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Co-Dependency and Depressive Symptoms among Wives of Alcoholics

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Abstract

Background: Alcoholism carries with it a host of social problems. Both the drinker and the family unit are affected. When the wife is a co-dependent it interferes with the recovery of the alcoholic.

Objectives: A study was conducted to assess the level of co-dependency and depressive symptoms among wives of alcoholics.

Methods: A descriptive Co-relational design was used to assess the co-dependency and depressive symptoms. Sample size was 100. Non Probability Convenience sampling technique was used for selecting the samples.

Results: 52% of the subjects were found to be moderately Co-dependent and 48% were found to be highly co-dependent. 75% of the samples had shown severe depression symptoms. Findings showed a positive correlation between co-dependency and depression. Significant relation was found between co-dependency and demographic variables like age, number of children, type of family, duration of married life, duration of alcohol consumption by husband and alcoholic history in parents. Significant relation was found between depressive symptoms and demographic variables like age, number of children, educational status, occupational status, type of family and duration of alcohol consumption by husband.

Conclusion: The present study revealed positive correlation between co – dependency and depression among wives of alcoholics.

Keywords: Co-dependency; Depressive symptoms; Alcoholics.

Introduction

Alcohol is one of the leading causes of death and disability globally and in India. Alcohol and its relationship to ill health have been recognized as an important public health challenge even though alcohol use has been part of the cultural traditions in different societies. Alcoholic beverages have been used in human societies since the beginning of recorded history.

Alcoholism carries with it a host of social problems. Both the drinker and the family unit are affected. Alcohol can have devastating effects on the family. Numerous marriages have been destroyed by alcohol, both emotionally and financially. Children of alcoholics are emotionally disturbed due to alcoholic parents. Approximately twenty percent of adults grew up with a family member with an alcohol problem. These adults themselves are at risk for developing substance abuse problems. Emotional issues such as guilt, depression, and relationship problems are often found in children of alcoholics.[1] Children of alcoholics (COAs) face special problems as a

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result of living in a home disrupted by alcohol problems. An estimated 6.6 million children under the age of eighteen live in households with at least one alcoholic parent.[2]

Co-dependence was originally defined in the late 1970s and early 1980s to help families and spouses of individuals with alcohol and drug problems. When the wife is a co-dependent it interferes with the recovery of the alcoholic.[3]

Alcoholism also has negative effects on the spouse of an alcoholic. The spouse may have feelings of hatred, self-pity, and avoidance of social contacts, may suffer exhaustion and become physically mentally ill. Very often the spouse has to perform the roles of both parents. Family responsibilities shift from two parents to one parent. As a result, the non-alcoholic parent may be inconsistent, demanding, and often neglect the children, in exchange for keeping the family together.[4]

Need of study

Taking into account both recorded and unrecorded consumption, the highest amount of alcohol consumed per adult resident, is in Europe, especially in Russia and its surrounding countries, and in the established market economies of Western Europe and North America. The least amount of alcohol consumed per resident is in the mostly Islamic regions of the Eastern Mediterranean and in the lesser developed region of Southeast Asia, dominated by India. Between the sub region with the highest estimated consumption level (Europe C) and the sub region with the lowest (Eastern Mediterranean D) the difference in consumption is more than 20-fold.[5]

Although the recorded alcohol consumption per capita has fallen since 1980 in most developed countries, it has risen steadily in developing countries, alarmingly so in India. The per capita consumption of alcohol by adults[3] in India increased by 106.7% between 1970-1972 and 1994-96. The pattern of drinking in India has changed from occasional and ritualistic use to social use. Today, the common purpose of consuming alcohol is to get drunk. These developments have raised

concerns about the health and the social consequences of excessive drinking.[6]

A study was conducted in NIMHANS showed that 20% of women reported domestic violence and 94.5% of women identified their husbands' alcohol consumption as a risk factor in incidents of domestic violence. Findings showed that relation between alcohol and health outcome was complex and multidimensional[7]. Each member of the family may be affected by alcohol differently. Adjustment to an alcohol problem of husband may result in an increase in the family's emotional and physical illness and altered familial function. The most negatively affected family members were spouse and children of an alcoholic.[8]

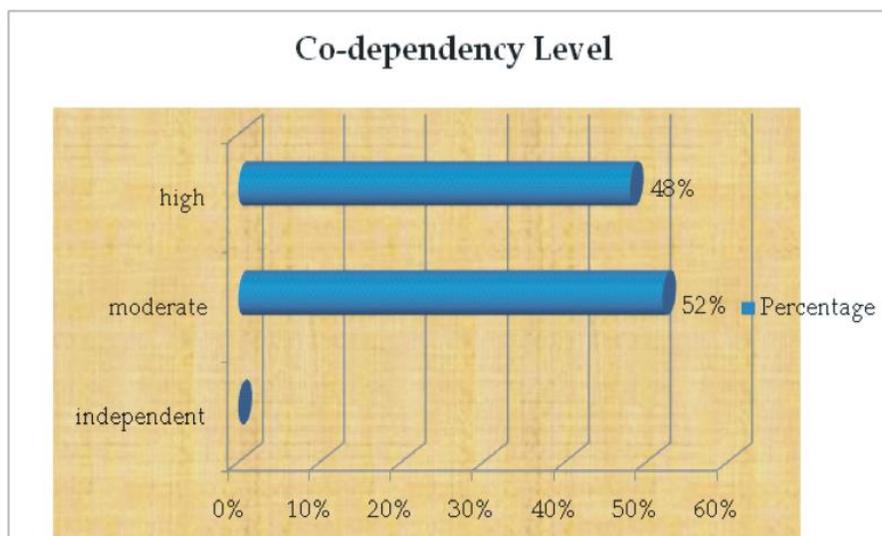
Long-term alcohol abuse can have dangerous physical and emotional effects. Alcoholism can also put financial strains on marriage. The money being spent on alcohol may cause problems and the strains among alcoholic wives. Trying to juggle alcoholism and marriage is tough because alcohol addiction can drain couples to the breaking point.[9]

With this knowledge in the background, a study was conducted to assess the level of co-dependency and depressive symptoms among wives of alcoholics, and to find the association between co-dependency, depressive symptoms and selected demographic variables.

Research Methodology

A descriptive co-relational design was used to assess the co-dependency and depressive symptoms. The study was done in Pandav Nagar, Wadarwadi. Population was Wives of alcoholics. Sample size was 100. Non probability convenience sampling technique was used for selecting the samples. After obtaining written consent tool was administered to the participants. Assurance was given regarding confidentiality and conducive environment was maintained. The average time taken by the respondents to

Figure 1: Co- dependency among Wives of Alcoholics



complete the questionnaire was approximately 10 minutes. Section 1 of the tool consisted of items related to socio demographic characteristics like age, religion, type of family, type of marriage, duration of married life, number of children, education and occupation. Modified Span Fischer Codependency Scale containing 14 items was used to assess codependency and Center for Epidemiologic studies depression scale (CES-D) was used to assess depressive symptoms among wives of alcoholics.

Major Findings

Section 1: Sample Characteristics

48% of subjects were in the age group of 20-30 yrs. Regarding number of children, 26% had only one child, 34% had two children, 32% had three children and only 8% of the sample had four children. 45% of sample had no formal education, 30% had primary education and 25% had secondary education. 42% of subjects

Figure 2: Depressive Symptoms among Wives of Alcoholics

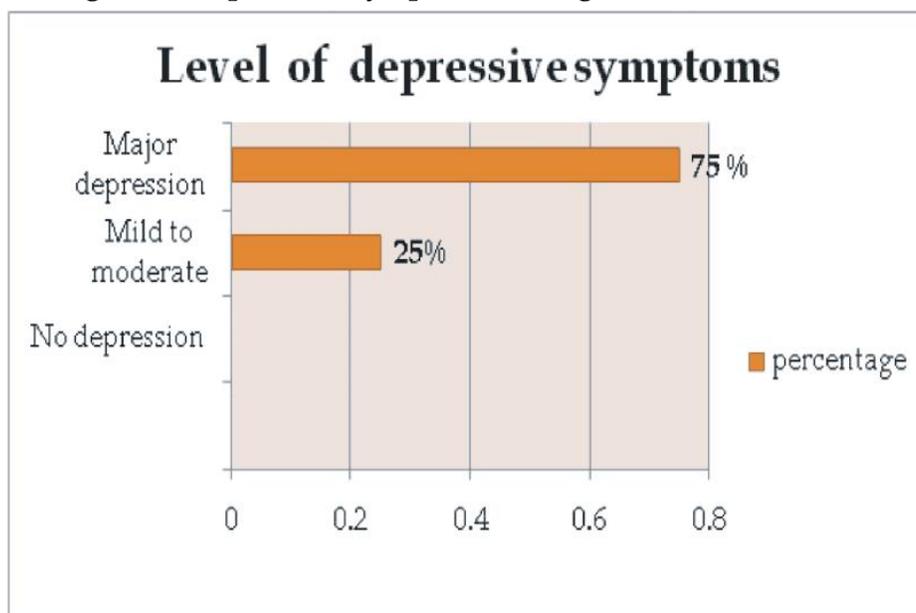
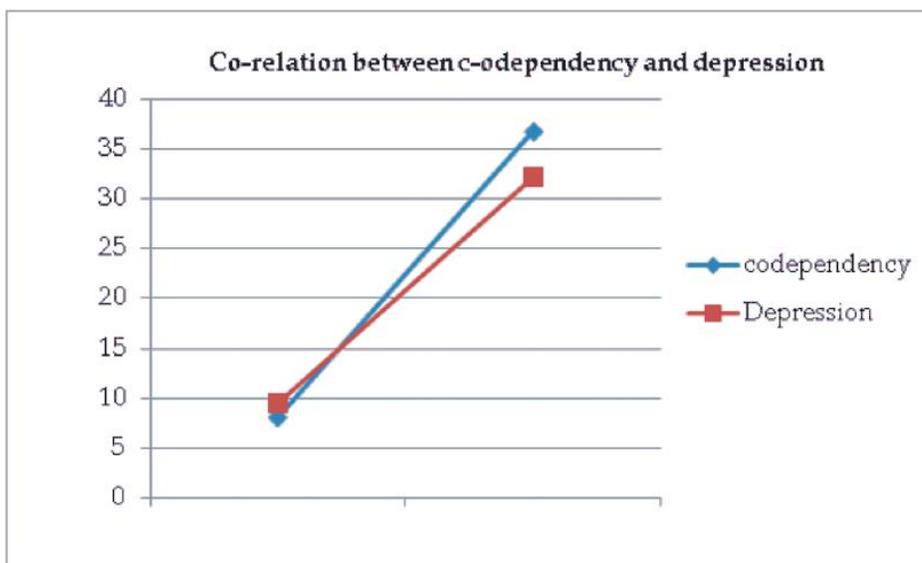


Figure 3: Co-relation between Co-dependency and Depressive Symptoms



were housewives, 40% were daily wagers and 18% were self-employed. 92% were Hindu and 8% were Muslim. 80% of the samples belonged to nuclear family. 51% of the samples had alcoholic history in parents and 49% had no alcoholic history in parents.

Section 2: Co- dependency among Wives of Alcoholics

52% of the samples were found to be moderately co-dependent, 48% were found to be highly co-dependent and none of them was completely independent.

Section 3: Depressive Symptoms among Wives of Alcoholics

75% of the samples had severe depression and 25% had mild to moderate depression.

Section 4:Co-relation between Co-dependency and Depressive Symptoms

The mean percent of co-dependency was 65.8% and standard deviation was 14.4%. The findings further showed that means percent of depression was 53.1% and standard deviation was 15.6%. The Karl Pearson co-relation coefficient was +0.842 showing a positive correlation between co - dependency and depression.

Section 5: Association between Co- dependency and Demographic Variables

Significant relation was found between co-dependency and demographic variables like age (14.02) number of children (13.3), type of family (11.03), duration of married life (9.77), duration of alcohol consumption by husband (6.07), and alcoholic history in parents (3.99).

Section 6: Association between Depression and Demographic Variables

Significant relation was found between depressive symptoms and demographic variables like age (12.35), number of children (16.47), educational status (10.77), occupational status (6.16), type of family (10.45), and duration of alcohol consumption by husband (8.44).

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Mental Health Morbidity in Older Adults: Psychosis

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Abstract

Psychosis is a state of having lost touch with reality. The chief symptoms of psychosis include hallucinations, which are false sensory perceptions of stimuli which are actually not present, and delusions, which are false and fixed beliefs not rooted in reality. Psychosis that develops in older individuals can be the result of a primary psychiatric disorder or secondary psychotic disorders including delirium, psychotic symptoms secondary to an identifiable medical condition or chemical agent (drugs or alcohol toxicity). Nurses make the assessment by taking history of the patient through interview, as well as by using formal questions and screening tools like Folstein's MMSE. In case of secondary psychosis, it is important to treat the underlying cause. Nurses have to establish trust with the elderly patient through active listening, promote medication compliance by educating patient and family members. They need to provide training in social skills and family and community living, adaptation and adjustment.

Keywords: Morbidity; Psychosis; Older adults; Mental health.

Mental Health Morbidity: Background

The Indian older adults are facing a number

of psychosocial changes. India, earlier and to a large extent still, has been and is agrarian economy and society. However, rapid economic changes such as urbanization, industrialization, globalization, emergence of women workforce, job linked migrations and emergence of new socio-cultural values, and breaking of joint families, are alienating older adults from main stream and compel them to stay alone and isolated. This demographic transition is causing enormous impact on psychological and physical health of the elderly resulting into a variety of psychogeriatric problems. Psychiatric problems in the elderly had not been given much attention till 70s in the country. India, though late to start, is moving fast in research explorations of various issues related to mental health of senior citizens. Psychogeriatric research in India includes prevalence studies of mental health morbidity, different psychiatric illnesses of old age like dementia, delirium, paranoid states, affective disorders especially geriatric depression, anxiety, suicidal behaviour, delusional disorders, addictions etc.; studies related to psychosocial profile and psychological well being, care giving and rehabilitation aspects etc.[1]

Organic brain syndromes and affective disorders are the commonest mental ailments prevalent in the elderly.[2,3] The problems of the older adults are manifold and different from the adults. Loneliness and hopelessness as well

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as feeling of separation often lead to stressful situations. Lack of social interaction caused by the loss of physical capabilities (e.g. mobility, hearing, sight, mental functioning, intelligence, memory etc.) and by retirement from work is likely to reinforce these feelings and may lead to further social withdrawal and segregation. [4] Studies indicate that mental health problems play an important role in morbidity and premature mortality.[5]

The common fear of getting old is related to losing power, independence and ability to perform activities of one's own choice. Depression and dementia has been widely studied in older adults. Other illnesses are not that widely studied. Similar has been the practice across the globe as well. Among neuro-psychiatric condition, dementia and depression are found to be leading contributors and in the elderly it shares 1/4th and 1/6th of all Disability Adjusted Life Years (DALYS) respectively.[6]

The most common psychiatric diagnoses responsible for chronic and persistent mental illness include schizophrenia, mood disorders, delusional disorders, dementia, amnesia and other cognitive or psychotic disorders.[7] Some older adults with severe and persistent mental illness have had mental illness for decades while others may have been diagnosed later in life. We start here with one such persistent and severe mental illness, that is, Psychosis.

Psychosis in Older Adults

Psychosis is a state of having lost touch with reality. A person showing psychotic behaviour is unable to know if what he or she is thinking and feeling about the real world was really true. The chief symptoms of psychosis include hallucinations, which are false sensory perceptions of stimuli which are actually not present, and delusions, which are false and fixed beliefs not rooted in reality.[7] Psychosis that develops in older individuals can be the result of a primary psychiatric disorder or secondary psychotic disorders including delirium, psychotic symptoms secondary to an identifiable medical condition or chemical

agent (drugs or alcohol toxicity).[11] Primary psychosis occurs in older adults who have had a lifelong schizophrenia, major depression or bipolar disorder with psychosis (chronic psychosis), and older persons who develop psychotic symptoms for the first time in old age (acute psychosis). Disease states associated with psychotic symptoms in older adults include:

- *Schizophrenia, Both early Onset (EOS) and Late Onset (LOS):* Schizophrenia is a severe psychotic disorder characterized by two or more of the following symptoms: delusions, hallucinations, disorganised thinking, disorganized behaviour, affective flattening or apathy.[7]
- *Delusional Disorder:* Delusional disorder increases in middle to old age[9] and is manifested by the presence of one or more non-bizarre delusions.[7]
- *Mood Disorders with Psychotic Features:* Both major depression and bipolar disorder can be accompanied by psychotic symptoms, both delusions and hallucinations.[9]
- *Delirium:* Delirium is a syndrome of brain dysfunction and usually is accompanied by hallucinations and misinterpretation of environmental stimuli.[9,10]. Hallucinations in delirium are typically visual and accompanied by illusions.
- Psychosis manifested with other diseases, like Parkinson's disease, Alzheimer's disease, and other dementias
- Psychosis related to substance use, abuse or other medications (polypharmacy)

Nursing Management

Assessment: The assessment of geriatric patients who present with psychotic symptoms (hallucinations or delusions) should focus on determining whether the psychosis is primary or secondary. The assessment should start with the interview. For this the nurse should establish a therapeutic bond with patients. Patience and active listening will help to form this bond and put the patient at ease. Older patients may take

time to respond to questions and should be given ample time to answer before assuming that there may be cognitive deficits. Interview the patient when he is most awake and alert. Sensory deficits should be kept in mind and corrected, if possible. Have a family member at the interview that is able to clarify and validate responses given by the patient.

Besides taking the thorough history of the disorder, the nurse may use formal questions and screening tools, as well as behavioural observation during the interview to help confirm a diagnosis of psychosis and its aetiology. The most well known tool is the Mini Mental Status Examination by Folstein (MMSE) and Geriatric Depression Scale (GDS). MMSE is a tool to assess cognitive and memory deficits and GDS assesses depression in old age, which is widespread. The nurse can ask about hallucinations directly by asking, "Do you hear or see things that others cannot hear or see?" For eliciting delusions, she may ask, "Do you think that people around you want to harm you?"

Treatment: After the assessment has been done to see whether the psychosis is primary or secondary and the time of onset of first symptoms (early or late), the treatment would start. In case of secondary psychosis, it is important to treat the underlying cause like medical illness, dementia, substance use disorder. In case of primary psychosis, it is vital to know the time of onset of symptoms to plan appropriate care.

- *Establishing Trust:* Older adults are often isolated, lonely and have sensory deficits that make undertaking investigations and treatment difficult. A safe environment and trusting relationship must be established before treatment starts.[12] Actively and non-judgementally listen to complaints of the elderly without reinforcing delusions and hallucinations. A matter of fact attitude towards delusions will be the most appropriate. It is important to understand experience and perspective of the person with regard to hallucinations and delusions to better understand his level of distress, and coping with them.

- *Pharmacotherapy:* If the individual is markedly distressed by hallucinations and delusions, then first control these psychotic symptoms by administering atypical (Risperidone, Olanzapine) and typical (Haloperidol, Fluphenazine) antipsychotics as prescribed. Unpleasant side effects of some of the antipsychotics such as extrapyramidal symptoms (EPS) may lead to the patient becoming non-compliant. Cognitive and sensory deficits and older person living on a fixed income and cost of the medicines can also make an elderly patient to not take medications regularly and correctly.

Nurses can promote medication adherence by carefully monitoring side effects, educating about management of the side effects, administering long acting injectable anti-psychotics.

- *Psychosocial Interventions:* Individual with schizophrenia needs comprehensive services at the individual, family and community level. Individual interventions improve the individual's function and ability to self-manage his disease.[13] Training in disease management and social skills is given in a group of older adults, where they can share their experiences, concerns and issues. Many of the older Individuals having life-long schizophrenia may have had several episodes of schizophrenia and hospitalizations and as a result forget the social skills (skills required to live in society). Thus, they need to adapt and adjust to community living again. Nurses in rehabilitative set-up can teach community living or social skills, such as cooking, cleaning, making conversation through hands-on training and role plays. [14] Nurses who have been trained in cognitive-behaviour therapeutic techniques may help in helping persons with schizophrenia manage their symptoms and maintain their treatment regimen.
- *Family and Community Support:* Psychoeducation should be designed to educate and support family members about schizophrenia and its treatment[13], since

majority of older persons with schizophrenia have lived with the disease for decades and family members have adapted to living with a chronically ill member. The content of the psychoeducation should be age appropriate, such as the effect of age on schizophrenic symptoms and treatment, as well as helping families plan for the care of their relative after they die.[15] Families of older persons with schizophrenia have the compounded difficulties of caring for a member who has a chronic disability as well as dealing with their own personal aging. Day care programmes or partial hospital programmes provide an alternative to extended hospitalization, through comprehensive services offered on an outpatient basis by a multi-disciplinary team of psychiatric nurses, psychiatrists, social workers and occupational therapists.[16]

- *Social Stigmatization:* Old age and psychotic disorders like schizophrenia are a double whammy to the older person. Therefore, social stigma may be doubly damaging to older persons with chronic psychotic disorders such as schizophrenia, and the person feels dehumanized. Programmes to combat stigma include: providing the individual with support to combat interpersonal stigma, encouraging the media to represent persons with schizophrenia in a more balanced manner, lobbying for better services for the mentally ill, developing confidence in the older adult through sharing their experience with mental illness with audiences of mental health professionals, students and lay persons.

Conclusion

Nurses have an integral role in the assessment and treatment of older adults with psychoses resulting from the multiple etiologies. They conduct medication groups and other disease management, community skills and

family psychoeducational groups. By dispelling misconceptions about psychotic disorder, specifically schizophrenia, they help to decrease stigma, promote an individual's self-esteem, and improve his quality of life.

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Strategies for Managing Aggressive, Violent and Potentially Violent Patients and Safety Precautions for the Nurse Practitioner

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Abstract

Aggression and violent behaviour can be attributed primarily to lower levels of serotonin. Apart from it there are other causes like family rearing practices, psychiatric illness or being under the influence of psychoactive substances. The risk factors in the potential for violence identified are past history of violence, client diagnosis and current behaviours. Working closely with aggressive and violent patients places the nurse at risk for being victimised. Rapid and efficient management of aggressive, violent and potentially violent patients is a critical skill. Effective violence management programs (that can be given as in-service education or induction program for nurses new to psychiatric units) can reduce the incidence of violence. Management of aggressive behaviour can be implemented to empower nurse practitioners to take precautions whenever necessary in a quick and efficient manner when dealing with aggressive, violent and potentially violent patients. Not all violence can be prevented, but with instruction, precaution, and training, violence can be successfully and effectively managed.

Keywords: Aggression; Violence; Debriefing; seclusion.

Introduction

All of us get angry at one or the other point of time but the intensity, frequency and duration of anger threshold varies from one individual to other. Being angry often affects one's physical as well as psychological health eventually leading to many life threatening complications. Alexander[1] identifies a cluster of characteristics, as given below, that describes anger:

- Intense distress
- Frowning
- Gritting of teeth
- Pacing
- Eyebrow displacement (raised, knitted, lowered)
- Clenched fists
- Increased energy
- Withdrawal
- Flushed face
- Emotional over control
- Change in tone of voice (either lowered, with words spoken between clenched teeth, or yelling and shouting)

Alexander[1] states that aggression can arise from such feelings states as anger, anxiety, tension, guilt, frustration and hostility. It has been evident that mental illness and aggression

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are closely associated. The Oxford Dictionary[2] defines violence as 'behaviour involving physical force intended to hurt damage or kill someone or something'. Children as well as adults are now bombarded with scenes of interpersonal violence highlighted by the media.

It has now become a common scenario in the life of nurses to have either experienced or witnessed being threatened, abused, attacked, harassed or confronted with a weapon by an aggressive patient. None of us can predict the future violence; aggression is usually a symptom of an underlying condition. The best type of management of any potentially violent patient lies in its prevention. Lewis and Dehn[3] found that assaults by clients in the community were caused partly by stressful living situations, increased access to alcohol and drugs, availability of lethal weapons, and noncompliance with medications. Implementation of effective violence reduction strategies can empower nurse practitioners to adopt precautionary measures when required to deal with an immediate crisis situation.

Shepherd and Lavender[4] found that aggressive behaviour was less common on psychiatric units with strong psychiatric leadership, clear staff roles, and planned and adequate events such as staff-client interaction, group interaction, and activities. Conversely, when predictability of meetings or groups and staff-client interactions were lacking, clients often felt frustrated and bored and aggression was more common and intense.

The capability to deal with aggressive patients and to perform diligently and vigorously in such emergencies demands critical thinking skills on the part of the practitioner. Violent management strategies must be adopted both in inpatient and outpatient departments due to reasons like minimal staffing, existing staff may not be equipped with required knowledge or skill, minimal inpatient stays. The pervasiveness of violent patient must be documented immediately.

It is obvious that if a violent and aggressive patient is prescribed involuntary

hospitalization, given medication, put in a crowded non therapeutic setting or put on seclusion or restrain, the threshold of his aggressiveness would increase and managing such patient would in turn be difficult. Understanding the psyche behind the violent patient is important as well as taking precautionary measures for self, the entire fraternity of nurse practitioners and all the caregivers is an immediate concern.

Safeguarding Measures to Be Taken By the Nurse Practitioners

The nurse managers should collaborate with other mental health professionals and conduct staff training programs focussing on global safety issues. Safety precautions should be taken when approaching the patient, right from the assessment phase. The nurse should introspect her own fears and anxieties in the pre interaction phase as it may exacerbate patient's agitation and may interfere with the assessment process. The nurse should introduce herself in the first meeting itself and her role as a helping professional in the process of recovery, however emotionally instable, intoxicated or disoriented patient may not be able to retain some information.[5]

The nurse should institute several measures to create several respectful, supportive contexts when interviewing the patients. Nijman and Rector[6] discovered that lack of psychological space—having no privacy, being unable to get sufficient rest—may be more important in triggering aggression than a lack of physical space. In addition to assessing the milieu, the nurse should monitor the patient carefully.

The three elements have been identified as key risk factors in the potential for violence: past history of violence, client diagnosis and current behaviours.[7] Also the situational and interactional factors associated with violence must be assessed. There should be same consistent staff approaching the patient every time as it is helpful in building rapport with the patient. It should be kept in mind that when interviewing the patient in a room, always sit near the door. Empathy can be conveyed

through active listening. The patient should be given his own personal space and avoid touching the patient without prior intimidation as it may be perceived as threatening to him.

Crucial details that a clinician may investigate to learn about a patient's history of violence include:

- (a) chronology of violent episodes from onset to present;
- (b) target(s) of violent behaviour;
- (c) severity of injury or intended injury from violence;
- (d) associated symptoms surrounding a violent episode;
- (e) ownership and use of weapons and weaponry skills;
- (f) criminal and impulsive behaviours such as destruction of property, reckless driving, suicide attempts, and self-mutilation remnants that may include cigarette burns, scars, and self-made tattoos.

In addition to obtaining detailed violence, family, and medical histories, mental status examination should be carried out. A thorough mental status examination allows to investigate delusions and hallucinations; delirium associated with neurological disease; signs of substance intoxication or withdrawal such as slurred speech, uncoordinated movements, dilated or constricted pupils, tremors, the smell of alcohol, and organic disruption of higher cognitive capacities. Finally, clinicians should conduct routine laboratory tests in order to help provide an accurate diagnosis and subsequent management and treatment for the patient.[8,9,10]

The specific non verbal communication used by the nurse can also greatly affect the outcome of the intervention. A calm and relaxed posture that does not tower over the patient is much less intimidating than posture in which hands are placed on the hips and nurse looms over the patient. Crossing the arms across the chest is another posture that communicates emotional distance and reluctance to help. The nurse's hands should be kept out of pockets and open posture should be maintained. Also

nurse must maintain an eye contact with the patient when interacting with the patient. Simple strategies like sitting with the seated patient, standing with the standing patient and walking alongside with the patient ,using simple short sentences and avoiding laughing or smiling inappropriately depicts willingness and enthusiasm to learn more about the patient's agitated behaviour conveys mutual understanding. Encourage the patient to communicate his concerns without interruptions and engage the patient participation in treatment decisions by providing information as much as possible. Communicating the expected behaviour encourages the patient to maintain control of his violent behaviour.

Staff debriefing[7] should be done that means the violent episode should be discussed with the staff and others. It includes who witnessed the incident in terms of what happened, what could have been done that would have prevented the incidence, the necessity of seclusion and restraining and how the client and staff felt in terms of seclusion and restraining. Some cathartic activities like physical activities can be useful in releasing aggression. Limit setting is a non-punitive, non manipulative act in which the patient is foretold about acceptable behaviour and the consequences of behaving unacceptably. Nurses must understand that whenever limit setting is implemented, the maladaptive behaviour will not immediately decrease; in fact it may briefly increase.

Lepage *et al*[11] found an association between increased numbers of young adults (18 to 20 years of age) on inpatient psychiatric units and higher rates of violence. It is important to consider the environment for all clients when trying to reduce or eliminate aggressive behaviour. Planned activities or groups such as card games, watching and discussing a movie, or informal discussions give clients the opportunity to talk about events or issues when they are calm. Activities also engage clients in the therapeutic process and minimize boredom. Scheduling one-to-one interactions with clients indicates the nurse's

genuine interest in the client and a willingness to listen to the client's concerns, thoughts, and feelings. If clients have a conflict or dispute with one another, the nurse can offer the opportunity for problem solving or conflict resolution. Expressing angry feelings appropriately, using assertive communication statements, and negotiating a solution are important skills clients can practice. If a client is psychotic, hyperactive, or intoxicated, the nurse must consider the safety and security of other clients, who may need protection from the intrusive or threatening demeanour of that client. Talking with other clients about their feelings is helpful, and close supervision of the client who is potentially aggressive is essential.[12]

It is the responsibility of the nurse to check at the time of admission that patient has no weapons, glass utensils, razors, blades, knives, rope or any long cloth that could be used as a medium for harming self or others when experiencing anger episodes. In order to detect the presence of weapons, metal detectors searches must be made available. Also panic buttons should be installed and locations should be marked.[5] Provision should be made so that the patient's bed is at place near to the nurse's station through which continuous vigilance can be done. Nurses should not approach the patient alone, or if approaching the patient ensures that other nurses are aware where one is and help can be provided when needed. It is constructive to avoid initial derogative remarks made by the patient. Avoid touching the patient when he or she becomes angry.

Talking down technique is also employed for bringing the agitated patient into a calmer state with the intention of preventing the occurrence of violent behaviour. It comprises a number of naturalistic skills which nurses have used. The nurse can also refer the clients to anger management groups (once the anger falls down) where they are taught problem solving and conflict resolution techniques.

Behavioural contracts (nursing care is planned to eliminate rewards the patient receives also allowing the patient to assume as

much as control as possible over violent behaviour), time outs(socially inappropriate behaviour can be decreased by short term removal of the patient from the situation) can be used also to gain control over anger and violence and token economy can be used to bring the desired behaviour.

The nurse should not administer chemical restraint to patients intoxicated with alcohol or other depressant agents, for the combination of neuroleptic medication and such agents may endanger a patient's level of consciousness.[5] When patient becomes unmanageable that is through behavioural therapies and medications, restraining and seclusion becomes the last resort. It has to be prescribed by the physician in written order. Care should be given during restraining also. The nurse should see that the patient's need for nutrition and elimination are met. Also the extremity that is restrained must be inspected to check for proper circulation. As per the instructions given by JCAHO[13] (Joint Commission on Accreditation of Healthcare Organizations) reissuing a new restrain must be done every 4 hours for adults and every 2 hours for children.

Conclusion

Nurses in every practice setting face the challenge of caring for perpetrators of violence. Lack of adequate education and training on the part of the nurses in terms of aggression and violence management can bring detrimental outcomes to nurse, patient himself, other patients or caregivers like physical injury or as fatal as death even. Developing an understanding of the causes and effects of violent behaviours enable to intervene in a therapeutic manner and provide comprehensive care. In the era of managed care and reduced staff ratio, violent incidences tend to become more recurrent. The three elements have been identified as key risk factors in the potential for violence: past history of violence, client diagnosis and current behaviours. Violence management strategies should be implemented at both institutional and

professional level. The best type of management of violence lies in its prevention. Though not all violence can be prevented, but with instruction, precaution, and training, violence can be successfully and effectively managed. In all acute care settings written policies should be made available regarding violent and potentially violent patients.

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Effectiveness of Educational Intervention on Knowledge and Attitude of Complementary Therapies among Nursing Professionals

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Abstract

Background: The health care system is changing incrementally and becoming more complex. As a result, many consumers seeking to take more responsibility for their health are turning to complementary and alternative therapies. The increased number of health care consumers choosing complementary therapies to augment treatment regimens and enhance health makes it imperative that the nurses become informed of these therapies and their utilization in the nursing practice. **Objectives:** A study was conducted to assess the knowledge of nurses on complementary therapies to evaluate the effectiveness of educational intervention on complementary therapies among nursing professionals, and to find out association of knowledge with their socio demographic characteristics. **Material and Methods:** Hundred nursing professionals above 20 years of age were studied. They were assessed for the level of knowledge on complementary therapies before the education/training, followed by the educational intervention carried out in relation to Therapeutic Yoga, Progressive Muscle Relaxation Therapy and Massage. The post test was carried out after the intervention by using structured questionnaire. The data were analyzed with descriptive and inferential statistics

wherever required. **Results:** The results revealed that there was an improvement in the knowledge on complementary therapies (pre test mean score 8.79 ± 2.12 and post test score was 16.19 ± 2.65) with effectiveness of 37.05% was statistically significant ($t=11.39$, $p<0.05$). Nurses exhibited a positive attitude and valued the significance of complementary therapies. The knowledge had significant association with socio demographic variables like age, education and occupation. **Conclusion:** The educational intervention/training was useful in improving knowledge and enhancing the attitude on complementary therapies in nursing practice. It is essential to raise the awareness on significance of complementary therapies in health care practice and seek behavioral change among health care professionals to improve the health care services.

Keywords: Educational intervention; Complementary therapies; Nursing professionals.

Introduction

Complementary therapies are becoming an increasingly important part of health care and enjoy growing popularity among the general public. It's commonly used to complement conventional health care practices and becoming more accepted by the bio medical health care providers.[1]

The increasing and widespread use of complementary and alternative medicine (CAM) in the general population requires

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health care professionals to have a knowledge and appreciation of their use to ensure that decisions about care are appropriate, safe and meet patient's needs. There is a need for more education and training of health care professionals in CAM. Educational institutions are beginning to incorporate CAM components into curricula and even offer courses/fellowships in integrative medicine.[2]

Despite the evidence for integration of complementary and alternative medicine into professional nursing practice; gaps exist on nurse's basic knowledge, skills and learning needs for further education to facilitate the integration of CAM into nursing practice. Nurses cannot advocate for CAM therapies, unless they themselves are familiar with these practices. It is necessary to first establish nurse's awareness, beliefs and better attitude related to CAM to incorporate the CAM into the clinical practice.[3]

Nurses performing CAM do not yet have sufficient knowledge or utilization practices, and there are difficulties with skills and time management. In addition, a wide gap exists between the self reported knowledge and actual application of therapies in the practice. Developing CAM educational programs or providing training for nurses is a simple and easy way to use the CAM therapies in nursing practices, where nursing focuses on the whole person.[4,5]

Researchers had demonstrated that the training or educational interventions improves the knowledge, attitude and enhances the perception on complementary therapies. [6] These therapies are gaining importance, where it has a positive effect on their physical and psychological well being; and becoming increasingly acceptable to the scientific community. Thus, a study was planned to assess the effectiveness of educational intervention on the knowledge and attitude of nurses about complementary therapies.

Material and Methods

A Quasi - experimental study, pre test post

test design without control group approach was used. The present study was conducted on 100 nursing professionals of five nursing institutes at Ahmednagar district, Maharashtra. The nursing professionals who were above 20 years of age, able to follow and practice complementary therapies and willing to participate were included in the study. The subjects were selected by probability method i.e. simple random sampling technique. For the assessment of knowledge, a self prepared and pre tested structured knowledge questionnaire was used. The correct response indicated the score of one (1) and wrong response zero (0).

After obtaining the informed consent, pretest was conducted on first day followed by the educational intervention/training on complementary therapies was implemented by experts for a total of 8 hours. The intervention included both theory as well as practical sessions. Theory session of 2 hours and practical sessions of 6 hours, wherein, therapeutic yoga, progressive muscle relaxation therapy (PMR) and massage was taught for two hours each. The posttest was carried out after one week of education/training by using the same questionnaire. The collected data was analyzed based on objectives by using descriptive and inferential statistics.

Results

Findings Related to Socio Demographic Characteristics

One third of nursing professionals (34%) belonged to 20 - 25 years of age group, majority (70%) was male, and half (51%) of them had Diploma level of education (GNM) followed by Bachelor degree (26%). Half of nursing professionals were student nurses while the remaining were staff nurses and nurse educators respectively, and 66% obtained information on complementary therapies through books and journals.

Table 1: Effectiveness of Educational Intervention on Knowledge of Complementary Therapies

Areas	Max. score	Pre test			Post test			Mean difference
		Mean	SD	Mean %	Mean	SD	Mean %	
Overview of CAM	04	2.37	0.82	59.25	3.57	0.76	89.25	30.00
Therapeutic yoga	06	2.54	0.95	42.33	4.63	1.08	77.13	34.80
PMR therapy	03	1.41	0.76	46.60	2.02	0.80	67.33	20.73
Massage	07	3.48	1.98	49.71	5.46	1.52	78.00	28.29
Overall	20	8.79	2.12	43.95	16.20	2.65	81.00	37.05

't' value: 11.39* p<0.05 level *Significant

Effectiveness of Educational Intervention on Knowledge of Complementary Therapies

The overall pre test mean score was 8.79±2.12 which was 43.95% of the total score indicating nursing professionals had average level of knowledge whereas the post test mean score was 16.19±2.65 which was 81%. Among the sub areas, therapeutic yoga had higher effectiveness with difference in mean percent of 34.8%. It interprets that the educational intervention/training significantly improved the knowledge (t=11.39, p<0.05). (Table 1) However, the training had demonstrated more effectiveness on various aspects of complementary therapies (Table 2). The knowledge had significant association with socio demographic characteristics like age (x²: 4.32), education (x²: 3.92) and occupation (x²: 4.02) at p<0.05 level.

Nursing Professionals' Attitude on Complementary Therapies

Majority (92%) felt that the complementary therapies were helpful to patients and families, followed by 78% who expressed openness to

the utilization of complementary therapies in clinical practice and 73% believed that these therapies did not cause any adverse reactions. 85% of them were interested in gaining additional knowledge/training on complementary therapies, whereas 64% of samples endorsed to integrate the complementary therapies into the mainstream medicine.

Discussion

Complementary therapies are the healing resources that encompass all health systems, modalities and practices used to prevent, treat illness and promote health and wellbeing. It is a therapeutic and preventive practice that is put forward as having the significant healing effects of medicine.[7]

Study findings revealed that the 66% of nursing professionals obtained complementary therapies related information through books and journals. Similarly, Holroyd, Zhang and Suen (2008) found in their survey that news

Table 2: Effectiveness of Educational Intervention on Various Aspects of Knowledge on Complementary Therapies

		N=100		
SN	Components	Pre test (%)	Post test (%)	Effectiveness (%)
1	Surya Namaskar controls the diabetes mellitus	07	74	70
2	Meditation increases the theta waves in the brain	05	71	66
3	Cortisol is the body's main stress hormone	24	84	60
4	Contra indication for massage - Bleeding disorders	21	79	58
5	Massage: Blocks the perception of pain impulses	31	86	55
6	Sequence of massage: stroking, kneading and friction	30	82	52
7	Origin of yoga (5000 year old) is India	41	84	43
8	Alternative tighten and relaxing muscle groups - PMR	44	85	41
9	Complementary therapies focus on holistic approach	42	82	40
10	Shavasana helps to maintain the blood pressure	51	88	37

papers and magazines (64.2%) were the most common sources of information for nursing professionals.[8]

The results depicted that the educational intervention was effective in improving the knowledge and attitude of nursing professionals on complementary therapies. It was congruent with a study carried out by Hessig, Archand and Frost (2008) that an eight hour educational intervention was useful in enhancing knowledge and, to some degree, increasing application of the therapies in practice. It was evident that there is a growing recognition of the need for more education and training of nurses in CAM.[9]

Overall, nursing professional under study exhibited a positive attitude and valued the significance of complementary therapies. Rojas and Grant (2009) studied nurses' knowledge and attitude on complementary therapies and observed that the attitude varied according to beliefs, practice and role, but were positive overall. The positive attitude would provide insight for realizing and sustaining robust changes to health care.[10]

The nurses' knowledge on complementary therapies had significant association with socio demographic variables like age, education and occupation. Similarly, Keyser, Cohen and Wagner (2006) also noted that several variables such as education, age and perceived health status were associated with knowledge and use of CAM.[11]

The results of this study provide the important implications for understanding the impact of training for developing and providing appropriate education. The education/training provides nurses with knowledge to support and advocate for their patients.

Conclusion

The complementary and alternative therapies are gaining importance rapidly in recent years. Educating the health care professionals including students regarding

these therapies will enhance their knowledge, and thereby increase utilization of these therapies in the clinical practice. Hence, the symptoms relief/management can be accomplished with minimal pharmacological measures.

The nursing professionals support complementary therapies because the therapies address healing within all human dimensions including mind, body and spirit. Further there is a need for increased knowledge and understanding through appropriate educational resources and incorporation in the curriculum to ensure safe and evidence based nursing care.

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Effect of Yoga on Insomnia among Post Menopausal Women in Selected Rural Areas at Vadodara

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Abstract

Introduction: Sleep disturbances have been a major concern of physicians, psychologists and social scientists especially since last few decades because of the rising trend of different sleep disorders. Sleep is clearly necessary for survival, because prolonged sleep deprivation leads to physical and cognitive impairment. **Objectives:** A study was conducted to evaluate the effect of yoga on insomnia among post-menopausal women in selected areas of Vadodara. **Material and Method:** The research approach used was Quantitative. The study was conducted using pre-experimental design with one group pre-test and post-test, on 30 post menopausal women in rural area of Vadodara using non-probability convenient sampling. The data were tabulated and analyzed in terms of objectives of the study, using descriptive and inferential statistics. **Results:** In the pre-test post-menopausal women had 55.83% level of insomnia and mean score was 40.20 ± 8.24 . In the post-test post-menopausal women had average 35.28% of insomnia and mean score was 25.40 ± 5.73 . The post-test mean insomnia score was significantly lesser than the pre-test mean insomnia score, indicating the effectiveness of yoga. **Conclusion:** The study findings revealed that yoga was highly effective in improving sleep quality of post-menopausal women.

Keywords: Evaluate; Effect; Yoga; Insomnia; Post

menopausal women.

Introduction

Woman is a precious creature of God. She has many roles in the society to perform being a daughter, sister, wife and a mother. She works easily with the opposite sex at work place but also has responsibilities to perform as a home maker and to rear a child. In order to perform these functions effectively her health needs has to be taken care and requires more attention.[1]

During menopausal period women experience both physiological as well as psychological changes. Physiological changes include hot flushes, joint pain, irritable bowel movements, weight gain and hair loss. Psychological changes include anxiety, depression, sleep disturbance and stress. Women experiences stress in many ways and can be external and internal. It can cause changes in body images, attitude towards ageing and also leads to mood changes.[2]

Menopause is a complex time in a woman's life leading to both physical and emotional challenges. Menopause currently affects the lives of millions of women globally and will be an issue of increasing concern as the

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population ages over the next few decades. The word menopause literally means the permanent physiological or natural cessation of menstrual cycle. In other words, menopause means the natural and permanent stopping of monthly reproductive cycles, which is usually manifest as a permanent absence of monthly periods or menstruation. Post-menopause refers to the period of life after menopause has occurred. It is generally believed that the postmenopausal phase begins when 12 full months have passed since the last menstrual period. From then on, a woman will be postmenopausal for the rest of her life.[3]

The best management of menopausal problems is accepting it with ease. Lord Krishna in Bhagavadgita says Yoga is nothing but equanimity towards the pairs of opposites like happiness and sorrow, loss and victory etc. Accepting the unavoidable is the best way to counter it. Human life is a continuous process of changes and menopause is one of them. Accepting this fact reduces major fraction of the problems since it induces a psychological strength to combat the same. Thus a psychological adaptability along with a few yogic practices may be sufficiently helpful for a woman in facing menopause, one of the major turning points of her life.[4]

Nurses play a vital role in maintaining women's health and to make them aware about menopause and stress related to it. Menopausal stress is usually mild to moderate. Some women may go through severe level of stress. The nurse should educate them to practice some sort of relaxation techniques, yoga or exercise to practice in daily life and give psychological support to the menopausal women.[5]

Material & Method

A quantitative research approach was used, with one group pre-test post-test pre-experimental research design. The study was conducted among post menopausal women in rural area of Vadodara. The sample for the present study comprised of 30 post-

menopausal women in rural area of Vadodara, selected through convenient sampling technique. Data collection tool consisted of 2 sections.

Section I consisted of items related to selected demographic data of sample and *Section II* was a structured insomnia rating scale, having 24 items. To ensure content validity of the tool, the self structured rating scale was given to 7 experts. The experts were selected based on their clinical expertise, experience and interest in the problem being studied. They were requested to give their opinions on the appropriateness and relevance of the items in the tool. The experts were from the field of Nursing, Psychiatry and Psychology. Modifications of items in terms of simplicity and order were made. The reliability was established by using spearman brown split-half method and test retest method. The reliability value of 0.81 indicated that the tool was reliable.

To conduct research study at rural area of Dabhoi tehsil at Baroda, formal written permission was obtained from the superintendent of Dabhoi Community health center. Data were collected from 30 subjects who met the inclusion criteria as per the study. The questionnaire was distributed for pre test and instructions were given on answering the questionnaire and doubts were clarified. Each post menopausal woman took an average of 15-20 minutes to complete the pre-test. On the 1st and 2nd day, the pre-test data was obtained using structured rating scale. Then from 3rd day to 18th day, 30 minutes' planned yoga was administered. On the 18th day and 19th day post-test was conducted using the same tool to assess the level of insomnia.

The data were analyzed using both descriptive and inferential statistics on the basis of the objectives and hypothesis of the study.

Findings

Description of Sample Characteristics

14 (46.7%) post menopausal women belonged to the age group of above 52 years of age. 24

Table 1: Range, Mean, Percentage and Standard Deviation of Pre Test and Post Test Level of Insomnia among Post Menopausal Women

Total no. of questions	Min- max marks	Observation	Obtained range	Mean	Percentage	S.D.
24	0-72	Pre test	34	40.20	55.83%	8.24
24	0-72	Post test	23	25.40	35.28%	5.73

Table 2: Mean, Standard Deviation, Mean Difference and ‘t’ Value of Pre- test and Post Test Scores

Parameter	Mean	Standard deviation	Mean difference	‘t’ _{cal} value	P value	‘t’ _{tab} value
Pre test	40.20	8.24				
Post test	25.40	5.73	14.8	13.690	.000	2.045

(80.0%) post menopausal women belonged to the primary education group, while 3 (10.0%) belonged to the secondary education group. 28 (93.3%) post menopausal women belonged to the joint family while 2 (6.7%) post menopausal women belonged to the nuclear family. 19 (63.3%) post menopausal women were housewives. 21 (70.0%) post menopausal women belonged to the married group while 8 (26.7%) were widows.

The overall pre-test mean insomnia score of the post menopausal women was 40.20 ±8.24 and post-test mean insomnia score of the post menopausal women was 25.40±5.73. The post-test mean insomnia score was significantly lesser than the pre-test mean insomnia score. This indicated that yoga was effective in relieving insomnia in post-menopausal women. There was no significant association between level of post-test score and selected demographic variables at 0.05 level of significant.

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Conflict of Interest

The author has no relationship/condition/

circumstances that present a potential conflict of interest.

Ethical Standards

This study was conducted after getting approval from the Institutional Ethics Committee and after obtaining written consents from all subjects

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