



“A STUDY TO ASSESS THE IMPACT OF STRUCTURED TEACHING PROGRAMME ON KNOWLEDGE OF SUICIDAL PREVENTION AMONG PARENTS OF ADOLESCENTS AT RURAL COMMUNITY RAJASTHAN”

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Abstract

Background: Suicide is a type of deliberate self-harm (DSH) and is defined as a human act of self-intentioned and self – inflicted cessation (death). Most often it ends with a fatal outcome. Removing suicide from the category of sin and crime, it was considered a psychiatric illness only from 19th century. Suicide was not discovered to be disease; it was declared to be one.¹ **Objectives:** To assess the knowledge on suicidal prevention among parents of adolescents before and after structured teaching programme. To assess the effectiveness of structured teaching programme on knowledge of suicidal prevention among parents of adolescents. **Methods:** The data was generated by using structured questionnaire. Non probability convenient sampling was adopted to select 60 subjects. The data was obtained from the study subjects were analyzed and interpreted in terms of the objectives and hypothesis of the study. Descriptive and inferential statistics were used for the data analysis and the P value set at 0.05 levels. **RESULTS:** The results from the study subjects from Jhalawar Rural community. Rajasthan was obtained. The mean post test score was 32.85 was higher than the mean pretest score 12.31. The compute ‘t’ value is 16.86($P \leq 0.001$), indicates that there was significant association between the pre-test knowledge scores and the selected demographic variable, (Age in years) ($P \leq 0.05$). **CONCLUSION:** This study revealed that the knowledge of parents of

adolescents regarding suicidal prevention was inadequate and was increased after the administration of structured teaching programme. Thus, the hypothesis was accepted.

Key words: - Structured teaching programme and suicidal prevention.

Introduction

The World Health Organization has defined —adolescents| as persons in the 10 to 19 –year age group. Today India has a population of 243 million of adolescents that is among the largest in the world. This is the generation which will shape India’s future. One of the most important commitments a country can make for its future economic, social, and political progress and stability is to address the health and development related needs of its adolescents.² Suicide is an act of taking once own life voluntarily. The word suicide is derived from two Latin words Sui meaning self and cedere meaning to kill oneself. Hence suicide is an act of willfully ending one’s own life. Suicide is a type of deliberate self-harm (DSH) and is defined as a human act of self-intentioned and self – inflicted cessation (death). Most often it ends with a fatal outcome.¹ removing suicide from the category of sin and crime; it was considered a psychiatric illness only from 19th century. Suicide was not discovered to be disease, it was declared to be one (vilza veith, 1969).³ When an adolescent commits suicide, everyone is affected. Family members, friends, teammates, neighbors, and sometimes even those who didn't know the adolescent well also might experience feelings of grief, confusion, guilt — and the sense that if only they had done something differently, the suicide could have been prevented. So it's important the parents of adolescents understand the forces that can lead adolescents to suicidal act and preventive measures to safe guard them from this evil act.

The rate of suicides and suicide attempts increases tremendously during adolescent period. Suicide is the third-leading cause of death for 15- to 24-year-olds, according to the Centers for Disease Control and Prevention (CDC). It even surpassed only by accidents and homicide.² Suicide rates differ between boys and girls. Girls think about and attempt suicide about twice as often as boys, and tend to attempt suicide. The common suicidal acts include overdosing on drugs or cutting themselves. The death rates due to suicide among boys are four times than girls. Perhaps the reason may be, they tend to use more lethal methods, such as firearms, hanging, or jumping from heights.² An adolescent with adequate support network of friends, family, religious affiliations, peer groups, or extracurricular activities may have an outlet to deal with everyday frustrations. But many adolescents don’t believe they have that, and feel disconnected and isolated from family and friends. These teens are at increased risk for suicide.

Objectives of the study

1. To assess the knowledge on suicidal prevention among parents of adolescents before and after structured teaching programme.
2. To assess the effectiveness of structured teaching programme on knowledge of suicidal prevention among parents of adolescents.
3. To associate pre-test knowledge on suicidal prevention among parents of adolescents with their selected demographic variables.

Research Hypothesis

H1: There will be significant difference between the pre-test and post- test level of knowledge regarding suicidal prevention.

H2: There will be significant association between the pre-test knowledge of parents of adolescents regarding suicidal prevention with selected demographic variable.

Research Methodology

Research Design: research approach and variables to be studied, pre-experimental one group pre-test and post-test design was adopted for this study.

Settings: This study was conducted in Jhalawar rural community, Rajasthan.

Sampling Technique: Sampling refers to the process of selecting the portion of population to represent the entire population. According to sampling criteria, Non-Probability Convenient Sampling technique was adopted to select 60 samples.

Data collection tool and techniques: Method of data collection includes development of tool, testing of validity, reliability and data collection procedure. Tool is the instruments used by the researcher to collect the data. A self-administered questionnaire was used by the investigator for the data collection. Development of the tool the tool was developed based on the following • Review of literature • Consultation with subject experts • Personal experience in clinical setting. • Consultation with statistician was done for data analysis. • Test was done for reliability by conducting a pilot study in the same area.

Scoring system: Maximum Score: 30 Minimum Score: 0 For each correct answer will be given one (1) mark for each incorrect answer will be given zero (0) mark The resulting scores were ranged as follows :

1. Adequate knowledge- 75%
2. Moderately adequate knowledge-51-75%
3. In adequate knowledge-below- $\leq 50\%$

Validity and Reliability

The content validity refers to which an instrument measures what it is supposed to measure [Polit] The prepared instrument along with the objectives, operational definitions, blue print and scoring key for validating the tool was submitted to 9 experts who include 1 Psychiatrist, 7 nurse educators and 1 statistician to establish content validity. Suggestions were taken and a final valid tool was prepared.

Reliability of instrument is a degree of consistency with which measures the attributes, it is supposed to measure, it refers to the extent to which the same results are obtained on repeated administration of the instrument. In order to establish the reliability of the tool, split-half method was used.

Ethical considerations

The proposed study was conducted after the approval of Dissertation Committee of the college. Permission was obtained from the Head of the Institution. Assurance was given to the participants regarding the confidentiality.

Data Collection

A formal permission was obtained from the medical officer of Jhalawar Primary health centre for conducting the main study. The investigator took consent from Parents of adolescents. Confidentiality was maintained during the data collection. The Data collection was done from 03-09-2020 to 29-09-2020. Pre-test was done by administering the questionnaire to the samples; the structured teaching programme was also conducted on the same day. The group consist 60 Parents of adolescents from Jhalawar rural community, Rajasthan. After an interval of 7 days post was conducted 42 using the same tool in the respective area. The participants were assisted by clarifying the doubts and concerns.

Statistical analysis

Statistical analysis used was chi square and Spearman's correlation. Students with academic problems and unsupportive environment at home perceived life as a burden and had higher rates of suicidal ideations. A Study was conducted on Self-harm and self-poisoning in southern India. The primary objective was to record cases of suicide and attempted suicide among a population of 108 000 people living in a primarily rural area of Southern India, with the aim of guiding policies and strategies to restrict access to poisonous compounds at community level. Method of study was Community-based surveillance over a period of 2 years. The overall suicide rate was 71.4 per 100 000 population; the highest burden was among men. Most people died through hanging (81, 54%) and self-poisoning (46, 31%). Of the 46 who died from self-poisoning, 78.3% had taken pesticides and 19.7% had eaten poisonous plants. Eighty per cent of the self-poisoning 22 cases obtained the poisonous substance in or in close proximity to the home, highlighting the importance of safe storage in the domestic environment. Of the 110 fatal and non-fatal self-poisoning cases, 87 (57.5%) were taken for treatment; 50 (57.4%) went to government hospitals and 37 (42.5%) to private facilities. This indicates the importance of including the private sector in the efforts to improve case management.

Results

The results from the study subjects from Jhalawar Rural community, Rajasthan was obtained. The mean post test score was 32.85 was higher than the mean pre-test scores 12.31. The compute 't' value is 16.86 ($P \leq 0.001$), indicates that there was significant association between the pre-test knowledge scores and the selected demographic variable, (Age in years) ($P \leq 0.05$).

This section presents the analysis and interpretation of data collection from 60 Parents of adolescents in order to assess the effectiveness of structured teaching program about suicidal prevention. The data collected from the parents of adolescents before and after the structured teaching programme was organized, tabulated, analyzed and interpreted by using descriptive and inferential statistics. The data collection was done based on the objectives of the study.

The findings of the study are discussed under the following headings:

Section –A: Demographic profile of parents of adolescents.

Section-B: Overall level of knowledge in pre-test and post-test knowledge of participants on suicidal prevention.

Section-C: Aspect wise pre-test knowledge of participants on suicidal prevention.

Section-D: Aspect wise post-test knowledge of participants on suicidal prevention.

Section-E: Evaluation of effectiveness of structured teaching programme on suicidal prevention among parents of adolescents.

Section-F: Association between knowledge and selected demographical variables.

- **Section –A:** Demographic profile of parents of adolescents.

TABLE 1: Classification of demographic Characteristics of respondents

N=60

Sl . No		Category	Respondents	
1.	Age (In years)	30-40	16	26.66
		41-45	24	40.00
		46-50	12	20.00
		Above 50	8	13.34
2.	Gender	Male	38	63.33
		Female	22	36.67
3.	Religion	Hindu	35	58.33
		Christian	5	8.33
		Muslim	15	25.00
		Others	5	8.34
4.	Educational Status	No Formal Education	18	30.00
		Primary Education	23	38.34
		Secondary /P U C	14	23.33
		Graduate/ Post Graduate	5	8.33
5.	Occupation	Daily Wages	15	25.00
		Private Employee	15	25.00
		Govt.	2	3.34
		Businessman	4	6.67
		Unemployed	24	40.00
6.	Income of the family per month (in Rs)	Less Than 3000	24	40.00
		3001-6000	18	30.00
		6001-9000	14	23.33
		Above 9000	4	6.67
7.	Number of children	One	12	20.00
		Two	25	41.66

		Three	17	28.34
		More Than Three	06	10.00
8.	Type of family	Nuclear	32	53.33
		Joint	19	31.67
		Extended	9	15.00
9.	Source of information	Mass Media	32	53.33
		Health Professional	10	16.66
		Friends & relatives	11	18.34
		Others	7	11.67

According to Table 1, describes the demographic characteristics of the samples. Regarding age highest age group sample were form 30-40 years, 24(40 percent). It also reveals that, highest 38 participants (63.33 percent) were males. Regarding the religion 35(58.33 percent) participants were Hindu. Regarding the educational status 23 participants (38.34 percent) were having primary education. Regarding occupation 24(40 percent) participants were found to be unemployed. In the area of income of the family per month 24(40 percent) participants were earning less than 3000. Regarding number of children majority of the participants 25 (41.66 percent) was having two children. Regarding the type of family majority of the participants 32(53.33 percent) was belonged to nuclear family. In the area of source of information majority of the participants 32 (53.33 percent) were found to be getting an information through mass media.

- **Section-B:** Overall level of knowledge in pre-test and post-test knowledge of participants on suicidal prevention.

Table 2: Overall level of knowledge scores in pre-test & post test

N=60

Categories	Pretest		Posttest	
	Scores	%	Scores	%
Inadequate	48	80	-	-
Moderately adequate	12	20	22	36.67
Adequate	-	-	38	63.33
Combined knowledge score	60	100	60	100

Above table 2 shows that during pre –test out of 60 participants 48(80%) had inadequate knowledge and only 12(20%) had moderately adequate knowledge. Whereas in post-test 38 of the participants (63.33%) had adequate knowledge scores and only 22(36.67%) had moderately adequate knowledge scores.

- **Section-C:** Aspect wise pre-test knowledge of participants on suicidal prevention.

Table 3: Aspect wise pre-test knowledge score on suicidal prevention.

N=60

Area wise pre-test knowledge scores of parents of adolescents on suicidal prevention	Inadequate		Moderately adequate		Total	
	Number	%	Number	%	Number	%
General aspects of Suicide	46	76.67	14	23.33	60	100.
Preventive aspects of Suicide	51	85.0	9	15.0	60	100.
Combined knowledge score	48	80.0	12	20.0	60	100.

It is evident that above table 3 shows that in the pre-test out of 60 participants in the aspects of general aspects of suicide 46 (76.67percent) have inadequate knowledge and 14(23.33percent)have moderately adequate knowledge in the aspect of suicidal prevention 51(85percent) have inadequate knowledge, and 9 (15percent) have moderately adequate knowledge. The overall score shows that 12(20percent) have moderately adequate knowledge and 48(80percent) have inadequate knowledge.

- **Section-D:** Aspect wise post-test knowledge of participants on suicidal prevention.

Table 4: Aspect wise post-test knowledge scores on suicidal prevention.

N=60

Area wise post-test knowledge scores of parents of adolescents	Moderately adequate		Adequate		Total	
	Number	%	Number	%	Number	%
General aspects of suicide	48	80.0	12	20	60	100
Preventive aspects of suicide	24	40.0	36	60	60	100
Combined knowledge score	24	40.0	36	60	60	100

Above table 4 shows that in the post test, out of 60 participants in the general aspect of suicide 12(20percent) have adequate knowledge 48(80percent) have moderately adequate knowledge. In the preventive aspect of suicide 36(60 percent) have adequate knowledge and 24(40percent) have moderately adequate knowledge. The overall score shows that 36(60percent) have adequate knowledge and 24(40percent) have moderately adequate knowledge.

- **Section-E:** Evaluation of effectiveness of structured teaching programme on suicidal prevention among parents of adolescents.

Table 5: Evaluation of effectiveness of structured teaching programme on suicidal prevention among parents of adolescents. Mean, Mean percentage, SD & 't value of pre& post test scores.

N=60

Area wise knowledge scores of parents of adolescents on suicidal prevention	Pretest			Posttest			Mean difference	t-value	Inference
	Mean	Mean %	SD	Mean	Mean %	SD			
General aspects of suicide	4.8	40	2.44	8.33	69.41	1.26	29.41	12.19	HS**
Preventive aspects of suicide	7.51	41.72	2.32	13.41	74.53	1.88	32.81	18.11	HS**
Combined knowledge score	12.31	20.52	8.8	32.85	21.75	36.25	1.23	16.87	HS**

Note: *Significance at 5% level for df (i.e. $P < 0.05$).

It is observed from this study that in the general aspect of suicide Mean \pm SD during pre-test is found to be 4.8 ± 2.44 with a mean percentage of 40 whereas during post-test it is 8.33 ± 1.2 and the mean difference of 29.41 with a mean percentage of 69.41.

Section-F: Association between knowledge and selected demographical variables.

Table 6: Association between knowledge and selected demographical variables

N=60

Demographic variable	Categories	Combined pretest knowledge score		Chi-square value	Df	t-value	Inference
		Below median	Above median				
Age (yrs)	30-40	10	6	4.17	1	3.841	HS
	41- Above 50	38	6				
Gender	Male	17	6	0.86	1	3.841	NS
	Female	31	6				
Religion	Hindu	27	6	0.15	1	3.841	NS
	Christian/ Muslim/Others	21	6				
Educational status	No formal education	13	6	2.32	1	3.841	NS
	Primary/ Secondary/ Graduate/ post graduate	35	6				
Occupation	Daily wages/ Private employee/ Govt employee/Businessman	30	6	0.63	1	3.841	NS
	Unemployed	18	6				
Family Income	Less than 3000	17	6	0.86	1	3.841	NS
	3000-Above 9000	31	6				
No. of Children	One/Two	31	6	0.86	1	3.841	NS
	Three and above	17	6				
Type of Family	Nuclear	27	6	0.15	1	3.841	NS
	Joint/Extended	21	6				
Source of information	Mass media	26	6	0.08	1	3.841	NS
	Health professional/ Friends/relatives/ Others	22	6				

Note:

1. The responses of some of the demographic variables have been merged as the expected frequencies was less than or equal to 5.
2. NS: Not significant ($P > 0.05$); S: significant ($P \leq 0.05$).
3. Critical value for 1 degree of freedom at 5% level of significance = 3.841.
4. Critical value for 2 degree of freedom at 5% level of significance = 5.991

It is evident from the above table(8) that chi square value computed for the Gender, Religion, Educational status, Occupation, Family income, No. of children, Type of family and Source of information with the level of knowledge is statistically not significant which indicates that there is no association between the pre-test knowledge scores with these demographic variables. Whereas the chi- square value computed for the Age is with the level of knowledge is statistically significant at 0.005 level of significance $P \leq 0.05$ which indicates that there is an association between the pre-test knowledge scores and the demographic variable.

Discussion:

Structured teaching programme is an effective teaching strategy and should be encouraged. The pre-test STP was prepared with the aim of improving knowledge of parents of adolescents on suicidal prevention in their future life.

The study was quasi experimental with one group pretest- posttest design (O1 X O2).The sample consisted of 60 parents of adolescents from the Jhalawar rural community, Rajasthan. Non probability convenient sampling was used this study was conducted over a period of 4 weeks from 03-09-2020 to 29-09-2020.

Conclusion:

1. To assess the existing knowledge regarding suicidal prevention among parents of adolescents.
2. To assess the posttest knowledge regarding suicidal prevention among parents of adolescents.
3. To assess the effectiveness of structured teaching programme on knowledge of suicidal prevention among parents of adolescents.
4. To associate pre-test knowledge on suicidal prevention among parents of adolescents with their selected demographic variables.

On the basis of the findings of the study the below said conclusion were drawn. It also brings out the limitations of the study in to picture. The implications given on various aspects like nursing education, nursing practice, nursing administration and also gives insight in to future studies.

Recommendation:

1. Comparative studies can be done in other settings.
2. A follow up study can be conducted to evaluate the skill after teaching programme.
3. A similar study may be replicated with control group.
4. An extensive teaching strategy protocol may be developed including all methods of suicidal prevention.

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Bibliography

1. Nightingale nursing times, how can suicide be prevented? , January 2006; 1(10):59.
<http://www.healthlawyers.org/Publications/Journal/Document>
2. Kanthan, common risk factors in adolescents suicide attempters revisited, March2001; 3: 11-13. <http://jpepsy.oxfordjournals.org/content/26/5/287.full>
3. Nightingale nursing times, methods used for committing suicide, February 2008;3(11):41-42. http://en.wikipedia.org/wiki/Stephen_Fry.
4. Gajalakshmi V, Peto R. Suicide rates in rural Rajasthan , North India : verbal autopsy of 39 000 deaths in 1997-98. Int J Epidemiol. 2007 Feb; 36(1):203-7. Epub 2007 Feb
www.ncbi.nlm.nih.gov/pubmed?db=pubmed&cmd=Link&LinkN
5. Sidhartha T, Jena s, Suicide behaviors in adolescents, Department of psychiatry, G.B. Pant Hospital, New Delhi, India.Indian J Peadiatr. 2006. Sep;73(9);783-8.
6. Bose A, Sandal Sejbaek C, Suganthy P, Raghava V, Alex R, Muliylil J, Konradsen F. Self-harm and self-poisoning in southern India: choice of poisoning agents and treatment. Trop Med Int Health. 2009 Jul; 14(7):761-5. Epub 2009 May 26.
www.ncbi.nlm.nih.gov/pmc/articles/PMC2777873.
7. Arun P, Chavan BS. Stress and suicidal ideas in adolescent students in Chandigarh. Indian Journal Med Sci. 2009 Jul; 63 (7) :281
8. Manoranjitham SD, Rajkumar AP, Thangadurai P, Prasad J, Jayakaran R, Jacob KS. Risk factors for suicide in rural North India . Br J Psychiatry. 2010 Jan; 196(1):26-30.
9. Pillai A, Andrews T, Patel V. Violence, psychological distress and the risk of suicidal behaviour in young people in India. Int J Epidemiol. 2009 Apr; 38 (2) : 459- 69. Epub 2008 Aug 24. www.ncbi.nlm.nih.gov/pubmed?db=pubmed&cmd=Link&LinkN.
10. Lalwani S, Sharma GA, Kabra SK, Girdhar S, Dogra TD. Suicide among children and adolescents in South Delhi (1991-2000). Indian J Pediatr. 2004 Aug; 71(8):701-3.
www.ncbi.nlm.nih.gov/pmc/articles/PMC2745855.
11. Banerjee S, Chowdhury AN, Schelling E, Brahma A, Biswas MK, Weiss MG. Deliberate

- self-harm and suicide by pesticide ingestion in the Sundarban region, India. *Trop Med Int Health*. 2009 Feb; 14(2):213-9. www.ncbi.nlm.nih.gov/pmc/articles/PMC3190511.
12. Cusimano MD, Sameem M. The effectiveness of middle and high school-based suicide prevention programmes for adolescents: a systematic review. *Inj Prev*. 2011 Feb; 17(1):43-9. Epub 2010 Nov 7. www.ncbi.nlm.nih.gov/pubmed/21059602.
13. White J, Morris J. risk, responsibility and uncertainty in school-based suicide Prevention programs. *Soc Sci Med*. 2010 Dec; 71(12):2187-94. Epub 2010 Oct www.ncbi.nlm.nih.gov/pubmed/21050629.
14. Pompili M. Suicide on my mind. A look back and ahead at suicide prevention in Italy. *Minerva Med*. 2010 Oct; 101(5):353-61 www.ncbi.nlm.nih.gov/pubmed/21048556.
15. Tompkins TL, Witt J, Abraibesh N. Does a gatekeeper suicide prevention program work in a school setting? Evaluating training outcome and moderators of effectiveness. *Suicide Life Threat Behav*. 2010 Oct; 40(5):506- www.ncbi.nlm.nih.gov/pubmed/21034213.
16. Leenaars AA, Wenckstern S. Suicide prevention in schools: the art, the issues, and the pitfalls. *Crisis*. 1999; 20(3):132-42. www.biomedexperts.com/Profile.bme/795237/Antoon_A_Leenaars.
17. Pirruccello LM. Preventing adolescent suicide: a community takes action. *J Psychosoc Nurs Ment Health Serv*. 2010 May; 48(5):34-41. www.ncbi.nlm.nih.gov/pubmedhealth/PMH0042051