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Original Article

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Stress and Coping Strategies among Employed and Unemployed Mothers

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Abstract

Introduction: In this modern society both men and women experience various patterns of stress. The stress faced by married employed women commonly referred to as a dual stress has drawn the attention of the researchers. As compared with the employed mothers unemployed mothers get more time to look after their children and family so that the child is expected to get timely attention and care required for their physical and mental development. Recent studies shows that working women still do the majority of the house work with child care taking priority over other chores. Many sacrifice leisure time and sleep to manage. *Method:* A quantitative approach, non-experimental comparative survey design was adopted. A total 100 samples (50 employed mothers and 50 unemployed mothers) were selected by using non-probable purposive sampling techniques, the target population were mothers of school going children and the accessible population were those who are in Nagaur city. The questionnaires were prepared under two sections.Section 'A'was ondemographic variables; section 'B' was on stress and coping strategies. The data was collected after getting consent from the mothers. Survey techniques were adopted and self-administered questionnaire was provided to each mother for the duration of 20-30 minutes. And data was compiled and tabulated for descriptive and inferential statistics. *Result:* Major findings of the study revealed that employed mothers had more stress than unemployed mothers in relation to physical, psychosocial and academic needs of children. Percentage distribution of stressors among employed mothers of school going children showed that 9.1% had always stress in relation to physical needs, 3.6% in relation to psychosocial needs and 11.6% in relation to academic needs of children. Among unemployed mothers majority (82.6%) had no stress in relation to academic needs of the child, whereas, only 4.0% always had stress in meeting the physical needs of their children but not in psychosocial and academic needs. Most of the employed and unemployed mothers used adaptive coping strategies in meeting the physical, psychosocial and academic needs of their children. Among the unemployed mothers 22% were used adaptive coping strategies in relation to physical needs whereas only 4.8% were used maladaptive coping strategies in relation to psychosocial needs. *Discussion:* This present study is supported by various other similar studies. It was found that employed mothers had more stress than unemployed mothers in meeting physical, psychosocial and academic needs of their children. Majority of employed and unemployed mothers used adaptive coping strategies in relation to fulfilling various needs of their children. *Conclusion:* Employed and unemployed mothers need to get more awareness regarding stress which they undergo while dealing with various aspects of day-to-day life especially in meeting the needs of their school going children. And there was a need to enhance more adaptive coping strategies and mustreduce maladaptive coping strategies.

Key words: Stress; Coping; School Going Children; Employed Mothers; Unemployed Mothers and School.

Introduction

Everyone experience various kinds of stress one time or the other throughout the life. Selye (1967), often called the "Father of stress" defines stress as a

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state manifested by a specific syndrome which consists of all the non-specifically induced changes within a biological system.

Coping could be defined as "things people do to master or tolerate and reduce stress [1]. These are the person's cognitive and behavioral effort to manage i.e., minimize, master or tolerate specific internal or external demands. Each person perceives and reacts to a stressful situation differently depending on his/her personal characteristics, abilities and experiences, and his/her external support system. The stress response, which was described as flight or fight response may be elicited by real potential or imagined threats leading to variety and multiple pattern of hormonal changes.

In this modern society both men and women experience various patterns of stress. The stress faced by married employed women, commonly referred to as a dual stress has drawn the attention of the researchers [2].

As compared to the employed mothers unemployed mothers get more time to look after their children and family so that the child is expected to get timely attention and care required for their physical and mental development. Recent studies shows that working women still do the majority of the house work with child care taking priority over other chores. Many sacrifice leisure time and sleep to manage needs of their children [3].

The problem faced by the mothers who are working badly affect their health causing malnutrition, depression, fatigue, abortion etc. which leads to poor care of the children and are subjected to stress towards child care [4].

Methodology

A quantitative approach, non-experimental comparative survey design was adopted. A total 100 samples (50 employed mothers and 50 unemployed mothers) were selected by using non-probable purposive sampling techniques, the target population were mothers of school going children and the accessible population were those who are in Nagaur city. The questionnaires were prepared under two sections. Section 'A' and section B. Section A consists of socio-demographic variables such as age, Religion, educational status, occupation, income of the family and number of school going children[5]. Section B was again divided in to 'a' and 'b' parts. Part 'a' includes mothers stress related to the physical, psychological and academic needs of the child. Part 'b' coping strategies used by the mother related to the physical, psychosocial and academic needs of the children [6]. All the mothers of the school going children between the age group of 5-7 years were included in the study.The data was collected after getting the ethical clearance and permission from the concerned authority of the school and informed consent from the mothers. Survey techniques were adopted and self-administered questionnaire was provided to each mother for the duration of 20-30 minutes. And data was compiled and tabulated for descriptive and inferential statistics.

Result

Major findings of the study revealed that employed mothers had more stress than unemployed mothers in relation to physical, psychosocial and academic needs of children.

Table 1: Distribution of mothers of school going children in relation to the stressors

S. No	Stressors	Employed Mothers (%)					Unemployed Mothers (%)				
		(0)	(1)	(2)	(3)	(4)	(0)	(1)	(2)	(3)	(4)
1	Physical	36.6	27.6	20.8	5.9	9.1	75	11.7	6.8	2.5	4.0
2	Psychosocial	27	30.6	28.4	10.4	3.6	74.6	13.2	6.4	0.8	-
3	Academic	19.6	36.8	24.4	7.6	11.6	82.6	10.2	4.4	2.8	-

0-Never, 1-Occasionally, 2-Sometimes, 3-Most of the times and 4-Always

Table 2: Comparison of mothers of school going children in relation to the stressors

S. No	Stressors	Employed Mothers		Unemployed Mothers		't'	Significance
		Mean	SD	Mean	SD		
1	Physical	15.9	6.19	5.96	5.56	08.42	p<0.001
2	psychosocial	06.6	2.72	1.56	2.09	10.33	p<0.001
3	Academic	07.6	3.20	1.50	2.00	11.40	p<0.001
	Total	30.08	8.62	9.04	8.28	12.43	p<0.001

Percentage distribution of stressors among employed mothers of school going children showed that 9.1% had always stress in relation to physical needs, 3.6% in relation to psychosocial needs and 11.6% in relation to academic needs of children.

Among unemployed mothers majority (82.6%) had no stress in relation to academic needs of the child, whereas, only 4.0 % always had stress in meeting the physical needs of their children but not in psychosocial and academic needs.

Comparison of employed and unemployed mothers in relation to three stressors revealed that there was a statistically significant difference ($p<0.001$) among three stressors among employed and unemployed mothers. So in the present study, the above findings (Table 2) depicted that, employed mothers had more stress than the unemployed mothers.

Most of the employed and unemployed mothers used adaptive coping strategies in meeting the physical, psychosocial and academic needs of their children.

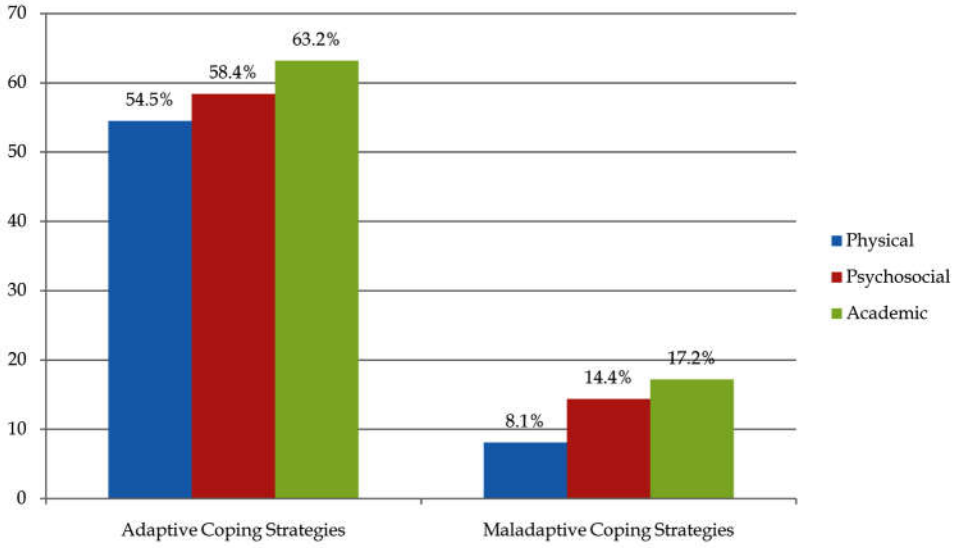

Fig. 1: Coping strategies adapted by employed mothers of school going children

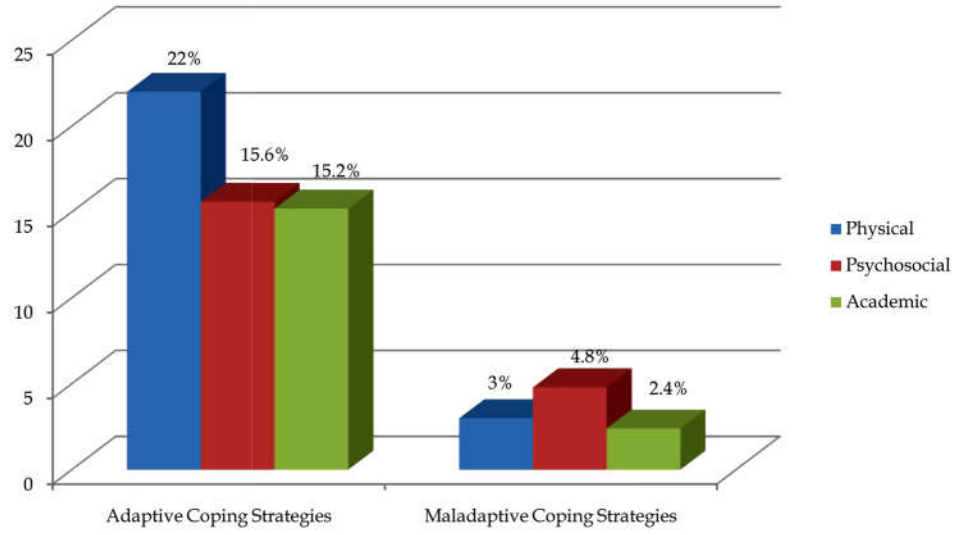

Fig. 2: Coping strategies adapted by unemployed mothers of school going children

Coping strategies scores (Fiure-1) of employed mothers of school going children reveals that, 63.2% of employed mothers used adaptive coping strategies in meeting academic needs and 14.4% were used maladaptive coping strategies in fulfilling psychosocial needs of the child.

Among the unemployed mothers 22% were used adaptive coping strategies in relation to physical needs whereas only 4.8% were used maladaptive coping strategies in relation to psychosocial needs (Figure-2).

Discussion

Percentage distribution of stressors among employed mothers of school going children showed that 9.1% had always stress in relation to physical needs, 3.6% in relation to psychosocial needs and 11.6% in relation to academic needs of children. Among unemployed mothers majority (82.6%) had no stress in relation to academic needs of the child, whereas, only 4.0% always had stress in meeting the physical needs of their children but not in psychosocial and academic needs.

Most of the employed and unemployed mothers used adaptive coping strategies in meeting the physical, psychosocial and academic needs of their children. 63.2% of employed mothers used adaptive coping strategies in meeting academic needs and 14.4% were used maladaptive coping strategies in fulfilling psychosocial needs of the child. Among the unemployed mothers 22% were used adaptive coping strategies in relation to physical needs whereas only 4.8% were used maladaptive coping strategies in relation to psychosocial needs.

Employed mothers had more stress than unemployed mothers in meeting physical, psychosocial and academic needs of their children. Majority of employed and unemployed mothers used adaptive coping strategies in relation to fulfilling various needs of their children.

This study was consistent with similar descriptive studies,

(1) The investigation was conducted to examine the stress among the working and non-working women. It was hypothesized that the working women has more stress than the non- working women. In order to verify the above hypothesis a sample of 90 women were taken. From which working women (N= 45) and non-working women (N= 45). The major findings of the study revealed that, mean and standard deviation scores of the married working women were 40.47 and 10.21 respectively. The mean and standard deviation scores of the married non-working women were 29.34 and 7.87 respectively. The 't' scores obtained for the mean difference is 4.46 which was very highly significant at 0.001 levels. This clearly implicated that the married working women had significantly very higher level of stress than married non-working women [7].

(2) A study was conducted to identify the relationship between parenting stress and employment status among 72 employed and 48 unemployed mothers on environmental, child, and personal variables. Results suggest that the level of parenting stress is not related to the employment status alone. However the factors contributing to reported stress do vary with employment status [8].

(3) A comparative study has been conducted on working and nonworking women, in order to examine the relationship between stress and working status. Data were gathered from 540 randomly selected women living in Turkey. Face-to-face interview method was used to collect data. It has been determined that total stress score of working women is higher compared to nonworking women and there is a significant difference between women's working status and total scores. Working women have high levels of stress than nonworking women [9].

Conclusion

In this study, it was concluded that, employed mothers had more stress than unemployed mothers in meeting physical, psychosocial and academic needs of their children. Majority of employed and unemployed mothers used adaptive coping strategies in relation to fulfilling various needs of their children.

Employed and unemployed mothers need to get more awareness regarding stress which they undergo while dealing with various aspects of day-to-day life especially in meeting the needs of their school going children. And there was a need to enhance more adaptive coping strategies to cope up with stress experienced while meeting the needs of their school going children and mustreduce maladaptive coping strategies.

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Assessment of Suicidal Behaviours and Knowledge on Suicidal Behaviours among Adolescents

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Abstract

Introduction: Adolescence has frequently been called "the tumultuous teens". During the past quarter-century, suicide among the young has emerged as a significant global public health problem. Given the alarming increase in suicide reported behaviours, preventing youth suicide has become an issue of paramount importance in recent years.*Objectives*: The study aimed to assess the suicidal behaviours and knowledge on suicidal behaviours, among adolescents in a selected residential area of Delhi. *Methods*: A descriptive survey was conducted on sixty adolescents, aged 10-19 years, selected through convenient sampling method from residential area of Delhi. A structured questionnaire was used for data collection and the data was analysed using descriptive and inferential statistics. *Results*: 85% of the adolescents were found to have mild suicidal behaviours and 91% of them had inadequate knowledge about suicidal behaviours. Further, no significant relationship was found between suicidal behaviours and selected socio demographic variables such as gender, religion, marital status of parents, monthly income of the family and family history of suicide.*Conclusion*: Results confirmed that adolescents require awareness, prevention and management techniques related to suicidal behaviours as they are at risk for suicidal behaviours. However, in India such studies are limited and need further exploration.

Key words: Adolescents; Suicidal Behaviour.

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Introduction

The world is home to 1.2 billion individuals aged 10-19 years. Adolescents aged between 10-19 years account for more than one-fifth of the world's population[1]. It is necessary to invest in adolescents as the future leaders and guardians of nations development [2].

Adolescents are generally perceived as a healthy age group, and yet 20% of them, in any given period, experience a mental health problem, most commonly depression or anxiety. In many settings, suicide is among the leading cause of death in young people [3]. Mental well-being is fundamental to good quality of life. Happy and confident adolescents are most likely to grow into happy and confident adults, who in turn contribute to the health and well-being of nations [2].Mental health problems among adolescents carry high social and economic costs, as they often develop into more disabling conditions later in life. Suicide is among the top three causes of death among youth worldwide. According to WHO (World Health Organization), every year, almost one million people die from suicide and 20 times more people attempt suicide; a global mortality rate of 16 per 100,000, or one death every 40 seconds and one attempt every 3 seconds, on an average rate [4]. The numbers of suicides are increasing in India and the increasing rates during recent decades are consistent with the global trend. India accounts for 10% of world's suicides. According to the latest national crime record bureau report, there are over 1.2 lakhs suicides in 2006 and 1.3 lakhs in 2007 [5]. This study aimed to assess the suicidal behaviours and knowledge on suicidal behaviours, among adolescents in a selected residential area of Delhi.

Methodology

Research approach in this study was quantitative with a descriptive survey design to assess the suicidal behaviours and knowledge on suicidal behaviours among adolescents residing in a selected residential area of Delhi. 60 adolescents between 10-19 years of age of Dilshad Colony, Delhi were selected through convenience sampling technique. The tool used for the study was structured questionnaire developed by us. The structured questionnaire was divided into two parts to assess the suicidal behaviours and to assess the knowledge on suicidal behaviours among adolescents. Part1: Section-A consisted of questions related to personal and family details. Section-B consisted of 23 items to assess the suicidal behaviours among adolescents. Part2 consisted of 40 items to assess the knowledge on suicidal behaviours among adolescents. Content validity of the tool was established by seven experts who were from the field of Psychiatry, Nursing and Clinical Psychology.The Reliability of the rating scale to assess suicidal behaviours was calculated using Cronbach's alpha formula and the reliability (r) was found to be 0.99 and for the knowledge questionnaires KR-20 was used and the reliability (r) was found to be 0.80.Before the collection of data, a formal administrative approval was sought from the concerned authorities, i.e., Residential Welfare Association of the area to conduct the study. Ethical clearance to conduct the study was taken from the Institutional Ethical Committee.The data was collected from 23rd October to 6th November 2015. The purpose of the study was explained to the respondents and their consent for participation in the study was taken. The data taken were subjected to analysis using descriptive and inferential statistics.

Results

Findings Related to the Suicidal Behaviours among Adolescents

51(85%) adolescents had mild suicidal behaviours. Moderate suicidal behaviours were seen in 5(8.3%) adolescents. 4(6.7%) of the adolescents had no suicidal behaviours and none were found to have severe suicidal behaviours.

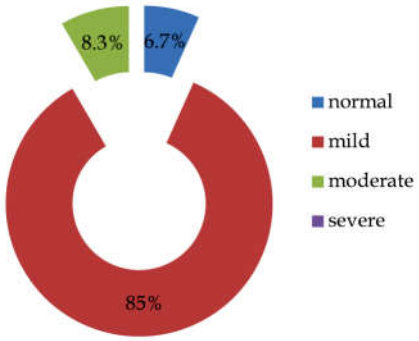

Fig. 1: Doughnut diagram showing frequency percentage distribution of adolescents by the severity of suicidal behaviours

Table 1: Mean, Median, Standard deviation, possible range of scores, range of obtained scores of suicidal behaviour score and obtained by the assessment of knowledge on suicidal behaviours among adolescents n=60

	Possible range of scores	Range of obtained scores	Mean	Median	Standard deviation (SD)
Suicidal behavior	0-46	0-14	3.466	2	3.088
Knowledge scores	0-40	10-26	16.88	17	2.99

Findings Related to the Level of Knowledge on Suicidal Behaviours among Adolescents

55(91.7%) adolescents had inadequate knowledge on suicidal behaviours and only 5(8.3%) had adequate knowledge on suicidal behaviours.

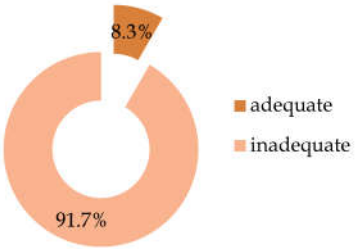

Fig. 2: Doughnut diagram showing frequency percentage distribution of the adolescents according to their level of knowledge on suicidal behaviours among adolescents

Findings Related to Relationship between Suicidal Behaviours and Selected Socio Demographic Variables among Adolescents

The obtained value of Fisher exact test to establish relationship between suicidal behaviours and gender, religion, marital status of parents, monthly income of family and family history of suicide were found to be not significant at 0.05 level of significance. This showed that there was no significant relationship between the suicidal behaviours and gender, religion, marital status of parents, monthly income of family and family history of suicide.

Discussion

The findings of the present study revealed that 85% of adolescents had mild suicidal behaviours. The findings are similar to the findings by Dogra, Olayinka [6] et al. where they reported that adolescents had higher rates of suicidal behaviour. In their study, out of 1429 youth, 20% reported suicidal ideations and 12% reported they had attempted suicide in the last year.

The findings of the present study revealed that 91.7% of adolescents had inadequate knowledge about suicide and there was a need for awareness among them. The finding is similar to the findings by Kalafat and Elias [7], where they had experimental group which gained more knowledge than the control group after attending classes of suicide awareness intervention. The findings of the study is similar to the findings of the study by Arya.S, where 49% adolescents had low, 41% average and 10% had high knowledge towards suicide [8].

The findings of the present study revealed that there was no significant relationship of suicidal behaviours with demographic variables like gender, religion, marital status of parents, monthly income of family and family history of suicide. The findings are in contrast to the findings of the study by Gould MS, Fisher P [9] et al. where there was a significant independent impact of family history of suicidal behaviour. the study findings are also in contrast to the findings of the study by Fergusson DM, Woodward LJ [10], Horwood LJ where they found that the childhood profile of those at greatest risk of suicidal behaviour was that of a young person reared in a family environment characterized by socio-economic adversity, marital disruption etc.

Conclusion

Adolescents require a special focus as they represent an important developmental link between childhood or environmental circumstances and adult outcomes, in which previous adaptation patterns or difficulties may decrease, continue, intensify, or change. They have a range of behavioural problems, as it is described in various Nursing literature. Unfortunately, some may at one point or another perceive suicide as a permanent answer to problems that are more often than not just temporary. The self doubts, confusion, and pressures to succeed or conform can come at a high price for troubled adolescents.[11] Keeping this in mind, this researcher prepared an informational booklet based on identified suicidal behaviours among adolescents so as to prevent suicidal behaviours in them and also in others.

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Original Article

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A Study to Assess the Etiological Factor in Patients with Schizophrenia Admitted in Selected Mental Health Centre of Pune City

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Abstract

Decades of research on schizophrenia have not produced major breakthroughs, but gradual progress has been made in identifying risk factors and clarifying the nature of the etiologic process [1,2]. Schizophrenia ranks among the top 10 causes of disability in developed countries worldwide[3]. One of the most positive areas of schizophrenia research today is in the area of identification of early risk factors for development of schizophrenia[4].The purpose of this paper is to describe the etiological factors in patients with schizophrenia and the prevalence of schizophrenia among the population according to demographic variables.A univariant descriptive research design was used. Data was collected from all the accessible subjects diagnosed as schizophrenia (n=105) using multiple choice closed ended questionnaire. In situation where the study subject could not answer data was referread from patient's case history file. Analysis revealed that 52.38% cases were male while 47.62% were female among which 53.33% were unmarried, 17.14% were married and 29.52% were separated. 68.57%cases were notedto be underpsychosocial influences, whereas 15.23%cases due to biological influences and 14.28% cases where noted to be under multifactorial influence. The findings concluded that males are more affected than females with peak age group between 35-65 (late adulthood).

Keywords: Schizophrenia; Etiological Factors; Mental Health Centre.

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Introduction

Over the years, much debate has surrounded the concept of schizophrenia [2]. Decades of research on schizophrenia have not produced major breakthroughs, but gradual progress has been made in identifying risk factors and clarifying the nature of the etiologic process [1].

Globally, the median incidence of schizophrenia was 15.2/100,000 persons, and the central 80% of estimates varied over a fivefold range (7.7–43.0/ 100,000)[3]. India ranks 47th with "DAILY rate" of 268.903 [9,10].

Need of the study: Despite being a syndrome, there is a large part of the scientific community interested in the etiology of schizophrenia. Etiology is the study of the causes or origination of a disease, though sometimes (like in the case of schizophrenia) it is used on a syndrome. Schizophrenia is considered to be caused by some combination of genetics and environmental factors [6]. The rate ratio for males: females were 1.4:1. Prevalence estimates also show prominent variation. The median lifetime morbid risk for schizophrenia was 7.2/1,000 persons [9].

Material and Methods

A univariant descriptive study was carried out at a Mental Health Care Centre of Pune, Maharashtra state for 2 weeks from 1st Dec 2015 to 16thDec 2015. Informed consent was taken from authority as well asrespondents of schizophrenia. Selection criteria for study are confirmed cases of schizophrenia admitted in mental health centre during the study period were included cases. The cases were diagnosed by qualified psychiatrist according to WHO ICD -10 classification.

The tool was divided into 2 parts. Section A consists of socio – demographic profile comprising of gender, age group, marital status, education; Section B comprise of multiple choice questionnaire regarding different etiological factors of disease in terms of genetics, physiological, psychosocial, biochemical and multifactorial factors.

Results

In Figure 1 as per the ages 0.95% of cases were in age group of adolescence (12-19 years), 20.95% of cases were in age group of young adulthood (20-30 years), 64.76% cases were in age group of late adulthood (30-65 years) and 13.33% cases were in age group of old age (65 years). The maximum frequency is of age group 30-65 years while the lowest is for age group 12-19 years.

In Table 1, as per gender, the highest frequency is 55 of male and 50 were female

In Figure 2, the maximum frequency is of unmarried clients with frequency of 56% and frequencies for married and separated are 18% and 31% respectively.

Fig. 1: Distribution of respondents according to age group**N**=105

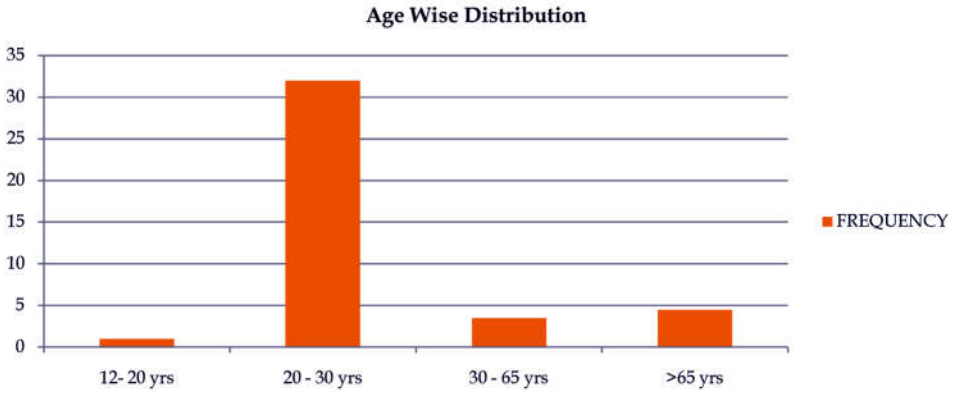

Table 1: Distribution of respondents according to gender N = 105

Gender	Frequency	Percentage (%)
Male	55	52.38
Female	50	47.62

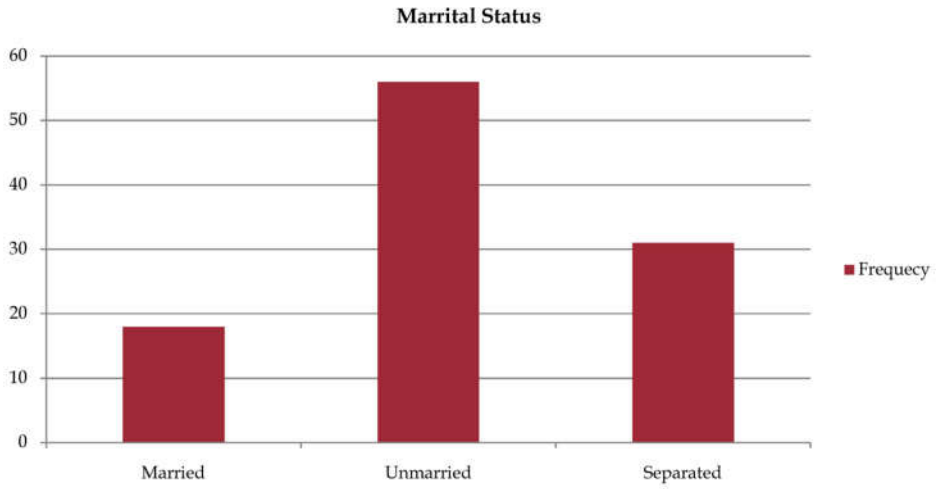

Fig. 2: Distribution of respondents according marital status N = 105

In table 2, the maximum frequency is of degree holders with frequency of 55 and followed by intermediate (19), High school(13), Middle (10) and Post-Graduation (08) respectively.

In table 3, 68.57% of schizophrenic cases are due to psychosocial factor, where as 15.24 % is due to genetics and 14.28% due to multifactorial causes.

Table 2: Distribution of respondents according Education N = 105

Education	Illiterate	Primary	Middle	High School	Intermediate	Degree/ Diploma	Post-Graduation
Frequency	0	0	10	13	19	55	8
Percentage%	0	0	9.52	12.38	18.09	52.38	7.61

Table 3: Distribution of respondents according Etiological factors N = 105

Etiological factors	Genetics	Biochemical	Physiological	Psychosocial	Multifactorial
Frequency	16	02	00	72	15
Percentage%	15.24	1.91	00	68.57	14.28

Discussion

The present study, sex wise distribution of cases shows more in males than in females were as a study done by McGrath J et al (2004) studied the incidence and prevalence of schizophrenia, the distribution of rates was significantly higher in males compared to females; the male/female ratio median was 1:0.4 [5,7]. Jablensky et al studied the incidence of schizophrenia, in WHO DOSMED study, 6 out of 8 sites reported an excess proportion of males over females. The findings concluded that males are more affected than females with peak age group between 30-65 (late adulthood) [8].

Similar finding found in Madhura D Ashturkar1, Jaggnath V Dixit states that epidemiological aspects of schizophrenia, the distribution of rates was significantly higher in males compared to females. Distribution of cases of schizophrenia according marital status shows that, 53.33% cases were unmarried, 17.14% cases were married and 29.52% cases were separated [10], were as a study done by Eaton (1985) found that marital status has been associated with the risk of schizophrenia; the increased risk of developing schizophrenia for unmarried as compared with married people ranges between 2.6 and 7.2. It has been suggested that marriage exerts a protective effect which delays the onset of illness in women [7].

Conclusion

Overall study brought out the observations on the etiological factors of schizophrenia. It was generally observed that psychosocial factors contribute more for schizophrenia. Sex wise distribution of cases shows more in males than in females in their late adulthoods (30-65). The study further concluded that the cases reported with schizophrenia have been educated up to degree level and majority were unmarried.

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Original Article

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Assessment of Prevalence of Depression among Elderly Living with their Families and Living in Old Age Home

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Abstract

Introduction: Depression has been identified as a silent killer of modern era. Apart from being a pathological mood disturbance characterized by feelings, attitudes and beliefs the person has about oneself and his environment such as pessimism, hopelessness, helplessness, low self esteem and a guilt feeling, depression is the most common disturbance of mood experienced by the elderly. A significant number of the elderly today are likely to have physical and mental morbidity besides having psychosocial problems. Among the various mental disorders of old age, depression is the commonest problem observed in the community. *Objectives*: The study aimed to investigate the prevalence of depression among elderly living with their families and living in old age home in selected areas of Delhi. *Methods:* A descriptive survey was conducted on hundred elderly (50 elderly living with their families and 50 living in old age home) aged 60 years and above purposely selected from residential areas of Delhi. A standardized tool was used for data collection and the data were analyzed using descriptive and inferential statistics. *Results*: Results revealed that the elderly living with their families were more prone to depression as compared to elderly living in old age home. Further, education status had a significant relationship with the prevalence of depression among elderly living with families. Conclusion: Results confirmed that the prevalence of depression was more among elderly living with their families. However, in India such studies are limited and need further exploration.

Keywords: Elderly; Depression; Old Age Home; Prevalence.

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Introduction

Ageing is a progressive development in the life span and is a marker of life's journey towards growth and maturity [1]. It encompasses a series of processes that begin with life and continues throughout the life cycle of an individual. As stated by WHO, the term 'Old age' defines not only an individual's appearance, but also refers to the loss of power, role and position. Loss of full possession of facilities and the proneness to physical diseases causes an individual to become more dependent on others, a fact that requires consideration in order to determine the well being and satisfaction of the elderly [2].

The Government of India adopted 'National Policy on Older Persons' in January, 1999, that defines 'senior citizen' or 'elderly' as a person who is of age 60 years or above [3]. As people age, they are more likely to have mobility difficulties and chronic conditions such as cancer, stroke and dementia. They are also vulnerable to depression, as many face loneliness and poverty. Mental illness, low morale, poor rehabilitation and admission to residential care have all been found to be correlated with either social isolation or loneliness or both [4]. The elderly often have multiple co-existing medical and psychological problems. Cardiovascular diseases, respiratory disorders, hearing and visual impairments, depression, and infections such as tuberculosis are common problems in elderly populations [5].

In the present scenario, depression is considered as an important public health challenge, especially in developing countries, however, this problem is not new. The World Health Organization (WHO) in 1990, described depression as a major, worldwide cause of disability. However, depression is under treated in this age group, and perhaps particularly so because it

is not yet perceived as a priority public health problem in developing countries. Depression, along with other mental health disorders, has long been segregated and neglected. Mental and behavioral disorders are estimated to account for 12% of the global burden of disease which affects approximately 450 million people [6]. However, most countries allocate less than 1% of their total health expenditures to mental health budgets.

It is estimated that depression affects approximately 350 million people worldwide; constituting a major portion of mental health disorders. According to the World Mental Health Survey, approximately 6% people aged 18 years and above have had an episode of depression in the previous year. Lifetime prevalence rates of depression range from 8 to 12% in most countries [7]. According to the WHO Global Burden of Disease report 2004, depression was the leading cause of burden of disease during 2000-2002, ranked as third worldwide. It is projected to reach second place of the DALYs (disability adjusted life years) ranking worldwide by the year 2020 and first place by 2030. According to a WHO report, patients aged over 55 years with depression have a four times higher death rate than those without depression, mostly due to heart disease or stroke. The contribution of depressive disorders to suicide are widely recognised[8].The Chennai Urban Rural Epidemiology Study (CURES) showed the prevalence of depression among population over 20 years as 15.1%. Studies in primary care settings point to a higher prevalence of depressive disorders amongst the elderly (with chronic co-morbid diseases), ranging from 10 to 25%. A meta-analysis of 74 studies, including 487,275 elderly individuals found the worldwide prevalence rate of depressive disorders to be between 4.7 to 16%. This study indicates a comparatively higher prevalence of geriatric depression in India (21.9%) [9].

Depression decreases an individual's quality of life and increases dependence on others. People with depression suffer from impairment of all major areas of functioning, for instance, personal care, family responsibilities, and social-occupational capabilities. Elderly people tend to be less healthy physically, and are more socially withdrawn. They are less satisfied with the manner in which they handle their problems and social life [10]. People with depression suffer overly from various medical disorders and die prematurely. Geriatric populations with depression are at a higher risk for chronic diseases like coronary heart disease (CHD), cancer, diabetes mellitus and hypertension. These people use medical services more often, thus raising the cost of medical services to the community at large [3].

WHO set "depression" as the theme for the World Mental Health Day held on 10 October 2012 in order to address the rising magnitude and deal with problems associated with it. It was intended to create awareness in the public that depression can affect anyone and that it is a treatable condition. People should be alert to the early signs of depressive disorders as it impacts not only the individuals but also their families and peers.

The researcher came across some elderly, who were living with their families which did not provide them with basic facilities to meet their physical, psychological, social and emotional needs. They were abused and were not loved, revered and taken care of despite living with the family, these elderly were seemingly very vulnerable to depression and other emotional problems. On the other hand, the elderly who were institutionalized were also found to be dealing with the feelings of abandonment inspite of being with a large group of people of similar age, needs, issues and concerns. In some places they were not provided with basic facilities to meet their physical, psychological, social and spiritual needs and also the need for love and care. Interestingly, some old age homes and elderly community and residential facilities are so good that they fill the void of a family that is uncaring and abusive. So, while living at home has its own merits and demerits, living in old age homes also has its plus and minus points. This intrigued the mind of the researcher to investigate whether elderly living in homes or old age homes are more vulnerable to depression and other emotional problems.

Methodology

The research approach of this study was quantitative with a descriptive comparative design to assess the prevalence of depression among elderly living with their families and living in old age home. 100 elderly; out of which 50 elderly living in Rohini, Sector-5 with their families and 50 living in old age homes namely Sandhya senior citizen home and Aradhana old age home were selected by convenient sampling technique. The tool consisted of three sections. Section-1 consisted of questions related to demographic profile and Section-2 was a standardized tool i.e., Geriatric Depression Scale (GDS) which consisted of 30 items to assess the depression. The scale was found to have 92% sensitivity and 89% specificity when evaluated against diagnostic criteria. The validity of the tool has been supported through both the clinical practice and research. In a validation

study comparing the long and short forms of the GDS for self-rating of symptoms of depression, both were successful in differentiating depressed from non-depressed adults with a high correlation (r =0.84, p<0.001) (Sheikh and Yesavage, 1986) [11] and reliability of the tool was established by administration of the tool to a sample of 10 elderly who were living with families and living in old age home in selected areas of Delhi. Reliability was worked out by using Cronbach's alpha and was found to be 0.84. Thus the tool was established to be reliable for the study. Section-3 consisted of rating scale to assess the prevalence of depression. For the collection of data, a formal administrative approval was sought from the Palika Parishad Samaj Kalyan Samiti, New Delhi for including elderly for research purpose from both old age homes. Ethical clearance to conduct the study was taken from the Institutional Ethical Committee. The purpose of the study was explained to the respondents and their consent for participation in the study was taken. The data taken were subjected to be analyzed using descriptive and inferential statistics.

Results

Findings Related to the Demographic Profile

The frequency and percentage computation of the study subjects showed that 27(54%) elderly living with families and 4(8%) elderly living in old age home were within the age group of 60-64 years, 14(28%) elderly living with families and 21(42%) elderly living in old age home were within the age group of 65-69 years, 7(14%) elderly living with families and 15(30%) elderly living in old age home were within the age group of 70-74 years and 2(4%) elderly living with families and 10(20%) elderly living in old age home were within the age group of 75years and above age group. Out of 100 elderly, 25(50%) men and 25(50%) women living with families and 25(50%) men and 25(50%) women were living in old age home. The marital status of the elderly revealed that 34(68%) elderly living with families and 6(12%) elderly living in old age home were married, and 2(4%) elderly living in old age home were unmarried, 9(18%) elderly living in old age home were divorced whereas 16(32%) elderly living with families and 33(66%) elderly living in old age home were widow/widower. The educational status of the elderly revealed that 1(2%) elderly living in old age home had primary education, 27(54%) elderly living with families and 9(18%) elderly living in old age home secondary education, 23(46%) elderly living with families and 40(80%) elderly living in old age home were graduates. Thus most of the elderly living with families had secondary education and elderly who were living in old age home were graduates. The working status of the elderly revealed that 4(8%)

Table 1: Demographic profile of the elderly by their age, gender, marital status, education, occupation and economic status

$*n_{1+}n_2=100$

S. No	Sample Characteristics	Elderly living with their families (n_1), %age	Elderly living in old age home (n_2), %age
1.	**Age (in years)**		
	a. 60-64years	27(54%)	4(8%)
	b. 65-69years	14(28%)	21(42%)
	c. 70-74years	7(14%)	15(30%)
	d. 75 years and above	2(4%)	10(20%)
2.	**Gender**		
	a. Male	25(50%)	25(50%)
	b. Female	25(50%)	25(50%)
3.	**Marital Status**		
	a. Married	34(68%)	6(12%)
	b. Unmarried	0	2(4%)
	c. Divorce	0	9(18%)
	d. Widow/ Widower	16(32%)	33(66%)
4.	**Education**		
	a. Primary	0	1(2%)
	b. Secondary	27(54%)	9(18%)
	c. Graduate	23(46%)	40(80%)
5.	**Working Status**		
	a. Working	4(8%)	0
	b. Not Working	46(92%)	50(100%)
6.	**Economic Status**		
	a. Dependent	42(84%)	0
	b. Independent	8(16%)	50(100%)

* $n_{1=}$ Elderly living with their families
$n_{2=}$ Elderly living in old age home

Table 2: Findings related to prevalence of depression faced by elderly living in families' old age home $*n_1+n_2=100$

Numbers of Group (Frequency of subjects)	Range of scores	Range of obtained scores	Mean	S.D	Std. Error	Mean Difference	Unpaired t-test	p-value
Elderly living with their families (Group 1) (n_1=50)	0-30	1-26	11.36	6.91	0.977	2.880	2.420;	0.001**
Elderly living in old age home (Group 2) (n_2=50)	0-30	2-19	8.48	4.79	0.678			

**t (98) = 1.98, Significant at 0.01 level of significance, $p<0.01$
* $n_{1=}$ Elderly living with their families
$n_{2=}$ Elderly living in old age home

samples were working and 46(92%) samples were not working in elderly who were living with families and 50(100) samples were not working in elderly who were living in old age home. 42(84%) were economically dependent and 8(16) were economically independent in elderly who were living with families and 50(100) were independent from elderly who were living in old age home.

The obtained mean and standard deviation for the study subjects were 11.36 and 6.91 for Group 1, while for Group 2 findings were 8.48 and 4.79 respectively. By applying unpaired t – test to find the significance of difference between the two means, t – value was calculated as 2.420 at 98 degrees of freedom. This indicates that depression was more prevalent among the elderly living with their families as compared to elderly living in old age home.

23(46%) of elderly living with families and 36(72%) of elderly living in old age home were normal, 21(42%) of elderly living with families and 14(28%) of elderly living in old age home had mild depression and 6(12%) of elderly living with families and none of the elderly living in old age home had severe depression.

Table 3: Relationship between the levels of depression among the elderly living with families and demographic variables (age, gender, marital status, education, working status, economic status $*n_1$ =50

S. no	Variables		Elderly Living With Families			Test	p-value
			Normal	Mild Depression	Severe Depression		
1.	**Age (in years)**						
	a.	60-64years	12(52.2%)	13(61.9%)	2(33.3%)	FISHER	
	b.	65-69years	9(39.1%)	3(14.3%)	2(33.3%)	EXACT	0.204
	c.	70-74years	2(8.7%)	3(14.3%)	2(33.3%)	TEST	
	d.	75 years and above	0	2(9.5%)	0		
2.	**Gender**					Fisher Exact	
	a.	Male	13(56.5%)	10(47.6%)	2(33.3%)	Test	0.893
	b.	Female	10(43.5%)	11(52.4%)	4(66.7%)		
3.	**Marital Status**						
	a.	Married	19(82.6%)	11(52.4%)	4(66.7%)	FISHER	
	b.	Unmarried	0	0	0	EXACT	0.100
	c.	Divorce	0	0	0	TEST	
	d.	Widow/ Widower	4(17.4%)	10(47.6%)	2(33.3%)		
4.	**Education**						
	a.	Primary	0	0	0	FISHER	
	b.	Secondary	5(21.7%)	18(85.7%)	4(66.7%)	EXACT	0.001**
	c.	Graduate	18(78.3%)	3(14.3%)	2(33.3%)	TEST	
5.	**Working Status**					Fisher Exact	
	a.	Working	3(13%)	1(4.8%)	0	Test	0.446
	b.	Not Working	20(87%)	20(95.2%)	6(100%)		
6.	**Economic Status**					Fisher Exact	
	a.	Dependent	18(78.3%)	19(90.5%)	5(83.3%)	Test	0.543
	b.	Independent	5(21.7%)	2(9.5%)	1(16.7%)		

** $p<0.01$, significant at 0.01 level of significance.
* $n_{1=}$ Elderly living with their families

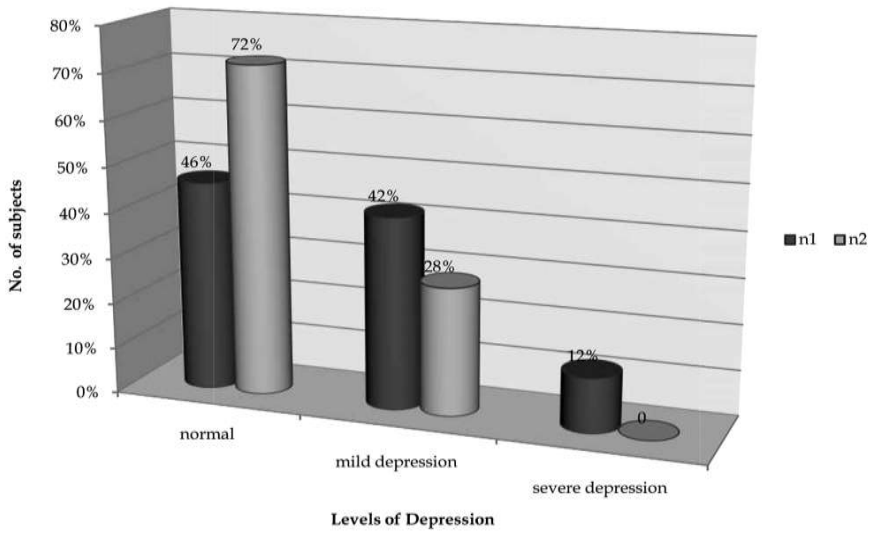

Fig. 1: Findings related to the frequency and percentage distribution of the elderly living with their families and living in old age home by the severity level of depression faced by them

Table 4: Relationship between the levels of depression among the elderly living in old age home and demographic variables (age, gender, marital status, education, working status, economic status * n_2=50

S. no	Variables		Elderly Living in Old Age Home		Test	*p*-value
			Normal	Mild Depression		
1.	**Age (in years)**					
	a.	60-64years	4(11.4%)	0	Fisher Exact Test	
	b.	65-69years	15(42.9%)	6(40%)		0.570
	c.	70-74years	9(25.7%)	6(40%)		
	d.	75 years and above	7(20%)	3(20%)		
2.	**Gender**				Chi-Square Test=	
	a.	Male	17(48.6%)	8(53.3%)	0.095;	0.953
	b.	Female	18(51.4%)	7(46.7%)	DF= 1	
3.	**Marital Status**					
	a.	Married	3(8.6%)	3(20%)	Fisher Exact Test	
	b.	Unmarried	2(5.7%)	0		0.539
	c.	Divorce	6(17.1%)	3(20%)		
	d.	Widow/Widower	24(68.6%)	9(60%)		
4.	**Education**					
	a.	Primary	0	1(6.7%)	Fisher Exact Test	
	b.	Secondary	6(17.1%)	3(20%)		0.287
	c.	Graduate	29(82.9%)	11(73.3%)		
5.	**Working Status**					
	•	Working	0	0	Fisher Exact Test	1.000
	•	Not Working	35(70%)	15(30%)		
6.	**Economic Status**				Fisher Exact Test	
	•	Dependent	0	0		1.000
	•	Independent	35(70%)	15(30%)		

Findings related to the relationship between the level of depression among the elderly residing with families and at old age home with selected variables.

Fishers exact test and chi-square test were used, the *p*-value was calculated and found that there was only significant relationship between the education status and levels of depression faced by elderly living with families and no significant relationship between the demographic variables and levels of depression faced by elderly living in old age home.

Discussion

In present study results revealed that, 42% of the elderly living with their families had mild depression and 12% had severe depression. These results were in line with the study findings by Maulik [12], according to which 53% of the elderly in community dwelling in West Bengal suffered from depression. Also the study by Kim et al [13] found that 63% of the elderly at the elderly welfare centre and public health centers in

Korea had depression.

The findings of the present study revealed that 28% of the elderly living in old age homes had mild depression. These findings were not in agreement with the study by Wijeratne et al [14], which found that 56% of institutionalized elders in Colombo had depression.

Using the key score and leveling the margins for mild and severe depression, the study showed that among the geriatric population, 41% had mild or severe depression. Out of these 70% suffered from mild and 12% from severe depression. These results were consistent with the study by Khatri J.B. [15] in which it was found that depression among geriatric population in Nepal was 53.2% as measured by Geriatric Depression Scale.

In present study there is a significant association between the education and levels of depression among elderly living with families. Another study by Khatri J.B. [15] also showed that depression has significant correlation with sex and education whereas study by Jariwala V [16] et al showed that depression in elderly is significantly associated with gender, low financial support, and marital status.

On comparing the prevalence of depression among elderly living with their families and living in old age home using GDS-30, the present study showed prevalence of depression was more among elderly living with their families, these results were in contrast to the study undertaken by Deepa. M [17] et al which showed that elderly living in old age homes had higher prevalence of depression than the elderly living with families. Also Chadha N. [18] in a study reported that the mean score of depression was higher among the institutionalized elderly compared to the non-institutionalized group. However study conducted by George S. [19] et al found that there was a high prevalence of depression among geriatric population, residing both in old age homes as well as in own homes and found no significant difference between the two settings.

Conclusions

During the study, we found that elderly living with families and in old age home had experienced mild and severe depression, though elderly living in old age home experienced only mild depression. This indicates that the prevalence of depression was more among elderly living with their families as compared to elderly living in old age home. The study revealed statistically significant relationship between the levels of depression faced by elderly living with their families and their education status.

The study shows clear importance of healthy psychological environment for elderly, hence a constant strive must be made by nurse administrators to ensure creating awareness about the same. Nursing administrators can organize small awareness programmes, health talks, skits and even provide educational materials for elderly in the community and institutionalized settings. Also there exists a need of improving the atmosphere in old age homes by engaging them in some sort of diversional activities. At the same time, community in general must be sensitized towards the psychological needs of the elderly and equipped with ways and means of keeping elderly happy.

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Original Article

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A Study to Explore the Stress and Related Factors among the Students of Hostel Accommodation of Selected Residential Schools at Hubballi

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Abstract

Background: Students living in hostel face many difficulties and hurdles such as financial crisis, adjustment issues, personal helplessness, distress, changes in eating and sleep habits and many other issues. *Objective:* To assess the level of stress and related factors leading to stress among the students of hostel accommodation in selected residential schools. *Methodology:* A descriptive study was conducted to explore the stress and related factors among the students of hostel accommodation of selected residential schools at Hubballi, Karnataka. Totally 45 hostel students were selected by non-probability convenient sampling technique. The level of stress and related factors were assessed by structured stress assessment scale. *Results:* The study result reveal that highest mean stress score of 46.66% was obtained in the area of interpersonal relationship in hostel, 45.42% score in academic stress, 43.06 % of stress related to hostel environment and the lowest mean stress score 25.50% was found in the area of hostel policy. The combined mean stress score found to be 44.26 per cent. In relation to level of sterss15 (33.33%) were having Mild stress, 29(64.40%) were having moderate stress and 01(02.22%) were having severe stress. With regard to the significance of the association between the level of stress with their selected personal variables; age, distance of hostel from residence, family income and duration of stay in hostel were found significant at 0.05 levels. *Conclusion:* The study findings concluded that the majority of hostel students of residential schools were had moderate level stress.

Keywords: Level of Stress; Hostel Students; Residential Schools.

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Introduction

Stress is experienced by every human being irrespective of age, religion and nationality. The word stress is derived from a Latin word "stringers" that means to bind tight and it is the shortened form of distress which denotes noxious human experiences [1].

Education is a part of child develop, it stated with the birth and lasted till the time of death. It is a process in which an individual learn new skills and information. The main goal of education is to encourage the individual to acquire tasks, knowledge, facts and traits which previously not obtained [2].

The hostel is place where students stay for pursuing formal education away from their home. But the concept of hostel is not only limited to place of residence, hostel is a human practical laboratory. Therefore hostel is not simply a place for living; it is a center of education [3].

A hostel is like a family of students with the superintendent as the head. Students develop a sense of friendship and fellow feeling. Students learn the value of discipline. It teaches them a sense of responsibility in matters of taking care of books, clothes and health. Students do all the works with their own hands, thus becoming self-dependent. While it is equally important to find time for using a library and reading room, play grounds, health club, swimming pool and getting trained to improve their skills and

achieve wholesome development [4].

Living away from family for a specific period of time leaves some enduring experiences in the life of the students. In these new life style students learns to live independently and learn how to compromise with the other students and roommates [5].

Students living in hostel face many difficulties and hurdles such as financial crisis, adjustment issues, personal helplessness, distress, changes in eating and sleep habits and many other issues [6].

Methedology

The exploratory descriptive survey was conducted at selected residential schools of Hubballi. Administrative approval to conduct the survey was taken from the head of the residential school and informed consent was taken from each participant individually to participate in the survey. Forty five hostel students were selected for study by using non probability convenient sampling technique. Structured stress assessment scale was administered to all the participants to collect the data. The stress assessment scale consisted of two sections: 1&2. Section 1 consisted the items related demographic variables and section 2 consisted 50 items related to level of stress and hostel related factors leading to stress.

Results

Findings Related to Personal Variables of Hostel Students of Selected Residential Schools

Majority of students 19(42.22%) were in the age group of 13 years, in terms of gender majority were males 31(68.88%), majority of student's hostel from residence was within 50 Kms 26(57.77%), majority of student's family income per month was above Rs.5000 per month 37(82.22%), majority of students belonged to nuclear family 38(84.44%), majority of students had duration of hostel stay less than one year 33(73.33%) and majority of students not had the experience of previous stay in hostel 39(86.66%).

Findings Related to Area Wise Distribution of Stress Scores and Level of Stress

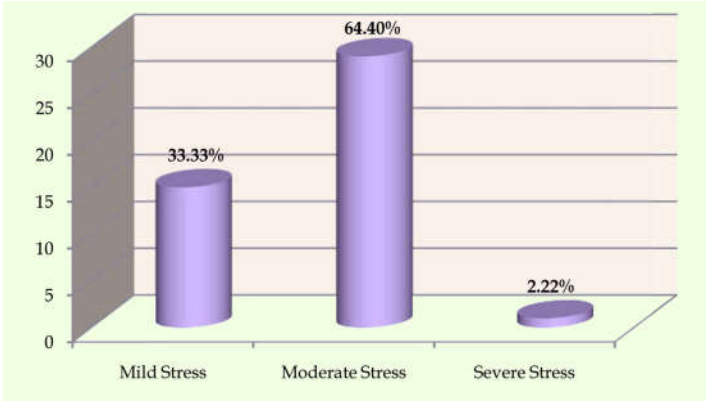
Table no. 1 reveals that, area wise mean stress scores among students of selected residential schools, highest mean stress score of 46.66% was obtained in the area of interpersonal relationship in hostel, 45.42% score

Table 1: Area wise mean stress scores of hostel students of selected residential schools

No	Stress Areas	Statements	Max. score	Range score	Mean	Stress score Mean (%)	SD
A	Academic stress	14	11	4-11	6.36	45.42	1.69
B	Hostel environment	16	10	4-10	6.89	43.06	1.46
C	Interpersonal relationship in hostel	18	12	6-12	8.40	46.66	1.55
D	Hostel policy	02	01	0-1	0.51	25.50	0.50
	Combined	50	33	17-33	22.13	44.26	3.36

Table 2: Level of stress among hostel students of selected residential school n=45

Level of Stress		
Mild stress Frequency (%)	**Moderate Stress Frequency (%)**	**Severe Stress Frequency (%)**
15(33.33)	29(64.40)	01(02.22)



Graph 1: Percentage distribution of level of stress among hostel students of residential schools

in academic stress, 43.06 % of stress related to hostel environment and the lowest mean stress score 25.50 per cent was found in the area of hostel policy. The combined mean stress score found to be 44.26 per cent.

The data presented in the Table no. 2 shows that, 15(33.33%) were having Mild stress, 29(64.40%) were having moderate stress and 01(02.22%) were having severe stress.

Findings Related to Association between the Level of Stress among Hostel Students and Their Selected Personal Variables

With regard to the significance of the association between the levels of stress with their selected personal variables; some variables like age, distance of hostel from residence, family income and duration of stay in hostel were found significant at 0.05 level and the variables like gender, type of family and previous stay in hostel were not significant at 0.05 level.

Discussion

The findings of the present study reveal that, the majority of hostel students of residential schools were having moderate level of stress. Highest level of hostel student's stress was related to the area of interpersonal relationship in hostel and lowest level of stress was related to the hostel policy. It also revealed association between levels of stress was found with only few socio-demographic variables. The findings of the present study are in contrast to the study undertaken in Nigeria [7] which showed that 53% of the respondents were dissatisfied with their residences & the variables which explained satisfaction were the social qualities of the residences.

Conclusion

Physical separation from beloved parents may lead to mount the stress continuously with change in the environment, climate, food, language; decision making etc, constant parental pressure to excel in studies may also become the added stress among the children at hostel stay. Facilities at the hostel aids in stress-reducing from the entities like separation from the parents, restriction for food, clothes, outing, etc. so it is advisable to frame the rules and regulations with some relaxation in order to help students to cope better, and also the facilities like recreation, meditation, play hours needs to be given importance while framing the rules and regulations of the hostel which would enable the students to grow as responsible citizen and contribute to the development of the nation.

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Dermatology International	2	5000	500
Gastroenterology International	2	5500	550
Indian Journal of Agriculture Business	2	5000	500
Indian Journal of Anatomy	3	8000	800
Indian Journal of Ancient Medicine and Yoga	4	7500	750
Indian Journal of Anesthesia and Analgesia	3	7000	700
Indian Journal of Anthropology	2	12000	1200
Indian Journal of Biology	2	4000	400
Indian Journal of Cancer Education and Research	2	8500	850
Indian Journal of Communicable Diseases	2	8000	800
Indian Journal of Dental Education	4	4500	450
Indian Journal of Forensic Medicine and Pathology	4	15500	1550
Indian Journal of Forensic Odontology	2	4500	450
Indian Journal of Genetics and Molecular Research	2	6500	650
Indian Journal of Law and Human Behavior	2	5500	550
Indian Journal of Library and Information Science	3	9000	900
Indian Journal of Maternal-Fetal & Neonatal Medicine	2	9000	900
Indian Journal of Medical & Health Sciences	2	6500	650
Indian Journal of Obstetrics and Gynecology	3	9000	900
Indian Journal of Pathology: Research and Practice	3	11500	1150
Indian Journal of Plant and Soil	2	5500	550
Indian Journal of Preventive Medicine	2	6500	650
International Journal of Food, Nutrition & Dietetics	3	5000	500
International Journal of History	2	6500	650
International Journal of Neurology and Neurosurgery	2	10000	1000
International Journal of Political Science	2	5500	550
International Journal of Practical Nursing	3	5000	500
International Physiology	2	7000	700
Journal of Animal Feed Science and Technology	2	4100	410
Journal of Cardiovascular Medicine and Surgery	2	9100	910
Journal of Forensic Chemistry and Toxicology	2	9000	900
Journal of Microbiology and Related Research	2	8000	800
Journal of Orthopaedic Education	2	5000	500
Journal of Pharmaceutical and Medicinal Chemistry	2	16000	1600
Journal of Practical Biochemistry and Biophysics	2	5500	550
Journal of Social Welfare and Management	3	7500	750
New Indian Journal of Surgery	3	7100	710
Ophthalmology and Allied Sciences	2	5500	550
Otolaryngology International	2	5000	500
Pediatric Education and Research	3	7000	700
Physiotherapy and Occupational Therapy Journal	4	8500	850
Urology, Nephrology and Andrology International	2	7000	700
SUPER SPECIALITY JOURNALS			
Indian Journal of Emergency Medicine	2	12000	1200
Indian Journal of Surgical Nursing	3	5000	500
Indian Journal of Trauma & Emergency Pediatrics	3	9000	900
International Journal of Pediatric Nursing	3	5000	500
Journal of Community and Public Health Nurisng	2	5000	500
Journal of Geriatric Nursing	2	5000	500
Journal of Medical Images and Case Reports	2	5000	500
Journal of Nurse Midwifery and Maternal Health	3	5000	500
Journal of Organ Transplantation	2	25900	2590
Journal of Psychiatric Nursing	3	5000	500
Psychiatry and Mental Health	2	7500	750

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Academic Stress and Eating Pattern among the Student Nurses

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Abstract

Background: Stress is thought to influence human eating behavior. As young adults transition from school to university and move in to an independent living situation, there is a high risk for unhealthy eating pattern. *Objectives:* The present study aimed to assess the relationship between academic stress and eating pattern among the student nurses. *Method:* A correlational study was conducted. A self-administered questionnaire was used including structured questions on demographic characteristics, rating scale for academic stress and eating pattern to assess the academic stress and eating pattern. The convenient sample technique was used to select 100 student nurses from a selected College of Nursing in Uttar Pradesh, India. *Result:* 65% of the study subjects were found to have moderate academic stress. A little more than half of the study subjects were having unhealthy eating pattern and rest were found to have healthy eating pattern. There was statistically significant correlation between academic stress of the student nurses and their eating pattern. No significant statistical relationship was found between academic stress of student nurses and their demographic variables, i.e., gender, community and body mass index. No significant statistical relationship was found between eating pattern of student nurses and their demographic variables, i.e., gender, community and body mass index. The study also revealed some common unhealthy eating pattern among studentnurses, such as meal skipping (62%), eating outside (73%), midnight snacking (69%) and fast food consumption (59%) were prominent among them. *Conclusion:* Result confirmed that there was positive relation between academic stress and eating pattern. Some unhealthy eating habits particularly meal skipping, eating outside, midnight snacking and food consumption were common among student nurses and were associated with stress.

Keywords: Academic Stress; Eating Pattern and Student Nurses.

Introduction

Modern life is full of hassles, deadlines, frustrations, and demands. For many people, stress is so common place that it has become a way of life. Stress isn't always bad. In small doses, it can help them perform under pressure and motivate them to do their best. But when they are constantly running in emergency mode, their mind and body pay the price. They can protect themselves by recognizing the signs and symptoms of stress and taking steps to reduce its harmful effects. Stress is a normal physical response to events that make people feel threatened or upset their balance in some way. When they sense danger—whether it's real or imagined—the body's defenses kick into high gear in a rapid, automatic mobilization process known as the "fight-or-flight" response [1]. Stress may be viewed as an individual's reaction to any change that requires an adjustment or responses, which can be physical, mental or emotional. Responses directed at stabilizing internal biological processes and preserving self-esteem can be viewed as healthy adaptations to stress [2].

Physiological or biological stress is an organism's response to a stressor such as an environmental condition or a stimulus. Stress is a body's method of reacting to a challenge. The body's way to respond to stress is by sympathetic nervous system activation

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which results in the fight-or-flight response. Because the body cannot keep this state for long periods of time, the parasympathetic system returns the body's physiological conditions to normal (homeostasis). In humans, stress typically describes a negative condition or a positive condition that can have an impact on a person's mental and physical well-being [3].

Students are learners with a social life that is disassociated from classroom learning. The impression that students spend the majority of their college life partying is not accurate. In fact, the reality is that students spend most of their time in class, reading textbooks, studying for exams or working either part-time jobs or college-work study. The desire to be recognized through their academic pursuits and not defined by their social activities are part of the learning process. Student life might have some common aspects, but when grouped together, it varies according to individual schools and their norms. What might be a popular activity at one particular college, will not be the norm at every college. Individual aspects and commonalities are what comprise the concept of student life [4].

Nursing schools are now recognized as a stressful environment that often exerts a negative effect on the academic performance and psychological well-being of the students [5]. It is a known fact that students are subjected to different kinds of stressors, such as the pressure of academics with an obligation to succeed, an uncertain future, and difficulties of integrating into the system [6].Torres and Nowson defined stress as any general response of the body that either overwhelms or threatens the body and its ability to maintain homeostasis. Studies looking at the effect of stress on eating habits have shown that the level of the stressor has an impact on the individual's eating habits [7]. People living in a stressful environment, often eat as a way of dealing with stress or as a way to calm themselves [8]. Eating has been theorized as a coping strategy for stressful situations [9].

Methodology

Research approach in this study was quantitative with correlational design to assess the relationship between academic stress and eating pattern among student nurses in a selected College of Nursing in Uttar Pradesh, India. 100 sample were selected through convenience sampling technique. The tool used for the study was structured questionnaire, which was divided in three parts to assess the academic stress and eating pattern. Part 1 consisted of questions related to the demographic profile. Part 2 consisted of 33items to assess the academic stress among student nurses. Part 3 comprised of 25 items to assess the eating pattern among student nurses. The content validation of tool was done by seven experts from the field of Psychiatry, Nursing and Clinical Psychology. The reliability of the tool to assess academic stress and eating pattern was established using Cronbach's Alpha formula and the reliability was found to be 0.08 and 1, respectively. For the collection of data, a formal administrative approval was sought from the concerned authorities of selected College of Nursing to conduct the study. Ethical clearance to conduct the study was taken from theInstitutional Ethical committee. The data was collected from 16th October to 23rd October 2015. The purpose of the study was explained to respondents and their consent for participation in the study was taken. The data taken were subjected to analyse using descriptive and inferential statistics.

Results

Findings Related to the Academic Stress among Student Nurses

The data indicated that out of 100 study subjects, 65% had moderate academic stress, 18 percent had mild academic stress and 17 percent had severe academic stress (Figure1).

Findings Related to the Eating Pattern among Student Nurses

The data indicated that out of 100 study subjects, more than 50 percent were found to be having unhealthy eating pattern, i.e., 52% and rest 48 percent were found to be having healthy eating pattern (Figure 2).

Table 1: Mean, standard deviation, possible range and range of obtained score f academic stress and eating pattern scores f student nurses n=100

Category	Possible range of scores	Range of obtained scores	Mean	Standard deviation
Academic stress	00-297	57-279	150.63	52.64
Eating pattern	25-100	39-93	68.08	9.97

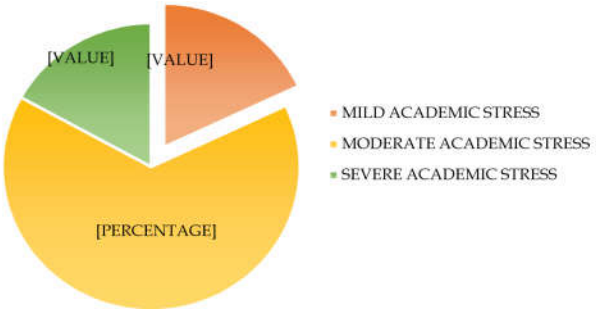

Fig. 1: Pie Diagram showing the frequency distribution of the study subjects by their academic stress

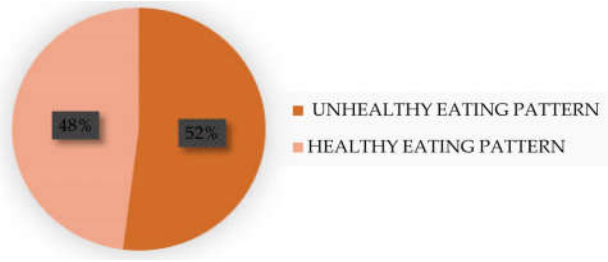

Fig. 2: Pie diagram showing the frequency distribution of the study subjects by their eating pattern

Findings Related to Relationship between Academic Stress and Eating Pattern among Student Nurses

The coefficient of correlation(r) was calculated to find the correlation between academic stress and eating pattern. The computed value of r was 0.454, which was higher than the table value, 0.197 at df (98) at 0.05 level of significance. It indicated that there was positive and statistically significant relationship between academic stress and eating pattern among student nurses. So, it can be said that academic stress affects eating pattern among student nurses

Findings Related to Association between Academic Stress and Eating Pattern with Selected Demographic Variables

The Chi-square test and Fisher's Exact test were computed to establish the relationship between academic stress and eating pattern with selected demographic variables, i.e., gender, types of community and body mass index of student nurses. A statistically non-significant relationship was found between academic stress as well as eating pattern and selected demographic variables of student nurses at 0.05 level of significance.

Discussion

Most of us live in a stressful environment, and we often eat as a way of dealing with stress or as a way to calm ourselves [8]. Eating has been theorized as a coping strategy for stressful situations [9]. Regarding the aim of this study, the results found that, there was statistically significant correlation between academic stress of the student nurses and their eating pattern. At the same time, findings revealed that, the little more than half of students (52%) had unhealthy eating pattern.

This finding was consistent with Gan et al. [10], who highlighted the presence of unhealthy eating behaviors and inadequate nutrient intake among university students. They lack knowledge of healthy food choices that may affect habits and nutritional status negatively. University students had frequent snacking habits and a higher frequency of fast food consumption [11]. The present study found that there was statistically significant co-relation between eating pattern and academic stress. Similar findings were reported among Chinese university students who found a significant association between stress and eating habits [12].

The present study found that there was statistically significant co-relation between eating pattern and academic stress. Similar findings were reported among Chinese university students who found a significant association between stress and eating habits [13].

The findings of the present study revealed some common unhealthy eating pattern among students nurses including meal skipping (62%), eating outside (73%), midnight snacking (69%) and fast food consumption (59%) were prominent among them which is consistent with the findings of study of Shi et al [14], Savige et al [15], Chin et al [16] and Wallace [17] which also revealed that some common unhealthy eating patterns among adults included meal skipping, eating away from home, snacking and fast food consumption.

Many studies showed that people (particularly women and restrained eaters) responded to high levels of stress by consuming foods high in calories, fewer main meals, and fewer portions of vegetables [18,19]. Similarly, this study showed that's students with high level of academic stress showed significantly unhealthy eating habits such as skipping breakfast, infrequently daily meals, and infrequent fruits consumption. Other eating habits such as snacking between meals, eating fast meals, infrequent vegetable consumption were also common among stressed students but without significant association. In this study, the percentage of underweight students was 20% and 5% were obese. This may be partly because females constituted the majority of the study population, and also females are more cautious about

their weight than males [20].

Conclusion

Stress related to academics is a reality of student nurses. The stress leading to various health problems, be it physical, psychological, social and spiritual, is also a reality. A systematic study which substantiates the correlation between stress and eating pattern may help in looking at ways and means of addressing the stress related to academic and associated physical health problems as well due to the unhealthy eating pattern.

Young people should have everything to be happy about, but as the generation with the least responsibility they actually experience the most stress. This study found that more than 65% of students felt stressed significantly. Through this systematically conducted study, there is an evidence to prove that mental health and physical health are related thatstress is the root cause of many of the physical ailments. Many physical ailments are a result of unhealthy eating practices which people resort to under stress. Once stress as the root cause of physical health problems is recognized, one can take proactive measures to take care of their mental health so that physical health is also taken care of. These measures may include an adequate and healthy diet, adequate sleep, and sign off Facebook, quit smoking, try to see the positive side, take short breaks in between study or working period and regular practice of relaxation techniques such as yoga, meditation, physical exercise and walks, deep breathing exercises and visual imagery etc.

Research study related to academic stress and eating pattern needs to be conducted routinely to monitor the stress level and improve the unhealthy eating habits for all round healthy development of the individual. There is also need to conduct research studies to explore the cause of stress and other unhealthy life style, health practices related to stress such as sleep and rest pattern.

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Paternal Postnatal Depression- Sad Dad Syndrome

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Abstract

Fatherhood is a unique and joyful experience. Nevertheless, it might trigger stress and negative feelings that lead to depression in fathers especially the fathers of first child born to them [1]. When the first baby is born, Naturally it is the time to be happy, but some fathers may not feel that way, instead they feel confused or even sad.[1] The depression state which develops among fathers after the birth of the first child is also termed as "sad dad syndrome or postnatal depression in fathers". Postpartum depression, once expected only in new mothers, is now estimated to occur in 25% of new fathers as well. Employment status, history of psychiatric treatment, and unintended pregnancy, relationship problems, Added financial pressures, feeling of isolation, Alteration in lifestyle and lack of support from family members and friends, Changes in marital relationship, physical health problems, Lack of wife's attention, added financial burden or a job loss, Enhanced domestic workload, Lack of sound sleep are common causes for depression in father. Common symptoms of paternal depression includes Perceiving future in a miserable bleak way and worrying too much about the future, poor concentration, Feeling sad, isolated, anxious, feeling of guilt, Becoming irritated, hostile and aggressive, no interest in sex, performing poorly at work, loss of energy, lack of interest in usual activities, irritability, anxiety, sleep disturbances playing less with their babies.

Keywords: Postnatal Depression; Postpartum Depression; Maternal Depression; Syndrome.

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Introduction

Fatherhood is a unique and joyful experience. Nevertheless, it might trigger stress and negative feelings that lead to depression in fathers especially the fathers of first child born to them [1]. When the first baby is born, naturally it is the time to be happy, but some fathers may not feel that way, instead they feel confused or even sad [1]. The depression state which develops among fathers after the birth of the first child is also termed as 'sad dad syndrome or postnatal depression in fathers'. Postpartum depression, once expected only in new mothers, is now estimated to occur in 25% of new fathers as well. Paternal postpartum depression can be difficult to assess. New fathers may seem more angry and anxious than sad. And yet, depression is present. Maternal depression is associated with many hormonal and biochemical changes that are directly related to child birth. As the child bearers, women have been the primary focus for studies of physiological and psychological changes during and after pregnancy. But Fathers who are not directly susceptible to child birth-related biochemical or hormonal changes are subject to psychosocial stressors and develops depression. Depressed father may not involve in caring the baby as a normal father, which in turn develop negative consequence in babies' psychological development. More recent literature has begun to uncover changes in dads as well. A few studies have found hormonal changes in men about to become fathers [2].

The term depression is so commonly used in day to day life that it fails to convince the people around that depression could be a disease in itself [2]. The World Health Organization has identified depression as the number one psychiatric cause of disability in the world and projected that it would rank second in the world as a cause of disability by 2020 [3]. An analysis of

previous research has revealed that about 10 percent of fathers experience prenatal or postpartum depression, with rates being highest in the 3 to 6 month postpartum period [4]. This preponderance has led to the consideration of depression by some researchers as 'the common cold of psychiatric disorders' [5]. Unfortunately, only one third of all people with depression seeks help, are accurately diagnosed, and obtain appropriate treatment [3]. Postpartum depression in men is a significant and recent emerging issue in the field of Psychiatric Nursing. Much attention has been paid to the maternal depression. However, men also experience depression after the birth of a child, and that paternal depression are linked to maternal depression. Maternal depression was identified as the strongest predictor of paternal depression during the postpartum period [6].

Cause of Paternal Depression

The true cause of paternal depression is still unknown. Depression in general is generated by stressful and emotional situations and the birth of baby can also is a demanding experience for the new parents. Fatherhood pressure and related responsibilities increase the stress to develop depression. First time dads who are not economically too sound are susceptible to experience Paternal Postnatal Depression. Employment status, history of psychiatric treatment, and unintended pregnancy, relationship problems, added financial pressures, feeling of isolation, alteration in lifestyle and lack of support from family members and friends, changes in marital relationship, physical health problems, lack of wife's attention, added financial burden or a job loss, Enhanced domestic workload, lack of sound sleep are common causes for depression in father. One of the important factors is, partner's (mother of the baby) depression. Besides these, father's own social factors, personality, family history and previous 'mental health' history are also important in affecting his chances of getting depression. The most common correlate of paternal depressive symptoms pre- and post birth was having a partner with elevated depressive symptoms or depression; Poor relationship satisfaction was also frequently associated with depression in men. The scientific study of predictors of men's depressive symptoms pre and post birth remains in its infancy [7]. Biological point of view, low level of testosterone, cortical, estrogen hormone which decreases after the child birth may cause depression in men.

Symptoms

It can be defined as a type of depression noticed slowly or suddenly with symptoms ranging from mild to severe. Common symptoms of paternal depression include perceiving future in a miserable bleak way and worrying too much about the future, poor concentration, feeling sad, isolated, anxious, feeling of guilt, becoming irritated, hostile and aggressive, no interest in sex, performing poorly at work, loss of energy, lack of interest in usual activities, irritability, anxiety, sleep disturbances and Playing less with their babies.

Effect of Paternal Depression

When left untreated, paternal postpartum depression limits men's capacity to provide emotional support to their partners and children. Research conducted by University of Oxford psychiatrist Paul Ramchandani, found that kids whose fathers had been depressed in both the prenatal stage and the first month of infancy "had the highest risk of subsequent psychopathology." And the effect was especially strong in boys who had had depressed fathers [7]. An infant's development is more severely disrupted when both parents are depressed than when only one parent is depressed [8]. An infant's heightened levels of the stress hormone cortisol resulting from unresponsive or chaotic parenting, can hamper normal brain growth and self-regulatory ability in the early life [9]. If primary care giver & do not support child development it may affect adversely on cognitive and emotional development of the child. Depressed father often avoids playing and caring for the child, which ultimately leads to the development of insecure attachments. This, in turn, may cause psychopathology for many psychiatric disorders such as conduct problems or hyperactivity in future. Paternal major depression was associated with lower psychosocial functioning, elevated suicidal ideation and attempt rates in sons in young adulthood, and depression in daughters [10]. In case of psychotic symptoms along with severe depression, father may cause harm, maltreatment and even infanticide.

Diagnosis of Paternal Depression

There is not yet one single official set of diagnostic criteria for paternal postpartum depression. The Edinburgh Postnatal Depression Scale (EPDS) has been validated and used extensively in screening for depression in new mothers, both in English speaking and non-English speaking communities [11]. While some studies have reported the use of the EPDS with fathers, none have validated it for this group.

According to the epidemiological studies, one in 10 new fathers experience prenatal or postpartum

depression, a condition long thought to affect only mothers. The men are at highest risk for depression three to six months after the birth of a child, and their depression often corresponds with depression in the mother. It was found that prenatal and postpartum depression was evident in about 10% of men. New fathers were generally happiest during the early weeks after their baby's birth, with depression starting in the 3-to-6-month postpartum period and ranging between 10% and 25% [12].

Prevention and Treatment

The mother (wife) can play important role in the prevention of depression among father along with the family member's, friends and fathers who have already experienced such a state in their life after the birth of the first child. Depression in fathers can be overcome by mothers by setting aside an hour or two each week together, meeting up with friends and socializing with people and the family. Sharing parenting roles with fathers, sharing advice, stories and feelings, getting involved in physical activities like a walk through the park, investing time in hobbies etc. may lower fathers' feelings of isolation [13]. Community services include explaining role of father and care of the child. There should be Provision for Paternity leave from the government and private sectors for their employees; So that the father can give time to partner and child. Couple therapy would be best if both parents are having depressive symptoms [14]. If the symptoms persist, father alone or along with partner and family member can approach psychologist and psychiatrist [15]. A complete assessment can be made to diagnose the level of depression and start with antidepressant drugs. "The important thing to remember is that all of the negative consequences of PPND are avoidable," says Dr. Courtenay. "Although it's a very serious—and sometimes life-threatening—condition, with proper treatment and support, men can fully recover from PPND. Getting help can save a man's life—or his marriage [16]. Clinicians treating depressed parents need to evaluate potential contributing factors (e.g., parenting skills, expressed emotion, modeling of depressotypic coping patterns) and address those that can be modified [17]. A more detailed assessment of fathers during the postnatal period is recommended, especially when their partners are also depressed, so that the condition will be promptly recognized and treated [18]. Antidepressant medications, cognitive behavioral therapy, and interpersonal psychotherapy (IPT) are considered as effective treatments for major depression [19].

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Review Article

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Culture- Bound Syndromes in India

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Abstract

Culture plays a decisive role in coloring the psychopathology of various psychiatric disorders. However, some psychiatric syndromes are limited to certain specific cultures. These disorders are called culture specific or culture bound syndrome. The last two decades have witnessed an increased interest in the cross cultural study of psychiatric disorders. Culture-bound syndrome is a broad rubric that encompasses certain behavioral, affective and cognitive manifestations seen in specific cultures. These manifestations are deviant from the usual behavior of the individuals of that culture and are a reason for distress/discomfort. This entitles these manifestations for a proper labeling and subsequent management. However, the available information and literature on these conditions suggest that at least some of them are/have been more widely prevalent than being considered. These conditions could be relabeled as functional somatic syndromes.

Keywords: Culture; Culture Bound Syndrome.

Introduction

The concept of 'culture-bound syndromes', initially introduced by Yap in the 1950's and 1960's, refer to psychopathological entities having a geographically defined prevalence, and are largely determined by the beliefs and assumptions prevalent in the native culture [1].

A culture-bound syndrome, culture-specific syndrome or folk illness is a combination of psychiatric and somatic symptomsthat are considered to be a recognizable disease only within a specific society or culture. The term culture-bound syndrome was included in the fourth version of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994) which also includes a list of the most common culture-bound conditions [2]. According to DSM IV, culture-bound syndrome denotes recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category. Many of these patterns are indigenously considered to be 'illnesses', or at least afflictions and most have local names. Although presentations conforming to the major DSM-IV categories can be found throughout the world, the particular symptoms, course, and social response are very often influenced by local cultural factors. In contrast, culture-bound syndromes are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations [3].

Though no clear cut diagnostic criteria have been devised as of now, majority of Cultural Bound Syndrome share the following characteristics:

- Categorized as a disease in that culture.
- Widespread familiarity in that culture.
- Unknown in other cultures.
- No objectively demonstrable biochemical or organ abnormality.
- Treated by folk medicine/ traditional healers[3].

In India, common culture bound syndromes are Dhat Syndrome, Possession Syndrome, Koro,Gilhari

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syndrome, Suddu, Bhanmati sorcery, culture-bound suicide (sati, santhra), ascetic syndrome, nuptial psychosis, mass hysteria etc [3].

The present article will discuss the socio-demographic, clinical profile of various culture bound syndromes in the Indian subcontinent.

Dhat Syndrome

Dhat is derived from sanskrit word 'Dhatu' meaning precious fluid. SusrutaSamhita (ancient Indian text of surgery) has described 7 Dhatus in the body. Dhatus are elixir of the body. Disturbances of it can cause physical and mental weakness. Of all seven, Semen is considered to be the most precious. CharakSamhita (ancient text of Indian Medicine) describes a disorder resembling Dhat Syndrome by the name 'Shukrameha'. Shukra is the word used for sperms in Sanskrit. Another term denoting semen is 'Veerya' which in Sanskrit means bravery, valor and strength [4].

- 40 meals = 1 drop of blood
- 40 drops of blood = 1 drop of Bone Marrow
- 40 drops of bone marrow = 1 drop of semen[4]

Dhat syndrome is a clinical entity recognized both by general public as well as medical practitioners in which nocturnal emissions lead to severe anxiety and hypochondriasis, often associated with sexual impotence. Patient usually presents with various somatic, psychological and sexual symptoms. Patient attributes it to the passing of whitish discharge, believed to be semen (Dhat), in urine [4].

This gives rise to belief that loss of excessive semen in any form e.g. masturbation, nocturnal emissions etc. is harmful. On the other hand its preservation will lead to health and longevity. Thus, the belief in precious and life-preserving properties of semen is deeply ingrained in Indian culture. The belief is further reinforced by traditional healers and perpetuated by friends and elders who had suffered from this syndrome.

This is Characterized by Following Features

- Generalized weakness
- Aches and pains all over body
- Tingling and numbness in various parts of body especially peripheries
- Easy fatigue
- Lassitude
- Loss of appetite, weight loss, loss of attention and concentration
- Excessive worrying
- Panic attacks
- Sadness of mood
- Forgetfulness
- Feelings of guilt (especially towards masturbation during adolescence)
- Sexual complaints are that of premature ejaculation and erectile dysfunction
- Sometimes patient also reports of foul smelling semen and less viscous semen
- The syndrome is seen usually in people from lower socioeconomic strata who seek help from traditional healers before reaching Hospitals[5]

Treatment mainly consists of counseling which is directed towards removing the misconceptions regarding apprehension of semen loss. This counseling is combined with general sex education. Specifically, fears regarding masturbation and nocturnal emissions are allayed. Symptomatic treatment can be given for underlying anxiety, depression, hypochondriasis and sexual dysfunction [6].

Possession Syndrome

Trance and possession disorders(possession hysteria) are characterized by the control of person's personality by a 'spirit', during the episodes. Usually the person is aware of the existence of the other(i.e. possessor), unlike in multiple personality[6].

Person Speaks in changed tone, even gender changes at times if the possessing soul is of opposite sex.Usually seen in rural areas or in migrants from rural areas.

Majority of these patients are females who otherwise don't have any outlet to express their emotions.Syndrome is seen in all parts of India. Many religious shrines hold special annual festivals where hundreds of people get possessed simultaneously. These people are looked upon as special by their families and villages which reinforce the secondary gains. This syndrome is included in ICD-10 under Dissociative disorders. Treatment includes careful exploration of underlying stress which precipitated the possession attack.Antidepressants and anxiolytics are helpful in certain cases [3].

Culture Bound Suicide

*Sa*ti : Self-immolation by a widow on her husband's pyre.According to Hindu mythology, Sati the wife of

Dakhsha was so overcome at the demise of her husband that she immolated herself on his funeral pyre and burnt herself to ashes. Since then her name 'Sati' has come to be symptomatic of self-immolation by a widow. It was seen mostly in Upper Castes notably Brahmins and Kshatriyas and banned in India since 19th century. There has been only one known case since 1904 (in Rajasthan).

Jouhar : Suicide committed by a women even before the death of her Husband when faced by prospect of dishonour from another man (usually a conquering king). Most notable example is Rani Padmini of Chittor (Rajasthan) to evade the invading army of Sultan from Delhi in 15th century. More recently, hundreds of women killed themselves by jumping in wells during partition of India to avoid rioters violating their honour.

Santhara/Sallekhana: Voluntarily giving up life by fasting unto death over a period of time for religious reasons to attain God/ Moksha. It is seen in Jain Community who celebrates these events as religious festivals. Person initially takes liquids, later even refusing to take them. Recently 4 cases were reported from Rajasthan [3].

Koro

It is seen in northeastern states like Assam. It is commonly known as genital retraction syndrome. There is fear of genitalia retracting into abdomen leading ultimately to death. It is seen in both sexes. Affected male patient believes that his penis is shrinking and may disappear into his abdominal wall and he may die.Females affected infrequently, believing that their breasts and vulva are shrinking.Person applies external retractors to the genitalia in form of clamps, chains etc. to avoid it retracting back. It may occur as epidemics and is usually based on the culturally elaborated fears regarding nocturnal emission and masturbation. It is described as a syndrome in ICD-10 and DSM-IV. Treatment includes reassurance and talks to the patient on sexual anatomy as well as psychotherapy [7].

Ascetic Syndrome

It is firstly described by Neki in 1972. It appears in adolescents and young adults. Ascetic syndrome is characterized by social withdrawal, severe sexual abstinence, practice of religious austerities, lack of concern with physical appearance and considerable loss of weight [8].

Suudu

It is a culture specific syndrome of painful urination and pelvic "heat" familiar in south India, especially in the Tamil culture. It occurs in males and females. It is popularly attributed to an increase in the "inner heat" of the body often due to dehydration. It is usually treated by the following:

- Applying a few drops of sesame oil or castor oil in the navel and the pelvic region
- Having an oil massage followed by a warm water bath
- Intake of fenugreek seeds soaked overnight in water

The problem has also been known to exist in other parts of South India and the methods of treatment are also similar[9].

Gilhari(Lizard) Syndrome

It is characterized by patient complaining of small swelling on the body changing its position from time to time as if a gilhari (squirrel) is travelling in the body. Neither much literature available nor nosological status is clear. The belief that the gilahari (lizard) will rise in the back and after reaching in the neck will kill the person is so strong that the patient himself and/or the relatives produce him for crushing or killing the gilahari in vital area which is very painful and cruel leading to serious consequences. The perception and belief is so strong that it may be described as delusion and tactile hallucination. The patient repeatedly keeps on showing the swelling and the relatives also believe and argue that they have noticed the swelling but on examination no such swelling is observed[10].

Bhanmati Sorcery

Belief in magical spells that produce evil spirits to cause psychiatric illness i.e. conversion disorders, somatization disorders, anxiety disorder, dysthymia, schizophrenia etc. or physical illnesses.This Cultural Bound Syndrome is seen in South India [11].

Mass Hysteria

Mass hysteria (also known as collective hysteria, group hysteria, or collective obsessional behavior) is a phenomenon that transmits collective delusions of threats, whether real or imaginary, through a population in society as a result of rumors and fear. There have been short lasting epidemics of mass hysteria where hundreds to thousands of people were seen to be believing and behaving in a manner in which ordinarily they wont.*E.g.* the God Ganesha's idols drinking milk all over India in 2006 lasted for almost a week [3].

A report by choudhary et al. in 1993 of an atypical hysteria epidemic in a tribal village of the State of Tripura, India. Twelve persons, eight female and four male, were affected in a chain reaction within a span of ten days. The cardinal feature was an episodic trance state of 5 to 15 minutes duration with restlessness, attempts at self-injury, running away, inappropriate behavior, inability to identify family members, refusal of food and intermittent mimicking of animal sounds. The illness was self-limiting and showed an individual course of one to three days duration [3].

Nuptial Psychosis

A stress- induced dissociative or psychotic state occurring in young brides who are poorly prepared for marriage. It occurs among very young women in India whose lives are disrupted by arranged marriages. Sexual trauma, separation from the family, and stress contribute to symptoms of confusion, hysteria and suicidal intentions[13].

Conclusion

There is a need to reconsider Cultural Bound Syndromes in the light of the available literature. Relabeling and inclusion of these manifestations in the mainstream diagnostic categories in the upcoming revisions of the diagnostic manual would pave way for a better understanding and management of these conditions

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Review Article

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Postnatal Bipolar Affective Disorder: A Case Study

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Abstract

Bipolar disorder is a disorder of mood, in which a person has episodes of both elevated and depressed mood. These episodes of major change of mood are associated with distress and disturbance of function. Women who give birth, approximately 50 to 80% experience the "postnatal blues" following delivery. The incidence of mild to moderate depression is 10 to 16%. Severe, or psychotic, depression occurs rarely, in about 1 or 2 out of 1000 postpartum women. So special attention should be given to pregnant mothers who have past history of any psychiatric disorders. Possibly the psychiatrist face difficulty to make definite diagnosis of bipolar affective disorder (BPAD) against postnatal blues because the symptoms of postnatal blues usually begins 3 to 4 days after delivery, worsen by days 5 to 7, and tend to resolve by day 12. The aetiology of postnatal BPAD may very likely be a combination of genetic, hormonal, biochemical, psychodynamic and environmental influences. The treatment of postnatal BPAD varies with the severity of illness and may be treated with mood stabilizers, antidepressants and anxiolytics, along with supportive psychotherapy, cognitive therapy, group therapy, and family therapy. Multidisciplinary team, family members and friends may play vital role in the management of patient with postnatal BPAD.

Keywords: Postnatal; Bipolar Affective Disorder; Case Study; Multidisciplinary Team; Treatment.

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Introduction

26 years old primimother with gestational age 37 weeks 4days in early labor got admitted in to Obstetrics and Gynaecology department at 10 am on 14/12/2015 with complaints of pain in abdomen. Patient was denied for the vaginal delivery due to personal reasons. So she underwent LSCS at 1:50 pm and baby girl was delivered at 2:10 pm. Apgar score was 7 at first minute and 9 at fifth minute with 2.8 kg birth weight. Placenta was delivered completely and general health condition of mother was normal.

On second day of postnatal period, the woman suddenly developed certain affective and somatic symptoms like anxiety, irritable mood, feeling overwhelmed, unable to accept baby girl, hopelessness, childish behaviour, frequent mood swings and disturbed sleep pattern and appetite. So she was referred to psychiatric department for further proceedings.

The psychiatrist continuously assessed her for further 7 days and later diagnosed her a case of 'bipolar affective disorder, current episode mild depression' based on the above mentioned clinical features, past psychiatric history and findings of mental status examination. Psychiatrist put her on following pharmacological management,

Tab Perinorm 10 mg HS

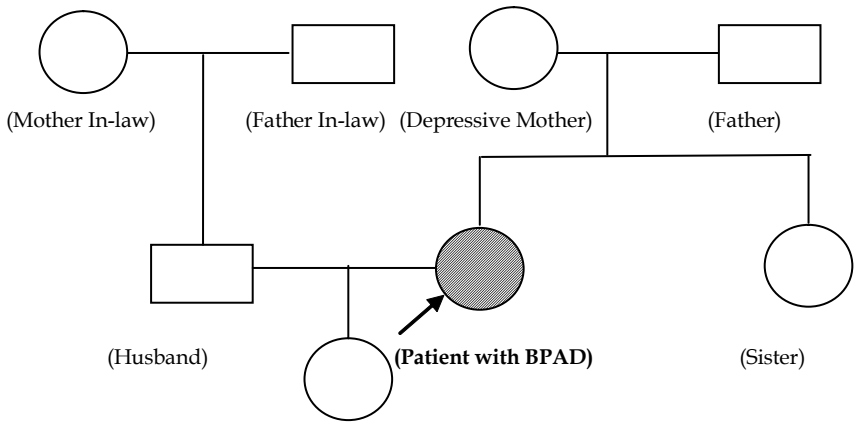
Tab Anxit 0.25mg HS,

Tab Betnesol 1 Stat,

Tab Rantac 150 mg HS,

Tab Imipramine 50 mg bd.

Family History



Mental Status Examination

The woman looked restless and was uncooperative. She had difficulty to establish eye-to-eye contact and rapport. Initiation of speech was minimal with delayed reaction time and slow rate of speech. She was anxious with labile predominant mood. She was aware of her abnormal behaviour and willing to take treatment.

Definition

Bipolar Affective Disorder is characterized by episodes of mania and depression in the same patient at different times. Typically, the patient experiences extreme highs (mania or hypomania) alternating with the extreme lows (depression); interspersed between the highs and lows are periods of normal mood [1].

Classification

As per ICD 10 classification BPAD is classified into 7 subtypes namely,

F31.0 Bipolar affective disorder, current episode hypomania

F31.1 Bipolar affective disorder, current episode mania without psychotic symptoms

F31.2 Bipolar affective disorder, current episode mania with psychotic symptoms

F31.3 Bipolar affective disorder, current episode mild or moderate depression

F31.4 Bipolar affective disorder, current episode severe

F31.5Bipolar affective disorder, current episode severe depression with psychotic symptoms

F31.6 Bipolar affective disorder, current episode mixed [2].

Patient is diagnosed as a case of BPAD, current episode mild to moderate depression (F 31.3).

Epidemiology

Lifelong prevalence rate of BPAD is 0.3-1.5%. It has significant morbidity and mortality rates. Approximately 25-50% of individuals with bipolar disorder attempt suicide, and 11% actually commit suicide. It occurs equally in both sexes. Rapid-cycling bipolar disorder (4 or more episodes a year) is more common in women than in men. Most cases commence when individuals are aged 15-28 years[1] [2].

Patient was 26 years old and had past history of BPAD.

Etiology

According to book precise cause is unknown. Bipolar disorder has a number of contributing factors, including genetic, biochemical, psychodynamic, and environmental elements.

Genetics Factors

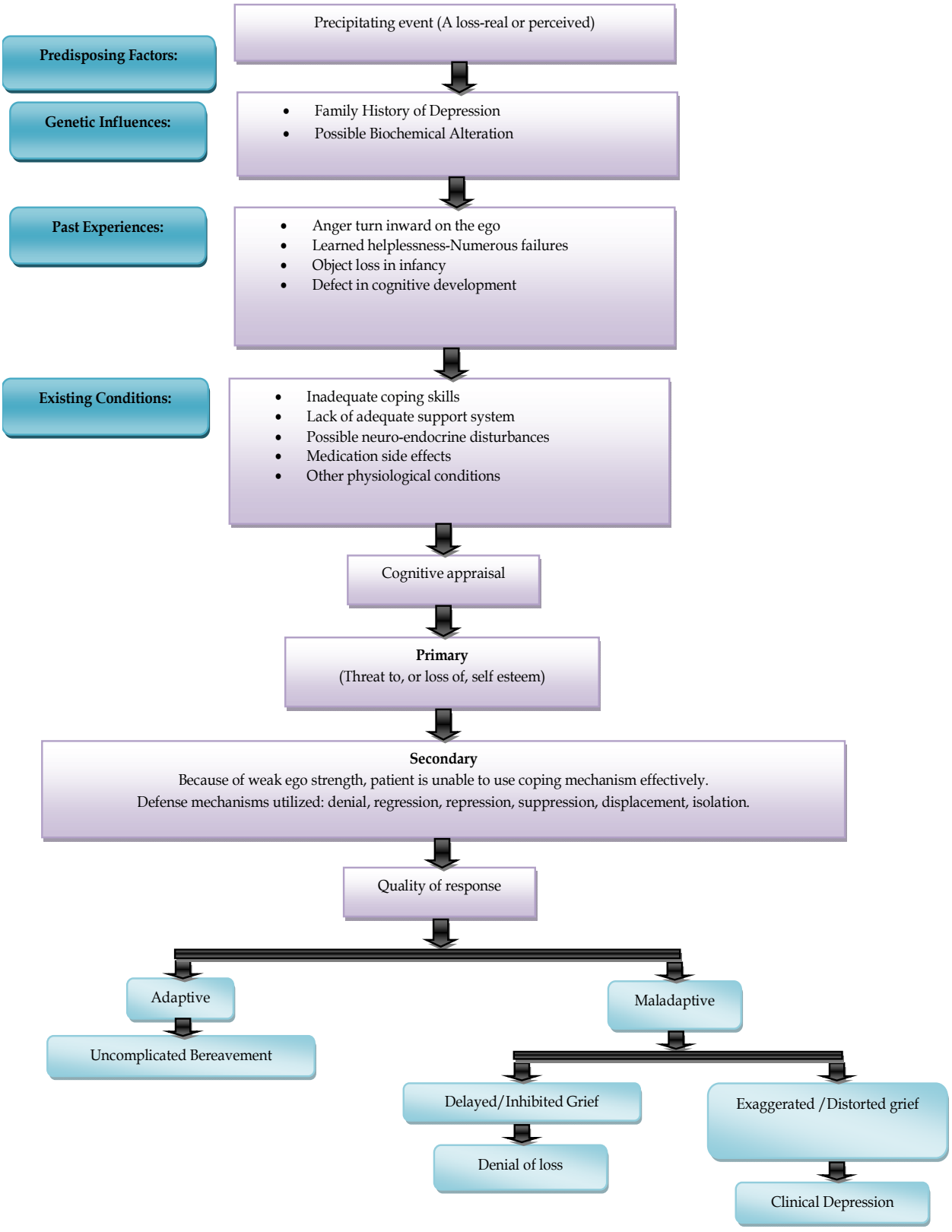
Twin, family, and adoption studies all indicate strongly that bipolar disorder has a genetic component. Bipolar disorder, especially BPI, has a major genetic component. First-degree relatives of people with BPI are approximately 7 times more likely to develop BPI than the general population.

Biochemical Factors

Catecholamine hypothesis -an increase in epinephrine and norepinephrine causes mania and a decrease in epinephrine and norepinephrine causes depression. Drugs like cocaine, which also act on this neurotransmitter system, exacerbate mania. Hormonal imbalances and disruptions of the hypothalamic-pituitary-adrenal axis [2].

Psychodynamic Factors

Depression is the manifestation of the losses, i.e., the loss of self-esteem and the sense of worthlessness. Therefore, that mania serves as a defense against the feelings of depression.



Psychodynamics of Bipolar Disorder (Depression) using Transaction Model of Stress/ Adaptation

Environmental Factors

Pregnancy is a particular stress for women with a manic-depressive illness history and increases the possibility of postpartum psychosis.

For the patient, there seems to be a mixture of causative factors namely biochemical, psychodynamic and environmental. During pregnancy there are hormonal imbalances and the disruption of the hypothalamic-pituitary-adrenal axis. Further, pregnancy is particular stress for women with a history of manic depressive illness and the increase the possibility of postpartum psychosis and poor self-esteem and faulty family dynamics may also predispose BPAD.

The Transactional Model

Bipolar disorder most likely results from an interaction between genetic, biological and psychosocial determinants. The transactional model takes into consideration these various etiological influences as well as those associated with past experiences, existing conditions and the individual perception of the event [1,3].

Signs and Symptoms

According to the book, signs and symptoms are as follows;

Manic Episode

- Expansive, grandiose, or hyperirritable mood.
- Increased psychomotor activity, such as agitation, pacing and hand wringing.
- Rapid speech with fight of ideas.
- Decreased need for sleep and food.
- Impulsivity, impaired judgment.

Depressive Episode

- Low self-esteem.
- Overwhelming inertia.
- Feeling of hopelessness, apathy.
- Difficulty concentrating or thinking clearly.
- Psychomotor retardation.
- Anhedonia, Suicidal ideation [4].

Patient in the current episode presented with anxiety, irritable mood, feeling overwhelmed, unable to accept baby girl, hopelessness, childish behaviour, frequent mood swings and disturbed sleep pattern and appetite.

Diagnostic Criteria

According to the book, diagnosis is made on the basis of history, presenting, signs and symptoms, mental status examination, ICD 10 criteria and American Psychiatric Association diagnostic criteria for manic episode [2].

In this case also, patient's history was taken. Patient was also examined and observed for mental status and signs and symptoms.

Treatment of Bipolar Depression

Comprehensive Clinical Assessment - Bipolar Depressive Episode

Clinical assessment requires patient cooperation and may not be possible if the patient is severely slowed physically and mentally.

It is essential to obtain collaborative information especially in cases where cognitive impairment is suspected:

- Suicide risk assessment.
- Exclude organic causes (neurological disorder, systemic disease, substance misuse, drug induced).
- Sophisticated appraisal of possible psychotic symptoms - especially pathological/delusional guilt and hallucinations.
- Check compliance with mood stabilizers.
- Conduct routine hematological and biochemical investigations (urea and electrolytes, full blood count, thyroid function tests, therapeutic drug monitoring).
- Additional investigations if indicated (e.g., brain scan, cognitive/ dementia screen)[5,6].

Continuing Failure to Respond

- Confirm correct diagnosis
- Re-evaluate psychological/social factors responsible for maintaining depression
- Consider adjunctive psychological therapies

Medications for Long-Term Treatment of Bipolar Disorder

Long-term treatment is often called the 'maintenance' phase of treatment or 'relapse prevention'. The goal of long-term treatment for bipolar disorder is to maintain

a stable mood and to prevent a relapse of mania or a depressive episode.

- Lithium: (Aim for serum concentration of 0.6 - 0.8 mEq/L)OR
- Valproate: (Usual dose range 1000 - 2500 mg; serum concentration 350 - 700 ìmol/L)OR
- Carbamazepine: (Usual dose range 600 - 1200 mg; serum concentration 17 - 50 ìmol/L)OR
- Lamotrigine: (Usual dose range 50 - 300 mg; serum concentration not useful)[6].

Pharmacological Intervention - Depressive Episode

New Depressive Episode	Breakthrough Depressive Episode On Single Mood Stabilizer	Failure To Respond
Initiate and optimizemoodstabilizer(Lithium, lamotrigine) **OR** mood stabilizer and antidepressant concurrently(MAOI, TCAs, SSRI)	Add antidepressant: [(SSRIs) and venlafaxine form the first-line choice of treatment.] MAOIs and TCAs should be considered as second-line treatment choices. **OR** Add second mood stabilizer (after blood levels) eg: Lamotrigine, combining of lithium and carbamazepine	Switch/substitute antidepressants **OR** Switch/substitute mood stabilizers **OR** Electroconvulsive therapy

Psychosocial Treatments

Learning to live with a continuous illness that is episodic is a major issue for people with bipolar disorder and their families.

- As an adjunct to somatic treatment.
- Repeated episodes of mania and depression tend to lead to increased rates of divorce, family breakdown, unemployment, a break in social networks and education, and financial difficulties

Cognitive Behaviour Therapy

Therapy aims at correcting the depressive negative conditions e.g. hopelessness, worthlessness and replacing them by new cognitive ideas and behavioural responses. It is used in mild to moderate depression and can be used along with somatic treatment.

Interpersonal Therapy

Therapy attempts to recognize and explore interpersonal stressors, role disputes and transitions, social isolation or social skill deficits, which acts as precipitants for depression.

Psychoanalytic Psychotherapy

Therapy aims at changing the personality itself rather than just ameliorating the symptoms. Its usefulness is uncertain.

Behaviour Therapy

This includes the various short term modalities like social skill training, problem solving techniques, assertiveness training, self control therapy, activity scheduling and decision making techniques. It is useful in mild cases of depression.

Group Therapy

Group psychotherapy can be useful in mild cases of depression. It is very useful method of psycho education in both recurrent depressive disorder and bipolar disorder.

Family and Marital Therapy

The main purpose is to ensure continuity of treatment and to reduce the intra-familial and interpersonal difficulties and to reduce or modify stressors which may help in a faster and complete recovery[6,7].

Conclusion

People who manage their bipolar disorder well provide assurance and hope that living with it and achieving a good lifestyle is now possible. The wider community is now more aware and understanding of bipolar disorder, and here are highly effective treatments now available. While there remains no cure, there is no reason to think that treatments will not improve even further in the future. Future research will aim to reduce the side effects of existing treatments and to develop better ones. With treatment, a person with bipolar disorder can lead a good quality of life.

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[1] Flink H, Tegelberg Å, Thörn M, Lagerlöf F. Effect of oral iron supplementation on unstimulated salivary flow rate: A randomized, double-blind, placebo-controlled trial. J Oral Pathol Med 2006; 35: 540-7.

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Article in supplement or special issue

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Corporate (collective) author

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Unpublished article

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Personal author(s)

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Chapter in book

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No author given

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[9] National Statistics Online—Trends in suicide by method in England and Wales, 1979-2001. www.statistics.gov.uk/downloads/theme_health/HSQ 20.pdf (accessed Jan 24, 2005): 7-18. Only verified references against the original documents should be cited. Authors are responsible for the accuracy and completeness of their references and for correct text citation. The number of reference should be kept limited to 20 in case of major communications and 10 for short communications.

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