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A Study to Assess the Knowledge of Primary School Teachers and Effectiveness of the Computer Assisted Planned Teaching Program on Health Appraisal of School Children in Selected Schools of Dhamtari District, Chhattisgarh

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Abstracts

The main aim of the study was to assess the knowledge of primary school teachers and effectiveness of computer assisted planned teaching program on health appraisal of school children in selected schools of Dhamtari District, Chhattisgarh. Keeping the objectives of the study in view, the researcher selected one group pretest and post-test pre-experimental design. The study was carried out in a group of 50 primary school teachers from selected schools of Dhamtari Chhattisgarh, selected by non-probability purposive sampling and a self-structured questionnaire was administered to assess the knowledge of primary school teachers. After pre-test a computer assisted planned teaching program on health appraisal of school children was administered. Data collection was analyzed by using descriptive and inferential statistics. Results of the study revealed that primary school teachers have average knowledge

Keywords: Health Appraisal of School Children; Primary School Teacher.

Introduction

Children are the nation's hope and pride. Since they are the future of the country an unhealthy malnourished child today will contribute to unhealthy future of the country. Dr. A.S.K. Felix (2005) in School Health Program in Manipur under NRHM of India (2005-2010) quotes that "childhood holds a very important place in the life of every human being". It is observed that school going children suffer from various diseases. When these diseases are not recognized and treated initially and allowed to progress to chronic stage, the child becomes slave from the particular disease which remains as an obstacle all through his school age preventing him to achieve academic success as well as all round development.

Schools are powerful places to shape the health, education and well-being of our children.Health appraisal is of benefit to school health program in a number of ways. First, it affords the school authorities

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the opportunity to detect signs and symptoms of common diseases as well as signs of emotional disturbances that could impede the learning activities of school children. Besides, health appraisal helps in providing information to parents and school personnel on the health status of school children (Cornacchia, Olsen & Nickerson). The teacher needs to observe children carefully every day. The teacher should be given certain hints to identify any defects in children who need medical attention. These include unusually flushed face, rash, cough, sneezing, sore throat, fever, rigid neck, restlessness, vomiting, headache, diarrhea, dullness and scabies. This helps the child to seek early medical aid. Only with the nurses continued guidance the teacher will be able to fulfill these tasks.

Ananthakrishnan, et al. (2001) conducted a study in Kedar village in Tamilnadu to evaluate the health status of 1349 school children and assess the community's perception of their health problems. The important morbidities observed were anaemia (57.1%), worm infestation (46.4%), malnutrition 6 Chetna Sahu / A Study to Assess the Knowledge of Primary School Teachers and Effectiveness of the Computer Assisted Planned Teaching Program on Health Appraisal of School Children in Selected Schools of Dhamtari District, Chhattisgarh

(57.6%), riboflavin deficiency (32.9%), nutritional skin disorders (11.6%), and dental caries (27.9%), etc. This emphasizes on the need of early identification and treatment of the health problems of the school children.

Madhu Gupta et al. 2009 observed in their study that there is high prevalence of ocular morbidity among school children. Refractive errors were the most common ocular disorders. Prevalence of ocular morbidity was 31.6% (CI=29.9-32.1%), refractive errors 22% (CI=21.1-22.8%), squint 2.5% (CI=2.4-2.6%), color blindness 2.3% (CI=2.2-2.4%), vitamin A deficiency 1.8 % (CI=1.7-1.9%), conjunctivitis 0.8% (CI=0.79-0.81%). This emphasizes on the strong need for the early identification of vision impairment in the school children.

Health appraisal includes an assessment of the present health and health needs of students as well as teachers. Both health professional and teachers participate in this activity. Observation, identification and encouragement in the correction of remedial defects are important steps in health appraisal. At the time of health check-up of children, the parents should preferably be present to give the full history of the child's health and the present illness if any. All possible measures should be taken to promote normal health and development of the child. Health counseling of pupils and parents is also part of health appraisal. School health services assist in the identification and education of scholastically backward or handicapped (physically, mentally and psychologically) or sick children and their followup (S. Kamalam).

Since the role of teachers is pivotal, their training and continuing education must be pursued with vigor and concern. The basic training program of school teachers covers most of the area of child learning, the teachers are provided in-service training for school health activities. The purpose of their training is to motivate school teachers to play effective and assisted role and responsibility of ensuring good health and clean environment conductive for education / learning for school children. Besides short term training, the medical officer and health workers maintain regular contact with teachers for school health activities. So there is a need for health personnel to take active part in educating the teachers on health appraisal of school children.

Statement of Problem

"A study to assess the knowledge of primary school teachers and effectiveness of the computer assisted planned teaching program on health appraisal of school children in selected school of Dhamtari District, Chhattisgarh."

Objectives

- To determine the pre and post interventional knowledge of primary school teachers regarding health appraisal of school children.
- To seek relationship between selected demographic variables and level of knowledge in pre-test.
- To determine the effectiveness of computer assisted planned teaching program on health appraisal of school children in terms of gain in knowledge in post-test.
- To identify the association between the pretest knowledge level of teachers regarding health appraisal of school children with selected demographic variables.

Methods and Material

The study is evaluative in nature. One group pretest and post-test pre-experimental design was used in the study. In this design the investigator introduces a test before and after treatment (x), which is depicted as 01 and 02 respectively. In the present study the base measure will be the knowledge score and treatment will be computer assisted planned teaching program on health appraisal of school children.

Sample	Pre-test	Treatment	Post-test
	Day 1	Day 1	Day 8
Primary School Teachers	01	х	02

Key-

01- Pretest knowledge score

02- Post-test knowledge score

x- Computer assisted planned teaching program

The setting for the present study was in selected primary schools of Dhamtari, Chhattisgarh. In this study the target population consists of all primary school teachers in Dhamtari district (C.G.). Thesample for the study comprises of primary school Chetna Sahu / A Study to Assess the Knowledge of Primary School Teachers and Effectiveness of the Computer 7 Assisted Planned Teaching Program on Health Appraisal of School Children in Selected Schools of Dhamtari District, Chhattisgarh

teachers in selected school of Dhamtari. Selection of population was as per non-probability purposive sampling method. The sample size consists of 50 subjects. The study protocolwas approved by the ethics committee of PG College of Nursing, Bhilai, Chhattisgarh and permission to conduct theresearch in schools was obtained from Headmasters of all schools included in study.

A tool was developed for primary school teachers to assess knowledge regarding health appraisal of school children. The self structured questionnaire consists of 3 sections, i.e. section A, section B and section C. Section A consists of socio demographic variables viz. type of school authority, age, sex, marital status, general education, professional qualification, teaching experience, teacher training program and source of information on health appraisal. Section B comprises of 10 questions of yes or no type, to assess the availability and practice of school health appraisal practice by school teachers. Section C comprises of 18 knowledge questions related to health appraisal of primary school children. The questions are prepared in different areas of viz. health appraisal, health record, physical examination and minor illnesses in primary school children. A score of 1 was given to each correct response and 0 scores for each wrong response.

Feasibility was established by administering the

tool on 6 primary school teachers in DAV Public School, HUDCO, Bhilai. The tool was found reliable (r =0.82).Main study was carried out in a group of 50 primary school teachers from selected schools of Dhamtari Chhattisgarh, selected by non-probability purposive sampling and a self structured questionnaire was administered to assess the knowledge of primary school teachers. Followinga brief presentation about the study, a written consentwas sought from the school teachers for participation in the study. After pre-test a computer assisted planned teaching program on health appraisal of school children was administered.

Data collection was analyzed by using descriptive and inferential statistics. Results of the study revealed that primary school teachers have average knowledge regarding health appraisal of school children before administration of computer assisted planned teaching program.

Results

The total mean in pre-test is 9.5 and in post-test is 14.78 respectively. The 't' value calculated is 18.93, which shows that the difference in mean of pre-test and post-test is highly significant.

N=50

	Variables	Frequency(f)	Percentage %
Age	< 21 years	8	16
	21-30 years	21	42
	31-40 years	10	20
	41-50 years	7	14
	51-60 years	3	6
	> 60 years	1	2
Gender	Male	20	40
	Female	30	60
Marital Status	Married	25	50
	Unmarried	25	50
General education	10+2	22	44
	Graduate	12	24
	Postgraduate	16	32
Professional	B.Ed.	8	16
Qualification	M.Ed.	1	2
	Nursery Teacher training	5	10
	Primary school teacher training	11	22
	Any other	5	10
	No special training	20	40
Teaching Experience	< 1 Year	12	24
_	1-10 Years	24	48
	11-20 Years	8	16
	21-30 Years	2	4

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	> 30 Years	4	8
Source of information	Through training	9	18
on health appraisal	Workshop	3	6
	Seminar	1	2
	Conference	1	2
	Health Professionals	26	52
	Mass media	5	10
	Health mela	2	4
	Reading literature	2	4
	Friends	1	2

Table 2: Analysis of check list to assess the participation of primary school teachers in health appraisal activities

Practice of health appraisal		ency(f)	Percentage %	
	Yes	No	Yes	No
Have you participated in health appraisal program	15	35	30	70
Have you got any special training in health appraisal of school children	6	44	12	88
Does your school include health appraisal as a part of school curriculum	43	7	86	14
Do you perform daily observation of student's health	36	14	72	28
Does your institute conduct additional teacher's training program on health appraisal	18	32	36	64
Do you maintain health records of students	35	15	70	30
Does you conduct interview / conferences with parents & guardians	21	29	42	58
Do you give health education to students regarding good health practices	50	0	100	0
Do you discuss with students about the screening tests and physical examination	41	9	82	18
Do you feel it is necessary to have additional information about health appraisal	50	0	100	0

Table 2 explains that 30% of school teachers have experience of participating in health appraisal program, 12% have special training in health appraisal of school children, 86% say that health appraisal is a part of school curriculum, 72% participated in the health check-up of students, 36% agreed that their institute conducted additional teacher's training program on health appraisal, 70% maintained health records of students, 42% conducted interview / conferences with parents & guardians, 100% of them give health education to students regarding good health practices, 82% discuss with students about the screening tests and physical examination, 100% of them agreed that it is necessary to have additional information about health appraisal.

Table 3: Area wise analysis of pre and post interventional knowledge level of school teachers regarding health appraisal of school childrenN=50

Areas of health appraisal	Maximum PossibleScore	Mean	Pre Test MeanScore %	SD	Mean	Post Test Mean Score %	SD
Health Appraisal	4	2.56	14.2	1.21	3.66	20.3	0.74
Health Record	2	1.02	5.6	0.49	1.46	8.1	0.5
Physical examination	7	3.5	19.4	1.08	5.58	31	0.92
Minor illnesses	5	2.46	13.6	1.12	4.08	22.6	0.82
Total	18	9.54	52.8	3.9	14.78	82	2.98

Table 4: Overall comparison of pretest and posttest level of knowledge as per criteria

N=50

Level of knowledge	Pı	Pre-test		Pre-test Post-test		ost-test
0	Frequency	Percentage %	Frequency	Percentage %		
Excellent	2	4	45	90		
Good	42	84	5	10		
Average	6	12	0	0		
Total	50	100	50	100		

Table 3 indicates that the post-test knowledge mean score was (3.66) in health appraisal, (1.46) in health record, (5.58) in physical examination, (4.08) in minor illnesses was greater in all the area as

compare to the pre-test knowledge mean score in (2.56), (1.02), (3.5), and (2.46) respectively.

Table 4 depicts the comparison between pretest and post test knowledge score. In the pre test 2(4%)

are in excellent criteria, 42 (84%) in good criteria and 6 (12%) in average criteria. Where as in posttest level

of knowledge 45 (90%) are in excellent criteria, 5 (10%) in good criteria and none 0 (0%) in average criteria

Table 5: 't' test analysis to find out the effectiveness of the computer assisted planned teaching program on health
appraisal of school childrenN=50

Knowledge assessment test	Mean	Mean %	SD	't' value	P value	DF
Pre-test	9.5	52.7	2.25	10.00	0.05	10
Post-test	14.78	82.1	1.60	18.93		49

Table 6: Chi-square analysis to find out the association of selected socio-demographic variable with pre-test knowledge score

Study Variable	Critical value	Chi-square value	DF	Inferences
Age	24.99	10.15	15	Not significant
Gender	7.82	0.77	3	Not significant
Marital status	7.82	1.18	3	Not significant
Education	18.9	1.8	6	Not significant
Teaching experience	21.03	22.01	12	significant

Table 5 indicates clearly that there is significant improvement in the knowledge level of pre-test and post-test scores. The total mean in the pre-test is 9.5 and in post test is 14.78. The SD in pre-test is 2.25 and in post-test is 1.60 which shows that the data is consistent. As 't' value calculated is 18.93, which is highly significant i.e. greater than (P>0.05) level of significance at df = 49. This data signifies that the computer planned assisted teaching program was effective in improving the knowledge of the primary school teachers regarding health appraisal of school children.

Table 6 shows that the chi-square value of teaching experience (22.01) at df 12 (P<0.05) is greater than the critical value (22.03), it indicates that there is significant association betweenlevel of knowledge and teaching experience, while there is no significant association between other variables.

Discussion

The present study shows that the primary school teachers are lacking in knowledge about health appraisal of school children. They are not aware about the importance of keeping health records and regular physical observation. They also were having less knowledge regarding the minor illnesses in school children. Based on assessment researcher has prepared the computer assisted planned teaching programme on health appraisal of school children. This can be useful to all primary school teachers in assessing the health status of school children.

The findings of this study suggest that the teachers were having average knowledge about health appraisal of school children. The reason for this inadequate state of affairs could be that no particular school personnel are specifically detailed to take responsibility for the provision of health appraisal practices. Every teacher does whatever she thinks should be done at a particular time, and that is all. School health appraisal should not be handled haphazardly. It is the contention of this author that the purpose of school health appraisal would be better served if it is rendered under the portfolio of the school counsellor. So, it is necessary that the nurse directed program should be conducted to impart knowledge to primary school teachers regarding the health appraisal of school children. The findings of the present study have implications for nursing practice, nursing administration, nursing education, nursing research; community. This is a humble attempt by researcher in improving the knowledge of primary school teachers regarding health appraisal of school children.

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Relations between Parent-Teen Conflict and Emotional Intelligence of Adolescents

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Abstract

The aim of the study is to identify the relationship between parent- teen conflict and emotional intelligence of adolescents. The objectives of the study were to determine the extent of parent-teen conflict among adolescents, to determine the emotional intelligence of adolescents, to identify the relationship between parent- teen conflict and emotional intelligence of adolescents and to find out the association between extent of parent- teen conflict and selected demographic variables. Erik Berne's transactional analysis principles were used for conceptual frame work of the study. This correlational research study was conducted on 200 adolescents from JDT Islam high School, Calicut. Data were collected from sample after getting necessary permission from the school authorities, consent from parents and assents from subjects. Data were analyzed with SPSS package version 17. Result of the data analysis identified that 46.5% adolescents are free from conflict, 42% have mild conflict, only 10% had moderate conflict and 1.5% had severe conflict with parents. The study concluded that there is significant relationship between parent- teen conflict and emotional intelligence of adolescents (p= 0.001) and also parent- teen conflict had significant association with selected demographic variables like religion (p=008), place of residence (p=.016), type of family (p=0.002), number of children (p=.004) educational status of father (p=.000) and mother (p=.022).

Keywords: Adolescent; Parent-Teen Conflict; Emotional Intelligence.

Introduction

Human development is the most complex process occurring in nature. Every human being will go through various stages of development from infancy through adolescence till they reach adulthood. Among these stages, adolescence is the most turbulent one. The parents and the society expect adolescent to behave like an adult forgetting the fact that adolescent is neither an adult nor a child. The main developmental task of adolescence is to establish their own identity. Failure to achieve this will lead to role confusions which may in turn lead to psychological or emotional problems. Parents of adolescents, may become frustrated and angry that the teen seems no longer responding to the parental authority. Methods of discipline that worked well in earlier years may no longer have an effect and parents may feel frightened and helpless about the choices their teens are making. As a result, parent-teen conflict will occur. Conflict is a term broadly conceptualized and defined as a disagreement between individuals or groups of individuals.

A naturalistic study of early adolescents found that conflicts with parents and sibling occurred at the rate of approximately 20 per month or one in every three days [1]. Another study on adolescents with primary headache identified that there is a negative relationship between parent-teen conflict and psychological functioning of adolescents [2]. A longitudinal study done on adolescents for 5 years indicated that the emotional autonomy will be less for the adolescents who have negative family relationship [3].

As per Eric Erickson's theory of psychosocial development, each stage of development has its own developmental task; failure of attainment of which leads to conflicts in the individual. Developmental task of adolescence is establishment of a sense of identity [4]. If the child fails to achieve this, it may lead to role confusion and in turn, will have a negative impact on emotional development.

Emotional intelligence is a task that every individual need to achieve during childhood itself. There are many factors which adversely affect the emotional intelligence. Adolescents who are academically brilliant may sometimes socially and interpersonally poor. By possessing a high Intelligence Quotient (IQ), success may not come automatically. But by increasing the Emotional Quotient (EQ), the adolescents can become more productive and successful at what they do and they can also help others too. High emotional intelligence will definitely help an adolescent to reduce stress by decreasing conflict, improving relationships and understanding.

From own experience and extended review, the researcher has observed that many adolescents suffer from emotional problems. Some studies have proved that parent - teen conflict during adolescence is a quite natural phenomenon and several studies showed that parent - teen conflict has a negative impact on child's development [5,6].

During adolescence, parent- teen conflict is a major problem that both parents and teens are facing which requires solution. However, there has been little research on the underlying processes that could explain how parent-teen conflict results in adolescent problem behavior. As a result, there are no procedures that have been proven effective in improving adolescent adjustment by enhancing parent-teen relations and could find literature regarding the effect of these conflicts on emotional development of adolescents. So the study to assess the relationship between parent-teen conflict and emotional intelligence of adolescents was conducted.

The purpose of the study was to identify the relationship between parent-teen conflict and emotional intelligence of adolescents, with a view to improve their emotional intelligence by promoting healthy parent teen relationship. The objectives of the study were to determine the extent of parent-teen conflict among adolescents, to determine the emotional intelligence of adolescents, to identify the

relationship between parent-teen conflict and emotional intelligence of adolescents and to find out the association between extent of parent-teen conflict and selected demographic variables.

Methodology

Quantitative descriptive correlational design was used to find the relation between parent teen conflict and emotional intelligence of adolescents. Erik Berne's transactional analysis principles were used for the conceptual frame work of the study. The study was conducted on 200 adolescents who were selected randomly from JDT Islam high school, Velimadukunnu, Calicut. The tools used were demographic proforma to assess the socio demographic characteristics of subjects, rating scale for assessing parent- teen conflict of adolescents and emotional intelligence scale for assessing emotional intelligence of adolescents. Content validity index of the rating scale was established as 0.9. Parent teen conflict rating scale was translated into Malayalam and back translation to English was done to ensure its clarity. The content validity and reliability of the parent-teen conflict rating scale were assessed by Chronbach's alpha and were 0.9 and 0.716 respectively. Reliability of the emotional intelligence scale was already established and it is 0.90. Pilot study was conducted after getting permission from the school authorities. Ethics committee approval was obtained from Institutional Review Board at Aster MIMS Hospital, Calicut. Study was conducted at JDT Islam high school Vellimadukunnu after obtaining permission from the school authorities. Consent was taken from parents of the selected adolescents and ascent was taken from the adolescents. Two hundred adolescents aged 13-17 years who satisfied the inclusion and exclusion criteria were selected at random for study. Demographic proforma was administered to students to collect socio demographic data. After that, parentteen conflict was assessed using rating scale and emotional intelligence was determined using emotional intelligence scale.

Results

Data collected from 200 participants were subjected statistical analysis using SPSS version 17 to find out the frequency, percentage and relationship between selected factors. Their demographic characteristics are shown in Table 1.

Socio demographic variable	Frequency	Percentage (%)
Age		
13 years	100	50.0
14 years	63	31.5
15 years	37	18.5
Gender		
Male	82	41.0
Female	118	59.0
Religion		
Hindu	75	37.5
Muslim	116	58.0
Christian	9	4.5
Place of residence		
Urban	108	54
Rural	92	46.0
Type of family		
Nuclear	113	56.5
Extended	66	33.0
Joint	21	10.5
Number of children in the family		
1	34	17
2	99	49.5
3	60	30.0
More than 3	7	3.5

 Table 1: Distribution of adolescents based on age, gender, religion, place of residence, type of family and number of children in the family
 (n=200)

Table 2: Distribution of adolescents based on educational status of parents and monthly family income. (n=200)

Socio demographic variable	Frequency	Percentage (%)
Father education		
Profession	43	21.5
Graduate or post graduate	39	19.5
Intermediate or Post high school diploma	60	30.0
High school certificate	31	15.5
Middle school certificate	23	11.5
Primary school certificate	4	2.0
Mother education		
Profession	22	11.0
Graduate or post graduate	52	26.0
Intermediate or Post high school diploma	76	38.0
High school certificate	26	13.0
Middle school certificate	16	8.0
Primary school certificate	8	4.0
Monthly income (in rupees)		
>32050	16	8.0
16020-32049	31	15.5
12020-16019	38	19.0
8010-12019	34	17.0
4810-8009	32	16.0
1601-4809	25	12.5
<1600	24	12.0

Table 1 shows that most of the adolescents were 13 year old (50%) and were females (59%). Most of the subjects belonged to Muslim religion (51%) and lived in urban areas (54%), were from nuclear family (56.5%) and there were 2 children in 49.5% of the families.

mothers (38%) were educated up to intermediate or post high school diploma level. About 21.5% of fathers and 19.5% mothers had professional educational qualification 19.5% of fathers and 26% of mothers were graduates or post graduates. Most of the families (51.5%) were having monthly income between Rs. 12019-16020

Table 2 shows that most of the fathers (30%) and

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Socio demographic variable	Frequency	Percentage (%)
Father occupation		
Profession	43	21.5
Semi profession	45	22.5
Clerical, shop owner, farmer	44	22.0
Skilled worker	32	16.0
Semi- skilled worker	23	11.5
Unskilled worker	11	5.5
Unemployed	2	1.0
Mother occupation	28	14.0
Profession	38	19.0
Semi profession	18	9.0
Clerical, shop owner, farmer	21	10.5
Skilled worker	13	6.5
Semi- skilled worker	40	20.0
Unskilled worker Unemployed	42	21.0

Table 3: Distribution of adolescents based on occupational status of father and mother

Table 3 shows that about 44% of fathers and 33% of mothers were professionals and semiprofessionals and 22% fathers were clerical or shop owner or farmers. Among the mothers 20% were unskilled workers and 21% were unemployed.

Majority of the samples were from lower middle class (44%) and (36%) were from upper middle class family.

This section deals with the extent of parent- teen conflict among adolescents measured by the rating scale prepared by researcher.

Table 4 shows that most of the adolescents (46.5%) were free from conflicts. About 42% had mild conflict, 10% had moderate conflict and 1.5% had severe conflict.



Fig. 1: Distribution of adolescents based on socio economic status

(n=200)

Extent of Parent- teen conflict	Frequency	Percentage
No conflict	93	46.5
Mild	84	42.0
Moderate	20	10.0
Severe	3	1.5

able 4: Frequency or Percentage (%	distribution of extent of parent teen conflict	(n=200)
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Table 5: Frequency and percentage of conflicts in autonomy

Sl. No.	Statements	F	⁰∕₀
1	My parents always listen and understand my view points	154	71.3
2	My parents involve me in decision making	83	41.5
3	My parents criticize my dressing code	103	51.5
4	I feel that there is too much interference from the members of my family in my	82	41.0
	personal affairs		
5	My parents allow me to select dress according to my wish	148	74.0
6	My parents always used to quarrel with me in simple matters like cleaning bed room	83	41.5
7	My parents never allow me to spend money according to my wish	106	53.0
8	My parents always criticize my hair style	74	37.0
9	I feel that I am not getting enough freedom in my home	48	24.0

Sl. No.	Statements	F	%
1	I feel that my friends are more concerned about me than my parents	66	33.0
2	I discuss all my personal problems with my friends than my parent's	68	34.0
3	My friends always support my view points where as my parents always criticize it.	55	27.5
4	My parents complaint that I am always wandering with my friends	98	49.0
5	My parents complaint that if I spend more time with my friends it		
	will affect my studies	63	29.2
6	My parents resist making relationships with strangers especially		
	through chatting	88	44.0
7	My parents used to criticize my friends	134	67.0
8	My parents tell that all my mischievous behavior are leaned from my		
	friends	89	44.5

Table 6: Frequency and percentage of conflicts in establishing intimacy

Table 5 shows that most of the adolescents report autonomy related conflicts with parents in selecting dress (74%), their view points (71.3%) and spending money (53%).

Table 6 shows that most of the adolescents (67%) reported that their parents are criticizing their friends. About 49% adolescents reported that their parent's complaint that they are always wandering with their friends.

Table 7 shows that about 46% of adolescents reported that their parents are not interested in their co- curricular activities and 45% reported that their parents make them feel guilty if their performance is below their expected level.

Table 8 shows that 46% of the adolescents reported that their parents were not helping them as much they want.

Table 7: Fre	quency and percentage of conflicts in achievements		(n=200)
Sl. No.	Statements	f	%
1	My parents are interested in my co-curricular activities	92	46.0
2	My parents are supporting me in achieving good grades in my academic activities	59	29.5
3	My parents used to compare me with my friends in matters of		
	academic achievements	80	40.0
4	My parents are criticizing me in participating sports or arts	58	29.0
5	My parents makes me feel guilty if my performance is below their		
	expected level	90	45.0
Fable 8: Fre	quency and percentage of conflicts in self- centeredness		(n=200)
Sl. No.	Statements	f	%
1	My parents tells that I am irresponsible in house hold activities	73	36.5
2	My parents tells that I used to talk about myself more	75	37.5
3	My parents tells that I am considering them only as objects to finish my		
0	needs	51	25.5
4	I used to quarrel with my parents for getting things done	66	33.0
5	My parents complaint that I am concerning only own my need	50	25.0
6	I feel my parents did not help me as much as I need	92	46.0
Table 9: Fre	quency and percentage of conflicts in identity		(n=200)
Sl. No.	Statements	F	%
1	My parents will not agree with the common dressing code in our group	82	41.0
2	My parents never allow me for going outside with people outside the family	163	81.5
3	My parents criticize that I am wasting electricity and water	100	50.0
4	I used to quarrel with my parents regarding the volume of TV and the		
	programme	86	43.0
5	My parents doesn't like the music which I like the most	47	23.5
6	My religious thought often clash with my parent's thoughts	59	29.5
7	My parents doesn't allow me to be trendy	60	30.0
8	My parents insist to choose a profession which is not interested to me	55	27.5

Table 9 shows that about 81.5% adolescents reported that their parents never allow them for going outside with people outside the family and 50%

reported that parents criticize them for wasting electricity and water.

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(n=200)

Table 10: Frequency and percentage of conflicts with risk taking behavior of adolescents			(n=200)
Sl. No.	Statements	f	%
1	My parents scold me when I involve in fight with others	92	46.0
2	My parents resist me when I explore strange things	140	70.0
3	My parents complaint that I am more interested in doing frightening things	143	71.5
4	My parents criticize me for preferring risk taking friends	52	26.0
5	My parents do not support affairs with opposite sex	85	42.5
6	My parents criticize my dietary habits	78	39.0

Table 11: Mean and Standard deviation of emotional intelligence of adolescents

Variable	Mean	SD
Emotional intelligence	109.33	26.64

Table 12: Association between parent- teen conflict and emotional intelligence of adolescents

Extent of parent- teen conflict	Emoti intelli	ional gence	D	F	f	p value
	Mean	SD	Between group	Within group		
No conflict	127.34	15.21	3	196		
Mild conflict	96.88	22.67	-	-		
Moderate conflict	86.15	26.47	-	-	52.96	0.000*
Severe conflict	53.67	20.50	-	-		

(* Significant at p < 0.05 level)

Table 13: Association between parent- teen conflict and selected socio demographic variables

Variables	Z ²	DF	p value
Age	4.197	3	.241
Gender	4.197	3	.241
Religion	17.296	6	.008*
Place of residence	10.387	3	.016*
Type of family	21.091	6	.002*
Number of children	24.423	9	.004*
Father's education	49.726	15	.000*
Mother's education	27.988	15	.022*
Father's occupation	14.287	18	.710
Mother's occupation	13.630	18	.753
Monthly income	19.839	18	.342
Socio- economic status	12.796	9	.172

*Significant at p<0.05

Table 10 shows that about 71.5% of adolescents reported that their parents complaint that they are more interested in doing frightening things and their parents resist when they explore strange things.

Table 11 shows that the meanemotional intelligence score of adolescents was 109.33 with a standard deviation of 26.64.

Table 12 reveals that there is significant relationship exist between parent=teen conflict and emotional intelligence of adolescence (P=0.000). So the null hypothesis is rejected and research hypothesis is accepted.

Table 13 shows that parent- teen conflicthad significant association with religion, place of residence, type of family, number of children in the family, educational status of father and mother.

Results of the data analysis identified that about 46.5% adolescents are free from conflict, 42% have mild conflict, only 10% had moderate conflict and very less number of adolescents (1.5%) have severe conflict with parents. The study concluded that there is significant relationship between parent-teen conflict and emotional intelligence of adolescents (p=0.001) and also parent-teen conflict had significant association with selected demographic variables like religion (p=008), place of residence (p=.016), type of family (p=0.002), number of children (p=.004) educational status of father (p=.000) and mother (p=.022).

Discussion

A previous literature shows that there are substantial individual differences, and there are many parents and adolescents between whom there is little conflict [3]. Even though the parent-teen conflict is a natural phenomenon during adolescence the present study support the finding of the previous study that there are substantial individual differences among adolescents, in matters of parent – teen conflict. In this study 46.5% of adolescents were free from conflict. In 1991 study a study was conducted by Paikoff on adolescents revealed that Malay and Indian adolescents experienced more conflict with their parents compared to Chinese adolescents [6]. In the present study 52.5% of adolescents had parent – teen conflict.

A study conducted by Feldman SS in 1988 at Stanford University regarding factors influencing age expectations for adolescent autonomy reveled that adolescents parents held significantly later age expectations than adolescents [7]. Present study also supports the previous study finding that parents had higher autonomy expectations while compare to adolescents. In this study, most of the adolescents (60.2%) had reported that their parents are not listening and understanding their view points and reported there is autonomy related issues like dressing (47.2%), personal affairs (24%) and spending money (35.2%). In another study conducted by Allison in 2004, regarding parent-adolescent conflict in early adolescence reported that parent-adolescent conflict is most commonly seen in chores like care of room and helping in house hold activities [8]. In the present study only 17.1% of adolescents reported conflict related to this same issue.

A study on parents and peers influences on emotional adjustment during adolescence revealed that adolescents begin to relay on peers more often than parents as sources of support [9]. In this study the adolescents (42.1%) reported that their view points are more supported by their friends than their parents and also they reported that their parents criticize them for spending more time with friends.

The main aim of the study was to explore the relationship between extent of parent-teen conflict and emotional intelligence of adolescents. It was found that there is a significant association between parents -teen conflict and emotional intelligence of adolescents (p=<0.001). Lewandowski in 2009 identified that parent-teen interactions as predictors of depressive symptoms in adolescents and poor family relationship affect teen's emotional functioning [2]. Sharma A (2013) identified that a home atmosphere comprising of rejection, neglecting the child and indifferent parent- child relationship affect the expression of child, thus causing poor development of emotional intelligence in child [10]. Naghavi (2012) revealed that a relationship between emotional intelligence and family functioning of adolescents [11] that supports the findings of the present study.

A meta-analysis was conducted by Laursen on change in parent-child conflict across adolescence has shown that conflict frequency often peaks during early adolescence and then decreases towards middle and late adolescence, but intensity and negative effects seem to increase with adolescent age and peak in mid-adolescence [12,13]. This study also supports the previous meta-analysis result that conflict is common among early adolescents than middle adolescents. This shows that as age of the adolescence increases, the incidence of parent-teen conflict decreases supporting the findings of the present study. There is no gender difference seen in parent teen conflict in this study and is supported by a study conducted in Orleans [14].

Present study concluded that there is a significant relationship between present-teen conflict and emotional intelligence of adolescents (p=0.001) and also extent of parent-teen conflict is associated with demographic variables like religion (p=008), place of residence (p=.016), type of family (p=0.002), number of children (p=.004) Educational status of father (p=.000) andmother (p=.002).

Good emotional intelligence is considered as a base for emotional and cognitive development of adolescents. Hence the causes of poor emotional intelligence in adolescent is a new area which needs to be investigated more. Nurse researchers should focus on gaining more insight into environmental and social factors that can contribute to parent – teen conflict. Nurses, with their unique knowledge and skills can assess with the goal of preventing or intervening parent-teen conflict often seen in adolescents. Adolescent health is sprouting specialty where pediatric nurses have greater role and the findings of this study may pave way for further investigations on role of emotional intelligence in controlling problem behaviors in adolescents.

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A Study to Assess the Effectiveness of Structured Teaching Programme on Selection of Toys among Mothers of Under Five Childern in Selected Rural Areas, Tirupati

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Abstract

Background: Play is a natural and most easily available out let for children's expression of needs and feelings. It is necessary stimulation for optimal development and support for their natural curiosity. Spontaneous play evolves from children's need for self-expression, mastery in the environment and integration of past and current experiences. Young children play with exhilaration and total enjoyment. A play is important for the children's physical, psychosocial and intellectual development. Medium of play, children can learn what no one can teach them. They learn about their world and how to deal with this environment of object, time, space, structure, and people. They learn about themselves operating within the environment what they can do, how to relate to things and situations and how to adopt themselves to the child. Objectives: To assess the knowledge and knowledge on practices among mothers of under five children regarding selection of toys. To evaluate the effectiveness of Structured teaching programme on selection of toys among mothers of under five years children. To associate the relationship between demographic variables and knowledge among mothers of under five years children on selection of toys. To associate the relationship between demographic variables and knowledge on practices among mothers of under five years children on selection of toys. Methods: An experimental study involving 50 Mothers of under five children were taken for the study. Pre-experimental research design was adopted for this study.Data were collected using a structured questionnaire. It included data regarding sociodemographic characteristics and questions pertaining to knowledge on selection of toys, and knowledge on practices on selection of toys. Results: Out of 50 mothers of under five children 50% (25) had inadequate knowledge, 32% (16) had moderate knowledge and only 18% (9) had adequate knowledge. With regards to knowledge on practices 26% (13) had inadequate knowledge on practices 64% (32) had moderate knowledge on practices and only 10%(5) had adequate knowledge on practices regarding selection of toys among mothers of under five children in pre-test. Out of 50 mothers of under five children majority 86% (43) had adequate knowledge, 14% (7) had moderate knowledge and none of them had inadequate knowledge. With regards to knowledge on practices majority 68% (34) had adequate knowledge on practices, 32% (16) had moderate knowledge on practices and none of them had inadequate knowledge on practices regarding selection of toys among mothers of under five children in post-test. Conclusion: A majority of mothers of under five children were having adequate and moderately adequate knowledge, knowledge on practices on selection of toys and demographic variables were statistically significant, hence it can be concluded that, there is an improvement on level of knowledge, and knowledge on practices on selection of toys in posttest.

Keywords: Structured Teaching Programme; Mothers of Under Five Children, Toys.

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Play is a natural and most easily available out let for children's expression of needs and feelings. It is necessary stimulation for optimal development and support for their natural curiosity. Spontaneous play evolves from children's need for self-expression, mastery in the environment and integration of past and current experiences. Young children play with exhilaration and total enjoyment. A play is important for the children's physical, psychosocial and intellectual development. Medium of play, children can learn what no one can teach them. They learn about their world and how to deal with this environment of object, time, space, structure, and people. They learn about themselves operating within the environment what they can do, how to relate to things and situations and how to adopt themselves to the child. In play children continually practice the complicated, stressful processing of living communicating and achieving satisfactory relationship with others [1].

The origin of toys is prehistoric; dolls representing infants, animals, and soldiers, as well as representations of tools used by adults are readily found at archaeological sites. The origin of the word "toy" is unknown, but it is believed that it was first used in the 14th century. Toys are mainly made for children. Playing with toys is important when it comes to growing up and learning about the world around us. Younger children use toys to discover their identity, help their bodies grow strong, learn cause and effect, explore relationships, and practice skills they will need as adults. Adults use toys to form and strengthen social bonds, teach, remember and reinforce lessons from their youth, discover their identity, exercise their minds and bodies, explore relationships, practice skills, and decorate their living spaces [2].

Children use fine and gross motor skills in their play. They react to each other socially. They think about what they are doing or going to do. They use language to talk to each other or to themselves and they very often respond emotionally to the play activity. The integration of these different types of behaviors is key to the cognitive development of young children. Play is not hierarchical. Depending on the circumstances, children may engage in any of the different types of play [3].

Play teaches children how to interact with others and learn about the world. The toys you select for your young child affect his development. Your child's current developmental stage plays a major role in toy selection. Observe the skills he is currently learning, such as fine motor skills, letter recognition, counting, self-care and language development, as a

guide for selecting toys that enhance those skills [4].

In 2006, 22 toy-related deaths were reported by the U.S. Consumer Product Safety Commission involving children under the age of 15. Riding toys were the No. 1 cause for toy-related deaths, with toy nails, pegs and rubber balls also causing fatalities. The majority of these deaths occurred because of motor vehicles or suffocation caused by the toys. Additionally, there were an estimated 220,050 toyrelated injuries in 2006. These injuries were treated in hospital emergency rooms and include children of all ages. However, 165,100 of these injuries happened to children under the age of 15. These injuries included lacerations, bruising and abrasions, with the head and face as the most affected areas. Riding toys were again the No. 1 cause. Riding toy injuries and deaths can also be related to falls and drowning [6].

More than three billion toys and games are manufactured and sold each year, and they come in so many different shapes and sizes. Children in 5years and under are most often at the highest risk of a toy-related injury, but essentially no child is safe without the proper supervision and knowledge. Choking is generally the most common toy-related injury, but with so many different toys and games, children are also left open to burns, fractures, falls, bruising suffocation, drowning, and poisoning [6].

Choosing appropriate toys for children is an important responsibility for the early childhood professional. Despite the great number of toys available to children in their homes, as well as in child care settings, many toys are inappropriate or even dangerous for young children. The need for open-ended opportunities is great since toys provided to young children support play, an essential element in child development [5].

A young child's growth and development can be supported and enhanced through play. Toys bring parents or caregivers and children together in play. Early brain development is enhanced through these relationships. Some children may need toys that have been adapted to accommodate a motor, visual, or other disability. All children benefit from toys that promote safe physical activityplay enhances all areas of development, including cognitive, language, social, physical, and emotional development [8].

The impact of sex-specific toy choice has implications for children's learning and attitudes far beyond the playground. Play with masculine toys is associated with large motor development and spatial skills and play with feminine toys is associated with K. Kousar Nazma & A. Padmaja / A Study to Assess the Effectiveness of Structured Teaching Programme 21 on Selection of Toys among Mothers of Under Five Childern in Selected Rural Areas, Tirupati

fine motor development, language development and social skills [7].

Methodology

After obtaining the permission from Health officer, the subjectswere approached individually the data was collected, informed consent was taken from the participants after explaining the purpose of the study. The sample was selected by convenient sampling technique. The data collected with 5 mothers per day. For each mother 15mts for pre-test and 15mts for post-test, 45mts for structured teaching programme was given.

Inclusion Criteria

- Mothers who are curious and having sound mind.
- Mothers who are willing to participate in the study.

Results

Table 1 revels that out of 50 mothers of under five children majority 44%(22) were in the age group of 21-25 years and only 8%(4) were at age group of 31 years and above. With regarding to religion majority 72% (36) were Hindus, and only 4% (2) were Christians. In relation to educational status of mothers majority of mothers 66% (33) were having Illiterate and only 8% (4) were having technical education. In relation to Education of the father majority 34% (17) were having primary education and only 20% (10) were having technical education. With regards to occupation of the mother majority 66% (33) were home makers, whereas only 6% (3) were employee. With regards to occupation of the father 60% (30) were doing business and only 4%(2)were laborers. Pertaining to type of family majority 68% (34) were from nuclear family, and only 2% (1) were from single parent family. With regard to number of under five children majority 58% (29) were having two children and only 6% (3) were having four children. With regard to family income per month majority 60% (30) were below 10,000 and only 6% (3) were 20,001 and above income status. In relating to place of residence majority 60% (30) were from urban and only 10% (5) were from urban slum.

Table 2 shows that out of 50 mothers of under five children 50% (25) have inadequate knowledge, 32% (16) have moderate knowledge and only18% (9) have adequate knowledge. With regards to knowledge on practices 26% (13) have inadequate knowledge on practices 64% (32) have moderate knowledge on practices and only 10% (5) have adequate knowledge on practices regarding selection of toys among mothers of under five children in pre-test.

Table 1: distribution of selected demographic variables among mothers of under five children (n=50)

S. No	Demographic variable	Frequency	Percentage
1.	Age of the mother		
	Below 20 years	10	20
	21-25 years	22	44
	26-30 years	14	28
	31 years and above	4	8
2.	Religion		
	Hindu	36	72
	Muslim	12	24
	Christian	2	4
3.	Education of mother		
	Illiterate	33	66
	Primary Education	5	10
	Secondary Education	8	16
	Technical Education	4	8
4.	Education of the father		
	Illiterate	12	24
	Primary Education	17	34
	Secondary Education	11	22
	Technical Education	10	20
5.	Occupation of the mother		
	Home maker	33	66
	Employee	3	6
	Laborer	10	20
	Others	4	8

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6.	Occupation of the father		
	Business	30	60
	Employee	15	30
	Laborer	2	4
	Others	3	6
7.	Type of family		
	Nuclear	34	68
	Joint	12	30
	Extended	3	6
	Single parent family	1	2
8.	Number of under five children		
	One	11	22
	Two	29	58
	Three	7	14
	Four and above	3	6
9.	Family income per month		
	Below 10,000	30	60
	10,000- 15,000	7	14
	15,001-20,000	10	20
	20,001 and above	3	6
10	Place of resident		
	Urban	15	30
	Rural	5	10
	Urban slum	30	60

 Table 2: Distribution of level of knowledge and knowledge on practices regarding selection of toys among mothers of under five children in pre-test
 (n=50)

S. No	Variable	Inade	equate	Moderatel	y Adequate	Adequate		
		f	- %	f	%	f	- %	
1.	Knowledge	25	50	16	32	9	18	
2.	Knowledge on Practices	13	26	32	64	5	10	

Key: f = frequency

%= percentage

 Table 3: Distribution of level of knowledge and knowledge on practices regarding selection of toys among mothers of under five children in post-test
 (n=50)

S. No	Variable	Inade	equate	Moderatel	v Adequate	Adequate		
		f	%	f	%	f	%	
1.	Knowledge	0	0	7	14	43	86	
2.	Knowledge on Practices	0	0	16	32	34	68	

Table 4: The effectiveness structured teaching programme on selection of toys among the mothers of under five children

						(11-50)	
S. No	Variables	Mean	Std. Deviation	t-test	p value	sig	
1.	Pre test Knowledge	5.52	1.909	1.077	10 550	بلديك	
	Post test Knowledge	8.62	1.159	1.877	13.752	**	
2.	Pre test Practice	8.46	2.270	1 000	14545	بلديله	
	Post test Practice	12.88	1.239	1.809	14.547	**	

Significance: **P<0.01 level

Table 3 indicates that, out of 50 mothers of under five children majority86% (43) have adequate knowledge, 14% (7) have moderate knowledge and none of them have inadequate knowledge. With regards to knowledge on practices majority 68% (34) have adequate knowledge on practices, 32% (16) have moderate knowledge on practices and none of them have inadequate knowledge on practices regarding selection of toys among mothers of under five children in post-test. Table 4 indicates that there is a significant improvement in the level of knowledge and knowledge onpractices related to selection of toys among mothers of under five children at P<0.01 level.

Association between demographic variables with level of knowledge in pre test among mothers of under five children

There is a significant association between level of knowledge in pretest regarding selection of toys with

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Education of the mothers of under five children at p<0.01 level.

There is a significant association between level of knowledge in pretest regarding selection of toys with occupation of the mothers of under five children at p<0.01 level.

Association between demographic variables with level of knowledge in post test among mothers of under five children

There is a significant association between level of knowledge in posttest regarding selection of toys with age of the mothers of under five children at p<0.01 level.

There is a significant association between level of knowledge in posttest regarding selection of toys with type of family of the mothers of under five children at p<0.01 level.

There is a significant association between level of knowledge in posttest regarding selection of toys with Education of the mothers of under five children at p<0.05 level.

Association between demographic variables with level of knowledge on practices in pre test among mothers of under five children

There is a significant association between level of knowledge on practices in pretest regarding selection of toys with Education of the mothers of under five children at p<0.01 level.

There is a significant association between level of knowledgeon practices in pretest regarding selection of toys with occupation of the mothers of under five children at p<0.01 level.

Association between demographic variables with level of knowledge on practices in post test amongmothers of under five children

There is a significant association between level of knowledge on practices in posttest regarding selection of toys with Education of the mothers of under five children at p<0.05 level.

There is a significant association between level of knowledge on practices in posttest regarding selection of toys with number of under five children in family at p<0.05 level.

Discussion

The first objective of the study to assess the knowledge and knowledge on practices among mothers of under five children regarding selection of toys. In present study revealed that out of 50 mothers of under five children 50% (25) have inadequate knowledge, 32% (16) have moderate knowledge and only 18% (9) have adequate knowledge. With regards to knowledge on practices 26% (13) have inadequate knowledge on practices 64% (32) have moderate knowledge on practices and only 10%(5) have adequate knowledge on practices regarding selection of toys among mothers of under five children in pre-test.

It reveals that out of 50 mothers of under five children majority 86% (43) have adequate knowledge, 14% (7) have moderate knowledge and none of them have inadequate knowledge. With regards to knowledge on practices majority 68% (34) have adequate knowledge on practices, 32% (16) have moderate knowledge on practices and none of them had inadequate knowledge on practices regarding selection of toys among mothers of under five children in post-test.

Esma Sulu Ugurlu et al (2012) conducted a study on examination of knowledge and applications about toy selection of mothers. Who have child 1-3 age group.Objectives of the study are to determine of knowledge and applications about toy selection of mothers who have child 1-3 age group. The study concluded that Mothers who participated in research determined to need for information about toy selections for children according to age group [9].

The second objective of the study to evaluate the effectiveness of Structured Teaching Programme on selection of toys among mothers of under five children.

It reveals that there is a significant improvement in the level of knowledge and knowledge on practices related to selection of toys among mothers of under five children at P<0.01 level.

This study was supported by Chan. JX et al (2013) conducted a study on Toysafety in Singapore. A cross-sectional questionnaire study at KK Women's and Children's Hospital, The study concluded that study highlights the current knowledge deficit in toy safety issues and the need for improvements in regulation, education and surveillance in order to minimize the risk of toy-related injuries in children [10].

The third objective of the study to associate the relationship between demographic variables and knowledge among mothers of under five children on selection of toys.

It reveals that there is an association between the demographic variables with level of knowledge regarding selection of toys, with Education and occupation of mothers at P<0.01 level in Pre-test.

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Age of the mother and type of family at P < 0.01 level and Education of the mother at P < 0.05 level in Posttest.

The present study was supported by Elif Celebi Oncu et al (2010) conducted a study on Preschool children's using of play materials creatively. Results showed that most of the children cannot be able to show creative expressions with different kinds of play materials in their play [11].

The fourth objective of the study to associate the relationship between demographic variables and knowledge on practices among mothers of under five years children on selection of toys.

It reveals that there is an association between the demographic variables with level of knowledge on practices of selection of toys with education of mothers at P < 0.01 level and occupation of the mother at P < 0.05 level in Pre-test. And education of mother and number of under five children at P < 0.05 level in Post-test.

The present study was supported by Diana L. et al (1993) conducted a study on teaching families to evaluate age-appropriatetoys. The study focused on Nurses should stress to parents that they need not purchase the most frequently advertised toy to promote their child's growth and development skills. The study concluded that all parents, regardless of income, education, and resourcefulness, to promote and stimulate their child's gross and fine motor skills, social development, and cognitive development through the use of toys [12].

Conclusion

Out of 50 mothers of under five children the study findings in pre-test 50% (25) have inadequate knowledge, 32% (16) have moderate knowledge and only 18% (9) have adequate knowledge. With regards to knowledge on practices 26% (13) have inadequate knowledge on practices 64% (32) have moderate knowledge on practices and only 10% (5) have adequate knowledge on practices regarding selection of toys among mothers of under five children.

On knowledge on practices that out of 50 mothers of under five children in post-test majority 86% (43) have adequate knowledge, 14% (7) have moderate knowledge and none of them have inadequate knowledge. With regards to knowledge on practices majority 68% (34) have adequate knowledge on practices, 32% (16) have moderate knowledge on practices and none of them have inadequate knowledge on practices regarding selection of toys among mothers of under five children.

The effectiveness structured teaching programme on selection of toys among the mothers of under five children, there is a significant improvement in the level of knowledge and knowledge on practices related to selection of toys among mothers of under five children at P<0.01 level.

The data provided that the mother of under five children knowledge and knowledge on practices of selection of toys had markedly improved after structured teaching programme than before.

Recommendations

Based on the study findings, the following suggestions are proposed:

- A study could be conducted using the post-test after one month, six months, and one year to see the retention of knowledge.
- The study could be conducted with large samples.
- The study could be replicated in different settings, such as slum areas to strengthen the findings.
- A similar study could be conducted using experimental and control group.
- A comparative study could be done in rural and urban settings.
- A similar study conducted by administering selfinstructional material on selection of toys which could also serve as reference material for the mothers.
- A descriptive study to assess the knowledge attitude and practice of mothers on selection of toys could be under taken.

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Knowledge, Attitude and Practice Regarding Complementary Feeding among Mothers of Infants in Urban and Rural Areas of Tirupati

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Abstract

Objective: To compare the knowledge, attitude and practice regarding complementary feeding among mothers of infants in urban and rural areas of Tirupati. Methodology: The present study was descriptive study. The data was collected from NGO colony and Karakambadi areas of Tirupati, during Feb 2016 to Mar 2016. There were 100 participants including 50 urban mothers whilst for a comparative assessment a group of 50 rural mothers were also selected to meet the purpose of the study. Subjects age range was set between 18 -39 years. The study sample comprised of infant mothers. While inclusion criteria the mothers whose infants are in the age group 6 months to 12 months, were selected as samples. Sample was selected by convenient sampling technique. The data was collected by using Structured questionnaire and information booklet was given. The data was interpreted through SPSS-20. Results: The study findings showed a significant difference between urban and rural mothers of infants in knowledge, attitude and practice regarding complementary feeding. t- value for knowledge was 7.723, attitude 4.913 and practice 0.805. p- value for knowledge and attitude was 0.00 and practice 0.424. There was significant difference in level of knowledge between urban and rural mothers of infants in association with education of mother and occupation of mother were significant at p<0.05 level. Level of attitude was significantly different in association with education of mother, occupation of mother, occupation of father, income, type of family and source of information were significant at p<0.05 level. Differences were also identified in level of practice with age, education of mother, occupation of father, income, type of family, number of children and source of information were significant at p<0.05 level. Conclusion: In conclusion, the knowledge, attitude and practice of mothers of infants regarding complementary feeding in urban areas is more than the rural areas of Tirupati. This study was successful in presenting a better understanding of the issues associated with the early and delayed introduction of solid foods to infants.

Keywords: Mothers of Infants; Complementary Feeding; Malnutrition.

Introduction

Children constitute a major proportion of the global population today. They are truly the foundation of a Nation. "A healthy child is a sure future" is one of the themes of WHO [1]. India registers the highest number of child deaths across the globe. The high prevalence of malnutrition contributes to over 50 per cent of child deaths. Infants

and young children are at an increased risk of malnutrition from six months of age onwards, when breast milk alone is no longer sufficient to meet all their nutritional requirements and complementary feeding should be started [2].

The World Health Organization (WHO) recommends exclusive breast feeding for the first six months of life, with the addition of complementary feeds at six months with continued breast feeds until

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at least the age of two [3].

Breastfeeding should continue together with weaning food up to and beyond second year of life. However, infant feeding and weaning practices have cultural, social and economical roots making malnutrition more than a medical problem. It has been indicated in many studies all over the world that these practices are the subjects strongly influenced by customs, beliefs, superstitions, religion, cultural pattern, mother's education and socioeconomic status of the family [4].

The word 'Weaning' is derived from Anglo-Saxon word 'Wenian' means to be accustomed to something different. The concept of 'Weaning' has now changed to 'complementary feeding' for the simple reason that, with the introduction of other nutritious food, breast feeding needs to continue for a period of 2 years [5].

A critical period of child growth is in the first 2-3 years of life when growth faltering is common and exclusive breast feeding in the first 6months, and appropriate complementary feeding after 6 months, are essential to meet the nutritional needs of the growing child. In addition to lack of access due to limited availability and affordability of a diverse diet, traditional home-prepared complementary foods in many contexts are either too viscous or watered down, monotonous, and have low energy and micronutrient density and poor protein quality [6].

The level of child under nutrition remains unacceptable throughout the world, with 90% of the developing world's chronically undernourished children living in Asia and Africa [7].

Afghanistan has the highest rate of 91/1000 followed by Pakistan 81/1000. India is the third highest in child mortality rate among SAARC countries with 48 deaths per 1000 live births according to PTI [8].

As per the Infant and Young Child Feeding (IYCF) guidelines, in India around 40 per cent of children remain without any complementary source of feeding till they attain eight months of age. The commonest reason for delayed complementary feeding was the notion "the child will vomit everything." Another important reason was ignorance [9].

In India, a collected data shows that just over half of 6-9months old are breast fed along with complementary foods and only 39 per cent of 20-23 months old are continued with breast feeding. In India, IMR is 43.19 deaths/1000 live births. Of this, males comprise 41.9 deaths/1000 live births and females 44.63 deaths/1000 live births. In Andhra Pradesh, IMR among 4-12 months is 32.4 per cent, according to 2014 statistics [12].

The issue of underweight children is particularly serious in rural areas and among the poorest families, ethnic minorities and lower castes [13].

Globally, optimal breastfeeding could prevent 13 per cent of deaths of children aged less than five years while appropriate complementary feeding (CF) practices might result in an additional 6 per cent reduction in under-five mortality, especially in developing countries as ours [14].

Methodology

After ethical permission obtained from the institution the subjects were approached individually with permission of community authorities. The data was collected from 100 participants including 50 urban mothers and 50 rural mothers. The sample was selected by convenient sampling technique. After obtaining informed consent the data was collected and confidentiality of the subjects was maintained. In order to check the hypothesis appropriate statistical analysis was used by SPSS version 20.

Measures

Structured Questionnaire: Consists of two sections.

Section I: consists of socio-demographic data such as age of the mother, gender of the infant, education of the mother and father, occupation of the mother and father, family income per month, type of family, residence, type of diet and source of information on complementary foods for infants.

Section II: consists of three parts.

Part A: Consists of 15 multiple choice questions related to assess the knowledge of mothers of infants regarding complementary feeding.

Part B: Consists of 5 point attitude scale, which contains 5 questions related to attitude of mothers of infants regarding complementary feeding.

Part C: Consists of 10 dichotomous questions to assess the hygienic feeding practices of mothers.

Score Interpretation

Scoring key was prepared for section –I by coding the socio-demographic data.

In section II, part-A and part-C each correct answer has a score of '1' and wrong answer, a score of 'zero'. Thus a maximum score of 15 were allotted to knowledge of mothers on complementary feeding M. Manjusha & A. Padmaja / Knowledge, Attitude and Practice Regarding Complementary Feeding among Mothers of Infants in Urban and Rural Areas of Tirupati

and score of 10 were allotted to hygienic feeding practices of mothers. The scores were interpreted in the following manner: less than 50 per cent inadequate knowledge, 51-75 per cent moderately adequate knowledge and more than 75 per cent adequate knowledge.

Part B Attitude Scale

Total items in this tool were 5. A five point Likert Rating scale (5, 4, 3, 2, 1) was used and the responses were categorized as strongly agree, agree, undecided, disagree and strongly disagree. Questions 1-5 have positive scoring. The total score was 25. The total score reflects the level of positive attitude towards complementary feeding. The score was categorized as follows Low positive attitude less than 13, moderately positive attitude 14-20, highly positive attitude more than 20.

Results

Table 1 represents infant mothers' knowledge on complementary feeding practices between rural and urban. Out of 50 rural mothers 21 (42%) had inadequate knowledge, 27 (54%) had moderate knowledge and 2(4%) had adequate knowledge. Out of 50 urban mothers 1 (2%) had inadequate knowledge, 22 (44%) had moderate knowledge and 27 (54%) had adequate knowledge.

Table 1: Distribution of knowledge scores among rural and urban mothers of infants regarding complementary feedingpracticesn=100

Variables	Inade	RURAL Inadequate Mode rate Ad equate						URBAN Inadequate Mode rate /				
	N	%	N	%	N	%	N	%	N	%	N	%
Knowledge	21	42	27	54	2	4	1	2	22	44	27	54

Table 2: Distribution of attitude scores among rural and urban mothers of infants regarding complementary feeding practices n=100

Variables	RURAL Low +VE Moderately +VE Highly +					y +VE	URBAN +VE Low +VE Moderately +VE Highly +VE						
	Ν	%	Ν	%	Ň	%	Ν	%	Ν	%	N	%	
Attitude	1	2	8	16	41	82	0	0	3	6	47	94	

Table 3: Distribution of practice scores among rural and urban mothers of infants regarding complementary feeding practices.n=100

Variables	RURAL Inadequate Moderate Adequate						URBAN Inadequate Moderate Adequate					
	Ν	%	Ν	%	Ν	%	Ν	%	Ν	%	Ν	%
Practice	2	4	11	22	39	78	0	0	10	20	40	80

 Table 4: Comparison of knowledge, attitude and practice of mothers of infants regarding complementary feeding practices in rural and urban areas
 n=100

				URBAN		t-value	p-value	Significance	
Score	Mean	Ν	SD	Mean	Ν	SD		-	-
Knowledge	7.72	50	2.627	11.54	50	2.032	7.723	0.00	**
Attitude	20.04	50	2.523	22.54	50	2.052	4.913	0.00	**
Practice	7.84	50	1.095	7.98	50	0.622	0.805	0.424	NS

*= p<0.05

**= p<0.01

Table 2 reveals that out of 50 rural mothers 1 (2%) had low positive attitude, 8 (16%) had moderate positive attitude and 41 (82%) had high positive attitude. Out of 50 urban mothers none had low positive attitude, 3(6%) had moderate positive attitude and 47 (94%) had high positive attitude.

Table 3 reveals that out of 50 rural mothers 2(4%) had inadequate knowledge on practices, 22 (11%) had moderate knowledge on practices and 39 (78%)

had adequate knowledge on practices.

Out of 50 urban mothers none had inadequate knowledge on practices, 10 (20%) had moderate knowledge on practices and 40 (80%) had adequate knowledge on practices.

Table 4 explains that among rural infant mothers, mean of knowledge was 7.72 and standard deviation was 2.627; mean of attitude was 20.04 and standard deviation was 2.523 and mean of practice was 7.84 and standard deviation was 1.095. Among urban infant mothers, mean of knowledge was 11.54 and standard deviation was 2.032; mean of attitude was 22.54 and standard deviation was 2.052 and mean of practice was 7.98 and standard deviation was 0.622.

Discussion

Findings of the present study revealed that mothers of infants in selected urban area were having significantly high level of knowledge, attitude and practice when compared to mothers of infants in selected rural area.

In rural area, level of knowledge in association with demographic variables showed that education of mother and occupation of mother were significant at p<0.05 level and education of father and income were significant at p<0.01 level.

In urban area, source of information was significant at p<0.05 level and education of mother, occupation of mother, number of children and religion were significant at p<0.01 level.

In rural area, level of attitude in association with demographic variables showed that education of mother, occupation of mother, occupation of father, income, type of family and source of information were significant at p<0.05 level and age was significant at p<0.01 level.

In urban area, age, gender, education of mother, education of father, occupation of mother, occupation of father, income, type of family, number of children and religion, source of information was significant at p < 0.05 level and type of diet was significant at p < 0.01 level.

In rural area, level of practice in association with demographic variables showed education of mother, education of father, occupation of father, number of children, type of diet and religion were significant at p<0.05 level.

In urban area, age, education of mother, occupation of father, income, type of family, number of children and source of information were significant at p<0.05 level and gender and education of father were significant at p<0.01 level.

Limitations of the Study

The study is limited to mothers who are in selected rural and urban areas of Tirupati. The study is limited to the mothers who are having children of 6 to 12 months of age. Period of study is 4 weeks.

Implications

The study results would help the nurse to enlighten their knowledge and care for infants in community. Nurses can be instrumental in preventing nutritional related deaths and helping the mothers of infants by teaching about complementary feeding and hygienic practices. Provide anticipatory guidance to mothers regarding complementary feeding in Pediatric wards, outpatient departments, Well-baby clinics, PHC, Sub centers and Anganwadi centers. In the curriculum there should be more emphasize on complementary feeding. Nursing students should be encouraged in planning and implementing incidental and planned health education programmes regarding complementary feeding. Nurse administrator should take efforts to guide and provide competent information and AV aids to health professionals to conduct health education programme effectively and efficiently. Nurse administrator shall find out effective strategies for complementary feeding services. The study reveals that there is a need for extensive research to find out behaviour modifications after teaching programmes. Nursing research shall be pursued on newer method of teaching, focusing on interest, quality and cost effectiveness. College or university must make compulsory clause/clue/requirement of conduct for research study.

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A Study to Assess the Impact of Visual Media Usage on Visual Acuity and Selected Visual Problems among Children Attending Selected Eye Hospital, Coimbatore

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Abstract

Visual impairment is a global public health problem. Children with low vision may suffer from delayed growth and developmental and education problems. The World Health Organization reported that every minute somewhere in the world, a child goes blind. For most of them, there is no curative treatment of the underlying pathology. Vision plays a vital role in a child's interpretation of the world. Visual impairment has a serious impact on a child's physical and emotional development. Objectives: The main aim of the study was to assess the Visual Media Usage, Visual Acuity and Visual problems of children and to correlate the impact of visual Media usage with visual acuity. Methods: Descriptive correlational study design, variables studied were Visual Media usage, Visual Acuity and Visual Problem. Results: Correlation indicates that the obtained 'r' value was 0.792. It implied that there was a positive correlation between Visual Media usage with Visual Acuity at p<0.001 levels. Conclusion: Children who were high VMU viewers had more visual related and other problems and low visual acuity when compared to children with normal viewing. Fathers those who are well educated and family income is more the availability of visual medias at home endangers children for high usage.

Keywords: Visual Media Usage (VMU); Visual Acuity (VA); Visual Problems; Log MAR Value.

Introduction

Eye is an organ which reacts to light for several purposes and allows vision as a conscious sense organ. Rod and Cone cells in the Retina allow light perception and vision including color differentiation and the perception of depth. The human Eye can distinguish about 10 million colors. Visual Acuity (VA) is a quantitative measure of the ability to identify black symbols on a white background at a standardized distance as the size of the symbols is varied (American Optometric Association, 1990).

Refractive errors occur when the shape of the eye prevents light from focusing directly on the Retina. The length of the eyeball either longer or shorter, the changes in the shape of the cornea, or aging of the lens refractive can cause errors. Nearsightedness (myopia) is a condition where the objects appear clearly, while objects far away appear blurry, when light comes to focus in front of the retina instead of on the Retina. Farsightedness (Hyperopia) is a common type of refractive error where distant objects may be seen more clearly than objects that are near. Astigmatism is a condition in which the eye does not focus light evenly onto the retina. This can cause images to appear blurry and stretched out, as the eye ages the lens can no longer change shape enough to allow the eye to focus close objects clearly (Vue, 2003).

Vision plays an important role in children interpretation of the world ,visual impairment has serious impact on a child physical and emotional development. Children with low vision may suffer delayed growth and development. The American Acadamy of Pediatrics issued guidelines recommending children are watching television frequently can negatively affect early brain development (Al-Madhi, 2002).

Normal VA based on the Snellen chart is 20/20, means that a person can see small detail from 20 feet away as same as a person with normal eyesight would see from 20 feet (6 meters). VA is measured with the help of Snellen chart. Snellen charts are named after the Dutch ophthalmologist Herman Snellen who developed the chart in 1862. Classification of Visual acuity by WHO 6/6 is normal, 6/9-6/12 considered mild Vision loss, 6/18-6/36 is considered moderate visual impairment, 6/60-3/ 60 is considered as severe Vision loss, 3/60-1/60 is considered as Blindness (World Health Organization, 1990).

A cross sectional study was conducted in India to determine the causes of severe visual impairment (SVI) and blindness, 4643 children from different school were participated in this study. Distance VA was measured for each eye using a Log Mar LEA chart. Visual loss was classified to the WHO categories of Visual Acuity defined as presenting VA <3/60 in the better eye, SVI as VA <6/60 to 3/ 60 in the better eye, and VI as VA <6/18 to 6/60 in the better eye. 65 children were identified with SVI 58.5% were blind and 41.5% were SVI. The major Anatomical site of SVI was the Retina in 33.8%, lens in 15.4% and normal appearing globe in 15.4%. The major underlying an etiology of SVI was undetermined in 56.9% and perinatal factors 21.5% mainly Retinopathy of Prematurity (Heijthuijsen, 2013).

The American Acadamy of pediatrics has recognised execssive TV viewing ,internet use as major contributions to childhood physical and mental health problems. Over use of visual medias causing visual problems in children ,because they are not following good viewing habits while watching the visual medias .In children because of their habits of watching visual medias like Television, Internet use, and playing Videogames, that they are not maintaing proper distance while watching TV. Children spend more than two hours per day in front of the Television and Internet (Gilbert, 1953).

A study was conducted in a selected school in Kanchipuram district in India. 628 students were screened, result of this study shows that, 30.57% of students were identified as vision defective, and from which 43.75% are Boys and 56.25% of them are Girls. Significant differences were found with respect of their Residential area that is 27.08% were in Rural, 34.37% of them were from Urban and 38.55% were residing in semi urban. But there was no awareness among the students and parents regarding the consequences of uncorrected vision problems. This statement has been proved, that the number of vision defective students wore glasses were 7.26%. The remaining 92.74% of students are unaware about their problems (Prema, 2011).

Extensive viewing of the computer screen can lead to eye discomfort, fatigue, blurred vision and headaches, dry eyes and other symptoms of eyestrain. These symptoms may be caused by poor lighting, glare, an improper work station set-up, vision problems of which the person was not previously aware, or a combination of these factors. Children can experience many of the same symptoms related to computer use as adults. However, some unique aspects of how children use computers may make them more susceptible than adults to the development of these problems (Kozeis, 2009).

The life style habits adopted by children as a result of spending time in front of television and computers screen are often determine to their health .children who are watching visual medias more ,spend less time doing physical activities, but they are eating snacks and packed food items in front of the visual medias, children who spend more times in front of television perform poor academically. This inverse relationship the grater viewing, lower the achievement for three basic skills that is reading, writing and mathematics. Excessive television seeing causing aggressive and violet activities in children (Ouarmby, 2009).

Vitamin A is an important for vision because it is needed to form the pigment Rhodopsin. Retina is the part of the eye that is responsible for converting light rays into neurological signals that can be converted into images. Cells in the Retina, known as the rods and cones, need Rhodopsin in order to absorb light rays. Rhodopsin is important for all kinds of vision, which allows you to see in low light conditions. A lack of vitamin A can impair body's ability to make Rhodopsin, resulting in vision problems. In children, vitamin A deficiency is the leading cause of preventable blindness and is typically due to malnutrition. Vitamin A deficiencies can also affect the vision. A mild deficiency can make it hard for you to see in low light conditions and can also cause small changes in the whites of your eyes. A severe deficiency results in eyes becoming dry, ultimately causing scarring of the eye that leads to blindness (Cole, 2011).

Methods

The study was conducted at Lotus Eye Hospital, Coimbatore, Tamilnadu, India among 150 outpatient children attending eye clinic in the year 2013. A prior formal written permission was obtained from the authorities of Lotus Eye Hospital and pediatric department to conduct the study. Informed consent was obtained from the parents and children. The investigator collected the data by interview method. First the child was enrolled for study, and then subjected for visual assessment with help of Snellen chart. The questionnaire was completed during the waiting time.

The instrument used for the present study was part I consist of ten questions regarding Visual Medias viewing habits of children. Scored as three, two, one the maximum score was 13 and minimum score is 10. Part 2 is the sleeping and eating habits of children, it has six questions. Scoring is three, two and one, Maximum score is 18 and minimum score is six. Visual acuity Performa consist of letters and numbers of different languages, 7 lines are there, going up letters size is increasing bottom six letters and top one letter is present. Visual Acuity is converted to Log MAR value. Demographic variables were Age, Gender, Gestational age at birth, Neonatal illness and Visual aid used, Father's occupation, Father's education, Mother's education, Mother's occupation, Family income, visual Medias available at home and Family food pattern.

Results

The outcome of the study was computed using SPSS package both descriptive and inferential statistics which are discussed under.

Demographic Characteristics of Child and Family

Includes 47 % of children belongs to the age group between 8-10 years and 63% of children were Female. A majority of the children 51.5 % born after > 37 completed weeks. 59% of children have no Neonatal Illness and 62% of children were not using any visual Aid. Family Profile include 44% of Fathers were Graduate, 36% have own business, 47% of mothers were graduate, 65% of mothers were house wife, 50% children from family income of Rs > 15000 per month and 76% of children were non vegetarian.

Visual Media Usage of Children

100 (72%) children used computer per day < 3

hours 94(62.7%) of children used Television > 6 hours per day. 111 (74%) children used Video Games less than 3 hours per day 87(58%) of children used < 20 hours per Week 35 (23.3%) of children used dim light and 43(28.7%) not using light while watching Television. 74(49.3%) of children sitting < 5 meters from the television. High usage of visual Medias 59% of children and 41% low usage of Visual Media. The mean value of visual media usage were 22.21.



Fig. 1: Distribution of Computer, Television, Video Games Usage per Day

Eating and Sleeping Habits of Children

Most of the children 107 (70.9%) of children slept 6-8 hours in the night time. 113 (74.8%) of children usual bed time is after 10 'o' clock. Majority of children 146(96.7%) eating food while watching TV, most of them consumed fruits and vegetables more than three times per week 104(68.9%). 72(47.7%) of children eating Fish and Milk product four times per week. 81(83.6%) playing out door games only in weekend days.

Visual Acuity of Children

21(13.8%) children had VA 6/9, 26 (17.1%) had 6/12 VA, 26(17.1%) children had 6/18, 24(15.8%)



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had VA, 6/24, 16(10.5%) VA 6/36, 18(11.8%) children had VA more than 6/60. The mean value of visual acuity was 0.4723, high usage 0.6209 and low usage 0.2554.

Vision Related Problems

One child has more than one problem, most of the children had dim vision, Eye strain, Head ache, Eye inflammation 18.4%, 17.8%, 17.1%, 13.8% and none of the children had Swelling and Night Blindness.



Fig. 3: Distribution of Vision Problems

Correlation between Visual Media Usage with Visual Acuity of Children

Positive correlation (r=0.79) significant at p<0.001] between the Visual Media Usage with Visual Acuity .The present study depicts high Usage of Visual Medias causing low Visual acuity in children.

Correlation between Visual Media Usage with Eye Problems

Correlation between VMU with eye problems of pain (0.308), Irritability (0.324), Itching (0.235), Redness (0.189), Watery Eye (0.359) shows significantly positive relationship between Visual Media usage with eye problems at p<0.05 level.

Association of Visual Media Usage with Child Profile and Family Profile

There is an association between Visual Media Usage with the gender- female children are more affected because of high usage (6.16) significant p<0.05, In family profile Fathers Education (7.84) and Family Income (5.99) showed significant at p<0.05.

Conclusion

- Children who were high VMU viewers had more visual related and other problems and low visual acuity when compared to children with normal viewing.
- Fathers those who are well educated and family income is more, the availability of visual media at home endangers children for high usage.

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A Pre Experimental Study to Assess the Effectiveness of Structured Teaching Programme on Level of Awareness among Adolescent Girls Regarding Complications and Prevention of Stress in Selected Hostels at Tamil Nadu

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Abstract

It is observed that suicidal rate is high among adolescence, that too in girls child due to high pressure from academic side and from parents side. The support system available for adolescence are not accessible if they stay in hostel that add their stress level more and complicate their coping mechanism. School-related situations such as tests, grades, studying, self-imposed need to succeed, as well as that induced by others are the main sources of stress for high school students Uncompensated stress leads to depression, anxiety, fear and anger that result in poor academic performance and suicidal risk. Adolescence knows which is stress provoking situations but we believe that the complication of stress is danger that need to be addressed quickly. So it is necessary for adolescent children having awareness about the complications of stress and its preventive measures. The present study investigates the awareness among the adolescent girls staying in hostel regarding complication of stress and prevention of stress. A total of 60 samples were taken by lottery method. Tool consists of two session, demographic variable and structured closed ended question. After ethical clearance and informed concern Post test was conducted after 7 days of STP. Tables and figures were used to describe the data. Thus the difference in the level of awareness was confirmed by Paired't' test value 8.89 which was significant at p< 0.001 level. It shows that the structured-teaching programme was effective and the subjects gained knowledge in complication and prevention of stress.

Keywords: Stress; Complications; Prevention; Adolescence; Structured Teaching Programme.

Introduction

Stress and anxiety in children and teenagers are just as prevalent as in adults. Negligence of parents, high expectations in academic or other performances, abused childhood, growing up tensions and demand for familial responsibility etc. the main causes of childhood and teen stress. Parents who are not emotionally available for their children or lack positive coping mechanisms themselves, often spur stress in their offspring. Kouzma and Kennedy reported that school-related situations – such as tests, grades, studying, self-imposed need to succeed, as well as that induced by others – are the main sources of stress for high school students . Stressed children show signs of emotional disabilities, aggressive behavior, shyness, social phobia and often lack interest in otherwise enjoyable activities. In a study Dawood (1995) found that students stress affects their academic performance. He further showed that the most frequently mentioned stressor by students was school and fear related stressors. Many teenagers tend to become non-conformist and fall prey to teenage depression in response to a variety of growing up anxieties. However, stress induced fears and anxiety in children adversely affects children's performances at various levels. Hodge (1996) investigated that prevalence of stress were found particularly among those students who were by their 40 S.K. Mohanasundari / A Pre Experimental Study to Assess the Effectiveness of Structured Teaching Programme on Level of Awareness among Adolescent Girls Regarding Complications and Prevention of Stress in Selected Hostels at Tamil Nadu

nature prone to anxiety.

Adolescence is a crucial phase in life and the presence of conditions like depression, anxiety and stress at this stage of life is a matter of concern. Depression in this population has been shown to be associated with increased risk of suicidal behavior, homicidal ideation, tobacco use and other substance abuse into adulthood. It has been noted that the majority of suicides in India are by those below the age of 30 years and also that around 90% of those who die by suicide have a mental disorder. Increasing concern has been expressed about the mental health of students in higher education. Concerns have been articulated by students themselves and by the academic staff who teach them. The World Health Report has quoted India as having a substantial prevalence of childhood and adolescent mental health disorders. The present study was carried out with an objective to study the levels of knowledge regarding complications of stress and it prevention, among school students the association with various socio demographic characteristics of the students. The hypothesis is students will have adequate awareness regarding complications of stress and its preventive measures and STP is effective in improving their awareness regarding complications and prevention of stress.

Objectives

- 1. To assess the level of awareness among adolescent girls regarding complications and prevention of stress
- To assess the effectiveness of STP on level of awareness among adolescent girls regarding complications and prevention of stress
- To associate the selected demographic variables with pre test awareness on complication and prevention of stress

Method

A quantitative approach, A pre experimental was conducted for the target population of adolescent girls with accessible population of girls staying in Chidambaram, Nandanar Govt girls hostel & K.G.Kandigai Govt Girls hostel Tamil Nadu in an urban setting. Inclusion criteria of the study are adolescent girls who are staying in the hostel during the period of the study, aged between 15 and 18 years & are studying between 9th to 12th standard. A total of 60 students were selected by simple random sampling technique by adopting lottery method. The conceptual framework for the study was derived from General Systems Theory. The self administered structure tool was prepared after an extensive review of literature and books and validity of the tool were obtained by experts in the field of nursing. The tool consists of 2 sessions. Session-I: are demographic variable. Session-II are structured closed ended questions (MCQ) (30) which focus on complications and prevention of stress. Pilot study was conducted for the 10% of total sample. The reliability and feasibility of the tools and study was observed. The actual data were collected from the sample after obtaining concern from the ample and ethical clearance from the hostel incharge. Structured teaching programme was conducted on next day of pre test. After 7 days post test was conducted. The data were complited & tabulated for data analysis. Escriptive and inferential statistics were used to analyze the data.

Result

Figure 1: Age: Out of 60 subjects, more than 43.33 % (26) of them belonged to the age group of 15 years, 23.33% (14) belonged to 16 years, 23.34% (14) belonged to 17 years, and 10% (6) belonged to 18 years.



Fig. 1: frequency distribution of the adolescent girls according to age



Fig. 2: frequency distribution of the adolescent girls according to educational status

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Figure 2: Educational status: A total of 12 students were studying 9th standard, 17 were studying 10th standard, 15 were studying 11th standard, and 16

were studying 12th standard.

Table 1 shows the distribution of demographic characteristics of the subjects.

Table 1: frequency	and percentage	distribution of	demographic	characteristics	of the	adolescent	girls	
								N = 60

S. No.	Demographic Variables	Number/Frequency	Frequency Percentage (%)
1	Religion		
	• Hindu	45	75.00
	Christian	10	16.67
	Muslim	05	08.33
2	Previous history of hostel stay		
	• Yes	0	0.00
	• No	60	100
3	Duration of hostel stay		
	• 1 year	20	33.33
	• 1 to 3 years	40	66.67
	• 4 to 7 years	0	0.00
	above 7 years	0	0.00
4	Place of living		
	• Rural	45	75.00
	• Urban	15	25.00
5	Educational status of the mother:		
	Uneducated	28	46.67
	Primary education	19	31.67
	Higher secondary education	08	13.33
	Graduate	05	08.33
6	Educational status of the father:		
	Uneducated	19	31.67
	Primary education	12	20.00
	Higher secondary education	15	25.00
	Graduate	14	23.33
7	Occupation of the mother:		
	 Unemployment 	23	38.33
	 Professional worker 	08	13.33
	 Non professional work 	29	48.34
8	Occupation of the father:		
	 Unemployment 	06	10.00
	 Professional worker 	17	28.34
	 Non professional worker 	37	61.66
9	Type of family		
	Joint family	16	26.60
	Nuclear family	44	73.34
10	No of siblings		
	• 0	05	08.33
	• 1	12	20.00
	• 2	23	38.33
	 3 and above 	20	33.34

- Religion: As for as the religion is concerned, majority 75% (45) of them were Hindu, 16.67% (10) of them were Christians and the remaining 8.33% (5) were Muslims.
- Previous history of hostel stay: While considering the previous history of hostel stay, it was found that none of them had stayed in any hostel previously.
- Duration of hostel stay: Regarding the present duration of hostel stay, 33.34% (20) of them were staying <1 year in the hostel, and remaining

66.67% (40) were staying 1 to 3 years in the hostel.

- Place of living: Regarding residency 45 of them came from rural area and remaining 15 of them came from urban area.
- Educational status of the parents: Majority of parents were uneducated, (mothers were 46.67% and fathers were 31.67%), minority of them were graduates (mother from 8.33% and fathers from 23.33%)
- Occupation of the mother: Regarding the occupational status of the parents, majorities

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were non professional workers, 6 were not working, and remaining 17 subject's fathers were professionals.

Type of family: Regarding family structure 16

samples were from joint family, and 44 subjects

were from nuclear family.

• No of siblings: While considering the number of siblings, 5 of them had no sibling, 12 had 1 sibling, 23 had 2 siblings and remaining 13 subjects had 3 and more siblings.

 Table 2: Frequency and percentage distribution of pre and post-test awareness of the adolescent girls regarding complication and prevention of stress
 N=60

S. No.	Level of awareness	Pre-test	knowledge	Post-test knowledge	
		No.	%	No.	%
1.	Inadequate awareness	37	61.7	3	5
2.	Moderately adequate awareness	21	35	8	13.3
3.	Adequate awareness	2	3.3	49	81.7
	Total	60	100	60	100

 Table 3: Comparison of mean and standard deviation of awareness score regarding various aspects of stress reduction techniques in pre and post-test
 N=60

Awareness	Pre test		Post test		Paired 't' test	'p' value	
	Mean	SD	Mean	SD		_	
Complication and prevention of stress	3.21	1.41	13.9	1.08	8.89	<0.001 (S)	

S- Significant

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 Table 4: Association of demographic variables with pre-test knowledge on complication and prevention of stress

 N=60

De	mographic variables	Mean	Standard deviation	Kruskal Wallis	'p' value
Ag	e				
•	15 years	25.04	6.45		
•	16 years	28.97	4.54	0.489	0.548
•	17 years	24.80	7.40		(NS)
•	18 years	21.8	5.24		· · ·
Re	ligion				
•	Hindu	26.4	6.10		
•	Christian	23.28	2.60	1.04	0.211
•	Muslim	19.75	1.03		(NS)
Ed	ucational Status				
•	9 th standard	27.7	4.35		
•	10 th standard	19.1	7.15	2.346	0.616
•	11 th standard	25.7	4.95		(NS)
•	12 th standard	26.6	6.94		
Ed	ucational status of the father				
•	Uneducated	23.09	6.49		
•	Primary education	24.9	4.93		
•	Higher secondary education	26.3	5	1.673	0.578
•	Graduate	27.7	7.73		(NS)
Ed	ucational status of the mother				
•	Uneducated	24.8	5.96		
•	Primary education	25.1	5.53		
•	Higher secondary education	27.3	6.41	0.92	0.724
•	Graduate	22.9	8,88		(NS)
Oc	cupation of the father:				
•	Unemployment	23.13	3.87		
•	Professional worker	19.5	6.63	0.847	0.452
•	Non professional worker	25.13	5.65		(NS)
Oc	cupation of the mother				
•	Unemployment	25.6	6.5		
•	Professional worker	24.5	7.60	1.21	0.682
•	Non professional worker	26.0	5.82		(NS)
No	of siblings				
•	0	23.02	3.98		
•	1	24.73	5.17	3.78	0.942
•	2	27.77	6.67		(NS)
٠	3 and above	24.11	5.59		

NS - Non Significant

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Table 2 reveals that 37 (61.7%) of adolescent girls had inadequate awareness, 21 (35%) of them had moderately adequate awareness, and only 2 (3.3%) had adequate knowledge on complications and prevention of stress in pre-test. In post-test 8 (13.3%) of them had moderately adequate awareness, 49 (81.7%) had adequate awareness and 3 (5%) had inadequate awareness.

It shows that the LCD teaching programme was very effective in improving the knowledge level of the adolescent girls regarding complication and prevention of stress.

Table 3 reveals that mean knowledge score in complication & prevention of stress was 3.21 with standard deviation of 1.41 in the pre-test. In the posttest the mean score was 13.9 with standard deviation of 1.08.

Thus the difference in the level of knowledge was confirmed by Paired 't' test value 8.89 which was significant at p < 0.001 level.

It shows that the structured-teaching programme was effective and the subjects gained knowledge in complication and prevention of stress.

Table 4 shows that the mean pre-test knowledge score obtained by the adolescent girls with the age group of 16 years had higher knowledge score. The Kruskal Wallis test shows that the age group of adolescent girls had no significant influence on the pre-test knowledge.

Further, the results revealed that the adolescent girls belonged to Hindu religion had a mean score of 26.4 with standard deviation of 6.10, Christian had a mean score of 23.8 with standard deviation of 2.6 and the Muslims had a mean score of 19.75 with standard deviation of 1.03.

The Kruskal Wallis' test infers that the religion of adolescent girls had no significant influence on the pre-test knowledge score.

Further, the results showed that the educational status of the adolescent girls also had no significant influence in the pre-test knowledge.

The above table shows that the mean score obtained by the samples of graduated father is 27.7 with standard deviation of 7.73. Where as the mean score obtained by the children of uneducated father is 23.09 with standard deviation of 6.49. The Kruskal Wallis test infers that there is no influence on the knowledge score of the adolescent girls with educational status of the father.

The result also showed that the educational status of the mother also had no significant influence in the pre-test knowledge level of the adolescent girls. The result also showed that the occupational status of the parents also had no significant influence in the pre-test knowledge.

The above table reveals that the adolescent girls who have 2 siblings had higher mean knowledge score of 27.77 with standard deviation of 6.67. The mean score of adolescent girls who had 1 sibling is 24.73. The adolescent girls who have 3 and above siblings had mean knowledge score of 24.11 with the standard deviation of 5.59. The adolescent girls who have no sibling had mean knowledge score of 23.02 with standard deviation of 3.98.

The Kruskal Wallis test infers that there is no significant influence in the knowledge level of adolescent girls with no of siblings.

The Kruskal Wallis test infers that there is no significant association between the demographic variables (Age, religion, educational status, occupation of the parents, educational status of the parents and number of siblings) and level of awareness regarding complication and prevention of stress.

Discussion

In the present study the above tables and figures it revealed that 37 (61.7%) of adolescent girls had inadequate awareness, 21 (35%) of them had moderately adequate awareness, and only 2 (3.3%) had adequate knowledge on complications and prevention of stress in pre-test. In post-test 8 (13.3%) of them had moderately adequate awareness, 49 (81.7%) had adequate awareness and 3 (5%) had inadequate awareness.

The mean knowledge score in complication & prevention of stress was 3.21 with standard deviation of 1.41 in the pre-test. In the post-test the mean score was 13.9 with standard deviation of 1.08.

Thus the difference in the level of knowledge was confirmed by Paired 't' test value 8.89 which was significant at p < 0.001 level.

It shows that the STP teaching programme was very effective in improving the knowledge level of the adolescent girls regarding complication and prevention of stress.

The Kruskal Wallis test infers that there is no significant association between the demographic variables (Age, religion, educational status, occupation of the parents, educational status of the parents and number of siblings) and level of awareness regarding complication and prevention

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of stress.

A similar study was investigated by Sibnath D, the academic stress and mental health of Indian high school students and the associations between various psychosocial factors and academic stress. A total of190 students from grades 11 and 12 (mean age: 16.72 years) from three government-aided and three private schools in Kolkata India were surveyed in the study. Data collection involved using a specially designed structured questionnaire as well as the General Health Questionnaire. Nearly twothirds (63.5%) of the students reported stress due to academic pressure - with no significant differences across gender, age, grade, and several other personal factors. About two-thirds (66%) of the students reported feeling pressure from their parents for better academic performance. The degree of parental pressure experienced differed significantly across the educational levels of the parents, mother's occupation, number of private tutors, and academic performance. In particular, children of fathers possessing a lower education level (non-graduates) were found to be more likely to perceive pressure for better academic performance. About one-thirds (32.6%) of the students were symptomatic of psychiatric caseness and 81.6% reported examination-related anxiety. Academic stress was positively correlated with parental pressure and psychiatric problems, while examination-related anxiety also was positively related to psychiatric problems. Academic stress is a serious issue which affects nearly two thirds of senior high school students in Kolkata. Potential methods for combating the challenges of academic pressure are suggested.

Recommendations

- At school, adolescents should be trained on how to manage stress and anxiety
- Knowledge about mental health and academic stress should be promoted among the parents of the adolescents and taught strategies to help improve the resilience and coping strategies of their children.

Conclusion

The mental health of students, especially in terms of academic stress and its impact has become a serious issue among researchers and policymakers because of increasing incidence of suicides among students across the globe. Unfortunately, the magnitude of mental health problems of children and adolescents has not yet been recognized sufficiently by the policy makers in many countries. Unexplained headaches, migraine and hypertension are becoming alarmingly common among teenagers often an outcome of their stressful lives. Even recreational activities like sports, music, painting or swimming have become as competitive as studies. Hostalization of children is trend now to succeed because of parents concern for the welfare of the children. The overall unemployment situation in India has also provoked parents to put pressure on their children for better performance. Some of the parents wish to fulfil their unfulfilled dreams through their children. All these put pressure on children and put them at the end of stress and related complication. This study assessed adolecenct girls awreness about the complication and prevention of stress. Potential methods for combating the challenges of academic and social pressures are suggested.

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Child Abuse and Neglect

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Introduction

The World Health Organization (WHO) defines child abuse and child maltreatment as "all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power [1]."

A Child Abuse and Neglect Child abuse is more than bruises and broken bones. While physical abuse might be the most visible, other types of abuse, such as emotional abuse and neglect, also leave deep, lasting scars. The earlier abused children get help, the greater chance they have to heal and break the cycle—rather than perpetuate it. By learning about common signs of abuse and what you can do to intervene, you can make a huge difference in a child's life.

Child abuse and neglect affect children's health now and later, and costs to our country are

Abstract

A Child Abuse and Neglect Child abuse is more than bruises and broken bones. While physical abuse might be the most visible, other types of abuse, such as emotional abuse and neglect, also leave deep, lasting scars. At least one in four children have experienced child neglect or abuse (including physical, emotional, and sexual) at some point in their lives, and one in seven children experienced abuse or neglect in the last year. The earlier abused children get help, the greater chance they have to heal and break the cycle—rather than perpetuate it. By learning about common signs of abuse and what you can do to intervene, you can make a huge difference in a child's life.

Keywords: Child Abus; Neglect Child; Emotional Abuse.

significant. Neglect, physical abuse, custodial interference, and sexual abuse are types of child maltreatment that can lead to poor physical and mental health well into adulthood. The physical, psychological, behavioural and economic consequences of child maltreatment are explained below.

Meaning of Child Abuse

Child abuse is more than bruises or broken bones. While physical abuse is shocking due to the scars it leaves, not all child abuse is as obvious. Ignoring children's needs, putting them in unsupervised, dangerous situations, or making a child feel worthless or stupid are also child abuse. Regardless of the type of child abuse, the result is serious emotional harm.

Neglect is the ongoing failure to meet a child's basic needs and is abuse. A child may be left hungry or dirty, without adequate clothing, shelter, supervision, medical or health care. A child may be put in danger or not protected from physical or emotional harm. They may not get the love, care and attention they need from their parents. A child who's neglected will often suffer from other abuse as well. Neglect is dangerous and can cause serious, longterm damage - even death.

Prevalence of Child Abuse and Neglect

- 1 in 4 children suffer abuse.
- An estimated 702,000 children were confirmed by child protective services as being victims of abuse and neglect in 2014 [1].
- At least one in four children have experienced child neglect or abuse (including physical, emotional, and sexual) at some point in their lives, and one in seven children experienced abuse or neglect in the last year [2].

Risk Factors of Child Abuse and Neglect

While child abuse and neglect occurs in all types of families – even in those that look happy from the outside – children are at a much greater risk in certain situations.

Domestic Violence

Witnessing domestic violence is terrifying to children and emotionally abusive. Even if the mother does her best to protect her children and keeps them from being physically abused, the situation is still extremely damaging. If you or a loved one is in an abusive relationship, getting out is the best thing for protecting the children.

Alcohol and Drug Abuse

Living with an alcoholic or addict is very difficult for children and can easily lead to abuse and neglect. Parents who are drunk or high are unable to care for their children, make good parenting decisions, and control often-dangerous impulses. Substance abuse also commonly leads to physical abuse.

Untreated Mental Illness

Parents who are suffering from depression, an anxiety disorder, bipolar disorder, or another mental illness have trouble taking care of themselves, much less their children. A mentally ill or traumatized parent may be distant and withdrawn from his or her children, or quick to anger without understanding why. Treatment for the caregiver means better care for the children.

Lack of Parenting Skills

Some caregivers never learned the skills necessary for good parenting. Teen parents, for example, might have unrealistic expectations about how much care babies and small children need. Or parents who were themselves victims of child abuse may only know how to raise their children the way they were raised. In such cases, parenting classes, therapy, and caregiver support groups are great resources for learning better parenting skills.

Stress and Lack of Support

Parenting can be a very time-intensive, difficult job, especially if you're raising children without support from family, friends, or the community or you're dealing with relationship problems or financial difficulties. Caring for a child with a disability, special needs, or difficult behaviours is also a challenge. It's important to get the support you need, so you are emotionally and physically able to support your child.

Types of Child Abuse

There are several types of child abuse, but the core element that ties them together is the emotional effect on the child. Children need predictability, structure, clear boundaries, and the knowledge that their parents are looking out for their safety. Abused children cannot predict how their parents will act. Their world is an unpredictable, frightening place with no rules. Whether the abuse is a slap, a harsh comment, stony silence, or not knowing if there will be dinner on the table tonight, the end result is a child that feel unsafe, uncared for, and alone.

Emotional Child Abuse

Sticks and stones may break my bones but words will never hurt me? Contrary to this old saying, emotional abuse can severely damage a child's mental health or social development, leaving lifelong psychological scars. Examples of emotional child abuse include:

- Constant belittling, shaming, and humiliating a child.
- Calling names and making negative comparisons to others.
- Telling a child he or she is "no good,"

"worthless," "bad," or "a mistake."

- Frequent yelling, threatening, or bullying.
- Ignoring or rejecting a child as punishment, giving him or her the silent treatment.
- Limited physical contact with the child no hugs, kisses, or other signs of affection.
- Exposing the child to violence or the abuse of others, whether it be the abuse of a parent, a sibling, or even a pet.

Child Neglect

A very common type of child abuse – is a pattern of failing to provide for a child's basic needs, whether it be adequate food, clothing, hygiene, or supervision. Child neglect is not always easy to spot. Sometimes, a parent might become physically or mentally unable to care for a child, such as with a serious injury, untreated depression, or anxiety. Other times, alcohol or drug abuse may seriously impair judgment and the ability to keep a child safe.

- Older children might not show outward signs of neglect, becoming used to presenting a competent face to the outside world, and even taking on the role of the parent. But at the end of the day, neglected children are not getting their physical and emotional needs met.
- Physical abuse involves physical harm or injury to the child. It may be the result of a deliberate attempt to hurt the child, but not always. It can also result from severe discipline, such as using a belt on a child, or physical punishment that is inappropriate to the child's age or physical condition.
- Many physically abusive parents and caregivers insist that their actions are simply forms of discipline – ways to make children learn to behave. But there is a big difference between using physical punishment to discipline and physical abuse. The point of disciplining children is to teach them right from wrong, not to make them live in fear.

Child Sexual Abuse

It's important to recognize that sexual abuse doesn't always involve body contact. Exposing a child to sexual situations or material is sexually abusive, whether or not touching is involved. While news stories of sexual predators are scary, what is even more frightening is that sexual abuse usually occurs at the hands of someone the child knows and should be able to trust most often close relatives. And contrary to what many believe, it's not just girls who are at risk. Boys and girls both suffer from sexual abuse. In fact, sexual abuse of boys may be underreported due to shame and stigma.

Effects on Child

All types of child abuse and neglect leave lasting scars. Some of these scars might be physical, but emotional scarring has long lasting effects throughout life, damaging a child's sense of self, ability to have healthy relationships, and ability to function at home, at work and at school. Some effects include:

- Lack of Trust and Relationship Difficulties. If you can't trust your parents, who can you trust? Abuse by a primary caregiver damages the most fundamental relationship as a child that you will safely, reliably get your physical and emotional needs met by the person who is responsible for your care. Without this base, it is very difficult to learn to trust people or know who is trustworthy. This can lead to difficulty maintaining relationships due to fear of being controlled or abused. It can also lead to unhealthy relationships because the adult doesn't know what a good relationship is.
- Core Feelings of Being "Worthless" or "Damaged." If you've been told over and over again as a child that you are stupid or no good, it is very difficult to overcome these core feelings. You may experience them as reality. Adults may not strive for more education, or settle for a job that may not pay enough, because they don't believe they can do it or are worth more. Sexual abuse survivors, with the stigma and shame surrounding the abuse, often especially struggle with a feeling of being damaged.
- Trouble Regulating Emotions. Abused children cannot express emotions safely. As a result, the emotions get stuffed down, coming out in unexpected ways. Adult survivors of child abuse can struggle with unexplained anxiety, depression, or anger. They may turn to alcohol or drugs to numb out the painful feelings.

Problem of Shame and Guilt

Aside from the physical damage that sexual abuse can cause, the emotional component is powerful and far-reaching. Sexually abused children are tormented by shame and guilt. They may feel that they are responsible for the abuse or somehow brought it upon themselves. This can lead to self-loathing and sexual problems as they grow older – often either excessive promiscuity or an inability to have intimate relations.

The shame of sexual abuse makes it very difficult for children to come forward. They may worry that others won't believe them, will be angry with them, or that it will split their family apart. Because of these difficulties, false accusations of sexual abuse are not common, so if a child confides in you, take him or her seriously. Don't turn a blind eye!

Alarming Signs

The earlier child abuse is caught, the better the chance of recovery and appropriate treatment for the child. Child abuse is not always obvious. Some of the common warning signs of child abuse and neglect, we can catch the problem as early as possible and get both the child and the abuser the help that they need.

- ▲ Warning signs of emotional abuse and neglect
- Excessively withdrawn, fearful, or anxious about doing something wrong.
- Shows extremes in behaviour (extremely compliant or extremely demanding; extremely passive or extremely aggressive).
- Doesn't seem to be attached to the parent or caregiver.

Acts either inappropriately adult (taking care of other children) or inappropriately infantile (rocking, thumb-sucking, throwing tantrums).

- ▲ Warning signs of physical abuse child
- Frequent injuries or unexplained bruises, welts, or cuts.
- Is always watchful and "on alert," as if waiting for something bad to happen.
- Injuries appear to have a pattern such as marks from a hand or belt.
- Shies away from touch, flinches at sudden movements, or seems afraid to go home.
- Wears inappropriate clothing to cover up injuries, such as long-sleeved shirts on hot days.
- ▲ Warning signs of neglect in child
- Clothes are ill-fitting, filthy, or inappropriate for the weather.
- Hygiene is consistently bad (unbathed, matted and unwashed hair, noticeable body odor).

- Untreated illnesses and physical injuries.
- Is frequently unsupervised or left alone or allowed to play in unsafe situations and environments.
- Is frequently late or missing from school
- ▲ Warning signs of sexually abuse child
- Trouble walking or sitting.
- Displays knowledge or interest in sexual acts inappropriate to his or her age, or even seductive behaviour.
- Makes strong efforts to avoid a specific person, without an obvious reason.
- Doesn't want to change clothes in front of others or participate in physical activities.
- An STD or pregnancy, especially under the age of 14.
- Runs away from home.

Myths and Facts of Child Abuse and Neglect

Myths

- Physical abuse is just one type of child abuse. Neglect and emotional abuse can be just as damaging, and since they are more subtle, others are less likely to intervene.
- While it's easy to say that only "bad people" abuse their children, it's not always so black and white. Not all abusers are intentionally harming their children. Many have been victims of abuse themselves, and don't know any other way to parent. Others may be struggling with mental health issues or a substance abuse problem.
- Child abuse doesn't only happen in poor families or bad neighbourhoods. It crosses all racial, economic, and cultural lines. Sometimes, families who seem to have it all from the outside are hiding a different story behind closed doors.

Fact

While abuse by strangers does happen, most abusers are family members or others close to the family. It is true that abused children are more likely to repeat the cycle as adults, unconsciously repeating what they experienced as children. On the other hand, many adult survivors of child abuse have a strong motivation to protect their children against what they went through and become excellent parents.

How to Identify Abusive Behaviour in Yourself?

- Do you see yourself in some of these descriptions, painful as it may be? Do you feel angry and frustrated and don't know where to turn? Raising children is one of life's greatest challenges and can trigger anger and frustration in the most even tempered. If you grew up in a household where screaming and shouting or violence was the norm, you may not know any other way to raise your kids.
- Recognizing that you have a problem is the biggest step to getting help. If you yourself were raised in an abusive situation, that can be extremely difficult. Children experience their world as normal. It may have been normal in your family to be slapped or pushed for little to no reason, or that mother was too drunk to cook dinner. It may have been normal for your parents to call you stupid, clumsy, or worthless. Or it may have been normal to watch your mother get beaten up by your father.
- It is only as adults that we have the perspective to step back and take a hard look at what is normal and what is abusive. Read the above sections on the types of abuse and warning signs. Do any of those ring a bell for you now? Or from when you were a child? The following is a list of warning signs that you may be crossing the line into abuse:

How do you Know when you've Crossed The Line?

- You can't stop the anger. What starts as a swat on the backside may turn into multiple hits getting harder and harder. You may shake your child harder and harder and finally throw him or her down. You find yourself screaming louder and louder and can't stop yourself.
- You feel emotionally disconnected from your child. You may feel so overwhelmed that you don't want anything to do with your child. Day after day, you just want to be left alone and for your child to be quiet.
- Meeting the daily needs of your child seems impossible. While everyone struggles with balancing dressing, feeding, and getting kids to school or other activities, if you continually can't manage to do it, it's a sign that something might be wrong.
- Other people have expressed concern. It may be easy to bristle at other people expressing concern. However, consider carefully what they have to say. Are the words coming from someone you

normally respect and trust? Denial is not an uncommon reaction.

If you have a history of child abuse, having your own children can trigger strong memories and feelings that you may have repressed. This may happen when a child is born, or at later ages when you remember specific abuse to you. You may be shocked and *overwhelmed by your anger*, and feel like you can't control it. But you can learn new ways to manage your emotions and break your old patterns.

Remember, you are the most important person in your child's world. It's worth the effort to make a change, and you don't have to go it alone. Help and support are available.

Tips for Changing your Reactions

- Learn what age appropriate is and what is not. Having realistic expectations of what children can handle at certain ages will help you avoid frustration and anger at normal child behaviour. For example, new-borns are not going to sleep through the night without a peep, and toddlers are not going to be able to sit quietly for extended periods of time.
- Develop new parenting skills. While learning to control your emotions is critical, you also need a game plan of what you are going to do instead. Start by learning appropriate discipline techniques and how to set clear boundaries for your children. Parenting classes, books, and seminars are a way to get this information. You can also turn to other parents for tips and advice.
- Take care of yourself. If you are not getting enough rest and support or you're feeling overwhelmed, you are much more likely to succumb to anger. Sleep deprivation, common in parents of young children, adds to moodiness and irritability – exactly what you are trying to avoid.
- Get professional help. Breaking the cycle of abuse can be very difficult if the patterns are strongly entrenched. If you can't seem to stop yourself no matter how hard you try, it's time to get help, be it therapy, parenting classes, or other interventions. Your children will thank you for it.
- Learn how you can get your emotions under control: The first step to getting your emotions under control is realizing that they are there. If you were abused as a child, you may have an especially difficult time getting in touch with your range of emotions. You may have had to

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deny or repress them as a child, and now they spill out without your control. Helping an abused or neglected child.

What should you do if you suspect that a child has been abused? How do you approach him or her? Or what if a child comes to you? It's normal to feel a little overwhelmed and confused in this situation. Child abuse is a difficult subject that can be hard to accept and even harder to talk about.

Conclusion

We can make a great difference in the life of an abused child, especially if we take measures to stop the abuse at the earliest.

While interacting with an abused child, the best thing we can provide is reassurance and unconditional support. It is important to identify child abuse and neglect and take appropriate action at the earliest for better compliance of abused and neglected victims.

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Is Sleep of Child to Be Assessed?

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Introduction

The growth and development of child depends on the nutrition and sleep. Sleep is an important physiological need of a child. Sleep improves and promotes alertness, memory, creativity and performances. The performance of a children who is getting adequate sleep is better than who is getting less adequate sleep that is why the observation of sleep in necessary.

Each child has different sleep needs.

Age Recommended Note recommended

0-3 months, 4-11 months, 1-2 years, 3-5 years, School aged children 6- 13 years, Adolescence 14-17 years, Young adults 18- 25 years, 14 to 17 hrs. 12 to 15 hrs. 11 to 14 hrs. 10 to 13 hrs. 9 to 11 hrs. 8 to 10 hrs. 7 to 9 hrs. Less than 11 hrs. More than 19 hrs. Less than 10 hrs. More than 18 hrs. Less than 9 hrs. More than 8 hrs. Less than 8 hrs. More than 14 hrs. Less than 7 hrs. More than 11 hrs. Less than 7 hrs. More than 11 hrs. Less than 6 hrs. More than 11 hrs.

Abstract

In human life growth and development is considered, childhood is a period is considered as golden period. For this golden period most of the time it needs nutrition and sleep. Sleep which maintains the human life in a cycle. So this sleep considered a very important basic need which should be assessed and taken care whenever deviation persists.

Keywords: Sleep; Sleep and Children; Sleep Disorders; Sleep Deprivations.

Sleep and Disorders

- Attention deficit hyperactivity disorder (ADHD)
- Gastroesophageal reflux disease (GERD)
- Pervasive developmental disorders
- Mental retardation
- Down syndrome
- Prader-Willi syndrome
- Smith-Magenis syndrome
- Tourette disorder
- Nocturnal asthma
- Depressive disorders
- Anxiety disorders
- Mania
- Neuromuscular disorders
- Nocturnal seizures
- Kleine-Levin syndrome or periodic hypersomnia
- Chronic fatigue syndrome
- Headaches
- Blindness with associated sleep disorder

Prevalence

Surveys report that 20–25% of youths have some type of sleep problem. The following are commonly reported in children aged 2–15 years:

- Nightmares (30%) are more common in younger youths
- Sleep walking with at least more than 1 episode occurs in 25-30% of youths and is most common in children aged 3-10 years
- Insomnia occurs in 23% of youths
- Enuresis rates decrease from 8% in children aged 4 years to 4% in children aged 10 years
- Bruxism is reported in 10% of youths and may occur in people of any age
- Grinding and clenching teeth at night is reported in 5-8% of adults
- Sleep rocking or head banging is reported in 5% of youths, with head banging being common in infants and in children aged 9 months to 12 years
- OSAS is the most common reason for sleep laboratory referral and affects an estimated 1 to 4% of children [8].
- Narcolepsy (0.01-0.20%) may be underestimated in children because a classic tetrad of symptoms is uncommon in this age group; only about 10% of children show all the symptoms: excessive daytime sleepiness, cataplexy, hypnagogic hallucinations, and sleep paralysis; semipurposeful automatic behavior, disrupted nocturnal sleep, sudden onset of weight gain, obstructive sleep apnea, and, especially, anosmia, should increase clinical suspicion [10].
- Bedtime resistance in school-aged children has been reported at 15% and is often associated with limit-setting disorder

Symptoms of a Sleep Disorder

Symptoms that call for a sleep evaluation can include:

- Excessive snoring
- Lapses in breathing/gasping for air
- Bed wetting in children older than 6 years old
- Multiple nighttime arousals
- Difficulty initiating or maintaining sleep
- Restless sleep
- Hyperactivity
- Unusual movements/behavior during sleep

- A decline in school performance
- Excessive drowsiness/daytime sleepiness
- Sleep walking
- Sudden inability to move



Nurse's role in launch sleep nurse role in improve the habit of sleep in children is a part of health education and make a parents to understand about the importance of sleep as per their age of children.

When a child come to OPD or IPD, the nurses have the responsibility to ask about the sleep and its pattern, habit of a particular child. The nurse must educate the mother to keep the bedtime routine are

Because human beings spend a third of their time sleeping, it is essential to emphasize the need for good sleep hygiene to children, adolescents, and their families. Sleep hygiene includes the following:

- 1. Keeping the room quiet, dark, and comfortable
- 2. Practicing a simple bedtime ritual that includes voiding
- 3. Limiting time spent in bed
- 4. Not eating or drinking heavily for about 3 hours before bedtime
- 5. Maintaining the bedroom for sleeping only
- 6. Removing distractions, such as television
- 7. Avoiding medications
- 8. Considering the effect of sleep partners (including pets)
- 9. Maintaining a consistent sleep schedule
- 10. Avoiding naps

- 11. Exercising regularly
- 12. Taking a hot bath or drinking something warm before bedtime
- 13. Regular time to go to bed with the relaxing experience without T.V.

Sleep Deprivation to be Notified by Parents

- 1. Nightrrnarce
- 2. Sleep terrors/sleep walking
- 3. Sleep apnea
- 4. Narcolepsy

Sleep Apnea

About 3 percent to 12 percent of children snore, while sleep apnea syndrome affects 1 percent to 10 percent of children. The most common reasons for sleep apnea in children are enlarged tonsils or obesity.

Symptoms Include

Snoring, restlessness, pauses in breathing, frequent awakenings, and daytime sleepiness.

Restless Sleep/Periodic Limb Movement Disorder

Restless sleep can be a sign of periodic limb movement disorder. Some research has suggested an association between ADHD and periodic limb movement disorder. In some cases, it is caused by iron deficiency.

Symptoms Include

Poor sleep and subsequent daytime drowsiness - particularly limp hands and feet.

Hypersomnia: Hypersomnia is a relatively rare sleeping disorder affecting under 1 percent of the population. It is slightly more common in females than in males and typically starts in early adulthood. While we do see some cases, it is very rarely found in children and slightly more commonly in teenagers.

Symptoms Include: Long periods of sleep often in excess of 10 hours, difficult to wake up from a deep sleep, fatigue during the day, feel compelled to nap multiple times even in socially unacceptable places.

Insomnia: Insomnia in the pediatric population is very different than insomnia in the adult population. Although both involve sleeplessness, the causes vary significantly. Although parents often want to turn to a prescription to treat their child's insomnia, it is much more important to look for any underlying medical or psychological problems that may need to be treated first.

Symptoms Include: Irritability, mood swings, hyperactivity, depressed mood, aggressiveness.

Narcolepsy: Narcolepsy is a chronic sleep disorder resulting from the brain's inability to regulate sleepawake cycles. At various times throughout the day, children with narcolepsy experience the fleeting urge to fall asleep for periods lasting from a few seconds to several minutes.

Symptoms Include: Excessive and overwhelming daytime sleepiness, sudden ability to move, sleep paralysis, hallucinations upon awakeing or as falling asleep, and suprisingly, insomnia at typical socially accepted bedtimes.

Nightmares/Night Terrors: Nightmares are most common among preschoolers (children aged 3-6 years) because this is the age at which normal fears develop and a child's imagination is very active. The child may dream about danger or a scary situation. Nightmares may involve disturbing themes, images or figures such as monsters, ghosts, animals or bad people.

Symptoms Include: Night sweats, screaming, enlarged pupils, heavy breathing, confusion, fatigue, memory loss.

REM Sleep Behaviour Disorder (RBD): In a child with REM sleep behavior disorder (RBD), the paralysis that normally occurs during REM sleep is incomplete or absent, allowing the child to "act out" his or her dreams. RBD is characterized by the acting out of vivid, intense and violent dreams. It is most often found in males, but overall is a very unusual diagnosis in children.

Symptoms Include: Talking, yelling, punching, kicking, sitting, jumping from bed, arms flailing, and grabbing while asleep.

Sleep Paralysis: Sleep paralysis is a temporary phenomenon which occurs either just after waking up from sleep or before going into deep sleep where, for a certain period of time, there are delayed or limited responses to brain commands. Eventually the brain restores order and normal body functions return, thus ending of the period of paralysis. While associated with narcolepsy, it is also seen as an independent, normal feature of sleep. It also runs in some families.

Symptoms Include: Lack of energy, irritability, mood swings.

Enuresis/Bed wetting: Recent findings show children with sleep apnea are at greater risk for nocturnal enuresis (bed wetting) than children without sleep apnea. Although it is very common, children with sleep apnea may wet the bed because they do not get restful sleep and therefore have a decreased arousal response that prevents them from awakening when their bladders are full.

Symptoms include: Urination in bed, fullness of the bladder.

Somniloquy/Sleep Talking: Otherwise known as sleep talking, this condition refers to talking aloud while asleep. It can be quite loud, ranging from simple sounds to long speeches, and can occur many times during sleep. Listeners may or may not be able to understand what the person is saying. It is very common and is reported in 50 percent of young children, with most of them outgrowing it by puberty.

Symptoms include: Talking during sleep, child usually does not remember doing this.

Somnambulism/Sleep Walking: Otherwise known as sleep walking, somnambulism is characterized by walking while asleep. On occasion, nonsensical talking may occur while sleepwalking. The person's eyes are commonly open, but have a characteristic glassy "look right through you" characteristic. This activity most commonly occurs during middle childhood and young adolescence. Approximately 15 percent of children between 4 and 12 years of age will experience sleepwalking.

Symptoms Include: Walking during sleep, child usually does not remember the event.

Delayed Sleep Phase Syndrome (DSPS): A child or teenager who remains awake at least two hours past their usual bedtime because they are unable to fall asleep may have delayed sleep phase syndrome (DSPS). DSPS usually starts during the teen years and affects about 7 percent (1 out of 15) of teens.

Symptoms Include: Trouble falling asleep at a usual bedtime, difficulty waking up in the morning, daytime sleepiness.

Conclusion

The healthy sleep habit helps to build a good child. The sleep deprivations in children can be helped initially with changes to environment and habits surrounding bedtime

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Batten Disease

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Abstract

Batten disease is extremely rare juvenile inherited disorder but it is the most common of neuronal ceroid lipofuscinoses (NCLs). It is fatal disorder that affects the nervous system. After 4 to 6 years of normal development, children with this condition develop progressive vision loss, intellectual and motor disability, behavior and personality changes, speech difficulties, and seizures. Most people with Batten disease die in their teens or early twenties. it can be diagnosed with help of Fluorescent deposits, Visual Evoked Potentials and Electroretinograms, Blood tests, Urine tests, Skin or tissue sampling, Electroencephalogram (EEG), Brain scans, Measurement of enzyme activity and DNA analysis. There is cure for Juvenile Batten disease. Therefore specialist symptom management and therapy is essential to assist in maintaining a good quality of life for children and their families. Holistic support for parents, siblings and wider family members is extremely important throughout their journey.

Keywords: Juvenile Batten Disease; Inherited Disorder; Neuronal Ceroid Lipofuscinoses (NCLs).

Introduction

Juvenile Batten disease is one of a group of progressive degenerative neurometabolic disorders, known as the neuronal ceroid lipofuscinoses (NCLs). NCLs are characterized by genetic mutations which disrupt cells' ability to dispose of wastes, resulting in the abnormal accumulation of certain proteins and lipids (fats) within the nerve cells of the brain and other tissues of the body resulting in progressive neurological impairment including developmental regression, seizures, blindness, behavior changes and dementia. Neuronal Ceroid Lipofuscinoses (NCLs) is commonly referred to as Batten disease. The Neuronal Ceroid Lipofuscinoses (NCLs) denote several different genetic life-limiting neurodegenerative diseases that share similar features. Batten disease is named after the British

paediatrician who first described it in 1903 by Dr Frederik Batten.. Although Batten disease is the *juvenile* form of NCL, most doctors use the same term to describe all forms of NCL.

Synonyms

Spielmeyer-Vogt-Sjögren-Batten disease, Batten-Mayou disease, Vogt-Spielmeyer disease, neuronal ceroid lipofuscinoses (NCLs).

Common Forms of Batten Disease

There are many forms of NCL. Mutations in at least eight different genes are known to cause Batten disease. There are four main types of Batten disease each was named according to its age of onset. The symptoms of each are similar, but the age of onset and rate of progression vary.



Fig. 1: Forms of beaten disease

Table	1:	Forms	of	Batten	Diseases
l able	1:	Forms	or	Batten	Diseases

- Infantile NCL begins before age 2 and progresses quickly; most children live into their midchildhood years.
- 2. Late infantile NCL begins between 2 to 4 years of age; the normal lifespan is 8 to 12 years.
- 3. Juvenile NCL begins between ages 5 and 8; the normal lifespan is teens to early 20s.
- 4. Adult NCL usually begins before age 40; the lifespan varies.

However, several variant late forms were discovered complicating the matter. It wasn't until the first genes associated with Batten disease were discovered that researchers learned that different mistakes in the same gene can result the same disease with various ages of onset. Like mistakes in the *CLN1* gene can cause disease beginning in the infantile, late infantile, juvenile or adult periods.

Classic name	Gene	Gene make	Reported forms and age of onset
Infantile BD	CLN1 or PPT1	Soluble lysosomal enzyme (palmitoyl protein thioesterase 1)	CLN1 disease, infantileCLN1 disease, late infantileCLN1 disease, juvenileCLN1 disease, adult
Late infantile BD	CLN2 or TPP1	Soluble lysosomal enzyme (tripeptidyl peptidase 1)	CLN2 disease, late infantileCLN2 disease, juvenile
Juvenile BD	CLN3	Lysosomal & multi-organelle transmembrane protein (CLN3)	CLN3 disease, juvenileCLN3 disease, adult
Adult BD (or Parry or Kufs type A)	CLN4 or DNAJC5	Soluble cysteine string protein alpha (CSPa) chaperone protein affecting synapses (CSPa)	CLN4 disease, adult autosomal dominant
Finnish Variant late infantile BD	CLN5	Soluble lysosomal protein, but not an enzyme (CLN5)	CLN5 disease, late infantileCLN5 disease, juvenileCLN5 disease, adult
Variant of the late infantile BD	CLN6	Transmembrane protein, Endoplasmic Reticulum (ER) (CLN6)	CLN6 disease, late infantile
Adult, Kufs Turkish Variant late infantile BD	CLN7 or MFSD8	Major facilitator superfamily domain containing protein 8, Transmembrane protein;	CLN6 disease, adult Kufs type A CLN7 disease, late infantile
Northern Epilepsy Variant late infantile	CLN8	Endolysosomal transporter (CLN7/MFSD8) Transmembrane protein; ER, ER-Golgi intermediate complex (CLN8)	CLN8 disease, late infantileCLN8 disease, EPMR
BD Late Infantile NCL - Congenital BD	CLN10 or CTSD	Soluble lysosomal enzyme (Cathepsin D)	CLN10 disease, congenitalCLN10 disease, late infantileCLN10 disease,
	CLN11 or GRN	Progranulin	juvenileCLN10 disease, adult CLN11 disease, adultHeterozygous mutations cause frontotemporal lobar dementia
	CLN12 or ATP13A2	P-type ATPase	CLN12 disease, juvenileMutations also cause Kufor-Rakeb syndrome
Adult onset BD (or Kufs Type B)	CLN13 or CTSF	Soluble lysosomal enzyme (Cathepsin F)	CLN13 disease, adult Kufs type B
	CLN14 or KCTD7	Potassium channel tetramerization domain- containing protein 7	CLN14 disease, infantileMutation also causes progressive myoclonic epilepsy-3
Infantile Osteopetrosi	CLCN7 encodes for CLC7	containing protoner.	Frogroom e my outside tynepoy o

Incidence

- Its exact prevalence is unknown.
- Juvenile Batten disease is the most common type of NCL,
- Commonly seen are 5 to 10 years old children.
- One in every 50,000 births in the United States.

- Collectively, all forms of NCL affect an estimated 1 in 100,000 individuals worldwide.
- Batten disease is more common in parts of northern Europe, such as Sweden or Finland. where approximately 1 in 12,500 individuals are affected.

Genetic Pattern of Batten Disease

The NCLs are caused by abnormal genes, which are unable to produce the required proteins. As a result, the cells do not work properly and this leads to the development of symptoms associated with these diseases. Juvenile Batten diseases are mostly caused by mutations in the *CLN3* gene. A small percentage of cases are caused by mutations in other genes. This gene provides instructions for making a protein whose function is unknown.

Inheritance of Batten Disease

Batten disease is an autosomal recessive disorder, meaning that it only occurs in a child if both parents carry the genes for the disease.

A child born to parents, who both carry the autosomal recessive mutation in the relevant gene, has a 25% (1 in 4) chance of inheriting the abnormal malfunctioning genes from both parents and developing a form of Batten disease. They will have a 50% (1 in 2) chance of inheriting one abnormal gene, which would make them a carrier who is unaffected by the disease. There is a 25% (1 in 4) chance of the child being born with two normal genes and therefore being non-affected (not a carrier).



Fig. 2: Inheritance of batten disease:

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When it is known that both parents are carriers of the abnormal gene, we refer to there being a 2 in 3 chance of a child being a carrier, once it is established that they are unaffected by the disease.

If a child has only one parent with the gene, that child is considered a carrier and may pass the gene on to his own child, causing Batten disease if his partner carries the gene as well.

With any pregnancy, the probability of a child inheriting one or both genes from their parents is the same each time, irrespective of any sibling's status.

Expected Symptoms

These disorders all affect the nervous system and typically cause progressive problems with vision, movement, and thinking ability. The different types of NCLs are distinguished by the age at which signs and symptoms first appear. Some people refer to the entire group of NCLs as Batten disease, while others limit that designation to the juvenile form of the disorder.

Most people with juvenile Batten disease live into their twenties or thirties.

Children with juvenile Batten disease experience most or all of these symptoms in the following and sometimes overlapping order. However, each child is different so the exact onset and severity of symptoms cannot be predicted.



Fig. 3: Symptoms of Batten disease

 Blindness or vision problems in previously healthy children between 5 and 10 years old. Vision impairment is often the first noticeable sign of juvenile Batten disease, beginning between the ages of 4 and 8 years. Vision loss tends to progress rapidly, eventually resulting in blindness within 10 years.

- 2. After vision impairment has begun, children with juvenile Batten disease begin to fall behind in school and lose previously acquired skills (developmental regression), Intellectual decline and disability. Inability to keep up with classmates, usually beginning with the ability to speak in complete sentences. Affected children have difficulty learning new information.
- 3. Seizures usually begin about 9 years old but can develop at any time during the disease.
- 4. Subtle to more pronounced personality changes and behavioral problems beginning age 6.
- 5. Echolalia (repetitive speech) followed by a loss of speech.
- 6. Dementia, Psychosis and sometimes hallucinations.
- 7. Beginning usually in their teens, affected children lose motor skills starting with movement abnormalities that include rigidity or stiffness, slow or diminished movements (hypokinesia), ataxia, Parkinsonism and stooped posture. Over time, they lose the ability to walk or sit and require wheelchair assistance.
- 8. Potential cardiac involvement in the late teens to early 20s.
- 9. Affected children may have difficulty sleeping that begin in mid- to late childhood.
- 10. Premature death in the late teens to early 20s



Fig. 4: Diagnostic measures

Diagnostic Methods

Juvenile and other forms of Batten disease can be diagnosed with help of combination of The following tests.

- 1. *Fluorescent Deposits:* The accumulation of autoflourescent ceroid lipofuscin deposits throughout the body is a hallmark sign of juvenile Batten disease. These deposits can sometimes be detected by visually examining the back of the eye. Over time, these deposits appear more pronounced, the thickness of their retina is reduced, and opthamologists see circular bands of different shades of pink and orange at the optic nerve and retina in the back of the eye. Doctors call this a "bull's eye."
- 2. Visual Evoked Potentials and Electroretinograms: These are recordings of electrical signals in the visual processing center of the brain. Several forms of NCL show some type of abnormality in these signals.
- 3. *Blood tests:* These tests can detect abnormalities that may indicate juvenile Batten disease, such as abnormal white blood cells (vacuolated lymphocytes), which are common in several metabolic disorders.
- 4. *Urine tests:* These tests can detect the presence of elevated levels of a substance called dolichol that is found in the urine of many patients with NCL.
- 5. Skin or tissue sampling: The accumulation of ceroid lipofuscin deposits throughout the body is a hallmark sign of Lysosomal Storage Diseases. These deposits can be detected by viewing skin cells under a microscope or in some cases, by visually examining the back of the eye.
- 6. *Electroencephalogram (EEG):* An EEG uses special patches placed on the scalp to record electrical activity inside the brain. This helps doctors see telltale patterns in the brain's electrical activity that suggest a patient has seizures and whether those seizures are typical of juvenile Batten disease or one of the other NCLs.
- 7. *Brain scans:* Imaging can help doctors look for changes in the brain's appearance. Two commonly used imaging techniques are computed tomography, or CT, and magnetic resonance imaging, or MRI. Both are sophisticated technologies that may be able to detect that certain brain areas are shrinking in NCL patients.
- 8. *Measurement of enzyme activity:* In several NCLs such as the Infantile and Late Infantile (not Juvenile) forms, certain enzymes are greatly

reduced or totally absent. Measuring the level of these enzymes in white blood or skin cells can separate JNCL from enzyme-deficient NCLs.

 DNA analysis: Screening DNA blueprints obtained from blood or skin samples for mistakes in one or more of the 14 genes associated with NCL is a definitive method of diagnosing NCLs.

Inference

There can often be difficulty seeing the signs described above. For example, the interior surface of the eye can appear normal early in the disease when auto flourescent deposits are very small. Vacuolated lymphocytes and dolichols may be present at levels too low to detect in blood or urine. The only definitive diagnosis for genetic diseases like Batten is a DNA test.

Treatment

Recently there is no cure for juvenile batten disease and but treatments do exist to manage the symptoms and make the child more comfortable and supportive therapy is much essential to assist in maintaining a good quality of life for children and their families. Seizures can be controlled with antiseizure medications, and other medical problems can be treated as needed. Physical and occupational therapy can help the patient hold on to physical functioning as long as possible before the muscles atrophy.

Some studies have shown early data that doses of Vitamin C and Vitamin E can help slow the disease, though no treatment has been able to stop it from being fatal.

Comprehensive and holistic support for child, parents, siblings and wider family members is extremely important throughout their period of survival.

Recent developments in gene therapy, enzyme replacement, and drug discovery are making clinical trials for treatments in various forms of Batten disease possible.

Genetic Consideration

After knowing that a child or young person has a form of NCL some families will have younger siblings who may be affected but have not displayed any symptoms. It may also be possible that older unaffected siblings are carriers of the disease and may want to understand how this may affect their family choices when they become older. When only one parent is a carrier of the abnormal gene, and the other is non-affected, there is a 50% chance that any child will be an unaffected carrier. In this case if parents are considering having additional children, they can access specialist advice and support from their local clinical genetics service following a referral from their Gene product. Prenatal testing may be possible in the early stages of any future pregnancy.

Practical Implications for Families

As the illness progresses, special equipments and assistive devices will become necessary.

Items are likely to include specialist seating, buggies/wheelchairs, supportive aids and equipment for visual impairment, bathing and toileting aids, hoisting equipment and a specialist bed/mattress.

Made changes in the home environment. So that it can enable the family to appropriately care for an child with the disease. These may include installing ramps, widening doorways and providing suitable floor surfaces. A purpose-built wet room with a specialist bath or shower is commonly needed and there are various other aspects that will require consideration.

Family needs continuous educational support from various professionals

Specialist support and possibly schools or colleges will often play a role at some point in each individual's journey.

Juvenile Batten disease will cause significant financial challenges as well as having emotional challenges. Many parents find they have to take on a full-time caring role, which understandably can add to the economic as well as emotional strain.

Support groups such as the Batten Disease Support and Research Association provide support and information on treatments and research. Meeting other families who have gone through the same thing or are going through the same stages can be a great support while coping with Batten disease.

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Acquired Tracheo Esophageal Fistula: A Clinical Case report

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Abstract

A trachea esophageal fistula (TEF) is a congenital or acquired communication between the trachea and esophagus. TEFs often lead to severe and fatal pulmonary complications. It is a life threatening condition & usually occurs secondary to trauma or invasion of anatomic structures in the mediastinum by neoplasm and foreign bodies. It is uncommon for infants to ingest articles large enough to produce esophageal damage. Failure to diagnose foreign body ingestion at time can allow time for erosion into the wall of the esophagus with subsequent severe to profound injury to the esophagus, the trachea or both. Esophageal impacting of button batteries must be distinguished from impacting of other foreign bodies because of their severe complications. Button batteries represent a low percentage of all foreign bodies swallowed by children and esophageal location is even less frequent. Swallowed button batteries rarely remain in esophagus, Injuries can take place even after few hours; and therefore, endoscopy must be performed as soon as possible. We present a case of battery ingestion in a one-year-old infant resulting in acquired TEF. The history, diagnostic and surgical management was stressed in this case report.

Keywords: Acquired Trachea Esophageal Fistula; Infant; Battery Ingestion; Rigid Broncoscopy.

Introduction

Foreign body ingestion in children is a very common problem. It is estimated that 80% of all cases of swallowed foreign bodies occur in children, mainly between 6 months and 3 years of age. More than 90% of swallowed batteries pass through the gastrointestinal (GI) tract and do not cause a problem. Only, a minimum percentage of them remain in esophagus; moreover, these cases are developed with severe damage and later complications. Certain foreign bodies might cause severe injuries either because of their characteristic features or because of the level they become lodged at. An estimated 40 percent of foreign body ingestions in children are not witnessed, and in many cases, the child never develops symptoms. A retrospective review found that 50 percent of children with confirmed foreign body ingestions were asymptomatic. The incidence of button battery ingestion is about 10 cases in every million people every year, which is very low. If a battery becomes impacted in the esophagus, it may penetrate the esophageal wall and cause a tracheo-esophageal fistula (TEF). Thus early diagnosis and extraction of the battery are very important. Flexible versus rigid endoscopy for removal of foreign body impaction in the esophagus is useful. The risk of

development of TEF increases after the ingestion and its symptoms include food aspiration, fever, cyanosis, mediastinitis, pneumonia, and respiratory distress. The first step in suspected foreign body ingestion is a chest X-ray. In case more than several hours have passed since ingestion, it is recommended to perform a radiographic contrast test to rule out perforation.6 In some circumstances an esophageal foreign body may cause a meditational mass, which can be diagnosed by chest X-ray. Thoracotomy and fistula repair are also routine approaches. The present case report is describing history, diagnostic and management measures for the 1 year old infant with battery ingestion that ended as acquired tracheaesophageal fistula complicated with pneumonia.

Case Report

A one year female child with 7.8kg presented with complains of cough, vomiting after feeds, and difficulty in breathing on 7/09/2016 (2 days later on battery ingestion) parents brought child to AIIMS OPD, parents gave history of battery ingestion. Rigid Broncoscopy was done under general anesthesia and the foreign body was removed on 07/09/2016. In Investigation few large granular lymphocytes are noted. RBC size shows microcytes, few lymphochromic cells, few macrocytes and polychromophilic cells. Mild thrompocytopenia is present.after rigid broncoscopy the child was observed for any complication and got discharged home. After few days child game with the same complains associated with apple ingestion. She was diagnosed to have acquired trachea-esophageal fistula" & was admitted with a plan of surgery in order to keep the airway and GIT patent. Surgery: Thorocotomy was done on 08/09/2016. Wide tracheo-esophageal fistula 2-3cm proximal to larynx. Right thorocotomy was done, diverticulam of fistual, trachea and esophageal repair done. Tracheal repaird with using 5-0 prolene, esophageal repaird using 4-0 vicryl done with transverse closure of esophagotomy. Pleural flip applied between trachea and esophagus.

Child tolerated very well and showed significant improvement. Vitals are stable and general condition was good. Post operatively child was ordered for NPO, IV fluids, antibiotis and analgesics that includes IV fluids Iso –p 32ml.hour, Inj Cafotaxim 400mg IV 12 hourly, Inj Amikacin 80 mg IV 12 hourly, Chest tube care, and PCM suppository 170mg TDS. An NG tube was placed and feeding started on 2nd post operative period.on 11/09/2016 She was discharged with stable vital signs and NG tube in situ to be reviewed in OPD. On discharge advised to give 80 ml of NG feed at every 2 hours, syrup A-Z (Multivitamin) 1 tablespoon BD for 7 days, and Syp Iron 1spoon for 7 days were prescribed. Follow up done after 7 days in pediatric surgery OPD. NG tube was removed in OPD & child started to have oral feed.

Discussion

For the child thorocotomy was done as a surgical management to on 08/09/2016 inorder to protect tha patient airway. Wide tracheo-esophageal fistula 2-3cm proximal to larynx. Right thorocotomy was done, diverticulam of fistual, trachea and esophageal repair done. Tracheal repaird with using 5-0 prolene, esophageal repaird using 4-0 vicryl done with transverse closure of esophagotomy. Pleural flip applied between trachea and esophagus. Surgical approach was considered to be effective approach than conservative management to treat acquired TEF for the this child. This case report is supported by Yalçin. et all study on Management of acquired tracheoesophageal fistula with various clinical presentations. The result showed Five girls and two boys with a median age of 36 months (range, 2-156 months) were treated for acquired tracheoesophageal fistula. The presenting symptoms were respiratory difficulty (n = 3), coughing (n = 2), and dysphagia with coughing (n = 2), with a median duration of 30 days (range, 1-730 days). The etiologies were disc battery ingestion (n = 3), placement of endoesophageal prosthesis for caustic esophageal stricture (n = 2), corrosive ingestion with extensive burn (n = 1), and blunt chest trauma with subsequent emergency tracheotomy (n = 1). The site of the fistulae were proximal (n = 3) and middle (n = 1) trachea, left main bronchus (n = 1), and nearly the entire posterior wall of the trachea (n = 2). The patients were variously managed: conservatively with eventual spontaneous closure (n = 1), primary repair (n = 2), and colon interposition after cervical esophagostomy (n = 4)based on the clinical evaluation on admission and the follow-up status. Stenosis of the proximal esophagus (n = 2) and esophagocolonic anastomosis (n = 2) were the only complications encountered after treatment and were successfully managed with dilatation. The best therapeutic approach for acquired tracheoesophageal fistula can be determined with careful consideration of relevant parameters on admission, including medical history, presenting findings, etiology, and characteristics of the fistula, in addition to the clinical evaluation in the follow-up period. In general, conservative management should precede definitive surgical intervention both to allow for possible spontaneous closure and also to achieve optimal preoperative status. Primary repair or a staged surgical approach can be best selected by giving priority to the patient's airway security.

Acquired trachea-esophageal fistula (TEF) is a rare complication of foreign body ingestion, and most commonly occurs when older children ingest buttontype batteries or coins [1,2,3]. To our knowledge, there have been no reports of an acquired tracheaesophageal fistula in an infant. This is of note because the small size of the airway in children less than one year of age can readily and rapidly produce devastating hypoxic injury during attempts to diagnose and make the necessary anatomic repairs.

According to the American Association of Poison Control Centers for the year 2005, there were 5100 cases of non-automotive battery ingestion and 12,740 cases of ingestion of toys or coins in children less than 6 years of age. Despite this huge volume, outcomes are usually good. There were 16 major reaction outcomes and 1 death from battery ingestion and 5 major reaction outcomes and 0 deaths from coin or toy ingestion. Many of these ingestions are not witnessed, and it has been shown that nearly 50% of children with known foreign body ingestion are asymptomatic. Thus it is likely that the true number of uneventful foreign body ingestions in children is much higher.

Button batteries represent about 2% of all foreign bodies, although this percentage seems to be increasing. Epidemiology of button battery ingestion seems to be changing trends in the last years and there are more cases of severe complications related to them, which were reported recently. They seldom remain in the esophagus; however, these few cases are prone to develop severe injury even after some hours.

Button batteries that are located in esophagus can cause damage mainly by four different and independent mechanisms.

- First, they might cause damage in surrounding tissue because of direct pressure, as any other foreign body, although this mechanism alone should not cause severe injuries.
- Secondly, batteries containing mercury have been proved to release it, making its absorption to systemic circulation possible and, therefore, risking systemic toxicity.
- Alkaline leakage can take place when button batteries are immersed in saline solution. It may

cause caustic damage in esophageal mucosa as well. Alkaline burns are characterized by liquefactive necrosis, fat saponification, and inflammatory cell infiltration and they represent the most severe histologic damage caused in surrounding tissues.

 Finally, experimental models in animals have shown that a button battery can complete an electrolyte circuit when lodged in esophagus, releasing enough electrical energy to burn surrounding tissues immediately and, in addition, the generation of this external electrolytic current might hydrolyze tissue fluids and produce hydroxide at the battery's negative pole.

Management of esophageal button battery requires early diagnosis, therefore suspecting diagnosis in children with characteristics foreign body ingestion is mandatory. Obtaining a thorough history from caretakers or potential witnesses to the ingestion will be helpful in identifying a foreign body. A chest Xray image should be performed whenever ingestion is suspected, even in the presence of non-specific symptoms, if foreign body ingestion cannot be ruled out by clinical history. A chest X-ray image will be enough to recognize the round foreign body with double-ring shadow or double density, which makes it different from a coin. They are also slightly more translucent and show a step-off on lateral radiographic views, which can easily be obtained if there is any doubt.

Once diagnosis is established, endoscopy should be performed as soon as possible. Some other methods have been reported to remove the battery as using emetics, a Foley catheter or a magnet. They do not seem to be safe enough and a complete exploration of esophagus should be performed in order to check esophageal mucosa, to assess injury caused and to rule out early complications.

When the button battery is located beyond the stomach, serial radiographic examinations should be used to monitor its progress and to ensure it continues to advance through the intestinal tract.

When an elementory body is found, it seems reasonable to set a nasogastric tube, start gastric protection treatment with proton-pump inhibitors, and nil per oral until either a radiological contrast study or endoscopy is performed 2 or 3 days later to make sure there is no further damage.

Esophageal stenosis is probably the most common complication after elementory body due to button battery ingestion, even if it is seems to be underreported. Endoscopic balloon dilatation seems to be a safe and effective solution in these cases. .

Finally, prevention is the best management of all. Parents and caretakers should be aware of the potential danger of button battery ingestion and the importance of providing immediate care. Security of devices containing button batteries should be reviewed in order to find the way they cannot be released by children. In addition, the permanence of the battery in esophagus determines the risk of severe injuries; and therefore, the establishment of a maximum size by manufactures will diminish the probability they become lodged there. None of the more severe consequences of battery ingestion were reported to happen in small batteries.

Conclusion

Even though The incidence of button battery ingestion is about 10 cases in every million people every the incidence of button battery ingestion is increasing in the last years and the early diagnosis when they become lodged in esophagus, is of capital importance to diminish the risk of potential fatal complications. Endoscopic/bronchoscopic removal and a close follow-up by a multi-disciplinary group of physicians are essential to deal with both early and late complications.

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

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[4] American Academy of Periodontology. Sonic and ultrasonic scalers in periodontics. J Periodontol 2000; 71: 1792-801.

Unpublished article

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

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