

The Potential Impact of Family Life Education and Lay Counselor Training on Poverty in Developing Countries: The Example of India

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Approximately one third of the world's 1.2 billion poorest people on earth live in India. It is home to more people living in poverty than any other country in the world. Although overall poverty rates in India have decreased in the past several decades because of India's emphasis on poverty reduction and community development since independence, the number of people at or below the poverty line remains in the hundreds of millions. Poverty in India, as in many developing countries, is not just the absence of income but the presence of an ongoing state of helplessness, hopelessness, powerlessness, inequality, and marginalization of the poor. This article examines how Lay Counselor Training and Family Life Education can have a potentially powerful and long-lasting impact on the socio-economic development of individuals, families, and communities in India. The authors highlight how professionally trained Indian counselors and family life educators, in cooperation with NGO's and professionals from other areas of the world, can help reduce poverty and enhance healthy human development through the training of lay persons in both rural and urban areas, and how these efforts can, in turn, potentially augment the economic conditions of families and communities. These effects become mutually reinforcing since the economic development of families and communities is also likely to enhance the mental and emotional health of family members and the overall resilience of the family. Hence, a multimodal approach to poverty reduction is needed. In this article India serves as an example for other developing countries.

Key Words: India; poverty reduction; developing countries; lay counselor training; family life education


Introduction

According to the World Health Organization (WHO) poverty is the greatest cause of suffering on earth. WHO estimates are that approximately 1.2 billion people in the world live in extreme poverty (less than one dollar per day). Poverty contributes greatly to various illnesses because of living conditions that involve a lack of nutritious food, decent shelter, clean water, adequate sanitation, and available or satisfactory health care (World Health Organization, 2018). The impact of poverty on human health and welfare in developing countries such as India is particularly alarming. Although the alleviation of poverty has been a major focus of policy makers ever since India became an independent nation, poverty in India continues to be a pervasive phenomenon (Katyal, 2015; Udin, 2015). Poverty in India, as in other developing countries, is not just the absence of income but the presence of an ongoing state of helplessness, powerlessness, inequality, and marginalization that is caste, class, and gender based (Katyal, 2015; Rao, 2013).

Although there is empirical evidence that some

developing countries (e.g., Botswana; Ghana; Brazil; Peru; Cambodia; Costa Rica) have made strides forward in reducing poverty (Fosu, 2010; Joshi, 2012), hundreds of millions of families around the world today still do not have adequate health care, nutrition, education, shelter, drinkable water, and other critical elements that promote healthy development (Shah, 2013; World Bank, 2016). According to UNICEF (2016; 2010), between 22,000 and 25,000 children die each day because of poverty related conditions. Close to 30 percent of all children in developing countries are estimated to be underweight or undersized (World Hunger and Poverty Facts and Statistics, 2016). Almost

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half of the world (over 300 billion people) live on less than \$2.50 per day, with South Asia and sub-Saharan Africa accounting for much of the deficit (Joshi, 2012; Shah, 2011). It is estimated that more than 80% of the world's population lives in countries where income differentials are increasing rather than decreasing (Chen & Ravallion, 2008; Shah, 2011).

Strategic programs designed to reduce poverty and enhance all aspects of human development in both urban and rural areas can be categorized as *direct* or *indirect*. Specialists in academic disciplines and professional training programs in India that are not directly aimed at alleviating poverty, such as those in Family Life Education (FLE) and the field of counseling, often wonder how they can have an impact on poverty reduction and the economic development of individuals and families. A close examination reveals that there has been a steady increase in these academic training programs in India, as well as employment opportunities for counselors and family life specialists, the past couple of decades (Carson & Chowdhury, 2000; Carson, Jain, & Ramirez, 2009; Carson, Carson, & Chowdhury, 2007; Chowdhury, Carson, & Carson, 2006; Chowdhury, 2011). Family life specialists are commonly trained at the undergraduate and graduate level in programs such as Home Science (Human Development, Family Studies, and Family Resource Management), Social Work, Psychology, and related fields. Counselors and therapists are typically trained at the graduate level in Clinical and Counseling Psychology, Social Work, Marriage and Family Therapy, and in more recent years in India, Counselor Education. Indians trained in these disciplines can partner with professionals outside the country in a nation-wide effort to build stronger marriages and families, as well as to train to lay counselors who can make a measureable difference in the mental and emotional health of children and adults in both rural and urban communities.

The purpose of this article is to examine how more indirect strategies of poverty reduction and community development, specifically Lay Counselor Training (LCT) programs and Family Life Education (FLE), can have a potentially powerful and long-lasting impact on the socio-economic development of individuals and families in India. Specific examples will highlight how a training-the-trainers approach to LCT and FLE conducted by Indian citizens themselves, and supported in part by the international community both financially and in terms of human capital, can help reduce poverty and enhance healthy human development. As Udin (2015, p. 17) notes with regard to India, "Economic growth and employment opportunities in themselves may not be sufficient to improve the living conditions of the poor. They need to be accompanied by measures that enhance the social

and physical conditions of existence". Of course, it is important to acknowledge that improved economic circumstances of individuals and families (including and perhaps especially the poor) have the potential to influence the mental and emotional health of children and adults in the immediate and extended family system as much as the overall emotional and relational health of family members can impact the economic situation of the family and community. In one sense it does not matter which comes first, the chicken or the egg, as the economic and social-emotional conditions of the family and community are intimately intertwined.

Breaking the Cycle of Intergenerational Poverty

In the year 2000, the Millennium Summit of the United Nations General Assembly made an historic global commitment to end poverty. The leaders pledged that they would reach specific goals for reducing poverty by 2015, resulting in the "Millennium Development Goals". The World Bank's Report of 2000/2001 identified not only a lack of income and assets as central to poverty, but also low levels of health and education, vulnerability and exposure to risk, insufficiency of political and social voice, and powerlessness. In addition to a focus on income generation, poverty issues have typically been examined with an emphasis on discrete groups, such as children, women, rural dwellers, and indigenous people. In contrast, a broader focus on the interconnectedness of the lives of poor mothers, fathers, and children can lead to a greater understanding of the chronic poverty that is transmitted from one generation to the next in developing countries.

Joint efforts by adults and youth, according to International Center for Research on Women or ICRW (2003), may be the key to breaking the intergenerational cycle of poverty. To build awareness of the intergenerational cycle of poverty and support for necessary action, the ICRW identified four key areas to end the cycle of poverty. These include:

- Equal opportunities for girls in education, women and youth in employment.
- The need to build intergenerational alliances within families and communities.
- Adequate sexual and reproductive health and rights options for women and youth.
- The need to ensure a stronger role for civil society and for good governance.

In India, although most of these issues are being addressed at the central and state governmental level as policy decisions to reduce poverty, the successful implementation of these policies remains in question. Due to over population, lack of adequate governance,

political interferences, and corruption at the local, state and national level, minimal successes or failures in all targeted areas are evident in the majority of developing countries of the world.

Poverty in India

Approximately one third of the world's billion-plus poorest people on earth live in India according to the U.N.'s Millennium Development Goals report (Bhowmick, 2014). Forty-six percent of malnourished children in the world live in India, and India had the highest number of under-five deaths in the world in 2012 (1.4 million children). According to some researchers, overall poverty rates in India have decreased the past few decades, including in more recent years. For example, a review by Guduri (2017) of a Report of the Expert Group to Review the Methodology for Measurement of Poverty sponsored by the Planning Commission of India (2014) indicated that the overall number of individuals in poverty in India went from 407.1 million in 2004-2005 (37.2 %) to 354.7 million in 2009-2010 (29.8%) to 269.8 million in 2011-2012 (21.9%). Guduri notes that the percentage of both rural and urban poor showed a steady decline during these years. However, these may be conservative estimates. Others have argued that the number of poor in India still remains in the hundreds of millions (Rao, 2013; Ruhl & Revenga, 2016), and that there is evidence that almost one third of the country's population of close to 1.3 billion continues to live near or below the poverty line even though the country's poverty rate is only about half as high as it was three decades ago (Azad India Foundation, 2017; Lalmalsawma, 2013). Hence, estimates of poverty in India continue to vary.

A large proportion of poor people live in rural areas, with poverty remaining a chronic condition for almost 30 per cent of India's rural population. Poverty is most prevalent among members of Scheduled Castes (SC's) and Scheduled Tribes (ST's) in India's rural areas, as well as among the urban slum people. The poorest states are found predominantly in the northern parts of the country: Chhattisgarh, Bihar, Jharkhand, Odisha, West Bengal, Uttar Pradesh, Rajasthan, Madhya Pradesh, and Uttarakhand (Bhowmick, 2014; Lalmalsawma, 2013). These states together have high percentages of ST's and SC's. The context of poverty continues to evolve over time, especially in India in relation to the fast changing social norms, ethos and values. These changes happen mainly because the multi-cultural, multi-lingual, multi-religious, and multi-political and economic climate has far reaching consequences.

Rural poverty conditions in India, according to the

Poverties website (2013a), involve the following: (a) 50% of these Indians do not have proper shelter; (b) 70% do not have access to decent toilets (which contributes to bacteria related diseases); (c) 35% of households do not have a nearby water source; (d) 85% of villages do not have a secondary school; and (e) Over 40% of these same villages do not have proper roads connecting them. These statistics bear witness to the fact that geographic isolation creates not only physical distance between the majority of Indians and government based programs and services, but psychological barriers and emotional distance as well. As with many developing countries, urban poverty in India is also a direct effect of rural migrations fleeing from poverty (Poverties, 2013b).

Poverty alleviation programs in India differ depending on whether they are intended for rural areas or urban areas (United Nations Development Programme, 2018). Along with urban slum development programs, most poverty reduction programs are designed to target rural poverty since 75% of the poor in India live in rural communities (Mondal, 2018; Skyskool, 2016). Most prone to poverty in rural areas are families engaged in agricultural employment and marginal self-farming, as well as those who are day service laborers or self-employed in small businesses (Pathak, 2014; Poverty, 2013a). Personal, demographic, socio-economic, and environmental factors (especially in rural areas) that interact with being poor include: unemployment; poor health; substandard living conditions and housing; gender inequality; inadequate educational systems; low literacy rates; child labor practices; the failure of village industries to compete with corporate industries and factories in terms of quality and price of goods; a lack of socio-political power to enact positive change; exposure to corruption at all levels of society; widespread contamination of market areas due to black money; exploitation of the poor by the wealthy in both rural and urban sectors; unequal distribution of land and other assets, and scarcity of land ownership; growing indebtedness of rural Indians who depend on borrowings from the money-lenders and land-lords to meet even their basic needs and expenses; restricted access to productive assets; natural disasters resulting in excessive flooding, drought, and the destruction of homes and communities; and caste membership that results in oppression to specific groups and communities of people; to name a few. In addition, many people (again, especially in rural areas) do not practice family planning for religious, social, or economic purposes, thus forcing parents to care for large numbers of children. Hence, poverty becomes a self-reinforcing cycle across the generations that becomes exceedingly difficult to break.

The Culture of Poverty and Learned Helplessness

According to Dixon and Frolova (2012, p. 1), “Being in existential poverty means living in a state of, or near, persistent material poverty while also being socially excluded, marginalized, or disadvantaged. It is a life-disempowering experience, one that privileges both immediacy over the future and welfare over work. This results in learned helplessness, manifesting as a lack of will to take control of life. The existentialist explanation is that those in this mental state do not have an authentic way of life”. In cases of poverty, the resources are fewer, resulting in less ability to avoid and face repeated trauma or negative experiences in life that contribute to learned helplessness. Learned helplessness then tends to be passed down in families, without people being aware. Such is the case among the rural poor and urban slum population in India. Since learned helplessness is a mindset associated with poverty, it can continue for generations in the family even if members obtain gainful employment and eventually work themselves out of poverty per se.

In addition, because of the “*reservation policy*” enacted by the Government of India, people below the poverty line, which includes the Scheduled Caste and Scheduled Tribe population, often want to continue in the same manner to get the benefits from this policy. This deep-seated sense of learned helplessness continues today in realms that may not be directly related to work. Much of the time, learned helplessness of people in poverty is related to a loss of personal identity and control over their life. The consequences of generations of these experiences sometimes include suicide, intra-familial abuse, criminal activities, alcoholism, depression, and other social maladies (Mohanty, Pradhan, & Jena, 2015).

Direct and Indirect Approaches to Poverty Reduction in India

Strategic programs designed to reduce poverty and enhance all aspects of human development in both urban and rural areas can be categorized as *direct* or *indirect*. Examples of direct efforts to reduce poverty in India have included, for example: available and appropriate education for children at all levels; literacy education for parents and other caregivers; improved widespread healthcare; access to microfinance loans to support cottage industry and small business development; the enhancement of sustainable agricultural technologies, irrigation, and life stock rearing; and the promotion of rural non-farm employment, to name a few. However, as Ruhl and Revenga (2016) have noted, we cannot assume that economic growth alone will automatically

translate into more optimal human development outcomes. According to these investigators, the recent past demonstrates that problems such as under-nutrition and open defecation are endemic and not confined to the poor, as is environmental pollution in parts of the country which has catastrophic effects on people's health (Ramachandran, 2012; Tyagi, 2017). Thus, some aspects of the life of the poor in India have not, and in all probability will not, improve with economic development alone.

Other *direct* poverty reduction and community development strategies in India the past few decades, although not an exhaustive list, include the following (see United Nations Development Program, 2018): (1) Available and affordable housing in both rural and urban areas; (2) Strategic programmatic engagement for the poor at the state level; (3) The creation of employment and entrepreneurship opportunities, especially for Women; (4) Improving efficiency of health care systems in multiple states, including support for newborn and infant healthcare services; (5) Governance and accelerated livelihoods support in states such as Chhattisgarh, Jharkhand, and Odisha; (6) Increasing access to HIV/AIDS prevention and care for vulnerable people; (7) Strengthening national capacities in tribal areas; and (8) Improving efficiency of vaccination systems in multiple states. Although there is evidence that these kinds of strategies can and do make a positive difference in the lives of both rural and urban poor (see, for example, Planning Commission: Government of India, 2015), India remains in great need of ongoing partnerships between community members and both governmental agencies and NGO's in an effort to reduce poverty and augment development. One successful example in rural India has been the establishment of Agricultural Development Centers throughout the country. This project, known as Krushi Vikash Kendra (KVK), provides people involved in various aspects of agriculture with the modern technological know-how of improving their overall quality of life. However, indirect strategies that can decrease poverty rates and enhance individual and family development also need to be promoted and enacted throughout the country. Two such efforts include lay counselor training and family life education.

Associations Among Poverty, Mental Health, and Substance Abuse in Developing Countries

According to the World Health Organization (2016), about 450 million people globally suffer from a mental health disorder, and seventy-five percent of that population live in developing countries with little or no access to treatment. Both government and non-governmental organizations (NGO's) tend to focus

more on concrete issues related to poverty reduction and community development than on mental health issues. Thus, people who suffer from mental and emotional disorders in developing countries often do so in isolation because of the stigmatization and shame associated with mental illness in their families and communities, coupled with the scarcity of counseling and treatment-related services (Stutterheim, 2015). Moreover, any attempt to provide counseling or therapy for the masses is a relatively new phenomenon in India, and there are multiple taboos against individuals and family members revealing family secrets or weaknesses and seeking help from someone outside the family who is a counseling professional. Typically people seek the guidance and assistance of older family members or religious leaders who may or may not be that helpful to them.

The United Nations (2018) estimates that worldwide approximately 85 to 90 percent of the children and adolescents who experience a mental health issue live in low-income countries. Health emergencies and natural disasters that cause lasting stress and trauma often exacerbate mental health problems for children and families living in impoverished environments. Relief efforts often overlook or are not able to adequately address mental health issues after these kinds of events. The World Health Organization's (2016) approach to promoting mental health in resource limited countries includes strengthening families and communities, creating supportive and capacity building environments, developing personal and life skills, providing early childhood development and health services, and empowering women.

Mental Disorders and Substance Abuse as Associated with Disability and Reduced Work Productivity in Developing Countries

The relationship among mental illness, addictions, lost work productivity, and quality of life in developing countries such as India is significant (see Nadkarni, Vellerman, Dabholkar, Shinde, & Bhat, 2015; Nadkarni et al., 2015; Thara, 2002). Results of the Global Burden of Diseases (GBD), Injuries, and Risk Factors Study of 2010 (Whiteford, Degenhardt, Rehm, Baxter, & Ferrari, 2013), sponsored by the WHO, revealed a strong connection between mental disorders, substance use disorders, and three major criteria. These included: disability adjusted life years (DALYs), years of life lost to premature mortality (YLLs), and years lived with disability (YLDs). Mental disorders (most notably depressive disorders and anxiety disorders), and alcohol and drug abuse, were the leading causes of YLDs worldwide and other GBD indicators. Further, the burden of mental

disorders and substance use disorders increased by 37.6% between 1990 and 2010 worldwide, which was partly perpetuated by population growth and aging (Whiteford et al., 2013) – both characteristic of rapid growth countries such as India.

Other studies have shown that 3.8% of all global deaths and 4.6% of global disability-adjusted life years were attributable to alcohol abuse alone (Rehm, Mathers, Popova, Thavorncharoensap, & Teerawattananon, 2009). The social harm resulting from alcohol abuse accounts for a major added proportion to health costs. Hence, there appears to be a definite link between mental disorders and substance abuse with disability and lower work productivity, including in the developing world. In India, “vote bank” politics also contribute significantly to substance abuse among rural, tribal, and urban slum dwellers. Improvement in population health is only possible if developing countries, including India, make the prevention and treatment of mental disorders and substance use disorders a public health priority ((Nadkarni, 2018; Nadkarni, et al, 2015; Stutterheim, 2015; Whiteford et al., 2013).

Overview of Mental Health and Family Problems in India

People in India are experiencing many of the same personal and relational difficulties that can be found in many parts of the world today (Carson, 2017; Carson, Jain, and Ramirez, 2009; Carson & Chowdhury, 2006; Carson, Carson, & Chowdhury, 2007; Chowdhury, 2011; Chowdhury, Carson, & Carson, 2006; Sonpar, 2005). These problems include, but are not limited to: family and couple conflict stemming from a host of factors (including, for example, inter-caste marriages, and conflicts within or among families over dowries, difficulties with in-laws, etc.); problems with communication in marriages and families; sexual problems in marriage; disagreements over child-rearing and perceived under-involvement of husbands in dealing with domestic problems and issues; high expectations parents have of children (including academic pressures on youth to succeed academically and vocationally); child abuse and other forms of domestic violence; inter-generational conflicts such as difficulties with in-laws (e.g., mother-in-laws/daughter-in-laws); and a gradual weakening of the joint family system (especially in urban areas) and loss of the role and function of the elderly. Additionally, examples of mental health illnesses and problems include those associated with physical illness, disability, and HIV/AIDS (e.g., helplessness, hopelessness, depression); adolescent conduct disorder; suicide; anxiety and stress-related disorders; and alcohol and drug abuse (see also Baradha, 2006;

Carson, Chowdhury, Choudhury, & Carson, 2002; Carson, Chowdhury, Perry, & Pati, 1999; Das, 2007; Gulati & Dutta, 2014).

On a national level in India, mental health disorders, and marital and family problems, are not adequately addressed. Despite well-intentioned efforts on the part of the government, the mental health needs and problems faced by all Indian citizens have not been met with any consistent effort by the Indian government or social welfare system (Chavan et al., 2013; Kashyap, 2004; Natrajan and Thomas, 2002; Patel & Thara, 2003). Moreover, mental health counseling is relatively new in India and remains in the early stages of development (Carson, Jain, & Ramirez, 2009; Raney & Cinarbas, 2005). In addition, outpatient counseling and therapy are generally foreign concepts and practices except in a few major cities, such as Delhi, Mumbai, Chennai, Hyderabad, and Bangalore (Carson, Jain, & Ramirez, 2009; Nadkarni et al., 2015). Until recently, and with few exceptions, counseling has been a practice confined to mental hospitals, inpatient hospital programs, residential psychiatric centers, and a small number of NGOs (Chavan et al., 2013; Kumar, 2002). Moreover, there is an extreme shortage of mental health professionals in India given its large population (Archarya, 2001; Patel et al., 2014; World Health Organization and Ministry of Health, 2006). It is simply not possible for so few trained professionals, most of whom are located in major cities, to meet the mental health care needs of over one billion Indians, most of whom (roughly 70%) live in rural areas. Given this reality, there is an urgent need for trained lay counselors and family life specialists who can help address these needs throughout the country.

Furthermore, there is a need for family-based approaches in the delivery of mental health services in India, and for marriage and family counseling in general (Chowdhury, 2011; Chowdhury & Carson, 2006; Mittal & Hardy, 2005; Prabhu, 2003). Poverty for both urban and rural families poses a unique set of risks for children and families (Gulati & Dutta, 2014), and families need to be helped and empowered through training in effective parenting and family life education. According to Chowdhury (2011, p. 51):

No amount of progress can be made in improving the stability of family life without the intimate and purposeful involvement of parents in child care and rearing the human capital. While this challenge may be seen as obvious and simple on the surface, it involves a fuller understanding of the cultural and social dynamics in which parenting is enacted.

Finally, there has been a strong call for family involvement in mental health patient care in India for several decades (Kashyap 2004; Sethi 1989). This has been evidenced, for example, by the growth of family

wrap-around services for treatment of the mentally ill which were initiated at places such as the National Institute for Mental Health and Neuro Sciences (NIMHANS) in Bangalore and the Christian Medical College in Vellore (Bhatti & Varghese, 1995; Carson & Chowdhury, 2000; Carson, Jain, & Ramirez, 2009). A positive trend is the increasing number of doctors in Social and Preventive Medicine, psychologists, counselors, family therapists, and other trained family professionals in India such as Family Life Educators who are deeply committed to the training of specialists who are promoting the direct involvement of families in the mental health care of children and adults (see e.g., Bhatti & Varghese, 1995; Das, 2007; Karuppaswamy & Natrajan, 2005; Rastogi, Natrajan, & Thomas, 2005).

Poverty and Mental Health Connections in India

Given that India is the second most populous country in the world with an estimated 2014 population of 1.261 billion people, it is probable that India is home to a proportionate percentage (approximately 17.5%) of the world's mentally ill. Estimates of the number of people with mental illness in India are that nearly 5% of the population suffers from common mental disorders, such as depression and anxiety, and that the prevalence of mental disorders in India is approximately 70.5 per 1000 in rural and 73 per 1000 in urban populations (Health Minds, 2018; National Institute of Health and Family Welfare, 2014). However, mental disorders among children and adolescents are estimated to range from 12% to 13.8%. Thus, a conservative estimate of individuals with a diagnosable mental disorder in India may be close to 10% of the population or somewhere between 80 and 100 million people (Health Minds, 2018; Mascarenhas, 2018). Estimates of the treatment gap in India, defined as the difference between those who require care and those who receive care, could be as high as 90% (Mascarenhas, 2018). The country is in desperate need of mental health care.

The National Mental Health Programme (National Institute of Health and Family Welfare, 2014), launched in 1982 (see also Roy & Rasheed, 2015), mandated delivery of mental health services to administrative units (villages, blocks, districts and towns) through the District Mental Health Programme (DMHP), which currently, more than 30 years since its initiation, only operates in 123 of the 640 districts in India. The DMHP has shown mixed results. Some goals have been met in some regions, while people in many remote rural areas still remain under-served (van Ginnekin et al, 2014). Although such reforms may increase capacity of services at the grassroots level, the overall mental health situation in India

essentially remains largely unaltered (Dasgupta, 2014). The complexity of the problems of mental illness, together with poverty, demand fundamental change at the macro, meso, and micro levels (Gopikumar, 2014).

Opinion is sharply divided on whether poverty is the main cause of mental disorders in developing countries, including in India. This debate was triggered by a study conducted in the 1990's by Vikram Patel of London's Institute of Psychiatry and his colleagues. Patel's study, with updated information which has been published in various articles (see e.g., Patel, de Souza, & Rodrigues, 2003; Patel, Pereira, Fernandes, & Mann; 1998; Patel, Weiss, & Mann, 2010) and a recent book (Patel, Minas, Cohen, & Prince, 2014), investigated the relationship between poverty, disability and mental disorders in the Indian state of Goa. Patel found that more than 40 percent of adults attending primary health care clinics had a common mental disorder (CMD) such as anxiety or clinical depression. Women were two to three times more likely to have CMDs than men, although it is not certain whether this finding was confounded by social biases against women and a greater willingness to report on the part of women. There was also some evidence that individuals living with others who had poor mental health were more likely to report poorer mental health themselves. The study concluded that poverty was a critical risk factor in mental illness, and that disability and gender in India were strongly associated with mental disorders, most notably depression and anxiety. Patel noted that clinical depression, for example, can be triggered by adverse life-events such as physical illness, housing problems, unemployment, inadequate nutrition and health care, and parental concerns about their children (e.g., health and education). Moreover, being poor means that people are more likely to experience such events and will have fewer resources to draw upon. Hence, the relationship between impoverishment and mental illness is bi-directional; i.e., poverty can lead to mental illness, which can then worsen the economic circumstances of the person and their family.

At the same time, Patel and his colleagues (Patel, de Souza, & Rodrigues, 2003; Patel et al., 1998; Patel, Weiss, & Mann, 2010) emphasized that mental disorders in India (like elsewhere) are present at all income levels, as well as in all social classes and castes and not simply among the poor. He also noted that not all mental disorders appear to be increasing in India. Patel specifically attributes India's growing incidence of anxiety and clinical depression to rising inequality, as witnessed in many other developing countries. A study by Gopikumar (2014) supports Patel and his colleague's findings by providing evidence that mental illness in India was associated with other aspects of

health, well-being, and personal contentment. Hence, in combination with poverty and homelessness, the effects of untreated mental illnesses are devastating. Patel leaves readers with two critical challenges; first, that the major task for public health workers is to identify the protective and nurturing qualities in those who do not become anxious or depressed when faced with poor economic circumstances; and second, that preventative strategies aimed at strengthening protective factors in local communities may be a more sensible investment of scarce resources than duplicating the extensive health systems of the developed world. Both of Patel's challenges support the assertion that there is a need for wide scale training of lay counselors and family life specialists in India and other areas of the developing world (see also Patel et al., 2010).

One criticism of Patel's studies in Goa has been that he may have an excessive focus on the relation between mental health problems and poverty in India, and one that overlooks the prevalence of mental and emotional illness among the middle and upper middle classes (see, for example; Chavan, Gupta, Sidana, Arun, & Jadhav, 2013; Katyal, 2015; Rao, 2013). However, Patel's contention that the family environment, as well as addictions and mental and emotional disorders are, in all probability, associated with poverty is supported by some degree of empirical evidence.

The Role of NGO's in Addressing Mental Health Issues and Family Problems in India

Non-Governmental Organizations (including religious and non-religious), in cooperation with cooperating government institutions and agencies, can play a unique and pivotal role in creating and supporting model programs in mental health treatment that can be replicated or adapted in differing environments, and in raising public awareness about various types of mental illness. One of the strengths of NGO's in developing countries is their emphasis on alleviating poverty and promoting sustainable development, as well as working in partnerships and networking with other agencies, academic institutions, and individuals (Carson, Jain, & Ramirez, 2009; Haider, 2013). Furthermore, multidisciplinary teams often work in cooperation with families and community volunteers, and typically with less red tape and administrative bureaucracy.

Another advantage is that even though NGO's (including in India) are limited in scope and sometimes sustainability, they can bring innovations in practice and training, and with far less stigma, than formal psychiatric services (Kamath, 2014; Patel et al., 2014). As Patel and Thara (2003) note, NGO's are

acknowledged by the state and national government as non-profit or welfare oriented institutions or agencies that can serve as advocates, service providers, activists, and researchers on a range of issues in human development. Furthermore, historically in India, volunteerism and lay leadership and involvement on the grassroots community level have been central to these NGO endeavors. Since the key to change is first and foremost education and awareness, NGO's can employ a training-the-trainers approach that targets and recruits interested leaders and other individuals in local communities and equips them with potentially life-changing information and skills for citizens. Resources and support for those in need of mental health assistance can then be enacted.

As the fields of counseling, family therapy, and family life education continue to take root in India and other countries in Asia and around the world, there will be ample opportunity for cooperation and collaboration among professors in academic settings, trained mental health practitioners at home and abroad, counseling/therapy trainees, and those working in NGO's that have mental health as one of their main priorities. Since mental health is the least developed and most neglected area even in the non-governmental and private sectors of health care in India (Chavan et al., 2013), the learning and training process between NGO's and academics and practitioners in counseling, family therapy, social work, and related fields can be mutually beneficial. According to Thara and Patel (2003), more NGO's today (both secular and religious) are investing in enhancing the knowledge and skills of their staff through providing opportunities for their participation in workshops, conferences, seminars, and short-term formal training in mental health work. Moreover, an increasing number of universities, colleges, and institutes in India, are sending their students to NGO's for field placements and internships. Especially needed are trainers who are willing to go out and work in the rural areas of the population in India and other developing countries; i.e., to the "hard places" (places where outsiders rarely go or want to go), even if for brief periods of time.

The Potential Impact of Family Life Education on Poverty Reduction in India

Family Life Education in the Indian Context

Family Life Education, similar to lay counselor training and education, is a relatively new phenomenon in developing countries, including India. As Chowdhury (2006, p. 4) notes with regard to the family system: The purpose of Family Life Education (FLE) is to

change or modify the behavior of individuals through the absorption of new information, as well as practice new skills of relating and communicating more lovingly and effectively. Moreover, education becomes a means for human resource development by sharpening awareness and by motivating individuals to grow. It can empower families to face the challenges of modern life.

Chowdhury (2006) outlines the common subject matter areas of FLE with a focus on the Indian context. These areas include: healthy family roles, functions, and boundaries; effective parent training and education for families throughout the life span (e.g., effective approaches to childrearing and discipline; essentials of child and adolescent development); education regarding the critical importance of literacy; preventing various types of child and elder abuse and neglect; marriage preparation, education and enrichment throughout life; communications skills training and basic problem solving strategies for parents and children/adolescents, as well as dealing with inter-generational conflict; increasing awareness about family planning and healthy human sexuality, as well as gender roles and inequality in the immediate and extended family system (e.g., girls and women as the worst victims of poverty); basic health, hygiene and sanitation, and nutrition and diet education; ways that immediate and extended family members can help reduce risk factors in the lives of children and adolescents; values and character education (thus impacting all levels of society); balancing work and family issues; enhancing the family's knowledge about effective financial and resource management; the impact of modern technology on family life; and strengthening marriages and families through empowering all members of the family and use of a family resiliency approach; to name a few. Traditionally, these functions and roles were taught and modeled by grandparents, aunts, uncles, and other extended family members in society. However, because of the rapid loosening of joint family ties in India and many developing countries today there has become a tremendous need for a more formal and comprehensive approach to education for family living.

To date there has been a relatively minimal national effort on the part of the Indian government or NGO's to prepare couples for marriage, or to build strong marriages and more resilient families throughout the lifespan. However, Family Life Education can have an impact on poverty reduction through the enhancement of individual and family development in India. These strategies and potential outcomes are outlined in Table 1.

Table 1: Family Life Education Content and Practice Areas Potentially Influencing a Reduction in Poverty

Issue	FLE Area	Potential Impact
Caste discrimination	Education regarding local, state, and national government in bringing down the caste gap	Family and community voice and empowerment; reduced exploitation of the poor
Gender inequality	Education about hazards of gender inequality and advantages of healthy gender functions and roles in the family	Enhanced marital relationships; more harmonious and cooperative male and female relationships in the community that support women's contributions to economic and social development
Family and community economic development/small business promotion	Family resource management; community capacity building and cooperatives; microfinance opportunities	Gainful employment; increased income
Parent/child and parent/adolescent conflict/ inter-generational conflict	Parent education and training/ child behavior management; communication and problem solving skills training; positive parenting	More positive family relationships and improved mental health of family members; reduction in child and elder physical abuse
Education of boy and girl children and reduction of child labor practices	Parental support and involvement in children's schooling, and advantages for child and family unit	Elevated employment opportunities when children get older; skill development among adolescents
Adult literacy	Advantages of and assistance with both local and online literacy education resources	Increased job and self-employment opportunities which enhance family income
Family planning	Education about the positives of birth control and the socio-religious barriers that prevent family planning	Smaller families, especially in rural areas, with more physical and nutritional resources per family
Problems with infant/toddler care and understanding essential needs and milestones in child and adolescent development	Basic developmental education 0 to 18 years of age	Healthy child and adolescent development; helping children better help themselves
Marital conflict and estrangement	Culturally appropriate marriage enrichment	Strong marriages/ stronger families
Sexual problems in marriage; sex education and healthy sexual development for children and adolescents	Sex education that is culturally and developmentally appropriate and sensitive in the marital and family system	Happier and more satisfying marital relationships; reduced teen pregnancies; lower incidence of family sexual abuse
Corruption at all levels of society	Civility awareness, values education, and character development	Increased resilience against being taken advantage of or taking advantage of others
Unhygienic living conditions	Basic Home Science management and care; awareness of personal health hygiene needs and habits	Improved health of all family members that increases work- time and productivity
Domestic violence	Creating awareness about the cost and consequences of domestic violence in terms of social, economic and personal development	Improving the quality of family life, strengthening marriages
Community violence	Increased awareness of consequences of community violence	Enhancing healthy community living

Counseling and Lay Counselor Training in Developing Countries

Counseling is a rapidly growing profession in many areas of the world today, including in some developing countries (e.g., Gerstein, Heppner, Aegisdottir, Leung, & Norsworthy, 2009; Hohenshil, 2013; Moodley, Gielen, & Wu, R. 2012; Moodley, Lengyell, Wu, & Gielen, 2015; Seung-Ming, Clawson, Norsworthy, , Tena, Szilagyi, & Rogers, 2009). The growth of counseling in some parts of the developing world has been slow but steady in terms of the increasing number of professional training programs, as well as the involvement of both secular and religious NGO's in the training of lay counselors and initiation of lay counselor training programs (see, for example, Carson, 2017; Carson, Lawson, Casado-Kehoe, & Wilcox, 2011; National Board for Certified Counselors, 2012, 2016; Patel, Chowdhary, Rahman, & Verdell, 2011; Patel & Thara, 2003; Patel, Weiss, Chowdhary, Naik, & Pednekar, 2010). There is increasing evidence that well trained lay counselors can have a measureable and long-lasting impact on the lives of children, adolescents, adults, couples, families, and communities (Dewing, Matthews, Cloete, Schaay, & Simbayi, L., 2014; Juen, Siller, Lindenthal, Snider, & Nielsen, 2013; Patel et al., 2011). The findings of these various studies are significant given the density of population and scarcity of resources in developing countries such as India which do not make it possible for the mental health needs of people to be met through professionally trained counselors and therapists alone. The most effective lay counselors and lay counselor trainers no doubt come from within the culture in which they live and work.

According to Patel et al. (2011), there are two major barriers that impede successful mental health treatment in developing countries. These include the lack of skilled human resources and the acceptability of counseling as a needed and socially accepted practice for the vast majority of citizens. Counseling in resource limited countries is often seen as something needed only or primarily by the mentally ill, and not by general members of society (Carson et al., 2011; Carson, 2017). Moreover, there are often cultural taboos about seeking counseling or therapy among people in developing nations that involve social stigma, ostracism, and the protection of marriage and family secrets. Such is the case in India (Kashap, 2004; Mittal & Hardy, 2005; Patel et al., 2011; Sonpar, 2005). Hence, the normalization of counseling for all societal members is greatly needed in the developing world. This process can only occur through culturally sensitive, appropriate, and competent counseling practices that are promoted through public awareness and education efforts in both

rural and urban areas.

Examples of evidenced based trainee learning and competency, as well as client-related outcomes, for trained lay counselors assisting community members in India include the successful treatment of alcohol abuse (Nadkarni et al. 2015), as well as depression and anxiety disorders (Patel, Weiss, Chowdhary, Naik, & Pednekar, 2010). Data from other countries supporting the efficacy of lay counseling training programs and approaches to helping citizens include counseling individuals with HIV who are struggling with various psychosocial problems in South Africa (Kagee, 2012), post-traumatic stress disorder (PTSD) among Rwandan and Somalian refugees living in Uganda (Neuner, Onyut, Ertl, Odenwald, & Schauer, 2008), and traumatized children and families in Nepal (Keats & Sharma, 2014). These studies provide empirical support for the notion that trained lay counselors in developing countries can be a useful and cost-effective way for helping individuals with a variety of substance use and psychological disorders.

The Potential Impact of Lay Counselor Training on Poverty Reduction in India

Example of The International Lay Counselor Training Program

The International Lay Counselor Training Program (ILCTP), developed by Carson (2017) and Carson, Lawson, Casado-Kehoe, and Wilcox (2011), covers the essential elements of lay counseling in a two to five day period depending on the needs and requests of trainees (see Table 2). This program has been evolving since the mid 1990's and has been implemented in one form or another over the past 20-plus years in numerous locations throughout India and other South Asian countries, including Nepal, Bangladesh, Sri Lanka, and Myanmar. The program operates on a minimal level of funding from two international NGO's and one Indian NGO that support indigenous community development projects. Since the shorter program can be conducted over a 2-3 day weekend, it is often more feasible that initial participants can attend the training from a particular area or region, in comparison with other programs that require a greater time commitment.

The ILCTP is a strongly applied program that is culturally sensitive and relevant in helping trainees become proficient in the basics of counseling knowledge and skill. Often these trainings are conducted through translation depending on participant's level of competency in English. Although community citizens are also often invited to attend, the ILCTP largely utilizes a *training the trainers* approach (Carson, 2017; Carson et al., 2011;

Carson & Chowdhury, 2000). Here, select trainees who are mentored in key locations become lay counselor trainers and small group facilitators to others in their respective areas, communities, and sometimes places of religious worship.

The ILCTP also trains leaders and other interested volunteers (e.g., lay counselor trainees associated with secular and religious NGO's and other community agencies and organizations) to be able to offer free or low cost counseling services in their local communities, either in people's homes or other facilities (e.g., schools, community centers, places of worship). One major goal of the program is to create sustainable lay counseling activities that can help meet the personal and relational needs of individuals, couples, and families in that geographical area. One strength of the ILCTP is its flexibility. Different versions of the program can be conducted in time blocks ranging from two days to one full week. ILCTP

trainees have also been invited back for a second year of additional training in some areas throughout India and Nepal. Developers of the ILCTP and various counselor trainers have received positive written and verbal feedback from program participants at the end of the training for a number of years. In addition, ongoing communications throughout the year, as well as testimonials from the same individuals participating in more training a second year, is that they not only use their knowledge and skills throughout the year but also report seeing positive outcomes in those they have counseled (Carson, 2017).

Training modules in the full five day ILCTP program are presented in Table 2. Hours of training listed for each module may vary depending on the person(s) doing the training, as well as the needs and requests of the trainees. Topics were generated in cooperation with NGO leaders and academic professionals in India over a period of several years.

Table 2. Overview of ILCTP Training Modules

DAY 1 TRAINING MODULES	
<i>Module 1:</i>	Foundations of Counseling, and Basic Counseling Skills and Techniques; Group Counseling; Essentials of Counseling Ethics.
DAY 2 TRAINING MODULES	
<i>Module 2:</i>	Couples and Marriage Counseling.
<i>Module 3:</i>	Family Counseling. Essentials of Counseling Children and Adolescents.
DAY 3 TRAINING MODULES	
<i>Module 4:</i>	Overview of Major Child, Adolescent, and Adult Psychopathological Disorders; Making Referrals for Psychiatric Care.
DAY 4 TRAINING MODULES	
<i>Module 5:</i>	Overview of Chemical Addictions and Substance Abuse, and Other Major Addictions (sexual, gambling, internet).
DAY 5 TRAINING MODULES	
<i>Module 6:</i>	Trauma Counseling and Crisis Intervention (including working with clients experiencing grief and loss; domestic violence; histories of physical and sexual abuse; suicidal counselee's; those who have experienced environmental disasters; etc.).
<i>Module 7:</i>	(Optional): Special Topics in Counseling Upon Host Country/Area Request (e.g., parental separation and divorce; helping victims of human trafficking; counseling families with disabling conditions and acute and chronic illness; etc.).

Lay Counselor Training and Poverty Reduction in India

Lay Counselor Training (LCT) and practice has the potential to help reduce poverty in the lives of individuals and families in the same way as Family

Life Education. Although the areas and extent of impact may be more indirect than direct, LCT can have both short and long term effects on poverty reduction and alleviation in both urban and rural communities. Known and trusted lay leaders must not always wait for people to reach out to them for help, but rather take

the initiative in identifying at-risk or hurting individuals and families and asking them how they can be helpful to them. Sometimes this will come through community support and friendship, but at other times people will need the wise counsel of someone (or a small group of trained lay leaders) who has the essential knowledge and skills to apply the right

assistance at the right time to the particular area of struggle and need. One major outcome can be that individuals, couples and families are freed and empowered to engage their own poverty issues and economic development more directly, fervently, and creatively. The potential impact of these lay counseling-related endeavors are outlined in Table 3.

Table 3. Lay Counselor Training Program Content and Practice Areas Potentially Influencing a Reduction in Poverty

Issue	LCT Area	Impact on Poverty
Everyday problems with adjustment and coping for children, adolescents, adults and the elderly	Basic counseling principles and skills for helping people throughout the lifespan	Increased work productivity in and outside the home resulting from improved mental health and family relationships
Behavioral and emotional disturbances of children and adolescents; mental health issues with adults and the elderly	Understanding the more common mental and emotional disorders of people throughout life; helpful counseling interventions provided by lay individuals in the family and community; timely and appropriate professional referral when needed	Augmentation in work-related motivation, creativity, and productivity; increased energy and confidence important for entrepreneurship
Substance abuse/ chemical addictions, and other types of addictions	Individual and community lay assistance and support; possible small group counseling with trained lay group leaders	Reduced work-related absences/ increased work productivity that elevates family income
Trauma and loss associated with but extending beyond being poor; rebuilding life after tragedy and natural disasters	Immediate and appropriate crisis intervention and/or trauma counseling; support and counseling groups for traumatized children, adults, and families	Improved mental and emotional health of individuals within and beyond the family that can positively impact physical health and work-related activities
Marital conflict and estrangement	Marriage counseling	Strong marriages that promote team work between husbands and wives in family and beyond
Gender inequality causing difficulties and distress in marriages and families	Marital counseling; promotion of gender equality of married partners and children	Enhanced marital relationships that provide a healthier environment for everyone in the family; equal education for boy and girl children
Parent/child and parent/ adolescent conflict/ inter-generational conflict	Family counseling throughout the lifespan as needed	Enhanced family relationships, fewer problems with in-laws; reduction in various types of child and elder abuse
Education of boy and girl children and reduction of child labor practices	Parent counseling that emphasizes parental involvement in each child's education	Elevated employment opportunities when children get older
Adult literacy	Family counseling that literacy education and opportunities	Increased job and self-employment opportunities that enhance family income
Domestic violence	Increased awareness of consequences and costs of domestic violence	Increased quality of life, empowering families
Community violence	Increased awareness of consequences of community violence	Enhancing healthy community living

Use of a Training-the-Trainers Approach to LCT and FLE

Cooperation between family life educators or specialists, as well as professional counselors and therapists in India and other countries, serves as the impetus to program development and implementation of training at various training sites. Sources of funding for these exchanges can come primarily from NGOs, including various external grant-funding organizations, agencies and programs (e.g., WHO, UNICEF, USAID, World Bank), and various religious organizations and NGO's involved in community development in India and other developing countries. While a detailed discussion of the content and procedures inherent to a training-the-trainers approach is the subject of other publications (see Carson, Jain, & Ramirez, 2009; Carson & Chowdhury, 2000), the basic steps to such program development and training can include: (1) Identification of "meta-visors" in India for both FLE and LCT programs (i.e., individuals with professional specializations in FLE and/or counseling and counselor training); (2) Meta-visor identification of lay counselor training areas, sites, and interested lay trainees in rural and urban areas across the sub-continent; (3) Training of lay leaders in FLE and/or LCT in key content and practice areas in various geographical areas both rural and urban; and (4) Trained leaders and support individuals engage in training others in these geographical areas around the country. Indeed, this training-the-trainers approach has been successfully used in the education of family life educators, family therapists, and mental health counselors in India (see Carson & Chowdhury, 2000; Carson & Chowdhury, 2006; Carson, Chowdhury, & Ramirez, 2009), who themselves have gone on to train lay counselors and family specialists throughout the country and in other South Asian countries (Carson, 2017).

Conclusion

Mental health is one of the least developed and most neglected areas of health care in developing countries. As Carson (2017) has noted, the extreme scarcity of mental health professionals and services available in resource limited countries leaves hundreds of millions of people without even the most basic mental health and family related assistance. However, adequately trained lay counselors and family life educators can make widespread and potentially long-term differences in the lives of children, adolescents, adults, marriages, families, and communities. These trained lay individuals can also help create greater awareness of people's mental health and family based needs through public education. Hence, the needs and demands for

skilled lay counselors and lay family life educators in developing countries of the world have never been greater. Academic institutions, community agencies, and NGO's from both within and beyond that country, in cooperation with national government programs, can contribute greatly to lay counselor training and family life education efforts in poverty ridden areas. Such training can enhance people's overall quality of life and have a measurable impact on community development and economic productivity.

Poverty reduction efforts in India that include lay counselor training and family life education can serve as an example for other developing countries. These endeavors require the collaboration and teamwork of community leaders and professionals representing a wide range of training and experience. Training lay leaders and workers in the areas of family life education and lay counseling are but some ways that poverty can be reduced and communities strengthened. As families are helped to become more resilient, and supports for children and youth are expanded, family members as community citizens are more empowered to move forward in all areas of life, including areas of economic development that are within their reach. Further, as individuals and families are able to mobilize help from lay resources in their communities and areas, they can find relief from mental, emotional, and family-related problems that interfere with work productivity and income generation. Two old and wise proverbs thus become more fulfilled, whether it be in India or elsewhere: "The family is a haven in a heartless world," and "In the abundance of counselors there is safety".

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