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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/HSQ20.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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Counseling Services in Schools: Nurses in Forefront

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Children and adolescents constitute almost 40 percent of India's population. The forces of globalization, urbanization and free market economy have brought with them fresh challenges to provide a condusive environment to the development of children. The school plays a crucial role in the development of cognitive, social, emotional & moral functions and competencies in a child. However, in the contemporary system of education, schools have seriously marginalized and compromised on their role in guiding, regulating the psychological development of children and promoting psychosocial competence as they have to cope with heavy syllabi and curricula, poor teaching facilities and highly competitive examinations. In addition, there is limitation of resources and commercialization of education. School education has become a serious source of stress for children and parents.

Why Mental Health Care Facilities In Schools?

- Almost all children attend school at some time during their lives.
- Schools are often the strongest social and educational institutions available for intervention.
- Schools have profound influence on children, their families, and the community.
- Young peoples' ability and motivation to stay in school, to learn, and to utilize what they learn is affected by their mental well-being.
- Schools can act as a safety net, protecting children from hazards, which affect their learning, development and psycho – social well - being.
- In addition to the family, schools are crucial in building or undermining self – esteem and a sense of competence.
- School mental health programmes are effective in improving learning, mental well – being, and channelizing management of mental disorders.
- Teachers have often received some training in developmental principles. This makes them potentially well qualified to identify and remedy mental health difficulties in school children.

Issues Related to Mental Health of School Children

Issues of well – being and psychosocial competence affect the entire school community including students, teachers, school administration and members of the surrounding community. Specific mental health programmes addressing these issues

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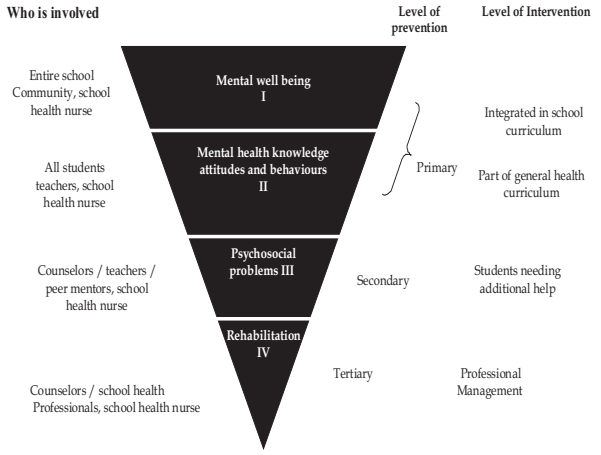
improve coping skills, decrease stress and increase support for a healthy school community. Mental health and learning go hand in hand.

Mental health knowledge, attitudes and behaviours affect all students and teachers. Educational interventions can make an important impact on the identification and handling of psychosocial and mental health problems. It is important to identify children with psychosocial problems early and target them for intervention. These early problems in school frequently predispose serious problems such as school failure and school dropout, early pregnancy, drug and alcohol abuse, delinquency and low levels of adult earnings. A few children develop serious mental disorders based on specific biological vulnerabilities just as some children develop other medical disorders such as diabetes, cancer and asthma.

Treatment by counselors and school health professionals is as important as a receptive and supportive school environment.

Framework for School Mental Health Programme

The following diagram illustrates the psychosocial and mental health issues in any school system and indicates who is likely to be involved by these issues:



Levels I through IV can be linked to primary, secondary and tertiary prevention measures. Primary prevention and health promotion (Levels I and II) target the causes of healthy and unhealthy conditions with interventions, which promote healthy behaviours and prevent a disorder from developing. Secondary prevention (Level III) targets selected population of high-risk children to protect against the onset of the disorder. Tertiary prevention (Level IV) targets children who already have developed the disorder with the intent of treating the disorder, reducing the impairment from the disorder, rehabilitation and / or preventing relapse.

Counseling in Schools

Counseling is a relationship stated as non – possessive warmth, genuineness, a sensitive understanding of children's thoughts and feelings. It is a "delicate alliance" involving empathy and good listening, which helps the counselor to understand and explore the problems, view them in varied perspective and ultimately solve them through effective rapport building.

Successful Counseling of Children & Adolescents Depends Upon

1. The level of psychosocial development of the child & adolescent.
2. The relationship the child & the adolescent share with the parents.
3. Identifiable event, which may have led to the problem behaviour.
4. Child and adolescent's recognition that there is a conflict.
5. Child and adolescent's ability to recognize and label feelings, emotions and consequence of behaviour.
6. Parental support.

Choice of solution remains with the child and adolescent. Each person is unique and once the counselee is able to view his/her world and

relationship objectively and clearly, he / she is competent and develops skills to handle future problems. However, counseling services can be made more effective and acceptable to children and their parents if teacher and school health nurses work in coordination and collaboration with counselors.

Role of Counselors in School

1. Vocational guidance
2. Counseling Children
3. Home school liaison
4. Coordination in school
5. Developmental group work
6. Organizing inclusive education
7. Psychological Testing
8. Diagnoses & assessment work

Role of the Teacher

- Early detection of student having problem.
- Liaison between parent and counselor
- Observation of student and feedback to the counselor.
- Maintaining therapy plan in school set up.
- Acting as a support person.

Role of a School Health Nurse

- Promoting the development and maintenance of a safe and healthful environment.
- Exploring community resources for children's health care.
- Assisting in securing physical, emotional and other examinations of children.
- Explaining to parents and teachers the findings of the medical examinations.
- Assisting parents to secure correction of defect.
- Follow all children in need of correction.
- Guidance and counseling of students.
- Referring students to other health professionals, if required.

Conclusion

Schools and institutions have unprecedented opportunity to improve the lives of young people. As nations have mood towards a commitment to universal education, school are finding it necessary to expand their role by providing health services including mental health services to deal with factors interfering with schooling. The Aim of these school – based interventions is to provide an experience that would strengthen the children's coping abilities to counter environmental stress and disadvantages with which they sometimes have to cope while growing.

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Effectiveness of Self- Instructional Module on Oppositional Defiant Disorder among the School Teachers in a selected School at Bengaluru: A Quasi Experimental Study

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Bengaluru

Abstract

Background

Literature reveals that imparting the knowledge on ODD among parents and teachers will prevent the evolving conduct disorders.

Objective

A study was conducted to find out the effectiveness of Self Instructional Module (SIM) to impart the knowledge on ODD among the school teachers and to find out the association between the selected socio- demographic variables with the knowledge level on ODD among school teachers.

Methodology

Thirty Primary and high school teachers were selected randomly. A pre-test to assess the knowledge of school teachers on ODD was administered, a self instructional module on ODD was given, followed by administration of post-test by structured interview schedule.

Results

The mean, SD and the frequency and percentage distribution of teachers by their pre and post- test knowledge scores revealed that the Self-Instructional Module which was administered to the school teachers was effective in improving their knowledge on ODD. This was proved by paired't' test at 5% level of significance. As regards the association between the selected socio- demographic variables and pre-test knowlegde scores, it was found that only marital status had a significant relationship with knowledge scores at 5% level of significance.

Keywords: Oppositional defiant disorder; Self instructional module; School teacher.

Introduction

Children are beautiful and they create their world very special. All children are oppositional from time to time, particularly when they are tired, hungry, stressed or upset. Children don't know how to express the deviant behavior but the conflict, anxiety; separation leads the children to behave abnormally. They may argue, talkback, and disobey, defy parents, teachers and other adults. Oppositional defiant disorder, also called ODD, is a common behavior problem seen in children and teenagers.

Oppositional behavior is often normal part of development for 2 to 3 years old and early adolescents.[1]

Oppositional defiant disorder [ODD] is a recurrent pattern of negativistic, defiant disobedient and hostile behavior toward authority figures that persists for at least 6 months- according to DSM IV. [2]Behaviors

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shown by children having ODD include the following: losing one 's temper, arguing with adults, actively defying requests, refusing to follow rules, deliberately annoying other people, blaming others for one's own mistakes or mis-behaviour, and being touchy, easily annoyed or angered ,resentful ,or vindictive[3].

ODD is thought to occur in about 6% of all children. It is more common in families of lower economic status. The disorder is often apparent by the time a child is about six years old. Opposition is natural and beneficial process for children to shape their personality. It can lead to pathological symptoms also. Oppositional disorders should be managed rapidly to prevent them from becoming chronic or evolving towards oppositional defiant or conduct disorders [4].The exact cause of ODD is not known, but it is believed that a combination of biological, genetic and environmental factors may contribute to the condition.

Since child spends considerable amount of his time in school therefore, if the school teachers have adequate knowledge regarding deviant behavior they can identify the children's with ODD early and correction or appropriate management can be done at initial stage. Early intervention will prevent the oppositional disorders from becoming

Chronic or conduct disorders. Keeping this information in the background, a quasi – experimental study was conducted to assess the effectiveness of self instructional module on Oppositional Defiant Disorders among the school teachers in selected schools at Bengaluru and to find out the association between the knowledge scores and the selected variables, such as age ,gender, marital status, qualification, and work experience..

Materialas and methods

An Evaluative research approach and Quasi experimental one group pre test and post test design was used in this study. This study was approved by the ethical committee of Dhanwantari Nursing College Bengaluru. It was carried out in a selected school at Chikkabanawar; Bengaluru.Simple random sampling technique was used to select the sample. Data was obtained from 30 primary and high schoolteachers working in the selected school. A Structured interview schedule was used to collect the data. The instrument consisted of two parts .Part I consisted of socio demographic proforma, Part II, consisted of 30 questions devided into areas such as definition, etiology, signs and symptoms, diagnosis, early identification, management and prevention of ODD. Knowledge scores were classified in to 3 categories for interpretation. If the score was less than 39%, the knowledge level was considered to be inadequate, if the score was 40% to 75%, the knowledge level was average and if the score was76% and above the knowledge level was adequate. Content validity of the tool was established by expert professionals in Psychiatric Nursing, and Psychiatrist, Psychologist and Biostatistician. The reliability of the tool was calculated by using an alpha–coefficient method. The tool was found to be reliable. [r=0.82]. A self instructional material on ODD was prepared. After obtaining the permission from the school authority for conducting the study, informed consent was taken from each teacher for their willingness to participate in the study. On day one pretest was done by administering structured interview schedule to each sample. Self instructional module was given to teachers. After 7 days the post test was conducted by using the same tool

Results

Data were analyzed by descriptive and inferential statistics which included mean, mean score percentage, standard deviation, paired't' test, and Chi Square analysis.

Table 1 shows the distribution of demographic variables. In this study majority of the school teachers were in an age group between 20-49. 44 % of them were male and 56% of them were female. Seventy three percent of the subjects had 4 to 6 years of

Table 1 : Percentage distribution of sample subjects according to their socio demo graphic chracteristics

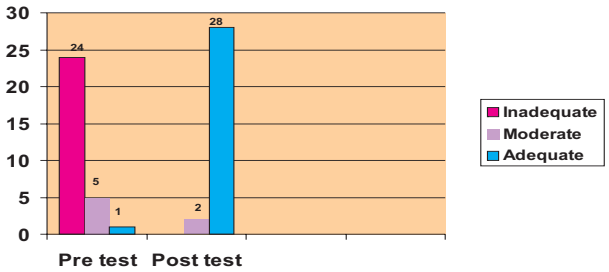
n=30

Subject	Frequency	Percentage %
AGE		
20-29 Years	12	40
30-39 Years	11	36
40-49 years	5	17
50 years and above	2	07
GENDER		
Male	13	44
Female	17	56
RELEGION		
Hindu	20	67
Muslim	3	10
Christian	7	23
Others	Nil	-
MARITAL STATUS		
Married	25	83
Bachelor	5	17
Widow/separated	Nil	-
QUALIFICATION		
Diploma	6	20
UG	20	67
PG	4	13
EXPERIENCE		
1-3 years	nil	-
4-6 years	22	73
7-9 years	3	10
10 and above	5	17

working experience and 67% of them were UG qualified.

The findings of the study (Figure 1) revealed that in the pre-test, out of 30 subjects, 24 had inadequate knowledge, 5 had moderate knowledge and only1 school teacher had adequate knowledge on ODD. However, after the administration of the SIM on ODD, when the post-test was conducted, the knowledge of the school teachers regarding ODD improved a great deal. In the post-test, 28 teachers were found to have adequate knowledge, while 2 had average knowledge and none of the subjects were found to have

Figure 1 : Frequency distribution of the school teachers according to their pre and post - test knowledge scores on ODD



inadequate knowledge on ODD. Hence, when comparing the post- test scores with pre- test scores, majority of the teachers' [93%] knowledge level on ODD was found to be adequate. This indicated that there was a

Table 2 : Comparison of mean, sd of pre and post test knowledge scores of the school teachers on odd and't' value

n=30

Knowledge level	Max Score	Mean	SD	't' Value	'P' Value
Group					
Pre test	30	15	3.0	32.6	2.042
Post test	30	25	2.3		
				*Significant	

* Significant at 5 % level, i.e.-p<calculated' value

knowledge gain among the school teachers after the administration of SIM.

The study findings (Table-2) showed that the mean pre-test score of the subjects was 15 with a SD of 3.0. However, in post-test the mean score was 25 with a SD of 2.3.The improvement was statistically tested by paired't' test and the result were found to be significant at 5 % level. As regards the association between the level of knowledge on ODD and selected socio-demographic variables, it was seen that there was a significant relationship between pre-test knolegde scores of teachers on ODD and the marital status at 5 % level However, no signigicant association was found between pre-test knowledge and other variables like age, gender, qualification, and work experience.

Discussion

The mean and SD of pre and post- test knowledge scores of the school teachers revealed that the Self Instructional Module on ODD which was administered on the school teachers was effective, which was proved by paired't' test. As far as the association between the pre-test knowledge and the socio demographic variables is concerned, it was seen that only marital status was associated with knowledge score at 5% level of significance. SIM on ODD was found to be helpful for the teachers to identify the ODD and teach the parents about its timely management to prevent evolving into conduct disorders. The findings of this study were supported by a study done by Victoria Trix,'Strategies for Teaching Children with ODD'. The study revealed that counseling the teachers to work on identifying the type of activities that are likely to cause frustration in the child can help him or her develop appropriate coping mechanisms to deal with those frustrations[7]. In the present study, it was seen that the SIM on ODD was an effective strategy to improve the knowledge of school teachers on ODD. ODD is widely prevalent among adolescents, especially male children. Imparting the knowledge to the school teachers on ODD will be helpful in their timely and effective management.

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Culture-Bound Syndrome or Folk Illness

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Introduction

There are some diseases that have very limited distributions around the world due to the fact that they are caused by unique combinations of environmental circumstances and cultural practices. These are generally referred to as culture-bound syndrome, culture-specific syndrome or folk illness. These 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.

Meaning of Culture

Patterns of behavior (values, perceptions, meaning, beliefs and practices) shared by a group of people performing essential tasks of daily living.

Meaning of Culture bound

Whenever people live as part of a culture, they are to some extent imprisoned by it – with limited exposure to other cultures or ways of thought. They think that their culture is superior to all others.

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Definitions of culture-bound syndrome

a. Culture-bound syndromes are a combination of psychiatric and somatic symptoms that are considered to be a recognizable disease only within a specific society or culture. There is no objective biochemical or structural alterations of body organs or functions, and the disease is not recognized in other cultures.

b. Culture-bound syndromes are defined as'episodic and dramatic reactions specific to a particular community - locally defined as discrete patterns of behavior'.

Prevalence and etiology

Culture-bound syndrome or folk illness is very familiar in the culture. This syndrome is more common in teenagers and adults, it affects both sexes equally. This syndrome's exact cause is idiopathic, but may be due to certain ego defence mechanisms. Projection, depression and shame or guilt arealso reasons for culture-bound syndrome.

Some common features

Culture-bound syndrome patients usually have some kind of acting out that attracts cultural attention, amnesia is common. The triggers of their behavior may be difficult to isolate as they are not being perceived in Western culture as stressors. Culture-bound syndromes are often seen in people having histrionic personalities, and somatic symptoms

are often predominant. The patient's laboratory investigations reveal no biochemical or tissue abnormalities. These syndromes improve spontaneously or need sedation or antipsychotic medications. Treatment requires collaboration with traditional healers.

Cultural influences on psychiatric syndromes

- Cultural influence on the formation of a disorder (Pathogenic effect).
- Culture selecting certain coping patterns to deal with stress, like family suicide (Psychoselective effect).
- Culture promoting the frequency of occurrence (Psychofacilitating effect).
- Culture shaping folk responses to the clinical condition (Psychoreactive effect).

Management

Psycho-Pharmacological management for reducing the symptoms, psychological management like culture bound psychotherapy and collaboration with folk / traditional healer are some of the measures included under management.

Conclusion

Culture bound syndrome is a cluster of symptoms and behaviors that can be probably related to cultural emphases and to specific stress situations which are typical of particular populations and complete lack of familiarity of the condition to people in other cultures. Therefore awareness of culture bound syndromes is very important for all the levels of health care professionals in order to make culturally appropriate diagnoses, timely management and appropriate treatment.

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Types of culture-bound syndromes seen in Asian countries are,

Name of the disease	Geographical localization	Symptoms
Running amok	Malaysia, Indonesia, Philippines, Brunei, Singapore	Suddenly withdraws from family and friends, then bursts into a murderous rage, attacking the people around him often followed by a claim of amnesia.
Dhat syndrome	India and Bangladesh	Comprises vague somatic symptoms of fatigue, weakness, anxiety, loss of appetite, guilt and sexual dysfunction, attributed by the patient to loss of semen in nocturnal emissions, through urine.
Koro	Chinese and Malaysian Populations In Southeast Asia; Assam	An episode of sudden and intense fear or delusion that the penis (or in the rare female cases, the vulva and nipples) will recede into the body and possibly cause death.
Latah	Malaysia and Indonesia	Hypersensitivity to sudden fright, often with echopraxia, echolalia, command obedience, and dissociative or trance like behavior. The Malaysian syndrome is more frequent in young girls.
Shenjing shuairuo	Chinese	Similar to neurasthenia, symptoms include physical and mental fatigue, dizziness, headaches and other pains, difficulty concentrating, sleep disturbance, and memory loss.
Shenkui	Chinese	Marked anxiety or panic symptoms including dizziness, backache, fatigability, general weakness, complaints of sexual dysfunction, insomnia.
Taijin kyofusho	Japanese	Fear and guilt about embarrassing others with one's appearance or behavior prominent in younger people.

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A Study to Assess the Effectiveness of Structured Teaching Programme on Knowledge Regarding the Prevention of Suicidal Behavior among Adolescents of Selected Pre-University College Students at Tumkur, Karnataka

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Abstract

Adolescent age group is a very susceptible age group. These children are in phase of transition and undergo a lot of physical, social, hormonal, psychological and behavioral changes. Suicide is third leading cause of death among teenagers and young adults in their early twenties. The present study aimed to assess the knowledge of adolescents regarding prevention of suicidal behavior by evaluating the effectiveness of Structured Teaching Programme (STP) and to find out the association between the existing knowledge scores of adolescents and selected socio demographical variables i.e. age, gender, religion, type of family, educational status of parents, family income, and source of knowledge.

The research approach used for this study was evaluative approach with pre-experimental one group pre-test post-test design. Non probability convenient sampling technique was adopted for the study. The sample consisted of 60 adolescent students studying at Shri Devi pre-university college of Tumkur, Karnataka. The structured knowledge questionnaire was used to assess the knowledge which consisted of 8 items on baseline information and 40 structured knowledge questionnaire on suicide. The data were analyzed by descriptive and inferential statistics. The results showed that the overall mean pre-test knowledge score was 19.3 and standard deviation 2.43, whereas mean post-test knowledge score was 30.1 and standard deviation 3.79 with difference of mean and standard deviation 10.9 and 1.36 respectively. Calculated paired't' value (tŠ§ 25.91) was greater than tabulated value (tŠ§ 1.960). This indicated that the gain in knowledge score was statistically significant at $P < 0.05$ levels. The investigator concluded that the structured teaching programme in the present study was effective in providing the knowledge regarding prevention of suicidal behavior among adolescents. Suicide prevention programmes should be applied to the 'at risk' population prior to a suicide attempt.

Keywords: Effectiveness, Suicidal Behavior, Adolescents, Structured Teaching Programme, Pre-university Colleges.

Introduction

Adolescents suffer with a feeling of loss, for the childhood they leave behind and undergo a period of adjustment to their new adult identity. Faced with these feelings and lacking effective coping mechanisms, adolescents can become over whelmed and turn to escapist measures such as drugs, withdrawal and ultimately suicide[1]. According to the World Health Organization annual estimates, approximately one million people die from suicide and every 10 to 20 minutes more people attempt to suicide worldwide. This

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represents one death for every 40 seconds and one attempt for every 3 seconds on average [2].

Asetiline, James and Schilling (2007) studied that suicide is a leading cause of death in children and youth in the United States. This study examined the effectiveness of the Signs of the Suicide (SOS) prevention program in reducing suicidal behavior. 4133 students in high schools in Columbus, Georgia, western Massachusetts, and Hartford, Connecticut were randomly assigned to intervention and control groups during the 2001-02 and 2002-03 school years. Self-administered questionnaires were completed by students in both groups approximately 3 months after program implementation. Significantly lower rates of suicide attempts and great knowledge and more adaptive attitudes about depression and suicide were observed among students in the intervention group. Student's race/ ethnicity, grade, and gender did not alter the impact of the intervention on any of the outcomes assessed in this analysis. SOS continues to be the only universal school-based suicide prevention program to demonstrate significant effect of self-reported suicide attempts in a study utilizing a randomized experimental design. Moreover, the beneficial effects of the SOS were observed among high school aged youth from diverse racial/ethnic backgrounds, highlighting the programs utility as a universal prevention program [3].

Suicide is only preventable, once committed it is no longer treatable. College students are vulnerable group attempting suicide. Adolescents should be educated in the Pre-University College regarding suicide prevention. Teachers have a very important role to help the students in their emotional problems and suicide prevention.

Many preventive measures can be taken for prevention of suicidal behavior among adolescents. Amongst them, educational programs are more effective. In the present study the investigator used the structured teaching programme to improve the adolescents' knowledge regarding preventions of suicide.

There are very few studies done on fatal suicidal behaviors in adolescents in India, and there is a great need to conduct such research in this important area. So the researcher selected this particular topic for the study. The present study aimed to assess the knowledge of adolescents regarding prevention of suicidal behavior by evaluating the effectiveness of structured teaching programme (STP) and to find out the association between the existing knowledge scores of adolescents and selected socio-demographical variables i.e. age, gender, religion, type of family, educational status of mother, educational status of father, family income, source of knowledge.

Methodology

The research approach used for this study was evaluative approach with pre experimental one group pre-test post-test design. The independent variable was structured teaching program and the dependent variable was knowledge of adolescents regarding prevention of suicidal behavior. Non probability convenient sampling technique was adopted for the study. The sample consisted of 60 adolescent students studying in selected pre-university college of Tumkur. The setting of the study was Shri Devi Pre-University College, Tumkur.

To assess the knowledge on prevention of suicidal behavior, a structured knowledge questionnaire was used. The first part of the questionnaire consisted of 8 items on baseline information of the subjects i.e. age, gender, religion, educational status of mother, educational status of father, type of family, family income, source of knowledge and the second part consisted of 40 items divided in 5 areas such as definition and terminologies , incidence and prevalence , etiology and risk factors , plans and methods and prevention and management of suicide .

The 40 questions were multiple choice questions and for each correct answer score given was 1 and 0 score was given for wrong answer. The score ranged from minimum of 0

to a maximum of 40. The level of knowledge scores were interpreted as per the following:

Good Knowledge: Score from 31-40 (75- 100%)

Average Knowledge: Score from 21-30 (50-75%)

Poor Knowledge: Score from 0-20 (0-50%)

Experts in the field ofMental Health Nursing gave the content validity of tool and tool was tested for reliability on 10 PUC students during pilot study by using split half method and by applying Karl Pearson's correlation coefficient formula. Correlation coefficient (r) was found to be 0.79. On the first day pre- test was conducted, on the third day structured teaching program was administered to the PUC students and on the seventh day post- test was administered.

The investigator took the formal permission from the principal of Shri Devi Pre- University College Tumkur to collect the data. The investigator introduced himself, explained the purpose of the study and the verbal consent was obtained from the subjects. The pre-test included assessment of subject's knowledge through structured knowledge questionnaire., The time given to answer the question was 40 minutes. The structured teaching programme was administered on the third day after the pre-test. The post-test was carried out on the 7th day by using the same tool.

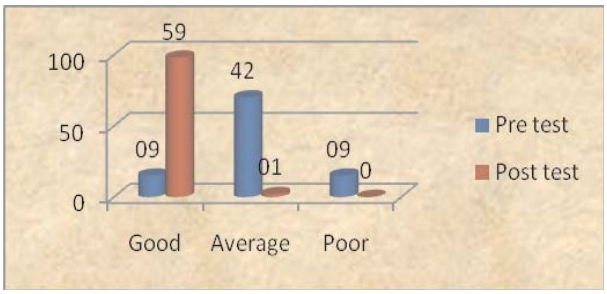
The data obtained were analyzed in the terms of the objectives of the study using descriptive and inferential statistics. The data analysis was done by organizing data on master data sheet and using descriptive and inferential statistics.

Results

Findings related to socio-demographic variables

- Majority of the subjects, that is, 27 (45%) belonged to age group 18-19 years and 17-18 years.
- In terms of gender, 35(58%) subjects were males where as 25 (42%) were the females.
- Majority of the subjects, that is,45 (75%) belonged to Hindu religion and 3 (5%) belonged to Christian religion.
- 40(67%) subjects belonged to nuclear family.
- 28 (47%) subjects had their family income between Rs. 5000 to 10000 per year, where as 15 (25%) had below Rs. 50000.
- In 35 (58%) subjects, news papers, journals, magazines were the source of knowledge related to suicide prevention and the health personnel were the sources of knowledge for 3(5%) subjects only.

Figure 1 : Distribution of knowledge of PUC students during pre-test and post-test



Findings on knowledge of adolescents on prevention of suicidal behaviour

The major findings of the study showed that during the pre test 09 (15%) of the subjects had good knowledge regarding prevention of suicidal behavior, 42(70%) of the subjects had average knowledge and 09 (15%) of the subjects had poor knowledge regarding prevention of suicidal behavior. After the introduction of the STP, in the post test there was significant increase in the knowledge scores. Out of 60adolescents, 59 (98%) were found to have good knowledge and 01 (02%) had average knowledge related to prevention of suicidal behavior. This showed that the STP was an effective method to improve the knowledge of adolescents regarding prevention of suicidal behavior.

Findings related to evaluation of effectiveness of STP

Overall mean pre-test knowledge score was 19.3 with standard deviation of 2.43, whereas mean post-test knowledge score was 30.1 with standard deviation 3.79. The difference of mean and standard deviation was10.9 and 1.36 respectively.

Calculated paired't' value (t□25.91)was greater than tabulated value (t□1.960). This indicated that the gain in knowledge scorewas statistically significant at P<0.05 levels. Therefore, the structured teaching programme on prevention of suicidal behavior was found to be effective in improving in the knowledge of adolescents regarding suicide prevention.

Findings related to the association between pre-test knowlede scores and selected socio-demographic variables

In the present study it was found that there was no association between the socio-demographic variables(age, gender, religion, educational status of parents, type of family, family income, source of knowledge) and pre-test knowledge scores of adolescents as the chi-square calculated valuewas found to be less than the tabulated value in all cases.

Discussion

The study was experimental in nature which was carried out in Shri Devi Pre-University College. The data was analyzed by descriptive and inferential statistics. The mean post test scores of knowledge were more than pretest scores. Hence the study proved that the structured teaching program was effective in providing the knowledge regarding prevention of suicidal behavior among adolescents.

The findings of the study were supported by the some of the similar studies conducted by Jena and Siddhartha (2004) who investigated the suicidal behavior among adolescents. Suicidal behaviors were thought to be specific suicidal plan and suicide attempt. In this study, the researchers felt the need that professionals like general practitioners, school and college teachers should be trained in identifying and preventing suicidal behaviors in adolescents [4].

In another study the efficacy of a school based prevention programme for reducing suicide potential among high risk youth was tested. A sample of 105 youth at suicide risk participated in a three group, repeated measures and intervention study. All groups showed decreased suicidal risk behaviors, depression, hopelessness, stress and anger; all groups also reported increased self-esteem and network social support. Increased personal control was observed only in the experimental groups and not in the assessment only control group. The potential efficacy of the experimental school based prevention programme was demonstrated [5]. The present study also points towards the effectiveness of teaching programmes in enhancing the knowledge of adolescents regarding suicide prevention.

Psycho-educational programs are among the most commonly applied suicide prevention approaches for young people, a fact substantiated by the present study, as well as another study which examined the effectiveness of these programs in a controlled study by assessing the effect on knowledge, attitudes, coping and hopelessness. 14 to 18-year-old students were administered structured questionnaires before and after the program to assess the effect on knowledge, attitudes, coping and hopelessness. The program had no effect on coping styles and levels of hopelessness. However, a positive effect on knowledge could be identified and an interaction effect of the program with gender on attitudes was also found. A negative impact of the program could not be found. The findings from this study suggested that the psycho-educational programs in schools may influence knowledge about suicide and attitudes towards suicidal persons but may not affect the use of coping styles or levels of hopelessness [6].

Interpretation and conclusion

The study showed that the most of the adolescents had average knowledge on prevention of suicidal behavior before the administration of STP. However, the knowledge improved a great deal after the administration of the STP. The present study enabled the students to become aware about preventive measures for suicidal behavior and motivated them to take care of them and prevent incidence of suicides in society by educating their friends and their neighbors as well.

Nurse educators have an ample opportunity to educate adolescents and youth regarding prevention of suicides. The community psychiatric nurse needs to enhance their knowledge on identification and avoidance of risk factors among the adolescents. Considering that suicide is leading causes of death among adolescents in India, further education related to prevention of suicidal behavior, coping mechanisms to overcome the stressful events for nursing students is required at Diploma, Graduate and Post-graduate level. The findings of the study and the STP can be used as reference materials for student nurses.

The nursing administrator should take an initiative in making health policy and developing protocols in providing education to the patients during hospital visits and involve patients in the promotion of their healthy habits and improvement of coping skills during stressful events. Thus, the findings of the study have implications for nursing education, practice and research.

The study proved that the structured teaching program was effective in providing the knowledge regarding prevention of suicidal behavior among adolescents and hence this tool can be used very often as an effective teaching and educational method.

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Anorexia Nervosa: A Case Study

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Introduction

Ritu is a 20 years old woman who is brought to the hospital by her two elder brothers, who support her on either side. She is very weak and on admission to the unit, her height is recorded at 5'2" and weight as 25 Kg. Her B.P. was recorded as 78/50 mm Hg. and pulse 58/ min. She was found to be anemic, malnourished and complained of being very tired. Her history revealed that she was the youngest of 5 siblings who were all married and her father died 2 years ago. She worked and lived alone in another city away from her mother and siblings. She was an aspiring actress, who temporarily worked in an Ad-Agency. She developed a pattern of eating less when her colleague commented that she should diet as she regarded her slim figure as crucial to her success in the showbiz. She maintained her low weight both by exercising and restricting food intake. She worked odd hours and ate a sandwich or a fruit during the daytime and avoided mealtime and eating with others. Her dinner used to be of some vegetables. She did not acknowledge that she was too thin and her extreme fasting had created the illness. She was diagnosed as having Anorexia Nervosa.

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What is Anorexia Nervosa?

- Anorexia Nervosa is intense fear of gaining weight or becoming fat, even though underweight.
- It is a psychological disorder characterized by self-starvation and weight loss.

Anorexia Nervosa begins with a desire to diet and lose weight. Anorexic people are terrified by the thought of gaining weight. They eventually do not eat enough to sustain a healthy body weight. They suffer from a distorted body image; perceive themselves as overweight when actually they are thin. The disorder may lead to various medical complications and if not treated appropriately, may result in death.

What are the causes

- Psychological, social, biological, cultural and familial factors[1] play a role in the development of the disorder.
- There have recently been some arguments that it has a genetic or organic basis, but it has not yet been proved.
- Media promotes anorexia nervosa as it propagates that slim is 'in'.
- It may be triggered by an event such as the end of a relationship or death of someone significant.
- It may start when a person is going through a difficult life stage.
- Anorexic people often come from families that overvalue high achievement.

- In families where members are too dependent on each other, child may fear growing up and by starving the body, they can prevent their emerging sexuality and thus remain child.

Symptoms

The following symptoms[2,3,4] are present in confirmed cases of anorexia.

- Refusal to maintain body weight at or above 85% of normal for a person of that age and height.
- An intense fear of gaining weight or becoming fat even though underweight.
- A distorted body image, with a perception of being overweight even when thin.
- Absence of at least 3 consecutive menstrual cycles.

Other features may include

- Strict rules about eating and an abnormal occupation with food.
- Excessive exercise and denial of the problem.
- Efforts to hide their condition such as by wearing bulky concealing clothing, hiding off.
- Tiredness, depression, decreased concentration.
- Social withdrawal.

Associated medical complications[2,3,4] related to starvation include

- Very low heart rate.
- Dry sallow skin, brittleness of hair and nails.
- Fine hair on face and arms.
- Impaired kidney function
- Low B.P., electrolyte imbalances.
- Constipation and abdominal pain.
- Hormonal disturbances.
- Anemia
- Osteoporosis

Prevalence

The age of onset of anorexia nervosa usually is 13 to 17 years. It is more commonly seen among females, with male-female ratio ranging from 1:6 to 1:10[1]. Only 5% to 10% of all cases have been men.

Treatment

The primary aim of the treatment of anorexia nervosa is to address the underlying psychological and interpersonal factors and to restrict weight loss in a caring, humane manner. Treatment is most effective when it consists of a multidisciplinary approach including psychotherapy, nutritional advice and medical monitoring.

Treatment modalities planned and implemented for Ms.Ritu were

- Ms. Ritu was immediately placed on therapeutic bed rest to conserve energy and calories.
- An intravenous line was started to restore fluid and electrolytes.
- Nutritional restoration and medical monitoring was provided. A target diet was established in conjunction with Ms.Ritu, who was slowly coached to eat the required amount of calories for a healthy diet.
- Individual psychotherapy was started to alter her dysfunctional thoughts and values about eating, weight and body shape.
- Family members of Ms. Ritu were counseled about developing strategies for communication and provision of contact and support to Ms.Ritu.

Nursing Management

Nursing interventions planned and taken for Ms.Ritu were

1. Consult with dietician to provide nutritious foods and fluids with regard to her preferences.

2. Monitor vital signs, food and fluid intake, output & weight daily at same time and under same conditions. A weight gain of 3 to 5 lb/week is medically acceptable. Weight gain of over 5 lb in a week may result in pulmonary edema.
3. Supervise meals, remain with patient up to 1 hour after eating.
4. Monitor activity level to prevent excessive exercise.
5. Use support, firm matter of fact approach in regulating Ms.Ritu's eating behavior.
6. Help her to review her own and others' bodies realistically. Low self esteem in-patient is associated with overly high expectations, need for approval & acceptance from others. Help her to see her positive attributes.
7. Encourage social nature of eating. Address patients' expressed fears regarding weight gain.
8. Provide health teaching regarding healthy eating and impairment of health due to low weight.
9. Enhance her communication and socialization skills through participation in-group activities with peers and family members.
10. Encourage and educate family members of Ms. Ritu about open communication and expression and family meal therapy to change eating behaviors. Because families may feel guilty, helpless and frightened, the nurse should convey a supportive and non-blaming attitude.

With several weeks of treatment Ms. Ritu started to increase her fluid and food intake and gaining weight gradually. Her Hb level showed slow and steady increase. She started feeling energetic and socialized more with her family members and peers.

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