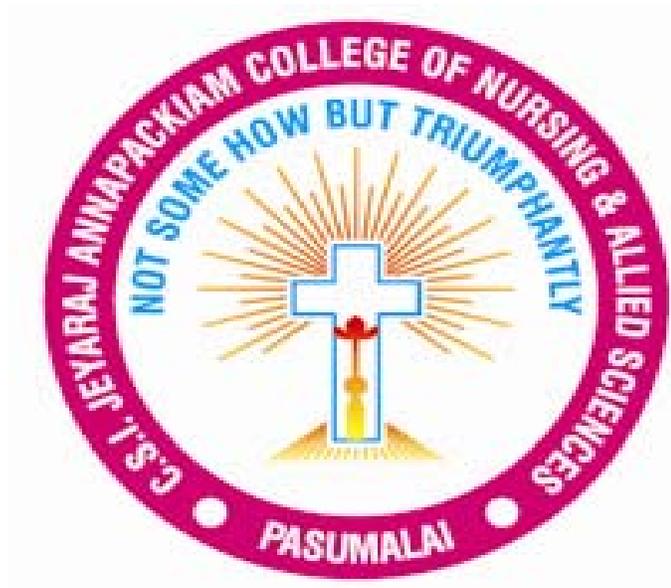


**A QUASI EXPERIMENTAL STUDY TO EVALUATE THE EFFECTIVENESS OF
PLANNED TEACHING PROGRAM REGARDING SELECTED CHILDHOOD
MENTAL DISORDER ON KNOWLEDGE AND ATTITUDE AMONG PRIMARY
SCHOOL TEACHERS AT SELECTED INSTITUTIONS IN MADURAI.**



**A DISSERTATION SUBMITTED TO
THE TAMILNADU DR. M.G.R.MEDICAL UNIVERSITY, CHENNAI,
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF
MASTER OF SCIENCE IN NURSING**

APRIL - 2012

CERTIFICATE

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under the Tamilnadu Dr. M.G.R.Medical University, Chennai.

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College seal

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EXAMINERS:

1. _____

2. _____

Prof. Dr. (Mrs). C. JOTHI SOPHIA M. Sc (N), RN.RM, Ph.D.,

Principal

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I WILL MAKE YOU AS MY SIGNET RING - Hag 2:23

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CHAPTER - I

INTRODUCTION

“You must always be puzzled by mental illness. The thing I would dread, if I became mentally ill, would be your adopting sense attitude; that you could take it for granted that I was deluded”

-Ludwig Wittgenstein

Although it is sometimes assumed that childhood are times of carefree bliss, as many as 20% of children and adolescents have one more diagnosable mental disorder. Most of these disorders may be viewed as exaggerations of normal behaviors and emotions

Children have some type of serious mental illness, one that significantly interferes with daily life. The term "mental illness" is not entirely accurate, since there are many "physical" factors including heredity and brain chemistry that might be involved in the development of a mental disorder. As such, many mental disorders can be effectively treated with medication, psychotherapy or a combination of both.

Like adults, children and adolescents vary in temperament. Some are shy and reticent; others are socially exuberant. Some are methodical and cautious; others are impulsive and careless. Whether a child is behaving like a typical child or has a disorder is determined by the presence of impairment and the degree of distress related to the symptoms.

There is much overlap between the symptoms of many disorders and the challenging behaviors and emotions of normal children. Thus, many strategies useful for managing behavioral problems in children can also be used in children who have mental disorder

Furthermore, appropriate management of childhood behavioral problems may prevent temperamentally vulnerable children from developing a full-blown disorder

The most common mental disorders of childhood and adolescence fall into three broad categories:

Anxiety disorders

Mood disorders

Disruptive behavioral disorders

However, most cases are not severe and can be competently managed by an appropriately trained primary care practitioner and severe cases are best managed in consultation with a child and adolescent psychiatrist.

Rates of mental health problems among children increase as they reach adolescence. Disorders affect 10.2% of boys aged 5-10, rising to 12.7% of boys aged 11-15, and 5.8% of girls, rising to 9.64% of girls aged 11-15, Mental Disorder more common in boys, National Statistics online, 2004.

The most frequently identified mental health problems were somatic complaints 7%, delinquent 7%, attention problems 6% and aggression behavior 5% (Sawyer et al. 2000)

In 2004-2005, 7% of children aged less than 15 years were reported to have some form of mental or behavioral problem as a long-term health condition, with rates

rising from very low levels among children aged less than five years to 10% of children aged 10-14 years

Attention Deficit Hyperactivity disorder is a condition that becomes apparent in some children in the preschool and early school years. It is hard for these children to control their behavior and or pay attention. It is estimated that between three and five percent of children have ADHD, or approximately 2 million children in the United States. This means that in a classroom of 25 to 30 children, it is likely that at least one will have ADHD (Source: NIMH, www.nimh.nih.gov, Feb 11, 2009)

Conduct disorder, also known as disruptive behavior disorder, is a disorder that involves chronic behavior problems during childhood and adolescence including stealing, fighting, or bullying others. Conduct disorder affects 1 to 4 % of 9-17 year olds, depending on exactly how the disorder is defined, and seems to be more common in boys than in girls. (Source: SAMHSA, www.mentalhealth.samhsa.gov, March 18 2009)

Depression is a treatable illness, major depression is more than a sad mood, and Depression affects a young person's ability to think, feel and behave in a normal manner. Major Depression can lead to school failure, alcohol and drug use, and even suicide. At any point in time, 1 in every 10 children and adolescents are affected by serious emotional disturbances. (Source: SAMHSA, www.mentalhealth.samhsa.gov, March 18 2009)

SIGNIFICANCE AND NEED FOR THE STUDY

Prevalence of mental disorder among children has been reported to be 14-20% in various studies. According to world health report 2000, 20% of children and adolescents suffer from a disabling mental illness worldwide

In recent years, there have been several population studies giving fairly reasonable estimates on the prevalence of childhood mental disorders in low and middle income countries because these countries have much larger proportion of child population

Reported rates are 17.6% in 1-15 yrs old in Ethiopia; 15% among 5-10 yrs olds of Bangladesh; 12.7% in 7-14 yrs old urban Brazilian school sample and 7% in 7-14 yrs rural Brazilian school.

Studies from India have revealed the prevalence rates to be 12.5% in 0-16 yrs from Bangalore; 9.3% in 8-12 yrs old in Kerala and 6.3% in 4-11 yrs old school children in Chandigarh.

Overall rates in India and other middle and low income countries range between 6%-15% which are on the lower side as compared to reported rates from certain western countries such as Canada 18.1%, Germany 20.7%, Switzerland 22.5%, and USA 21%. It is also known that many more children have problems that can be considered “sub threshold” since these may not meet the diagnostic criteria.

Occasional studies available looked at incidence of single, specific disorder such as depression, OCD, anxiety, etc. Incidence of major depressive disorder and dysthymia was reported as 3.3% and 3.4% respectively in a study from the US

One year incidence of OCD was 0.7% and sub clinical OCD was 8.4%, One year incidence of phobic disorder was 0.4%, whereas sub syndrome and sub threshold phobia was 8% and 16.9% respectively.

Although incidence studies are more difficult, more expensive, less feasible and more time consuming, but these are more valuable as these provide the possibility of studying the risk factors and understanding the context of development of disorders; and knowledge of early manifestations of illness, indicating intervention opportunities for primary prevention.

STATEMENT OF THE PROBLEM

A quasi experimental study to evaluate the effectiveness of planned teaching program regarding selected childhood mental disorders on knowledge and attitude among primary school teachers at selected institutions in Madurai.

OBJECTIVES

1. To assess the pre-test level of knowledge and attitude regarding childhood mental disorders among primary school teachers.
2. To assess the post-test level of knowledge and attitude regarding childhood mental disorders among primary school teachers.
3. To assess the difference of pre-test, post-test level of knowledge and attitude.
4. To identify the relationship on post-test level of knowledge with attitude.
5. To associate post-test level of knowledge and attitude with selected demographic variables (Age, experience, marital status, disorder in family, place of residence).

HYPOTHESIS

H₁: There will be a significant difference in pre-test and post-test level of knowledge score regarding childhood mental disorders.

H₂: There will be a significant difference in pre-test and post-test level of attitude score regarding childhood mental disorders.

H₃: There will be a significant relationship between post-test level of knowledge and attitude regarding childhood mental disorders.

H₄: There will be a significant association between the post-test knowledge score with selected demographic variables.

H₅: There will be a significant association between the post-test attitude score with selected demographic variables.

OPERATIONAL DEFINITION

KNOWLEDGE

In this study, it refers to the understanding of childhood mental disorders assessed by a structured questionnaire on childhood mental disorder among primary school teachers.

ATTITUDE

In this study it refers to way of thinking beliefs and feelings regarding childhood mental disorders as measured by three point Likert scale.

PLANNED TEACHING PROGRAM

In this study, it refers to the systematically developed instruction and teaching aid designed to provide information about the childhood mental disorders.

SCHOOL TEACHERS

In this study, it refers to teachers working in primary schools with D.Ed who has minimum of two years of teaching experience and teaches students from 1st –5th standard.

EFFECTIVENESS

In this study, it refers to the output of planned teaching program in terms of improvement in the level of knowledge and attitude among the primary school teachers as measured by a questionnaire and three point Likert scale.

CHILDHOOD MENTAL DISORDER

In this study, it refers to Children, has got good physical health, altering normal school and is classified with disorders which affect the behavior, emotions, moods, thoughts, including the entire family.

ASSUMPTIONS

1. Primary school teachers will have inadequate knowledge regarding childhood mental disorders.
2. Planned teaching program will improve the level of knowledge and promote a better attitude on childhood mental disorders among primary school teachers.

3. Improvement of knowledge and attitude on childhood disorder and by linking with their profession will help in early identification of children affected with mental disorders.

LIMITATION

This study is limited to primary school teachers with minimum of two years of experience.

PROJECTED OUTCOME

The study finding will help to improve the level of knowledge and to change the attitude of primary school teachers regarding the childhood mental disorder, by understanding their professional role relating to early identification of the children who shows sign and symptoms of mental disorder.

CHAPTER II

REVIEW OF LITERATURE

Review of literature is an essential step in development of a research project. It involves the systematic identification, location, scrutiny and summary of written materials that contain information on a research problem. The investigator reviewed the related literature to broaden the understanding and gain insight into the selected problem under the study.

A good research does not exist in the vacuum. The research findings should be an extension of previous knowledge and theory as well as a guide for future research activity. A thorough study of literature provides a foundation to base new knowledge. A review of literature provides the concept to continue or return for the contemplated research, an understanding of the status of research in the problem area and clues the research approach, method, instrumentation, and analysis.

This chapter consists of,

1. Literature review related to childhood mental disorder
2. Literature review related to teaching program among school teachers

LITERATURE RELATED TO CHILDHOOD MENTAL DISORDER

Bhatia V, et.al, (2010) conducted study on psychiatric morbidity among children in Chandigarh. This community based study by house to house visit after selecting a sample by stratified random technique from the 47 sectors in urban areas and 27 villages in Chandigarh. A total of 250 households in urban and 50 households in rural areas were covered which consisted of 362 children (313 urban and 49 rural) who were enrolled and psychiatric morbidity was assessed by using R

Kellner & B F Shaffield (1979) scale. They found prevalence of high morbidity related to psychiatric symptoms among children in Chandigarh, India highlights the significance and need to develop comprehensive mental health care program for Children.

Edwardraj.s, et.al (2010) conducted study on perceptions about intellectual disability in Vellore, South India. Eight focus groups were conducted in three settings and included the mothers of children and adolescents with intellectual disability (four groups, n = 29), community health workers (two groups, n = 17) and schoolteachers (two groups, n = 16). Our results suggest that cultural and religious beliefs perpetuated negative attitudes towards disability. Public awareness, education and community-level interventions for reducing the misconceptions and stigma related to intellectual disability are needed in addition to culturally sensitive treatment methods to improve the attitude towards and management of intellectual disability.

Manjula M, et.al, (2009) conducted a study adopted a two-group comparison with pre- and post assessments design to examine the efficacy of cognitive behavioral therapy in the treatment of panic disorder at Department of Mental Health and Social Psychology, National Institute of Mental Health and Neurosciences, Bangalore. The sample consisted of 30 patients sequentially allotted to the CBI (n = 15) and behavioral intervention (BI, n = 15) groups. Assessment was done using a semi structured interview schedule, panic disorder severity scale, Agoraphobic cognitions questionnaire, Behavioral avoidance checklist, and Panic appraisal inventory. The CBI group was provided with comprehensive cognitive behavior therapy and the BI group with psycho-education and applied relaxation. CBI was found to be superior to BI in the reduction of panic symptoms, behavioral avoidance, safety behaviors, and

cognitions. A large percentage of the CBI group patients met the criteria for clinically significant change with a large magnitude of change.

Gupta R, et.al, (2009) conducted study on development of attentional processes in Attention Deficit hyperactive disorder (ADHD) and normal children at Centre of Behavioral and Cognitive Sciences, University of Allahabad, India. They examined the development of attentional processes in children with ADHD and normal children Two hundred forty children (120 in each group) in the age range of 6-9 years participated in the study. Four tasks: Stop-Signal, attentional disengagement, attention network, and choice delay task were administered. Stop signal reaction time, switch costs, conflict effect, and percentage choice of short delay reward was higher in ADHD group compared to normal group. Together these results indicated that the deficits in control processes accumulate with age in ADHD children Present study favors the conceptual view of ADHD as a stable deficit in cognitive control functions, which are implicated in the pathology of ADHD. These results have theoretical implication for the theories of executive control and ADHD.

Malhotra S, et.al (2009) of Postgraduate Institute of Medical Education and Research, Chandigarh conducted study on Incidence of childhood psychiatric disorders in India A representative sample of school children was assessed through a two stage evaluation process involving teacher's rating (N=963) and parent rating (N=873). Children who scored below the cut-off for psychiatric disorder (N=727) on both the screening instruments were re-contacted six years later. 186 children and their families were personally available for reevaluation. All the children and their parents were re-assessed on Parent Interview Schedule; Strengths and Difficulties Questionnaire: and detailed clinical assessment by a psychiatrist. Psychiatric diagnosis was made as per ICD 10 criteria. Data on children who were found to have

psychiatric disorder were compared with those who did not have psychiatric disorders. 20 children out of 186 followed up had psychiatric disorder giving the annual incidence rate of 18 per 1000 per year. Children who had disorder at follow-up did not differ from those who did not on age, gender and psychological (temperament, parental handling, life stress and IQ) parameters at baseline.

Suvarna BS, et.al (2009) from Melaka Manipal Medical College, India conducted study on Prevalence of attention deficit disorder among preschool age children in preschool age children in kindergartens of south west, Mumbai. One thousand two hundred fifty (599 males and 651 females) children aged between 4-6 years, were selected from 40 kindergartens in 6 localities in south west Mumbai. One hundred fifty two (12.2%) children were diagnosed to have ADHD. This study recommends the need for diagnosis and treatment of ADHD in preschool age children.

Khanna S, et.al,(2007) Department of Psychiatry, National Institute of Mental Health and Neurosciences, Bangalore Conducted study on Childhood obsessive-compulsive disorder. The obsessions and compulsions noted in 16 cases of obsessive-compulsive disorder in children were compared to the phenomenology seen in 398 cases during a decade. Fewer obsessions, more compulsions, more frequent washing and repeating compulsions characterized the childhood group

Das PP, et.al, (2007) from Department of Psychiatry, Postgraduate Institute of Medical Education & Research, Chandigarh conducted study on Understanding childhood depression Major depressive disorder in children is a severe and a chronically disabling disorder. This population appears to be a special group in terms of consequences of poor psychosocial and academic outcome and increased risk of substance abuse, and suicide. Studies have revealed several major findings in genetic,

familial, psychological, and biological aspects of such depression, some of which have explored into the issue of its relationship with adult depression. Considerable advances have been made now in the area of childhood depression providing a better understanding of its nature.

Kalra V, et.al, (2005) Department of Pediatrics, All India Institute of Medical Sciences, New Delhi conducted study to establish the diagnosis of autism amongst children with derangements of language, communication and behavior; ascertain and treat the co-morbidities; identify underlying cause and create a sensitivity and awareness among various health care professionals. Behavioral modification by early intervention and stimulation improved the core symptoms of autism. Important co-morbidities included mental retardation (95%), hyperactivity (53%) and seizures (10%) cases. Control of co-morbidities in these children facilitated child's periodic assessment and implementation of intervention program. In the registry initiated 62 patients were enrolled at AIIMS and 6 were identified from other hospitals.

Rahi M, et.al,(2005) of Maulana Azad Medical College, New Delhi conducted study to find out the magnitude of probable psychopathology in children and study association of psychopathology with demographic, developmental and social factors. Childhood Psychopathology Measurement Schedule (CPMS) was used to measure the magnitude of probable psychopathology in 620 children from an urban slum of Miraj (Maharashtra). A second schedule recorded demographic, developmental and social factors. The study indicates CPMS score > 10 was observed in 102 children (16.5%). It was significantly higher in children aged 7-10 years, in males, belonging to lower socioeconomic status, large families, being first born, having low birth weight (LBW); body mass index (BMI) less than 18.5. Low maternal

education and alcohol abuse in father also had significant association with CPMS score > 10. Findings suggest a need to educate the community about psychological implications of LBW, large family size and overcrowding in children. Improving maternal education and controlling alcoholism could help in reducing childhood psychopathology.

Sharma RK, et.al, (2004) A cross sectional experimental study on childhood anxiety disorders conducted in the psycho-physiology lab of a tertiary care multi-specialty teaching hospital. Assessments were carried out using a semi structured interview, STAIC (State and Trait Anxiety Inventory for Children); CDRS (Childhood Depression Rating Scales); SCARED (Self-Report for Childhood Anxiety-Related Disorders). Autonomic reactivity was tested using the standard Battery of tests. There were differences between 34 children and adolescents (age range, 8-14 years) with a diagnosis of childhood anxiety disorder and a control group of 30 age-and sex-matched subjects from a nearby school in autonomic activity and reactivity between individuals with anxiety disorder and non-anxious control subjects. Findings are suggestive of autonomic rigidity or diminished physiologic flexibility in children with anxiety disorder.

Mathur GP, et.al, (1995) of B.R.D. Medical College, Gorakhpur conducted study to evaluate the role of Anganwadi Workers (AWW) for detection and prevention of disability in children below 6 years of age. Trained AWWs identified disabilities and instituted preventive measures like immunization and supplementary nutrition. Repeat survey after 6 month of follow-up. Amongst the 1545 children, AWW identified disability in 126 subjects which were verified in 118 cases by pediatricians. The disability rate was 7638 per 100,000 populations. Visual, mental, orthopedic, speech and hearing disabilities rates were 4790, 2654, 583, 518 and 453

per 100,000 population, respectively. In the repeat survey, 35 of the 74 children with visual disability (mostly xerophthalmia), 4 of the 9 with orthopedic disability and 3 of the 7 with hearing disability could be managed satisfactorily. They found AWW can help in early detection and appropriate management of incipient and preventable childhood disabilities.

LITERATURE RELATED TO TEACHING PROGRAM ON CHILDHOOD MENTAL DISORDER AMONG SCHOOL TEACHERS

Lian WB, et.al (2011) of Children's Hospital, Singapore. Conducted study in Demands for diagnostic and intervention services in childhood developmental and behavioral disorders (CDABD) have increased in Singapore. With earlier enrolment of some 50 000 children in pre-schools, early childhood educators must be well-versed in normal development (ND) and CDABD, to help detect children with potential difficulties and refer for early diagnosis and intervention. Knowledge, attitudes and practices in ND and CDABD were evaluated among 503 pre-school teachers, most aged 30-44 years. With a median pre-school experience of 6.0 (0.1, 40) years, most had received formal training in early childhood but not special-needs (SN) education. The study reveals pass rate in knowledge ($\geq 50\%$ total-score) was achieved in 56%, with the overall median total-score of 50 (0, 87) %. In specific blocks on ND, autistic spectrum disorder and attention deficit/hyperactive disorder, pass-rate was achieved in 66%, 68% and 32%, with median block-scores of 56 (0, 100)%, 50 (0, 100)%, 40 (0, 100)% respectively. This study demonstrated educational deficits in CDABD among our pre-school teachers. Yet, most care and want to improve their skills to aid integration and improve SN education, calling for more training and resource support. Necessary changes in policy and resource allocation should occur to allow better-integrated adults of tomorrow.

Russell-Mayhew S, et.al, (2007) of University of Calgary, Canada conducted study to examine the effectiveness of a wellness-based prevention program on elementary and junior high students' body image, personal attitudes, and eating behaviors. Group differences in measures of student attitudes and eating behaviors are examined to determine the effect of targeting different participant combinations (students, parents, and teachers) in 10 groups. For elementary schools, student participants consisted of control (no intervention) (n = 36), student only (n = 81), student/parent (n = 124), student/parent/teacher (n = 103), and parent/teacher (n = 149). For junior high schools, student participants consisted of control (n = 143), student only (n=215), student/parent (n=65), student/parent/teacher (n = 14), and parent/teacher (n = 177). Overall, complete data was available for 1,095 students, 114 parents and 92 teachers. This study indicates that self-concept and eating attitudes and behaviors were positively affected by participation in the program, may be more effective in changing attitudes and behaviors when teachers and parents are involved.

Probst P, et.al, (2007) University of Hamburg, conducted study on a teacher training program for Autism Spectrum Disorders (ASD), based on "structured teaching" (Mesibov et al., The TEACCH approach to autism spectrum disorders, 2006) was developed and evaluated within a Pre-Post design. In total, 10 teachers working with 10 students with ASD (mean age 10.0 years) in special education classrooms in Germany were involved in the training, The Pre-Post outcomes measured by teacher questionnaires indicated significant improvement on the Classroom Child Behavioral Symptom Scale as well as on the corresponding Classroom Teachers' Stress Reaction Scale. In addition, teachers implemented two structured teaching methods on average in their classrooms. These findings provide

some first evidence for the clinical and social validity of the training program examined.

Rodrigo MD, et.al, (2001) Department of Psychiatry, Kelaniya, in SriLanka conducted study to assess the knowledge and attitudes towards attention deficit hyperactivity disorder (ADHD) among primary school teachers in the Gampaha District. Descriptive cross sectional study was conducted in randomly selected schools of Gampaha district using a stratified sampling method. The knowledge and attitudes on ADHD were assessed by a self-administered questionnaire distributed among all the consenting primary school teachers in the selected schools. The study reveals total of 202 completed questionnaires of 210 distributed were returned. The majority showed good understanding about ill effects of ADHD, teachers' role in management and counterproductive effects of punishment. Three-fourths had a positive attitude towards behavioral therapy. However, only a minority had adequate knowledge about the presentation of ADHD and its treatment with medication. More than 80% of teachers believed that the parents were to be blamed for the child's ADHD. The majority of participating teachers also believed that behavioral disturbances caused by ADHD children were deliberate and malicious. Teachers who had training in child psychology recorded a significantly higher knowledge and had a more favorable attitude.

CONCEPTUAL FRAMEWORK

Stufflebeam's CIPP model for evaluation serves as a comprehensive framework for guiding evaluations of programmes, projects, personnel, evaluation systems etc. It is decision-oriented in order to provide knowledge and a value base for making or defending decisions. This poster is designed to provide information on the development, usefulness, and application of the CIPP; so that it may help readers better understand the model. Additionally, further reading pertaining to the development of the model, as well as its application in various case studies, is provided in the reference section.

The model was proposed by Dan Stufflebeam's when he was at Ohio State University. The main components of CIPP are,

- **C** - Context or things in the environment
- **I** - Input or resources consumed
- **P** - Process, the flow of activities and the decisions made (same as formative evaluation)
- **P** - Product, the output (same as summative evaluation)

CONTEXT

The first component of a system is things in the environment. For the system to work well in the environment should contribute to achieve the purpose of the system. It refers to demographic variables of primary school teachers (Age, Sex, Experience, Marital status, Prior information, Disorder in family, Place of residence) and pre test Structured questionnaire to assess the level of knowledge and attitude about childhood mental disorders among primary school teachers.

INPUT

It is the process that allows the context to be change, so that is useful to the system, the plan needed to accomplish the desire task. The task is the Development of structured teaching program on childhood mental disorders through the use of teaching aids like charts, and slides.

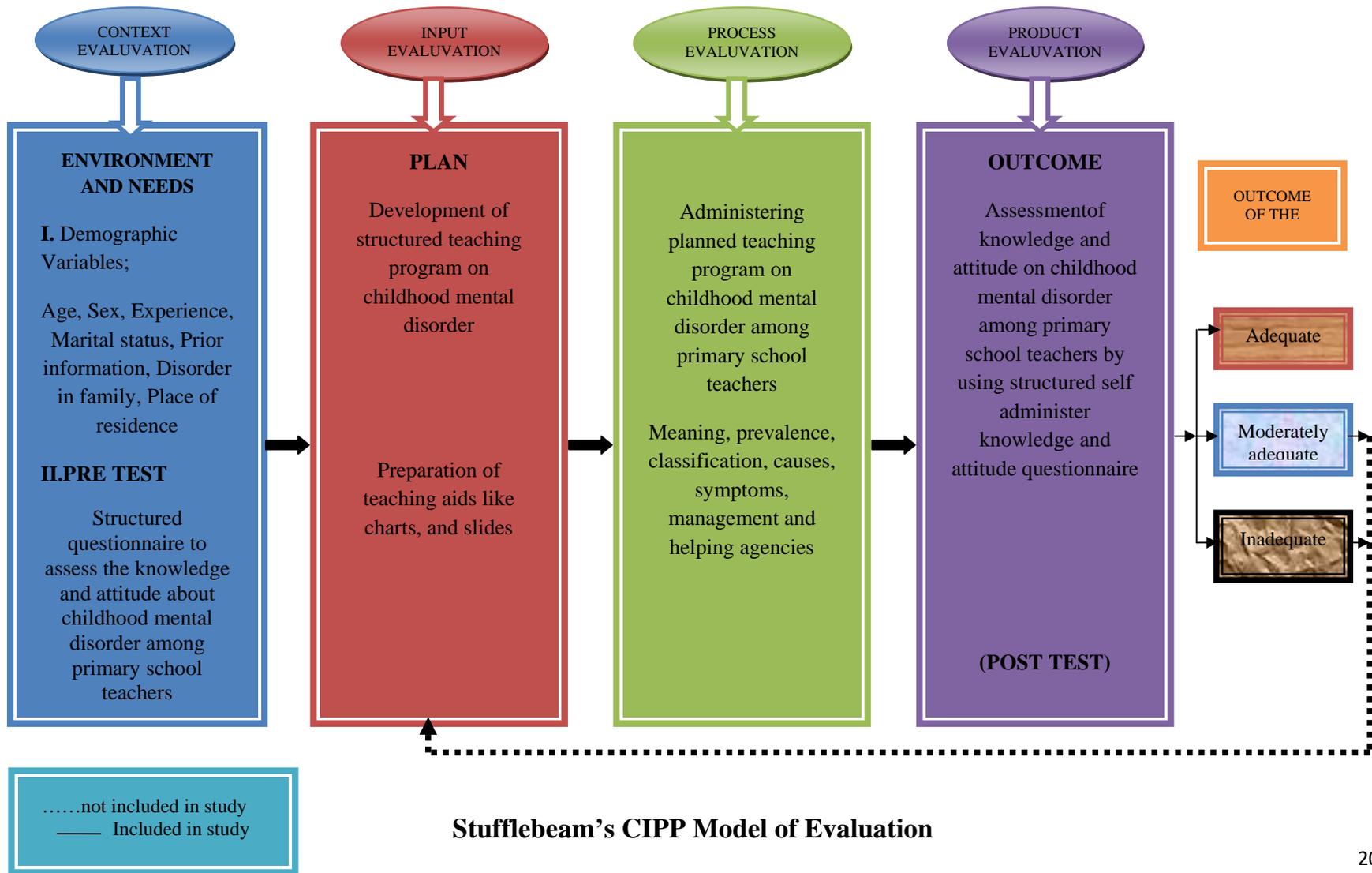
PROCESS

Based on the context and input, the system returns to process and the process was evaluated by administering planned teaching program on childhood mental disorders among primary school teachers and assessed the process on the following areas of knowledge, meaning, prevalence, classification, causes, symptoms, management and helping agencies.

PRODUCT / OUTPUT

The output was identified by the assessment of level of knowledge and attitude on childhood mental disorder among primary school teachers by using structured self administer questionnaire on knowledge and attitude. After the post-test assessment, post evaluation is done to find out the outcome of the study.

FIGURE 1 CONCEPTUAL FRAMEWORK



CHAPTER III

METHODOLOGY

Methodology is a significant part of the study which enables the researcher to project the research undertaken. This chapter includes research approach, research design, variables, settings, population, sample and sample size, sampling technique, development and description of the instrument, content validity of the tool, pilot study, data collection procedure, plan for data analysis and protection of human rights.

RESEARCH APPROACH

The research approach used for this study is experimental approach.

RESEARCH DESIGN

A Quasi experimental design was adopted with one group pre-test, post-test design.

SETTING OF THE STUDY

The study was conducted at primary schools in Madurai such as OCPM primary school situated 8 Km away and Government primary school in Thiruparankundram situated 5 Km away from C S I Jeyaraj Annapackiam college of nursing, Madurai. The investigator met the primary school teachers and conducted the study with the help of principal of the concerned institution.

POPULATION

Target

The target population was all primary school teachers in Madurai.

Accessible

The accessible population was primary school teachers who are with the qualification of secondary grade education working at OCPM Primary school and government primary school, Madurai.

SAMPLING TECHNIQUE

In this study, purposive sampling method was used to select the samples.

SAMPLE

Secondary grade teachers in primary schools at OCPM Primary school and government primary school, Madurai as samples in this study.

SAMPLE SIZE

The sample includes 60 secondary grade teachers in primary schools at OCPM Primary school and government primary school, Madurai.

CRITERIA FOR SAMPLE SELECTION

The samples were selected based on the following inclusion and exclusion criteria.

Inclusion criteria

- Teachers with secondary grade qualification working in primary schools.

- Teachers who were present on the time of pre-test of this study.

Exclusion criteria

- Teachers with other than secondary grade qualification working in primary schools.
- Teachers who were not present on the time of pre-test of this study.

DESCRIPTION OF THE INSTRUMENT

In this study, data collection was done by using structured interview questionnaire. This instrument was developed by the investigator with the help of various resources and review of literature. The questionnaire was prepared to assess the level of knowledge and attitude of primary school teachers on selected childhood mental disorder. The tool consists of three parts.

Part – A

Questionnaire prepared by the investigator to collect the demographic data of the primary school teachers. The demographic variables such as age, sex, years of experience, marital status, prior information, disorders in family and place of residence.

Part – B

It consists of knowledge based structured questionnaire regarding childhood mental disorder, with 30 questions in the following conditions like, Anxiety disorder, Mental retardation, Dyslexia, Attention deficit hyperactivity disorder, Autism, Separation anxiety disorder, Childhood depression disorder, Obsessive-compulsive disorder.

Part – C

Three point Likert scale was used to assess the level of attitude among primary school teachers on childhood mental disorder. This instrument consists of 20 questions among which 10 questions were positively scored and 10 questions are negatively scored, higher the score higher the attitude.

SCORING PROCEDURE

Part – A

Questionnaire prepared by the investigator to collect the demographic data of the primary school teachers, such as age, sex, years of experience, marital status, prior information, disorders in family and place of residence.

Part - B

The questions were of multiple choice formats. Each questions had four responses, with one correct response. A score of 1 was given for the correct answer and score of zero for the wrong and incomplete responses, thus maximum knowledge score was 30. All the questions had one correct response. For the purpose of the study, the knowledge score was classified as follows

0 – 50% - Inadequate knowledge

51 – 75% - Moderate adequate knowledge

76 – 100% - Adequate knowledge

Part – C

The items are measured on a three point scale. It includes statements on attitude among primary school teachers regarding childhood mental disorders. There are totally 20 statements. A score of 2 was given for agree, score of 1 was given for disagree and score of 0 was given for uncertain. The maximum score of measuring attitude of primary school teachers was 40.

ATTITUDE	AGREE	DISAGREE	UNCERTAIN
Positive Statement	2	1	0
Negative Statement	1	2	0

Attitude score was interpreted as follows,

81 - 100% - Positive attitude

61 – 80% - Neutral attitude

0 – 60 % - Negative attitude

VALIDITY AND RELIABILITY OF TOOL

The questionnaire was developed by the investigator with help of extensive literature review and expert opinion. Expert opinion was obtained to confirm the content validity of the tool was obtained from 8 experts including 4 nursing experts, 1 clinical psychologist, 1 sociologist and 2 medical officers. The experts were requested to check the relevance, sequence and adequacy of the items in the interview schedule. Based on their valid suggestion a few items were modified and final tool was prepared

as per the suggestion given by the experts. The Tamil translation for tool was validated by Tamil experts.

Reliability of the tool was established through test-retest method. After administration tool among 6 primary school teachers (10% of the sample population), after a gap of a week, the retest was given. The Karl parson's coefficient of correlation was computed and reliability for knowledge was found to be 0.99% and the reliability for attitude was found to be 0.99%. The tool was found to be reliable.

PLANNED TEACHING PROGRAM

The investigator made the planned teaching program with review of literature and with the expert's opinion. The content of the teaching program includes definition, types, causes, signs and symptoms and management available for the childhood mental disorders. The average time taken for the teaching program was around one hour.

DATA COLLECTION PROCEDURE

Data was collected among primary school teachers for a period of six weeks. Purpose of the study was explained to the headmistresses of both schools. The teachers of the respective school were approached by the investigator. An initial rapport was established with the teachers. Details of the study are explained to them. A convenient time and date was fixed for data collection and planned teaching program. Purposive sampling technique was used for collecting samples. The sample size includes 60 primary school teachers. The teachers were gathered in one classroom and the teaching program was administered after the needed explanation. The time limit was one hour. The post-test was administered to the same group with

same structured questionnaire with a gap of one week. All the teachers were very cooperative. The investigator expressed her gratitude to the school headmistress and the teachers for their cooperation during the entire study.

PLAN FOR DATA ANALYSIS

The data was analyzed in terms of the objectives of the study using descriptive and inferential statistics. The plan of data analysis were follows

1. Organize the data in a master data sheet.
2. Frequency and percentage distribution were used to analyze the demographic data for primary school teachers.
3. Frequency and percentage distribution were used to assess the level of knowledge and attitude of childhood mental disorders among primary school teachers.
4. Mean, mean percentage, standard deviation and inferential measures 'z' were used to assess and compare the pre-test and post-test knowledge and attitude.

PILOT STUDY

The pilot study was conducted during the month of July 2011 at Harvipatti in Madurai town among 6 primary school teacher to evaluate the effectiveness of planned teaching program and to find out the feasibility of conducting the main study. The structured questionnaire was used for data collection. The time taken to complete tool was found to be satisfactory in terms of simplicity and clarity. The administration of the tool and intervention through planned teaching program were implemented. The feasibility with regards to the availability of the sample and cooperation of

respondents, accessibility of setting and financial requirement was established. Pilot study helped the investigator to confirm the feasibility of carrying out the main study.

PROTECTION OF HUMAN RIGHTS

Research proposal was approved by the dissertation committee prior to the pilot and the main study Permission was sought from The Principal and Head of the Mental Health Nursing department of C.S.I Jeyaraj Annapackiam College of Nursing, Madurai. A formal consent was obtained from the respondents of the study (primary school teachers) before administering the questionnaire.

CHAPTER IV

DATA ANALYSIS AND INTERPRETATION

This chapter deals with the analysis and interpretation of the data. The data were collected through structured interview questionnaire among 60 primary school teachers regarding childhood mental disorder. This result was computed using descriptive and inferential statistics based on the objectives of the study. The findings of the study were presented in this chapter under the following headings.

1. Distribution of primary school teachers based on the demographic variables.
2. Distribution of pre-test and post-test knowledge of childhood mental disorders among primary school teachers.
3. Distribution of pre-test and post-test attitude of childhood mental disorders among primary school teachers.
4. Difference between pre and post-test level of knowledge among primary school teachers.
5. Difference between pre and post-test level of attitude among primary school teachers.
6. Difference of pre-test, post-test level of knowledge and attitude
7. Relationship between post-test level of knowledge and level of attitude of childhood mental disorders among primary school teachers.
8. Association of knowledge with the selected demographic variables on childhood mental disorders among primary school teachers.
9. Association of attitude with the selected demographic variables on childhood mental disorders among primary school teachers.

Table 1.a**DISTRIBUTION OF PRIMARY SCHOOL TEACHERS BASED ON THEIR
DEMOGRAPHIC VARIABLES****(N = 60)**

Sl. No	Demographic variables	Number	Percentage
1	Age		
	1) Below 30 years	15	25
	2) 31-35 years	18	30
	3) 36-40 years	6	10
	4) 41-45 years	13	21.7
	5) >45 years	8	13.3
2	Sex		
	1) Male	12	20
	2) Female	48	80
3	Experience		
	1) 2- 5 years	29	48.3
	2) 6-10 years	16	26.7
	3) 11-15 years	4	6.7
	4) >15 years	11	18.3

Table 1.a shows that among the primary school teachers, majority 18 (30%) of the teachers belonged to the age group of 31-35 years, 48(80%) of the teachers are female and 29(48.3%) of the teachers are with the experience of 2-5 years.

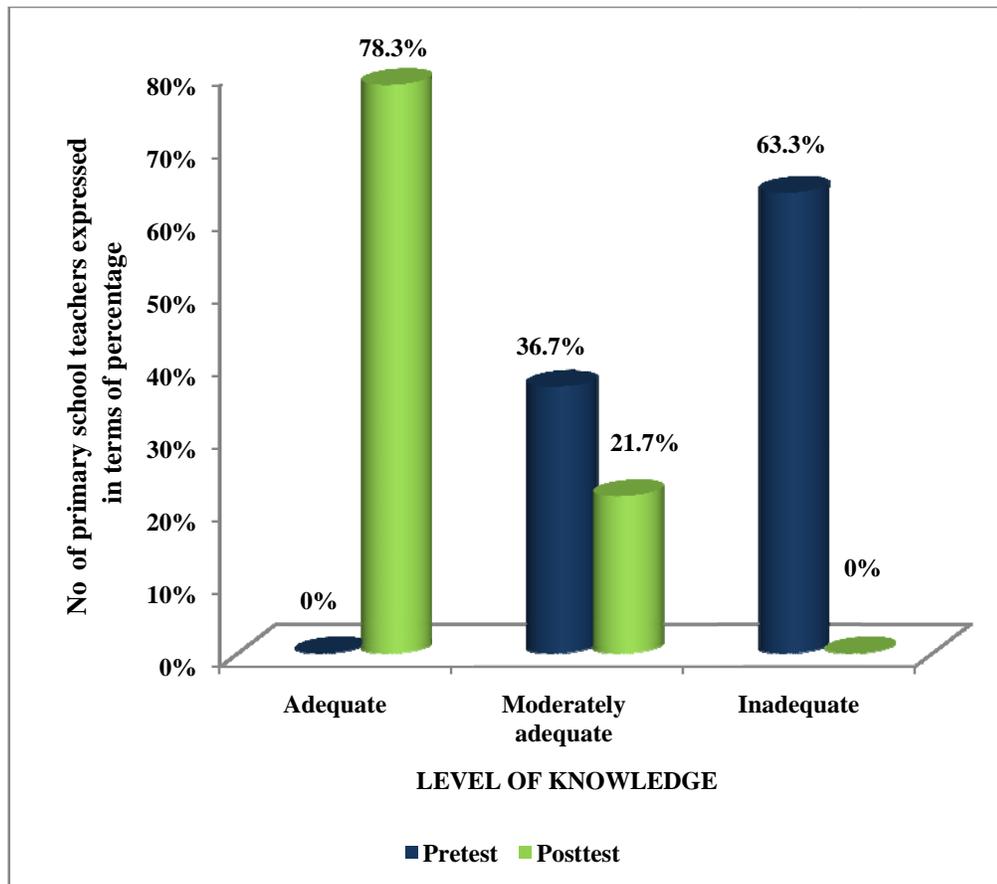
Table 1.b**DISTRIBUTION OF PRIMARY SCHOOL TEACHERS BASED ON THEIR
DEMOGRAPHIC VARIABLES****(N = 60)**

Sl. No	Demographic variables	Number	Percentage
4	Marital status		
	1) Married	46	76.7
	2) Unmarried	11	18.3
	3) Widow/widower	3	5
	4) Divorced /separated	0	0
5	Prior information		
	1) Yes	37	61.7
	2) No	23	38.3
6	Disorder in family		
	1) Yes	2	3.3
	2) No	58	96.7
7	Place of living		
	1) Rural	33	55
	2) Urban	27	45

Table 1.b reveals that among the primary school teachers, majority 46(76.7%) of the teachers are married, 37(61.7%) of the teachers have prior information regarding childhood mental disorder, 58(96.7%) of the teachers don't have disorder children in their home and 33(55%) of the teachers lives in rural area.

FIGURE 2

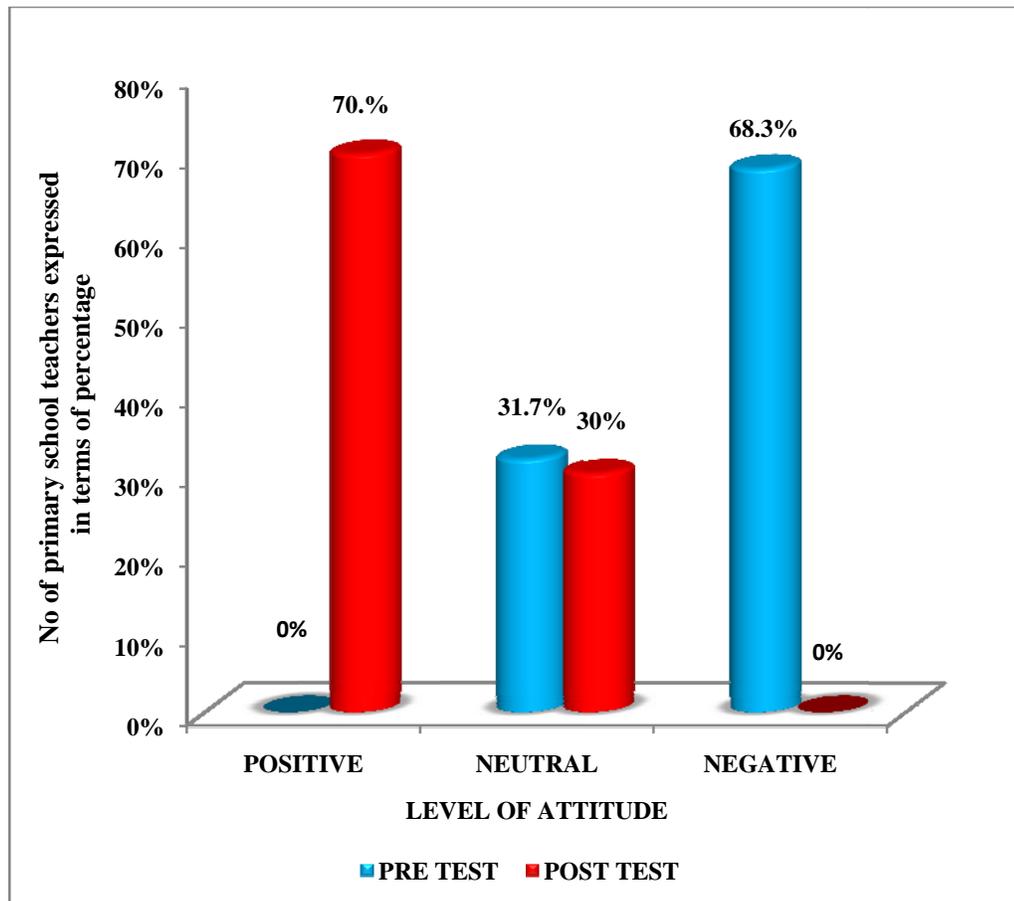
**DISTRIBUTION OF PRE TEST AND POST TEST LEVEL OF KNOWLEDGE
ON CHILDHOOD MENTAL DISORDER AMONG PRIMARY SCHOOL
TEACHERS**



The above figure reveals the sample distribution of pre-test and post-test knowledge. 38(63.3%) had inadequate knowledge and 22(36.7%) had moderately adequate knowledge. The post-test knowledge revealed that 47(78.3%) had adequate knowledge and 13(21.7%) had moderately adequate knowledge.

FIGURE 3

DISTRIBUTION OF PRE TEST AND POST TEST LEVEL OF ATTITUDE ON CHILDHOOD MENTAL DISORDER AMONG PRIMARY SCHOOL TEACHERS



The above figure reveals the sample distribution of pre-test and post-test regarding attitude. 41(68.3%) had negative attitude and 19(31.7%) had neutral attitude. The post-test attitude revealed that 42(70%) had positive attitude and 18(30%) had neutral attitude.

Table 2.a

PRE AND POST TEST LEVEL OF KNOWLEDGE OF CHILDHOOD MENTAL DISORDER AMONG PRIMARY SCHOOL TEACHERS

(N = 60)

Group	Mean	SD	MD	“Z” test Value
Pre test	13.08	3.93		
			12.32	*28.65
Post test	25.4	2.63		

*Significant at 0.05 level

The above table reveals that the obtained ‘z’ value was found to be highly significant at the level of $p < 0.05$. It is inferred that the primary school teachers exposed to the planned teaching program had significant increase in post-test knowledge

Table 2.b

PRE AND POST TEST LEVEL OF ATTITUDE OF CHILDHOOD MENTAL DISORDER AMONG PRIMARY SCHOOL TEACHERS

(N = 60)

Group	Mean	SD	MD	“Z” test
Pre test	17.9	6.61		
			16.1	*24.39
Post test	34	3.20		

*Significant at 0.05 level

The above table reveals that the obtained ‘z’ value was found to be highly significant at the level of $p < 0.05$. It is inferred that the primary school teachers exposed to the planned teaching program had significant increase in post-test Attitude

Table 3

**RELATIONSHIP BETWEEN POST TEST LEVEL OF KNOWLEDGE AND
LEVEL OF ATTITUDE ON CHILHOOD MENTAL DISORDER AMONG
PRIMARY SCHOOL TEACHERS**

(N = 60)

Group	Mean	SD	“r” Value
Knowledge	25.4	2.63	
			*0.55
Attitude	34	3.20	

*Significant at 0.05 level

The above table reveals the obtained knowledge mean score was 25.4 with a standard deviation of 2.63 and obtained attitude mean score was 34 with standard deviation of 3.20. The ‘r’ value was 0.55 was positive and significant at 0.05 significant level. It is inferred that there is a significant relationship between post-test knowledge and attitude of childhood mental disorders among primary school teachers.

TABLE 4.a.1

**ASSOCIATION OF KNOWLEDGE WITH THE SELECTED
DEMOGRAPHIC VARIABLES ON CHILDHOOD MENTAL DISORDER
AMONG PRIMARY SCHOOL TEACHERS (N = 60)**

S.NO	Demographic variables	Level of Knowledge		Chi Square
		Below Mean	Above mean	
1	Age			
	Below 30 years	7	8	
	31 – 35 years	8	10	
	36 – 40 years	3	3	# 1.11
	41 – 45 years	4	9	
	>45 years	3	5	
2	Experience			
	2-5 years	13	16	
	6–10 years	8	8	#3.52
	11–15 years	0	4	
	>15 years	4	7	

Not significant

Table 4.a.1 presents the association between post-test level of knowledge with selected demographic variables among primary school teachers. Regarding age, the χ^2 was 1.11 ($p < 0.05$) which was not significant. Regarding experience, the χ^2 was 3.52 ($p < 0.05$) which also was not significant.

TABLE 4.a.2

**ASSOCIATION OF KNOWLEDGE WITH THE SELECTED
DEMOGRAPHIC VARIABLES ON CHILDHOOD MENTAL DISORDER
AMONG PRIMARY SCHOOL TEACHERS (N = 60)**

S.NO	Demographic variables	Level of Knowledge		Chi Square
		Below Mean	Above mean	
3	Marital status			
	Married	20	26	
	Unmarried	4	7	# 0.27
	Widow/Widower	1	2	
	Divorced/Separated	0	0	
4	Disorder in Family			
	Yes	2	0	# 2.99
	No	23	35	
5	Place of Residence			
	Yes	15	18	# 0.43
	No	10	17	

Not significant

Table 4.a.2 presents the association between post-test level of knowledge with selected demographic variables among primary school teachers. Regarding Marital Status, the χ^2 0.27 was ($p < 0.05$) which was not significant. Regarding Disorder in Family, the χ^2 was 2.99 ($p < 0.05$) which was not significant. Regarding place of residence, the χ^2 was 0.43 ($p < 0.05$) which was not significant.

TABLE 4.b.1

**ASSOCIATION OF ATTITUDE WITH THE SELECTED DEMOGRAPHIC
VARIABLES ON CHILDHOOD MENTAL DISORDER AMONG PRIMARY
SCHOOL TEACHERS (N = 60)**

S.NO	Demographic variables	Level of Attitude		Chi Square
		Below Mean	Above mean	
1	Age			
	Below 30 years	10	5	
	31 – 35 years	7	11	
	36 – 40 years	4	2	# 3.91
	41 – 45 years	5	8	
	>45 years	4	4	
2	Experience			
	2-5 years	16	16	
	6–10 years	11	8	# 5.72
	11–15 years	0	4	
	>15 years	3	7	

Not significant

Table 4.b.1 presents the association between post-test level of attitude with selected demographic variables among primary school teachers. Regarding age, the χ^2 was 3.91 ($p < 0.05$) which was not significant. Regarding experience, the χ^2 was 5.72 ($p < 0.05$) which was not significant

TABLE 4.b.2

**ASSOCIATION OF ATTITUDE WITH THE SELECTED DEMOGRAPHIC
VARIABLES ON CHILDHOOD MENTAL DISORDER AMONG PRIMARY
SCHOOL TEACHERS (N = 60)**

S.NO	Demographic variables	Level of Attitude		Chi Square
		Below Mean	Above mean	
3	Marital status			
	Married	20	26	
	Unmarried	8	3	# 1.93
	Widow/Widower	2	1	
	Divorced/Separated	0	0	
4	Disorder in Family			
	Yes	0	2	# 2.06
	No	30	28	
5	Place of Residence			
	Yes	19	14	# 1.68
	No	11	16	

Not significant

Table 4.b.2 presents the association between post-test level of attitude with selected demographic variables among primary school teachers. Regarding Marital Status, the χ^2 was 1.93 ($p < 0.05$) which was not significant. Regarding Disorder in Family, the χ^2 was 2.06 ($p < 0.05$) which was not significant and regarding place of residence, the χ^2 was 1.68 ($p < 0.05$) which was also not significant.

CHAPTER - V

DISCUSSION

The study was conducted to evaluate the effectiveness of planned teaching program on level of knowledge and attitude regarding the childhood mental disorders among primary school teachers in Madurai.

This study was conducted by quasi experimental design. Subjects were selected by purposive sampling method. The sample size was 60.

A questionnaire and Likert scale was used to find out the knowledge and attitude among primary school teachers regarding childhood mental disorders. The responses were analyzed through descriptive measures (mean, frequency, percentage, standard deviation) and inferential statistics (chi-square, 'z' test).

Discussions on the findings are arranged based on the objectives specified in this study.

The first objective of this study was to assess the pre-test level of knowledge and attitude regarding childhood mental disorder among primary school teachers.

The pre test knowledge revealed 38(63.3%) and 22(36.7%) had moderately adequate knowledge. And the pre test attitude for all 41(68.3%) had negative attitude and 19 (31.7%) had neutral attitude. The pre test knowledge (Mean = 13.08, SD = 3.93). The pre test attitude (Mean = 17.9, SD = 6.61)

These findings were consistent with study done by Brook U., et.al.,(2000) found that knowledge and attitude was high among samples but the existing knowledge of the sample in this study were not satisfactory. This is due the fact that a

mental abnormality among school children was not included in their educational syllabus.

The second objective of this study was to assess the post-test level of knowledge and attitude regarding childhood mental disorder among primary school teachers.

The post test knowledge revealed 47(78.3%) had adequate knowledge and 13(21.7%) had moderately adequate knowledge, the post test attitude revealed 42(70%) had positive attitude and 18(30%) had neutral attitude. The post test knowledge (Mean = 25.4, SD = 2.63). The post test attitude (Mean = 34, SD = 3.20)

These findings were consistent with study done by Probst P., et.al. (2008) The Pre-Post outcomes measured by teacher questionnaires indicated significant improvement on the Classroom Child Behavioral Symptom Scale as well as on the corresponding Classroom Teachers' Stress Reaction Scale. This is due to the fact of providing a planned teaching program to the primary school teachers was effective in improving their knowledge and attitude regarding the childhood mental disorder.

The third objective of this study was to the difference of pre-test; post-test level of knowledge and attitude.

The above table reveals that the obtained knowledge pre-test mean score was 13.08 with a standard deviation of 3.93; post-test mean score was 25.4 with a standard deviation of 2.63 and the mean difference of pre and post-test was 12.32 and obtained attitude pre-test mean score was 17.9 with standard deviation of 6.61; post-test mean score was 34 with a standard deviation of 3.20 and the mean difference of pre and post-test was 16.1. It is inferred that there is a significant difference between pre-test,

post-test level of knowledge and attitude of childhood mental disorders among primary school teachers.

These findings were consistent with study done by Ghanizadeh A., et.al. (2006) Knowledge about childhood disorder was found to be very low. This fact can be improved with the help of Health and Educational Ministry by promoting a special course on childhood mental disorder for teachers and education should be part of the curriculum in faculty training. Providing these educational programs on television and radio may be highly effective as they were the most common source of information.

The fourth objective of this study was to identify the relationship on post-test level of knowledge with attitude.

The obtained post-test knowledge mean score was 25.4 with a standard deviation of 2.63 and obtained attitude mean score was 34 with standard deviation of 3.20. The 'r' value was 0.55 which was positive, was significant at 0.05 significant levels. It is inferred that there is a significant relationship between post-test knowledge and attitude on childhood mental disorders among primary school teachers.

These findings were consistent with study done by Nielsen SS., et.al, (2008) showed there is a significant relationship between level of knowledge and attitude. This fact reveals if there is improvement simultaneously the attitude of a person is improved.

The fifth objective of this study was to associate post-test level of Knowledge and Attitude with selected demographic variables

Regarding the association between selected demographic variables with post-test level of knowledge and attitude among primary school teachers, the result revealed that there is no significant association between level of knowledge and attitude with all selected demographic variables (Knowledge; regarding age, the χ^2 was 1.11 ($p < 0.05$), regarding experience, the χ^2 was 3.52 ($p < 0.05$), Regarding Marital Status, the χ^2 0.27 was ($p < 0.05$), regarding Disorder in Family, the χ^2 was 2.99 ($p < 0.05$), regarding place of residence, the χ^2 was 0.43 ($p < 0.05$), [attitude; Regarding age, the χ^2 was 3.91 ($p < 0.05$), regarding experience, the χ^2 was 5.72 ($p < 0.05$), regarding Marital Status, the χ^2 1.93 was ($p < 0.05$), regarding Disorder in Family, the χ^2 was 2.06 ($p < 0.05$), regarding place of residence, the χ^2 was 1.68 ($p < 0.05$)]. Hence, the hypothesis H_4 and H_5 were rejected. The investigator feels that in spite of all the variables the planned teaching program will improve the knowledge and attitude of primary school teachers regarding childhood mental disorders.

CHAPTER-VI

SUMMARY AND RECOMMENDATION

This chapter deals with the summary and conclusion drawn. It focuses on the implications and gives recommendations for nursing practices, nursing research, nursing administration and nursing education.

SUMMARY OF THE STUDY

The focus of the study to evaluate the effectiveness of planned teaching program on level of knowledge and attitude of childhood mental disorder among primary school teachers at selected institutions in Madurai. A review of literature helped the investigator to develop the conceptual framework, questionnaire, Likert scale and methodology. The review was done with the help of various literatures. The conceptual frame work adopted for this study was derived from Stufflebeam's CIPP model for evaluation; it serves as a comprehensive framework for guiding evaluations of program, projects, personnel, evaluation systems etc.

Research design adopted for the study was experimental design. A questionnaire was developed and used for collecting data about level of knowledge and attitude of primary school teachers on childhood mental disorders. The tool was found to be reliable and feasible. The reliability of the tool was established by test-retest method. The tool was administered among 6 primary school teachers at Madurai and retest was given. Karl parson's coefficient of correlation was computed and reliability of the level of knowledge found to be 0.99% and the reliability for level of attitude found to be 0.99%. The tool was found to be reliable. Data gathered were analyzed and interpreted in terms of the study objectives.

The main study was conducted in primary schools in Madurai with help of the school headmistress for a period of six weeks. Purposive sampling technique was used to collect data from the respondents of the study. Data were organized and interpreted by using both descriptive and inferential statistics.

MAIN FINDINGS OF THE STUDY

Regarding level of knowledge and attitude in the pre-test among primary school teachers, 38(63.3%) had inadequate knowledge and 22(36.7%) had moderate knowledge about childhood mental disorders. Regarding level of attitude 41(68.3%) had negative attitude and remaining 19(31.7%) of the total primary school teachers had neutral attitude towards childhood mental disorders

Regarding the effectiveness of planned teaching program, mean score for post-test level of knowledge was higher than pre-test level of knowledge. It was 13.8 in pretest and 25.4 in post test. The mean score of attitude in post-test is 34 increased from pretest mean score 17.9. This shows that there was significant difference between pre-test and post-test level of knowledge and attitude regarding childhood mental disorder among primary school teachers. This shows that the planned teaching program was effective. It was observed that the planned teaching program plays a vital role in improving the level of knowledge and attitude of primary school teachers.

Regarding the relationship between post-test level of knowledge and attitude, there was a positive correlation between post-test level of knowledge and attitude.

Regarding association between level of knowledge and attitude with selected demographic variables, there was no significant association between levels of

knowledge and level of attitude with demographic variables like age, sex, marital status, experience, prior information.

Regarding association between levels of knowledge and attitude with selected demographic variables, there was no significant association between their knowledge and attitude with childhood mental disorder with their age, sex, marital status, experience and prior information of the primary school teachers.

CONCLUSION

The main conclusion of this present study is that education plays fundamental role in bringing changes in knowledge and attitude of the primary school teacher. The investigator hopes that the planned teaching program could increase their level of knowledge and attitude on childhood mental disorders among primary school teachers.

IMPLICATIONS

The findings of the study have several implications in following field. It can be discussed on four areas namely nursing practice, nursing administration, nursing education and nursing research.

IMPLICATIONS OF NURSING PRACTICE

1. The study findings will help the mental health nurse to create an awareness program to the school teachers regarding the early identification of childhood mental disorders with the help of effective audio-visual aids.
2. The findings emphasize the need for early detection regarding childhood mental disorder through the medical professionals.

3. Special training sessions should be given to the teachers about the childhood mental disorders in all school levels.

IMPLICATIONS OF NURSING ADMINISTRATION

1. The present study will help the nursing administrative authority to recognize the need for developing appropriate education program on childhood mental disorder for school teachers.
2. Nursing administration should provide necessary facilities to conduct awareness program on childhood mental disorders with nearby child specialty hospitals.
3. The administration should allocate budgets for developing educational materials like pamphlets, posters, slides, cassettes, etc. which contain information about childhood mental disorders.

IMPLICATIONS OF NURSING EDUCATION

1. The study emphasizes the need for educating the nursing personnel through in-service or continuing education program to update their knowledge regarding childhood mental disorders.
2. The nursing education should prepare the nurses to practice as 'Nurse Counselor', 'Nurse Educator' and 'Nurse Communicator' to early identification of childhood mental disorder through mental status examination and physical examination.
3. Nursing student must improve their level of knowledge for diagnosing a childhood mental disorder through history and signs and symptoms.

IMPLICATIONS OF NURSING RESEARCH

1. The findings of the study help to expand the scientific body of professional knowledge upon which further research can be conducted.
2. Based upon this study, in-depth research studies of various factors contributes for childhood mental disorders among school teachers can be conducted
3. Large scale studies can be conducted in consideration of other contributing variables.

RECOMMENDATIONS

1. A similar study can be undertaken with large number of samples which might lead to generalization
2. A similar study can be conducted as a comparative study between government and private school teachers
3. A similar study can be conducted in another setting
4. A similar study can be undertaken by utilizing other domain like practice

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APPENDIX - V

gFâ : m

F;Yò: ã<tU« Éd;fS;F rÇahd Éilia F;Ælí« ()

bga® :

1.taJ :

1. 30 taâ%F Ñœ
2. 31 - 35 taJ
3. 36 - 40 taJ
4. 41 - 45 taJ
5. 45 taâ%F nkš

2.ghÈd« :

1. M©
2. bg©

3.jšfsJ mDgt« (tUlšfËš)

1. 2 - 5 tUl«
2. 6 - 10 tUl«
3. 11 - 15 tUl«
4. 15 tUlœâ%F nkš

4. âUkzª jFâ :

1. âUkz« Mdt®
2. âUkz« Mfhjt®
3. Éjit
4. ÉthfuªJ bg%wt®

5. ij%F K<ò FHªijfS;F V%ogL« kdehy« rh®ªj ãuçridfÿ g%oj nfÿÉÿgfl
iU;»Ö®fsh?

1. M«
2. išiy

6. cšfÿ FL«gªâš kdehy« ghâ;fÿgfl FHªijfÿ iU;»wh®fsh?

1. M«
2. išiy

7. iUÿâl«?

1. ef®ÿòw«
2. »uhkÿòw«

gFâ : M

F¿Yò: ã<U« Édh;fS;F rÇahd Éilia F¿Æh« ()

1. kd; ftiy v<whš v<d?

1. ftiyahf iUǻjš

2. gakhf iUǻjš

3. Jaukhf iUǻjš

4. nk%oT¿a midǻJ«

2. kd; ftiyÆ< bghJthd m¿F¿fŸ v<d?

1. glgIŸò

2. ga«

3. ijaǻJoŸò mǻfÇǻjš

4. nk%oT¿a midǻJ«

3. kd; ftiy V%ogLtj< fhuÂfŸ v<d ?

1. kd Bâahd fhuzšfŸ

2. gu«giu (kugQ;fŸ _y«)

3. clš Bâahd fhuzšfŸ

4. nk%oT¿a midǻJ«

4. kd; ftiyia v>thW Fiw;fyh« ?

1. nfhgǻij btËŸgLǻJjš

2. mGif

3. goŸgoahd rij js®î cǻâ

4. ö;fkhâiu vLYgj< _y«

5. kd; ftij;fhd bghJthd á»çir v<d?

1. mt®r< á»çir

2. bjhÊ%ogÆ%á á»çir

3. m<th%owš elçij;fhd á»çir

4. FL«g Áá»çir

6. kdey« F<Wjš v<whš v<d ?

1. m<îâwÅ< msî 70 ;F Fiwî

2. m<îâwÅ< msî 100 ;F Fiwî

3. m<îâwÅ< msî 120

4. bjÇahJ

7. kdey« F<çatU;fhd m<Fçfÿ v<d ?

1. clš msÉš äyhhik

2. kdjsÉyhd äyhhik

3. òâT®ik mâfkhjš

4. nk%Tç;a midçJ«

8. kdey« F<Wtj%ofhd bghJthd fhuÂfÿ v<d ?

1. m<ò k%W« ghr« išyhhik

2. kugQ;fÿ _y«

3. ÉgçJfÿ

4. nk%Tç;a midçJ«

9. kdehy« F<at@fÿ mâfkhf ghâ;fÿgfoU^ajhš v§F mDÿg nt©L«?

1. FH^aijfÿ fhÿgf«

2. kU^aJtkid

3. áwÿò gÿËfÿ

4. bghJthd gÿËfÿ

10.kdehy« F<at@fÿ v>thW gÆ%WÉ;fÿgL»wh®fsh ?

1. cl%gÆ%á

2. Édho Édh Æfœçá

3. bjhÊš rh^aj á»çir k%W« thœ;if^aw< ts®çá

4. nk%T;a mid^aJ«

11.f%wš FiwghL v<whš v<d ?

1. ö§Ftâš ãuçrid

2. Rtháÿgâš ãuçrid

3. f%gâš ãuçrid

4. clš ey ãuçrid

12.f%wš Fiwghfo%fhd bghJthd m_iF_i v<d ?

1. mGif

2. gÿË brštj%fhd ÉUÿg« išyhik

3. bghGJ ngh;F elto;ifÆš ÉUÿg« iU^ajš

4. nk%T;a mid^aJ«

13.vG^ajikÿò FiwghL v<whš v<d ?

1. eÿgâš cÿs ãuçrid

2. rŸjŸfis cz®táš cŸs ãuørid
3. bg<áiy ãoŸgâY«, ga<gLŸJtâY« cŸs ãuørid
4. F¿pLfis vGJtáš cŸs ãuørid

14.f%owš Fiwgh£il FiwŸgj%ofhd tÊ v<d ?

1. bghJ njh%owŸâš ftd« brYŸj nt©L«
2. rÇahd f%owš KiwikÆš ftd« brYŸj nt©L«
3. f%owš FiwghL cŸs FHªijfis jÉ®;f nt©L«
4. bjÇahJ

15.ftd g%owh;Fiw V%ogLŸJ« Äifahd ia;f« v<whš v<d ?

1. ftd g%owh;Fiw V%ogLŸJ« ãuørid
2. Äifahd ia;f« V%ogLŸJ« ãuørid
3. ö©LjÈš cŸs ãuørid
4. nk%oT¿a midŸJ«

16.ftd g%owh;Fiw V%ogLŸJ« Äifahd ia;fŸâ%ofhd fhuÂfŸ v<d ?

1. jÂik
2. ÉgŸâdhš
3. gu«giu _y«
4. nk%oT¿a midŸJ«

17.ftd g%owh;Fiw V%ogLŸJ« Äifahd ia;f« cŸs FHªijfis v>thW

f©LãoŸÖ®fŸ / milahs« fh©Ö®fŸ ?

1. mo;fo gÿË ntiyfËš ftd« brYᄁj iayhik
2. btËÿòw ö©Ljyhš vËjhf ftdçáijî V%ogLjš
3. âdrÇ ntiyfis kwªJ ÉLjš
4. nk%T;a midᄁJ«

18.ftdÿ g%owh;Fiw V%ogLᄁJ« Äifahd ia;fᄁâ%fhd á»çir v<d ?

1. btËÿòw ö©Ljš V%ogLᄁJ« fhuÂfis Fiwᄁjš
2. elᄁij á»çir
3. FL«g; fšÉ
4. nk%T;a midᄁJ«

19.kd iW;f« v<whš v<d ?

1. cz®çá nfshW
2. ts®çá FiwghL
3. clšey FiwghL
4. nk%T;a midᄁJ«

20 .kd iW;f« tUtj%fhd fhuÂfÿ v<d ?

1. ntiy g®;F« bg%onwh®
2. f®ÿg fhyᄁâš V%ogL« kdmGᄁJ«
3. eu«òk©lyᄁâš V%ogL« brašghL Fiwî
4. k»œçáa%ow FL«g NœÃiy

21 . kd iW;fᄁij fLgLᄁJ« tÊfÿ v<d ?

1. fLlikÿò gÆ%çá

2. áw¥ò gÿË
3. bg%onwh®fÿ jšfÿ FHªijfS;F gÆ%çá mËªjš
4. nk%T; a midªJ«

22 . ãÇÉdhš V%ogL« ftiy rh®ªj FiwghL v<whš v<d ?

1. ÉU«at®fËl« iUªJ V%ogfl ãÇî
2. ÉU«at®fql< nr®ªJ iUªjš
3. kdÃiy nfhshW
4. nk%T; a midªJ«

23 . ãÇî rh®ªj ftiyFiwgh£o%ofhd fhuÂfÿ v<d ?

1. kugQ;fÿ
2. NœÃiy fhuÂfÿ
3. f®¥g fhyªš V%ogL« kdehy mGªJ« / cisçrš
4. nk%T; a midªJ«

24 . ãÇî rh®ªj ftiyFiwgh£o%ofhd á»çir v<d ?

1. fyªjhÇÊ k%W« csÉaš á»çir
2. kUªJfÿ
3. elªij gÆ%çáfhd á»çir
4. nk%T; a midªJ«

25. FHªijfS;F V%ogL« kd mGªj« v<whš v<d?

1. Fiwªj kdÃiy k%W« elto; ifÆš btW¥ò
2. ga«
3. c%orhf«

4. fdí fhQjš

26 . FH^aij gUt^áš V%ogL« kd mG^áj^áš%ofhd fhu^Áf^Ÿ v<d?

1. thœif ^Áfœif^Ÿ

2. Nœ^Áiy fhu^Áf^Ÿ

3. kugQ_if^Ě FiwghL

4. nk%oT_ia mid^áJ«

27.FH^aij gUt^áš V%ogL« kd mG^áj^áš%ofhd ^á»çir v<d?

1. j^Á miw^Æš ófo it^ájš

2. kU^aJf^Ÿ _y«

3. mt^á»çir

4. ~^Ÿsfoš ^á»çir

28 . fflha^ŸgL^áJ« kd cisçrš neh^Ě v<whš v<d ?

1. bjhl^áçáahf V%ogL« njit^Æšyhj v^ázšfS«, brašghLfS«

2. ^áu«ik

3. rKjha^á%F Ku^ágfl el^áij

4. TLjš òy< cz^á

29 . fflha^ŸgL^áJ« kd cisçrš neh^Ě_ifhd fhu^Áf^Ÿ v<d?

1. tWik

2. _isÆš
3. fhz¥gL« ntâaş bghUłfĚ« msî Fiwjš
4. K<ò V%ogłl clšeyFiwî
5. kJgHj;f«

30 .fłlha¥gL«J« kd cisçrš nehĚ;fhd á»çir v<d?



1. mç;th%owš elçij;fhd á»çir
2. mâf¥goahd j©lid
3. mt@r<á»çir
4. Ah@nkh< kh%oW á»çir

gFâ : i

Fç;¥ò: ã<tU« Édh;fS;F rÇahd Éilia Fç;Ælí« ()

v<	Édh;fY	Mnkhâ; »<nw<	Mnkhâ; fÉšiy	bjÇahJ
1	kdey« ghâ;f¥głl FHªijfY M;nuhõkhf iU¥gh©fY			
2	kdey« Fç;ç;a FHªijfS;F mç;îçâw< Fiwthf iU;F«			
3	kdey« ghâ;f¥głl všyh FHªijfĚ« elto;iffY Éçâahrkhdjhf iU;F«			

4	kdey« ghâ;fÿgfl FHªijfis KGtJkhf FzÿgLªj ïayhJ			
5	kdey« ghâ;fÿgfl FHªijfS;F kWthoêf mËÿgâš bg%onwh®fË< ftdK« k%oW« mutizÿð« K;»a gšF t»j»<wJ,			
6	všyh FHªijfSnk kdey« ghâ;fÿgl thCEÿð cÿs®fÿ			
7	k;fÿ kdey« ghâ;fÿgfl FHªijfis g%o; jtwhd mãÿãuha« itªJ cÿsd®			
8	kdey« ghâ;fÿgfl FHªijfis itªâUÿgJ nftykhd x<W			
9	kdey FiwghL v<gJ eh« brCEjttWfS;fhf bfhL;fÿgfl j©lid.			
10	kdey« ghâ;fÿgfl FHªijfis itªâU;F« bg%onwh® jšfÿ FHªij g%o;a ãuçridia ahÇIK« brhšy;TlhJ			
11	FHªijfS;F V%ogL« kdey nfhshWfis f©l;LJ fodkhd x<W			
12	kdey FiwghL v<gJ kugQ;fÿ _y« bg%onwhÇlÄUªJ FHªijfS;F V%ogL« nehahF«			
13	kdßâahd ãuçrifÿ kdey FiwghLfis mâfÇ;fç brCE»wJ.			
14	kdey FiwghLfS;fhhd m;F;fÿ btËÿgL« nghJ ghâ;fÿgfl FHªijfS;F cldoahf á»çir mË;fÿgl			

	nt©L«			
15	kdey FiwghL;fhhd m;F;fis Éiuthf f©l;ªJ á»çir nk%bfhÿtj< _y« mj< Éisîfis FiwªJ Élyh«			
16	FHªijfS;F V%ogL« kdey FiwghLfÿ g%o;ç gÿË MáÇa®fshš f©l;ªa iayhJ			
17	gÿË;TlîfËš kdey« ghâ;fÿgfl FHªijfÿ k%ow FHªijfSl< gHf; TlhJ			
18	kdey FiwghL V%ogL;tj%oF _isÆš fhzÿgL« ntâ bghUshd eu«ò flªâÿ fhuz«			
19	kdey« ghâ;fÿgfl FHªijfS;F clš eyK« ghâ;fÿgfoU;F«.			
20	nfhgÿgLjš / Äifahd ia;f« / mâfkhd ftiy, k%W« mo;fo ml<ªoªjš ngh<wit kdey Fiwgh£o%ofhd m;F;fÿ			