IJSN

Indian Journal of Surgical Nursing

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Assessment of Illness Perception among Post Myocardial Infarction Patients

Pramilaa R.

Abstract

A descriptive study was undertaken to assess the illness perception among post Myocardial Infarction patients at Jayadeva Institute of cardiovascular sciences and research. All patients admitted with Myocardial Infarction were selected using convenience sampling technique and sample size comprised of 50 patients. A standardized tool, Illness Perception Questionnaire- Revised was used to collect self reports. The findings revealed that mean score was 166.28, standard deviation was 1.617 and mean percentage was 87.5. The results were further analyzed by correlation analysis within the categories of illness perception. Although all the categories were not correlated, there was a positive correlation with over all score of illness perception and all categories. Pertaining to association with the illness perception score and demographic variables, no association was found.

Keywords: Illness perception; Illness perception Questionnaire-Revised; Myocardial Infarction.

Assessing illness perception is important in patients with negative cardiac tests for understanding and predicting outcomes.[1] Myocardial Infarction (MI) is a major and usually sudden illness that can have serious psychological and functional impact on patients.[2] There is growing evidence corroborating that the perception of the disease plays an important role in the degree of compliance.[3] Research investigating the role of illness perceptions in medical conditions has grown rapidly in recent years. This has been spurred initially by the development of scales to reliably measure illness beliefs, such as the Illness Perception Questionnaire (IPQ), and subsequently by the strong associations found between patients' perceptions of their illness and behavioral outcomes. Research on illness perceptions has confirmed that patients' beliefs are associated with important outcomes in a broadening range of illnesses and risk factor testing.

Illness perceptions are the organized cognitive representations or beliefs that patients have about their illness. These perceptions have been found to be important determinants of behavior and have been associated with a number of important outcomes, such as treatment adherence and functional recovery. A recent study found that illness perceptions, measured in patients prior to undergoing investigations for chest pain, were important determinants of reassurance immediately following the investigation and one month later. Those patients who had already developed ideas that their illness was going to last a long time were the least reassured following exercise stress testing. Another factor that is likely to be important is the delay before the diagnostic test is undertaken. A long delay allows more time for negative illness beliefs to become established. This may include negative or catastrophic ideas about symptoms, as well as a reduction in work hours or leisure activities. All of these factors make subsequent reassurance considerably more difficult.[4]

Recent developments in treatment during the acute stage of MI have resulted in improved survival and fewer complications for patients.[5] However, these gains in the acute phase of the illness contrast with the small progress that has been achieved in understanding and improving the rehabilitation phase of the illness.[6] The assessment of illness perceptions may have a valuable role in identifying which patients are likely to benefit from rehabilitation programs as

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they are currently structured. Patients who perceive that their heart disease has little hope of being controlled may benefit from another intervention before attending a rehabilitation program. This intervention could be specifically targeted at changing this perception. Perhaps more importantly, future research should examine the efficacy of brief psychological interventions designed to elicit and if necessary modify specific illness perceptions in facilitating adaptation.

Statement of the problem

A study to assess illness perception among post myocardial infarction patients at selected cardiac hospital.

Objectives of the study

1. Assess the illness perception score among post myocardial infarction patients.
2. Correlate the scores of each category of illness perception among post myocardial infraction patients.
3. Associate the scores of each category with selected demographic variables.

Materials and Methods

Research methodology: The research design adopted for the study is descriptive explorative design.

Research setting: The setting for the study was cardiac wards at Sri Jayadeva Institute of Cardiovascular sciences and research, Bangalore.

Population

Target population: All patients diagnosed to have Myocardial Infarction.

Accessible population: Patients diagnosed with Myocardial Infarction admitted in cardiac wards of Sri Jayadeva Institute of Cardiovascular sciences and research, Bangalore.

Sampling technique: The sampling technique adopted for this study was convenience sampling of non- probability type.

Sample size: The sample size for the present study was 50.

Sampling criteria

Inclusion criteria

- Patients with the diagnosis of MI.
- Patients who can read English or Kannada .
- Patients who are willing to participate in this study.
- Patients who are available during data collection period.

Exclusion criteria

- Patients who are not oriented.
- Patients who are blind.

Tools for data collection

Section-A: Consists of demographic data

Section-B: Comprises of Illness Perception Questionnaire-Revised to assess the illness perception of post myocardial infarction patients. It is a standardized instrument. It has 38 items on view of patient's illness. Apart from this, it contains 9 items for identity category and 18 items on views of cause of illness.

Method of data collection

Permission was obtained from the authorities of the hospital and the respondents meeting the inclusion criteria were selected using convenience sampling method. The tool was distributed to them and collected after the completion of the self reports. The data was collected in the month of May 2013. The respondents were very cooperative.

Data analysis and interpretation

The demographic characteristics of the respondents are shown in table 1.

Table 1: Percentage distribution of respondents according the demographic variables

N=50

Variable	Frequency	Percent
Age Group		
Below 40 Years	9	18.0%
41 - 50 Years	26	52.0%
Above 50 Years	15	30.0%
Gender		
Male	26	52.0%
Female	24	48.0%
Smoking		
Yes	21	42.0%
No	29	58.0%
Alcohol		
Yes	21	42.0%
No	29	58.0%
Hypertension		
Yes	45	90.0%
No	5	10.0%
DM		
Yes	44	88.0%
No	6	12.0%
Regular Exercise		
Yes	0	0.0%
No	50	100.0%
Diet		
Vegetarian	4	8.0%
Non-vegetarian	46	92.0%
Site of Myocardial infarction		
Anterior	31	62.0%
Posterior	13	26.0%
Inferior	12	24.0%

Table 2: Distribution of levels of Illness Perception Score with respective to their categories

N=50

Categories of IPR-Q	Low	Medium	High
Identity	0 (0.0%)	46 (92.0%)	4 (8.0%)
Timeline - Acute/Chronic	3 (6.0%)	41 (82.0%)	6 (12.0%)
Consequences	3 (6.0%)	40 (80.0%)	7 (14.0%)
Personal Control	4 (8.0%)	42 (84.0%)	4 (8.0%)
Treatment Control	12 (24.0%)	36 (72.0%)	2 (4.0%)
Illness Coherence	7 (14.0%)	37 (74.0%)	6 (12.0%)
Timeline - Cyclical	0 (0.0%)	49 (98.0%)	1 (2.0%)
Emotional Representations	5 (10.0%)	43 (86.0%)	2 (4.0%)
Illness Perception Score	4 (8.0%)	40 (80.0%)	6 (12.0%)

Table 1 shows the percentage distribution of respondents according to their demographic variables. With regarding to the age group 18% belonged to less than 40 years of age, 52% to 41- 50 age group and 30% were above 50 years of age. Related to gender, 52% were males and 48% were females. Pertaining to their habits of smoking and alcohol 42 % were smokers and alcoholics. With regard to risk factors, 90% were hypertensives, 88% were diabetics, none of them performed regular exercise and 92% were non-vegetarians. In relation of site of MI, 62% had anterior wall MI, 26% posterior wall MI and 24% were diagnosed to have inferior wall MI.

Table 3: Mean, Standard deviation and mean% of Illness Perception Score with respective to their categories

N=50

Categories	Mean	SD	Mean %
Timeline - Acute/Chronic	26.54	0.930	88.5 %
Consequences	28.16	0.650	93.9 %
Personal Control	24.82	0.850	82.7 %
Treatment Control	21.76	0.625	87.0 %
Illness Coherence	21.02	0.622	84.1 %
Timeline - Cyclical	19.02	0.141	95.1 %
Emotional Representations	24.96	0.450	83.2 %
Illness Perception Score	166.28	1.617	87.5 %

Fig 1: Bar diagram of mean percentage of illness perception score of respondents

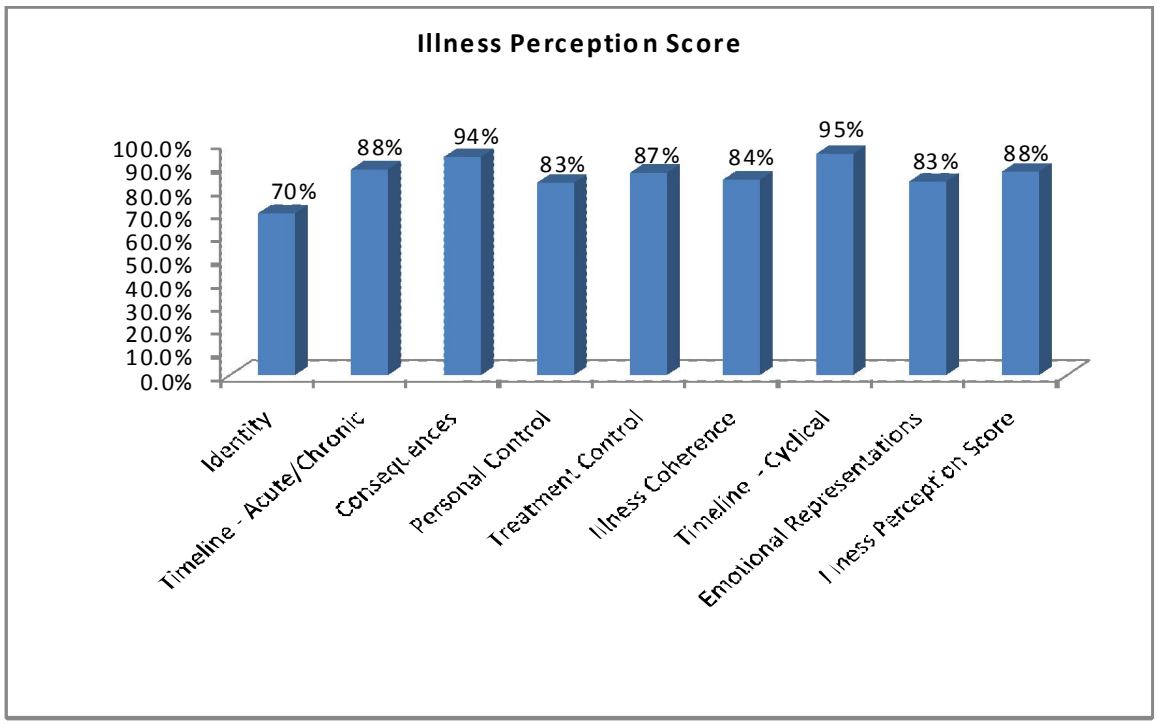

Table 2 reveals the level of illness perception score with respective to their categories. The levels were classified as low, medium and high. The percentage of low, medium and high level of identity was 0%, 92% and 8%; timeline – acute/ chronic was 6%, 82% and 12%; consequences was 6%, 80% and 14%; personal control was 8%, 84% and 8%; treatment control was 24%, 72% and 2%; illness coherence was 14%, 74% and 12%; timeline- cyclical was 0%, 49% and 1%; emotional representations was 5%, 43% and 2% and illness perception score was 8%, 80% and 12% respectively.

Table 3 shows the mean, standard deviation and mean % of illness perception score corresponding to their categories. The scores of mean, standard deviation and mean percentage for timeline- acute/ chronic was 26.54, 0.930 and 88.5%; consequences was 28.16, 0.650 and 93.9%; personal control was 24.82, 0.850 and 82.7%; treatment control was 21.76, 0.625 and 87%; illness coherence was 21.02, 0.622 and 84.1%; timeline- cyclical was 19.02, 0.141 and 95.1%; emotional representations was 24.96. 0.450 and 83.2%; the total illness perception score was 166.28, 1.617 and 87.5% respectively. The mean percentages are represented in the form of graph in Fig 1.

Table 4 displays the correlation analysis within categories of illness perception questionnaire- revised. The category identity has positive correlation with

Table 4: Correlation analysis within categories of illness perception questionnaire- revised

N=50

Categories	1	2	3	4	5	6	7	8	9
1. Identity									
2. Timeline - Acute/Chronic	0.27								
3. Consequences	0.47**	0.23							
4. Personal Control	-0.39**	-0.16	-0.43**						
5. Treatment Control	0.10	-0.33*	0.05	0.42**					
6. Illness Coherence	0.35*	0.02	0.14	-0.19	0.01				
7. Timeline - Cyclical	0.55**	0.07	0.19	-0.14	0.06	0.46**			
8. Emotional Representations	0.03	0.30*	-0.26	-0.07	-0.25	0.00	0.01		
9. Illness Perception Score	0.37**	0.55**	0.33*	0.32*	0.37**	0.40**	0.33*	0.21	

*P< 0.05 level of significance ** P< 0.01 level of significance

Table 5: Association of illness perception score and selected demographic variables

N=50

Demographic variables	Illness Perception Score			Fisher's Exact Value	p - value
	Low	Medium	High		
Age Group					
Below 40 Years	1 (11.1%)	7 (77.8%)	1 (11.1%)	2.112	0.838
41 - 50 Years	1 (3.8%)	22 (84.6%)	3 (11.5%)		
Above 50 Years	2 (13.3%)	11 (73.3%)	2 (13.3%)		
Gender					
Male	2 (7.7%)	20 (76.9%)	4 (15.4%)	0.709	0.870
Female	2 (8.3%)	20 (83.3%)	2 (8.3%)		
Smoking					
Yes	2 (9.5%)	17 (81.0%)	2 (9.5%)	0.458	0.999
No	2 (6.9%)	23 (79.3%)	4 (13.8%)		
Alcohol					
Yes	2 (9.5%)	17 (81.0%)	2 (9.5%)	0.458	0.999
No	2 (6.9%)	23 (79.3%)	4 (13.8%)		
Hypertension					
Yes	4 (8.9%)	35 (77.8%)	6 (13.3%)	0.524	0.999
No	0 (0.0%)	5 (100%)	0 (0.0%)		
DM					
Yes	3 (6.8%)	35 (79.5%)	6 (13.6%)	1.461	0.510
No	1 (16.7%)	5 (83.3%)	0 (0.0%)		
Exercise					
Yes	0 (0.0%)	0 (0.0%)	0 (0.0%)	--	--
No	4 (8.0%)	40 (80.0%)	6 (12.0%)		
Diet					
Vegetarian	0 (0.0%)	4 (100%)	0 (0.0%)	0.436	0.999
Non-vegetarian	4 (8.7%)	36 (78.3%)	6 (13.0%)		

consequences, and timeline- cyclical and has negative correlation with personal control at P<0.01 level of significance. The second category timeline- acute/ chronic has positive correlation with emotional representations and negative correlation with treatment control at P<0.05 level of significance. The third category consequences has negative correlation with personal control at P<0.01 level of significance. The fourth category personal control has positive correlation with treatment control. And the sixth

category illness coherence has positive correlation with timeline- cyclical at P< 0.01 level of significance.

Table 5 shows association between demographic variables and level of illness perception score and it was found that there was no association.

Discussion

Assessment of illness perception score

The total scores of illness perception with regard to mean, standard deviation and mean percentage was 166.28, 1.617 and 87.5% respectively. The mean percentage of illness perception in all categories were more than 80%; of which timeline-cyclical was highest (95.1%) and lowest being personal control (82.7%).

Correlation of illness perception scores

The correlation analysis among the illness perception scores was computed using Karl Pearson's coefficient of correlation. The analysis revealed that the category identity has positive correlation with consequences, and timeline-cyclical and has negative correlation with personal control at P<0.01 level of significance. The category timeline-acute/chronic has positive correlation with emotional representations and negative correlation with treatment control at P<0.05 level of significance. The category consequences has negative correlation with personal control at P<0.01 level of significance. The fourth category personal control has positive correlation with treatment control. And the sixth category illness coherence has positive correlation with timeline - cyclical at P< 0.01 level of significance. The findings of the study are supported by a study that examined illness perception and their correlates in coronary heart disease. Results revealed men attributed their coronary heart disease more often to risk behaviors and internal factors while women perceived stress as the cause of their coronary heart disease more often. Stronger perceived competence was related to weaker illness identity, strong control cure and less severe consequences.[7]

Association of illness perception scores with selected demographic variables

It is quite evident from the findings that there was no significant association between the demographic variable sand scores of illness perception.

Conclusion

Patients' illness perceptions influence health outcomes after MI. Supporting MI patients in increasing their perception of personal control could be a primary nursing strategy in rehabilitation programs aimed at facilitating health behavior, decreasing experiences of fatigue, and increasing health related quality of life.

Negative perceptions about heart disease in the days following admission to hospital with first MI are associated with the development of subsequent new episodes of depression. The need for cardiac rehabilitation program that encompass the understanding of the disease arise. The finding of a study also reveals intervention (cardiac rehabilitation) caused significant positive changes in patients' views of their MI and intervention group has a faster rate (within 3 months after MI) of return to work than control group.[8]

Implications of the study

- An in-hospital intervention designed to change patients' illness perceptions can result in improved functional outcome after MI.
- The early identification of illness perceptions could improve the outcome of cardiac rehabilitation programs.
- The examination of how individuals perceive MI may help health-care professionals individualize secondary preventive strategies, thereby improving adherence to health-care regimens.

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Application of Peplau's Interpersonal Theory in Nursing Practice

Ramesh C.

Abstract

A nursing theory is a set of concepts, definitions, relationships, and assumptions or propositions derived from nursing models or from other disciplines and project a purposive, systematic view of phenomena by designing specific inter-relationships among concepts for the purposes of describing, explaining, predicting, and /or prescribing. A theory is a group of related concepts that propose action that guide practice. Theory refers to "a coherent group of general propositions used as principles of explanation" The importance of nursing theories in education is to reinforce the nursing practices of patient treatment and care. Students who understand why a certain procedure is performed or what to expect from particular patients and situations have a basis for learning the actual practices that make up patient care and treatment. Nursing theory also defines the role of a nurse in the medical field, hospital or medical practice. It creates what is known as a body of knowledge for both the nurse in training and the veteran.[1]

Key Words: Nursing theories; Nursing process; Pneumonia.

Peplau's Interpersonal Theory

Peplau's theory focuses on the interpersonal processes and therapeutic relationship that develops between the nurse and client. The interpersonal focus of Peplau's theory requires that the nurse attend to the interpersonal processes that occur between the nurse and client. Interpersonal process is maturing force for personality. Interpersonal processes include the nurse- client relationship, communication, pattern integration and the roles of the nurse. Psychodynamic nursing is being able to understand one's own behavior to help others identify felt difficulties and to apply principles of human relations to the problems that arise at all levels of experience. This theory stressed the importance of nurses' ability to understand own behavior to help others identify perceived difficulties.[2]

Peplau's theory of interpersonal relations provides a useful framework for investigating clinical phenomena and guiding nurses' actions. Through this interpersonal relationship, nurses assess and assist people to: (a) achieve healthy levels of anxiety interpersonally and (b) facilitate healthy pattern integrations interpersonally, with the overall goal of fostering well-being, health, and development. This relationship also provides the context for the nurse to develop, apply, and evaluate theory-based knowledge for nursing care. Nurse interpersonal competencies, investigative skill, and the theoretical knowledge as well as patient characteristics and needs are well important dimensions in the process and outcomes of the relationship. The structure of the interpersonal relationship was originally described in four phases. Her theory focuses primary on the nurse-client relationship in which problem-solving skills are developed.[2]

The four phases of nurse-patient relationships are:

1. Orientation:
   * During this phase, the individual has a felt need and seeks professional assistance.
   * The nurse helps the individual to recognize and understand his/ her problem and determine the need for help.
2. Identification
   * The patient identifies with those who can

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help him/ her.

* The nurse permits exploration of feelings to aid the patient in undergoing illness as an experience that reorients feelings and strengthens positive forces in the personal ity and provides needed satisfaction.

3. Exploitation
   * During this phase, the patient attempts to derive full value from what he/ she are offered through the relationship.
   * The nurse can project new goals to be achieved through personal effort and power shifts from the nurse to the patient as the patient delays gratification to achieve the newly formed goals.
4. Resolution
   * The patient gradually puts aside old goals and adopts new goals.
   * This is a process in which the patient frees himself from identification with the nurse.

Throughout theses phases the nurse functions cooperatively with the patient in the nursing roles of:

1. Counseling Role - working with the patient on current problems.
2. Leadership Role - working with the patient democratically.
3. Surrogate Role - figuratively standing in for a person in the patient's life.
4. Stranger - accepting the patient objectively.
5. Resource Person - interpreting the medical plan to the patient.
6. Teaching Role - offering information and helping the patient learn.[5]

The orientation phase marks a first step in the personal growth of the patient and is initiated when the patient has felt need and seeks professional assistance. The nurse focuses on knowing the patient as a person and uncovering erroneous preconceptions, as well as gathering information about the patient's mental health problem. The nurse and patient collaborate on a plan, with consideration of the patient's educative needs. Throughout the process, the nurse recognizes that the power to accomplish the tasks at hand resides within the patient and is facilitated through the workings of the therapeutic relationship.[3]

The focus of the working phase is on: (a) the patient's efforts to acquire and employ knowledge about the illness, available resources, and personal strengths, and (b) the nurse's enactment of the roles of resource person, counselor, surrogate and teacher in facilitating the patient's development toward well-being. The relationship is flexible enough for the patient to function dependently, independently, or interdependently with the nurse, based on the patient's developmental capacity, level of anxiety, self-awareness, and needs.[3]

Termination is the final phase in the process of the therapeutic interpersonal relationship. Patients move beyond the initial identification with the nurse and engage their own strengths to foster health outside the therapeutic relationship. In addition to addressing closure issues, the nurse and patient engage in planning for discharge and potential needs for transitional care.[3]

Peplau's Theory and Nursing process

Peplau defines Nursing Process as a deliberate intellectual activity that guides the professional practice of nursing in providing care in an orderly, systematic manner.

Peplau explains 4 phases such as:

* Orientation: Nurse and patient come together as strangers; meeting initiated by patient who expresses a "felt need"; work together to recognize, clarify and define facts related to need.
* Identification: Patient participates in goal setting; has feeling of belonging and selectively responds to those who can meet his or her needs.
* Exploitation: Patient actively seeks and draws knowledge and expertise of those who can help.
* Resolution: Occurs after other phases are completed successfully. This leads to termination of the relationship.[4]

In Nursing Process, the orientation phase parallels with assessment phase where both the patient and nurse are strangers; meeting initiated by patient who

expresses a felt need. Conjointly, the nurse and patient work together, clarifies and gathers important information. Based on this assessment the nursing diagnoses are formulated, outcome and goal set. The interventions are planned, carried out and evaluation done based on mutually established expected behaviours.[4]

Peplau's Theory Application in Nursing Process

The nursing process for Mr. X based on Peplau's theory is as follows:

Patient Profile

Name	:	Mr. X
Age	:	36 years
Gender	:	Male
Religion	:	Hindu
Education	:	Graduate
Occupation	:	Business
Marital Status	:	Married
Diagnosis	:	Pneumonia
Theory Applied	:	Peplau's Inter Personal Relationship Theory

Nursing Process for Patient with Pneumonia[6&7]

1. Ineffective airway clearance related to presence of secretions, inflammatory process secondary to pneumonia.

Goal: To minimize the secretions, clear the airway & maintain normal airway.

Nursing Implementations

- Established rapport to patient to gain the trust and cooperation.
- Assessed patient's condition to know and determine patient's needs.
- Monitored and recorded V/S to establish base line data.
- Auscultated lung fields, noting areas of decreased/absent airflow and adventitious breath sounds to identify areas of consolidation and determine possible bronchospasm or obstruction.
- Assisted patient to change position every 30 minutes to mobilize secretions.
- Elevated head of bed and align head in the middle to facilitate breathing.
- Provided health teachings regarding effective coughing and deep breathing exercise to expel the mucous.
- Encouraged to increase fluid intake to liquefy secretions.
- Encouraged steam inhalation to moisten secretions and alleviate congestion.
- Administered meds as ordered to reduce bronchospasm and mobilize secretion.

Evaluation

- After 3-4 hours of nursing interventions, the patient's respiration was improved and difficulty of breathing have been relieved.
- The patient was able to maintain a patent airway.

2. Ineffective breathing pattern related to presence of tracheo-bronchial secretions and nasal secretions secondary to pneumonia.

Goal: To remove the secretions, to improve the breathing pattern, to relieve dyspnea.

Nursing Implementations

- Instructed patient to increase oral fluid intake to 8-10 glasses increased mucus and sputum secretions can lead to dehydration; increased water intake can help dissolve secretions.
- Instructed patient to do deep breathing exercise after demonstrating proper technique Deep breathing exercise increases oxygen intake and can help alleviate dyspnea.
- Kept environment allergen free (dust, feather pillows, smoke, pollen) Presence may trigger allergic response that may cause *further increase in mucus secretion.*

- Suctioned the airway naso, tracheal/oral to remove the secretions and to promote ventilation.
- Educated proper hand washing to prevent infections such as nosocomial infections.
- Positioned the patient in semi fowler's position a distended abdomen can interfere with normal diaphragm expansion.
- Encouraged patient to eat nutritious foods such as green leafy vegetables and lean meat to increase feeling of comfort, to prevent allergic reactions that can cause respiratory distress.
- Reviewed client's chest x-ray for severity of acute/ chronic conditions to enable the body to recuperate and repair.

Evaluation

- Patient verbalized understanding and demonstrate proper deep breathing technique to facilitate proper oxygenation to alleviate hyperventilation.
- Patient was free of cyanosis and established normal breathing pattern.

3. Impaired gas exchange related to alveolar capillary membrane changes, congestion secondary to inflammation.

Goal

- After nursing interventions the patient will demonstrate ease in breathing.
- To relieve congestion.
- To promote gas exchange.

Nursing Implementation

- Monitored vital signs and assessed patient's conditions to establish baseline data.
- Auscultated lungs for crackles, consolidation and pleural friction rub determine adequacy of gas exchange and detect areas of consolidation and pleural friction rub this signs may indicate hypoxia.
- Assessed LOC, distress and irritability determine circulatory adequacy.
- Observed skin color and capillary refill which is necessary for gas exchange to tissues.
- Encouraged rest prevents tissue oxygen demand and enhances tissue oxygen perfusion.
- Encouraged elevated head of bed to facilitate lung expansion to enhance breathing.
- Performed chest physiotherapy after nebulization to dislodge the secretions, for easy expectoration.
- Administered oxygen as ordered improves gas-exchange decrease work of breathing.

Evaluation

- The patient demonstrated ease in breathing.
- The patient's verbalized understanding of the causative factors that could aggravate the condition and appropriate factors that could help the patient relive from gas exchange impairment.
- Improved gas exchange.[6&7]

Summary of Theory Application

Orientation Phase

* Patient was initially reluctant to talk due to breathing difficulty.
* Patient was expressing that his health condition is poor.
* Nurse established therapeutic relationship with the patient.

Identification

* The patient participates and interdependent with the nurse.
* Expresses the need to get relief from breathing problem.
* Expresses need for improving the health condition.
* Expresses need to know more about prognosis, discharge and home care and follow up.

Exploitation

* Patient explains that he gets relief breathing difficulty.
* Cooperates and participates actively in performing breathing exercises.
* Patients cooperates during the nursing interventions.

Resolution

* Patient expressed that breathing difficulty has reduced a lot and she is able to breathe normally.
* He also expressed that she would come for regular follow up after discharge.

Conclusion

With the help of the theory of interpersonal relations, the patient's needs could be assessed. It helped him to achieve them within her limits. This theory application helped in providing comprehensive care to the client. Patient was very cooperative. The application of this theory revealed how well the supportive and educative in nursing care aspects.

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IJSN
Volume 2, Number 1

Impact of Exercise on Type 1 Diabetes in Children

Lizzie Raveendran

Introduction

Exercise offers many health-promoting benefits for people with and without diabetes. Physical activity is associated with many health benefits and is an important part of any healthy life style. For individuals with type 1 diabetes, exercise provides additional benefits.

Being active is most beneficial when it's done on a regular basis.

Children with type 1 diabetes need to be active. Physical activity has an impact on the blood glucose levels. It also results in a greater sense of well-being, help with weight control, improved physical fitness, and improved cardiovascular fitness, with lower pulse and blood pressure and improved lipid profile.

A study by Gabriel *et al*[1] demonstrates that aerobic exercise training can improve endothelial function in different vascular beds in patients with long-standing type 1 diabetes, who are at considerable risk for diabetic angiopathy.

Benefits of exercise

In addition to all of the usual health benefits of exercise, such as weight control, stress reduction, improved muscular strength and flexibility, and reduced bone loss, a sound exercise program can also help children with type 1 diabetes better to maintain the blood glucose levels within the normal limits and reduce their risk of heart disease later.

Exercising on a regular basis can improve the sensitivity and number of insulin receptors in the body, according to the American Council on Exercise; this in turn helps train the muscles to use insulin better. These improvements in insulin utilization may lead to a decrease in insulin requirements for some individuals, but because people with type 1 diabetes are unable to make any insulin, no amount of exercise will ever eliminate the need for insulin injections.

People with type 1 diabetes are at an increased risk for heart attack, stroke and other cardiovascular diseases, but regular exercise can help reduce the risks. Consistent physical activity has been proven to raise HDL cholesterol, lower LDL cholesterol and reduce triglycerides in the bloodstream. Physical activity also improves blood flow, increases the heart's pumping power and reduces blood pressure.

It is worth noting that exercise has not consistently been shown to improve blood glucose control in people with type 1 diabetes. However, given its other numerous benefits, exercise is still an important part of living well with type 1 diabetes.

Exercise Risks and How to Avoid Them

Exercise can be risky to anyone who hasn't been physically active in awhile, but there are several potential risks that people with type 1 diabetes must carefully consider prior to beginning an exercise program. You should have a lengthy discussion with your health care provider to better understand how exercise influences blood glucose, and how to avoid potential problems, minimize risks, and recognize when you need to get additional information or medical care. Here are four of the most common problems that you must consider and address when

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planning your exercise program.

Hypoglycemia

Exercise typically reduces blood sugar levels especially when combined with insulin injections. When blood sugar drops too low, a complication known as hypoglycemia (low blood sugar) occurs. Hypoglycemia can happen during exercise, right after exercise, or even up to 24 hours after you work out. Symptoms of hypoglycemia can be mild and gradual, but it is more common for them to occur quickly. In rare cases, individuals may not experience any symptoms of hypoglycemia at all. By paying close attention to how you're feeling, and by knowing how to recognize and treat symptoms of low blood sugar correctly, you can prevent problems before they put you at risk of injury.

Because the risk of hypoglycemia increases with exercise, it is important to plan your new exercise regimen carefully (more on that below). Here are some ways people with type 1 diabetes can reduce their risk of hypoglycemia during and after exercise.

- Always check your blood sugar before, during, and after exercise.
- Talk with your doctor about whether adjusting your insulin doses (or basal infusion rates, if you use an insulin pump) around planned exercise is right for you. Adjusting insulin doses around planned exercise can minimize your need for extra snacks prior to exercise, thereby helping you manage your weight.
- Never adjust these doses under any circumstances, without consulting your physician first.
- Eat 15-30 grams of carbohydrates 30 minutes prior to any physical activity that is not part of your regular fitness plan for diabetes management. Talk to your doctor or diabetes educator for specific guidelines.
- In order to ensure that insulin is not absorbed too quickly, increasing the risk of hypoglycemia, it is best to avoid giving any insulin injections prior to exercise into areas of the body that will be worked during exercise (upper thighs and tricep region of the upper arms).
- Do not skip planned meals prior to exercise or go too long without eating.
- Carry an easy-to-consume source of fast-acting sugar (such as juice, hard candy, or glucose tablets) when you exercise. You will use this to treat hypoglycemia should it occur.
- Drink plenty of water before and during exercise. Dehydration can affect blood glucose levels.
- Avoid exercising in extreme weather conditions.
- In special cases, athletes and people who have successfully adopted a long-term fitness plans will need specific self-management instructions from their physicians.

Discontinuing basal insulin during exercise is an effective strategy for reducing hypoglycemia in children with T1D, but the risk of hyperglycemia is increased.

Poor Blood Sugar Control

In some cases, exercise can cause blood sugar levels to rise, resulting in hyperglycemia. If your blood glucose levels are not in your target range, talk to your doctor before beginning an exercise program. To prevent exercise-related blood sugar problems:

- Do not exercise if your blood glucose is above 250 mg/dL and you have ketones in your urine. Call your doctor's office for additional advice.
- Check your glucose level before, during, and after exercise, to see how your exercise has affected it. Share this information with your doctor.

Diabetic Retinopathy

In this condition (damaged blood vessels in the retina of the eye), exercise could damage the eyesight. Strenuous activities could lead to bleeding or retinal detachment, so one may need to avoid certain activities, such as weight lifting or jogging. The doctor must be consulted to recommend appropriate exercise activities.

Reduced Sensation or Pain in the Extremities

Because diabetes can cause nerve damage (neuropathy) and interfere with blood circulation, many people with diabetes can lose all or part of the sensation in their feet. To prevent exercise-related foot problems:

- Check your feet for cuts, blisters, or signs of infection on a regular basis.
- Wear good, properly-fitting shoes with ample cushioning and support
- Wear synthetic, wool or cotton-blend socks (not 100% cotton) that minimize moisture problems.

If you experience pain in your legs (or other extremities) at anytime during or after your exercise routine, contact your doctor right away. Exercise-induced pain can be a symptom of one or more diabetes-related complications that require medical attention. If numbness or pain becomes constant or severe, talk to your doctor about alternate forms of exercise that may be appropriate.

Tips for exercising safely

- Do not exercise if blood sugar is over 250 mg/dL or ketones are present.
- Make sure the blood sugar is in the target range before exercise-to avoid low blood sugar.
- Remember to wear identification.
- Drink water to avoid dehydration.
- Talk with the doctor about lowering the insulin dose that is taken before exercise.
- Inject the insulin before exercise in a site other than the parts of the body that will be used during exercise. For example, in case of running, do not inject insulin in the leg.
- May eat 15 to 30 grams of quick-sugar food (hard candy, fruit juice, honey) 15 to 30 minutes before exercise.
- If case of organized sports, give the coach a list of the symptoms of low blood sugar and instructions about what to do if it occurs.
- Have some quick-sugar food (hard candy, fruit juice, honey) on hand at all times.
- Watch for symptoms of low blood sugar up to 24 to 36 hours after exercise. .

Conclusion

In essence, exercise helps your child control his or her diabetes. And in the long run, this will reduce the chances of your child experiencing certain health problems related to diabetes. You can read more about the benefits of physical activity for people with type 1 diabetes in our article about exercise and type 1 diabetes.

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A Study to Assess Knowledge and Practices of Mothers about Management of Children with Enuresis Residing in Mana Raipur

Liza S. Pappachan

Abstract

Title: A study to assess knowledge and practices of mothers about management of children with Enuresis residing in Mana Raipur**. Objectives: (a)** To assess the knowledge of mothers regarding management of children with Enuresis.(b) To assess the practices of mothers regarding management of children with Enuresis (c)To correlate knowledge and practices in mothers about management of Enuresis in children with selected demographic variables**. Research Design:** Descriptive research design **Material:** Self administered structured questionnaire prepared by the investigators. **Sample:** 50 mothers who were having Enuretic children. **Sampling technique:** A non-probability convenient sampling technique was used for selecting 50 mothers who met the designated set of criteria during the period of data collection. **Results:** The knowledge of adolescent girls in urban area regarding Anorexia Nervosa was significantly higher as compared to the adolescent girls of rural area. **Conclusion**: The mothers had very less knowledge about the meaning of Enuresis than the management of Enuresis. Only 52% of the mothers follow good practices about management of children with Enuresis. The level of knowledge is independent of the selected demographic variables.

Keywords: Enuresis.

Introduction

Glazener and Evans (2002)[1] said that Nocturnal Enuresis (bed-wetting) is a socially disruptive and stressful condition which affects around 15-20% of five year olds. Cher, Lin, and Hsu (2002)[2], have identified a number of acute and chronic family stressors such as parental separation, suboptimal parenting, birth of a sibling, family disorganisation, poor quality of home care, non-supportive environment, faulty parental attitudes, etc., and also demographic factors such as family size, birth order, and parental education as risk factors which may precipitate or maintain Enuresis .

Ahuja (2002)[3], defined Enuresis "as repetitive voiding of urine, either during the day or night, at inappropriate places. These state affairs in normal in infancy. Technically, Enuresis is diagnosed only after 5 years of age. The most common cause is psychological stress, e.g. emotional disturbances, insecurity, sibling rivalry, death of parents."

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Problem statement

A study to assess knowledge and practices of mothers about management of children with Enuresis residing in Mana Raipur**.**

Objectives

1) To assess the knowledge of mothers regarding management of children with Enuresis.
2) To assess the practices of mothers regarding management of children with Enuresis.
3) To correlate knowledge and practices in mothers about management of Enuresis in children with selected demographic variables.

Research Methodology

The researcher has adopted an exploratory survey

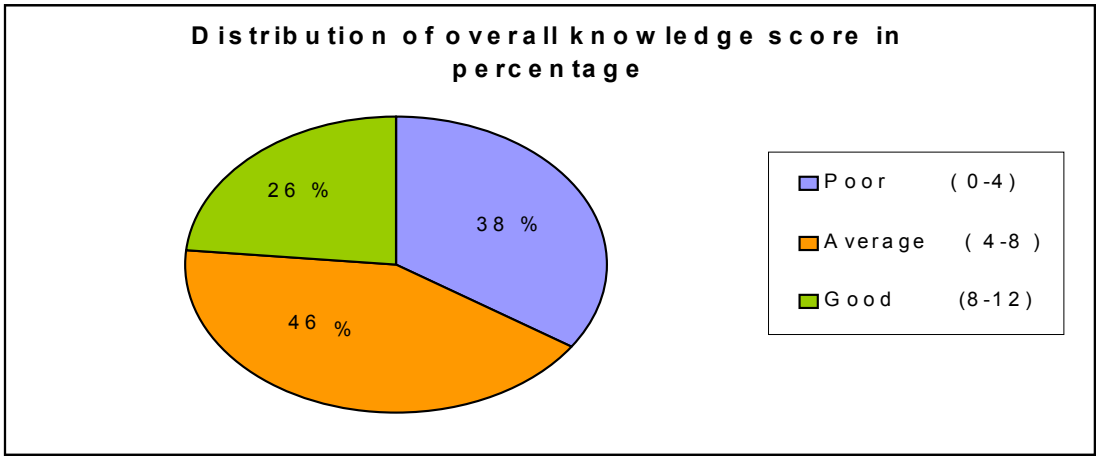
method to assess the knowledge and practices of mothers about management of children with Enuresis. A non-probability convenient sampling technique was used for selecting the mothers. Data was collected from 50 mothers who were having Enuretic children. The duration of data collection for each participant was 30-40 minutes and the subject herself administered structured questionnaire.

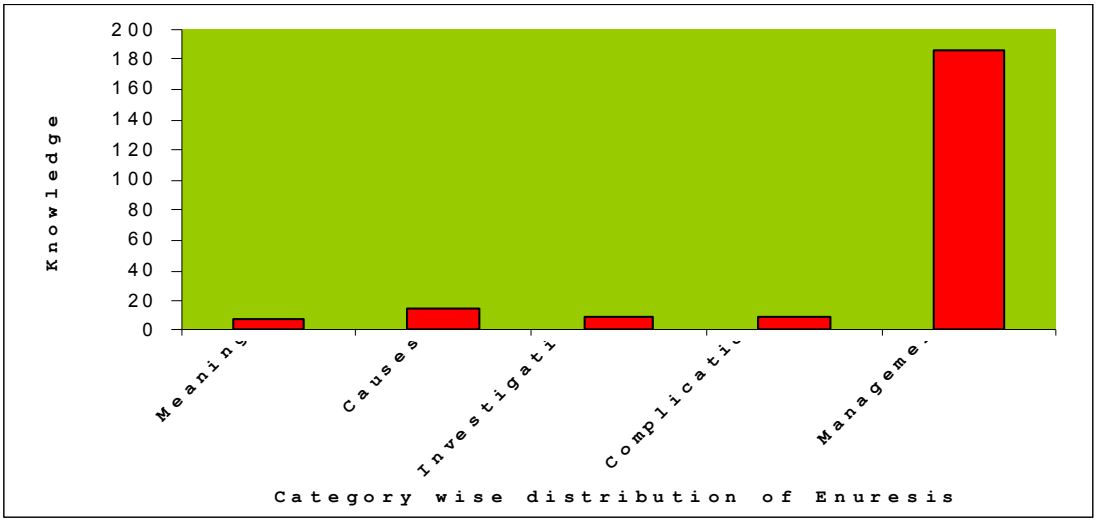
Major Findings

- Mothers knowledge obtained indicates that the highest percentage score i.e. (37.2%) in the area of management of Enuresis and lowest percentage score in the meaning of Enuresis (0.08%) . Thus mothers had very less knowledge about the meaning of Enuresis than the management of Enuresis
- The score range 40 – 60 shows the better management practices i.e. 48% mothers follow better practices to manage the child with Enuresis. The score range 20 – 40 shows the good practices and score 0 – 20 shows poor practices as such 52% of the mothers follow good practices about management of children with Enuresis.
- The findings on relationship between the knowledge and practices with selected demographic variables of mothers having children with Enuresis shows that there was no association between the knowledge and practices with the age of children , age of mother, mother's education, working and non working mother, type of family and number of children. Thus the level of knowledge is independent of the selected demographic variables.

Conclusion

Among the psychological problems, Enuresis is





one of the most prominent problems seen in children. Psychosocial environmental factors have a major modulator effect on Enuresis. Parents sometimes avoid seeking help due to feelings of shame or embarrassment, or because they believe that nothing can be done and they must wait for their child to "grow out of it". The researchers' main aims of the study are to provide support and to encourage families to come forward to discuss the problem.

The investigator felt that this study would help in developing a better understanding and provide base line of data on the management of children with Enuresis.

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