

Cognitive Dissonance among Health Educators due to Gap in Knowledge and Practice of Teaching Skills in Kathmandu

Bhagwan Aryal, Anup Adhikari

Abstract— The improved way of communication and even the use of technologies in education have replaced the traditional roles of health educators. Several modern teaching skills are applied at the college level. Skill of set induction, skill of stimulus variation, skill of questioning, skill of explanation and skill of closure are some of the common skills to be used in every class. However, several factors may lead health educators to not practice the learnt teaching skills in the classrooms. Cognitive dissonance can occur in many areas of life, but it is particularly evident in situations where an individual's behavior conflicts with beliefs that are integral to their self-identity. An Education graduate after completing their studies may have strong conviction to use proper skills of teaching in classroom, but later could not transform that into the practice. This may result in cognitive dissonance. This article highlights the factors responsible for the creation of the gap between knowledge and practice in applying modern teaching skills among Nepalese health educators and explains how the health educators cope with the problem created by the difference in knowledge and practice of teaching skills.

Index Terms— Cognitive dissonance, Health educator, Teaching skills, Kathmandu

I. INTRODUCTION

According to Sampath, Panneerselvam & Santhanam, modern teacher sees education as a process of interaction between the child and their environment. The role of teacher in education has been shifted in emphasis from the teacher to the pupil as the central figure. Teachers are changing their traditional roles and several institutions, colleges and universities are now giving emphasis to teacher training too(1). Richards defines, "Training involves understanding basic concepts and principles as a pre-requisite for applying them to teaching and the ability to demonstrate principles and practices in the classroom"(2).

The problem of practicing skills by Faculty of Education (FoE) graduates at school level is even worse. According to Nepal most of the teachers did not have clear concept of curriculum. His study in Kaski district shows that the teachers were giving the answers to their students as they like, without necessary study of the various parts of curriculum(3). Similarly, Sharma also found that the school teachers carried on their daily instruction without any kind of teaching

methods (except lecture) and materials(4). On the same, Khanal found none of the teachers using teaching aids in schools of Chitwan district. She found that the teachers were unable to conduct class activities in a sequential way and thus the set objectives of the class were not achieved most of the times. She found 50 percent health educators possessed a clear voice, 25 percent of them used gestures and 35 percent of them well practiced the classroom movement during teaching. Contrastingly, she found that the teachers were interested in teaching health and physical education courses and the students were satisfied with their teaching activities(5).

Khanal also studied on the situation of teaching health and physical education in higher secondary schools of Kathmandu district. He found that 20 percent teachers occasionally used lesson plan in teaching and the most used method of teaching was demonstration (60 %)(6). On a next study in Dhading district, Pandey found that the 60 percent of teachers had poor lesson plan preparation skill. Interestingly, she found that all of the health educators concerned their curriculum but 60 percent of them had poor skill to relate content with their curriculum. It was found that the teaching load of the teachers was very high, 60 percent of them used to teach six periods a day, thus the most used method of teaching was lecture and discussion(7).

In master degree health education curriculum of Tribhuvan University (TU), contents of the specific teaching skills are included in some courses. Such skills are practiced in the micro-teaching programs too. However, the health education teachers after the end of their college education do not implement such skills in real classrooms. Education degree holders are called the trained one in teaching. However, they themselves are not able to practice or they do not practice trained skills in their respective institutions. Later on this difference in their past knowledge and knowledge of teaching skills when do not become real, the teachers face a high degree of cognitive dissonance.

In order to deal with their dilemma, most of the educators drop their knowledge of using better teaching skills in classrooms and stick on the out-dated, ineffective and orthodox teaching skills. In Nepal, Faculty of Education, TU; and other several universities and organizations are involved in training teachers of various levels but several researches

Bhagwan Aryal, Assistant Professor, Central Department of Education, Tribhuvan University, Nepal.

Anup Adhikari, General Secretary, Nepal Family Development Foundation (NPDF), Kathmandu

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have proved that there is no creation of effective classroom teaching/learning in schools of Nepal. A common criticism is that training does not prepare prospective teachers for the job that they have to perform. It is also found that the educators having good knowledge on the various teaching methods do not apply those in classrooms.

II. MATERIALS AND METHODS

A. Study area and setting

Health education colleges in Kathmandu valley was the study site and Health educators who teach Health education at Bachelor level were the respondents of this study.

B. Research design

Descriptive and cross-sectional study was conducted to carry out the research.

C. Sampling technique and sample size

Census technique was used for the data collection and the total sample size obtained was 48.

D. Ethical considerations

Initially the consent was taken from the Health education college administrator for the research. Then informed and verbal consent was taken from the respondents before asking them questions. Similarly, the respondents were informed about the process of answering the questions. They were allowed quitting if they did not further want to respond. Questions were not asked in a way that hurt their dignity. They were assured of the privacy, unanimous and confidentiality of their responses.

E. Inclusion and Exclusion criteria

The participants who were teaching Health education in more than two schools and/or colleges were not repeated in the data collection process.

III. FINDINGS

A. Gap in knowledge and practice of teaching skills

Under the components of skill of set induction, Cent percent health educators exhibited proper knowledge of 'use of previous skills' but they were found poor in knowledge of 'use of appropriate devices' since 52 percent of them had no knowledge of using this skill. Use of previous knowledge to start the lesson was found satisfactory (75% averagely performed) in observation but the use of appropriate device was poorly practiced. While 58.3 percent of them did not practice at all, 33.3 poorly practiced it.

The skill of 'purposeful movement' (60.4%), the skills of 'change in interaction styles' (75%) and the 'change in sense channels' (72.9%) were comparatively low in knowledge among the six skills of stimulus variation. The most known skill was the 'change in speech pattern' (100%) in this category. Neither of the health educators in any of the six skills was found in 'excellent' category while observing the

practice. The skill of 'purposeful movement' was fairly practiced but 8.3 percent did not use it at all. The skill of 'meaningful gestures' was in average used by 50 percent of the health educators, yet about 42 percent of the health educators poorly applied it.

Table 1: Difference in frequency of health educators in knowledge and practice of teaching skills

Presence of knowledge	Skill component	Rating of practice (in %)			
		Good	Average	Poor	Not applied
100	Use of previous knowledge	16.7	75	8.3	0
47.9	Use of appropriate devices	0	8.3	33.3	58.3
60.4	Purposeful movement	33.3	33.3	25	8.3
91.7	Meaningful gestures	8.3	50	41.7	0
100	Change in speech pattern	16.7	25	16.7	41.7
75	Change in interaction styles	16.7	8.3	41.7	33.3
72.9	Change in sense channels	0	16.7	41.7	41.7
95.8	Change in posture	0	58.3	33.3	8.3
64.6	Prompting	0	8.3	50	41.7
39.6	Probing	0	8.3	16.7	75
62.5	Redirecting	0	16.7	16.7	66.7
100	Continuity	16.7	83.3	0	0
100	Fluency	50	8.3	41.7	0
100	Simplicity	16.7	41.7	41.7	0
41.7	Explicitness	0	41.7	25	33.3
93.8	Timing of finishing the class	0	25	33.3	41.7
100	Review of class/ summarizing	16.7	16.7	25	41.7

The knowledge of using skill of questioning was fairly present among more than 60 percent health educators in case of 'prompting' and 'redirecting' but about 60 percent health educators did not exhibit the proper knowledge of using 'probing' skill. On observation of the class, about 42 percent, 75 percent and 67 percent health educators were found not applying the skills of prompting, probing and redirecting respectively.

'Continuity', 'fluency' and 'simplicity' were known by all health educators but the knowledge of skill of 'explicitness' was found only among nearly 42 percent of the health educators as the components of skill of explanation. In observation, nobody showed 'good' rating in skill of 'explicitness' too and 33.3 percent of them even not applied this skill. The skill of 'continuity' was in average performed by 83.3 percent health educators. The skill of 'fluency' was

also poorly performed by about 42 percent and good by 50 percent health educators. Similarly, nearly 42 percent health educators exhibited poor use of ‘simplicity’ skill in their explanation and the same percentage made use of simple explanation.

About 94 percent health educators had proper knowledge of using the ‘timing of finish’ and 100% of them had the knowledge of ‘summarizing’ the lesson as the components of skill of closure. In observation, about 42 percent demonstrated very poor method of finishing the class because they continued to teach even after the bell. Similarly, regarding the skill of ‘reviewing or summarizing the class’ 25 percent of them were poor and about 42 percent were very poor.

A total of 83.3 percent of total health educators affirmed that they were unable to practice above stated teaching skills in their classes. Majority (91.7%) of permanent health educators confirmed this. This information matches with the data of observation where majority of health educators were unable to practice modern teaching skill properly.

B. Cognitive dissonance among the health educators

It was identified the kind of discomfort health educators felt on not practicing the modern skills of teaching in classes. About 93 percent of the teacher was not satisfied from the use of traditional teaching skills in their classrooms and about 94 percent stated they felt problems due to this. Tension (35.4%) was the most felt problem by the health educators followed by the uncomfortable feeling during teaching (29.2%).

Cognitive dissonance theory explains “the way in which people cope with and rationalize inconsistencies in their experience, such as holding incompatible beliefs, acting in ways that violate their values, being forced to choose one of two equally attractive alternatives, or discovering that their efforts were not worth the result obtained” (8).

Cognitive dissonance not only takes place in mind and creates some physical and mental problems but also creates obstacles in current profession. Dissatisfaction and lessened confidence may lead to consequence on professional status. Thus, the teachers were asked whether they had any further consequence of this discomfort on their profession. The findings are stated in the following table:

Table 2: Consequence of cognitive dissonance on profession

Nature of job		Others	Decreased respect to teaching profession	Lessened self-respect	Unsatisfied students	Total
Part-timer	n	3	1	6	4	14
	%	21.4	7.1	42.9	28.6	100
Contract	n	4	8	4	6	22
	%	18.2	36.4	18.2	27.3	100
Permanent	n	3	1	4	4	12
	%	25	8.3	33.3	33.3	100
Total No.		10	10	14	14	48
Total %		20.8	20.8	29.2	29.2	100

On the basis of nature of job, it seems about 43 percent part time health educators felt lessened self-respect due to the cognitive dissonance. Moreover, 28.6 percent of health educators found their students being unsatisfied on their teaching. Similarly, 36.4 percent of contract health educators had decreased respect towards their job. In total too, most of the health educators faced the problem of lessened self-respect (29.2%) and unsatisfied students (29.2%).

Table 3: Type of discomfort on not practicing teaching skills

Nature of job		Others	Tension	Stress	Losing confidence at teaching	Uncomfortable feeling during teaching	Total
Part-timer	n	1	6	2	0	5	14
	%	7.1	42.9	14.3	0	35.7	100
Contract	n	6	9	4	0	3	22
	%	27.3	40.9	18.2	0	13.6	100
Permanent	n	2	2	1	1	6	12
	%	16.7	16.7	8.3	8.3	50	100
Total no.		9	17	7	1	14	48
Total %		18.8	35.4	14.6	2.1	29.2	100

Table 3 shows that various types of discomforts were felt by the health educators. The part time and contract health educators felt tension the most but the most of the permanent health educators had the uncomfortable feeling during teaching. Interestingly, neither of part time and contract

health educators had the losing confidence at teaching but a permanent teacher faces this discomfort.

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C. Methods applied by the health educators to reduce discomfort

Cognitive dissonance refers “both to a lack of harmony among one’s thoughts and to the discomfort that results from this, which individuals are motivated to reduce by changing their mind or their behavior in the service of greater cognitive consonance”(8). A teacher on being unable to practice modern teaching skills as per their previous knowledge faces the cognitive dissonance and to reduce the discomfort, he/she does one of the three things, Change practice as per knowledge; Justify the practice by changing the conflicting cognition (Reduce the importance of conflicting belief); and Rationalize and Justify the practice by adding new cognitions. The methods applied by the health educators in reduction of discomfort are shown as follows:

Table 4: Methods applied to reduce dissonance by sex

Sex		Start applying modern teaching skills	Do not think much on the matter and continue teaching	Rationalize and justify	Total
Male	n	13	17	11	41
	%	31.7	41.5	26.8	100
Female	n	3	2	2	7
	%	42.9	28.6	28.6	100
Total no.		16	19	13	48
Total %		33.3	39.6	27.1	100

The table 4 depicts the fact that major 3 methods were applied by the health educators in reduction of the discomfort created due to difference in knowledge and attitude. Among the three methods, 39.6 percent of health educators did not think much on the matter and continued their usual way of teaching to reduce the discomfort. According to the cognitive dissonance theory, this method is called the reduction in importance of conflicting belief. When it is seen from sex of the health educators’ perspective, 41.5 percent of males applied this method but about 43 percent of female health educators said they start applying modern teaching skills in the classrooms. Changing the practice as per the knowledge is the best solution but 27.1 percent of total health educators still rationalize their practice of using traditional teaching skills by saying that the materials are insufficient and the college administrative appraisal is seriously lacking.

IV. IMPLICATIONS OF THE STUDY

Some implications are made on the basis of the findings and conclusion of the research. There is an urgent need to revisit the curriculum of M.Ed. in health education and its application. It seems theoretical and focuses more on cognitive aspect. It must be made practical. The micro-teaching and teaching practice programs conducted by the colleges at master level should focus on observation of

use of modern teaching skills in classrooms. The health educators themselves should be innovative, the knowledge they gained must be applied. Dogmatic statements and one-sided arguments are to be avoided by health education health educators. They have to say something which will support already existing ideas and beliefs and gradually introduce fresh ideas to replace wrong ones. Although the health educators need to correct themselves, the colleges should also be well facilitated, supportive and encouraging the health educators to apply modern teaching skills in the classrooms.

V. CONCLUSION

It is concluded that the majority of health educators had the knowledge of the five teaching skills. Only in some components of the skills, a few health educators did not represent the knowledge. However, the contract health educators were found more knowledgeable than part-timers and permanent ones even in such skills where the total health educators had poor knowledge. The health educators did not practice the trained skills of teaching or the skills they knew in classes in proper way. Neither of the health educators exhibited ‘excellent’ rating in any of the components of the five skills and a few only got the ‘good’ rating. Many of the health educators did not apply the skills at all and taught in very conformist and traditional way. They themselves also declared that they did not use the five skills regularly. Thus, there exists difference in knowledge and practice in using modern teaching skills.

The health educators stated the cause of gap in knowledge and practice of using modern teaching skills as ‘lack of availability of materials’, lack of knowledge, higher number of students in class, lack of reward from authority, pressure from management to teach in usual way and others. This had led them to dissatisfaction towards their job. They realized they were facing tension and uncomforted during teaching. It was hampering their profession too as they were losing self-respect and producing unsatisfied students. The health educators were reducing the importance of conflicting belief (use of modern teaching skills) as a method of dissonance management which is not a right option. It may further reduce the rate of application of modern teaching skills in the classrooms.

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Bhagwan Aryal, PhD, is an Assistant Professor of health education in Central Department of Education, Tribhuvan University, Nepal. Besides teaching and supervising theses and dissertations of Master and M.Phil. level students, he is involved in research and evaluation of a number of social and educational projects including early grade reading, child marriage, sexual and reproductive health, health education and promotion, etc.



Anup Adhikari is a general secretary of Nepal Family Development Foundation (NFDF). He had completed master's degree in population studies from Central Department of Population Studies. He had published many research articles in national and international journals. Currently he is working on Typhoid Vaccine study Nepal (TyVAC).