no doubt we can find ourselves in circumstances that challenge us. In mental health setting, presence of culture bound syndromes (are illness constituted by the personal, social, and cultural explanations and reactions of a given society to perceived dysfunctions or abnormalities in its members.) and Hwa Byung [4] (is a Korean culture bound syndrome observed among middle age, low income women who are overwhelmed and frustrated by the burden of caregiving for their in-laws, husbands and children resulting in somatic symptoms) are encountered by nurses, who should understand that these illnesses are related to anger arising from depression. These illnesses should be treated differently. Although we don't need to have a comprehensive understanding of the cultural and ethnic norms of all those who live in our society, we

do need to make an effort to communicate with our patients and understand their needs in order to provide appropriate transcultural care [4].

Campinha-Bacote's Model of Cultural Competence In Health Care Delivery

Five areas of cultural competency identified by Campinha Bacote were [5-6]:

- Cultural awareness defined as the process of conducting self-examination of one's own biases towards other cultures and the in-depth exploration of one's cultural and professional background. Cultural awareness also involves being aware of the existence of documented racism in healthcare delivery [5-6].
- Cultural knowledge is defined as the process in which the healthcare professional seeks and obtains a sound information base regarding the worldviews of different cultural and ethnic groups as well as biological variations, diseases and health conditions and variations in drug metabolism found among ethnic groups (Biocultural ecology) [5].
- Cultural skills is the ability to conduct a cultural assessment to collect relevant cultural data regarding the client's presenting problem as well as accurately conducting a culturally-based physical assessment [6].
- Cultural encounters is the process which encourages the healthcare professional to directly engage in face-to-face cultural interactions and other types of encounters with clients from culturally diverse backgrounds in order to modify existing beliefs about a cultural group and to prevent possible stereotyping [6].
- Cultural desire is the motivation of the healthcare professional to "want to" engage in the process of becoming culturally aware, culturally knowledgeable, culturally skilful and seeking cultural encounters; not the "have to." Cultural desire is the spiritual and pivotal construct of cultural competence that provides the energy source and foundation for one's journey towards cultural competence. Therefore, cultural competence can be depicted as a volcano, which symbolically represents that it is cultural desire that stimulates the process of cultural competence [5]. An example of such a situation might arise when a nurse is asked to care for an Arab patient whose political and/or religious beliefs are in direct contrast to his/her beliefs. In this case, too, commitment to the process of cultural desire

requires the nurse to be available to care for patients, even when there may be a natural instinct to resign oneself from the nurse-patient interaction [4].

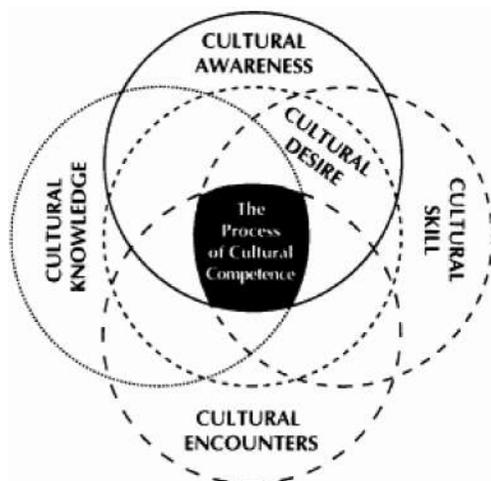


Fig. 1: Campinha-Bacote's Model of Cultural Competence in Health Care Delivery

Effectiveness in these five areas provides evidence of culturally competent psychiatric nursing care that is both appropriate and high quality [7]. Cultural competency requires the nurse to ask informed questions out of bias [8]. For example, a study of the association of ethnicity and sexual orientation (gay, lesbian or bisexual) with risk of suicide in black, Caucasian and Latino youth found that young age and substance abuse behaviour did not predict the risk of suicide attempt was associated with daily life experiences with multiple sources of stigma, bias, prejudice, and discrimination related to their sexual orientation and ethnicity [9]. These findings show the value of general cultural knowledge and the need to ask patients about their specific personal life experiences. Patient centred care requires knowledge of how social, cultural, and spiritual life experiences and personal characteristics may influence mental health, psychiatric nursing care and treatment outcomes without bias, assumptions or overly simplistic views of complex life experiences [8].

Factors in Cultural Assessment

Bechtel [10] recommended a model for assessing clients using six cultural phenomena: communication, physical distance or space, social organization, time orientation, environmental control, and biologic variations. Each phenomenon is discussed in more detail below.

Communication

Verbal communication can be difficult when the client and nurse do not speak the same language. The nurses should be aware that nonverbal communication has different meanings in various cultures. For example, some cultures welcome touch and consider it support-Spain and France consider a firm handshake a sign of strength and good character [10].

Physical Distance or Space

Various cultures have different perspectives on what they consider a comfortable physical distance from another person during communication. In the United States and many other Western cultures, 2 to 3 feet is a comfortable distance [9]. The nurse should be conscious of these cultural differences in space and should allow enough room for clients to be comfortable.

Time Orientation

Clients some cultures may not perceive the importance of adhering to specific follow-up appointments or procedures or time-related treatment regimens. Nurses should not label such clients as noncompliant when their behaviour may be related to a different cultural orientation to the meaning of time. When possible, the nurse should be sensitive to the client's time orientation, as with follow up appointments. When timing is essential as with some medications, the nurse can explain the importance of more precise timing [10].

Environmental Control

Environmental control refers to a client's ability to control the surroundings or direct factors in the environment [10]. People who believe that they have control of their health are more likely to seek care, to change their behaviour, and to follow treatment recommendations. Those who believe that illness is a result of nature or natural causes (personalistic or naturalistic view) are less likely to seek traditional health care because they do not believe it can help them.

Biologic Variations

Biologic variations based on physical makeup are said to arise from one's race, whereas other cultural variations arise from ethnicity. For example, sickle-cell anaemia is found almost exclusively in African Americans, and Tay-Sachs disease is most prevalent

in the Jewish community [10].

Nursing Assessment

Narayanasamy [11] developed the ACCESS model in order to help health professionals bridge the cultural gap and provide acceptable transcultural care:

- Assessment - focus on cultural aspects of client's lifestyle, health beliefs, and health practices
- Communication - Be aware of variations in verbal and non-verbal responses
- Cultural negotiation and compromise - become more aware of aspects of other people's culture as well as understanding client's views and explaining their problems
- Establishing respect and rapport - A therapeutic relation which portrays genuine respect for client's cultural beliefs and values is required
- Sensitivity - Deliver culturally sensitive care to a culturally diverse group
- Safety - Enable clients to derive a sense of cultural safety

It is always important to remember that just because a person looks different to ourselves, or even identifies with a different culture, they are still an individual. Their values, beliefs and practices may be the same as our own, or completely different - it is up to us to establish these similarities or differences, and acknowledge these in the way we treat our patients.

Self assessment is essential in the delivery of culturally competent psychiatry nursing care. Nurses should explore their responses to the following questions [12]:

- What personal characteristics of the patient have I noted, and what are my reactions, positive and negative, to those characteristics?
- What differences do I think may exist between the patient and myself, and what assumptions have I made based on them?
- Does the patient's appearance or language make me think that what I am seeing or hearing is abnormal?
- What labels am I subconsciously applying to this patient, and how did I learn them?
- What other explanations might account for patient's behaviour?
- Have I given the patient the opportunity to express beliefs, values, expectations and concerns about

symptoms and possible treatment [12]?

The nurse should be aware of the sociocultural stressors like prejudice, racism, discrimination, stigma or stereotypes governing the society that can hinder the delivery of psychiatric care. Additionally the nurse can ask further questions to elicit patient's understanding of the questions. These include [12]:

- What do you think is causing you problem?
- Has this happened before? If so what helped and made it worse?
- How is this problem affecting your home and work?
- What do you think will help you know?
- What is your goal for the treatment?
- What concerns do you have about the care you have received?

Therapeutic alliance-nurse and patient interactions in sorting out social, cultural, spiritual issues of the patient

- The culturally competent nurse should not assume knowledge of a patient based on causal observations of ethnicity or gender. Neither should a nurse draw generalizations about groups based on these factors.
- At the initial meeting, the nurse may rely on what he or she knows about a client's particular cultural group such as preferences for greeting, eye contact, and physical distance. Based on the client's behaviour, the nurse can alter that approach as needed. For example, if a client from a culture that does not usually shake hands offers the nurse his or her hand, the nurse should return the handshake. Variation among members of the same cultural group is wide, and the nurse must remain alert for these individual differences [10].
- The culturally competent nurse should emphasise the importance of social, cultural, and spiritual forces; recognizes the uniqueness of each patient; respects the nurse patient differences; and incorporates sociocultural information into psychiatric nursing care.
- To provide culturally competent care, the nurse must find out as much as possible about a client's cultural values, beliefs, and health practices. Often the client is the best source for that information, so the nurse must ask the client what is important to him or her – for instance, "How would you like to be cared for?" or "What do you expect (or want) me to do for you?" [12].
- An open and objective approach to the client is

essential. Clients will be more likely to share personal and cultural information if the nurse is genuinely interested in knowing and does not appear sceptical or judgmental. The nurse should ask cultural awareness questions even to clients from his or her own cultural background. Again, people in a cultural group vary widely, so the nurse should not assume that he or she knows what a client believes or practices just because the nurse shares the same culture [12].

- Healthy recognition of nurse patient socio-cultural differences can enrich health care experience for both patient and the nurse. Furthermore the nurse should view patient's family and friends as important allies as they are integral role in treatment process [13].
- Nurse should support the adaptive belief system of the patient and strive to incorporate them in nurse patient interactions. For example people feel better in the presence of their faith believers or spiritual networks. Additionally supernatural belief system also play a natural support system for people with mental illness as well as a culturally based way of understanding how the illness fits into patient's life. For instance some people believe that are guarded by a protected angel [13].
- A culturally competent mental health care system assesses cross cultural relations, understands the dynamics of cultural differences, expands knowledge about different cultures, and committed to adapt services to meet culturally based needs [13].
- The nurse actively can be involved in culturally responsive counselling considering ethnic identity, family influences, gender role socialization, religious and spiritual influences and immigration experiences.
- The nurse should encourage certain spiritual beliefs promote healthy living, stress reduction and enhance the quality of life for example avoidance of alcohol and psychoactive substance use. The degree of compatibility between the patient's and provider's belief systems can influence patient satisfaction with and response to treatment [14].

Conclusion

Culture has the most influence on a person's health beliefs and behaviours. Transcultural nurses are in an ideal position to demonstrate how the provision of culturally congruent care will shape health care in the future. Nurses need educational preparation to provide themselves with the knowledge, skills, and

attitudes essential to work with people from different cultures. Nurses today must recognize these critical needs and be committed to provide transcultural nursing care. To provide competent nursing care, nurses must be sensitive to and knowledgeable about factors that influence the care of clients including issues related to culture, race, gender, sexual orientation, and social and economic situation. Culture has the most influence on a person's health beliefs and behaviours.

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Lost Online, Then Lust Online

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Abstract

Internet sex addiction is an emerging issue world-wide. It commonly affects the younger generation. Phenomenologically, patients with internet sex addiction possess the characters of internet addiction and sex addiction. It has been conceptualized recently. This review focuses on – how people lost online, then lust online.

Keywords: Internet Addiction; Sex Addiction; Internet Sex Addiction.

Introduction

Decades back, affluents could only afford to use technology for communication, hence issues related to use of technology was a matter of affluents. With time, there is enormous growth in science and technology. Now a common man can avail the facility of technology for communication as it is easily available, accessible and affordable. Yesterday's affluent's issue became the issue of common man, today.

Mobile phones and internet technologies help in facilitating communication among people. Now, it is not merely medium of communication; it helps in exploring the information and entertainment world. People, who used to experience anxiety about socializing with on different situations, can comfortably communicate through technology with strangers. Mobile phones and internet are commonly

used technologies for communication in these days. The addiction of technology is commonly attracting the younger generation [1].

Internet Addiction – Understanding the Underlying Mystery

The addictive aspect of internet gained attention nearly two decades back and various terminologies like – “Internet addiction”, “Pathological internet use” and “Internet addictive disorder” have been interchangeably used to explain this entity [2]. Internets and mobiles have specific in built applications like – online game, which attracts the interest of young population to involve in playing online games [3]. These online games make an individual dissociated from self or project personal feelings to a new role identity, which is far from the reality of life [3]. A child or adolescent, who frequently indulges in online games with aggressive content, identifies himself/herself with the aggressor and it may not cause problem for him/her in the game. However, when it comes to the real life scene, the child tries to replicate the aggressive game experience without thinking about the consequences; the resultant being an impulsive or aggressive-disruptive behavior. Mobile and internet technologies also facilitate exposure of an adolescent to pornography & online gambling, hence also maintain other behavioral addictions like–sex addiction and pathological gambling [3]. Individuals addicted to internet may misuse particular categories of information or entertainment like – cybersex, online games, social networking or online chatting [2].

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Internet Sex Addiction – An Emerging Issue

Addictive behaviour related to sex also involves the same brain regions as seen with abuse of drugs [4].

Addiction to sex is characterized by a compulsive behaviour to involve in sexual activities, despite having adverse consequences [5]. Gender differences do exist among users with internet sex addiction. Prevalence of internet sex addiction is more common among males than females [6]. Men use cybersex more frequently and crave more for it, in comparison to their women counterparts, as found in a recent study [7]. Adolescents, who spend significant time online are at risk of indulgence in online sexual behavior, which is likely to influence their future marital life adversely [8].

Phenomenologically, a lot of similarities exist between sex addiction, compulsive sexual behavior and internet sex addiction (cyber-sex addiction) as a reason of which these terminologies are interchangeably used in many contexts [9]. The horizon of "Sex addiction" and "Compulsive sexual behavior" are much broader than "internet sex addiction". Individuals with internet sex addiction must meet the criteria of addiction for online (internet based) sexual activities. It may be related to virtual room chat or watching pornography in a compulsive manner for arousal. Patients with internet sex addiction may have overlapping features of sex addiction as well as internet addiction as explained

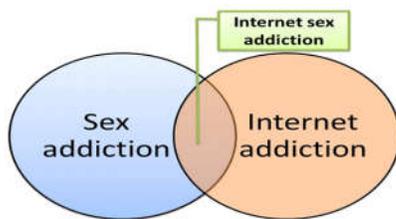


Fig. 1: Internet sex addiction

in Figure 1.

Internet sex addiction has many adverse impacts on the physical as well as psychosocial wellbeing of the individual. It may cause marital disharmony, relational issues, high risk sexual behaviour, financial loss, legal issues, loss of work, insomnia, sexual transmitted diseases etc [10]. The psycho-social impact of internet pornography on an individual is controversial. Some argue that internet pornography increases the risk of sexual violence and abuse, at the same time a counter argument exists, which emphasizes the protective role of internet pornography in channelizing the sexual impulses to a non-destructive mode. Many argue that pornography, which are soft-core and non-violent in nature may be harmless [5]. When the sexual impulses or compulsions fall into the pattern of addiction, it starts causing impairment.

Individuals, who get addicted to cybersex or online pornography, usually have addiction to the use of technologies like internet or mobile. Internet addiction plays the role of gateway to online sex addiction. There is no general consensus regarding the clinical features and criteria for diagnosis of cybersex addiction [11]. In a recent study on heterosexual males, it was found that individuals with tendencies of addiction towards cybersex had high approach or avoidance behavior towards sexually arousing stimuli [11]. Sexual addiction is frequently associated with problematic online pornography use [5]. Individuals having strong inclination towards violent hard-core pornography are frequently indulged in sexual aggression in comparison to those inclined towards non-violent soft-core pornography [5]. Laier et al (2014), in their study on female internet pornography users found that – craving, severity of psychological problems, sexual excitation sensitivity and sexual arousal related to pornographic pictures predict about tendencies towards cybersex addiction [12]. Comparing the issue of cybersex addiction among the genders revealed that – men have more craving and higher frequency of pornography use than women [13].

Addiction to cybersex leads to compulsive sexual behavior, which may result in dysfunctional coping, dysfunctional intimacy, addiction and conditioned problematic sexual behavior [14]. A study on online sex offenders revealed that many of them indulge in such criminal activities due to their compulsive sexual behavior [15]. These groups of people spend a considerable time on line. Individuals, who have addiction to cybersex often, get sexually aroused and experience craving with pornographic cues [16]. Various mental processes like – learning, gratification as well as reinforcement play vital roles in sustaining cybersex addiction [16].

Intervention Outlines

There is significant overlapping between the pathology of behavioral addiction (eg. Internet addiction) and substances addiction [17], hence the management approach to behavioral addiction may be guided by the principle of substance addiction management.

Psychological interventions like – cognitive behavioral intervention and stimulus control followed by graded exposure are effective in technology addiction [18]. Bipolar affective disorder is one of the common psychiatric co-morbidity associated with internet addiction including cybersex addiction and mood stabilizers are likely to be helpful in the management of cybersex addiction like bipolar

affective disorder [2]. Therapeutic target also focuses on management of psychiatric co-morbidities including anger management, impulse control, stress management, childhood trauma and grief[5]. Restricting internet use and focusing on relationship-oriented sexuality are also helpful [5]. Relapse prevention strategies, enhancement of intimacy, reconstruction of lovemap, reconditioning the arousal and coping skill training are also effective in reducing compulsive sexual behavior [14].

Carbonell et al (2009), had studied all published articles on PubMed and PsycINFO, between 1996 to 2005 and found that internet addiction (>85%) to be most studied and cell phone addiction (2.1%) to be least studied phenomenon of "technology addiction" [19]. But, considering the popularity of cell phones among people, especially in the adolescents, it needs to be studied with much emphasis in the coming years.

Conclusion

Patients with internet sex addiction (cyber-sex addiction) should be explored for internet addiction in other forms like chatting, shopping and gaming. Similarly, they should be also explored about offline addictive sexual behavior and paraphilias. These additional factors need to be considered in management plan as the roots of internet sex addiction spreads deep in the territory of sex addiction and internet addiction. This broader approach may help in delivering holistic care.

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31 Journal of Forensic Chemistry and Toxicology	2	9000	8500	900	850
32 Journal of Microbiology and Related Research	2	8000	7500	800	750
33 Journal of Orthopaedic Education	2	5000	4500	500	450
34 Journal of Pharmaceutical and Medicinal Chemistry	2	16000	15500	1600	1550
36 Journal of Social Welfare and Management	3	7500	7000	750	700
37 Meat Science International	2	5000	4500	500	450
38 New Indian Journal of Surgery	3	7500	6600	710	660
39 Ophthalmology and Allied Sciences	2	5500	5000	550	500
40 Otolaryngology International	2	5000	4500	500	450
41 Pediatric Education and Research	3	7000	6500	700	650
42 Physiotherapy and Occupational Therapy Journal	4	8500	8000	850	800
43 Urology, Nephrology and Andrology International	2	7000	6500	700	650
44 Indian Journal of Emergency Medicine	2	12000	11500	1200	1150
45 Indian Journal of Surgical Nursing	3	5000	4500	500	450
46 Indian Journal of Trauma & Emergency Pediatrics	3	9000	8500	900	850
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A Literature Review: Internet Addictions among Teens- Its Impact and Solutions

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Abstract

Aims and Objectives: This paper presents a critical review of published literature detailing the prevalence of Internet Addiction among Teens and its impact and solutions. *Background:* Since last two decades, our life changed dramatically because of wide distribution of computers & easy access to internet. Every individual owns a gadget with internet facility. We are enjoying video calls, instant messaging, downloading music, videos, playing games, doing online shopping, doing railway & flight tickets booking and many more things. Like a coin has its two sides, there are disadvantages of internet use e.g., long hangouts on social media, compulsive web surfing, online gambling, online shopping, online trading, online relationship, use of cyber-porn etc. *Design:* This literature review study addresses the aims and objectives. *Methods:* Following a literature search of electronic databases, 13 articles were retrieved that met the criteria in relation to the aims and objectives. *Results:* There is significant impact of internet addiction on life and a lifestyle modification through CBTI is the solution. *Conclusions:* we can't abstain from technology thus; balancing life with digital culture world is the only solution. *Nursing Implications:* These findings will help the nursing professional to make the people aware about the new kind of addiction, its hazardous impact on life and can encourage the people to live a balanced life with the digital culture world.

Keywords: Internet Addictions; Cognitive Behavior Therapy.

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Introduction

Over the past centuries, technologies have regularly come along completely changed our life, especially how we connect to each other. All technologies begin social revolutions. We are living through one such revolution now, called the internet. Benefits of internet are uncountable. It brings the world so close together today. It is always available and facilitates instant messages, video and audio calls, endless sources of information, entertainment, shopping, social networking, faster communication, easy to use, education and many more. However, apart from the uncountable benefits of internet use, purposeful and over use affects individual's life in a negative way too. Individuals are getting hooked on the Internet for pornography, Internet gambling, online shopping, searching non-important information or chatting for a very long time. Though very few interventional studies are carried out in this regard, but it is seen that Cognitive Behavior Therapy for Internet Addiction found to be useful in managing such addiction.

Internet Addiction

There are three basic factors to consider, preoccupation, withdrawal symptoms and tolerance (Young, 1998) [1] before we can ascertain that the youth have some form of Internet addiction.

Preoccupation-The youth's mind is constantly thinking of what he/she will be going to do online later while he/she is still in school. *Withdrawal Symptoms* - The youth tends to throw tantrums and exhibit violent behaviors not normally seen in other circumstances. *Tolerance* - Tolerance may develop as youth play game repeatedly over time. Youth have to spend considerably longer time online to feel the same

level of satisfaction as before.

Griffin (2005) [2] defined addiction as “any behaviour that features all the core components of addiction”.

The six core components of addiction, also given by Griffiths, are: *salience, mood modification, tolerance, withdrawal, conflict* and *relapse*.

Salience—A particular activity becomes the most important activity in a person’s life. It dominates their thoughts, feelings and behaviour. Even when the person is not actually engaging in the activity, they would still be thinking about it. *Mood modification* – The subjective experience that occurs in an individual after engaging in the particular activity is a modification in the mood. *Tolerance*—This refers to the process in which the particular activity needs to be consistently increased for the individual to feel the strength of the former effects. Basically, one dose of something has to be doubled or tripled for the individual to be affected by it again. *Withdrawal*—The unpleasant feelings, state or physical effects which occur when the particular activity is suddenly reduced or discontinued are called withdrawal symptoms. They may be psychological (e.g. moodiness) or physiological (e.g. insomnia). *Conflict*—The addicted person may suffer from interpersonal or intrapersonal conflicts. Someone who always chooses short-term satisfaction and disregards the consequences usually compromises their personal relationships, work, education, society and recreational activities. The intrapersonal conflicts usually involve feelings of guilt or helplessness which stem from the addict wanting to get better but feeling like they are simply unable to do it. *Relapse*—There will be a tendency for repeated returns to the earlier patterns of the particular activity. The most extreme patterns may be restored quickly even after years of abstinence or control.

Prevalence of Internet Addiction

Mishra et al. [3], conducted a survey with cross sectional design on 264 students from the different colleges of various streams like medicine, dental, nursing, pharmacology and agriculture, who are undergoing graduation found that 69.2% were normal and 30.8% were abnormal users in medical college, 68% were normal and 32% were abnormal users in nursing college, 50.5% were normal and 49.5% were abnormal users in pharmacology college, 57.5% were normal and 42.5% were abnormal users in dental college, 65.6% were normal and 34.4% were abnormal users in agriculture college.

Causes of Internet Addiction

Goel et al. [4] conducted a cross-sectional study of sample comprising of 987 students of various faculties across the city of Mumbai, found that those with excessive use internet had high scores on anxiety, depression, and anxiety depression.

Bhagat et al. [5], conducted to study internet addiction in relation to parental bonding. For this purpose, a sample of 200 students’ revealed, Psychological security and social interactive support may be the motives for adolescents with low parental support to use the Internet more than those who have high parental support.

Varghese Titto et al., [6] conducted a study in an attempt to analyze the media (including the traditional media) habits of teenagers in terms of the time spent for it, place and medium of accessing internet and the motivations for the usage of these media. Results show that more time in internet is spent on Social Networking sites compared to the time they spend for educational needs. The gratifications obtained from the usage of social networking sites are factor analyzed to a four factor structure, namely Communication, Connectivity, Relaxation and User friendliness.

Impact of Internet Addiction on Life

Li W et al. [7] conducted an exploratory qualitative study, using the focus group approach among 27 U.S. university students who self-identified as intensive Internet users, spent more than 25 hours/week on the Internet for non-school or non-work-related activities. Study participants reported a variety of adverse health and psychosocial consequences related to intensive Internet use. Many students failed to exercise and engage in face-to-face social activities because of the excessive amounts of time they spent on the Internet.

Syed Shah Alam, et al. [8] conducted a questionnaire survey among undergraduate students from two public universities in Malaysia. 205 responded out of 400 approached to examine the impact of Internet addiction. The descriptive results show from 200 respondents, the most effect of Internet addiction impact is on Psychological aspects (M=3.45) and Interpersonal aspects (M=3.26), followed by Physical problems (M=2.98) and Work problems (M=2.58), and finally, Internet addictive Behavioral problems (M=2.55).

Nicola et al. [9], conducted a survey and found Nomophobia (no mobile phone) is considered a disorder of the contemporary digital and virtual society and refers to discomfort, anxiety, nervousness

or anguish caused by being out of contact with a mobile phone.

Davey et al. [10], conducted a study and found that, mobile phone (smartphone) usage has a significant effect in causing psychological problems, affecting classroom performance, hampering of studies, eating, stress, etc.

Kim, Soohyun [11], examined the impact of adolescent Internet use on youth outcomes in Korea, six hundred and nine adolescents (10th and 11th graders) and result revealed Social and recreational-Internet use of the Internet was associated with lower academic achievement.

Prevention and Management of Internet Addiction

Young Kimberly S. [12], A total of 114 clients were evaluated on the Internet Addiction Scale. In this study, cognitive-behavioral techniques were applied and the data suggested that clients were able to decrease thoughts and behaviors associated with compulsive Internet use.

Khazaal et al. [13], As proposed on CBT of substance use disorders, clients are trained to monitor their thoughts and identify affective and situational triggers linked with their Internet behavior. It is found that client's ability to engage in offline activities improve from 2.67 (0.89) at 3rd session, to 4.66 (0.52) at the 12th session. Client's ability to control their computer use improved along a mean of 3.95 (SD=1.21) by the 3rd session to 4.33 (SD=0.58) by the 12th session and remains good at 6-month follow-up 4.22 (SD=0.75). The ability to abstain from sexually explicit online material improved along a mean of 2.15 (SD=0.91) by the 3rd session to 3.26 (SD=1.02) at the 12th session.

Conclusion

Internet addiction can lead to serious problems for the individuals. Though we cannot abstain from technology use but a balance is very much essential to live in a healthy way in a digital culture world. Research on Internet addiction is still in its infancy. Thus, further research is needed in this field.

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Suicide Prevention: A Brief Review

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Abstract

Suicide is among the second leading cause of death among adolescents. It is among the most important mental health issues affecting youth despite much research on its detection and prevention. There is a growing recognition that prevention strategies need to be tailored to the region specific demographics of a country and to be implemented in a culturally sensitive manner. This review throws light on magnitude of problem, nature of illness and how to help an individual who expresses suicidal ideation.

Keywords: Suicide; Prevention; Adolescents.

Introduction

Mankind marches toward growth and development; the changing pattern of societies is a living testimony to this growth and development. Suicide is an index of disturbed society is one of the leading causes of mortality and morbidity. The World Health Organization estimates that approximately 1 million people die each year from suicide. What drives so many individuals to take their own lives? To those not in the grips of suicidal depression and despair, it's difficult to understand, but a suicidal person is in so much pain that he or she can see no other option [1,2].

What do you Know about Suicide?

Suicide (*Latin suicidium, from Sui caedere, "to kill oneself"*) is the act of a human being intentionally causing his or her own death. Suicide is often

committed out of despair, or attributed to some underlying mental disorder which includes depression, bipolar disorder, schizophrenia, substance abuse, financial difficulties, troubles with interpersonal relationships and other undesirable situations play a significant role [3,4].

Do you Know the Extent of the Problem?

- Every year, almost one million people die from suicide; a "global" mortality rate of 16 per 100,000, or one death every 40 seconds.
- In the last 45 years suicide rates have increased by 60% worldwide. Suicide is among the three leading causes of death among those aged 15-44 years in some countries, and the second leading cause of death in the 10-24 years age group; these figures do not include suicide attempts which are up to 20 times more frequent than completed suicide.
- Suicide worldwide is estimated to represent 1.8% of the total global burden of disease in 1998, and 2.4% in countries with market and former socialist economies in 2020 [1,2].

What are the Common Misconceptions about Suicide?

- **Myth:** *Only others commit suicide. It will not happen to me.*
- **Fact:** Majority of the people has a fleeting thought of ending his/ her life in a crisis situation, but not everyone pursues the thought. When such thoughts repeat continuously, increases in frequency and severity and, begin to affect day-to-day activities, suicides are likely to occur.
- **Myth:** *If a person is determined to kill him/herself, nothing is going to stop them.*

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- **Fact:** Even the most severely depressed person has mixed feelings about death, wavering until the very last moment between wanting to live and wanting to die. Most suicidal people do not want death; they want the pain to stop. The impulse to end it all, however overpowering, does not last forever.
- **Myth:** *People who commit suicide are people who were unwilling to seek help.*
- **Fact:** Studies of suicide victims have shown that more than half had sought medical help in the six months prior to their deaths.
- **Myth:** *Talking about suicide may give someone the idea.*
- **Fact:** You don't give a suicidal person morbid ideas by talking about suicide. The opposite is true – bringing up the subject of suicide and discussing it openly is one of the most helpful things you can do.
- **Myth:** *It is not possible to identify a person likely to commit suicide. Nobody can suspect his/her intention.*
- **Fact:** This is not always true. Majority of people give a clue or warning sign or commit an act, which should be taken seriously (talking about death wishes, donating their belongings, writing sad stories, poems etc.).
- **Myth:** *A person who talks about suicide does not commit it, but only threatens in order to draw attention.*
- **Fact:** While some people use minor degrees of self-harm to draw attention of people around them, most people give clues at some point by talking about the same. Such clues should be taken seriously [5].

Are you Aware of the Warning signs of Suicide?

Adults	Teen Agers	Elderly
<ul style="list-style-type: none"> • Talking about suicide • Seeking out lethal means • Preoccupation with death • No hope for the future • self-hatred • Getting affairs in order • Saying goodbye • Withdrawing from others • Self-destructive behavior • Sudden sense of calm 	<ul style="list-style-type: none"> • Change in eating and sleeping habits • Withdrawal from friends, family, and regular activities • Violent or rebellious behavior, running away • Drug and alcohol use • Unusual neglect of personal appearance • Persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork • Frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc. • Not tolerating praise or rewards 	<ul style="list-style-type: none"> • Reading material about death and suicide • Disruption of sleep patterns • Increased alcohol or prescription drug use • Failure to take care of self or follow medical orders • Stockpiling medications • Sudden interest in firearms • Social withdrawal or elaborate good-byes • Rush to complete or revise a will

Are you Willing to help Someone? Here are some Tips to Prevent Suicide

Suicide prevention: tip #1: Speak up if you're worried

If you spot the warning signs of suicide in someone you care about, you may wonder if it's a good idea to say anything. What if you're wrong? What if the person gets angry? In such situations, it's natural to feel uncomfortable or afraid. But anyone who talks about suicide or shows other warning signs needs immediate help – the sooner the better.

Talking to a Person about Suicide

Talking to a friend or family member about their suicidal thoughts and feelings can be extremely

difficult for anyone. But if you're unsure whether someone is suicidal, the best way to find out is to ask. You can't make a person suicidal by showing that you care. In fact, giving a suicidal person the opportunity to express his or her feelings can provide relief from loneliness and pent-up negative feelings, and may prevent a suicide attempt.

Ways to Start a Conversation about Suicide

- I have been feeling concerned about you lately.
- Recently, I have noticed some differences in you and wondered how you are doing.
- I wanted to check in with you because you haven't seemed yourself lately.

Questions you can Ask

- When did you begin feeling like this?
- Did something happen that made you start feeling this way?
- How can I best support you right now?
- Have you thought about getting help?

What you can Say that Helps

- You are not alone in this. I’m here for you.
- You may not believe it now, but the way you’re feeling will change.
- I may not be able to understand exactly how you feel, but I care about you and want to help.
- When you want to give up, tell yourself you will hold off for just one more day, hour, minute – whatever you can manage [5,6].

When Talking to a Suicidal Person:

Do:	But don't
<ul style="list-style-type: none"> • Be yourself. Let the person know you care, that he/she is not alone. The right words are often unimportant. If you are concerned, your voice and manner will show it. • Listen. Let the suicidal person unload despair, ventilate anger. No matter how negative the conversation seems, the fact that it exists is a positive sign. • Be sympathetic, non-judgmental, patient, calm, accepting. Your friend or family member is doing the right thing by talking about his/her feelings. • Offer hope. Reassure the person that help is available and that the suicidal feelings are temporary. Let the person know that his or her life is important to you. 	<ul style="list-style-type: none"> • Argue with the suicidal person. Avoid saying things like: "You have so much to live for," "Your suicide will hurt your family," or "Look on the bright side." • Act shocked, lecture on the value of life, or say that suicide is wrong. • Promise confidentiality. Refuse to be sworn to secrecy. A life is at stake and you may need to speak to a mental health professional in order to keep the suicidal person safe. If you promise to keep your discussions secret, you may have to break your word. • Offer ways to fix their problems, or give advice, or make them feel like they have to justify their suicidal feelings. It is not about how bad the problem is, but how badly it's hurting your friend or loved one. • Blame yourself. You can't "fix" someone's depression. Your loved one's happiness or lack thereof, is not your responsibility.

Suicide prevention tip #2: Respond quickly in a crisis

If a friend or family member tells you that he or she is thinking about death or suicide, it's important to evaluate the immediate danger the person is in. Those at the highest risk for committing suicide in the near future have a specific suicide PLAN, the MEANS to carry out the plan, a TIME SET for doing it, and an INTENTION to do it.

The following questions can help you assess the immediate risk for suicide:

- Do you have a suicide plan? (PLAN)
- Do you have what you need to carry out your plan (pills, gun, etc.)? (MEANS)
- Do you know when you would do it? (TIME SET)
- Do you intend to commit suicide? (INTENTION)

If a suicide attempt seems imminent, call a help line, or take the person to an emergency room. Remove guns, drugs, knives, and other potentially lethal objects from the vicinity but do not, under any circumstances, leave a suicidal person alone.

Suicide Prevention Tip #3: Offer Help and Support

If a friend or family member is suicidal, the best way to help is by offering an empathetic, listening ear. Let your loved one know that he or she is not alone and that you care. Don't take responsibility, however, for making your loved one well. You can offer support, but you can't get better for a suicidal person. He or she has to make a personal commitment to recovery.

It takes a lot of courage to help someone who is suicidal. Witnessing a loved one dealing with thoughts about ending his or her own life can stir up many difficult emotions. As you're helping a suicidal person, don't forget to take care of yourself. Find someone that you trust—a friend, family member, clergyman, or counselor – to talk to about your feelings and get support of your own [7].

Helping a Suicidal Person

Get Professional Help

Do everything in your power to get a suicidal person the help he or she needs. Call a crisis line for advice and referrals. Encourage the person to see a mental

health professional, help locate a treatment facility, or take them to a doctor's appointment.

Follow-up on Treatment

If the doctor prescribes medication, make sure your friend or loved one takes it as directed. Be aware of possible side effects and be sure to notify the physician if the person seems to be getting worse. It often takes time and persistence to find the medication or therapy that's right for a particular person.

Be Proactive

Those contemplating suicide often don't believe they can be helped, so you may have to be more proactive at offering assistance. Don't wait for the person to call you or even to return your calls. Drop by, call again, and invite the person out.

Encourage Positive Lifestyle Changes

Such as a healthy diet, plenty of sleep, and getting out in the sun or into nature for at least 30 minutes each day. Exercise is also extremely important as it releases endorphins, relieves stress, and promotes emotional well-being.

Make a Safety Plan

Help the person develop a set of steps he or she promises to follow during a suicidal crisis. It should identify any triggers that may lead to a suicidal crisis, such as an anniversary of a loss, alcohol, or stress from relationships. Also include contact numbers for the person's doctor or therapist, as well as friends and family members who will help in an emergency.

Remove Potential Means of Suicide

Such as pills, knives, razors, or firearms. If the person is likely to take an overdose, keep medications locked away or give out only as the person needs them.

Continue your Support over the Long Haul

Even after the immediate suicidal crisis has passed, stay in touch with the person, periodically checking in or dropping by. Your support is vital to ensure your friend or loved one remains on the recovery track [6,8].

Conclusion

Suicide is a multifaceted problem and hence suicide prevention strategies should also be multidimensional. In India, suicide prevention is more of a social and public health objective than a traditional exercise in the mental health settings. It is time for every mental health professional to adopt proactive and leadership roles in suicide prevention and save the lives of thousands of young Indians.

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Subject Index

Tittle	Page No
A Literature Review: Internet Addictions among Teens- Its Impact and Solutions	121
A Study to Assess the Etiological Factor in Patients with Schizophrenia Admitted in Selected Mental Health Centre of Pune City	51
A Study to Explore the Stress and Related Factors among the Students of Hostel Accommodation of Selected Residential Schools at Hubballi	63
Academic Stress and Eating Pattern among the Student Nurses	67
Alcohol Dependence Among Inmates of Drug Deaddiction Centre: A Survey	9
Assessment of Prevalence of Depression among Elderly Living with their Families and Living in Old Age Home	55
Assessment of Suicidal Behaviours and Knowledge on Suicidal Behaviours among Adolescents	47
Attitude of Graduate Students towards Rape Victims	5
Communication by Nurses in Palliative Care	29
Co-morbidities in Schizophrenia: A Brief Review	17
Consultation Liaison Psychiatric Nursing: An Asset to Mental Healthteam	23
Culture- Bound Syndromes in India	77
Lost Online, Then Lust Online	117
Paternal Postnatal Depression- Sad Dad Syndrome	73
Postnatal Bipolar Affective Disorder: A Case Study	81
Restoring Hope with Dignity through Empowering Mental Health Team: A Time for Action	105
Role of Physiotherapists in Mental Health: Attitudes towards Disorders or Disorder of Attitudes?	13
Stress and Coping Strategies among Employed and Unemployed Mothers	41
Suicide Prevention: A Brief Review	125
The Effects of the Training of Life Skills and Positive Psychological Capital through the Art of Storytelling on Subjective Well-Being of Children with Visual Impairment	97
Unveiling Transcultural Psychiatry Nursing and Providing Culturally Competent Care	111

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Author Index

Tittle	Page No	Tittle	Page No
Amit Arya	17	Nida Wajid	67
Amit Singh	17	Prabhuswami Hiremath	73
Anju Hooda	55	Priya Sarkar	51
AnjuHooda	67	Rekha V. Mane	51
Anumol Joseph	105	Seema Rani	29
Anumol Joseph	111	Seema Rani	55
Anumol Joseph	23	Senthil P. Kumar	13
Anumol Joseph	9	Sheela Upendra	51
Asir John Samuel	13	Somashekarayya Kalmath	63
BinduShaiju	47	Sonia	111
Chris Thomas	77	Sujit Kumar Kar	17
Divya Gigy	105	Sujita Kumar Kar	117
Divya Gigy	9	Suresh Patil	63
Farzana Begum	121	Uma Joshi	97
Grace Gururani	9	Vaishali R. Mohite	73
Irasangappa B.M.	41	Veena Sharma	29
Irasangappa B.M.	81	Veena Sharma	47
Lijjy Mathew	55	Veena Sharma	67
Madonna Joy	47	Veena Sharma	9
Maneesh Kumar Sharma	77	Xavier Belsiyal C.	125
Nandita	97	Yashpreet Kaur	5

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