EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME ON KNOWLEDGE REGARDING RISK FACTORS AND PREVENTION OF SUICIDAL BEHAVIOUR AMONG ADOLESCENTS IN A SELECTED COLLEGE, SALEM.

By

Reg.No: 301231401

A DISSERTATION SUBMITTED TO

THE TAMILNADU DR. M.G.R. MEDICAL UNIVERSITY, CHENNAI,

IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE

DEGREE OF MASTER OF SCIENCE IN NURSING

PSYCHIATRIC (MENTAL HEALTH) NURSING

APRIL – 2014

CERTIFICATE

Certified that this is the bonafide work of **Mr. N.Loganathan,** Final Year M.Sc.(Nursing) Student of Sri Gokulam College of Nursing, Salem. Submitted in partial fulfillment of the requirement for the Degree of Master of Science in Nursing to the Tamilnadu Dr.M.G.R. Medical University, Chennai under the Registration No.**301231401.**

College Seal:

Signature: **…….**

Prof. Dr. K. TAMIZHARASI, Ph.D (N).,

PRINCIPAL,

SRI GOKULAM COLLEGE OF NURSING,

3/836, PERIYAKALAM,

NEIKKARAPATTI,

SALEM - 636 010.

EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME ON KNOWLEDGE REGARDING RISK FACTORS AND PREVENTION OF SUICIDAL BEHAVIOUR AMONG ADOLESCENTS IN A SELECTED COLLEGE, SALEM.

Approved by the Dissertation Committee on: 26.11.2013

Signature of the Clinical Speciality Guide: …….

Prof. S.VANITHA, M.Sc (N).,
Professor and Head of the Department,
Mental Health Nursing,
Sri Gokulam College of Nursing,
Salem - 636 010.

Signature of the Medical Expert: **……**

Dr. C. BABU, M.D.,
Consultant Psychiatrist,
Child and Adolescent and Deaddiction specialist,
Sri Gokulam Hospital,
Salem - 636 004.

……
Signature of the Internal Examiner with date

……...
Signature of the External Examiner with date

ACKNOWLEDGEMENT

"Appreciation is the highest form of prayer, for it acknowledges the presence of good wherever you shine the light of your thankful thoughts"

- Alan Cohen.

I wish to express my humble and sincere gratitude to **God Almighty,** Who showered his blessing, strength, wisdom and support on the dazzling path to complete this research work in an efficient manner.

I am sincerely thankful to **Dr.K.Arthanari, M.D,** Managing Trustee of Sri Gokulam College of Nursing for his encouragement, support and for the opportunity given to complete my project confidently and competently.

It is my privilege to express a deepest sense of gratitude to our respected Principal **Prof.Dr.K.Tamizharasi, Ph.D(N).,** Sri Gokulam College of Nursing for her enduring catalytic encouragement, guidance and support without that this work would have been an unrealised distant dream.

I would like to offer my special thanks to **Mrs. J. Kamini Charles, M.Sc(N).,** Vice Principal and Research Coordinator, Sri Gokulam College of Nursing, Salem for her invaluable suggestions, inspirational guidance and kind support for my research.

I would like to thank **Mrs. Lalitha P, M.Sc (N).,** Professor and former HOD of Mental Health Nursing for her tremendous support and help.

I am indebted to my Guide **Mrs. S. Vanitha, M.Sc (N).,** Professor and Head of Psychiatric Nursing Department for her immense support and guidance throughout the work. I am bounded with gratitude for her constant interest, untiring guidance, invaluable suggestions, continuous support and encouragement to complete this research work.

My special thanks are extended to **Dr.C.Babu, M.D.,** Consultant Psychiatrist, Child and Adolescent and Deaddiction specialist, Sri Gokulam Hospital, Salem, who provided me with treasured guidance and support throughout my study.

I extend my earnest thanks to **Mrs. J.Devikanna., M.Sc(N),** Reader, for her guidance, suggestion, support and motivation to make this study a feasible and a successful one.

My sincere thanks goes to **Mrs.D.Shoba Selvi, M.Sc.(N)., Mrs.Samaya Rani M.Sc.(N)., Mr.S.Nandakumar, M.Sc.(N).,** and **Mrs.Anusha, M.Sc.(N).,** Lecturers, Department of Mental Health Nursing, for their guidance and support in the process of completion of this research work.

A special note of thanks is expressed to **All M.Sc (N).,** Faculty Members Sri Gokulam College of Nursing, who rendered timely help and support to complete the study.

I extend my heartfelt gratitude to **The Principal** of Sri Vidya Mandhir College, Salem. For having given me permission to conduct my research in your esteemed institution.

I am thankful to **Mrs.A.Mary Manjula Rose, M.A,, M.Ed, M.Phil., Dr.N.Krishnan, M.A., Ph.D.,** whose editing suggestions and precise sense of language were decisive towards the completion of this research study.

I am obliged to the **Medical** and **Nursing Experts** for validating the tool and content used in this study.

I would like to offer my special thanks to **Mr. Jayaseelan P.,** Librarian, Sri Gokulam College of Nursing, Salem, and the librarians of Tamilnadu Dr. M.G.R. Medical University Chennai, NIMHANS, Bangalore and CMC college of Nursing

Vellore for their helping hands in providing all needed literature to complete this research study.

My sincere thanks goes to all the **Study Samples,** who took part in this study, without their cooperation and readiness to assist, the study would have not been possible.

I would like to express my heartfelt gratitude to my lovable parents **Mr. P.Nagarajan, Mrs. N. Vasanthi** and my caring **brother Mr.N.Dhanasekaran** for their earnest prayers, endless patience, steadfast inspiration and unremitted support throughout my endeavor.

My sincere and heartfelt thanks goes to **Ms.N.Ramya., Ms.A.Sahaya Vivitha., Ms. Gincy Jose and Mr.A.Sanjai Kumar,** who extended their help throughout my study.

I express my profound thanks to **All My Classmates (TITANS)** and **Friends** who extended their help throughout my study and who have always been there to encourage and inspire me.

Once again my immense thanks goes to all the **Members** who are involved directly as well as indirectly in completing my Dissertation in an amazing manner.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ANNEXURES

ABSTRACT

This study was carried out to assess the Effectiveness of Structured Teaching Programme on Knowledge regarding Risk factors and Prevention of Suicidal Behaviour among Adolescents in a selected College, Salem. A quantitative evaluative approach with a pre-experimental (one group pre test- post test) design was adopted, the setting of the study was Sri Vidya Mandir College, Salem. The sample size was 60, who were selected by systematic random sampling technique. A Structured Self-administered questionnaire was used to assess the knowledge of the adolescents. The investigator involved the adolescents on Structured Teaching Programme regarding Risk factors and prevention of Suicidal Behaviour by using a Power-point slide presentation followed with pre-test. On 7^{th} day, the post test was conducted. The collected data were analyzed by using both descriptive and inferential statistical methods, and interpretations were made based on the objectives of the study.

The study findings revealed that during Pre-test, the knowledge regarding risk factors and prevention of suicidal behaviour among adolescents 45(75%) had inadequate knowledge, 15(25%) had moderately adequate knowledge and none of them had adequate knowledge. During post test, 23 adolescents (38.33%) had adequate knowledge, 37(61.67%) had moderately adequate knowledge and none of them had inadequate knowledge. The mean score during pre-test was 9.9±3.88 and the mean score during post test was 17.03±4.12. The paired 't' value was 16.84 which was significant at $p \leq 0.05$ level. Thus it shows that the structured teaching programme was effective in improving knowledge regarding risk factors and prevention of suicidal behaviour among adolescents. Therefore the hypothesis H_1 was retained. There was no significant association found between the pre-test scores on knowledge regarding risk factors and prevention of suicidal behaviour and the selected demographic variables at $p \leq 0.05$ level. Hence the stated hypothesis H_2 was rejected. The study concluded that the structured teaching programme was effective among adolescents to improve the knowledge regarding risk factors and prevention of suicidal behaviour.

CHAPTER -I

INTRODUCTION

"Striving to live is fundamental for

Every human living creatures"

The term 'Adolescents', refers to the 'process of growing up' or to the 'period of life from puberty to maturity'. Adolescent is an in-between period beginning with the achievement of physiological maturity and ending with the assumption of social maturity that is with the assumption of social, sexual, economic and legal rights and duties of the adult. **(Buhler's, 1954)**

There are major developmental changes and challenges associated with the period of adolescents. As youth acquire and consolidate the competencies, attitudes, and values, so the social capital is necessary to make a successful transition into adulthood. Late adolescents and the period following, often referred to as emerging adulthood, have been noted as particularly important for setting the stage for continuous development through the life span as individuals begin to make choices and engage in a variety of activities that are influential on the rest of their lives. **(Nicole Zarrett, 2009)**

Adolescents undergo a period of adjustment to their new adult identity and suffer with a feeling of loss for the childhood they leave behind. Faced with these feelings and a lack of effective coping mechanism, adolescents can become over-whelmed and turn to escapist measures such as drugs, smoking and some other bad habits and finally that may lead to withdrawal from society and ultimately go to commit suicide. **(Malone et.al, 2000)**

Suicide is "to kill oneself" or the act of intentionally causing one's own death. Suicide is a fatal outcome of long-term process shaped by a number of interacting cultural, social, situational, psychological and biological factors. All these factors play a crucial role in moulding individual's thinking. **(Wikipedia, 2009)**

Suicide is not only a personal tragedy; it represents a serious public health problem. Suicidal behaviour is a leading cause of injury and death worldwide. Suicidal behaviour can be conceptualized as a continuum ranging from suicidal ideation to suicide attempts and completed suicide. **(Johnson, 2004)**

Risk factors for suicide include mental and physical illness, alcohol or drug abuse, chronic illness, acute emotional distress, violence, a sudden and major change in an individual's life, such as loss of employment, separation from a partner or other adverse events or in many cases, a combination of these factors. A number of psychological states increase the risk of suicide including hopelessness, loss of pleasure in life, depression and anxiousness, failure in love or educational problems, separation, physical or sexual abuse, emotional neglect, exposure to domestic violence while mental health problems play a role which varies across different contexts, and other factors, such as cultural and socio-economic status are also particularly influential. The impact of suicide on the survivors, such as spouses, parents, children, family, friends, co-workers and peers who are left behind, is immense and a poor ability to solve problems also plays a major role. **(Fontana, 2002)**

Suicide prevention must be transformed by integrating injury prevention and mental health perspectives to develop basic public health interventions that address the diversity of populations and individuals whose mortality and morbidity contribute to the burdens of suicide and attempted suicide. **(Farrow, 2002)**

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 that they have it and feel disconnected and isolated from family and friends. These teens are at increased risk of suicide. **(Kanthan, 2001)**

The prevention program has been designed to comply with the requirements for students and teacher education in suicide prevention which are now in effect in many countries across the globe. In all states, the program can also be used as part of ongoing in-service training related to student mental health. **(American Foundation for Suicide Prevention, 2009)**

The prevention of suicide is a collective responsibility of the government and the people. "Every citizen has a role to play in this noble cause. Suicides are not confined to any particular family. It can happen anywhere. The State has to create awareness of suicide prevention and create facilities for treatment and rehabilitation." **(Ramasubramanian, 2013)**

Learning more about factors that might lead an adolescent to suicide may help to prevent further tragedies. Even though it's not always preventable, it's always a good idea to be informed and take action to help a troubled teenager. **(Joint commission resource, 2001)**

Need for the Study:

The **World Health Organization (WHO)** estimates that about one million people die by suicide every year. It is the third leading cause of death. This represents a "global" mortality rate of 16 per 100,000 during 2010. One death occurs every 40 seconds. Suicide is a leading cause of death in the age group between 15 and 29

years. The mean suicidal rate for this age group is 7.4/100,000, Suicide rates is higher in males (10.5) than in females (4.1).

Worldwide the suicidal rate is estimated to represent 1.8% of the total global burden of disease in 1998 and the rate may get increase up to 2.4% in 2020.

According to UNICEF (2011), around 243 million people live in India, out of whom 40% of suicides were found among adolescents.

In India more than one lakh persons (1,35,445) lost their lives by committing suicide during the year 2012.

India alone contributes to more than 10% of suicides in the world. The suicide rate in India has been increasing steadily and has reached 11.2 per 100,000 in 2012, registering a 78% increase over the value of 1980 (6.3). A majority of suicide occurs among men and in younger age groups.

According to WHO (2012), out of every 1,00,000 people, 98 of them commit suicide annually. Worldwide the suicide rate has increased by 60% over the past 50 years in developing countries.

A report by World Health Organization states that 22.1/1,00,000 population committed suicide in Tamilnadu during 2011.

Tamilnadu has recorded the highest number of suicides due to family problems i.e. in 4824 members, 3663 people become victims to mental illness and 512 people committed suicide on account of passion related reasons whereas 238 people ended their lives occurring to failure in their examinations. **(Vijayakumar.S, The Hindu News, 2013)**

In the last two decades, the suicide rate has increased from 7.9 to 10.3 per 100,000 with very high rates in some southern regions. In a study published in the Lancet in June 2012, the estimated number of suicides rate in India (2010) was about

187,000. A large proportion of adult suicide deaths were found to occur in the age group of 15 - 29.

The four southern states - Tamil Nadu, Andhra Pradesh, Karnataka and Kerala contribute 42% suicide deaths in the case of men and 40% in the case of women. Maharashtra and West Bengal together accounted for an additional 15% of suicide deaths. Delhi recorded the lowest suicide rate in the country. In absolute numbers, most of the suicide deaths in the case of individuals, aged 15 years or the aged, were in Andhra Pradesh (28,000), Tamil Nadu (24,000) and Maharashtra (19,000). **(British Journal the Lancet, 2010)**

Tamil Nadu has reported the highest number of suicide victims (accounting for 12.3%) in 2010, third highest in 2011 (accounting for 11.8%) and highest in 2012 (accounting for 14.0%)

Among the cities, Bangalore (17%), Mumbai (14%), Chennai (11%) and Delhi (7%) accounted for nearly 50% of total suicides in the country **(Gupta, 2002).**

Palaniappan V.S., (2013) reported that in 2011 totally 2,747 suicides witnessed in West Zone of Tamilnadu (Namakkal, Salem, Dharmapuri and Krishnagiri) among 1,536 men, 1,016 women, 102 girls and 94 boys and in 2012 the Zone witnessed a marginal decline of just one case, registering 2,746 cases in Namakkal, Salem, Dharmapuri and Krishnagiri together.

Chen PC, Lee LK, et.al., (2005) conducted a survey for identifying prevalence, risk factors of attempted suicide and suicidal ideations on 99 samples, aged between 14 and 25 years, residing in a community Northern Quebec. A total of 34% of survey respondents reported a previous suicide attempt, and 20% had attempted suicide more than once. A suicide attempt had resulted with injury in about 11 % of those surveyed. The prevalence of suicidal ideation was also very high and

43% of subjects reported past thoughts of suicide and 26% had suicidal thoughts during the month before the survey.

Kirmayer, L.J, Malus, M, (2007) conducted a study to examine risk factors related to suicidal behaviour among adolescents through a survey method. 4,554 adolescent students were selected. The risk assessment was done by using the self-administered questionnaire. The Survey report showed that (312 of 4,454) the adolescent students had seriously considered attempting suicide. 4.6% of them had attempted suicide at least once during the 12 months preceding the survey. Female adolescents were more likely to put their suicidal thoughts into suicidal action than were male adolescents. The researcher concluded that the adolescent suicide behaviour should be viewed as a serious problem. Measures can be taken to prevent suicide by looking at the factors significantly linked to suicidal behaviour among the adolescents. Steps can then be taken to identify adolescents who have serious suicidal ideation so that intervention can be taken to reduce the suicidal rate.

International Association for Suicide Prevention, (IASP, 2011) reported that suicide in some countries is the leading cause of death in the world and it was one of the three leading causes of death in the case of persons less than 25 years old. According to the estimates by the IASP, every year around 10 and 20 million people try to commit suicide and about 1 million of them succeed, which is more than the total number of people murdered or killed in wars combined. This means that every 30-40 seconds one person dies by suicide. In the last decade alone more than 10 million people in the world committed suicide. In the past 45 years the number of deaths due to suicide increased by 60%. It is estimated that by 2020 the number of suicides will increase by half to 1.5 million per year.

Prevention programme is important for nurses to look at the mental health of their patients, "Nurses who work with teens are in a prime position to make a connection with them. The simple act of caring provides a safe environment for the teens to open up and express their personal problems." Strunk developed the Hospital's surviving the Teens suicide prevention program by Butler Foundation in 2001. Since then, she has educated approximately 6,000 middle and high school students in Ohio and Kentucky annually, as well as parents and school staff members on suicide, finding positive ways of coping with stressors, recognizing depression and suicidal behaviours, responding appropriately, using adaptive coping measures, and communicating well at home. Students also did a role play with Strunk relating to how to help someone depressed or troubled. The programme included listening and looking for signs of depression or suicide, asking questions, supporting the person, and telling an adult who can help or referring them to a mental health professional. **(Strunk, 2001)**

So, the researcher felt that this study needs to be conducted to evaluate the effectiveness of structured teaching programme on risk factors and prevention of suicidal behavior among adolescents at college level.

Statement of the Problem:

"A Study to Evaluate the Effectiveness of Structured Teaching Programme on Knowledge regarding Risk factors and Prevention of Suicidal Behaviour among Adolescents studying in a Selected College, Salem"

Objectives:

1. To assess the knowledge regarding risk factors and prevention of suicidal behaviour among Adolescents.

2. To evaluate the effectiveness of structured teaching programme on knowledge regarding risk factors and prevention of suicidal behaviour among Adolescents.
3. To associate the pre-test knowledge regarding risk factors and prevention of suicidal behaviour among adolescents with their selected demographic variables.

Operational Definitions:

Effectiveness:

It refers to increase in post-test score after administering structured teaching programme on risk factors and prevention of suicidal behaviour which will be assessed by using structured self administered questionnaire.

Structured teaching programme:

It refers to the systematically planned and organized LCD power-point teaching activity with specific objectives to improve knowledge on risk factors and prevention of suicidal behaviour.

Knowledge:

It is the verbal responses given by the adolescents regarding risk factors and prevention of suicidal behavior, which can be assessed through structured self-administered questionnaire.

Risk factors:

It refers to the reasons or factors that increase the suicidal attempt.

Prevention:

The structured teaching programme are given as knowledge, which are intended to prevent or reduce the risk of suicidal behaviour.

Suicidal behaviour:

It refers to any act that are exhibited by the client "to kill oneself".

Adolescents:

College going students in the age group between 18-21 years.

Assumptions:

1. Adolescents may have an inadequate knowledge on risk factors and prevention of suicidal behaviour.
2. Structured teaching programme may enhance the knowledge on prevention of suicidal behaviour among adolescents.

Hypotheses:

H_1 : There will be a significant difference between the pre-test and post test score on knowledge regarding risk factors and prevention of suicidal behaviour among adolescents at $P \leq 0.05$ level.

H_2 : There will be a significant association between the knowledge regarding risk factors and prevention of suicidal behaviour among adolescents with their selected demographic variables at $P \leq 0.05$ level.

Delimitation:

The study was delimited to:

1. The sample size 60.
2. The data collection period of 4 weeks.

Projected outcome:

The study was conducted to evaluate the effectiveness of structured teaching programme to increase knowledge regarding risk factors and prevention of suicidal behaviour among adolescents.

Conceptual Framework:

In this study **Modified Imogene King's Goal Attainment Theory, (1981)** was adopted as a conceptual framework. This was aimed at assessing the effectiveness of structured teaching programme on knowledge regarding risk factors and prevention of suicidal behavior. Imogene king explains the concept of nurse and the patient as 'they are expected to get involved mutually in communicating information, establishing goals and taking action to attain goals'. The goal achievement indicates when there is improvement seen followed with any defined intervention.

Components

1. Perception:

Perception is a state of being or process of becoming aware of something. Here the researcher bewares of inadequate knowledge existing among adolescents and the adolescents apprehend the need for attending the structured teaching programme regarding risk factors and prevention of suicidal behaviour.

2. Judgment:

Judgment is decisions which are made. Here the researcher decides to provide structured teaching programme regarding risk factors and prevention of suicidal behaviour to improve the knowledge, and the adolescents decides to participate in the research study.

3. Action:

This refers to the changes that are likely occurring among researcher and the adolescents followed with judgment. The researcher's action is to prepare adolescents to undergo structured teaching programme regarding risk factors and prevention of

suicidal behaviour to improve knowledge and the adolescents' action is getting ready to undergo the structured teaching programme.

4. Reaction:

Reaction means setting up of mutual goal. In this study the researcher and the adolescents together involved in setting mutual goal to improve knowledge regarding risk factors and prevention of suicidal behaviour.

5. Interaction:

This refers to the mutual understanding between two or more individuals who are involved in goal-directed perception. Here the researcher involve in assessing the adolescents demographic variables, collecting data on knowledge regarding risk factors and prevention of suicidal behaviour by using structured self administered questionnaire in pre test and providing structured teaching programme regarding risk factors and prevention of suicidal behaviour by interfacing the adolescents.

6. Transaction:

Transaction means achievement of the goal. The goal is attained in terms of improvement in knowledge regarding risk factors and prevention of suicidal behaviour which was assessed through structured self administered questionnaire during post test.

7. Communication:

The verbal and non-verbal communication pattern used to collect data and to transfer the knowledge between researcher and the adolescents.

8. Time and space:

Space refers to the actual setting used to conduct study and timing is referred as the duration of time consumed to assess and teach study subjects for attaining the goal. The planned structured teaching programme was given a period of 45 minutes to the adolescents in a selected Arts and Science college, Salem.

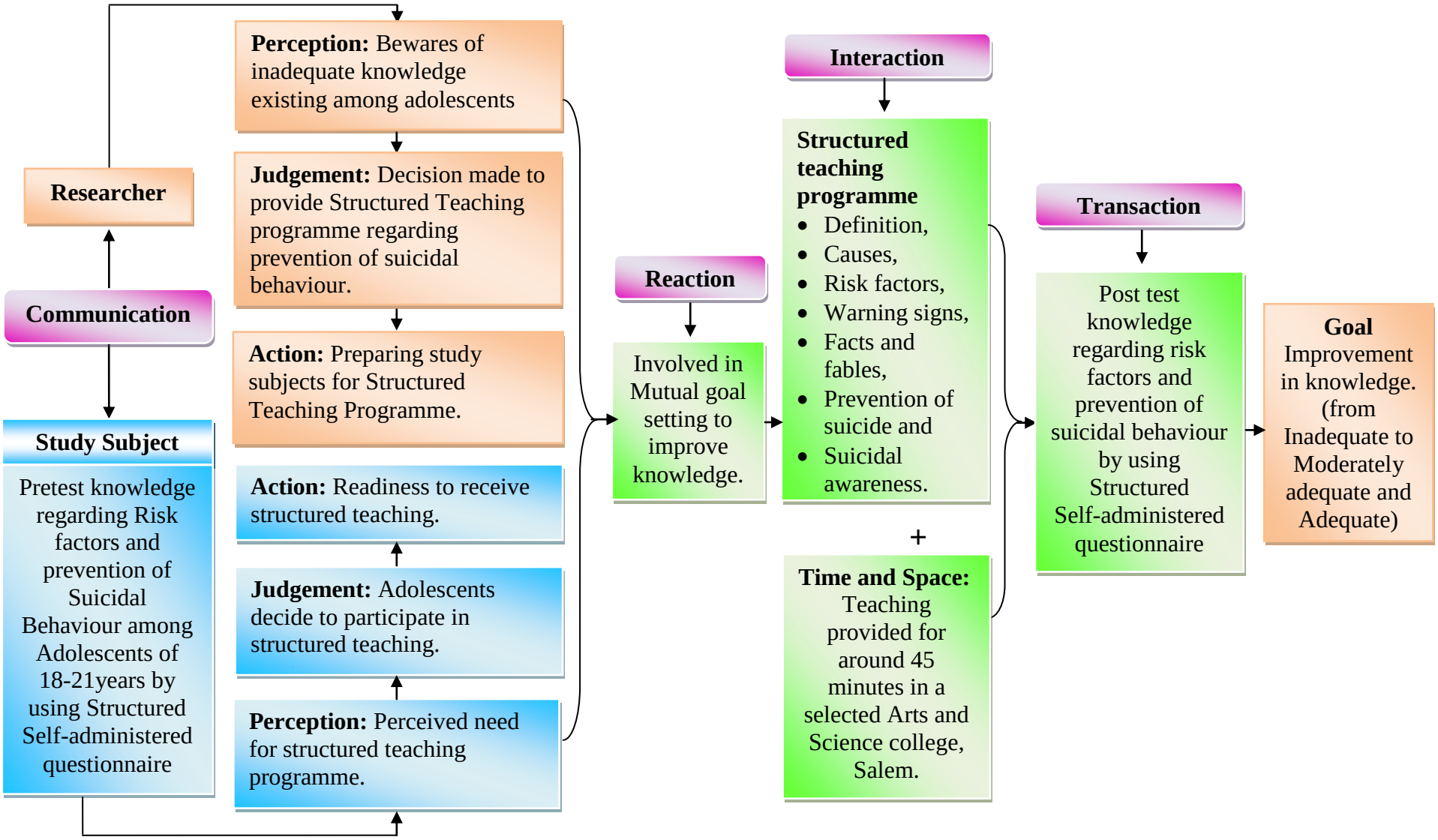


Fig-1.1: Conceptual Framework Based on Modified Imogene King's Goal Attainment Theory (1981) On Effectiveness of Structured Teaching Programme regarding Risk factors and prevention of Suicidal Behaviour among Adolescents.

Summary:

This chapter dealt with the introduction, need for the study, statement of the problem, objectives, operational definitions, hypotheses, assumptions, delimitations, projected outcome and conceptual framework.

CHAPTER -II

REVIEW OF LITERATURE

Review of literature is an essential step in the development of a research work. It helps the researcher to design the proposed study in a scientific manner so as to achieve the desired result. It helps to determine the gaps, consistencies and inconsistencies in the available literature about particular subject under the study.

Review of literature for the present study is classified under the following headings,

1. Literature related to risk factors and suicidal behaviour among adolescents.
2. Literature related to knowledge regarding risk factors and prevention of suicidal behaviour among adolescents.
3. Literature related to effectiveness of structured teaching programme on knowledge regarding risk factors and prevention of suicidal behaviour among adolescents.

1. Literature related to risk factors and suicidal behaviour.

Prasad.J, et.al., (2010) conducted a study on rates and factors associated with suicide among the age group of 15-24 years in Kanyakumari, Tamilnadu. The main objective of the study was to prospectively determine the suicide rate. The setting for the study was community block in rural South India. The study samples were selected randomly. The result showed that the average suicide rate was 92.2 per 100,000 people. The ratio of male to female suicide rate was 1:0.66; the age specific suicide rate for man has increased with age while that of female showed peaks in 15-24 years and over 65 years of age group and they found that depression is the main causative factor for committing suicide in the particular age group.

Aravind Pilai S, (2009) conducted a study to assess the prevalence and risk factors for suicidal behaviour among youth people in Goa, India. The objective of the study was to assess the risk factors and prevalence rate of suicide among the adolescents. The study samples were 3662 youths selected by using a convenient sampling technique from rural and urban communities in Goa. Suicidal behaviour during the recent 3 months and associated factors were assessed by using a structured interview those who had premarital sex, independent decision-making, physical abuse and alcohol use were identified as the major risk factors for suicidal behaviour. The result showed that 42.33% was due to depression, 12.19% drug use, 9.77% smoking, 7.11% drinking alcohol and 9.69% feeling hopelessness. The researcher concluded that violence and psychological distress were the dependent risk factors for suicidal attempts. Prevention programs for youth suicide in India had to address both the structural determinants of gender disadvantage and the individual experience of violence and poor mental health.

Tajma.M, (2009) conducted a study to assess the prevalence of suicide and related risk factors in Toyokawa, Japan. The objective of the study was to assess the prevalence rate and risk factors of suicide among adolescents. The data were obtained from 2436 adolescents by using interview technique. The result showed that 10.9% of adolescents were having suicidal ideation, 2.1% having a risk of attempted suicide and the prevalence rate was 2.8%. The researcher concluded that the suicidal risk and attempts were high while suicide ideation occurred at an earlier age and within the first year of suicidal ideation.

Park E, (2008) conducted a study to investigate the prevalence and risk factors of suicide attempt among late adolescents in Goyang, South Korea. The objective of the study was to find out the risk factors for attempted suicide and to

investigate the prevalence rate among late adolescents. The data were obtained through the web based survey by a Korean centre for disease control, and it was analyzed by using logistic regression method. The result showed that the prevalence rate of suicide attempt was 5.2% in South Korea. The risk factors of suicide attempt were due to suicidal ideation with 31.83%, depression 7.89%, drug use 4.67%, smoking 3.19%, feeling unhappiness 12.77%, drinking alcohol 2.39% and living with neither parent 22.4%. The researcher concluded that suicide prevention programs should be applied to the risk population prior to the suicide attempt.

Thompson A, (2009) conducted a study to assess the protective effects of self esteem and family support on suicide risk behaviour among the late adolescents in Egypt. The aim of this study was to examine the influence of self-esteem and family support on suicide risk behaviour. The data were collected by using two multidimensional assessment instruments after establishing reliability and validity, the tools were High School Questionnaire (HSQ) and the Measure of Adolescent Potential for Suicide (MAPS). Hierarchial multiple regression analysis was used to examine the moderating effect of family support on the relationship between self esteem and suicidal risk. 849 adolescents were assessed by using the multidimensional instrument and interviews. Slightly more than one half of the sample (54.3%) was male. Approximately 40% of the adolescents lived with both biological parents. Close to half (45%) of the participants perceived their family's financial status as much better than that of other youth. In consonance with the metropolitan demographics, 55% of female and 62% of male parents/guardians reported having had some college education, with 25% and 34% respectively, having earned a college degree or higher. The interaction of self-esteem and family support revealed a significant interaction term ($B = 0.03$, $b = 0.13$, $t = 4.27$, $p < .001$).

Adolescents with high family support reported significantly higher levels of self-esteem than those with low family support, t (837.2) = -7.49, p < .001. 37% of adolescents were identified with suicide risk. Suicide risk was significantly and positively associated with age (r = 0.08, p < .05). Finally the researcher concluded that the self esteem influences in late adolescents suicide risk behaviours for youth with low as well as high family support interventions designed to strengthen both self esteem and support resources are appropriate.

Agrebo, et.al., (2007) conducted a case control study on familial mental illness associated with an increased risk of suicide in young people in Denmark. The objective of the study was to estimate the risk of suicide in young people related to family and individual psychiatric and socio-economic factors. The research design was population-based nested case-control study. The Researcher found that 496 young people aged 10-21 had committed suicide during 2004-06 in Denmark and 24,800 controls matched for sex, age, and time. The result showed that parental factors associated with an increased risk for suicide in young people or early death, admission to hospital for a mental illness, unemployment, low income, poor schooling, and divorce, as well as mental illness in siblings and mental illness and short duration of schooling of the young people. The strongest risk factor was mental illness in the case of young people, and the researcher concluded that recognizing mental illness in young people and dealing with it appropriately could help prevent suicides. The high relative risk associated with a low socio-economic status of the parents may be confounded and over-estimated if not adjusted for mental illness and suicide in the family.

Hirsch J.K and Conner K.R, (2007) conducted a study on optimism and suicide ideation among young adult college students in New York City, USA. The objective of the study was to find the relationship between optimism and suicidal ideation. The result showed that the college students may be at an increased risk for suicide and out of 284 college students, most of them are female students numbering 185 (65%) aged 18 and over. The outcome measure was the beck scale for suicidal ideation even after controlling the factors of age, gender, depressive symptoms and hopelessness and a better understanding of its protective role in risk group and cross culturally is needed. The researcher concluded that prevention progress designed to enhance optimum in the college setting might decrease suicide risk.

Akaya, (2007) conducted a study on suicidal risk among the Vinnese College going adolescent students in Australia. The objective of the study was to find the suicidal risk among the college students. Among the college students 214 samples were selected (n=214 mean age 18.4 years). The result showed that the self reported survey of assessing demographic charactering of suicide was completed by 3 students. 81(37.9%) college students reported having suicidal risk in their lives. Girls had the risk significantly more often than boys (girls 48.5%, boys 29.1% at p=0.001), the researcher concluded that female gender, substance problem, college type and cigarette smoking were the influential factors in risk of suicide among the adolescents.

Fortune S, et.al., (2007) conducted a study on suicide among the adolescent group at Kennington Park, London. The objective of the study was to find out the risk among adolescents. This study used the interview method for collecting the data. The result showed that among 27 young people identified with suicidal risk, those who died by suicide were male accounting for 93% (n=25) were male with an average age

of 20.9 years (SD=2.4). The researcher found 3 types of suicidal process from the samples. In the case of Group I the suicidal process was long-standing and included deliberate self harm prior to their death and direct communication to friends and family about suicidal ideas and plans. Group II involved sub groups namely those individuals with a protracted suicidal process that lasted approximately 5-10 years and those with a brief suicidal process lasting approximately 1 year. In the case of Group III there was emergence of the suicidal process as an acute response to functioning well. The researcher concluded that a greater understanding of the pathway which leads young people to take their lives is important to ensure that prevention strategies and health service delivery are as effective as possible.

Siddhartha T, (2006) conducted a study to assess the suicidal behaviour among the college students in Orissa. The objective of the study was to find out the suicidal ideation and attempted suicidal rate among the late adolescents. The 1232 samples were selected between the age group of 19-23 for the study. The self structured questionnaires were used to find out deliberate self harm behaviour. The study result showed that 31.4% of them had the life time prevalence of suicidal ideation, whereas 12.8% had attempted suicide in their life time. The result proved that there was higher prevalence of suicidal ideation and deliberate self harm among college students.

Victoria N Folse, et.al., (2004) conducted a study on detecting suicide risk in adolescents and adults in emergency department, and tested the reliability and validity of the 4 item risk of suicide questionnaires (RSQ). The study expanded the implementation of the RSQ beyond its initial use with children and adolescents with psychiatric symptoms who were seeking treatment in a pediatric emergency department to include adolescent and adult patient in a level I trauma center. An

advanced practice psychiatric nurse verbally administered the RSQ to a convenience sample of 104 emergency department patients aged 12 to 82. Psychometric analysis demonstrated an adequate degree of reliability and criterion-related validity for the RSQ. Approximately 30% of all patients who participated screened positive for suicide risk. The result supports the continued use of the RSQ with adults exhibiting psychiatric chief complaints to determine imminent risk of suicide in patients who seek treatment in the emergency department. Nurses in all healthcare settings need to initiate suicide screening and implement nursing interventions directed toward suicide prevention.

2. Literature related to knowledge regarding risk factors and prevention of suicidal behaviour.

Sato R, Kawanishi C, et.al., (2010) conducted a study among the medical students regarding knowledge and attitude of suicidal prevention in Japan. The researcher administered a brief knowledge and attitude-assessment-questionnaire concerning suicide to students in their first, third, and fifth years at a Japanese medical school. Participants numbered 160 (94 men with a mean age of 21.8 years, SD = 3.01, and 66 women with a mean age of 21.2 years, SD = 2.64); In the knowledge part, only about half of the items were answered correctly (mean score was 4.21, SD = 1.28). Students of both sexes, without any significant differences, statistically analyzed declare that suicide is not about death, but about the end of suffering (67.74% males, 69.32% females). They say that suicide is one of leading causes of death among the young in developed countries (62.29% m, 56.82% f). They also assert that attempted suicide is a form of Russian roulette (70.49% m, 71.59% f). It is also said that people who talk about suicidal intentions should be considered seriously as a risk group (77.42% m, 78.41% f). There is a correlation between suicide and addictive

substances (87.10% m, 93.18% f), as well as depression episodes (90.32% m, 93.18% f). Loss of loving persons has a direct connection with suicidal behaviour (87.10% m, 69.32% f). There are some opportunities for those people to be helped by close friends (86.88% m, 93.18% f) and SOS services (86.88% m, 90.90% f). In a statistically more significant manner, correct answers are more frequently registered in female students who state that attempted suicide is more common in females ($\chi 2 = 4.28$, $p < 0.05$). It can be concluded that medical students display a substantial knowledge of suicide-related themes, which could make them successful participants in educational programmes for provision of better living skills aimed at more successful response to stressful living situations.

Amelia Marriaa, et.al., (2010) conducted a prospective longitudinal cohort study on prevention of suicidal behaviour on college students in Mid-Atlantic region of USA. In this a two-stage sampling design was employed. Only first-time undergraduate students aged 17 to 19 were eligible for the study. First, a screening questionnaire was administered during the first-year of class in public university to focus the adaptation in new environment, and the resulting screened sample (N=1249) represented that 89% of them have ideation in some point of their lives. An estimated 6% of all first-year students had current suicide ideation, and 6% had high depressive symptoms. Suicide ideation was somewhat more prevalent among women (7%) than men (5%), as were high depressive symptoms (8% of women, 3% of men). Interestingly, among individuals with suicide ideation, only a minority (40%) had high depressive symptoms. And the researcher concluded that the adolescents have lack of knowledge regarding prevention of suicide and that should be improved by training programmes.

Chien WT, Chan SW et.al., (2008) conducted a study to evaluate an education program on suicide prevention among general nurses in Hong Kong, China. The objective of the study was to evaluate the effect of an education programme on nurses' knowledge, attitude and competence on suicide prevention and management for patients with suicide attempt or ideation and their family members and to examine the strengths and weaknesses of the programme from the participants' perspectives.
54 registered general nurses from the medical and surgical units of two general hospitals completed the education programme. Focus groups were used for process (n = 24) and outcome evaluation (n = 18). 18-hour education programme on suicide prevention and management was undergone by the nurses. The findings suggested that the education intervention had benefited the participants by improving their attitude, confidence and professional skills in responding to patients with suicidal intent. The researcher concluded that barriers in the practice environment influenced nurse's abilities to give optimal care to this group of patients and their family members.

Protzky.H, et.al., (2009) conducted a study on suicide prevention among the adolescents in Belgium. Psycho educational programs are the most commonly applied suicide prevention approaches for the young people. The objective of the study was to examine the effectiveness of these programs in a controlled study by assessing the effect on knowledge attitude, coping and hopelessness. 18 to 25 years old students (n = 289) were administered structured questionnaires before and after the program. The result showed that the program had effect on coping styles and levels of hopelessness and a positive effect on knowledge could be identified with an interaction effect of the program with gender on attitudes. It also found that the overall knowledge after the psycho education was 76.26% so the researcher suggested

that psycho-educational programs in adolescents may influence knowledge about suicide and attitudes towards suicidal persons but may not affect the use of coping styles or levels of hopelessness

MacDonald MG, (2007) conducted a study on education on major knowledge about suicide to identify what training they may need about suicide prevention in Oakland University, USA. The study samples are 71 college-going adolescent students. It completed the 50 items and expanded revised facts on suicide quiz to examine their knowledge about suicide. The result showed that while overall knowledge was low for general information and for specific item concerning suicide among youth and elderly persons, knowledge was high on several items important for suicide prevention work. Higher suicide-related knowledge was found for knowing a suicide attempter, providing partial support for the hypothesis that personal experience with suicidal people may correspond with greater knowledge about suicide.

Thornhill J.C, et.al., (2006) conducted a study on the adult's suicide-related knowledge, implications for suicide awareness education among 190 young adults and 52 older adults in Queensland. Among 17-21 year olds (47 males, 143 females, M = 18.53, SD = 1.19), 52 adults aged 40-50 years (17 males, 35 females, M = 45.08, SD = 3.07) participated in this study. Suicide knowledge test scale was designed to assess participants' knowledge of adolescent suicide **(Pirito, et.al., 1988)** this scale consisted of 18 statements attitudes towards suicide, and a questionnaire consisted of 37 statements assessing attitudes, beliefs and feelings about suicide. The data were analysed by using analysis of variance (ANOVA). The result showed that participants scoring an average of 58.25% (SD= 15.11), displayed inadequate knowledge levels in relation to adolescent suicide with a mean score of 62%, (SD =19.55) on the suicide

knowledge test and there was no significant difference between young adults and older adults on their knowledge of adolescent suicide, $F(1, 237)=2.16$, $p> 0.05$. The researcher concluded that both the young and older adults indicated a substantial degree of personnel experience with suicide and others possessed a reasonable attitude to adult suicide. It also showed that females have better knowledge than young male adults and also there is a need for inclusion of suicide education in school-based programs.

MahmethEskin, (2006) conducted a study to investigate the opinions about suicide and reactions to a suicidal peer among 89 females and 78 males in Turkish high schools. The study result showed that a more number of male persons believed that suicide should be discussed among friends. Compared to males, females perceived that suicidal persons are mentally ill and to be punished in another world. Females show greater acceptance of a suicidal classmate than males, and an attitude for openly discussing about suicide was associated with higher acceptance of suicidal classmate.

Li XY, et.al., (2004) conducted a study on current attitude and knowledge about suicide prevention in community members with a qualitative study approach in Northern China. The objective was to understand the public's current attitudes and knowledge about suicide, which provide information on the development of targeted public education programs, and important components of the suicide prevention effort. 17 mental health professionals who were extensively trained in the methods of conducting focus group used a pre-test and post-test focus group on attitudes and knowledge about suicide and involved 101 focus groups and 18 individuals in depth interviews with a total of 842 community respondents from 6 regions in Northern China. The study result showed that in China the community is tolerant, sympathetic

and in some cases there is an acceptance of suicide but there remains a substantial underlying stigmatization of suicide, and in the post test 72% had adequate knowledge and the remaining 37.98% had inadequate knowledge. Community members have some underestimation of the importance of mental illness as a cause of suicide. The content of public health messages used in suicide prevention programs should be applied in vulnerable group in the community in future by both qualitative and quantitative research approaches.

Beautrias AL, et.al., (2004) conducted a study to examine knowledge and attitude about suicide in New Zealand. The young people aged 25 were selected as a study sample. The study result showed that the young people over-estimate the prevalence of young suicide and the fraction of suicide accounted over by youth deaths and hold both conservation and liberal attitudes towards suicide. The primary source of information about suicide is media. These findings raise concerns about the potential for media coverage of youth suicide issues or normalize suicide as a common thing and there by unacceptance response among young people and suggest a need for careful dissemination of accurate information about suicide by knowledgeable, respected and reputed sources.

3. Literature related to structured teaching programme on knowledge regarding risk factors and prevention of suicidal behaviour among adolescents.

Julie T. Weismoore, (2010) conducted a study to assess the signs of self-injury program which is the first known non-suicidal self-injury (NSSI) school-based prevention program for adolescents. The objective of the study was to increase knowledge, improve help-seeking attitudes and behaviours, and decrease acts of NSSI. A total of five schools implemented the program in selected classrooms (n = 274 adolescents; 51.5% female and 48.5% males, mean age = 16.07 years) that

consisted of predominantly Caucasian (73%) adolescents. Researchers collected pre-post evaluation surveys of the program, and feasibility interviews were conducted with the school guidance personnel who ran the program. The study results showed that prevention program produced appreciable effects 68.08% increased accurate knowledge and 72.88% of them improved in help-seeking attitudes and intentions among students. No significant changes were found in regards to self-reported formal help-seeking actions. The researcher concluded that the program may be an effective prevention program for school.

Orbach, I. and Bar Joseph, H, (2010) conducted a study on the impact of a suicide prevention program for adolescents on suicidal tendencies, hopelessness, ego identity, and coping in Israel. The objective of the study was to examine the effectiveness of an experiential suicide prevention program. 393 adolescents from 6 schools participated in the study. The samples were randomly divided into experimental (n = 215) and control (n = 178) groups. Pretest-post test design was used, and the students completed questionnaires of suicidal tendencies, hopelessness, ego identity, and coping ability before and after the prevention program. The experimental groups took part in seven-week 2-hour meetings. The result showed that experimental groups were superior to the controls, with at least some of the dependent measures pointing out the effectiveness of the program.

Spring, (2009) conducted a study to determine whether students who have been exposed to suicide prevention materials and activities on campus possessed a greater knowledge of suicide warning signs and recourse for help. The researcher used the suicide prevention exposure, awareness and knowledge survey- student version (SAMHSA, 2006). Based on the findings from a convenience sample of 292 students (154 freshmen, 16 sophomore, 72 juniors and 50 seniors) 207 (71%) of the

students reported that they had been exposed to materials such as brochures, postures, video, radio and television messages on campus-related to suicide prevention. Another 245(84%) students reported awareness of at least one resource to which a friend who is at risk for suicide could be referred. However, when asked about knowledge of at least one crisis hotline number that could be given to a friend at risk for suicide, only 139(48%) students indicated an affirmative response.

Knox, K. L., Litts, D. A., Talcott, G. W., et.al., (2007) conducted a cohort study to assess the risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force. The objective of the study was to evaluate the impact of the US Air Force suicide prevention programme on risk of suicide and other outcomes that share underlying risk factors. The total number of sample was 5,260,292 US Air Force personnel (around 84% were men). A multilayered intervention targeted at reducing risk factors and enhancing factors considered protective. The intervention consisted of removing the stigma of seeking help for a mental health or psychosocial problem, enhancing understanding of mental health, and changing policies and social norms. The study results showed that the implementation of the programme was associated with a sustained decline in the rate of suicide and other adverse outcomes. A 33% relative risk reduction was observed for suicide after the intervention; reductions for other outcomes ranged from 18-54%. The researcher concluded that a systemic intervention aimed at changing social norms about seeking help and incorporating training in suicide prevention has a considerable impact on promotion of mental health. The impact on adverse outcomes in addition to suicide strengthens the conclusion that the programme was responsible for these reductions in risk.

Aoun S and Johnson L.A, (2006) conducted a study to assess the impact of a suicide intervention programme from a consumer perspective in Australia. Self-administered questionnaires were distributed to consumers who had been referred to a suicide intervention counselor in the 2-year period of the programme in rural southwest Western Australia. The study result showed that three-quarters of respondents were positive about their experience with the service and half of the respondents no longer having thoughts of suicide, whereas only 20% of all respondents reported having attempted deliberate self-harm post-counseling. In dissatisfied group suicidal ideation and attempted self-harm were much higher. The dissatisfaction of respondents stemmed from the history of their treatment and the hassle created by many systems for them to access care. The researcher concluded that the overall outcome of this study is that, from the consumer's perspective, a high intensity approach to suicide intervention resolved is effective.

Claire Hayes, Mark Morgan, (2005) conducted a study to assess the effectiveness of psycho educational programme in Barcelona, Spain. The study was conducted among 706 young adolescents. Over 20% of adolescents identified themselves as experiencing difficulties and being in need of specific help in coping. A psycho educational Program 'Helping Adolescents Cope' was offered to 112 of them. This was adapted with permission, from the "Coping with Stress Course," devised by Albano et al. (1997). Participant's progress was monitored and evaluated using qualitative and quantitative measures. The researcher concluded that the psycho educational Program was found to be significantly effective in reducing participant's depression scores, in reducing their reliance on unproductive means of coping and overall in helping.

Aseltine, R. H. and DeMartino, R, (2004) conducted a study to evaluate the outcome of the signs of suicide (SOS) Prevention Program. The objective of the study was to examine the effectiveness of the signs of suicide prevention program in reducing suicidal behaviour. The total number of students selected from 5 high schools in Columbus, Hartford, were randomly selected as intervention and control groups. The researcher used Self-administered questionnaires which were completed by students in both groups approximately 3 months after program implementation. The result showed that significantly lower rates of suicide attempts and greater knowledge and more adaptive attitudes about depression and suicide were observed among students in the intervention group. The modest changes in knowledge and attitudes partially explained the beneficial effects of the program, and the researcher concluded that SOS is the first school-based suicide prevention program to demonstrate significant reductions in self-reported suicide attempts.

Eggert L.L, Thompson E.A, (2004) conducted a study to test the efficacy of the school-based prevention program for reducing suicide potential among high-risk adolescents. A sample of 105 youth at suicide risk participated in a three-group, repeated-measures intervention study. Participants involved in (1) an assessment plus 1-semester experimental programme, (2) an assessment plus 2-semester experimental program and (3) an assessment-only group were compared, using data from pre intervention, 5-month, and 10-month follow-up assessments. All groups showed decreased suicide risk behaviours, depression, hopelessness, stress, and anger; all groups also reported increased self-esteem and network social support. Increased personal control was observed only in the experimental groups, and not in the assessment-only control group. The potential efficacy of the experimental school-based prevention program was demonstrated. The necessary and sufficient strategies

for suicide prevention however need further study as the assessment-only group who received limited prevention elements showed improvements similar to those of the experimental.

Aoun, S. and Johnson L, (2001) conducted a study on consumer's perspective of a suicide intervention programme at Western Australia. The objective of this study was to assess the impact of a suicide intervention program from a consumer's perspective. Self-administered questionnaires were distributed to consumers who had been referred to a suicide intervention counselor in a 2-year period of the programme in rural southwest Western Australia. The result showed that Three-quarters of respondents were positive about their experience with the service, with half of the respondents no longer having thoughts of suicide whereas only 20% of all respondents reported having attempted deliberate self-harm post-counseling. Reported suicidal ideation and attempted self-harm were much higher in the dissatisfied group. However, the overall outcome of this study is that, from the consumer's perspective, a high intensity approach to suicide intervention resolved or improved the present problem and their ability to deal with it.

Ciffone.J, (2003) conducted a study on a classroom presentation on suicide prevention programme to adolescents in Chicago areas, USA. The objective of the study was to test the effectiveness of a suicide prevention program and this present study used an attitudinal survey to evaluate program effectiveness. The researcher selected sophomores from three suburban high school, and samples were selected randomly from the group. The intervention group consisted of 203 students (119 males and 68 females) and control group of 121 students (53 males and 68 females). Both groups completed the survey one day before the suicide prevention presentation and again 30 days following the presentation. The researcher used a logistical

regression method for analyzing the collected data. The study result showed that at baseline “most adolescents did not hold sensible or accurate views about suicidal behavior; 74% did not believe that teenagers who kill themselves are usually mentally ill; 55% would not seek out help for themselves if they felt very upset; 53% would not encourage a suicidal friend to seek help from a mental health professional; 44% would ignore or joke about a peer who threatens suicide, and 43% would counsel a suicidal friend without obtaining help from someone else. This study found that following intervention there was a positive significant increase in help-seeking for a peer, and help seeking for one-self, and there was an increased likelihood of self-disclosure to a friend about suicidal ideations, and also an increased awareness about the role of mental illness in students. The researcher concluded that two messages need to be communicated to all adolescents. They must understand that suicidal attempts and completions are usually symptoms of treatable psychiatric illnesses, and adolescents should prepare themselves for emergency emotional situations.

Summary:

This chapter dealt with the literatures related to risk factors and suicidal behavior, literatures related to knowledge regarding risk factors and prevention of suicidal behavior and literatures related to structured teaching programme on knowledge regarding risk factors and prevention of suicidal behaviour among adolescents.

CHAPTER -III

RESEARCH METHODOLOGY

The methodology of research indicates the general pattern of organising the procedure for gathering the valid and reliable data for the purpose of investigation. **(Polit D.F, and Hunger, 2003)**

The present study was carried out to determine the effectiveness of structured teaching progarmme on knowledge regarding Risk factors and Prevention of Suicidal behaviour among the Adolescents with a view to promote knowledge.

Research Approach:

The Quantitative evaluative research approach was adopted in this study.

Research Design:

The research design chosen for this study was Pre experimental research design. (One group pretest post test design)

O_1 X O_2

O_1: Pre test.

X: Intervention –Structured Teaching Programme.

O_2: Post-test.

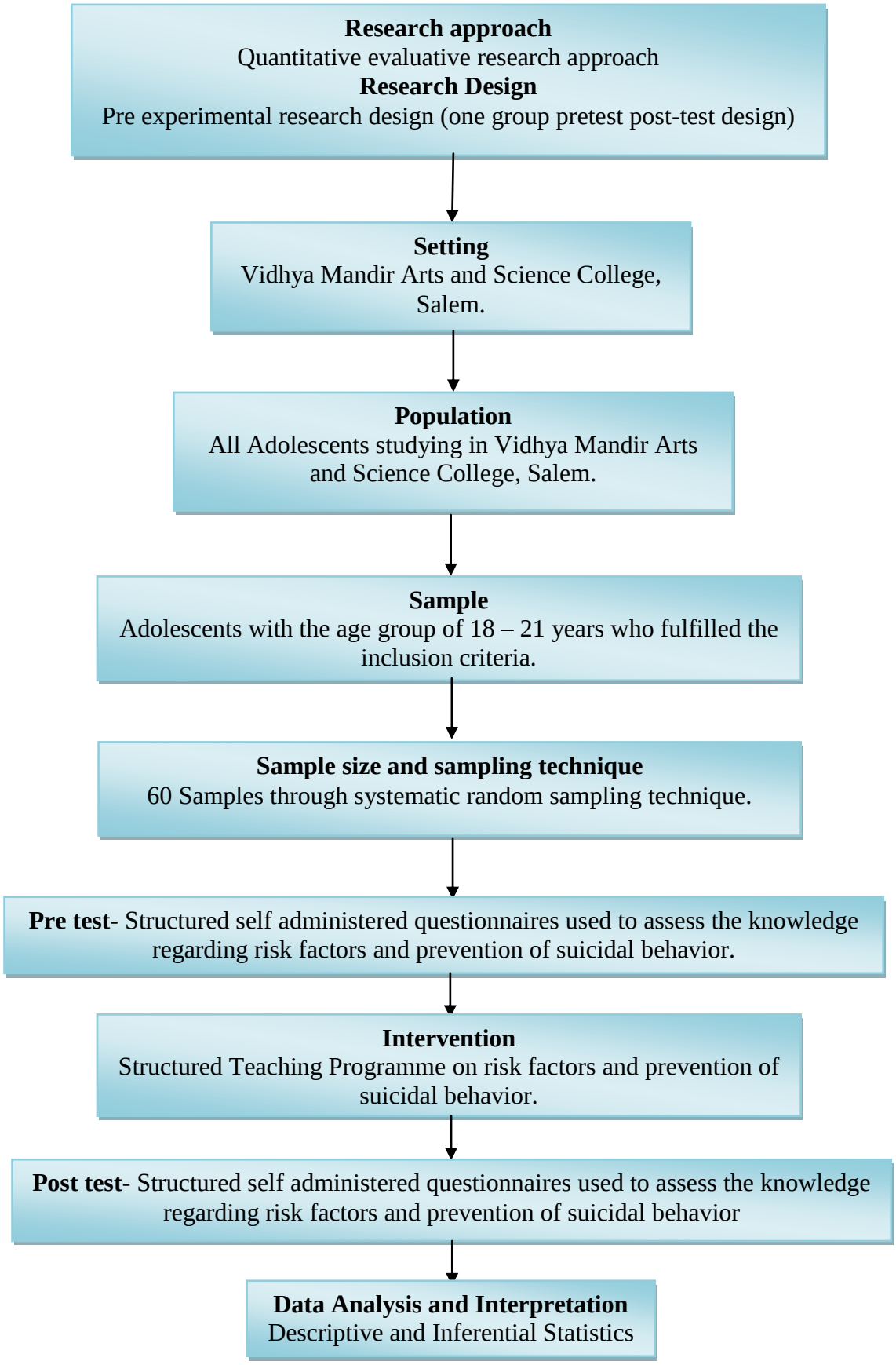


Fig-3.1: Schematic Representation of Research Methodology

Population:

Population is the set of people or entities to which the results of a research are to be generalised. **(Denise F. Polit and Beck, 2011)**

The study population consists of college adolescents both boys and girls. The total number of students in the college was 244.

Description of the setting:

The study was conducted in Sri Vidhya Mandir Arts and Science College at Neikkarapatti Salem. This college is a private organization. Which is 2km away from Sri Gokulam College of Nursing.

Sampling:

Sampling is the process of selecting a representative segment of the population under study. (**Denise F. Polit and Beck, 2011)**

- **Samples:**

  The samples comprised of the Adolescents between 18-21 years and who fulfilled the inclusion criteria.

- **Sample size:**

  The sample size of the study was 60.

- **Sampling technique:**

  Systematic random sampling technique was adopted for selecting the samples for the study. The total number of adolescents were 244. The sample size was 60. The samples were selected based on the availability.

$$K^{th} = \frac{\text{Total number of samples}}{\text{Sample size}}$$

$$= 244/60 = 4.06$$

Every 4^{th} sample was selected by using Simple random sampling technique (Lottery method).

Criteria for sample selection:

Inclusion criteria:

- Those who were in the age group of 18 to 21 studying in the selected college.
- Those who were available at the time of data collection.
- Both boys and girls willing to participate in the study.
- Person who can read and write Tamil and English.

Exclusion criteria:

- The adolescents who had already been exposed to any teaching on risk factors and prevention of suicidal behaviour.

Variables:

Independent variable : Structured teaching programme on risk factors and prevention of suicidal behaviour.

Dependent variable : Knowledge regarding risk factors and prevention of suicidal behaviour.

Extraneous variable : Age, sex, type of family, place of accommodation, religion, and family monthly income, educational status of parents and occupation of parents.

Description of the tool:

It consists of three sections,

Section-I: Demographic data.

This section consists of demographic variables like age, sex, type of family, place of accommodation, religion, and family monthly income, educational status of parents and occupation of parents.

Section-II: Structured self-administered questionnaire to assess the knowledge regarding risk factors and prevention of suicidal behaviour.

The Structured self-administered questionnaire was used to assess the knowledge. The questions were under the subheadings related to general information, risk factors and warning signs of suicide and prevention of suicidal behavior.

Table 3.1: Scoring key for knowledge questionnaire.

There were 24 questions where each correct answer was given the score of 1 and each wrong answer was given the score of 0.

Category	Score	Percentage
Adequate knowledge	17-24	70-100%
Moderately adequate knowledge	9-16	35-69%
Inadequate knowledge	0-8	0-34 %

Section III: Structured teaching programme on risk factors and prevention of suicidal behaviour.

Teaching programme includes definition of suicidal behaviour, causes, risk factors, warning signs of suicide, facts and fables of suicide, prevention of suicide and suicidal awareness.

Validity and reliability:

Validity:

Validity refers to the degree which an instrument measures what it is supposed to measure. (**Polit and Hungler, 2011)**

The validity of the tool was established in the consultation with the guide and the experts. The tool was validated by five experts in the field of psychiatric nursing and one from the field of medicine and another expert was a clinical psychologist.

The tool was found to be adequate and minor suggestions given by the experts which was incorporated.

Reliability:

Reliability is the degree of consistency or dependability with which an instrument measures an attribute. (**Denise F.Polit and Beck, 2011**)

The reliability of the tool was checked and established by using test – retest method, and the obtained r = 0.9 shows that the tool was highly reliable and it was considered for proceeding.

Pilot Study:

After obtaining the formal permission from Principal of Salem Sowdeshwari College, Salem, the pilot study was conducted from 22.07.2013 to 27.07.2013 among six study subjects. Pretest was conducted on 22.07.2013 with help the of structured self-administered questionnaire. Then the structured teaching programme was given regarding risk factors and prevention of suicidal behavior through LCD power point to the samples on the same day and the post test was conducted on 27.07.2013 with the same tool.

The findings of the pilot study revealed that it was feasible to conduct the main study.

Method of Data Collection:

Ethical consideration:

- Written permission was obtained from the Principal of Sri Vidhya Mandir Arts and Science College, Salem.
- Oral consent was obtained from the study subjects.

Period of Data Collection:

- The data was collected for a period of 4 weeks from 29.07.13 to 27.08.13.

Data collection procedure:

The study samples 60 were selected by the systematic random sampling technique from Sri Vidhya Mandir Arts and Science College, Salem. The selected samples were explained about the purpose of the study. Then the pre test was done on 01.08.13 by using a structured self administered questionnaire and the adolescents were subdivided into 4 groups (15 in each group) followed with, the structured teaching programme was given to each group regarding definition of suicidal behaviour, causes, risk factors, warning signs of suicide, facts and fables of suicide, prevention of suicide and suicidal awareness through LCD power point presentation for about 45 minutes. Post test knowledge was assessed on 7^{th} day by using the same tool.

Plan for Data Analysis:

Data was analysed by using both descriptive and inferential statistics.

- Demographic information was calculated by using frequency and percentage.
- The effectiveness of structured teaching programme was calculated by using inferential statistics (t-test).
- Association between the pretest knowledge regarding risk factors and prevention of suicidal behaviour with their demographic variables was calculated by using inferential statistics (chi-square analysis).

Summary:

This chapter dealt with the methodology. It consists of research approach, research design, description of the setting, population, sampling, variables, and description of the tool, validity and reliability, pilot study, method of data collection and plan for data analysis.

CHAPTER -IV

DATA ANALYSIS AND INTERPRETATION

Research data must be processed and analysed in an orderly fashion so that patterns and relationship can be discerned, validated, and hypotheses can be tested. Quantitative data analyzed through statistical analysis includes simple procedures as well as complex and sophisticated methods. (**Polit, 2004**)

This chapter deals with analysis and interpretation of the data collected to evaluate the Effectiveness of structured teaching programme on knowledge regarding Risk factors and Prevention of suicidal behaviour among adolescents in a selected college, Salem. The collected data was tabulated, organized and analyzed by using both descriptive and inferential statistics.

Section- A:

Distribution of adolescents according to their demographic variables.

Section- B:

Distribution of adolescents according to their pre-test score on knowledge regarding risk factors and prevention of suicidal behaviour.

Section- C:

a) Distribution of adolescents according to their post test score on knowledge regarding risk factors and prevention of suicidal behaviour.
b) Comparison between the pretest and post test scores on knowledge regarding risk factors and prevention of suicidal behaviour among adolescents.
c) Comparison of area wise Mean, SD, Mean percentage, Difference in mean percentage of pre-test and post test knowledge score regarding risk factors and prevention of suicidal behaviour among adolescents.

Section – D: Hypotheses testing

a) Effectiveness of structured teaching programme on knowledge regarding risk factors and prevention of suicidal behaviour among adolescents.

b) Association between the pretest knowledge regarding risk factors and prevention of suicidal behaviour among adolescents with their selected demographic variables.

Section – A

Distribution of adolescents according to their demographic variables.

Table.4.1:

Frequency and percentage distribution of adolescents according to their selected personal variables.

n=60

Sl.no	Personal variables	Frequency (f)	Percentage (%)
1.	Age in years		
	a. 18-19	28	46.67
	b. 19-20	22	36.67
	c. 20-21	10	16.66
2.	Sex		
	a. Male	25	41.67
	b. Female	35	58.33
3.	Religion		
	a. Hindu	59	98.33
	b. Christian	0	0
	c. Muslim	1	1.67
	d. Others	0	0
4.	Type of family		
	a. Nuclear family	41	68.33
	b. Joint family	19	31.67
5.	Place of accommodation		
	a. Hostel	3	5
	b. Home	57	95

Table – 4.1 shows that 28(46.67%) samples are in the age group of 18-19 years, 22(36.67%) are in the age group of 19-20 years and 10(16.67%) are in the age group of 20-21 years. Pertaining to the gender, 25(41.67%) are males and 35(58.33%) are females. Relating to religion, 59(98.3%) belongs to the Hindu religion and the remaining 1(1.67%) belongs to Muslim. Concerning to the type of family, 41(68.33%) are from nuclear family and 19(31.67%) are from the joint family. In relation to the place of accommodation, 3(5%) are staying in the hostel and 57(95%) are living at home.

Table.4.2:

Frequency and percentage distribution of adolescents according to their family related demographic variables.

n=60

Sl.No	Family related demographic variables	Frequency (f)	Percentage (%)
1.	Family monthly income		
	a. Below Rs.5000	38	63.33
	b. Rs.5001-10000	19	31.67
	c. Rs.10001 and above	3	5
2.	Educational status of father		
	a. No formal education	33	55
	b. Primary education	17	28.33
	c. Higher education	9	15
	d. Graduate	1	1.67
3.	Educational status of mother		
	a. No formal education	40	66.67
	b. Primary education	16	26.67
	c. Higher education	3	5
	d. Graduate	1	1.66
4.	Father's occupation		
	a. Unemployed	7	11.67
	b. Self employed	37	61.67
	c. Private employee	10	16.66
	d. Government employee	6	10
5.	Mother's occupation		
	a Home maker	52	86.66
	b. Self-employed	4	6.67
	c. Private employee	4	6.67
	d. Government employee	0	0

Table-4.2 describes the distribution of study samples according to the family related variables. Pertaining to family monthly income, 38(63.33%) samples have a family monthly income of below Rs.5000, 19(31.67%) have their family monthly income between Rs.5001 – 10000 and only 3(5%) have a family monthly income of Rs.10001 and above.

In relation to samples father's education concerned, 33(55%) have no formal education, 17 (28.33%) have primary education, 9(15%) have higher education and 1(1.67%) is a graduate.

Concerning to mother's education, 40(66.67%) have no formal education, 16(26.67%) have primary education, 3(5%) have higher education and 1(1.66%) is a graduate.

Relating to father's occupation, 7(11.67%) are unemployed, 37(61.67%) are self employed, 10(16.66%) are private employee and 6(10%) are government employees.

In terms of mother's occupation concerned, 52(86.66%) are home makers, 4(6.67%) are self employed and 4(6.67%) are private employees.

Section- B

Distribution of adolescents according to their pre-test score on knowledge regarding Risk factors and Prevention of Suicidal Behaviour.

Table 4.3:

Frequency and Percentage distribution of Adolescents according to the pre-test score on Knowledge regarding Risk factors and Prevention of Suicidal Behaviour.

n=60

SI.no	Knowledge	f	%
1.	Adequate Knowledge	-	-
2.	Moderately adequate Knowledge	15	25
3.	Inadequate Knowledge	45	75

The above table shows that during pre-test, most of the adolescents numbering 45(75%) have inadequate knowledge, 15(25%) adolescents have moderately adequate knowledge and none of them have adequate knowledge regarding Risk factors and Prevention of Suicidal Behaviour.

Section- C

a. Distribution of adolescents according to their post-test score on knowledge regarding Risk factors and Prevention of Suicidal Behaviour.

Table 4.4:

Frequency and Percentage distribution of Adolescents according to the post test score on Knowledge regarding Risk factors and Prevention of Suicidal Behaviour.

n=60

SI.no	Knowledge	f	%
1.	Adequate Knowledge	23	38.33
2.	Moderately adequate Knowledge	37	61.67
3.	Inadequate Knowledge	-	-

The above table shows that during post-test 23(38.33%) adolescents have adequate knowledge, 37(61.67%) have moderately adequate knowledge and none of them have inadequate knowledge regarding Risk factors and Prevention of Suicidal behavior.

b. Comparison between the pretest and post test scores on knowledge regarding Risk factors and Prevention of Suicidal Behaviour among Adolescents.

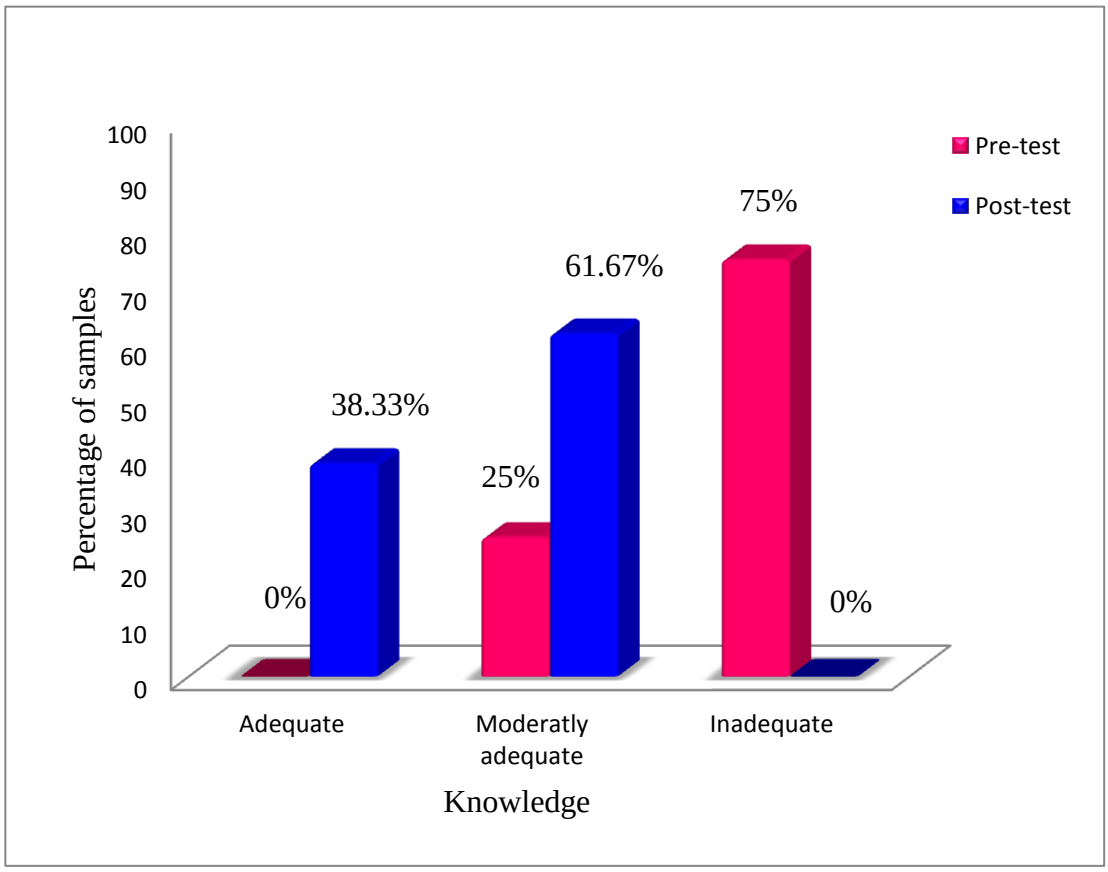


Fig-4.1: Percentage distribution of samples according to their pre test and post test knowledge score.

The above figure-4.1 shows that during pre-test, 15(25%) adolescents have moderately adequate knowledge, 45(75%) have inadequate knowledge and none of them have adequate knowledge. During post-test, 23(38.33%) adolescents have adequate knowledge, 37(61.67%) have moderately adequate knowledge and none of them have inadequate knowledge regarding Risk factors and Prevention of Suicidal Behaviour.

c. Comparison of area-wise Mean, SD, Mean percentage, Differences in mean percentage of pre test and post test knowledge score regarding risk factors and Prevention of Suicidal Behaviour among Adolescents.

Table 4.5:

Area wise Mean, SD, Mean percentage and differences in mean percentage of pre test and post test knowledge score regarding Risk factors and Prevention of Suicidal Behaviour among Adolescents.

n=60

SI. No	Area of knowledge	Maximum score	Pretest			Post test			Difference in Mean %
			Mean	SD	Mean %	Mean	SD	Mean %	
1.	General information	3	1.35	0.70	45	2.08	0.75	69.33	24.33
2.	Risk factors & Warning signs	11	4.45	1.35	40.45	7.27	1.50	66.09	25.64
3.	Prevention of Suicidal Behaviour	10	4.1	1.83	41	7.68	1.87	76.80	35.80

The above table-4.5 shows that the General information related pretest mean score is 1.35±0.70 which is 45%, post test mean score is 2.08±0.75 which is 69.33% with a difference of 24.33%.

Pertained to warning signs and risk factors, the pretest mean score is 4.45±1.35 which is 40.45%, post test mean score is 7.27±1.50 which is 66.09% with a difference of 25.64%.

In relation to prevention of suicidal behavior, the pretest mean score is 4.1±1.83 which is 41%, post test mean score is 7.68±1.87 which is 76.80% with difference of 35.80%.

Section - D

Hypotheses Testing

a. Effectiveness of Structured-teaching Programme on knowledge regarding Risk factors and Prevention of Suicidal Behaviour among Adolescents.

Table 4.6:

Mean, standard deviation, paired‘t’ test value of knowledge among adolescents before and after Structured-teaching Programme.

n=60

Knowledge	Mean	S.D	‘t’ Value	df	Table value
Pre test	9.9	3.88	16.84*	59	4.05
Post test	17.03	4.12			

*** Significant at p≤ 0.05 level**

The above table-4.6 shows that the mean score during pre-test is 9.9 ± 3.88, and the mean score during post-test is 17.03 ± 4.12. The paired‘t’ test value is 16.84 which is significantly higher than the table value of 4.05 at p≤0.05 level. Hence hypothesis H_1 is retained. Thus it becomes evident that the structured-teaching programme is effective in improving the knowledge regarding Risk factors and Prevention of Suicidal Behaviour among Adolescents.

b. Association between the pretest knowledge regarding Risk factors and Prevention of Suicidal Behaviour among Adolescents and their selected demographic variables.

Table 4.7:

Chi-square test on pre-test knowledge regarding Risk factors and Prevention of Suicidal Behaviour among Adolescents with their selected Demographic Variables.

n=60

SI.No	Demographic variables	df	χ^2	Table value
1.	Age in years	2	5.01	5.99
2.	Sex	1	2.76	3.84
3.	Type of family	1	0.025	3.84
4	Place of accommodation	1	0.11	3.84
5.	Religion	1	0.34	3.84
6.	Family monthly income	2	5.09	5.99
7.	Educational status of the father	3	3.06	7.82
8.	Educational status of the mother	3	3.97	7.82
9.	Father's occupation	3	4.36	7.82
10.	Mother's occupation	2	1.43	5.99

***Significant at p≤0.05 level**

The above table 4.7 shows that there is no significant association found between the knowledge regarding Risk factors and Prevention of Suicidal Behaviour among adolescents with their selected demographic variables at p≤0.05 level. Hence H_2 is rejected.

Summary:

This chapter dealt with the data analysis and interpretation in the form of statistical value based on the objectives. Frequency and percentage were used to assess the demographic variables. The paired 't' test was used to evaluate the effectiveness of structured-teaching programme on knowledge regarding Risk factors and Prevention of Suicidal Behaviour among the Adolescents. The chi-square test was used to find out the association between the knowledge among adolescents with their demographic variables. The result showed that the structured-teaching programme is effective in improving knowledge among adolescents.

CHAPTER -V

DISCUSSION

This study was done to determine the Effectiveness of Structured-Teaching Programme on Knowledge regarding Risk factors and Prevention of Suicidal Behaviour among Adolescents studying in a selected College, Salem.

Description of the demographic variables

The researcher found that majority of, i.e. 28 (46.67%) samples belong to 18-19 years of age, 35 (58.33%) of them were females, 59 (98.33%) were Hindus, 41(68.33%) were living in a nuclear family, 57(95%) of them were coming from home, 38(63.33%) of them have family monthly income of below Rs.5000, 33(55%) of the adolescent's fathers had no formal education, 40(66.67%) of the adolescent's mothers had no formal education, 37(61.67%) of the adolescents fathers were self employed and 52(86.66%) of the adolescent's mothers were home makers.

The first objective of the study was to assess the knowledge regarding Risk factors and Prevention of Suicidal Behaviour among Adolescents.

The pretest result shows that 45(75%) of the adolescents had inadequate knowledge, 15(25%) had moderately adequate knowledge and none of the adolescents had adequate knowledge regarding Risk factors and Prevention of Suicidal Behaviour.

Rajesh.M, (2010) conducted a study to evaluate the effectiveness of planned teaching program on knowledge of suicidal prevention among the adolescents in Punjab. The study consists of 60 samples selected by non probability convenient sampling method. The pretest result showed that 57(95%) had inadequate knowledge, 3(5%) had moderately adequate knowledge and none of them had adequate knowledge regarding prevention of suicide.

The second objective of the study was to evaluate the effectiveness of structured teaching programme on knowledge regarding Risk factors and Prevention of Suicidal Behaviour among Adolescents.

During pretest, the mean score was 9.9±3.88 and the post test mean and standard deviation score was 17.03±4.12. The paired 't' test value was 16.84 which are significantly higher than the table value of 4.05 at $p \leq 0.05$ level. Hence hypothesis H_1 is retained. This reveals that the structured teaching programme was effective in increasing the knowledge regarding Risk factors and Prevention of Suicidal Behaviour among Adolescents.

Nandagaon Veeresh.S, (2012) conducted a study to assess the effectiveness of structured teaching programme on knowledge regarding suicidal ideation and prevention of suicidal behaviour among adolescents in university students, Karnataka. 60 adolescents were selected by non probability convenient sampling. In this study, self administered questionnaires were used to collect data. The study result shows that the calculated paired 't' test value was 25.91, greater than the tabulated value of 1.960 which was significant at $p \leq 0.05$ level. The researcher concluded that the structured teaching programme was effective on the adolescents.

The third objective of the study was to associate the pre test knowledge regarding Risk factors and Prevention of Suicidal Behaviour among the Adolescents with their selected demographic variables.

In this study, there was no significant association found between the pretest knowledge among adolescents and their selected demographic variables at $p \leq 0.05$ level. Hence H_2 was rejected.

Shriharsha.C, (2013) conducted a study to assess the effectiveness of structured teaching programme regarding factors and preventive measures for suicidal

behaviour among adolescent college students at Bagalkot, Karnadaka. With the objective to associate the knowledge with their demographic variables such as age, gender, religion, parent's occupation and source of information. 50 adolescents were participated in the study. The researcher found that there was no association found between the knowledge regarding factors and preventive measures for suicidal behaviour and their selected demographic variables.

Summary:

This chapter dealt with the discussion of the study in reference to the objectives and supportive studies. All the three objectives have been obtained and one hypothesis was retained in this study.

CHAPTER -VI

SUMMARY, CONCLUSION, IMPLICATION AND RECOMMENDATIONS

This chapter consists of Summary, Conclusion, Implication to nursing service, Nursing education, Nursing administration, Nursing research, and Recommendations for further study.

Summary:

The Quantitative evaluative approach with pre- experimental one group pre test and post test design was used in the study to determine the effectiveness of structured teaching programme on knowledge regarding Risk factors and Prevention of Suicidal Behaviour among Adolescents. The conceptual framework for the study was based on Modified Imogene king's goal attainment theory. The tool used in this study consists of three sections. Section one was demographic variables and section two was structured self administered questionnaire to assess the pretest and post test knowledge and section three was structured teaching programme regarding risk factors and prevention of suicidal behavior. Systematic random sampling technique was used to select the samples, and data were collected from 60 adolescents of Sri Vidhya Mandhir Arts and Science College, Salem.

The data were collected and analyzed using both descriptive and inferential statistics. To test the hypotheses, paired 't' test and chi square tests were used. The significant value is tested at $p \leq 0.05$ level.

The major findings are,

- With regards to the demographic variables of adolescents, 28 (46.67%) of them belongs to 18-19 years of age, 35 (58.33%) of them were females; 59 (98.33%) were Hindus, 41(68.33%) of them were living in nuclear family, 57(95%) of them were coming from home, 38(63.33%) of them have a

family monthly income of below Rs.5000, 33(55%) of the adolescent's fathers have no formal education, 40(66.67%) of the adolescent's mothers have no formal education, 37(61.67%) of the adolescents fathers were self employed and 52(86.67%) of the adolescent's mothers were home makers.

- During pretest among 60 adolescents 45(75%) had inadequate knowledge, 15(25%) had moderately adequate knowledge and none of the adolescents had adequate knowledge regarding Risk factors and Prevention of Suicidal Behaviour,
- The pretest mean score was 9.9±3.88, and the post test mean score was 17.03±4.12. The paired 't' test value was 16.84 which is significantly higher than the table value of 4.05 at $p \leq 0.05$ level. Hence hypothesis H_1 is retained.
- There was no significant association found between the pretest knowledge on adolescents and their selected demographic variables at $p \leq 0.05$ level. Hence H_2 was rejected.

Conclusion:

The study was conducted to assess the Effectiveness of Structured Teaching Programme on knowledge regarding Risk factors and Prevention of Suicidal Behaviour among Adolescents in a selected college, Salem. The study findings showed that the structured teaching programme was effective in improving their knowledge. There was no significant association found between the knowledge of adolescents regarding Risk factors and Prevention of Suicidal Behaviour and their selected demographic variables. This study intervention would help the adolescent to run healthy life without any distress, reduce the risk of suicidal behaviour and also encourage them also to help those who have suicidal risk in the public or among friends.

Implications:

The findings of the study have implications in different aspects of nursing. i.e., nursing practice, nursing education, nursing administration and nursing research.

Nursing practice:

- Structured teaching programme regarding risk factors and prevention of suicidal behaviour need to be provided by the nurses which will reduce the risk of suicidal behaviour among the adolescents with mental health problem.
- Occupational nurses who work closer to colleges can teach the adolescent students on different aspects of suicide prevention.
- Student nurses can disseminate information on prevention of suicide among the risk group.

Nursing education:

- It is important to have education programme on prevention of suicidal behaviour for all nursing students and staff nurses, so that they can spread the information and improve the knowledge of the people while facing the risk factors.
- Suicidal prevention programme or training programme can be arranged by the faculty members in order to emphasize a healthy life style to the students.
- Nurse educator should take the initiative to conduct educational programme among staff nurses regarding the risk factors and prevention of suicidal behaviour. That will help spread the information among the people.
- Nurse educator can encourage the students to conduct health teaching sessions on prevention of suicidal behaviour.

Nursing administration:

- Nursing administrator can coordinate her activity along with the college staff, to encourage them to teach prevention programme to the adolescents in college.
- Nursing administrator can organize in-service educational programme for staff nurses and community health-care workers regarding prevention of suicidal behaviour among the people.
- Nursing administrator can provide opportunities for the nurses who working in college as a health care worker to attend training programme.

Nursing research:

- Nursing research is to be done to find out the various innovative methods to improve the knowledge regarding risk factors and prevention of suicidal behaviour among adolescents.
- The findings can be used as evidence-based practice by health-care nurse to increase the awareness among the college-going adolescents.
- The findings of the study would help expand the scientific body of professional knowledge upon which further research can be conducted.

Recommendations:

- Similar study can be conducted as comparative study between male and female adolescents in different settings.
- Similar study can be conducted for various age groups.
- Similar study can be done by using various teaching methods.
- Similar study can be conducted after identifying suicidal ideation for the adolescents.

- A similar study can be conducted in different populations such as professional and non professional students and workers.
- The study can be carried out to assess the quality of life among the adolescents.

Summary:

This chapter dealt with the summary, conclusion, implications and recommendations.

BIBLIOGRAPHY

Books:

- Basvanthappa, B.T. (2000). *Nursing Research.* New Delhi: Jaypee brothers Publishers.
- Bhatia, M.S. (2007). *Text Book of Psychiatry*, (3rd edition). New Delhi: C.B.S Publishers and Distributors.
- Burns Nancy and Susan K.Grove. (2004).*The Practice of Nursing Research Conduct-Crialle and Utilization,* (5thedition). Philadelphia: W.B sunders company publishers.
- Copper and Pierce. (2002). *Abnormal Psychology and Modern Life*, New York: Harper Collins Publishers.
- Dana worchel. (2010). *Text Book on Suicide Assessment and Treatment,* (1st edition). New Delhi: Springer's company publication.
- Eleanora. (1986). After suicide: A Ray of Hope. (1st edition). Iowa City. Lynn publication.
- Gail,W, Michele, T et.al., (2005). Principles and practice of psychiatric nursing. (8th edition). Missouri: Mosby Publication.
- Katherine,M. Fortinash, et.al., (1996). *Psychiatric Mental Health Nursing*, (1st edition). New York: Mosby publication.
- Kaplan and sadock's. (1998). *Synopsis is psychiatry* (8th edition) New Delhi: New B.L. Waverky Pvt.Ltd.
- Lalitha, K., (2007). *Mental Health and Psychiatric Nursing-an Indian perspective.* (2nd edition). Bangalore: V.M.G. Book Publishers.
- Louise, (2008). *Basic Concept of Psychiatric Mental Health Nursing*, (7th edition). New Delhi: Wilkins and Williams publishers.

- Mahajan, B.K. (1989). *Methods in Biostatistics.* New Delhi: Jaypee Brothers Publishers.
- Niraj Ahuja, (2011). *A Short Text Book of Psychiatry*. (7 TH edition). New Delhi: Jaypee Brothers Medical Publishers.
- Polit and Beck. (2004). *Nursing research principles and methods* (7th edition). Philadelphia: Lippincott Williams & Wilkins.
- Polit, D.F. and Hungler, B. (2000). *Nursing Research Principles and Methods*. New York: J.B. Lippincott.
- Ratherine, Fortinash, et.al., (1996). *Psychiatric mental health nursing.* (1st edition) New York: mosby publication.
- Robert, E. Hales, Stuart C. et.al., (2001). *Text book of psychiatry.* (3rd edition) New Delhi: Jayepee brothers publication.
- Ronald, M.Holmes, (2007). *Text book in suicide theory, practice and investigations,* (1st edition). California: Sage publication.
- Sreevani, R. (2009). *A Guide to Psychiatric and Mental Health Nursing.* (3rdedition) New Delhi: Jaypee Brothers Publishers.
- Sheila. I. Videbeck. (2007). *Psychiatric Mental Health Nursing*. (3rd edition). Philadelphia: Lippincott Williams & Wilkins.
- Stuart and Sudeen. (1979). *"Principles and Practice of Psychiatric Nursing.* London: C.V Mosby Publishers.
- Sundar Rao .P.S, (2000). *An Introduction to Biostatistics,* (3rd edition). New delhi: Practice hall of India. Pvt. ltd.
- Townsend, M.C. (2010). *Mental Health and Psychiatric Nursing-Concepts Based on Evidence Based Practice,* (6th edition) New Delhi: Jaypee Brothers Publishers.

♦ Varghese, M (1994). *Essential of Psychiatric and Mental Health,* Churchill livingstone publisher.

Journals:

♦ Anand Lingeswaran, (2010). Suicide management guidelines. *Nightingale Nursing Times*, 6(4), 24

♦ Aschkenasy,J.R, et.al., (2005). The non-psychiatric physician's responsibilities for the suicidal adolescents, *New York state Journal of Medicine,* 3, 97-104.

♦ Bridge,J.A et.al., (2007). Clinical response and risk for reported suicidal ideation and suicide attempts in pediatric antidepressant treatment. *Journal of the American Medical Association,* 297, 1683-1696.

♦ Center for disease control, (2012). Recommendations for a community plan for prevention and containment of suicide clusters. *Mortality and Morbidity Weekly Report*, 37, 1-11.

♦ Dakshina Murthy, (2012). Suicide among Adolescents, Indian Streams Research Journal, 2(3), 1-4.

♦ Hawton,K, Zahl.D et.al., (2003), suicide following deliberate self-harm: Long term follow up of patients who presented to a general hospital. *British journal of psychiatry,* 18(5),68.

♦ Jena,S and Sidhartha.(2004). Now fatal suicidal behaviours in adolescents. *Indian Journal of Psychiatry*, 46(4), 310-318.

♦ Karolina E. Krysinska, (2007). Loss by suicide-a risk factor for suicidal behaviour. *Journal of Psychosocial Nursing*, 41(7), 34-41.

♦ Kar N, Pany M et.al., (2006). Risk factors of adolescent suicide attempt, *Journal of Eastern Zonal Branch of Indian Psychiatric Society*, 1(1), 17-22.

- Kirsi S, Erkk L. et.al., (2004). Level of suicide intent predicts overall mortality and suicide after attempted suicide: 12 years follow –up study. *BMC psychiatry*, 4(11).
- Linda M.Pirruccello, (2010). Preventing adolescent suicide community takes action. *Journal of Psychosocial Nursing*, 48(5), 34-40.
- Linda J.Cook, (2011). The role of psychiatric nurse faculty in establishing a campus suicide prevention program. *Journal of Psychosocial Nursing and Mental Health Services*, 49(12), 22-28.
- Metha, A., Weber, B., & Webb, L.D. (2010). Youth suicide prevention: A survey and analysis of policies and efforts in the 50 states. Suicide and Life-Threatening Behaviour, 28(2), 150–164.
- Overholser JC. Hemstreet, (2004), Suicide awareness programme in the college, effect of gender and personal experience, *Journel of American Academy Child Adolescent Psychiatry*, 28(6), 923.
- Peter Ash, (2008). Suicidal behaviour in children and adolescents. *Journal of Psychosocial Nursing*, 46(1), 27-30.
- Portzky G, van Heeringen K,(2006). Suicide prevention in adolescents: a control study of the effectiveness of the school based psycho education programme. *Journal of Child Psychiatry*, 47(9), 910-918.
- Robert H. Asetine, (2004), An outcome evaluation of the suicide prevention programme, *American Journal of Public Health.*28 (5), 34.
- Thompson EA, Herting JR, et.al., (2004). Reducing suicide potential among high risk youth: test of a school based prevention programme. Suicide life threats behaviour. 25(2), 125.

- WHO, (2011). Preventing suicide in multicultural societies. *Nightingale Nursing Times*, 7(9).

Net references:

- American Academy of Child and Adolescent Psychiatry (1998). Teen suicide: Facts for families (#10). Retrieved March, 2003, from www.aacap.org/ publications/factsfam/suicide.htm
- Centre for Disease Control and Prevention. (2003). YRBSS: Youth Online: comprehensive results, from http://apps.nccd.cdc.gov/yrbss/index.asp.
- Cross W, Wyman PA. (2006). Training and motivational factors as predictors of job satisfaction and anticipated job retention among implementers of a school-based prevention program from www.ncbi.nlm.nih.gov/pubmed /16550457.
- Kalafat, J. & Brown, C.H. (2001). Suicide prevention and intervention: Summary of a workshop. The National Academy of Sciences, Retrieved April 22, 2003 from www.nap.edu/openbook/0309076242/html/4.html
- Pisani AR, Schmeelk-Cone K, et.al., (2012). Associations between suicidal high school students help-seeking and their attitudes and perceptions of social environment. J Youth Adolescent from www.ncbi.nlm.nih.gov/pubmed /23062099.
- Siddhartha Tanuj Shivan and Jena. Suicidal behaviour (2006). From http// www. medind.nic.in/icb/t06/i9/icbt06i9.
- Vijaykumar L. (2010) Suicide and its prevention. The urgent need in India from http://www.indianjpsychiatry.org/text.asp?2007/49/2/81/33252.
- http://www.fmhi.usf.edu/institute/pubs/bysubject.html.
- http://aepo-xdvwww.epo.cdc.gov/wonder/prevguide.

Newspaper references:

- Daniel, November, 2013, *NDTV*.
- Palaniappan V.S, January 3, 2013, *The Hindu News.*
- Vijayakumar.S, 2013, *The Hindu News*.

ANNEXURE - A

LETTER SEEKING PERMISSION TO CONDUCT A RESEARCH STUDY

From

Mr.N.Loganathan,

II year M.Sc., (N),

Sri Gokulam College of Nursing,

Salem.

To

The Principal,

Sri Gokulam College of Nursing,

Salem.

Respected Madam,

Sub: Permission to conduct Research Project–request- reg.

I, **Mr.N.Loganathan,** Final year M.Sc(N) student of Sri Gokulam college of Nursing is conducting research project in partial fulfillment of "The Tamilnadu Dr .M.G.R. Medical University, Chennai" as part of the requirement for the award of M.sc(Nursing) Degree.

Topic: "A Study to Evaluate the Effectiveness of Structured Teaching Programme on Knowledge Regarding Risk factors and Prevention of Suicidal Behavior among Adolescents in a Selected College, Salem"

I wish to seek permission to conduct the research study in Sri Vidhya Mandir Arts and Science College, Salem- 10.

Kindly do the needful.

Thanking you.

Date: Yours Sincerely,

Place: Salem

(Mr.N.Loganathan)

ANNEXURE - B

LETTER GRANTING PERMISSION TO CONDUCT A RESEARCH STUDY

SRI GOKULAM COLLEGE OF NURSING
3/836, Periyakalam, Neikkarapatti, Salem - 636 010.
Phone : 0427 - 6544550,2272240,2272250 Fax : 0427 - 2270200, 2447077
Email : sgcon2001@yahoo.com, sgcon2001@gmail.com

LETTER REQUESTING TO CONDUCT A RESEARCH STUDY Date : .....

To

The Principal,

Sowdeswari College,

Kondalampatti,

Salem- 636 010.

Respected Sir/Madam,

Sub: Permission to conduct Research Project–request- reg.

This is to introduce **Mr. N.Loganathan,** Final year M.Sc (N) student of Sri Gokulam college of Nursing. He is to conduct a research project which is to be submitted to "The Tamilnadu Dr .M.G.R. Medical University, Chennai" in partial fulfillment of university requirement for the award of M.Sc (Nursing) Degree.

Topic: "A Study to Evaluate the Effectiveness of Structured Teaching Programme on Knowledge Regarding Riskfactors and Prevention of Suicidal Behavior among Adolescents in a Selected College, Salem"

I request you to kindly permit him to conduct the pilot project in your esteemed institution from 22-07-13 to 27-07-13. He will adhere to the institutional policies and regulation.

Kindly do the needful,

Thanking you,

Date: 10-07-13

Place: Salem

Yours Sincerely,

(Dr.K.Tamizharasi)

SRI GOKULAM COLLEGE OF NURSING
3/836, Periyakalam, Neikkarapatti, Salem - 636 010.
Phone : 0427 - 6544550,2272240,2272250 Fax : 0427 - 2270200, 2447077
Email : sgcon2001@yahoo.com, sgcon2001@gmail.com

LETTER REQUESTING TO CONDUCT A RESEARCH STUDY

Date : .....

To

The Principal,

Sri Vidhya Mandir Arts and Science College,

Salem-10.

Respected Sir/Madam,

Sub: Permission to conduct Research Project–request- reg.

This is to introduce **Mr. N.Loganathan,** Final year M.Sc(N) student of Sri Gokulam college of Nursing. He is to conduct a research project which is to be submitted to "The Tamilnadu Dr .M.G.R. Medical University, Chennai" in partial fulfillment of university requirement for the award of M.sc(Nursing) Degree.

Topic: "A Study to Evaluate the Effectiveness of Structured Teaching Programme on Knowledge Regarding Riskfactors and Prevention of Suicidal Behavior among Adolescents in a Selected College, Salem"

I request you to kindly permit him to conduct the research project in your esteemed institution from 29-07-13 to 27-08-13. He will adhere to the institutional policies and regulation.

Kindly do the needful,

Thanking you,

Date: 10.07.2013

Place: Salem

Yours sincerely,

(Dr.K.Tamizharasi)

ANNEXURE C

LETTER REQUESTING OPINION AND SUGGESTION OF EXPERTS FOR CONTENT VALIDITY OF THE RESEARCH TOOL

From,

Mr.Loganathan.N,

Final Year M.Sc(N),

Sri Gokulam College of Nursing,

Salem, Tamil Nadu.

To,

(Through proper channel)

Respected Sir/ Madam,

Sub:Requesting opinion and suggestions of experts for establishing content validity of the tool.

I **Mr.Loganathan. N,** II Year M.Sc., (Nursing) student of Sri Gokulam College of Nursing, Salem, have selected the below mentioned Statement of the Problem for the research study to be submitted to The Tamil Nadu Dr. M.G.R. Medical University, Chennai as partial fulfillment for the award of Master of science in Nursing.

Topic: "A Study to Evaluate the Effectiveness of Structured Teaching Programme on Knowledge Regarding Risk factors and Prevention of Suicidal Behavior among Adolescents in a Selected College, Salem".

I request you to kindly validate the tool developed for the study and give your expert opinion and suggestion for necessary modifications.

Thanking you,

Yours sincerely,

Place : Salem

Date : **(Mr.Loganathan.N)**

Enclosed:

1. Certificate of validation
2. Criteria checklist of evaluation of tool
3. Tool for collection of data
4. Content of risk factors and prevention of suicidal behaviour.

ANNEXURE - D

TOOL FOR DATA COLLECTION

Instruction to the respondents:

Dear participants this section requires some of the personal information and you are requested to answer each question correctly. Your answers will be kept confidential.

Sample No:

Date :

SECTION -A

DEMOGRAPHIC VARIABLES

1) Age in years

a) 18-19 ( )

b) 19-20 ( )

c) 20-21 ( )

2) Sex

a) Male ( )

b) Female ( )

3) Type of family

a) Nuclear family ( )

b) Joint family ( )

4) Place of accommodation

a) Hostel ( )

b) Days scholar ( )

5) Religion

a) Hindu ( )

b) Christian ( )

c) Muslim ( )

d) Others ( )

6) Family monthly income (In rupees)

a) Below Rs.5000 ( )

b) Rs.5001-10000 ( )

c) Rs.10001 and above ( )

7) Educational status of father

a) No formal education ( )

b) Primary education ( )

c) Higher education ( )

d) Graduate ( )

8) Educational status of mother

a) No formal education ( )

b) Primary education ( )

c) Higher education ( )

d) Graduate ( )

9) Father's occupation

a) Unemployed ( )

b) Self employee ( )

c) Private employee ( )

d) Government employee ( )

10) Mother’s occupation

a) Home maker ( )

b) Self employee ( )

c) Private employee ( )

d) Government employee ( )

SECTION - B

STRUCTURED SELF ADMINISTERED QUESTIONNAIRE TO ASSESS THE KNOWLEDGE ON RISK FACTORS AND PREVENTION OF SUICIDAL BEHAVIOR

Instructions to the participants:

Kindly answer the questions below and provide the necessary information by filling up the space or placing a tick (√) mark against the option.

I. KNOWLEDGE REGARDING GENERAL INFORMATION

1. What is suicidal behavior?

a) Deliberately harming oneself ( )

b) Unintentional self harm ( )

c) Attention seeking behavior ( )

2. What are the causes of suicidal behavior? Except

a) Feeling of rejection ( )

b) Death of loved one ( )

c) Cause of unknown ( )

3. In which age group the suicidal behavior is more common?

a) 6-14 Year ( )

b) 15-29 years ( )

c) 30 years and above ( )

II. KNOWLEDGE REGARDING RISK FACTORS AND WARNING SIGNS OF SUICIDE

4. Which gender is more likely to commit suicide?

a) Male ( )

b) Female ( )

c) Equal to both male and female ( )

5. What is the following occupational area correlated to increase suicidal rate?

a) Rural occupation ( )

b) Urban occupation ( )

c) Semi urban occupation ( )

6. Who is having the lowest suicidal rate in India?

a) Single ( )

b) Married ( )

c) Widows ( )

7. Which one of the following factor is common for people to commit suicide?

a) Bereavement ( )

b) Grief ( )

c) Depression ( )

8. Which of the following childhood factor most leads to suicidal risk in adulthood?

a) Abuse of the child ( )

b) Improper schooling ( )

c) Dejection by the family ( )

9. Which is the most common method to attempt suicide in India?

a) Hanging ( )

b) Cutting one's wrist ( )

c) Drug and poison ( )

10. What is the behavioral clue of suicide?

a) Feeling no hope about future ( )

b) Sudden withdrawal from friends and family ( )

c) Feeling self as worthless ( )

11. Which is the verbal clue of suicide?

a) I am wishing to live up to my old age ( )

b) I am no more useful ( )

c) No comments passed ( )

12. Which one of the following non-verbal clue is reflected by a person with suicidal ideation?

a) Sadness ( )

b) Cool headedness ( )

c) Tendency to achieve goal ( )

13. Which one of the following is misconception about suicide?

a) Suicide is not inherited ( )

b) Once a person is suicidal he/ she suicidal forever ( )

c) Who kill themselves have previous history of suicide attempt ( )

14. Which of the following is true fact about suicide?

a) Suicide ideation person will give definite clues ( )

b) All suicidal individual are mentally ill ( )

c) We cannot stop a suicidal person ( )

III.KNOWLEDGE REGARDING PREVENTION OF SUICIDAL BEHAVIOR

15. What is an immediate reaction towards a suicidal ideation person?

a) Judge and lecture ( )

b) Avoiding the person because it is an attention seeking behavior ( )

c) Encourage the person to talk about his/her feelings ( )

16. Which method enables your body to release tension?

a) Sleeping ( )

b) Exercise ( )

c) Crying ( )

17. Which one of the following coping strategy helps to relieve from stress?

a) Relaxation ( )

b) Medication ( )

c) Intake of diet rich in minerals ( )

18. Which one of the following is more helpful for preventing suicide in people?

a) Physical illness prevention ( )

b) Social health promotion ( )

c) Mental health promotion ( )

19. What is mean by self esteem?

a) Positive and realistic view of themselves and their situation ( )

b) Negative view of themselves ( )

c) Will not trust others ( )

20. What type of skill is required to prevent self from attempting suicide?

a) Listening skill ( )

b) Coping skill ( )

c) Sympathizing skill ( )

21. What is the purpose of using problem focused coping skill?

a) Changing or eliminating the source of stress ( )

b) Releasing pent up emotions ( )

c) To modify their behaviour ( )

22. What is meant by self awareness?

a) Ability to recognize oneself ( )

b) Ability to recognize others ( )

c) Ability to recognize self and others ( )

23. What is meant by Assertiveness?

a) Violation of others ( )

b) Standing for their own rights without violating others ( )

c) Listening others activity ( )

24. What is an emergent action should be taken by a person during his/her suicidal thought?

a) Consult health care professionals ( )

b) Talk to everybody about your problem ( )

c) Take self-medication ( )

பங்கேற்பவர்களுக்கான நிபந்தனைகள்

அன்பான பங்கேற்பாளரே இப்பகுதிக்குஉங்களின் தனிப்பட்ட தகவல்கள் தேவைப்படுகின்றது. ஒவ்வொரு கேள்விக்கும் சரியான பதிலை குறிக்குமாறு கேட்டுக்கொள்ளப்படுகிறது. உங்களுடைய பதில்கள் பாதுகாப்பாக வைக்கப்படும்

வரிசை எண் :

பகுதி- அ

தனிநபர் விவரம்

1. வயது (ஆண்டுகளில்)

அ) 18-19 ( )

ஆ) 19-20 ( )

இ) 20-21 ( )

2. பாலினம்

அ) ஆண் ( )

ஆ) பெண் ( )

3. குடும்பவகை

அ) தனிக் குடும்பம் ( )

ஆ) கூட்டுக் குடும்பம் ( )

4. தங்கும் இடம்

அ) விடுதி ( )

ஆ) வீட்டிலிருந்துவருதல் ( )

5. மதம்

அ) இந்து ( )

ஆ) கிருத்துவர் ( )

இ) முஸ்லீம் ( )

ஈ) மற்றவை ( )

6. குடும்பமாதவருமானம் (ரூபாயில்)

அ) ரூ.5000 க்கும் குறைவு ( )

ஆ) ரூ.5001-10000 ( )

இ) ரூ 10001 மற்றும் அதற்கும் மேல் ( )

7. தந்தையின் கல்வித்தகுதி

அ) கல்வித்தகுதி இல்லை ( )

ஆ) ஆரம்பகல்வி ( )

இ) உயர்நிலைகல்வி ( )

ஈ) பட்டதாரி ( )

8. தாயின் கல்வித்தகுதி

அ) கல்வித்தகுதி இல்லை ( )

ஆ) ஆரம்பகல்வி ( )

இ) உயர்நிலைகல்வி ( )

ஈ) பட்டதாரி ( )

9. தந்தையின் தொழில்

அ) வேலையில்லாவர் ( )

ஆ) சுய தொழில் ( )

இ) தனியார் வேலை ( )

ஈ) அரசாங்கவேலை ( )

10. தாயின் தொழில்

அ) இல்லத்தரசி ( )

ஆ) சுய தொழில் ( )

இ) தனியார் வேலை ( )

ஈ) அரசாங்கவேலை ( )

பகுதி-ஆ

பங்கேற்பவர்களுக்கான நிபந்தனைகள்

கீழ்க்கண்ட கேள்விகளுக்கு பதிலலிக்குமாறு கேட்டுகொள்ளபடுகிறது மற்றும் இடைவெளி கொடுத்திருக்கும் இடத்தில் (√) மார்க் செய்யவும்.

I. தற்கொலை எண்ணங்களை பற்றிய பொதுவினாக்கள்.

1. தற்கொலை எண்ணம் என்றால் என்ன?

அ) தம்மைதாமே வருத்திக் கொள்ள நினைத்தல் ( )

ஆ) எதர்பாரதவிதமாக சுய தீங்கு நினைத்தல் ( )

இ) மற்றவர் கவனத்தை தன் பக்கம் திருப்புதல் ( )

2. கீழ்க்கண்டவற்றுள் எது தற்கொலை எண்ணத்திற்க்கு காரணியல்ல?

அ) மற்றவர் புறக்கணிப்பதால் மனம் வருந்துதல் ( )

ஆ) விரும்பிய ஒருவர் இறந்துவிடுதல் ( )

இ) ஏனென்று தெறியாமல் ( )

3. எந்த வயதில் தற்கொலை எண்ணம் பொதுவானது?

அ) 6-14 வயது ( )

ஆ) 15-29 வயது ( )

இ) 30 வயது மற்றும் அதற்கும் மேல் ( )

II.தற்கொலையின் காரணிகள் மற்றும் அபாய அறிகுறிகளின் அறிவைப் பற்றியது?

4. எந்த பாலினத்தை சார்ந்தவர்கள் அதிக தற்கொலையில் ஈடுபடுகின்றனர்?

அ) ஆண் ( )

ஆ) பெண் ( )

இ) சமநிலை/ஆண்,பெண் இருவரும் ( )

5. கீழ்கண்டவேலை இடங்களில் எந்த வேலை இடம் அதிக தற்கொலையின் எண்ணிக்கை அதிகமாக உள்ளது?

அ) கிரம வேலை ( )

ஆ) நகர வேலை ( )

இ) பாதிநகர வேலை ( )

6. இந்தியாவில் குறைந்தவிகிதத்தில் தற்கொலையில் ஈடுபடுகின்றனர்?

அ) தனிமனிதர் ( )

ஆ) திருமணம் ஆனவர் ( )

இ) விதவை ( )

7. கீழ்கண்டவற்றுள் எந்தகாரணி மக்கள் அதிகம் தற்கொலையில் ஈடுபட பொதுவான காரணம்?

அ) நஷ்டமடைதல் ( )

ஆ) தன் முனைப்பு ( )

இ) மனஅழுத்தம் ( )

8.கீழ்கண்டவற்றுள் எந்த குழந்தை பருவகாரணம் இளமை பருவத்தில் தற்கொலைக்கு வழி வகுக்கிறது?

அ) குழந்தையுடன் தகாதபழக்கம் கொள்ளுதல் ( )

ஆ) முறையாகபள்ளிக்குசெல்லாமை ( )

இ) குடும்பம் கைவிடுதல் ( )

9. இந்தியாவில் பொதுவானதற்க்கொலைமுறைஎது?

அ) தூக்குபோட்டுக் கொள்ளுதல் ( )

ஆ) மணிக்கட்டைஅருத்துக்கொள்ளுதல் ( )

இ) மருந்துமற்றும் விஷம் ( )

10. தற்கொலையின் நடத்தைஅறிகுறிகள் என்ன?

அ) எதிர்காலத்தைப் பற்றிய நம்பிக்கையின்மை ( )

ஆ) நண்பர்கள் மற்றும் குடும்பத்தினரிடமிருந்து நீங்குதல் ( )

இ) தன்னையே தரம் குறைவாக பார்த்துக் கொள்ளுதல் ( )

11. தற்க்கொலையின் வார்த்தைஅறிகுறிஎது?

அ) நான் நீண்ட நாட்க்கள் வாழ வேண்டும் ( )

ஆ) நான் வாழ தகுதியற்றவன் ( )

இ) எந்த வாக்குகளும் வெளிப்படுத்தாதிருத்தல் ( )

12. கீழ்கண்டவற்றுள் எந்த வாய்வார்த்தையற்ற வெளிப்பாடு தற்கொலை எண்ணம் உடையவர்களால் வெளிபடுத்தப்படுகிறது?

அ) சோகமாக இருத்தல் ( )

ஆ) எதையும் பொருட்படுத்தாதிருத்தல் ( )

இ) உடல் ரீதியாகதிடீர் மாற்றம் ( )

13.கீழ்கண்டவற்றுள் எது தற்கொலையை பற்றிய தவறான கருத்து?

அ) தற்கொலை பரம்பரையைச் சார்ந்து அல்ல ( )

ஆ) ஒருவர் ஒருமுறை தற்கொலையில் ஈடுபட்டால் அவர்கள் எப்பொழுதும் தற்கொலையில் ஈடுபட்டுகொண்டிருப்பார்கள் ( )

இ) தற்கொலையில் ஈடுபடுபவர் முன்பே தற்கொலை முயற்சியில் ஈடுபட்டவர்கள் ( )

14. கீழ்கண்டவற்றுள் எது தற்கொலையை பற்றிய உண்மையான கருத்து?

அ) தற்கொலையை எண்ணம் உடையவர்கள் கண்டிப்பாக ஏதேனும் முன் அறிகுறிகளை வெளிப்படுத்துவர் ( )

ஆ) தற்கொலையை செய்யும் அனைவரும் மனநலம் பாதிக்கப்பட்டவர்கள் ( )

இ) தற்கொலையை யாராலும் தடுக்கமுடியாது ( )

III.தற்கொலைஎண்ணங்களைதடுக்கும் முறைகள் அறிவைச் சார்ந்தது

15. தற்கொலையை எண்ணம் உடையவரை பார்த்த உடன் உடனடியாக என்ன செய்ய வேண்டும்?

அ) வாதாடுதல் மற்றும் அறிவுறை கூறுதல் ( )

ஆ)அவரை ஒதுக்க வேண்டும் ஏனென்றால் அது மற்றவர் கவனத்தை திசைதிருப்புவதற்க்கு செய்யும் செயல். ( )

இ) மனம் திறந்துபேசுவதற்க்கு தூண்டவேண்டும் ( )

16. மனஸ்தாபத்திலிருந்து வெளிவர எந்த முறை சிறந்தது?

அ) தூக்கம் ( )

ஆ) உடற்பயிற்சி ( )

இ) அழுகை ( )

17. கீழ்கண்டவற்றுள் எதுமனஅழுத்ததிலிருந்து வெளிவர உதவுகிறது?

அ) இசை/பொழுதுபோக்கு ( )

ஆ) மருந்துகள் ( )

இ) கனிமச்சத்து அதிகம் நிறைந்த உணவு எடுத்தல் ( )

18. கீழ்கண்டவற்றுள் எது மிகச்சிறந்த தற்கொலை முயற்சியை தடுக்க உதவுகிறது?

அ) உடல் ரீதியான நோயை குணப்படுத்துதல் ( )

ஆ) சமூக நலத்தை ஊட்டுதல் ( )

இ) மன நலத்தை ஊட்டுதல் ( )

19. சுய மரியாதை உடையவர்கள் எவ்வாறு காணப்படுவர்?

அ) தன்னைப்பற்றியும் அவர்களுடைய சூழ்நிலையைபற்றியும் உறுதியான எண்ணங்களையே கொண்டிருப்பார்கள் ( )

ஆ) தன்மீது நம்பிக்கை கொள்ளாதிருத்தல் ( )

இ) அடுத்தவர்களைநம்பாதிருத்தல் ( )

20. எந்த வகை திறமை ஒருவரை தற்கொலை செய்யாமல் காப்பாற்ற தேவையானது?

அ) கவனிக்கும் திறமை ( )

ஆ) வெளிவரும் திறமை ( )

இ) பரிதபிக்கும் திறமை ( )

21. பிரச்சனையை சமாளிக்கும் திறனின் முக்கியத்துவம் என்ன?

அ) மனஅழுத்தத்தை உண்டாக்கும் காரணங்களை நீக்குதல் (அ) மாற்றுதல் ( )

ஆ) உணர்ச்சிகளை வளைந்து கொடுத்தல் ( )

இ) குணத்தை மாற்றுதல் ( )

22. சுய விழிப்புணர்வு என்றால் என்ன?

அ) தன்னைப்பற்றி அறிந்து கொள்ளுதல் ( )

ஆ) மற்றவர்களைப்பற்றி அறிந்து கொள்ளுதல் ( )

இ) தன்னைப்பற்றியும் மற்றவர்களை பற்றியும் அறிந்து கொள்ளுதல் ( )

23. தன்முனைப்பு என்றால் என்ன?

அ) அடுத்தவர்களை புண்படுத்துதல் ( )

ஆ) அடுத்தவர்களுக்கு பாதிப்பு ஏற்படாமல் தன்னுடைய உரிமைக்காக போராடுதல். ( )

இ) அடுத்தவர்களின் நடவடிக்கைகளை கவனித்தல் ( )

24.தற்கொலை எண்ணத்தின் போழுது ஒருவர் உடனடியாக செய்யவேண்டியது என்ன?

அ) உடல் நலபாதுகாப்பாளர்களைஅனுக வேண்டும் ( )

ஆ) எல்லோரிடமும் தனதுபிரச்சனையை கூற வேண்டும் ( )

இ) தானாகமருந்துஎடுத்துக் கொள்ளவேண்டும் ( )

ANSWER KEY FOR KNOWLEDGE QUESTIONNAIRE ON RISK FACTORS AND PREVENTION OF SUICIDAL BEHAVIOUR

1	**a**	13	**b**
2	**c**	14	**a**
3	**b**	15	**a**
4	**a**	16	**c**
5	**a**	17	**a**
6	**b**	18	**c**
7	**c**	19	**a**
8	**a**	20	**b**
9	**c**	21	**a**
10	**b**	22	**c**
11	**b**	23	**b**
12	**a**	24	**a**

Scoring Key:

0-34 % – Inadequate Knowledge

35-69% – Moderately adequate Knowledge

70-100% – Adequate Knowledge

ANNEXURE – E

STRUCTURED TEACHING PROGRAMME

Name of the student teacher	: Mr.Loganathan.N
Topic	: Risk factors and prevention of Suicidal Behaviour
Group	: College students who between the age group of 18-21 years
Duration	: 45 minutes
Method of teaching	: Power point presentation
Medium of teaching	: Tamil and English
A.v aids	: Power point slides

CENTRAL OBJECTIVES:

At the end of the class the Adolescences will be able to understand about the risk factors and suicidal behaviour and gain adequate knowledge on prevention of suicidal behaviour and develop a positive attitude and skill towards the same

SPECIFIC OBJECTIVES:

At the end of the class the adolescence are able to,

1. define suicidal behaviour
2. list out the incidence rate of the suicide
3. list down the causes for suicidal behaviour
4. enumerate the risk factors of suicide
5. identify the warning signs of suicide
6. describe the facts and fables about suicide
7. discuss the prevention of suicidal behaviour
8. explain the suicide awareness

Time	Specific objectives	Content	Teachers activity	Learners activity
1 minute		**INTRODUCTION** Young people with mental health problems, such as anxiety, depression, bipolar disorder, or insomnia, are at higher risk for suicidal thoughts, as are teens experiencing major life changes, such as the divorce of parents, moving, or change in financial security. Victims of bullying are also more likely to think about suicide.	Introduce the topic	Ready to learn.
1 minute	define suicidal behaviour	**DEFINITION OF SUICIDAL BEHAVIOUR** Suicidal or suicidal behaviour is any action taken intentionally an individual kill self or deliberately harming oneself	Defining the term suicide and suicide behaviour with power point.	Asking doubts and clarifies
2 minute	listout the incidence rate of the suicide	**INCIDENCE** The World Health Organization (WHO) estimates that about one million people die by suicide every year. It is the third leading cause of death.	Lecturing with Power point slides	Listening.

		This represents a "global" mortality rate of 16 per 100,000population. one death every 40 seconds with this the suicide is leading cause of death in the age group of 15 to 29 years according to the latest World Health Organization mortality database(2010), The mean suicidal rate for this age group was 7.4/100,000, Suicide rates were higher in males (10.5) than in females (4.1). India alone contributes to more than 10% of suicides in the world. The suicide rate in India has been increasing steadily and has reached 11.2 per 100,000 of population in 2011. According to WHO the suicidal rate In India for every 1,00,000 people 98 of them commit suicide annually. A report by the World Health Organization states that 22.1out of every 100,000 persons commit suicide in Tamilnadu in the year of 2011. Most commonest method of attempting suicide by using drug and poison.		
3 minute	list down the causes for suicidal behaviour	**CAUSES** People who try to commit suicide are often trying to get away from a life situation that seems impossible to deal with. Many who make a suicide attempt are seeking relief from: • Feeling ashamed, guilty, or like a burden to others	Discussing the causes with power point slides	Listening and asking doubts.

5 minute	enumerate the risk factors of suicide	• Feeling like a victim • Feelings of rejection, loss, or loneliness Suicidal behaviors may occur when there is a situation or event that the person finds overwhelming, such as: • Death of a loved one • Dependence on drugs or alcohol • Emotional trauma • Serious physical illness • Unemployment or money problems **RISK FACTORS** **Physical factors** Chronic disablinig physical illness like ✓ Diseases of the nervous system ✓ Brain and spinal cord injury ✓ Seizure disorders ✓ Cancer ✓ HIV/AIDS ✓ Chronic obstructive pulmonary disease, especially in men ✓ Chronic hemodialysis-treated renal failure	Enumerating the risk factors with power point slides	Listening and asking doubts.

		✓ Pain syndromes ✓ Functional impairment **Psychological factors** ✓ Hopelessness ✓ Psychic pain ✓ Severe or unremitting anxiety ✓ Panic attacks ✓ Shame or humiliation ✓ Psychological turmoil ✓ Decreased self-esteem ✓ Extreme narcissistic vulnerability ✓ Behavioral features ✓ Impulsiveness ✓ Aggression, including violence against others ✓ Agitation **Biological factors** ✓ Family history of suicide (particularly in first-degree relatives) ✓ Family history of mental illness, including substance use disorders ✓ Suicide in monozygotic twins may be high as 18%		

		Psychosocial factors ✓ Recent lack of social support (including living alone) ✓ Unemployment ✓ Drop in socioeconomic status ✓ Poor relationship with family ✓ Domestic partner violence ✓ Recent stressful life event **Childhood traumas** ✓ Abuse of the child like physical abuse and Sexual abuse **Cognitive factors** ✓ Loss of executive function ✓ Closed-mindedness **Demographic factors** ✓ Male gender ✓ Widowed, divorced, or single marital status, particularly for men ✓ Adolescent and young adult age groups (age groups with highest numbers of suicides) ✓ White race ✓ Lesbian and bisexual orientation ✓ Individual in the highest and lowest social classes have higher suicide		

5 minute	identify the warning signs of suicide	rate than those in the middle classes. ✓ Urban occupation. **WARNING SIGNS OF SUICIDE** Individual may leaves behavioural, verbal and non-verbal clues to intent to their act. **i) Behavioural clues:** Ingestion of a small amount of some potentially lethal drugs Giving away prized possessions. Keeping affairs in order Writing suicidal notes. Sudden changes in mood. Withdrawing from friends and family **ii)Verbal clues** Passing negative statement “I want to die, end my life” “ I am going to kill myself. “ It’s too much to bear” “You would be better, without me” “Classmates, Families and friends do not care” “I am not useful”	Explaining the warning signs with power point slides	Listening and asking doubts.

		❍ " I don't want life anymore" ❍ "Everything is going wrong, no need for me to live" ❍ " This is the last time you will see me" ❍ Cannot think clearly ❍ Sees no sense of worth of own self ❍ Becomes hopeless ❍ Sees no sense of purpose in life and find no reason for living. **iii)Non- verbal clues** ❍ Addiction ❍ Sleeping much or too little ❍ Lack of interest in personal appearance ❍ Lack of interest in friends ❍ Lack of interest in social activities ❍ Poor performance in school or college ❍ Restless, lack of concentration ❍ Depressed mood ❍ Experiences unbearable psychological pain ❍ Weepy ❍ Irritable		

3 minute	describe the facts and fables about suicide	• Extreme sadness • Dramatic mood changes **FACTS AND FABLES ABOUT SUICIDE** **i)Fables :** People who talk about suicide do not commit suicide. Suicide happens without warning. **Facts :** Eight out of ten people who kill themselves have given definite clues and warnings about their suicidal intentions. Very subtle clues may be ignored or disregarded by others **ii)Fables :**You cannot stop a suicidal person. He or she is fully intent on dying. **Facts:** Most suicidal people are very ambivalent about their feelings regarding living or dying. Most are "gambling with death" and see it as a cry for someone to save them. **iii)Fables :** Once a person is suicidal, he or she is suicidal forever. **Facts :** People who want to kill themselves are only suicidal for a limited time. If they are saved from feeling of self destruction, they can go on to lead normal lives. **iv)Fables :**Improvement after severe depression means that the suicidal risk is over	Explaining the facts and fables about suicide with power point	Listening and asking doubts.

		Facts : Most suicide occur within about 3 months after the beginning of "improvement" when the individual has the energy to carry out suicidal intention. **v)Fables :**Suicide is inherited or "runs in families" **Facts :** Suicide is not inherited. It is an individual matter and can be prevented, however, suicide by a close family member increase an individual's risk factor for suicide. **vi) Fables :**All suicidal individuals are mentally ill and suicide is the act of a psychotic person. **Facts :** A larger percentage of people who commit suicide have been diagnosed with a mental disorder. However, many other are merely unable at that point in time to see an alternative solution to what they consider an unbearable problem. **vii) Fables :** Suicidal threats and gestures should be considered manipulative or attention-seeking behavior, and should not be taken seriously. **Facts :** All suicidal behavior must be approached with the gravity of the potential act in mind. Attention should be given to the possibility that the individual is issuing a cry for help. **viii)Fables :** If an individual has attempted suicide, he or she will not do it again.		

20minute	discuss the prevention of suicidal behaviour	**Facts :** Between 50% and 80% of all people who ultimately kill themselves have a history of previous attempt. **PREVENTION OF SUICIDAL BEHAVIOUR** **i)WELL-BEING PROMOTION** Strengthening communities, reducing social inequities, promoting social justice, enhancing social support and improving the specific skills of youth and their parents, are all part of an overall effort to promote the well-being of youth, their families and communities. Several promising approaches to promoting resilience and strengthening social environments are described in this section. ✓ Spirituality ✓ Importance attached to child-rearing and the extended family ✓ Respect for age, wisdom and tradition ✓ Respect for nature ✓ Generosity and sharing ✓ Cooperation and group harmony ✓ Autonomy and respect for others ✓ Composure and patience ✓ Relativity of time	Discussing the prevention of suicidal behaviour with power point	Listening and ask doubts.

		✓ Non-verbal communication. **ii)POSITIVE YOUTH DEVELOPMENT PROGRAMS** ✓ Direct teaching and skill building, ✓ Cultivation of relationships that enable the expression of emotional, behavioural and social competence. ✓ The development of opportunities for young people to experience meaningful connections with others and their communities. Many positive youth development programs are guided by the "six C's" 1. Competence - Positive view of one's actions in specific areas 2. Confidence - Internal sense of positive self worth and self efficacy 3. Character - Respect for societal and cultural norms, sense of morality, integrity 4. Connection - Positive bonds with people and institutions, such as peers, family and community 5. Caring/Compassion - Sense of sympathy and empathy for others 6. Contribution - Engaging in contributions to one's communit		

		iii)YOUTH SKILL BUILDING **Self esteem enhancement** People with high self-esteem have positive yet realistic views of themselves and their situations. They trust their own abilities, have a general sense of control in their lives, and believe that they will be able to meet most of their goals. High self-esteem means accepting yourself for who you are, and not depending excessively on the approval of others in order to feel good about yourself. People with high self-esteem take reasonable risks and do not feel they have to conform to the expectations of others. **Coping skills** Three broad types of coping strategies • appraisal-focused (adaptive cognitive) • problem-focused: Any coping behavior that is directed at reducing or eliminating a stressor, adaptive behavioral • emotion-focused: Directed towards changing one's own emotional reaction to a stressor ***Appraisal-focused*** strategies occur when the person modifies the way they think, for example: employing denial, or distancing oneself from the problem. People may alter the way they think about a problem by altering their goals		

		and values, such as by seeing the humor in a situation: "some have suggested that humor may play a greater role as a stress moderator among women than men" ***Problem-focused*** strategies try to deal with the cause of their problem. They do this by finding out information on the problem and learning new skills to manage the problem. Problem-focused coping is aimed at changing or eliminating the source of the stress. ***Emotion-focused*** strategies involve releasing pent-up emotions, distracting oneself, managing hostile feelings, meditating or using systematic relaxation procedures. Emotion-focused coping "is oriented toward managing the emotions that accompany the perception of stress There are six steps to making an effective decision: 1. Create a constructive environment. 2. Generate good alternatives. 3. Explore these alternatives. 4. Choose the best alternative. 5. Check your decision. 6. Communicate your decision, and take action.		

		Self awareness Self-awareness is the capacity for introspection and the ability to recognize oneself as an individual separate from the environment and other individuals. **Interpersonal communication skills** Interpersonal skills are the life skills that we use every day to communicate and interact with other people, both individually and in groups. People with strong interpersonal skills are usually more successful in both their professional and personal lives. **Problem solving skill** Working with others to identify, define and solve problems. ***Stages of Problem Solving*** ✓ Problem Identification ✓ Structuring the Problem ✓ Looking for Possible Solutions ✓ Making a Decision ✓ Implementation **Goal setting** Goal setting involves establishing specific, measurable, achievable, realistic and time-targeted goals**.**		

		➻ **Assertiveness** Communicating our values, ideas, beliefs, opinions, needs and wants freely. ➻ **Conflict resolution and meditation** ➻ **Stress management** Its involve the use of coping strategies in response to stressful situation. Coping strategies are adoptive when they protect the individual from harm or strengthen the individual's ability to meet challenging situation ✓ Relaxation ✓ Meditation ✓ Pets ✓ Music ➻ **Dealing with loss** ✓ Express yourself. Talking is often a good way to soothe painful emotions. Talking to a friend, family member, health professional or counsellor can begin the healing process. ✓ Allow yourself to feel sad. It's a healthy part of the grieving process. Crying enables your body to release tension. ➻ **Emotional regulation** I It can also be defined as extrinsic and intrinsic processes responsible for		

		monitoring, evaluating, and modifying emotional reactions **Distress tolerance** **Help seeking** **Refuting irrational beliefs** **Identifying and responding to distressed peers** **Empathy** **Moral development** **Leadership** **Citizenship skills** **Cultural sensitivity and awareness** **iv)MENTAL HEALTH PROMOTION** These programs are designed to support the development of specific skills in youth while also strengthening the overall social environment of the school to increase opportunities for belonging, acceptance and support. To learn important social, emotional and relational skills. Eight core skills that enable students to live healthy, productive and meaningful lives have been identified by the Collaborative to Advance Social and Emotional Learning (CASEL) 1. Communicate effectively 2. Ability to work cooperatively with others		

5 minute	explain the suicide awareness	3. Emotional self control and self expression 4. Empathy and perspective taking 5. Optimism, humour and self awareness 6. Ability to plan and set goals 7. Solving problems and resolving conflicts thoughtfully and non-violently 8. Bringing a reflective, learning-to-learn approach to all domains of life **SUICIDE AWARENESS** **Suicidal Thoughts: What to Do** If you have thoughts of suicide, these options are available to you: • Check yourself into the emergency room. • Call your local crisis agency. • Tell someone who can help you find help immediately. • Stay away from things that might hurt you. • Most people can be treated with a combination of antidepressant medication and psychotherapy. • Encourage the person to talk about his/her feelings • Stay calm and listen • Be accepting, DO NOT judge or lecture	Explaining the suicide awareness with power point	Listening and asking doubts.

CONCLUSION

A number of youth suicide prevention efforts are dedicated to increasing recognition of youth at potential risk for self harm and suicide. Most of these efforts are educational in nature and they are aimed at increasing the awareness of warning signs and risk factors for suicide among those who live, work and play in close proximity to youth – often referred to as gatekeepers. The most common audiences for these educational and training efforts include youth/peers, parents, school staff, family physicians, emergency room staff and other community gatekeepers like youth workers, police, probation officers, recreation leaders and youth volunteers.

தலைப்பு : தற்கொலை எண்ணங்களை தடுக்கும் முறைகள்

குழு : 18-21 வயதிற்குற்பட்ட கல்லூரி மாணவர்கள்

நேரம் : 45 நிமிடம்

கல்வி கற்ப்பிக்கும் முறை : சொற்பொழிவு மற்றும் விவாதம்

கற்பிக்க உதவும் சாதனம் : எல்சிடி

முக்கிய நோக்கம்.

அமர்வின் இறுதியில் மாணவர்கள் போதிய அறிவு பெற மற்றும் தற்கொலை எண்ணங்களை தடுக்கும் முறைகளை கண்டறிந்து தற்கொலை எண்ணங்கள் வராமல் செயல்படுத்த முடியும்.

குறிப்பிட்ட நோக்கம்.

மாணவர்கள் முடிவில்

- ✓ தற்கொலை எண்ணங்களை வரையறுக்க.
- ✓ தற்கொலையின் நிகழ்வுகளை பட்டியலிடு.
- ✓ தற்கொலைக்கான காரணங்களை வகைப்படுத்த.
- ✓ தற்கொலைக்கான அதிகப்படியான பாதிப்புடையவர்களை எண்ணிக்கையிடுக.
- ✓ தற்கொலைக்கான அறிகுறிகளை அறியப்படுத்துக.
- ✓ தற்கொலையை பற்றிய கருத்துக்களை விளக்குக.
- ✓ தற்கொலை எண்ணங்களை தடுக்கும் முறைகள் பற்றி விவாதிக்க.
- ✓ தற்கொலை எண்ணங்கள் ஏற்படும் பொழுது செய்ய வேண்டிய முதலுதவியை விவாதிக்க.

நேரம்	முக்கிய நோக்கம்	பொருளடக்கம்	ஆசிரியர் நடவடிக்கை	கற்பவர் நடவடிக்கை
1 நிமிடம் 1 நிமிடம் 2 நிமிடம்	தற்கொலை எண்ணங்களை வரையறுக்க. தற்கொலையின் நிகழ்வுகளை பட்டியலிடு	**முன்னுரை:** பயம், மன அழுத்தம், மன அழுத்தம் மற்றும் மன எழுச்சிநோய், தூக்கமின்மை போன்ற மன நோய் உள்ள இளைஞர்களுக்கு தற்கொலை எண்ணம் அதிகமாக காணப்படுகிறது. பெற்றோர்களின் விவாகரத்து, விட்டு செல்லுதல் அல்லது பண பாதுகாப்பிலிருந்து மாறுதல் போன்றவை இளைஞர்களின் வாழ்வில் சந்திக்கும் சூழ்நிலைகள், பாதிக்கப்பட்டவர்கள் தற்கொலையில் ஈடுபட விரும்புகிறார்கள். **வரையறை:** தற்கொலை (அ) தற்கொலை எண்ணங்கள் என்பது ஒருவர் தம்மை தாமே கொலை செய்யவோ அல்லது தம்மை தாமே வருத்திக் கொள்ள நினைத்தல் ஆகும். **நிகழ்வுகள்:** உலக நல குழு (WHO) ஒரு வருடத்திற்கு 1 மில்லியன் மக்கள் தற்கொலையினால் இறந்துள்ளனர் என்பதை கண்டுபிடித்துள்ளது. இது இறப்பதற்கான காரணங்களில்		

		மூன்றாவது வரிசையில் உள்ளது. இது உலகில் இறந்தவர்களின் எண்ணிக்கையில் 100000 மக்களில் 16 மக்கள் தற்கொலையினால் இறந்துள்ளனர், உலகநல குழுவின் தற்போதைய இறப்பவர்களின் குறிப்புகளின்படி (2010) 15-29 வயதில் உள்ளவர்களில் 40 வினாடிக்கு ஒரு இறப்பு தற்கொலையினால் ஏற்படுகிறது. இந்த வயதில் உள்ளவர்களின் நடுநிலை தற்கொலை அளவின் எண்ணிக்கை 7.4/100000 தற்கொலை செய்பவ்களில் பெண்களை விட (4.1)ஆண்களே (10.5)அதிகம். உலகில் இந்தியாவில் மட்டும் 10% க்கும் மேல் தற்கொலை நிகழ்கிறது. 2011-ல் இந்தியாவில் தற்கொலையின் எண்ணிக்கை 100000 மக்கள் தொகையில் 11.2% ஆக அதிகரித்துள்ளது. உலக நல குழுவின் தற்கொலை அளவின் அறிக்கையின்படி இந்தயாவில் 100000 மக்களில் 98 மக்கள் தற்கொலையில் ஈடுபட்டுள்ளனர். 2011-ல் உலகநல குழுவின் குறிப்பில் தமிழ்நாட்டில் 100000மக்களில் 22.1மக்கள் தற்கொலையில் ஈடுபட்டுள்ளனர். அதிகமாக தற்கொலை செய்து கொள்ளும் முறை மருந்தினாலோ அல்லது விஷத்தினாலோ ஏற்படுகிறது.		

3 நிமிடம்	தற்கொலைக்கான காரணங்களை வகைபடுத்து.	**காரணிகள்:** மக்கள் தன்னுடைய வாழ்க்கையின் நிகழ்வுகளுடன் போராட முடியாமல் வாழ்க்கையிலிருந்து விடுபட்டு செல்ல தற்கொலை முயற்சியில் ஈடுபடுகிறார்கள். பலர் தற்கொலை செய்ய காரணமாக இருப்பது. ✍ வெக்கப்பட்டு, அவமானப்பட்டு, மற்றவர்க்கு பாரமாக இருப்பதை நினைத்து. ✍ பாதிக்கப்பட்டதை நினைத்து மனம் வருந்துதல். ✍ மற்றவர்கள் நிராகரிப்பதை நினைத்தும், இழப்பு, அல்லது தனித்திருப்பதாக எண்ணுதல். கீழ்க்கண்ட சூழ்நிலைகளுக்கு மனிதன் முக்கியத்துவம் கொடுப்பதால் தற்கெலையில் ஈடுபடுகின்றனர். ✍ விரும்பிய ஒருத்தரின் இறப்பு. ✍ போதை பொருளுக்கு அடிதையாக உள்ளபோது. ✍ உணர்ச்சி வசப்படுதல். ✍ கொடிய உடல் நோய். ✍ வேலையின்மை அல்லது பணப்பிரச்சபைள்.		

5 நிமிடம்	தற்கொலைக்கான அதிகபடியான பாதிப்புடையவர் களை எண்ணிக்கை யிடுதல்	**அதிகமாக பாதிப்பிற்குள்ளவர்கள்** **உடல்ரீதியான காரணங்கள்:** ☹ நரம்பு மண்டல நோய் ☹ மூளை மற்றும் தண்டுவட நோய் ☹ வலிப்பு நோய் ☹ புற்று நோய் ☹ எச்.ஐ.வி / எயிட்ஸ் ☹ நீண்டகால மூச்சு குழாய் பாதிப்புஇமுக்கியமாக ஆண்களுக்கு ☹ நீண்டகால இரத்த சுத்திகரிப்பு-சிறுநீரக செயலிழப்பின் சிகிச்சை ☹ தீராத வலி ☹ உடல் பாகங்கள் செயலிழத்தல் **மனரீதியான காரணங்கள்** ☹ நம்பிக்கையின்மை ☹ மனரீதியான வலி ☹ அதிக பயம் ☹ அவமானம் அல்லது இழிவுபடுதல் ☹ மனகுழப்பம் ☹ தாழ்வு மனப்பான்மை		

		☹ பழக்கவழக்கங்கள் மாற்றம் ☹ முன்யோசனையின்றி செயல்படுதல் **குடும்ப ரீதியான காரணங்கள்** ☹ குடும்பத்தில் யாரேனும் தற்கொலையில் ஈடுபட்டிருந்தால் (முதல் நிலை சொந்தத்தில்) ☹ குடும்பத்தில் யாரேனும் போதை பழக்கத்திற்க்கு அடிமையாக இருந்தால். ☹ தற்கொலை ஒரே மாதிரியான இரட்டையருக்கு 18% அதிகமாக தாக்க வாய்ப்புள்ளது **மனசமூக காரணங்கள்** ☹ சரியான சமூக பாதுகாப்பின்மை (தனித்து வாழ்தல்) ☹ வேலையின்மை ☹ பணச்சரிவு ☹ குடும்பத்துடன் உறவு குறைதல் ☹ தற்போதைய சகிக்கமுடியாத நிகழ்வுகள் **குழந்தைபருவ பாதிப்புகள்** ☹ உடல் ரீதியாக அல்லது உடலுறவு ரீதியாக குழந்தையுடன் தகாத முறையில் நடத்தல் **ஆழ்ந்த சிந்தனை சார்ந்த காரணங்கள்** ☹ மனம் திறந்து பேசாதிருத்தல்		

5 நிமிடம்	தற்கொலைக்கான அறிகுறிகளை அறியபடுத்துக.	**சுயகுறிப்பு சார்ந்த காரணங்கள்** ☹ ஆண்கள் அதிக அளவில் பாதிக்கபடுகின்றனர். ☹ விதவை, விவாகரத்து செய்தவர்கள் (அ) கல்யாணம் செய்து தனித்திருத்தல். ☹ இளமை பருவம். ☹ வெள்ளை இனத்தவர். ☹ நடுத்தர வகுப்பை சார்ந்தவர்களை விட மேல் மற்றும் கீழ் வகுப்பை சார்ந்தவர்களே அதிகமாக தற்கொலைக்கு முயற்ச்சிக்கின்றனர். ☹ நகர வேலை. **தற்கொலையின் அபாய அறிகுறிகள்:** தற்கொலை செய்ய இருக்கும் நபர் தன்னுடைய பழக்க வழக்கத்திலும்இ வாய்வழியாகவும்இ மற்றசெயல்கள் மூலமாகவும் குறிப்புகளை வெளிப்படுத்துவார்கள். **பழக்க வழக்கத்தின் குறிப்புகள்** போதைப்பொருளை பயன்படுத்துவார்கள் தன்னுடைய விலைஉயர்ந்த பொருட்களை மற்றவர்களுக்கு கொடுத்தல் எல்லா சொத்துக்களையும் மாற்றுதல் தற்கொலை கடிதம் எழுதுவார்கள்		

		🧠 திடீர் மனநிலை மாற்றம் 🧠 நண்பர்களுடன் ஆர்வமின்றி இருத்தல் **வாய்வழி வார்த்தைகளின் குறிப்புகள்** 🧠 உறுதியற்ற வாக்குமூலம் வெளிப்படுத்துதல் • நான் சாகபோகிறேன், தற்கொலை செய்து கொல்ல போகிறேன் • என்னால் இதை தாங்கிக்கொள்ள முடியவில்லை • நான் இல்லை என்றால் நீ நன்றாக இருப்பாய் • வகுப்பில் படிப்பவர்களுடனும், குடும்பத்தினருடனும், மற்றும் நண்பர்களுடனும் அக்கரையின்றி இருத்தல் • நான் உபயோகமில்லாதவன் • இனி எனக்கு வாழ்வு தேவையில்லை • எல்லாம் தவறாகவே நடக்கிறது, நான் வாழவிரும்பவில்லை • இது தான் நீ என்னை பார்க்கும் கடைசி முறையாக இருக்கும் 🧠 தன்னையே தரம் குறைவாக பார்த்துக்கொள்ளுதல் 🧠 நம்பிக்கையின்றி இருத்தல் 🧠 வாழ்க்கையின் பயணை உணராதிருத்தல் **வாய்வழி அல்லாத குறிப்புகள்** 🧠 அதிக தூக்கம் (அ) குறைந்த தூக்கம்		

3 நிமிடம்	தற்கொலையை பற்றிய கருத்துக்களை விளக்குக	🧠 சுயதோற்றத்தில் ஆர்வமின்றி இருத்தல் 🧠 சமூக செயல்களில் ஆர்வமின்றி இருத்தல் 🧠 பள்ளி மற்றும் கல்லூரியில் நடத்தை குறைதல் 🧠 ஒவ்வின்மைஇ கவனக்குறைவு 🧠 நண்பர்கள் மற்றும் குடும்பத்தினரிடமிருந்து நீங்குதல் 🧠 மன அழுத்தம் 🧠 தாங்கிக்கொள்ள முடியாத மன வலி 🧠 அழுகை 🧠 எரிச்சல் அடைதல் 🧠 உச்சகட்ட மன அழுத்தம் **தற்கொலையை பற்றிய உண்மைகள் மற்றும் தவறுகள்:** i)**தவறு** :எவன் ஒருவன் தற்கொலை பற்றி பேசுகிறானோ அவன் தற்கொலை செய்துகொள்ளமாட்டான். முன் அறிகுறிகள் இல்லாமலே தற்கொலை நடக்கும். **உண்மை** :10-ல் 8 பேர் தற்கொலை செய்வதற்கு முன்பு குறிப்பு கொடுத்துவிட்டே தற்கொலை செய்து கொள்கிறார்கள்இ ஆனால் சில குறிப்புகளை (அ) அறிகுறிகளை மற்றவர்கள் கவனிப்பதில்லை. **ii)தவறு** : ஒருவர் முழுமையாக இறக்க நினைக்கும் பொழுது		

		அவர்கள் தற்கொலைக்கு உள்ளாவதை யாரலும் தடுக்கமுடியாது. **உண்மை** : தற்கொலை எண்ணம் உடையவர்கள் வாழலாமா இல்லை சாகலாமா என்ற இருவேறு கருத்துக்களுடன் இருப்பர், யாராவது நம்மை காப்பாற்றுவார்கள் என எண்ணுவார்கள். **iii)தவறு** ஒருவர் ஒருமுறை தற்கொலையில் ஈடுபட்டால்இ அவர்கள் எப்பொழுதும் தற்கொலையில் ஈடுபட்டு கொண்டிருப்பார்கள். **உண்மை** : ஒருவருக்கு தற்கொலை எண்ணம் ஒரு குறிப்பிட்ட காலத்திற்க்கு மட்டுமே இருக்கும். அவர்களை தற்கொலை எண்ணத்திலிருந்து திசைதிருப்பிவிட்டால் அவர்கள் சாதாரண வாழ்விற்க்கு சென்று விடுவார்கள். **iv)தவறு** : கடும் மனஅழுத்ததிலிருந்து முன்னேற்றம் அடைந்தால் தற்கொலை எண்ணம் குறையும். **உண்மை** : பெறுபாலும் தற்கொலை மன அழுத்தத்திலுருந்து முன்னேற்றம் அடைந்து 3 மாதங்களுக்கு பிறகு நடக்கிறது. **v)தவறு** : தற்கொலை பரம்பரையை சார்ந்து வருவது **உண்மை** : தற்கொலை பரம்பரையைச் சார்ந்து அல்ல. இது தனிமனிதனைச் சார்ந்தது. இதை தடுக்கலாம். மேலும் இது குடும்பத்திலுள்ள நெருங்கிய ஒருவர் தற்கொலை செய்திருந்தால் அது தனிமனித ஒருவரின் தற்கொலைக்கு காரணியாக உள்ளது.		

		vi)தவறு : தற்கொலைச் செய்யும் அனைவரும் மனநலம் பாதிக்கப்பட்டவர்கள். தற்கொலை என்பது மனநல நோயாளியின் செயல். **உண்மை** :தற்கொலை செய்தவர்களில் அதிக சதவீதம் மனநலம் பாதிக்கப்பட்டவர்கள் ஆவர். அதே சமயத்தில் மற்றவர்கள் பிரச்சனை ஏற்படும் சமயத்தில் என்ன முடிவு எடுக்கவேண்டும் என்று தெரியாமல் தற்கொலைக்கு முயற்சிக்கின்றனர். **vii)தவறு** : தற்கொலை மிரட்டல் மற்றவர்களின் கவனத்தை திசை திருப்பும் செயலாக கருத வேண்டும், அபாயமாக எடுத்து கொள்ள வேண்டாம். **உண்மை** : எல்லா தற்கொலைகளும் மனதின் முக்கிய செயலாக எதிர்நோக்க வேண்டும். ஒருவர் உதவியை எதிர்பார்க்கும் போது அவர்களை கவனிக்க வேண்டும். **viii)தவறு** : ஒருவர் ஒருமுறை தற்கொலையில் ஈடுபட்டிருந்தால் அவர் மறுபடியும் தற்கொலையில் ஈடுபடமாட்டார்கள். **உண்மை** : 50% முதல் 80% வரை தற்கொலை செய்தவர்கள் அதற்கு முன்பே தற்கொலை முயற்சியில் ஈடுபட்டவர்கள்.		

20 நிமிடம்	தற்கொலை எண்ணங்களை தடுக்கும் முறைகள் பற்றி விவாதிக்க	**தற்கொலையை தடுத்தும் முறைகள்** **1.நல்வாழ்வு தருதல்** சமூகத்தை வலுவக்குதல் சமூக பிரிவினைகளை குறைத்தல் சமூக நியாத்தை ஊட்டுதல், சமூக பலத்தை அளித்தல், இளைஞர்கள், பெற்றோர்களின் திறமையை முன்னேற்றுதல். ✓ கடவுள் நம்பிக்கை ✓ குடும்ப வாழ்க்கையில் ஆர்வம் காட்டுதல் ✓ பெரியவர்கள், படித்தவர்கள் மற்றும் கலாச்சாரத்திற்க்கும் மரியாதை கொடுக்க வேண்டும் ✓ இயற்கைக்கு மரியாதை கொடுக்க வேண்டும் ✓ உணர்வுகளை பகிர்ந்து கொள்ளுதல் ✓ ஒத்துழைப்பு மற்றும் குழுவுடன் இணைந்திருத்தல் ✓ சுய உரிமை மற்றும் மற்றவர்க்கு மரியாதை கொடுத்தல் ✓ சாந்தமாகவும்இ பெருமையாகவும் இருத்தல் ✓ நேரத்துடன் ஒத்துபோதல் ✓ வாரத்தைகளின்றி தகவல்களை பரிமாறுதல் **2.இளைஞர்களை உறுதிபடுத்தும் முன்னேற்ற திட்டங்கள்** ✓ நேர்முகமாக கற்ப்பித்தல் மற்றும் திறமையை வளர்த்தல். ✓ ஊணர்ச்சிகள்இ பழக்கவழக்கங்கள் மற்றும் சமூக		

		அதிகாரத்தை வெளிப்பத்த உறவுகளை விதைக்க வேண்டும். ✓ இளைஞர்களுக்கு மற்றவருடன் அர்த்தமுள்ள உறவு ஏற்பட வாய்ப்பளித்தல்இ சிறந்த முறையில் தகவல்களை பரிமாறிக்கொள்ளுதல். **ஆறு முக்கியமான செயல்கள்** இளைஞர்களின் உறுதிபடுத்தும் முன்னேற்ற திட்டத்திற்கு பயன்படுத்தப்படுகிறது. அவை **i) தன்னம்பிக்கை** - ஒரு இடத்தில் தன்னுடைய தனிபட்ட செயல்களை செய்யும் பொழுது தன்மிது நம்பிக்கை வைத்தல். **ii) மன தையிறியம்** - தனி மனிதன் எந்த செயலையும் தன்னம்பிக்கையுடனும்இ உறுதியாகவும் செயல்பட முடியிம் என நம்புதல் **iii) சுபாவம் -** சமூகம் மற்றும் கலாச்சார விதிகளை மதித்தல். **iv) இணைந்திருத்தல் -** நண்பர்கள;, குடும்பம் மற்றும் சமூகத்துடன் நல்ல பிணைப்பை உண்டாக்குதல். **v) அறவனைத்தல்** - மற்றவர்களுக்காக பரிதாபப்படுதல் மற்றும் உதவுதல் **vi) ஈடுபடுத்தல்** - சமூகம் சார்ந்த வேலைகளில் ஆர்வம் காட்டுதல்.		

		3.இளைஞர்களின் திறமைகளை வளர்த்தல் **தன்னம்பிக்கை ஊட்டுதல்** தன்னம்பிக்கையுடன் மனிதன் தன்னைப்பற்றியும் அவர்களுடைய சூழ்நிலையை பற்றியும் உறுதியான எண்ணங்களையே கொண்டிருப்பார்கள். அவர்களுக்கு அவர்களுக்கு அவர்களுடைய திறமைகளில் நம்பிக்கையிருக்கும், அவர்களுடைய வாழ்வில் கட்டுப்பாடு இருக்கும். மேலும் அவர்களால் அவர்களுடைய நோக்கத்தை அடைய முடியும். தன்னம்பிக்கை என்பது தம்மை தனக்காக ஏற்றுக்கொண்டு மற்றவர்கள் தம்மை நல்லவர்கள் என்று கூறுவதை எதிர்பாராமல் இருத்தல். தன்னம்பிக்கை அதிகமுள்ள மனிதர்கள் காரணத்துடன் கூடத்துடன் செயல்களில் ஈடுபடுவார்கள் மற்றும் மற்றவர்களின் உத்திரவாதத்தை எதிர்பார்க்க மாட்டார்கள். **பிரச்சனையிலிருந்து வெளிவரும் திறமை** இது மூன்று வகைப்படும். 1. முன்னேற்றத்தை கூர்ந்து நோக்குதல். 2. பிரச்சனைகளை கூர்ந்து நோக்குதல். 3. மனவலிமையை கூர்ந்து நோக்குதல்.		

		1. முன்னேற்றத்தை கூர்ந்து நோக்குதல். ⇗ ஒரு தனிநபர் அவருடைய எண்ணங்களின் சிந்திக்கும் திறமையை மாற்றி அமைப்பதே ஆகும். (எ.கா) ஒருவர் தன்னுடைய நோக்கம்இ அதனுடைய முக்கியத்துவத்தை அறிந்து அதனை அடைவதற்காக பலவழிகளில் பல்நோக்கு முனைப்புடன் செயல்படுத்தல். ஒருவர் பிரச்சனைகளில் இருக்கும்பொழுது சாந்தமாக இருப்பது அந்த பிரச்சனையில் இருந்து விடுபட உதவும் என நம்புகின்றனர் **2. பிரச்சனைகளை கூர்ந்து நோக்குதல்.** ⇗ பிரச்சனைகளை கூர்ந்து நோக்குவதன் மூலம் அதன் மூலகாரணத்தை கண்டறிய உதவும்இ மூலகாரணத்தை கண்டறிந்து அதனை சரிசெய்யும் வழிமுறைகளை கண்டறிதல், மற்றும் அதனை தீர்க்கும் புதிய முயற்சிகளை மேற்கொள்ளுதல். ⇗ பிரச்சனைகளை கூர்ந்து நோக்கி ஆராய்வதன் மூலம் பிரச்சனைகளுக்காண காரணத்தை மாற்றி அமைக்கவும் அல்லது ஒதுக்கவும் முடியும். **3. மனவலிமையை கூர்ந்து நோக்குதல்.** ⇗ ஒருவருடைய சுக துக்கங்களை பகிர்ந்து கொள்ளுதல், யோகாசனம் அல்லது மற்ற மன அமைதி தரும் செயல்கள் மன வலிமையை உறுதிபடுத்த உதவுகிறது.		

		⇗ ஆறு முக்கிய வழிகள் ஒரு முடிவை எடுப்பதற்க்கு உதவுகிறது. அவை, i) தனக்கு தகுந்த சுற்றுபுறத்தை அமைத்தல். ii) பல கோணங்களில் தீர்வுகளை எடத்தல். iii) தீர்வுகளை வெளிக்கொணர்தல். iv) சரியான தீர்வை செயல்படுத்தல். v) முடிவு சரியானதா என ஆராய்தல். vi) தீர்வை மற்றவர்களுன் பரிமாறுதல் மற்றும் செயல்படுத்தல். **⇜ சுய விழிப்புணர்வு** சுய விழிப்புணர்வு என்பது தனினைப்பற்றி தாமே தெரிந்து கொள்வது. மேலும் தம்மை சுற்றுச்சூழலிருந்தும் மற்றிவரிடமிருந்தும் பிரித்துணர்ந்து அறிந்திருப்பது. **⇜ மற்றவரிடம் சகஜமாக பேசிபழகும் திறன்** மற்றவரிடம் சகஜமாக பேசிபழகும் திறன் வாழ்க்கையில் முக்கியமானது. தினமும் மற்றவருடனும்இ மற்ற குழு அங்கத்தினருடனும் பேச இது தேவைப்படுகிறது. ஒருவருக்கு பேச்சுத்திறன் பலமாக இருந்தால் அவனால் வேலையிலும்இ செந்த வாழ்விழும் வெற்றி பெற முடியும். **⇜ பிரச்சனையை சமாலிக்கும் திறன்** மற்றவர்களுடன் வேலைசெய்யும் பொழுது, பிரச்சனைகளை		

		எவ்வாறு கண்டறிதல;, அதை சரியான முறையில் சரிபடுத்தல். **பிரச்சனையை சமாலிக்கும் முறையின் பிரிவுகள்** ✓ பிரச்சனையை கண்டறிதல் ✓ பிரச்சனையை வடிவமைதல் ✓ சரி செய்யும் வழிகளை தேடுதல் ✓ முடிவெடுத்தல் ✓ சேயல்படுத்தல் **ఴ நோக்கத்தை அமைத்தல்** ஒரு நோக்கத்தை அமைக்கும் பொழுது அதை முதன்மை படுத்திஇ செயல்படுத்தக்கூடியதாக, குறிப்பிட்ட காலத்தில் செயல்படுத்தக்கூடியதாக இருக்க வேண்டும். **ఴ தன்முனைப்பு** ➱ அடுத்தவர்களுக்கு பாதிப்பு ஏற்படாமல் தன்னுடைய உரிமைக்காக போரடுதல். ➱ தம்முடைய தகவல்கள் அதனுடைய, முக்கயத்துவம், மற்றும் தேவைகளை யாருக்கம் பாதிப்பு இல்லாமல் வெளிப்படுத்துதல். **ఴ மன அழுத்தத்தை சரிபடுத்துதல்** மன அழுத்தத்தை சரிபடுத்துவதற்க்கு பல்வேறு வகையான வழிமுறைகள் மேற்கொள்ளக்கடுகின்றன, அவை ☺ பொழுது போக்கு		

		☺ தியானம் ☺ செல்ல பிராணிகள் ☺ இசை **ఎ சரிவுகளை சரிபடுத்துதல் (அ) எதிர்கொள்ளுதல்.** ☺ பிரச்சனைகளை உணர்தல் ☺ வெளிப்படையாக நண்பர்களுடன், குடும்ப அங்கத்தினருடன் மற்றும் உடல்நலகாப்பாளர்கள் அல்லது ஆலோசகர் உடன் பேசுதன் மூலம் நல்ல தீர்வுகிடைக்கும். ☺ மனம் விட்டு அழுவதன் மூலம் உடல் இறுக்கத்தில் இறுந்து வெளிப்பட உதவும். **ఎ உணர்ச்சிவசத்தை கட்டுப்படுத்துதல்** இது உடல்ரீதியாகவோ, மனரீதியாகவோ ஏற்படக்கூடியவை, இதனை சரியான முறையில் உபயோகித்து அதன் பயன்பாட்டினை கண்டறிய வேண்டும். **ఎ துயரத்தின் சகிப்புத்தன்மை** **ఎ மற்றவர் உதவியை நாடுதல்** **ఎ பகுத்தறிவற்ற நம்பிக்கைகளை மறுத்தல்** **ఎ கற்பனையாக மற்றவர் உள்ளத்தில் புகுந்து அவர்களின் கிளர்ச்சியை அறிதல்** **ఎ அறநெறி வளர்ச்சி**		

		➢ **தலைமை பொறுப்பு** ➢ **குடியுரிமை திறன்கள்** ➢ **கலாச்சார உணர்திறன் மற்றும் விழிப்புணர்வு** ➢ **சமூக நீதி மற்றும் பன்முகத்தன்மை** **IV) மன நலத்தை அதிகப்படுத்துதல்:** இந்த திட்டம் ஒருவருடைய தனித்திறனை மேன்மை படுத்துவதற்க்கும் அதனை பலப்படுத்தி சமுதாயத்தில் தனிமனித ஒழுக்கத்தை காப்பதற்க்கும் உதவுகிறது. இந்த பகுதி ஒருவர் சமுதாயத்தின் முக்கியதிதுவம், மற்றும் உறவுகளின் முக்கியத்துவத்தை உணர்ந்து செயல்படுவதற்க்கு எட்டு வழிகள் உபயோகப்படுத்தப்படுகின்றன. அனைவருடன் இணைந்து சமூகத்தை பேணிகாப்பதையும், உணர்வுகளை கட்டுபடுத்துதலும் பற்றி கற்றுக்கொள்ளுதல். 1. மற்றவர்களுடன் நன்றாக பேசுதல் 2. அனைவருடனும் இணைந்து செயல்படுதல் 3. உணர்வுகளை கட்டுப்படுத்துதல் மற்றும் வெளிப்படுத்துதல் 4. பாசமாக இருத்தல் 5. நம்பிக்கை, நகைச்சுவை உணர்வு		

ANNEXURE - F

CERTIFICATE OF VALIDATION

This is to certify that the tool developed by **Mr.Loganathan.N**, Final year M.Sc Nursing student of Sri Gokulam College of Nursing, Salem (Affiliated to The Tamil Nadu Dr. M.G.R Medical University) is validated and can proceed with this tool and content for the main study entitled **"A Study to Evaluate the Effectiveness of Structured Teaching Programme on Knowledge Regarding risk factors and Prevention of Suicidal Behavior among Adolescents in a Selected College, Salem"**

Signature with Date

ANNEXURE - G

LIST OF EXPERTS

1. **Dr.C.Babu.MD,**
   Specialist in Deaddition and Child Psychiatry'
   Consultant Psychiatrist,
   Sri Gokulam Hospital, Salem.

2. **Dr. Babu Rangarajan, M.Sc(Psy), M.Phill(PSY)(Child.Psy)., PGDM (CPG), IDGC**
   Child & Clinical Psychologist,
   Neuro foundation,
   Salem.

3. **Mrs. R.Sreevani, M.Sc (N),**
   Professor and HOD Department of Psychiatric Nursing,
   Sri Devaraj URS College of Nursing.
   Kolar.

4. **Mrs. Meera Saravanan, M.SC (N),**
   Associate Professor, Mental Health Nursing,
   PSG College of Nursing,
   Coimbatore.

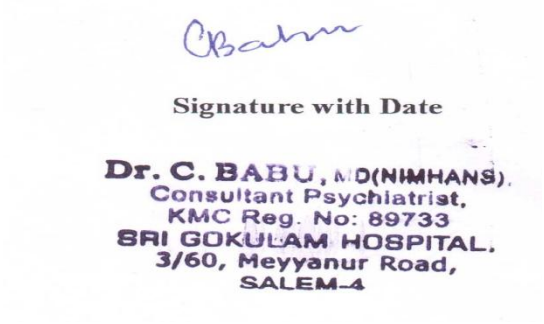
5. **Mrs.R, Naganandini, M.Sc(N),**
   Prinicipal,
   Dhanalaskhmi Srinivasa College of Nursing,
   Perambalur-12.

6. **Mr. P.Selva Raj, M.Sc. (N)**
   HOD, Psychiatric Nursing Dept,
   Shamuga College of Nursing,
   Salem.

7. **Mrs. Devi Arul. M.Sc (N),**
   Associate Professor,
   Mental Health nursing,
   Shamuga College of Nursing, Salem.

CERTIFICATE OF VALIDATION

This is to certify that the tool developed by **Mr.Loganathan.N**, Final year M.Sc Nursing student of Sri Gokulam College of Nursing, Salem (Affiliated to The Tamil Nadu Dr. M.G.R Medical University) is validated and can proceed with this tool and content for the main study entitled **"A Study to Evaluate the Effectiveness of Structured Teaching Programme on Knowledge Regarding risk factors and Prevention of Suicidal Behaviour among Adolescents in a Selected College, Salem"**



CERTIFICATE OF VALIDATION

This is to certify that the tool developed by **Mr.Loganathan.N**, Final year M.Sc Nursing student of Sri Gokulam College of Nursing, Salem (Affiliated to The Tamil Nadu Dr. M.G.R Medical University) is validated and can proceed with this tool and content for the main study entitled **"A Study to Evaluate the Effectiveness of Structured Teaching Programme on Knowledge Regarding risk factors and Prevention of Suicidal Behaviour among Adolescents in a Selected College, Salem"**

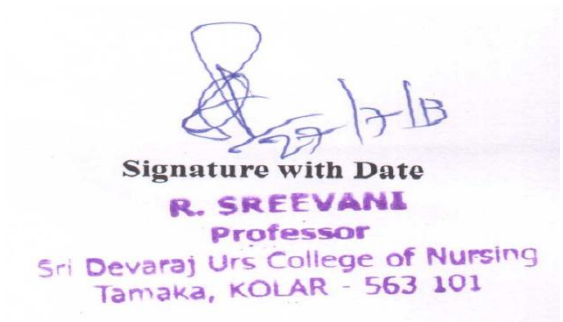
9/07/2013

Signature with Date

Dr. BABU RANGARAJAN
M.Sc(Psy), M.Phil (Psy) (Chi. Psy).,
PGDPM (CPC)., IDGC (NCERT, New Delhi)
Child & Clinical Psychologist
மனோதத்துவ நிபுணர் Rcl. CRR No: A 19151.

CERTIFICATE OF VALIDATION

This is to certify that the tool developed by **Mr.Loganathan.N**, Final year M.Sc Nursing student of Sri Gokulam College of Nursing, Salem (Affiliated to The Tamil Nadu Dr. M.G.R Medical University) is validated and can proceed with this tool and content for the main study entitled **"A Study to Evaluate the Effectiveness of Structured Teaching Programme on Knowledge Regarding risk factors and Prevention of Suicidal Behaviour among Adolescents in a Selected College, Salem"**



CERTIFICATE OF VALIDATION

This is to certify that the tool developed by **Mr.Loganathan.N**, Final year M.Sc Nursing student of Sri Gokulam College of Nursing, Salem (Affiliated to The Tamil Nadu Dr. M.G.R Medical University) is validated and can proceed with this tool and content for the main study entitled **"A Study to Evaluate the Effectiveness of Structured Teaching Programme on Knowledge Regarding risk factors and Prevention of Suicidal Behaviour among Adolescents in a Selected College, Salem"**

CERTIFICATE OF VALIDATION

This is to certify that the tool developed by **Mr.Loganathan.N**, Final year M.Sc Nursing student of Sri Gokulam College of Nursing, Salem (Affiliated to The Tamil Nadu Dr. M.G.R Medical University) is validated and can proceed with this tool and content for the main study entitled **"A Study to Evaluate the Effectiveness of Structured Teaching Programme on Knowledge Regarding risk factors and Prevention of Suicidal Behaviour among Adolescents in a Selected College, Salem"**

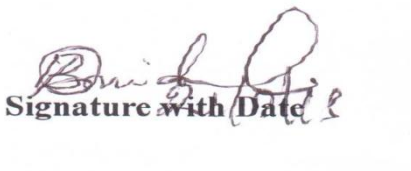
5/7/13

Signature with Date

Head of the Department
Dept. of Mental Health Nursing,
Shanmuga College of Nursing,
Salem - 636 007.

CERTIFICATE OF VALIDATION

This is to certify that the tool developed by **Mr.Loganathan.N**, Final year M.Sc Nursing student of Sri Gokulam College of Nursing, Salem (Affiliated to The Tamil Nadu Dr. M.G.R Medical University) is validated and can proceed with this tool and content for the main study entitled **"A Study to Evaluate the Effectiveness of Structured Teaching Programme on Knowledge Regarding risk factors and Prevention of Suicidal Behaviour among Adolescents in a Selected College, Salem"**



ANNEXURE – H

CERTIFICATE OF EDITING

TO WHOM IT MAY CONCERN

Certified that the dissertation paper titled **"A Study to Evaluate the Effectiveness of Structured Teaching Programme on Knowledge Regarding risk factors and Prevention of Suicidal Behavior among Adolescents in a Selected College, Salem."** by **Mr.Loganathan.N,** has been checked for accuracy and correctness of English language usage, and that the language used in presenting the paper is lucid, unambiguous, free of grammatical / spelling errors and apt for the purpose.

Signature:

Name and Designation: A. Mary Manjula Rose
Asst. Prof in English
M.A, M.Ed, M.Phil
S.T. Hindu College of Education

Date: 30-12-2013

HINDU COLLEGE OF EDUCATION NAGERCOIL-2 T.S.

CERTIFICATE OF EDITING

TO WHOM IT MAY CONCERN

Certified that the dissertation paper titled **"A Study to Evaluate the Effectiveness of Structured Teaching Programme on Knowledge Regarding risk factors and Prevention of Suicidal Behavior among Adolescents in a Selected College, Salem."** by **Mr.Loganathan.N,** has been checked for accuracy and correctness of Tamil language usage, and that the language used in presenting the paper is lucid, unambiguous, free of grammatical / spelling errors and apt for the purpose.

Signature:

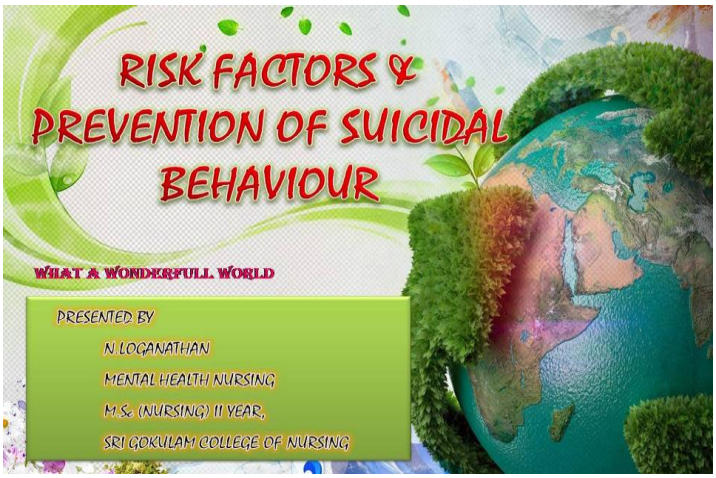
Name and Designation: Dr. N. KRISHNAN
Associate Professor

Date: 30-12-13

Dr. N. KRISHNAN, M.A.,Ph.D.
Research Co-ordinator (Humanities)
S. T. Hindu College
Nagercoil-629 002

ANNEXURE – I

PHOTOS



INTRODUCTION

Young people with mental health problems, such as anxiety, depression, bipolar disorder, or insomnia, are at higher risk for suicidal thoughts, as are teens experiencing major life changes, such as the divorce of parents, moving, or change in financial security. Victims of bullying are also more likely to think about suicide.

DEFINITION

Suicidal or Suicidal behaviour is any action taken intentionally an individual kill self or deliberately harming oneself

INCIDENCE

The World Health Organization (WHO) estimates that about one million people die by suicide every year. It is the third leading cause of death.

This represents a "global" mortality rate of 16 per 100,000 population. one death every 40 seconds with this the suicide is leading cause of death in the age group of 15 to 29 years according to the latest World Health Organization mortality database(2010), The mean suicidal rate for this age group was 7.4/100,000, Suicide rates were higher in males (10.5) than in females (4.1).

India alone contributes to more than 10% of suicides in the world. The suicide rate in India has been increasing steadily and has reached 11.2 per 100,000 of population in 2011.

According to WHO the suicidal rate In India for every 1,00,000 people 98 of them commit suicide annually.

A report by the World Health Organization states that 22.1out of every 100,000 persons commit suicide in Tamilnadu in the year of 2011. Most commonest method of attempting suicide by using drug and poison

CAUSES

People who try to commit suicide are often trying to get away from a life situation that seems impossible to deal with. Many who make a suicide attempt are seeking relief from:

- Feeling ashamed, guilty, or like a burden to others
- Feeling like a victim
- Feelings of rejection, loss, or loneliness

Suicidal behaviors may occur when there is a situation or event that the person finds overwhelming, such as:

- Death of a loved one
- Dependence on drugs or alcohol
- Emotional trauma
- Serious physical illness
- Unemployment or money problems

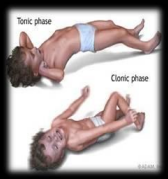
RISKFACTORS

Physical factors

Chronic disablinig physical illness like

Diseases of the nervous system

Brain and spinal cord injury



Seizure disorders

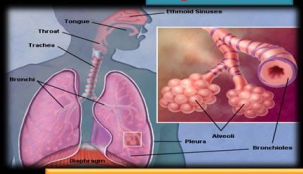
Cancer

HIV/AIDS

Pain syndromes

Functional impairment

Chronic hemodialysis-treated renal failure



Chronic obstructive pulmonary disease

Psychological factors

Depression

Severe or unremitting anxiety

Hopelessness

Aggression, including violence against others

Decreased self-esteem

Panic attacks

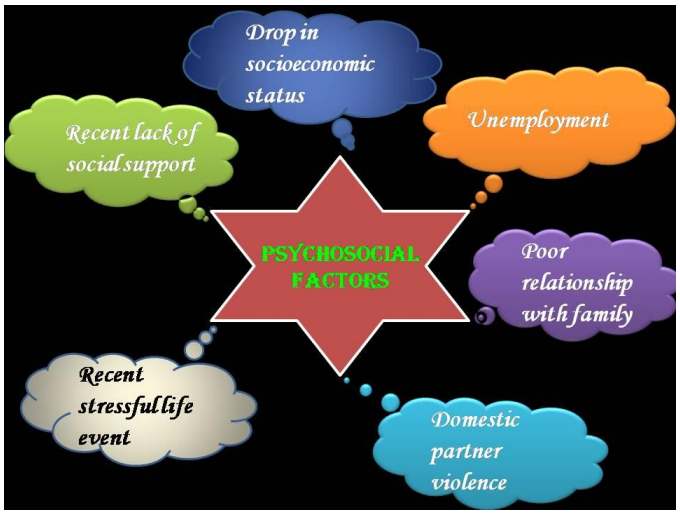
- Psychic pain
- Shame
- Impulsiveness
- Agitation

BIOLOGICAL FACTORS

Family history of suicide (particularly in first-degree relatives)

Family history of substance use disorders

Suicide in monozygotic twins may be high as 18%



Childhood traumas

- Abuse of the child like physical abuse and Sexual abuse

Cognitive factors

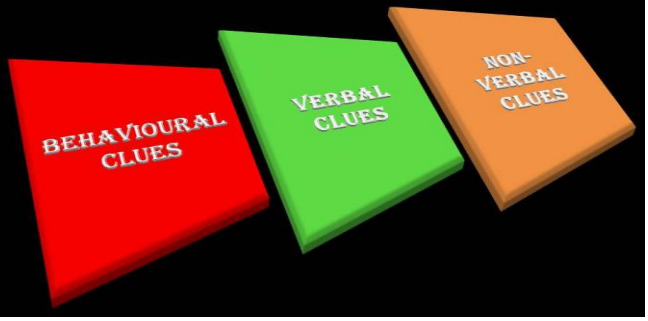
- Closed-mindedness

DEMOGRAPHIC FACTORS

- Male gender
- Widowed, divorced, or single marital status, particularly for men
- Adolescent and young adult and old age groups
- White race
- Lesbian and bisexual orientation
- Individual in the highest and lowest social classes have higher suicide rate than those in the middle classes.
- Urban occupation.

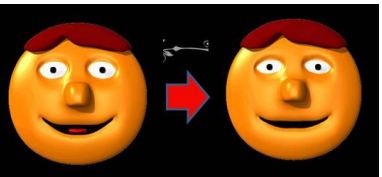
WARNING SIGNS OF SUICIDE

Individual may leaves behavioural, verbal and non-verbal clues to intent to their act.



1) BEHAVIORAL CUES

Ingestion of a small amount of some potentially lethal drugs



Sudden changes in mood.

- Withdrawing from friends and family
- Keeping affairs in order

Writing suicidal notes

II) VERBAL CUES

- Passing negative statement
  - "I want to die, end my life" " I am going to kill myself.
  - " It's too much to bear"
  - "You would be better, without me"
  - "Classmates, Families and friends do not care"
  - "I am not useful"
  - " I don't want life anymore"
  - "Everything is going wrong, no need for me to live"
  - " This is the last time you will see me"
- Cannot think clearly
- Sees no sense of worth of own self
- Becomes hopeless
- Sees no sense of purpose in life and find no reason for living.

III) NON-VERBAL CUES

- Addiction
- Lack of interest in personal appearance
- Lack of interest in friends
- Lack of interest in social activities
- Poor performance in school or college
- Restless, lack of concentration

- Sleeping much or too little
- Depressed mood
- Experiences unbearable psychological pain
- Weepy
- Irritable
- Extreme sadness

People who talk about suicide do not commit suicide. Suicide happens without warning.

Eight out of ten people who kill themselves have given definite clues and warnings about their suicidal intentions. Very subtle clues may be ignored or disregarded by others

Most suicide occur within about 3 months after the beginning of "improvement" when the individual has the energy to carry out suicidal intention.

Improvement after severe depression means that the suicidal risk is over

You cannot stop a suicidal person. He or she is fully intent on dying.

Most suicidal people are very ambivalent about their feelings regarding living or dying. Most are "gambling with death" and see it as a cry for someone to save them.

People who want to kill themselves are only suicidal for a limited time. If they are saved from feeling of self destruction, they can go on to lead normal lives.

Once a person is suicidal, he or she is suicidal forever.

Suicide is inherited or "runs in families"

Suicide is not inherited. It is an individual matter and can be prevented, however, suicide by a close family member increase an individual's risk factor for suicide.

All suicidal individuals are mentally ill and suicide is the act of a psychotic person.

A larger percentage of people who commit suicide have been diagnosed with a mental disorder. However, many other are merely unable at that point in time to see an alternative solution to what they consider an unbearable problem.

Suicidal threats and gestures should be considered manipulative or attention-seeking behavior, and should not be taken seriously.

All suicidal behavior must be approached with the gravity of the potential act in mind. Attention should be given to the possibility that the individual is issuing a cry for help.

WELL BEING PROMOTION

- ✓ Strengthening communities,
- ✓ Reducing social inequities,
- ✓ Promoting social justice,
- ✓ Enhancing social support and improving the specific skills of youth and their parents,

are all part of an overall effort to promote the well-being of youth, their families and communities. Several promising approaches to promoting resilience and strengthening social environments are described in this section.

- Spirituality
- Importance attached to child-rearing and the extended family
- Respect for age, wisdom and tradition
- Respect for nature
- Generosity and sharing
- Cooperation and group harmony
- Autonomy and respect for others
- Composure and patience
- Relativity of time
- Non-verbal communication.

POSITIVE YOUTH DEVELOPMENT PROGRAMS

- Direct teaching and skill building,
- Cultivation of relationships that enable the expression of emotional, behavioural and social competence.
- The development of opportunities for young people to experience meaningful connections with others and their communities.

Many positive youth development programs are guided by the "six C's"	
1.Competence	- Positive view of one's actions in specific areas
2.Confidence	- Internal sense of positive self worth and self efficacy
3.Character	- Respect for societal and cultural norms, sense of morality, integrity
4.Connection	- Positive bonds with people and institutions, such as peers, family, community
5.Caring/ Compassion	- Sense of sympathy and empathy for others
6.Contribution	- Engaging in contributions to one's community

YOUTH SKILL BUILDING

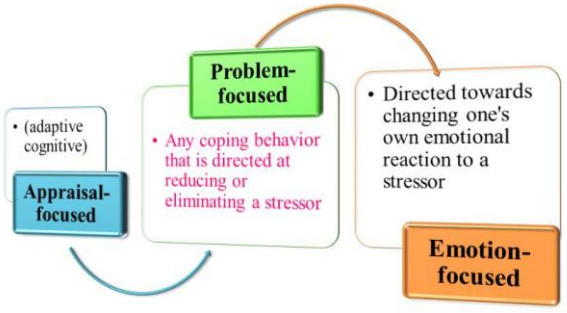
SELF ESTEEM ENHANCEMENT

People with high self-esteem have positive yet realistic views of themselves and their situations. They trust their own abilities, have a general sense of control in their lives, and believe that they will be able to meet most of their goals.

High self-esteem means accepting yourself for who you are, and not depending excessively on the approval of others in order to feel good about yourself. People with high self-esteem take reasonable risks and do not feel they have to conform to the expectations of others.

COPING SKILLS

Three broad types of coping strategies



1.APPRAISAL-FOCUSED

strategies occur when the person modifies the way they think, for example: employing denial, or distancing oneself from the problem. People may alter the way they think about a problem by altering their goals and values, such as by seeing the humor in a situation: "some have suggested that humor may play a greater role as a stress moderator among women than men"

2.PROBLEM-FOCUSED

strategies try to deal with the cause of their problem. They do this by finding out information on the problem and learning new skills to manage the problem. Problem-focused coping is aimed at changing or eliminating the source of the stress.

3.EMOTION-FOCUSED

strategies involve releasing pent-up emotions, distracting oneself, managing hostile feelings, meditating or using systematic relaxation procedures. Emotion-focused coping "is oriented toward managing the emotions that accompany the perception of stress

There are **six steps** to making an effective decision:

1. Create a constructive environment.
2. Generate good alternatives.
3. Explore these alternatives.
4. Choose the best alternative.
5. Check your decision.
6. Communicate your decision, and take action.

SELF AWARENESS

Self-awareness is the capacity for introspection and the ability to recognize oneself as an individual separate from the environment and other individuals.

INTERPERSONAL COMMUNICATION SKILLS

Interpersonal skills are the life skills that we use every day to communicate and interact with other people, both individually and in groups. People with strong interpersonal skills are usually more successful in both their professional and personal lives.

GOAL SETTING

Goal setting involves establishing specific, measurable, achievable, realistic and time-targeted goals

ASSERTIVENESS

- ❑ Standing for their own rights without violating others
- ❑ Communicating our values, ideas, beliefs, opinions, needs and wants freely.

CONFLICT RESOLUTION AND MEDITATION

STRESS MANAGEMENT

Its involve the use of coping strategies in response to stressful situation. Coping strategies are adoptive when they protect the individual from harm or strengthen the individual's ability to meet challenging situation

Relaxation

Music

Meditation

Pets

DEALING WITH LOSS

Express yourself. Talking is often a good way to soothe painful emotions. Talking to a friend, family member, health professional or counsellor can begin the healing process.

Allow yourself to feel sad. It's a healthy part of the grieving process. Crying enables your body to release tension.

EMOTIONAL REGULATION

It can also be defined as extrinsic and intrinsic processes responsible for monitoring, evaluating, and modifying emotional reactions

DISTRESS TOLERANCE

HELP SEEKING

REFUTING IRRATIONAL BELIEFS

- IDENTIFYING AND RESPONDING TO DISTRESSED PEERS
- EMPATHY
- MORAL DEVELOPMENT
- LEADERSHIP
- CITIZENSHIP SKILLS
- CULTURAL SENSITIVITY AND AWARENESS
- SOCIAL JUSTICE AND DIVERSITY

MENTAL HEALTH PROMOTION

These programs are designed to support the development of specific skills in youth while also strengthening the overall social environment of the school to increase opportunities for belonging, acceptance and support.

To learn important social, emotional and relational skills. Eight core skills that enable students to live healthy, productive and meaningful lives have been identified by the Collaborative to Advance Social and Emotional Learning (CASEL)

- Communicate effectively
- Ability to work cooperatively with others
- Emotional self control and self expression
- Empathy and perspective taking
- Optimism, humour and self awareness
- Ability to plan and set goals
- Solving problems and resolving conflicts thoughtfully and non-violently
- Bringing a reflective, learning-to-learn approach to all domains of life

SUICIDE AWARENESS

SUICIDAL THOUGHTS: WHAT TO DO

If you have thoughts of suicide, these options are available to you:

- Check yourself into the emergency room.
- Call your local crisis agency.
- Tell someone who can help you find help immediately.

- Stay away from things that might hurt you.
- Most people can be treated with a combination of antidepressant medication and psychotherapy.
- Encourage the person to talk about his/her feelings
- Stay calm and listen
- Take all threats seriously
- Be accepting, DO NOT judge or lecture

CONCLUSION

A number of youth suicide prevention efforts are dedicated to increasing recognition of youth at potential risk for self harm and suicide. Most of these efforts are educational in nature and they are aimed at increasing the awareness of warning signs and risk factors for suicide among those who live, work and play in close proximity to youth – often referred to as gatekeepers. The most common audiences for these educational and training efforts include youth/peers, parents, school staff, family physicians, emergency room staff and other community gatekeepers like youth workers, police, probation officers, recreation leaders and youth volunteers.