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"ESSENTIAL TITLE PAGE INFORMATION"

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1.INTRODUCTION:

The World Health Organization has defined "adolescents" as persons in the 10 to 19-year age group. Today India has a population of adolescents that is among the largest in the world. This is the generation which will shape India's future. Suicidal behaviour amongst adolescent students is a matter of great concern due to the tragic loss of prime years of life it entails. Suicide is the third leading cause of death among 15 to 25 years old age group. Suicide is one of the crudest expressions of social phenomenon and is the act of deliberately ending one's own life. Early identification and effective management of suicidal ideation and behaviour are paramount to saving lives. [1]

Psychiatric disorders are the strongest known risk factor of suicidal behaviour, and a previous suicide attempt is the best known predictor of subsequent suicide attempts and suicide. Hence, successful treatment of psychiatric disorders and successful health care interventions after attempted suicide may prevent future fatal and non-fatal suicidal behaviour.[2]

Suicide is a complex public health problem of global dimension. Suicidal behaviour (SB) shows marked differences between genders, age groups, geographic regions and socio- political realities, and variably associates with different risk factors, underscoring likely etiological heterogeneity. Although there is no effective algorithm to predict suicide in clinical practice, improved recognition and understanding of clinical, psychological, sociological, and biological factors may facilitate the detection of high-risk individuals and

assist in treatment selection. Psychotherapeutic, pharmacological, or neuromodulatory treatments of mental disorders can often prevent SB; additionally, regular follow-up of suicide attempters by mental health services is key to prevent future SB.[3]

Suicide takes a staggering toll on global public health, with almost one million people annually who die from suicide world-wide. The World Health Organization (WHO) has declared that reducing suicide-related mortality is a "global imperative," a welcome contrast to the traditional taboo that has surrounded suicidal behaviours (SBs). Cultural and moral beliefs about suicide, and unnecessarily pessimistic views about our current clinical capability to intervene and prevent suicide are barriers against patient self-disclosure and clinicians' routine inquiry about suicidal thoughts. Approximately 45% of individuals who die by suicide consult a primary care physician within one month of death, yet there is rarely documentation of physician inquiry or patient disclosure.[2]

According to a similar study conducted by the teaching faculty of Govt. College of Nursing, Eluru, West Godavari, Andhra Pradesh, findings of the study revealed that majority 199(79.6%) had inadequate knowledge, 49(19.6%) had moderate knowledge and 2(0.8%) had adequate knowledge with mean score value 5.0960.[4]

Previous surveys hardly show all the extent of the phenomenon, especially while talking about children and adolescents: a lack of data do not allow estimating a degree of spread,

intensity and dynamics of suicidality among young people. Furthermore, suicide is a culturally sensitive phenomenon that is why, in order to understand it, it is necessary to begin with attitudes. Some authors conceptualise suicide as a struggle among various conflicting attitudes towards life and death. As it is stated in the literature, permissive attitudes are mediating processes regarding suicide acts, therefore this issue is important in assessing risk for suicide.[3]

2. METHODOLOGY:

2.1 Study Design and Population

We conducted a non-experimental survey research study. We used demographic performa with a modified suicidal ideation questionnaire to collect the essential data from the mothers of adolescents to evaluate their awareness regarding suicidal behaviour among adolescents.

2.2 Inclusion and Exclusion Criteria:

Inclusion criteria: Mothers of adolescents who are willing to participate and available at the time of study.

Exclusion criteria: Mothers of adolescents who have previously attended awareness sessions regarding suicidal behaviour among adolescents and who arte able to comprehend the tool.

2.3 Sample, sampling and sample size

Study participants were primarily mothers of adolescents of selected wards at Angadipuram panchayat of sample size 100. Selection was carried out using convenience sampling technique.

2.4 Variables of the study

Research Variables: Suicidal Behaviour

Demographic variables: Age of the mother, Number of children, Number of children in the adolescent age group, Type of family, Religion, Education, Occupation of mother, Monthly family income, History of suicide in the family

2.5 Data collection procedure

Written permission was obtained from Angadipuram panchayat for conducting the research main study. A modified suicidal ideation questionnaire was used to assess the awareness of suicidal behaviour among mothers of adolescents. Data was collected by going from door to door and mothers who fulfils the criteria were collected as samples with sample size of 100.

The investigator provided the questionnaire to assess the awareness regarding suicidal behaviour among mothers. An information booklet regarding suicidal behaviour and itsidentification was provided.

2.6 Data processing and analysis

Semi structured interview was conducted in a face-to-face approach in Malayalam by the investigators.For the qualitative data, a framework approach to analysis was used. Both descriptive and inferential statistics were used for reaching the conclusion of the study.

2.7 Ethical Consideration and Informed consent

Ethical approval was obtained from Angadipuram panchayat for conducting the research study. Written consent was obtained from each mother after explaining about the study indetail.

1. RESULTS:

The findings of the study are presented in 3 sections

Section A: Distribution of demographic variables

Section B: Analysis of awareness regarding suicidal behaviour of adolescents amongmothers of adolescents

Section C: Association between the levels of awareness regarding suicidal behaviour with selected demographic variables

Discussion

The analysis of demographic variables shows that 7% samples belongs to age 30-34 years, 29% in the age of 35-39years, 47% in the age of 40-44 and 17% in 45-50 years. Regarding the distribution of mothers based on number of children 12% have one child, 60% have two children, 26% have three children, and remaining 2% have more than three children.

Regarding the number of children in adolescent age group 66% have one child in adolescent age group, 32% have two adolescent children and 2% have three adolescent children. Regarding the type of family 57% belongs to nuclear family and 43 % belongs to joint family. Regarding the religion status 40% are Hindus, 38% are Muslims and 22% are Christians. Regarding the educational status of mother 50% have primary education, 35% have secondary education, 13% are graduates and remaining 2% are post graduate. Regarding the occupation of mother 57% are home makers, 20% are self-employed, 21% are private employee and 2% are government employee. Regarding the monthly income 44% have monthly income of below 10000, 45% have 10000 -20000 and 11% have a monthly income of 21000 -30000. Regarding the residing area 90% reside in urban area, 10 % reside in rural area. Regarding the history of suicide in family 79% of them responded as not having a history of suicide in family and 21% responded as having a history of suicide in family.

The present study was supported to assess the awareness regarding suicidal behaviour of adolescents among

mothers of selected wards at Angadipuram panchayat, with a view to develop an information booklet. The sample was selected by convenient sampling technique. Data was collected from 100 mothers of adolescents in the age group of 12-19 years. The demographic variable such as age, number of children, number of children in adolescent age, type of family, religion, education, occupation, monthly family income and history of suicide in family.