Journal of

Mental Health Education

www.jmhedu.org

VOLUME- 1 ISSUE- 1 ISSN :2456-5733

January-December, 2017

Turning Knowledge into Action

MHEd

Mental Health Education

NIMHANS, BANGALORE, INDIA

Journal of Mental Health Education

The **Journal of Mental Health Education** is the official publication of **The Department of Mental Health Education, NIMHANS.** The journal is peer-reviewed, is published annually, and accepts high-quality work or writings in the broad fields of mental, neurological and neurosurgical health and promotion. The journal is being published through funding from the Dr RN Moorthy Foundation.

With the goal of dissemination of knowledge to increase the wider public awareness of mental health and to promote research in the field Mental Health Education, the Department of Mental Health Education publishes the Journal of Mental Health Education, a peer-reviewed online journal with Annual print compilation of issues. The first issue of the journal was published in 2017 under the Editorship of Prof. S.K. Chaturvedi and Dr. KS Meena.

Further details about the Department of Mental Health Education and its activities are available at http://mentalhealtheducationnimhans.org/

Journal Ethics

The Journal is committed to meeting and upholding standards of ethical behavior at all stages of the publication process. We follow closely the industry associations, such as the Committee on Publication Ethics (COPE), International Committee of Medical Journal Editors (ICMJE) and World Association of Medical Editors (WAME), that set standards and provide guidelines for best practices in order to meet these requirements.

Open Access Publication and Creative Commons Licensing

Digital Archiving

The contents of the Journal will be saved on a cloud server in case of a Website Malfunction.

Ahead of Print policy

Articles published online under the Ahead of Print model are considered published and can be cited and quoted using the DOI as the reference source

Areas of Publication

This multidisciplinary journal focuses publishing high quality, peer-reviewed papers in the area of mental, neurological and neurosurgical health and promotion, book reviews and brief articles. The Journal highlights issues in educating, training and developing a skilled, healthy and committed mental health workforce. The Journal of Mental Health Education is keen to receive original papers on mental health education and mental health promotion, methodology, training, research, policy development, and practice – particularly from a national and international perspective.

It considers for publication original research articles in the following areas:

- Mental Health Education
- Community Mental Health Education
- First Aid for Mental health
- Prevention, Promotion and Intervention in Mental Health
- Design, Implementation, Monitoring and Evaluation of Programs in Mental Health
- Mental Health Awareness
- Mental Health Literacy
- Stigma and Discrimination in Mental Health
- Digital Mental Health Education
- Public Mental Health
- Advocacy and policy making
- Research methodologies in Mental Health
- Health Education Materials
- Mental Health Education and Media
- Aids and Methodologies in Mental Health Education
- Theories and Evidence Based Research in Mental Health Education
- Legal and Ethical Principles in Mental Health Education

In the above-mentioned subjects, the journal invites submission of original research papers, brief reports, case discussions, debates, commentaries and controversies, narrative and systematic reviews, essays, letters to editor, correspondence and book reviews.

Potential readership for this journal includes but not limited to mental health professionals (psychiatrists, psychologists, psychiatric social workers, mental health nurses), health educators, public health professionals, people from the media, non-government organizations, administrators and policymakers working in the field of Mental Health.

Dr. Deepak Jayarajan
Assistant Professor, Psychiatric Rehabilitation Services, NIMHANS, Bangalore, India
Dr. G. Radhakrishnan
Assistant Professor, Department of Nursing, NIMHANS, Bangalore, India
Dr. Geetha Desai
Additional Professor, Department of Psychiatry, NIMHANS, Bangalore, India
Dr. John Vijay Sagar
Additional Professor, Department of Child and Adolescent Psychiatry, NIMHANS, Bangalore, India
Dr. Kavitha Jangam
Assistant Professor, Department of Psychiatric Social Work, NIMHANS, Bangalore, India
Dr. Manjunatha
Assistant Professor, Department of Psychiatry, NIMHANS, Bangalore, India
Dr. Manoj. K. Sharma
Additional Professor, Department of Clinical Psychology, NIMHANS, Bangalore, India
Dr. Mathew Verghese
Professor, Department of Psychiatry, NIMHANS, Bangalore, India
Dr. Nandeesh.B.N
Assistant Professor, Department of Neuropathology, NIMHANS, Bangalore, India
Dr. P T Sivakumar
Professor of Psychiatry, Consultant in Geriatric Psychiatry Unit, Department of Psychiatry, NIMHANS, Bangalore, India
Dr. Poornima Bhola
Additional Professor, Department of Clinical Psychology, NIMHANS, Bangalore, India
Dr. Prabhat Kumar Chand
Additional Professor, Centre for Addiction Medicine NIMHANS, Bangalore, India
Dr. Prabha.S.Chandra
Professor & HOD, Department of Psychiatry, NIMHANS, Bangalore, India
Dr. Prasanthi Nattala
Associate Professor, Department of Nursing, NIMHANS, Bangalore, India
Dr. Priya Treesa Thomas
Assistant Professor, Department of Psychiatric Social Work, NIMHANS, Bangalore, India
Dr. Reeta Mani
Associate Professor, Department of Neurovirology, NIMHANS, Bangalore, India
Dr.S.S.Meera
Speech Therapist Department of Speech Pathology and Audiology, NIMHANS, Bangalore, India
Dr. Sailaxmi Gandhi
Additional Professor, Head, Department of Nursing, NIMHANS, Bangalore, India
Dr. Santosh Loganathan
Additional Professor, Department of Psychiatry, NIMHANS, Bangalore, India
Dr. Seema Mehrotra
Professor, Department of Clinical Psychology, NIMHANS, Bangalore, India
Dr. Shripad Patil
Professor and HOD, Department of Neuromicrobiology, NIMHANS, Bangalore, India
Dr. Vandana.V.P
Associate Professor, Department of Speech Pathology and Audiology, NIMHANS, Bangalore, India
Dr. Vranda M.N.
Associate Professor, Department of Psychiatric Social Work, NIMHANS, Bangalore, India

INDEX

Editorial

Need of the hour: Mental Health for All

Meena K.S.

Address for Correspondence: **Meena K.S**, Associate Professor, Department of Mental Health Education, M. V. Govindaswamy building, NIMHANS, Hosur Road, Bangalore-560029, Phone Number: +91 8762689735, Email:meenaksiyer@gmail.com

---

The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Thus, in order to attain health, improvement of the mental health of individuals is essential. This is all the more important because mental disorders are responsible for a high degree of burden due to illness. Owing to this growing burden of mental disorders, it is essential that effective preventive and promotional measures be taken in mental health to reduce the impact of mental disorders on the individual and society. Prevention and promotion in mental health are essential steps in reducing the increasing burden due to mental disorders.

A considerable amount of research in the field of prevention and promotion in mental health has been reported during recent years, but most of this research has come from the developed countries with very little from the developing countries. Moreover, since most of the preventive and promotional programmes cater to the local culture of the western world, it is not clear whether the strategies currently in place would be effective across different countries and cultures. Information and knowledge is required to identify and assess those programmes that seem to hold the greatest promise and are supported by adequate evidence-based research. There is also a felt need to set up an information-generating system to share information among researchers so that they do not go about "re-inventing the wheel". Once the knowledge base for standardized evidence-based programmes has been identified, governments will need to be urged to formulate and integrate policies and programmes related to prevention and promotion in mental health, according to their specific needs.

The articles in the journal highlight some of the basic issues in the field of prevention and promotion in mental health with special reference to the evidence base. It is hoped that the research presented here with various mental health problems that community faces will assist in wider utilization of appropriate and effective interventions on prevention and promotion towards reducing the burden of mental disorders and in enhancing the mental health of populations.

Original Article

Help seeking behaviours among survivors of intimate partner violence in India

Supraja T.A[1], Mysore NarasimhaVranda[2]

Ph.D Research Scholar, Department of Psychiatric Social Work, NIMHANS, Bangalore
Associate Professor, Department of Psychiatric Social Work, NIMHANS, Bangalore

Address for Correspondence: Dr.Vranda M N, Associate Professor, Department of Psychiatric Social Work, National Institute of Mental Health and Neuro Sciences, Bangalore-560029, email id: vrindamn@gmail.com

Abstract

Background: Studies on the subjective experiences of Intimate Partner Violence (IPV) among Indian women are far and few and there are hardly any studies exploring the help seeking behaviours among these women.

Objectives: The purpose of this qualitative study was to explore the experiences of violence among female survivors of IPV who had moved out of an abusive relationship with a focus on the help seeking behaviours in these women.

Method: Purposive sampling technique was employed for this qualitative study. In-depth semi-structured interviews were conducted with 10 survivors of IPV who had sought shelter at the Government Reception Centre for Women, Bangalore Urban, India. Interviews were audio-taped with the consent of the participants and later transcribed for analysis. The transcribed data was coded and the main themes were summarized.

Results: Three major themes emerged from a thematic analysis of the interview transcripts; women reported personal and social attitudes, prevalent barriers to seeking assistance and available resources in their situations as being the major factors influencing their decision to seek help to move out of the abusive relationship.

Key words: Intimate partner violence, help-seeking, Survivors, Qualitative

Background

Violence within the home is universal across cultures, religions, class and ethnicity. Recent global prevalence rates indicate that 35% of women worldwide have experienced either intimate partner violence (IPV) or non-partner sexual violence in their lifetime. On an average, 30% of women who have been in a relationship report that having experienced some form of physical or sexual violence by their partner and globally, as many as 38% of murders of women are committed by an intimate partner (Berg et al., 2010). In India, 21.2% of women reported ever experiencing some form of

domestic violence in the community (Begum et al, 2015).

Past studies have identified the prevalence of certain forms of domestic violence and the rate of help seeking among specific populations. Bibi et al (2014) reported 31% prevalence of lifetime physical domestic violence from spouse or in-laws, while only 2% of them sought social or legal aid. Similarly, another study also found that only 5% of women experiencing intimate partner violence contacted a domestic violence programme while no one reported using criminal justice services (Raj & Silverman, 2007). The lifetime prevalence of domestic violence in a South Indian population was 32.2%, while factors such as early years of marriage, lower education level of either partner, employment in the wife and alcoholism in the husbands increased the risks for domestic violence for the women (Kamat et al, 2013). While some quantitative as well as qualitative studies have been conducted establishing prevalence rates of various forms of violence and also assessing help seeking behaviours among south Asian populations globally (Naved et al, 2006; Ahmad et al, 2009; Lee & Hadeed, 2009; Raj & Silverman, 2007), there are hardly any studies focussing on these issues from India (Panchanadeswaran & Koverola,2005). Further there is a need to explore the individual experiences of women experiencing intimate partner violence based on their cultural background. With this aim we planned this qualitative study focussed on exploring and understanding the help-seeking behaviours among women who had walked out of an abusive marital relationship.

Methodology

Participants were female survivors of intimate partner violence who had moved out of the marital relationship and had sought shelter at the Government Reception Centre for Women, Bangalore Urban, India. The participants for the study were referred to the researcher by the Superintendent of the Centre based on their records. The women were screened for the presence of any mental health complications and those women who were identified to have mental health issues were offered the option of getting an assessment from the National Institute of Mental Health and Neuro Sciences (NIMHANS). Women who screened negative were interviewed for the study.

Consecutive eligible and consenting women were recruited as participants to the study. The participants were briefed about the study and informed consent was sought. Written consent for was obtained from all participants confirming their willingness to participate in the study. In all, 12 women were approached for the study, however since two of them refused consent for the interviews, a total of 10 women were interviewed as part of the study. Out of this 8 women had consented to the interviews being audio-taped. Field notes were taken for all the interviews. All women were assured confidentiality and were interviewed in complete privacy in the interview / counselling rooms at the State home premises.

The ages of the participants ranged between 18 to 43 years. Six of them had completed 5^{th} to 10^{th} grade of schooling, while three of them had completed graduation and one participant was a post-graduate. Two of the women had been in an employment prior to leaving their homes and six of the women had atleast one child. A semi-structured interview guide was used for the in-depth interviews. The interview guide contained questions related to the women's experiences of violence and the means they adopted to handle the same. The interviews were conducted with the purpose of gaining an understanding of the ways in which these women responded in the face of challenges and

exploring the personal characteristics and environmental factors that supplied their capacity for resilience.

The interviews were conducted in *Tamil* and eight interviews were audio recorded. Field notes were made immediately after each interview. The audiotapes were transcribed verbatim and both the transcriptions and field notes were translated to English. The researcher's personal observations about the interview – experiences, impressions, challenges as well as observations about the data were recorded as memos.

Data Analysis

A thematic analysis approach was used to analyse the transcribed interviews. Data analysis was done using both deductive and inductive coding methods. The interviews were initially coded independently by the researchers and the codes generated were compared to integrate similar codes and subthemes. Patterns were identified and codes with similar patterns were merged to form the categories / sub-themes. The codes and subthemes across interviews were compared and later organized under three major themes.

Findings

The themes identified as factors influencing the help-seeking behaviours among the participants were (1) Personal and social attitudes to help seeking, (2) Barriers to seeking help for IPV and (3) Availability of resources

Women had sought assistance from different sources – family members, friends and tertiary systems like registered Governmental or non-Governmental organizations. The practice of help seeking varied among these women and in spite of currently being at a shelter home not all of them had voluntarily sought help. Their approach to help-seeking was influenced by the attitudes of and barriers concerning the same.

Personal and social attitudes to help seeking

Attitudes of the respondents, their family and the community had an impact on how, when and from whom these women sought help. Some women make a conscious choice to take help from others.

Like I said I wasn't even sure if I was misunderstanding what he was doing with an intention to care for me [...] but when I saw how the same thing was getting repeated more often, in spite of the efforts I was making, I decided I cannot do this by myself. (Woman 1)

Those women who had support from the family members felt comfortable taking help from them. Woman 4 reported staying at her parents' home for brief periods when her husband got violent, while woman 6 would confide in her sister about all the abuse her husband subjected her to. Quite a few women felt that being in touch with their family during times of difficulty was of great assistance to them. Whereas for others the absence of a good source of help within their network of family or friends delayed the process of help seeking,

From the time of my marriage, I've been looking for someone to help me with deciding what would be best to do, as I could not discuss it with anyone in the family. They were there to tell me how to do things (household work) but whenever I started talking about problems with him (husband) they would divert the topic. So I decided to keep it to myself. (Woman 6)

The various myths surrounding family life in the community and the socio-cultural stipulations for discussing these issues significantly influence these women's process of reaching a source of help outside their system. Friends and neighbours most often sympathized with the women when they came to know about the violence they were going through and shared similar experiences at times. While women reported that it was helpful that they could talk to someone, they did not get further guidance from them.

They would sometimes tell me about similar situations in some other families. They used to say that having been born as a woman; we had no other choice but to go through all this (Woman 4)

Although women in the neighbourhood gave me their sympathy, that was all I could get from them. (Woman 5)

Woman 2 explains how according to her, the attitudes of the society are unfavourable and sometimes even detrimental for survivors like her to approach for any help.

In our community, talking about one's family problems to parents is itself considered unacceptable for girls, then what to say about discussing it with others or asking for suggestions? [...]Those were the times I wished I was born a male. (Woman 2)

R9 shared how more than the attitudes, the judgements the society passes about the women who seek these services affected and delayed her choice to seek help.

The opinion that people start building based on your profile is something difficult to break - see what happened with me. Because I am a teacher, I am considered a know-all; that means I don't need people to clear my doubts. [...] That frightens me really. I can't imagine what people might have thought when I left home. (Woman 9)

Barriers to seeking help

While the respondents made a mention of barriers they faced to seeking help when they badly needed it, several of them reattributed this to the attitudes that are prevalent.

The fluctuations in his behaviour between when he was drunk and otherwise, had from time-to-time weakened my decision to discuss this with someone. Also so many women were facing some problem or the other in their life, but were managing by themselves. Shouldn't I be doing the same? (Woman 3)

Before the first time I spoke to my mother about this, I had so much of hesitation about taking something that needs to be dealt between us to other family members. I felt a little silly, like a school girl complaining to a teacher. I had always seen myself as a strong woman, who can deal thing by herself. (Woman 1)

Restrictions on the means of exploration about and access to resources by either the perpetrator or other family members leads to the women not being able to seek help when required. Also social and cultural barriers to seeking assistance for family issues coloured the picture of help-seeking for these women.

Now I can see how, much earlier I should have made this decision. But once we are married, we very rarely are allowed to go out and that too only with others in the family. There is no much interaction with any people outside the home. So no supportive person around it is so difficult to make the right decisions at the right time. (Woman 6)

Now, I was caught for quite a while just in waiting for things to improve. I was focussed more on his

drinking. In fact I sought help for it (herbal medication), without much success. I used to feel ashamed to speak about what exactly he did, because they were private things (sexual) between us. How could I speak about it to someone? (Woman 3)

Lack of awareness among the women about, whom to approach once they were looking out for help was by itself a barrier in spite of the need for it being identified by them.

Although I strongly felt about telling someone about it and finding out how to get out of this rut I had been pushed into, I didn't know whom to go to. All that I'd got from my family was advice on how to be a good wife. (Woman 2)

Availability of resources

Some of the women had left their homes without any plans of whom to approach. This was reportedly due to either the urgency of the situation that required them to leave immediately, or due to not having anyone to help or guide them about where to go or whom to approach.

Now, after having walking out of my home, ready to face any situation, I have landed in the hands of people who can help me with this. I believe that this help was God-sent. I had taken some money and jewels from home before leaving and that saw me through [...]I've now got a pole to hold on to. (Woman 2)

After the death of my mother, I almost had nobody to help me out in times of crisis. My brother, [...] gave some excuse or the other for two or three times when I had asked for help (shelter for a few days); I understood that he was not interested to help me. I didn't want to trouble him with my problems. (Woman 4)

Some of them felt that it was only as a matter of chance and their luck that they had ended up with a formal support system such as the shelter home.

Woman 5 said that in order to ensure safety from her husband, she had approached the police for assistance.

In fact when I left home, not knowing where to go, I just went to the police station saying that I had got lost in that place [...]staying at shelters for a day or two - then getting shifted. But at least I knew I was safe, and also my child. (Woman 5)

Woman 9 mentioned that as she had previously moved out of home due to violence, she knew exactly where to go and what to do.

I've been here four times in the past and received good support and guidance. So I keep in touch with them even in between when the violence is too difficult to bear.

Discussion & Conclusions

Understanding help seeking behaviours among survivors of intimate partner violence (IPV) is important in working towards formulating practical strategies and for improving the competencies of these women to handle and bring the violence to an end.

Through our qualitative assessment we have identified factors that influence help-seeking behaviours of women experiencing IPV. The findings from our study indicate that women start exploring about possible sources (formal or informal) for availing assistance from the time they are subjected to violence by their partners, however each woman's means of approaching for help and whom they sought help from depended on the presence as well as their awareness of availability of these resources. Women most often approached

informal support systems (family members) before contacting formal support systems. Our finding are complemented by the results of the study conducted by Hodges and Cabanilla (2011) determining factors associated with help seeking behaviour which revealed that spirituality, social support and education were positively related with higher level of attitude to seek help among battered women.

Women in this study reported getting only limited support from friends or neighbours. While results of past studies support our finding that women's strategies to deal with abuse are shaped by and reflect their social conditions, resources, and available options (Park, 2011), other studies have found that most women sought help from friends and perceived them as being moderately to very helpful (Mahapatra & DiNitto, 2013).

By and large the general pattern seen in terms of help seeking was that the women reached out to formal support systems (such as shelter homes) only after their other resources had been approached and were found to be either unavailable or unsupportive. Women who had previously sought assistance for IPV from a specific source (family or formal) and had benefitted from it, preferred to approach them first during a recurrence of IPV.

References

1. Ahmad, F., Driver, N., McNally, M. J., & Stewart, D. E. (2009). "Why doesn't she seek help for partner abuse?" An exploratory study with South Asian immigrant women. *Social science & medicine*, *69*(4), 613-622.

2. Begum, S., Donta, B., Nair, S., & Prakasam, C. P. (2015). Socio-demographic factors associated with domestic violence in urban slums, Mumbai, Maharashtra, India. *The Indian journal of medical research*, *141*(6), 783.

3. Berg, M. J., Kremelber, D., Dwivedi, P., Verma, S., Schensul,J. J., Gupta, K., & Singh, K. S. (2010). The effects of husband'salcohol consumption on married women in threelow-income areas of greater Mumbai. *AIDS and Behaviour*,*14*, S126–S135

4. Bibi, S., Ashfaq, S., Shaikh, F., & Qureshi, P. M. A. (2014). Prevalenceinstigating factors and help seeking behavior of physical domestic violence among married women of HyderabadSindh. *Pakistan journal of medical sciences*, *30*(1), 122.

5. Hodges TA and Cabanilla AS. (2011) Factors that impact help-seeking among battered black women. Journal of Cultural Diversity, 18(4), 120-125.

6. Kamat, U. S., Ferreira, A. M. A., Mashelkar, K., Pinto, N. R., & Pirankar, S. (2013). Domestic violence against women in rural Goa (India): Prevalence, determinants and help-seeking behaviour. *International Journal of Health Sciences and Research*, *3*(9), 65-71.

7. Lee, Y. S., & Hadeed, L. (2009). Intimate partner violence among Asian immigrant communities Health/mental health consequences, help-seeking behaviors, and service utilization. *Trauma, Violence, & Abuse*, *10*(2), 143-170.

8. Mahapatra, N., & Dinitto, D. M. (2013). Help-seeking behaviors of South Asian women experiencing domestic violence in the United States. *Partner Abuse*, *4*(3), 295-313.

9. Naved, R. T., Azim, S., Bhuiya, A., & Persson, L. Å. (2006). Physical violence by husbands: magnitude, disclosure and help-seeking behavior of women in Bangladesh. *Social science & medicine*, *62*(12), 2917-2929.

10. Panchanadeswaran, S., & Koverola, C. (2005). The voices of battered women in India. *Violence Against Women*, *11*(6), 736-758.

11. Park, S. (2011). *Domestic violence and help seeking behaviour among Vietnamese wives in Korea* (Doctoral Dissertation, Michigan State University, USA). Retrieved from http://etd.lib.msu.edu/islandora/object/etd%3A917/datastream/OBJ/view

12. Raj, A., & Silverman, J. G. (2007). Domestic violence help-seeking behaviors of South Asian battered women residing in the United States.*International Review of Victimology*, *14*(1), 143-170.

Original Article

Self Esteem and Emotional Intelligence Among College Teachers

Vigneshvaran K[1], DivyaMerciline A[2], Dr.K.V.Krishna[3], Sinu E[4]

Clinical Psychologist, Department of Clinical Psychology, NIMHANS, Bangalore
Lecturer, Department of Clinical Psychology, Sri Ramachandra Medical College, Chennai
Assistant Professor, Department of Psychology, Bharathiar University, Coimbatore
Assistant Professor, Department of Psychiatric Social Work, NIMHANS, Bangalore

Address for Correspondence: Dr.E.Sinu, Assistant Professor, Department of Psychiatric Social Work, National Institute of Mental Health and Neuro Sciences, Bangalore-560029, Phone: 9845145599, email id: esinu27@gmail.com

Abstract

Aim: To examine the level of self-esteem and emotional Intelligence among college teachers.

Method: A sample of 110 college teachers (both male and female) who have attended training programme on psycho-educational skills, hailing from Madurai region, Tamil Nadu have been selected using simple random sampling technique . The study was descriptive in nature. Culture Free Self-Esteem Inventory Emotional intelligence scale were used.

Results: More than one-fourth of them have high self-esteem and less than 17% of the teachers have low self-esteem. Mean self-esteem score of the college teachers is 69.57, which is fairly high. More than one-third (30%) of the school teachers have high emotional intelligence (EI) and few (18%) t have Low EI. Mean Emotional Intelligence score for the college teachers is 68.55%, which is fairly high. There is a positive correlation between self-esteem and emotional intelligence among college teachers ($r = +0.83$ $p<.05$).

Conclusion: Female teachers have more self-esteem and emotional intelligence than male teachers. Teachers who teach science subjects are having less self-esteem and emotional Intelligence than the teachers who handle arts subjects.

Key words: self-esteem and emotional Intelligence

Background

Emotional intelligence is essential for every individual in order to lead a balanced life.[1] The term emotional intelligence attempts to analyze the details of excitement, feeling and capability status of human beings.[2] There are many definitions given to this concept, Goleman (1995) defines the Emotional Intelligence (EI) as the ability to identify, regulate, and manage emotions in self and in others.[3]Further, it also shows the capacity of an individual to obtain, organize emotions and to conceptualize the information.[4]

Teachers play important role in inculcating knowledge to students. To play their role effectively, it is proved that they require certain skills. Researchstudies report that influence of EI in the success of the teacher's duty in both academic and non-academic areas.[1,5] In academic setting emotional intelligence is helpful for understanding the feelings of students in classroom, thus a teacher can respond appropriately to facilitate students to learn effectively.[6]They can guide students in regulating their emotions as well as in increasing their emotional and social development. Apart from this, emotional intelligence is reported to influence on one's physical and emotional health positively and is important for better work performance.[5]

In recent years, studies have been attempting to discover the link between EI and self-esteem (SE). Many researchers have proved the relationship between EI and SE and are found to be helpful in academic performance.[7] EI is strong predictor of self-esteem and it also explains the influence of social competence on self-esteem[8].

Self-esteem is being considered as the positive emotional response of an individual about oneself.. It is general personality trait and personal judgment of one's own value.[9]It is a sense of personal satisfaction.[10] and it influences one's view of family and society. Roger's theory self-esteem is useful in assessing the discrepancy between an individual's real self and ideal self.[11]High level of self-esteem is found to have a positive relationship with mental health.[12] There are studies in India that have established the relationship between EI and Self-esteem among students, however, there are no studies to see the relationship among these variables among college teachers. Hence present study aimed to examine the association between self-esteem and emotional intelligence among college teachers.

Methodology

The study used descriptive research design. All the teachers, who have attended training programme on Life Skill Education organized by Madurai District Administration and National Rural Health Mission (NRHM), Madurai Region, considered as study population.

Inclusion Criteria: Teachers who have attended training programme on Psycho-educational skills, hailing from Madurai region, Tamil Nadu. Both male and female teachers were included in the study.

Exclusion Criteria: Teachers who refused consent for the study.

Sampling: From the trained teacher's list, 110 teachers have been selected randomly by using simple random sampling technique (lottery method).

Tools: A semi-structured interview schedule was prepared to profile the demographic details of the Teachers. 40 items culture free Self-Esteem Inventory {Form-AD} by Battle[13] (1984), having 3 major areas namely Self-Esteem General, Self-Esteem Personal and Self Esteem Social was used to study the self-esteem of the college teachers. This tool has higher reliability (alpha = 0.97) and validity (alpha = 0.89). The 30 items Emotional Intelligence scale by Petrides & Furnhan[14] (2006) with four dimensions namely Well- being, Self-control, Emotionality, and Sociability were administered on the teachers. This tool has higher reliability (alpha = 0.94) and validity (alpha = 0.97). Collected data were analyzed using descriptive and inferential statistical tests.

Results

Socio-demographic details of the respondents reveal that mean age of the college teachers is 38.42 years and their age ranged from 34 years to 57 years. Majority of the teachers are Hindu, hailing from backward class, from urban background, from nuclear family, having 3 to 4 dependents at Home, and 2 earning members in their home. Mean years of teaching experience is 17 years and having on an average 45 students in the class.

Table 1 (Appendix) shows that 16.36% of teachers have low self-esteem general, 58.18% of them have moderate self-esteem general and around 25% have high level of general self-esteem. In the sub-domain personal self-esteem, 12.73%, 53.64% and 33.64% of them have low, moderate and high scores respectively. In the sub-domain of social self-esteem, few (10.9%) have low scores, 49.09% have moderate and 40% have high social self-esteem. Overall, 14% of teachers have low self-esteem, whereas 54.55% and 30.91% of them have moderate and high self-esteem respectively. Thus it is observed that few (12-16%) of the teachers reported to have low SE in all the domains, and 25-40% are having High self-esteem, whereas majority seem to have moderate self-esteem. Less than 17% of the teachers have low self-esteem, whereas more than 26% of them have High Self Esteem. The mean self-esteem score is found to be 69.57 %, which is fairly high. A maximum number of teachers are falling under the moderate category when it comes to domain wise comparison SE General (58.18), SE Personal (53.64) and SE Social (49.09) comparison.

Table 2 (Appendix) reveals the intelligence of the college teachers. In the sub domain of Well-being, 9.09% have got low scores, 61.82% have got moderate scores and 29.09% have high scores. Few (16.36%) respondents have low EI, 56.36% have moderate EI-self-control and another 34.55% have high EI-self-control. In sub-domain of EI-Emotionality 15.45% have low scores, 52.73% had moderate and 40.91% have high score. In sub-domain (EI-Sociability) 18.18%, 43.64% and 38.82% of the teachers have got low, moderate and high scores respectively. Overall few(15.45%) teachers have low EI, more than half of them (52.73%) are found to have moderate EI and 31.82% have high EI. Hence, similar to SE, few (9-18%) respondents reported low EI in all the sub dimensions, and 29-40% reported to have high EI, whereas majority of the teachers are reported to have moderate EI. Less than 18 percent of them have Low EI, whereas more than 30 percent of them have high EI. The mean EI score for the college teachers is found to 68.55%which is fairly high. There is a positive correlation between self-esteem and emotional intelligence among college teachers ('r'= 0.83 $p<.05$). In Table 3 (Appendix) There is strong positive association between socio-demographic variables such as age, monthly income, years of service with self-esteem and emotional intelligence ($p<0.05$).

Suggestions

Individual and group counseling to College Teachers could be offered by the professional Psychologists and Psychotherapists. More Group activities to improve the Self-Esteem and Emotional Intelligence for the College Teachers could be suggested and implemented. It is strongly recommended that the Introduction of 10 Life Skills Education Programme suggested by WHO (1997)[15] could be the part of their Academic programs. The 10 Life Skills namely, Self-Awareness, Empathy, Communication, Interpersonal Relationship, Coping with Stress, Coping with Emotions, Creative Thinking, Critical Thinking, Problem Solving, Decision Making, could be introduced. The College Teachers could actively participate in the Psycho-Education &training programmes. Action Oriented Training, Evaluation, Assessment and Intervention

Research Activities on various Psycho-Social areas could be carried out, and presented to both Academic and Practice world.

Conclusions

Female teachers have more self-esteem and emotional intelligence than male teachers. Teachers who teach science subjects are having less self-esteem and emotional intelligence than the teachers who handle arts subjects. Education plays key role in shaping children to have balanced emotion and to regulate their emotions which in turn promotes positive mental health of the school children.

References

1. Manju ND. Emotional Intelligence of B Ed Student Teachers. International Journal of Education and Psychological Research. 2014; 3(4): 41-45

2. Hassan ZR. The motivation and excitement. Tehran: Arasbaran Publication; 2007\

3. Goleman D. Emotional Intelligence: The Theory in Practice. Newyork: Basic Book; 1995.

4. Mayer JD, Salovey P. What is emotional intelligence? In: Salovey P, Sluyter DJ, editors. Emotional development and emotional intelligence: Educational implications. New York: Basic Books; 1997. pp. 3-31

5. Ramana TV. Emotional Intelligence and Teacher Effectiveness -An Analysis. Voice of Research. 2013; 2(2): 18-22.

6. Kumar S, Shani N. Emotional Intelligence among College Teachers – An Empirical Analysis. International Journal of Management. 2015; 6(3): 126-131.

7. Hasanvand B, Khaledian M. The relationship of emotional intelligence with self-esteem and academic progress. International Journal of Psychology and Behavioral Sciences. 2012; 2: 231-236.

8. Cheung C, Cheung HY, Hue M. Emotional Intelligence as a Basis for Self-Esteem in Young Adults. The Journal of Psychology, Interdisciplinary, and Applied. 2015; 149(1): 63-84.

9. Biabangard, Esmaeil. The methods of enhancement of self-esteem in children and adolescents. Tehran: The Council of Parents and Educators (in Persian); 1995&Byabangard, Esmail. Methods to increase the self-esteem in the children and teenagers. Tehran: The parents and teachers assembly Publication; 1384.

10. Bandura A, Adams NE. Analysis of self – efficacy theory in behavior change. Cognitive therapy& Research. 2002; 23(1): 287 – 310.

11. Hosseini, Ali M, Dejkam M, Mirlashari J. The Correlation between Self – esteem and Academic Achievement in Rehabilitation Students in Tehran University of Social Welfare and Rehabilitation. The Iranian Journal of Education in Medicine. 2007; 7(1): 137-142 (in Persian).

12. Malle BF, Horowitz LM. The puzzle of negative self-views: An explanation using the schema concept. Journal of Personality and Social Psychology. 1995; 68: 470-484.

13. Battle J. Culture-free self-esteem inventory for children and adults. Seattle, WA: Special Child Publications; 1981

14. Petrides KV, Furnham A. The role of trait emotional intelligence in a gender-specific model of organizational variables. Journal of Applied Social Psychology. 2006; 36: 552–569.

15. WHO. Life Skills education for children and adolescents in Schools. Geneva, Swizterland 1997.

Appendix

Table 1: Self-Esteem of College Teachers

Sl: No	Factors Self-esteem	Low		Moderate		High		Total	
		N	%	N	%	N	%	N	%
1.	General SE	18	16.36	64	58.18	28	25.45	110	100.0
2.	Personal SE	14	12.73	59	53.64	37	33.64	110	100.0
3.	Social SE	12	10.91	54	49.09	44	40.00	110	100.0

Table 2: Emotional Intelligence of the college teachers

Sl: No	Emotional Intelligence	Low		Moderate		High		Total	
		N	%	N	%	N	%	N	%
1.	Well being	10	9.09	68	61.82	32	29.09	110	100.0
2.	Self-control	18	16.36	62	56.36	38	34.55	110	100.0
3.	Emotionality	17	15.45	58	52.73	45	40.91	110	100.0
4.	Sociability	20	18.18	48	43.64	42	38.18	110	100.00
	Total	17	15.45	58	52.73	35	31.82	110	100.0

Table 3: Correlation between Self-esteem and Emotional intelligence with regard to Socio-demographic factors

Sl: No	Socio-Demographic factors	Self-Esteem		Emotional Intelligence	
		' r' value	Sig	' r' value	Sig
1.	Age	0.72	p<0.05	0.76	p<0.05
2.	Monthly Income	0.68	p<0.05	0.69	p<0.05
3.	Years of Service	0.74	p<0.05	0.70	p<0.05

Original Article

Life skills education program among high school children: An intervention study

Gayatri [1], Channaveer RM [2], Lakshmana G[3]

MSW, Department of Social Work, School of Social and Behavioral Sciences, Central University of Karnataka, Kadaganchi, Kalaburgi, Karnataka,
Head of the Department, Department of Social Work, School of Social and Behavioral Sciences, Central University of Karnataka, Kadaganchi, Kalaburgi, Karnataka
Assistant Professor, Department of Social Work, School of Social and Behavioral Sciences, Central University of Karnataka, Kadaganchi, Kalaburgi, Karnataka

Address for Correspondence: Lakshmana G , Assistant Professor, Department of Social Work, School of Social and Behavioral Sciences, Central University of Karnataka, Kadaganchi, Kalaburgi, Karnataka – 585367 email id: lakshmanagsagar@gmail.com

Abstract

Background: In the present study an attempt was made to study the efficacy of life skills education program among high school children, who were referred for academic backwardness. **Methodology:** Objectives of the present study were to assess the needs of referred children, impart the appropriate life skills and test the efficacy of the intervention. 15 ninth standard children consisting of 6 girls and 9 boys were referred by teachers in the school. The data was collected using life skills scale (Vrunda, 2011) and through interview method. The present study was carried out using AB Single Subject Design and the data was analyzed using non-parametric tests. Need Assessment show that the children had lack of self-awareness, Creative Thinking and Critical Thinking Skills. Based on the findings, the researcher used life skills activities suggested by WHO and implemented using group work approach.

Results: : Results show that out of 15 children 13 children's parents are either illiterates or educated up to 10th standard only and have very poor parental supervision. Wilcoxon Signed Ranks test shows that there is a significant difference between baseline and post intervention in the domains of Self Awareness ($p<0.05$), Creative Thinking ($p<0.001$) and Critical Thinking Skills($p<0.01$).It was also observed that parental supervision and academic performance had been increased significantly.

Discussion and Conclusion: Life skills are very important in each stage of life to cope with the various situations. Schools should integrate life skills into their academic activities and teachers should be trained on this. There is a need to identify children who have lack of skills in rural areas and teach them in order to make them compete with their urban counterparts

Key words: Life skill education, adolescents, intervention

Background

School education plays a vital role to develop an effective personality in one's life. Compilation of life skills education with school education would change the views of students about life. They can help the child to build a good personality and strengthen his/her knowledge in all settings to generate an effective future. Life skills education can be a remedial measure for eradicating the problems such as academic backwardness, communication, behavioral and emotional problems. Life skills education would provide an arena for acquiring these skills in various situations in life.

According to WHO (1997), "the abilities for adaptive and positive that enable individual to deal effectively with the demands and challenges" are called life skills.

According to UNICEF (2001) "Life-skills based education is -behavior change or behavior development approach -designed to address a balance of three areas i.e., knowledge, attitude, and skills".

Overall life skills are innumerable and the nature and definition of life skills are likely to differ across cultures and settings. However, analysis of the life skills field suggests that there are core set of skills that are at the heart of skills-based initiatives for the promotion of the health and well-being of children and Adolescents.

WHO has described ten life skills. They are

- Decision making
- Problem solving
- Creative thinking
- Critical thinking
- Effective communication
- Interpersonal relationship skills
- Self-awareness
- Empathy
- Coping with emotions
- Coping with stress

Decision-making helps to deal constructively with decisions about our lives. This can have consequences for health if young people actively make decisions about their actions in relation to health by assessing the different options and what effects different decisions may have.

Problem solving enables to deal constructively with problems in our lives. Significant problems that are left unresolved can cause mental stress and give rise to accompanying physical strain.

Creative thinking contributes to both decision-making and problem solving by enabling us to explore the available alternatives and various consequences of our actions or non-action. It helps us to look beyond our direct experience, and even if no problem is identified, or no decision is to be made, creative thinking can help us to respond adaptively and with flexibility to the situations of our daily lives.

Critical thinking is an ability to analyze information and experiences in an objective manner. Critical thinking can contribute to health by helping us to recognize and assess the factors that influence attitudes and behavior, such as values, peer pressure, and the media. Effective communication means that we are able to express ourselves, both verbally and non-verbally, in ways that are appropriate to our cultures and situations. This means being able to express opinions and desires, but also needs and fears. Moreover, it may mean being able to ask for advice and help in a time of need.

Interpersonal relationship skills help us to relate in positive ways with the people we interact. This may mean being able to make and keep friendly relationships, which can be of great importance to our mental and social well-being. It may mean keeping good relations with family members, which are an important source of social support. It may also mean being able to end relationships constructively.

Self-awareness includes our recognition of ourselves, of our character, of our strengths and weaknesses, desires and dislikes. Developing self-awareness can help us to recognize when we are stressed or feel under pressure. It is also often a prerequisite for effective communication and interpersonal relations, as well as for developing empathy for others.

Empathy is the ability to imagine what life is like for another person, even in a situation that we may not be familiar with. Empathy can help us to understand and accept others who may be very different from ourselves, which can improve social interactions, for example, in situations of ethnic or cultural diversity. Empathy can also help to encourage nurturing behavior towards people in need of care and assistance, or tolerance, as is the case with AIDS sufferers, or people with mental disorders, who may be stigmatized and ostracized by the very people they depend upon for support.

Coping with emotions involves recognizing emotions in others, being aware of how emotions influence behavior and being able to respond to emotions appropriately and ourselves. Intense emotions, like anger or sorrow can have negative effects on our health if we do not react appropriately.

Coping with stress is about recognizing the sources of stress in our lives, recognizing how this affects us, and acting in ways that help to control our levels of stress. This may mean that we take action to reduce the sources of stress, for example, by making changes to our physical environment or lifestyle. Alternatively, it may mean learning how to relax, so that tensions created by unavoidable stress do not give rise to health problems.

The life skills described above are dealt with here as far as they can be taught to young people as abilities that they can acquire through learning and practice. For example, problem solving, as a skill, can be described as a series of steps to go through, such as: 1) define the problem; 2) think of all the different kinds of solutions to the problem; 3) weigh up the advantages and disadvantages of each; 4) chose the most appropriate solution and plan how to realize it.

Review of literature

Sharma.S. (2003) has conducted a study on "Measuring life skills of adolescent in a secondary school Kathmandu; an experience". The objectives of this study were to develop a scale to measure life skills and to assess the levels of life skills in adolescents of a secondary school at Kathmandu. The study was a descriptive, cross sectional survey of adolescents, also supported by qualitative techniques with focus group discussion and interviews. Sample size of the study was 347 adolescents. Results shows that 176 adolescents (51%) had life skill scores above the mean, and was termed as having "high level" of life skills and 171(49%) had "low level" of life skills scores. Mother's education was significantly associated with increased level of life skills in adolescents (P=.001). Most of the teachers were not aware of the concept of life skills. Maternal education was significantly associated with higher life skill levels in adolescents. Connectedness and family support were other important factors influencing the level of life skills in the adolescents.

Sandhya Khera (2012) has conducted a study on "A Study Of Core Life Skills Of Adolescents In Relation To Their Self Concept Developed Through Yuva School Life Skill Programme". Objectives of the study were to study the relationship between Core affective life skills and Self-Concept of adolescents developed through YUVA School Life Skills Programme and to study the relationship between Core cognitive life skills and Self Concept of adolescents developed through YUVA School Life Skills Programme. The study investigated the relationship between self concept and core life skills selected randomly 500 adolescents studying in secondary classes of sarvodaya schools situated in south Delhi under gone for YUVA (SLP). The Major findings of the study that there is a positive co-relation between Core Affective Life Skill and Self Concept of adolescents which means those who posses these essential skills are better confidence in all aspects.

Parvathy.V. (2015) has conducted study on "Impact of life skills Education on adolescent in rural area". The objectives of the study were to know the knowledge of life skills among adolescent and to study the impact of life skills education on current knowledge level. The study was carried out in the coastal area school in the taluk of Karunagapally, Kerala, India.

A sample size of 57 was taken with 30 samples in experimental group and 27 samples in experimental group. The experimental and experiment–delayed groups were found similar in their socio-demographic status. The study has revealed significant impact of Life Skills Education training on adolescents. This opens up arena to conduct more research in this field with modifications and contextualization of training modules. Contextualization needs to cater the needs of the target group especially when it comes to the backward sections of the community.

TarunDeep Kaur2011 has conducted study on 'A Study Of Impact Of Life Skills Intervention Training On Emotional Intelligence Of College Adolescents'. The study was carried out to examine the effects of an intervention program on the emotional intelligence of college adolescents. Generalized Self Efficacy Scale, Sevenfold Emotional Intelligence Scale and Cooper Smith Self Esteem Inventory were used for pre and post test. The students who were low on test norms were selected for the EQ development program for three months. The results were analyzed using paired sample t test to examine pre post test mean difference which revealed a significant increase in the scores of EQ.

Methodology

Objectives of the present study were to assess the needs of referred children, impart the appropriate life skills and test the efficacy of the intervention**. Hypothesis of the study is that** there is a significant difference between pre and post level of life skills among high school children. The school teachers referred academically backward children for intervention. Total sample size is 15 Children, consisting of 6 girls and 9 boys.

Need Assessment and Tools for the study:

The researcher used Life skill development scale developed by M.N Vrunda was used for needs assessment. The assessment revealed that referred children had lack of skills in three domains i.e., of self-awareness, critical thinking, creative thinking. A semi-structured interview schedule was prepared to assess the demographic details of the respondents.

Need assessment and intervention plan:

Based on the need assessment researcher has planned the activities and conducted the following intervention using WHO life skills manual. (Table 1- Appendix)

Research Design:

In this study researcher adopted single subject research design, that is A-B Design. This design includes two level of assessment.

Pre intervention assessment (A)– Intervention level– Post assessment (B)

Intervention process:

As per the needs assessment, researcher has planned the intervention strategy, including activities related to the Creative Thinking, Critical thinking, and Self Awareness skills. Before starting, the activity researcher made children to make a ground rules for the sessions and all children should follow the rules. To conduct the activity researcher did the preparation such as making charts, collecting activity materials. Starting some children was not actively participated in the activities, but after some sessions researcher observed the active participation of all children. Sessions included activities such as playing games, group discussion, and acting. Last session ends up with the lighting candle and sharing feedback. After the last session researcher has given gap and collected the post intervention score, according to these scores there was a significant difference in the pre and post intervention score.

Analysis of Data:

Socio-demographic details were recorded using qualitative analysis. To know whether there is a significant difference in the pre and post scores of the PSS, the Kolmogorov-Smirnov test (Non-parametric test) was used. The academic progress was assessed by evaluating progress reports and qualitative reports which had been obtained from parents, teachers, friends and self- observation from the researcher to know the progress in other areas. Before the intervention, the informed assent was obtained from the participant and confidentiality was assured and maintained.

Results

Socio demographic details

The age group of the respondents is 14 to 15 years, majority of the respondents father's work as agriculturist, from lower socioeconomic backward, Hindu by religion (90%). About 53% mothers and 26% fathers of children have not attended formal schooling.

The **Table 2** (Appendix) explains about, effectiveness of creative thinking, Critical thinking and Self- Awareness skills intervention. The postintervention score of all three domains is higher than the pre – intervention mean. It shows an increase in the mean value. The Wilcoxon Signed Rank Test indicates a significant difference in the Pre-Intervention and Post-Intervention value. Hence, it is concluded that there is a significant improvement in all three domains.

Implications of the study

The life skills education plays crucial role towards the positive and healthy development of the adolescent. Pre and post score has shown the changes in life skills level of children. These skills make children to come up with new ideas and cope up with the various situations, which comes in day-to-day life. Researcher observed the changes in the children such as some children were not mingling with each other but during the activities children started to mingle, children started participating in activities, talking during the group discussion and lastly increase in confidence level in the communication and behavior of children.

Adoption of life skills education programme in academics will gives more knowledge towards life and it makes a children to grown up an effective personality in society.

Discussion and Conclusion

Life Skills are very important for each individual. Lack of life skills will lead to problems in the individual's life. Like Skills Education is very important from primary to higher education, especially in the stage of adolescence. The researcher has conducted Intervention with Adolescent group. The results shows that there is a significant difference between pre and post intervention scores. Life skills plays a vital role in building personality and facing the life. Identifying the children with lack of skills and conducting intervention in those areas will bring significant changes in one's life.

Some other studies have shown the positive results of life skill intervention. Most of the researcher suggested that adoption of life skill education in academics is very important and to implement properly in academic teachers should be trained in the life skills education. Sharma (2003) based on his study recommended that training of teacher in the life skill education context and policy of compulsory primary education.

References

1. Pan American Health Organization Division of Health Promotion and Protection Family Health and Population Program Adolescent Health,Life Skills Approach to Child and Adolescent Healthy Human Development.

2. Reddy's Foundation ,Life skills pursuit of Life – Life Skill facilitator Hand Book, Hyderabad

3. Sandhay Khera (2012) "Core Life Skills of Adolescents in relational to their self concept development through YUVA school life skill programme", International journal of social science and interdisciplinary research, vol I, November issue 2012, ISSN page no 116125.

4. S (2003) "Measuring life skills of adolescents in a secondary school of Khathmandu", Kathmandu University Medical Journal (2003) Vol 1, Issue 3 page no 170-176.

5. Parvathy (2015) 'Impact of life skills education on adolescent in rural area" International journal of advanced research 2015, Vol 3, Issue 2, Page no 788-794

6. TarunDeep Kaur2011 has conducted study on 'A Study Of Impact Of Life Skills Intervention Training On Emotional Intelligence Of College Adolescents'. Indian Journal of Psychological Science, December-2011, V-2 (2) (112-125)

Appendix

Table 1

Sl	Activities	Skills	Intervention Methodology	No. Of Session
1	Pass the feelings	Critical thinking	Act, playing game, group discussion	1
2	Relationship map	Critical thinking	Drawing relationship map, group discussion, playing games	1
3	I love my self	Self-Awareness, creative thinking	Group discussion, painting, group discussion	1
4	I Wish I hope	Self-Awareness, creative thinking	Group Discussion, meditation	1
5	Value voting	Critical thinking	Playing game, group discussion	1
6	Bad touch	Self-awareness, critical thinking	Video presentation, group discussion, act	1
7	Book of me	Self-Awareness, creative thinking	Making children to write about their life in book and presentation, Group discussion	2

Table 2

Skill	Level Of Assessment	Mean	Std. Deviation	Minimum	Maximum	Wilcoxon Signed Ranks Test
Creative Thinking	Pre Test	48.87	9.149	32	62	Sig. (2-tailed)
	Post Test	55.07	5.994	46	66	.001
Critical Thinking	Pre Test	33.60	4.823	24	41	Sig. (2-tailed)
	Post Test	38.13	3.623	33	46	.003
Self Awareness	Pre Test	36.53	5.502	30	18	Sig. (2-tailed)
	Post Test	42.60	3.355	34	47	.005

Brief Communication

Hybrid Training: e-learning model in Promotion of Mental Health

M. I Singh Sethi[1], Meena K.S.[2*] Sharmitha Krishnamurthy[1] Suvarna Agrawal[1] Xavier B.[1]

Fellowship Scholar Department of Mental Health Education, NIMHANS, Bangalore
Associate Professor, Department of Mental Health Education, NIMHANS, Bangalore

***Address for Correspondence:* Meena K.S,** Associate Professor, Department of Mental Health Education, M. V. Govindaswamy building, NIMHANS, Hosur Road, Bangalore-560029, Phone Number: +91 8762689735, email: meenaksiyer@gmail.com

Key words: e-learning, Mental Health Education, Promotion, Mental health, Training

Background

This is the era of technology; the world is getting smaller thanks to the internet. It is impossible to think of life without the internet. Internet has become an indispensable part of all industries and in the last decade has been widely incorporated in the healthcare sector. It shouldn't come as a surprise to anyone that internet is increasingly being used and accepted as a medium for mental health service delivery across the world. Since, internet has the potential for providing universal interventions and promoting the psychological wellbeing.

The Virtual Knowledge Network at NIMHANS-ECHO (HUB and SPOKEs) is been running in collaboration with Project ECHO, University of New Mexico, USA. In this model there are weekly live multi-point video conference sessions for Doctors in the periphery ie. The General practioners (GP) working in PHC's. The GP's get an opportunity to present clinical cases & get suggestions / guidance from the network Expert didactic modules covering various addictive disorders are carried out for these GP's. The GP's are awarded with a certificate of completion /CME points on completion of module evaluation.

VKN hybrid training is one of a kind training programme in India, which is helping medical, mental health and allied professionals to come under one roof through the power of internet and technology advancements. This way the people from various diversities come under one channel and share and learn new theories, concepts and their experiences of the cases they see during the practice. The challenges of working with a virtual session range from adapting existing teaching/skilling behaviors to competing for participant's/learners attention in an environment that one has limited control over. The benefits of the hybrid training synergize to offer a unique skilling experience to the learning champions.

Observations

The scholars of one-year Fellowship in Mental Health Education were posted in the Virtual Knowledge Network at NIMHANS, to learn and understand how use of virtual learning can become an innovative mode to enhance training and learning in the field of mental health education,

among masses staying at different parts of the country.

In spite of belonging to diverse backgrounds, the VKN posting was a new experience for all the Fellowship scholars. The one month rigorous posting at the Virtual Knowledge Centre gave them an insight of the potential of e-learning in terms of promoting Mental Health Education. The scholars also witnessed, how much work goes into making the virtual lessons available to the participants, behind the scenes of the live sessions which were conducted twice a week along with the technical difficulties the team had to face and the brilliance with which the overcame it.

During the VKN sessions it was also observed that, online health education has the potential to be the best of both worlds – to counter some of the barriers that prevent some people from seeking formal professional help by providing anonymity and easy access, while providing more in-depth and evidence-based information and guidance which might not be received from other informal sources such as friends or family members a finding which was also reported in other studies.[1]

Implications

In the past decade, there has been increasing interest in the use of the internet as platform for the delivery of public health interventions. Thus far, positive outcomes have been reported in RCTs of internet interventions across a wide range of clinical outcomes including and not limited to mental health problems1 [2] In this regard, The Department of Mental Health Education, NIMHANS simulating the Virtual Knowledge Network (VKN) model has planned to roll out a virtually interactive training session "First Aid for Mental Health" with the objective of giving people, a set of basic skills to assess those at risk for developing mental health problems and to provide initial assistance. At the end of the session, the participants would benefit by being able to spot the early signs that could lead to a mental health problem, feel confident helping someone experiencing a mental health problem, provide help on a first aid basis, help stop a mental health problem from getting worse, help someone recover faster and guide someone towards getting the right support.

This course is being developed targeting professionals, non-professionals, students and care-givers in the community. This course has been successfully running in real time by the Department of Mental Health Education, for the past 2 years and more than 400 people have been trained in this programme. Due to an increased demand from the people across the country and abroad the department has taken the initiative to start with this e-learning program.E-learning is a computer based educational tool or system that enables you to learn anywhere and at any time.

Today e-learning is mostly delivered though the internet, although in the past it was delivered using a blend of computer-based methods like CD-ROM. Technology has advanced so much that the geographical gap is bridged with the use of tools that make you feel as if you are inside the classroom.[3]E-learning offers the ability to share material in all kinds of formats such as videos, slideshows, word documents, PDFs or a Videoconference. Hybrid training model includes all these methods to impart knowledge and education.

Strengths & Limitations

The success of the e-learning model depends on two reasons. We'll first talk about the **Pragmatic Reasons** which makes the model stand out, reduced travel costs for trainers and trainees, being able to deploy training quickly and the facility of reaching out to a wider population in a small time. The second are the **Instructional Reasons** which make the model more effective than other tools. The option of having a real-time interaction between learners and instructor, the option of content

visualization and the most important is collaboration among participants and moderate social presence. All these reasons are imperative for the success of the e-learning model in mental health setting.[4]

To make it simple, imagine a real life scenario in a classroom. In an effort to enhance the credibility of course material, oftentimes a professor will summon a field specialist to give a lecture relevant to the topic at hand. In the traditional model of education, the professor would have to extend an invitation to said expert, and incur the costs of his flight, stay and training. With e-learning the professor has the ability to host a guest lecture without having to spend much money. It can be done virtually, with cameras for both the lecturer and the students, and with the use of microphones to facilitate the same level of interaction that would be possible if the lecturer were physically present in the room. The added benefit comes in when we are able to replay the lecture and gain even more out of it. Students that missed out can view the recording, or students that attended can watch it again to further their understanding.

This model has its own share of challenges and shortcomings. To name a few, there are a lot of technical issues one can experience with this platform, someone who is not technology savvy is in for a lot of trouble. The lack of interaction and engagement with participants is also a drawback of this model, although some might argue it is a blessing in disguise for people with social anxiety, but for most of the people basic human interaction is important and not everybody is comfortable sitting alone and learning. Moreover, practical skills are somewhat harder to pick up from online resources. There are some health concerns also, e-learning requires the use of a computer and other such devices; this means that eyestrain, bad posture and other physical problems that may affect the learner. Another difficulty with this platform is the lack of awareness in the community about such programs. The most important hurdle is preparing instructors to deliver training virtually, because the best of the minds in our country have a lot of catching up to do with technology and as already mentioned most of the people are of the school of thought that traditional blackboard teaching is the most effective.

Conclusion

Some of the most important developments in education have happened since the launch of the internet. This is the twenty first century and in this age of technology and globalization people use the internet for everything from learning how to cook on YouTube to getting knowledge on various diseases they might be suffering from on Medscape. There is a need for a reliable repository of information for the masses, which gives them appropriate, scientific and trustworthy information. Although the potential for broad population reach with Internet interventions is substantial, the current (albeit limited) evidence suggests that there are low levels of actual reach across a range of settings specially health care.

That is where e-learning modules come into picture. E-learning is here to stay, as computer ownership grows across the globe e-learning has become increasingly viable and accessible. Internet connection speeds are increasing, and with that, opportunities for more multimedia training methods arise. With the immense improvement of mobile networks in the past few years and the increase in telecommuting, taking all the great features of e-learning on the road is a reality with smartphones and other portable devices. Since they are very simple to use, easily accessible and not very difficult to update and maintain. It is the future of education in general and Mental Health Education in particular.

References

1. Griffiths F, Lindenmeyer A, Powell J, Lowe P, Thorogood M. 2006. Why are health care interventions delivered over the Internet? A systematic review of the published literature. J. Med. Internet Res. 8:e10

2. Bennett, G. G., & Glasgow, R. E. (2009). The delivery of public health interventions via the Internet: actualizing their potential. Annual review of public health, 30, 273-292

3. The New Virtual Classroom: Evidence-based Guidelines for Synchronous e-Learning, Ruth C. Clark, Ann Kwinn; ISBN: 978-0-7879-8652-0; March 2007, Pfeiffer

4. E.(2014). E-learning Concepts ,Trends, Applications (Vol. V 1.1) Retrieved September 22, 2017 from www.efrontlearning.net

View Point

Laying the foundation for a robust Public Mental Health with Mental Health Education

Krishnamurthy Sharmitha[1], Meena K.S.[2*], Kapanee Aruna, R. M. [3]

Fellow, Department of Mental Health Education NIMHANS, Bangalore
Associate Professor, Department of Mental Health Education NIMHANS, Bangalore
Assistant Professor, Department of Clinical Psychology NIMHANS, Bangalore

***Address for Correspondence:* Meena K.S**, Associate Professor, Department of Mental Health Education, M. V. Govindaswamy building, NIMHANS, Hosur Road, Bangalore-560029,
Phone Number: +91 8762689735, Email:meenaksiyer@gmail.com

Abstract

Mental illness places a huge socioeconomic burden on the community and is hence a major public health issue. One in four adults suffers from some or the other forms of mental illness in any given year. Mental Health along with physical health accrues the strong foundation for lifelong health and wellbeing. Shortage of Mental Health services is an issue of significant concern with Mental Health Systems becoming overburdened and short-staffed. One cost effective way of reducing this ever-increasing burden is by early prevention and promotion in mental health. Public Mental Health primarily works on promotion of mental health that allows people to embrace healthy lifestyles and foster environments that are conducive of good health. Mental Health can be enhanced by effective public health interventions. One of the core essential and important services of Public Health is Policy development through Information, Education, and Empowerment of people about health issues using culturally appropriate Health Education methodologies. This can bring down the stigma by creating awareness on prevalence of various Mental Health problems and services available that would enable one to reach out and seek help at the right time. Sharing the knowledge and skills more efficiently through good Mental Health Education practices can enhance the Mental Health literacy of the population and thereby contribute to the overall public Mental Health.

Key words: Public Health, Mental Health Education, Public Mental Health

Background

Good Mental Health lays the foundation to accrue good physical health; for without the former, one cannot fully achieve the latter. Mental illnesses contribute to the substantial burden of diseases worldwide. Mental Health issues are rising in the community at alarming levels and most illnesses affect the young and productive age groups of population, leading to increased disability burden, as well as the socioeconomic burden. Poor working knowledge and understanding of mental disorders in many communities have time and again been highlighted in studies conducted in India and across the globe. In the town of Agaro in Ethiopia, researchers had conducted studies to assess the perception of Mental Health problems by a community. Results showed a significant number of people had connected supernatural powers as causal agents of various Mental Health problems. This finding resonated with the findings of other studies conducted in Ethiopia and other African studies[1]. Developing countries like India and Morocco have studies to indicate diverse attributions of the symptoms of schizophrenia such as supernatural events, difficult life events, use of drugs and heredity or personality deficiencies [2]. Similarly in Iraq, one study indicated that the population did have a fair understanding of the various causes of mental illness, wherein although God's punishment and personal weakness were viewed as a significant cause, other causes mentioned were genetic factors, brain disease, negative life events, and substance abuse[3]. Hence, large-scale public health measures targeting the community at large, with multi-pronged strategy addressing the preventive, promotive, treatment and rehabilitation approaches will be beneficial. Facilitating empowerment through enhancement of knowledge, attitude and beliefs regarding the prevention, early recognition, and management of Mental Health problems commonly referred to as Mental Health Literacy (MHL) is crucial[4]. Mental Health professionals need to share their knowledge and skills more efficiently through good Mental Health Education practices and enhance the Mental Health literacy of the population and thereby contribute to the overall public Mental Health.

Connecting the Dots - Health, Mental Health, Public Health and Health Education

The definition of Health as articulated by the World Health Organization (WHO) is "a state of complete physical, social and mental wellbeing and not merely the absence of disease or infirmity"[5]. Health, in the wider context, is an interface of body and mind, with an equal balance placed on a constructive social environment and wellbeing, harnessing elements of happiness and prosperity. WHO defines Mental Health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"[6].Public health is the "science and art of preventing disease, prolonging life and promoting human health through organized efforts and informed choices of society, organizations, public and private, communities and individuals"[7]. Public health is incomplete in the absence of Public Mental Health and investing in the same can enhance population well-being and decrease vulnerability against illness, aid in recovery, reduce stigma thereby contributing to decreased prevalence of mental illness. Public Mental Health utilizes a life course approach, which is also systemic in nature when focusing on goals of prevention and promotion. In the broader realm of public health, Health Education is a focused sub-discipline, and is defined as "consciously constructed opportunities for learning, involving some form of

communication designed to improve health literacy, including improving knowledge, and developing life skills which are conducive to individual and community health"[8].The definition incorporates health literacy component whereby an individual is empowered to make decisions w.r.t to his/her own health including changing lifestyles and living conditions.

Evolution of Health Education

The very fact that an individual's behavior is critical to sowing the seed of 'Health' provided the impetus to the origin of Health Education as a skilled scientific field in itself. Traditionally, when health was conceptualized as merely an absence of disease, Health Education was completely based on prescriptive medical practice model, that was more a one-way path with no active participation from other key stakeholders. This was often labelled as a medical approach[8].This highly influential approach did not take into account socioeconomic and cultural factors of behavior change and nuances of individual decision-making process w.r.t health.This seriously started to wobble the primary objective of Health Education. With no effective outcomes being noticed, the focus shifted to behavioral determinants of health, which was a major breakthrough, as health began to be considered as the sole prerogative of the individual and it is the individuals' decisions on their lifestyle that would ultimately lay the path for a healthy life. Health Educators were brainstormed to take a rejig at the level of program planning to include individuals in the community as key stakeholders alongside health professionals where the latter function more as facilitators than being decision makers for meeting individual health goals. This paved the way to initiate data collection through Mental Health Education may be targeted at various audiences like teachers, adolescents and professionals through various mediums, online and off line, through promotive, preventive or educative approaches. It is also imperative to evolve Mental various means such as focus group discussions, in-depth interviews and surveys from intended target populations, in order to understand their attitudes, beliefs, practices and needs on health related topics; their limitations on the practical applications of behavioral lifestyle modifications, as well as socioeconomic determinants of health. Individuals were then suggested to make changes in their behaviors based on the information collected from them and in a manner that was conducive to their socio cultural milieu. This led to major shift in the manner in which Health Education was delivered, from a top-down to a collaborative and participatory approach.

Mental Health Education in the realm of Public Health: Going forward

Health Education is crucial to Public Health. Mental Health problems are a major public health issue. The National Mental Health Survey of India 2015-2016 grossly estimated the mental morbidity for adults as 10.6% and the lifetime prevalence as 13.7%[9]. An estimated 150 million people in the country need Mental Health intervention at some point of their lifetime, including both acute and chronic care, in both the urban and rural populations. There is a marked lack of Mental Health awareness in the country, which combined with other factors such as stigma, diverse culture, ethnicity, comorbid illness, limited human resources for Mental Health care and poorly integrated service delivery systems, leads to poor Mental Health care. Thus, going forward Public Mental Health requires a robust foundation of Mental Health Education to maximize the impact on the Community. Mental Health can be effectively enhanced by Mental Health Education interventions.

Health Educators who would be individuals in the community who may or may not be Mental Health professionals and who could be more practically effective in engaging their community Developing a group of Mental Health Educators, such as college

students, homemakers, industrial workers, would be useful as they would cater to their respective community sub-groups or to the larger community by increasing awareness about the presence of wide spectrum of mental health problems, common myths and misconceptions about the same, resources and treatment options available. All these lead to enhanced help seeking behavior amongst members of the community. Mental Health Educators could also significantly contribute to the betterment of the community by being vocal advocates of right to autonomy, right to seek information about treatments, exclusion brought about by stigma associated with mental disorders, importance of promotion and prevention in schools, places of work and neighbourhoods, necessity for services that would facilitate active community engagement and violation of human rights of those suffering with mental disorders. Mental Health Educators need to be grounded to reality and take a holistic path in increasing the health literacy of the target population. Both Health practitioners and Mental Health Educators need to work hand in hand to spin the bio psycho socio economic wheel to address the wide array of determinants of health. When Mental Health-related interventions are planned and implemented in the community, Mental Health Educators can be key stakeholders and be involved in the monitoring, evaluation, and communication of the crucial outcomes. The feedback loop thus helps to separate out the ineffective strategies and thereby preventing wastage of valuable resources. Mental Health Educators need to develop the skills to convene and manage Mental Health-related debates, develop the sense of accountability among a variety of stakeholders. Mental Health Educators need to collaborate and develop new partnerships that can together complement each other in working towards the Mental Health promotion of the community. Leveraging on their potential multitasking community engagement skills, they could bridge the gap between the public and policy makers to make health-related decisions in the best interest of the community. Mental Health Education and Mental Health Educators could thus play a crucial role in filling the void of public Mental Health thereby minimizing the health disparities.

References

1. Deribew A, Shiferaw Y. How are Mental Health problems perceived by a community in Agaro town? Ethiop J Health Dev. 2005; 19: 153-159.

2. Zafar SN, Syed R, Tehseen S, Gowani SA, Waqar S, Zubair A, et al. Perceptions about the cause of schizophrenia and the subsequent help seeking behavior in a Pakistani population – results of a cross-sectional survey. BMC Psychiatry. 2008; 8: 56.

3. Sadik S, Bradley M, Al-Hasoon S, Jenkins R. Public perception of Mental Health in Iraq. Int J Mental Health Syst. 2010; 4: 26

4. Jorm AF. Mental Health literacy: public knowledge and beliefs about mental disorders. British Journal of Psychiatry. 2000; 177:396-401.

5. World Health Organization, Promoting Mental Health: concepts, emerging evidence, practice http://www.who.int/mental_health/evidence/MH_Promotion_Book.pdf, retrieved February 01, 2017.

6. Winslow, Charles-Edward Amory. "The Untilled Field of Public Health". Modern Medicine.1920; 2: 183–191.

7. World Health Organization Health promotion glossary.

WHO/HPR/HEP/98.1Distr.: Limited. WHO 1998

8. Fielding, J. E. Health Education 2.0. Health Education& Behavior, 2013; 40(5), 513-519.

9. Gururaj G, Varghese M, Benegal V, Rao GN, Pathak K, Singh LK, et al. National Mental Health Survey of India, 2015-16: Summary. National Institute of Mental Health and Neuro Sciences, NIMHANS, Bengaluru; 2016.

Funded by DR. R.N. MOORTHY FOUNDATION

Mental Health Education
NIMHANS, BANGALORE, INDIA