Swati Patra *Editor*

Adolescence in India

Issues, Challenges and Possibilities

Springer

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Foreword

Adolescents are the key and assurance to the future progress and well-being of any nation. Developing an understanding of them in a comprehensive way is pertinent for all the stakeholders in the field, especially the educators. *Adolescence in India: Issues, Challenges and Possibilities*, edited by Prof. Swati Patra provides a valuable window on adolescence by exploring the unique and fascinating development during adolescence, identity formation, socio-behavioural influences, career and academics, specific issues, and challenges faced like aggression, violence, trauma, depression, suicide, and substance abuse and places these in a bio-psychosocial context. In the context of increased emotions and the elation of the adolescence stage, and the ensuing opportunities and risks, we bear a collective responsibility to alleviate our adolescents from experiences and exposures that could endanger their well-being.

This book is a combined effort of many scholars. It draws attention to the various aspects of adolescent development and highlights the multiplicity of development during this stage. The authors have provided a view of adolescents' developing mind: process of evolving self-awareness, a preoccupation with self, and the role of socio-cultural contexts in shaping adolescents' sense of identity.

The book chapters provide insightful learning about Indian adolescents, issues, and challenges in relation to their learning, academic achievement, peer relations, and career choices. An attempt is made to bridge the knowledge gap in dealing with disparities in developmental outcomes for adolescents with different types of disabilities. The influence of the digital world in shaping the lives of adolescents draws attention to the concerns faced by our youth in present times. Incisive perspectives on major mental health challenges faced by adolescents, aggression, violence, suicide, depression, substance abuse, and trauma highlight the protective factors, and provide learnings and insights on psychological strategies and preventive aspects.

To facilitate positive development in adolescents and improving their mental health and well-being, the different chapters in the book engage at length with life skills, expressive therapies, and cognitive behaviour therapy. The importance of family dynamics and relations is put forth as a significant aspect in order to help deal with the challenges during this major transitional period. Strengths-based approach focuses on positive adolescent development and the role of gratitude in particular in

promoting adolescent well-being. The pluralistic and diverse Indian context demands preventive interventions. The book presents a community approach to positive adolescent development to build an understanding of dealing with the challenges specific to this stage of development.

The book Adolescence in India: Issues, Challenges and Possibilities provides a valuable perspective on the many challenges that adolescents face and the exciting opportunities during this period in life. The significance of this book lies in facilitating an understanding of adolescents in the Indian context, their developmental processes, challenges, and interventions by drawing out their implications for the community.

As educators, it is our obligation to facilitate an understanding of adolescents, their aspirations, abilities, skills, beliefs, emotions, and values. We need to invest in adolescents as the human capital resource of our country.

This book is a good step in that direction and a value addition to the field.

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Preface

Adolescence is a stage that has been much researched on, much talked about, and discussed. The focus of discussion has been mostly on how challenging the stage of adolescence is and how adolescents are marked by confusion and conflicts regarding their roles and responsibilities. The stage has traditionally been described as a 'stage of storm, stress, and strain'. While there is no denying about the major changes at various levels including physical, social, and emotional during adolescence and the resultant issues and challenges concerning the adolescents, there is also a need to focus on the character strengths, assets, and aspirations of the adolescents. The positive aspects of adolescents need to be emphasized in the various approaches and programmes aimed at adolescent development. However, adolescent is not a uniform group as the socio-cultural context and background make adolescent a diverse group within the stage itself. The multitude of factors and social contexts in India affect adolescent development differently and have implications for prevention and intervention measures. The book highlights the Indian context in discussing the issues and intervention measures.

The significance of adolescence as a pertinent stage of human life warrants a specific book on the topic exclusively addressing the issues and concerns of this stage, understanding adolescents, their development, problems, and challenges. In addition, the book also highlights the way forward for dealing with the challenges of the adolescence stage by discussing the individual, group as well as community approach to prevention and intervention measures for the well-being of adolescents and to facilitate the journey of the adolescents in this phase of life.

The book has been divided into three broad parts with various chapters under each.

Part I: *Introduction* provides an overall introduction to the stage of adolescence and focuses on the crucial aspects of identity development and peer relations in adolescence.

Part II: *Concerns and Challenges* discusses the various issues related to adolescents ranging from learning and academic achievement, career to use of substance, aggression, depression, disability, trauma, and navigating the digital world.

The final Part III: *The Way Forward* highlights different measures to capitalize on adolescent strengths and develop skills to enable them to function effectively. At the same time, the important role of family and community in adolescent development and promotion of mental health and well-being of adolescents is also highlighted.

An interesting feature of each chapter is *Time to reflect* which explores some key aspects of the topic which sets us thinking. The book is a great learning resource for various stakeholders across disciplines to understand adolescents, their challenges, and focus on their possibilities.

New Delhi, India Prof. Swati Patra

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Chapter 1
Introduction to Adolescence in India: Issues, Challenges, and Possibilities

Swati Patra

Abstract The term 'adolescence' generates varied emotions, perception, and cognition within us. The fluidity of the adolescence phase of life highlights the role of socio-political-economic-cultural determinants influencing the developmental trajectories of adolescents. This affects significantly their development, health, and well-being. Given the huge demographic dividend of adolescents and young people in India and across the world, the key is to harness this potential resource to contribute actively towards their own development and progress as well as that of the society and nation. This requires that we not only discuss the issues, concerns, and challenges of adolescents but also the ways and possibilities for them to fulfil their potential, perform optimally, and thrive.

'Adolescence'!

What does the term mean? What image do we have of an adolescent? Do we have different emotions, perception, and cognition related to the term adolescent? Most probably, one would think of an adolescent as someone who is not a child anymore, has grown up, but is not yet an adult. So, adolescence is the transitional phase between childhood and adulthood, moving towards relative independence from parents and family. However, the experience during this phase is not uniform across cultures and contexts. Adolescents are not a homogenous group. The period of adolescence thus does not indicate a fixed time frame, rather it marks a phase of development which is characterized by dramatic physical changes and huge psychological changes. There are changes in cognitive, social, and emotional aspects of development, which further impact their interpersonal interaction and own personal achievement and excellence in life. Hence, adolescents need to be considered as a diverse group whose developmental trajectories are influenced by various demographic factors such as

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gender, socio-economic status, caste, race, disability, deprivation, and other situational factors. It is pertinent to keep this diversity in mind, the at-risk group as well as all adolescents while studying, designing, and developing programmes for their development and well-being.

The World Health Organization (WHO) defines adolescents as those between 10 and 19 years of age. It describes the young people as between 10 and 24 years of age group which includes the youth from 15 to 24 years of age. The National Youth Policy (http://mospi.nic.in/sites/default/files/publication_reports/Youth_in_India-2017.pdf) (2014) of the Government of India has defined youth as persons in the age group of 15–29 years. Thus, there are variations in the age range which highlights the fluidity of this stage and the role of socio-economic–cultural determinants influencing their development.

According to UNICEF (https://www.unicef.org/india/what-we-do/adolescent-development-participation), every fifth person in India is between 10 and 19 years, and India has the largest adolescent population (253 million) in the world. Further, around 21% of the Indian population is adolescents (Strategy Handbook, 2014). The Government of India has launched the National Adolescent Health Strategy (Rashtriya Kishore Swasthya Karyakram) in 2014 to address the challenges faced by this age group so that they can achieve the true potential of which they are capable.

What are the ***crucial gamechangers*** to turn this huge demographic dividend of the young people from just beneficiaries of different programmes and policies to active participants in the process of development, both their own and that of the nations? ***How can we make adolescents thrive*****?**

If we look at the historical development of the field of adolescence, it reflects a change in the theoretical perspectives used to understand adolescence and address their issues. The field of adolescence initially has been conceptualized as a stage of storm and stress by Hall (1904). It was viewed that adolescents in this transitional phase face various issues and challenges as they progress to adulthood. Freud's psychoanalytic approach emphasized the psychosexual stages of development and the early childhood experiences in influencing the adult personality and development (Ciccarelli & White, 2018a). However, neo-Freudians differed from Freud, and later on Erik Erikson proposed the psychosocial theory of development emphasizing a life span approach to development rather than early influences only (Erikson, 1959). The role of contextual factors and society were recognized as important factors for the development of adolescents. Erikson pointed out that a sense of competition develops among adolescents if they successfully master the developmental tasks of the particular stage, helping them to establish their role and identity in society.

Humanistic–Existential theories further emphasized the innate goodness and ability of each human being to grow and achieve (Rogers, 1961). It focused on positive traits in the individual and advocated individuals as capable of self-direction. The key words—choice, freedom, and growth—characterize adolescents which we need to recognize and accept in the context of their diverse backgrounds. This will help focus on the inherent capacities they have and unfold these to function effectively and excel.

Adolescents, however, do not function in a vacuum. There is a dynamic interaction with the context in which they live and operate. Bronfenbrenner has highlighted the systems approach affecting the development of the child in his ecological systems theory (Bronfenbrenner, 1979). He emphasizes an interaction of the growing child with the immediate environment which includes family, peer, and neighbour; intermediate environment of school, community; and the distal environment of the political, social–historical circumstances, cultural values, and laws. Vygotsky's socio-cultural theory also talks about the influence of socio-cultural environment on the learning and cognitive development of children (Vygotsky, 1978). It puts focus on encouraging children through the use of principles of scaffolding and zone of proximal development.

Adolescence is thus considered as a socio-cultural phenomenon characterized by cross-cultural variations in how it is interpreted and experienced (Ciccarelli & White, 2018b). This affects their development, health, and well-being. Amartya Sen in his capability approach highlights the importance of capabilities in the well-being of individuals. According to him, these capabilities enable individuals to do and to be that which they have reasons to value (Sen, 1992). Amartya Sen has based his capability approach on Nussbaum's (2003) conceptualization of well-being which talks about different capabilities across ten different domains (having good health, freedom of emotional expression, being able to laugh and play, having self-respect, contributing to community, etc. (Sen, 1997)).

To be, what human beings are able to be and do, is being true to oneself as underscored by humanistic theories. This also highlights the positive psychology perspective which builds on the humanistic theories. It helps the individual to thrive and maintain harmony with oneself and the environment around.

Positive psychology emerged in response to the exclusive focus of psychology on psychological problems and disorders faced by human beings after World War II (Snyder et al., 2011). Although this has helped a lot in our increasing understanding of the field of psychopathology, clinical manifestations, prevalence, diagnosis, etiology, treatment, and therapeutic intervention for mental disorders and other mental health conditions, it has neglected the other equally important aspect of human personality—the strengths, resilience, and optimal functioning of the individual.

The field of psychology initially had three missions—curing mental illness, making the lives of all people more fulfiling, and identifying and nurturing high talent (Snyder et al., 2011). However, the latter two missions were not pursued as vehemently as the first one. Positive psychology started as a field in psychology to address this imbalance when Martin Seligman declared it as the theme of the American Psychological Association in 1998 when he was elected as its president.

Broadly, positive psychology focuses on positive subjective experiences, positive traits, and positive institutions. Thus, it highlights the role of building up character strengths in the individual and also the influencing role of institutions such as family, school, and community in achieving optimal human functioning. A recent study on the relationship between adolescents' perception of their strengths, weaknesses, and wishes and their mental health indicates the need to focus more on building the strengths of adolescents (Devi & Patra, 2019). The study reported a majority of

students had a moderate level of mental health (61%), whereas 11% were languishing and only 28% were at the flourishing level of mental health. *Adolescents need to move beyond the average level of mental health towards flourishing and thriving.*

Various intervention programmes and youth development programmes utilize the principles of positive psychology to enable young people to build up strengths and resilience to achieve optimally and function effectively. One study suggests eight features related to adolescents' daily settings and experiences which can be used in community programmes to promote positive youth development (National Research Council & Institute of Medicine, 2002). These include physical and psychological safety; appropriate structure, e.g., clear and consistent rules and boundaries; supportive relationships; opportunities to belong, i.e., inclusion and engagement; positive social norms including rules of behaviour and values; support for efficacy and mattering (such as youth-based empowerment practices, focus on improvement, and being taken seriously); opportunities for skill building; and integration of family, school, and community efforts.

In the light of the above discussion, *the present book has adopted a positive psychology perspective to discuss the adolescence stage.* This book offers a unique perspective on the adolescence stage by discussing issues, concerns, and challenges of adolescents during this stage as well as ways for them to perform optimally and thrive. So, the major focus of the book is to highlight the challenges and provide ways to help adolescents thrive. However, this requires the readers a general and critical understanding of adolescent development.

Hence, the first three chapters describe the stage of adolescence in terms of the developmental aspects, their identity development, and peer relations. This provides the backdrop in which the issues of adolescents are discussed in later chapters. These issues and challenges range from immediate academic concerns and career-related concerns to effects of aggression, violence, and trauma on adolescent development. The book also includes a chapter on substance use among adolescents, which is an important concern across gender, type of family, rural–urban location, socio-economic status, and communities in which adolescents live. Further chapters focus on depression, suicide among adolescents, and also various mental disorders that affect this age group. Disability is another significant concern in adolescents, which has been focused on in the book. Moreover, the current trend of the use of technology in almost every sphere of life has impacted adolescents in a big way. Living in a digital world has its own benefits and challenges. Adolescents need to navigate the digital world in an effective way to take care of their mental health and well-being.

The book finally throws light on various preventive and intervention approaches to lead the adolescents to thrive. It focuses on individual character strengths such as building gratitude and resilience, and life skills among adolescents. Further, it focuses on the context or setting in which adolescents function such as peer group, family, and community. The socio-cultural context definitely needs to be considered when talking about adolescent well-being.

Thus, the book takes a comprehensive approach in discussing the issues, dealing with these issues, and helping adolescents to fulfil their potentials, thrive, and achieve optimal functioning in interaction with their context. It focuses on measures to

improve adolescent well-being at the individual level as well as at the family and the community context, which will help formulate appropriate plans, programmes, and policies to develop adolescents and the young people of our country as real assets.

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Part I
Introduction

Chapter 2
Development in Adolescence: An Introduction

Navshad Ahmad Wani

Abstract This chapter provides an introduction to the adolescence stage of development. It defines and highlights the multiplicity of adolescence. Various aspects of adolescent development are described. Further, it explains major theoretical perspectives on human development including historical, contemporary, Indian, and Buddhist approaches. The implications for the crucial transitional stage of adolescence are highlighted.

Keywords Adolescence stage · Aspects of development · Adolescents · Indian tradition · Theories of development

Introduction

Study of human life span from conception to death has fascinated researchers since long. Earlier known as developmental psychology, it is called human life span to highlight the study of each of the stages in this life span rather than focusing on specific stages of development. According to Overton (2010), "life-span development is the study of the development of living organisms from conception to the end of life". Thus, it entails a continual study of humans to understand basic processes underlying behaviour at various stages of life. The focus is on understanding how people change (dynamics) or stay the same (constancy) in all these aspects. Development spanning the entire life is characterized by an initial growth or evolution and then atrophy/loss (involution) in the later part of life.

Humans are complex beings and have evolved over generations. Psychologists try to understand the structure, function, and behaviour of organisms and their interactions with one another by considering them in the context of the long, continuing process of evolution. It is widely agreed that both heredity and environment are essential for everything we do, as a computer depends both on its hardware and software for its functioning. For instance, genes may predict a level of intellectual ability, but

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environmental inputs and stimulation may determine the actual intellectual level of the child. Hence, we need to note that both genetics and the environment influence human development. Societal and cultural factors play a significant role in human development.

The eastern perspectives like Confucian, Indic, Iranic, Taoist, and Hindu models of life span development provide different views from the Western models, highlighting the "one-theory-for-every-culture" developmental model, and thus broadening the area of life span development to a greater extent.

Knowledge of human life span development is required for optimum development and functioning of the individual at each stage of life. There are certain general characteristics of development that one needs to know in order to better understand the different developmental aspects of adolescence as follows.

Development is multidisciplinary. The study of life span development has been influenced by several academic disciplines like psychology, sociology, biology, anthropology, neuroscience, medicine, education, etc. One needs to adopt a multidisciplinary perspective while studying adolescence since their development, experiences, and behaviours are influenced by multi-factors, contexts, and fields.

Development is lifelong. Contrary to the common conception that development is till adulthood, it is lifelong, though the rate and nature of development may vary. Adolescents' development is influenced by development in earlier stages and also affects development in future life stages.

Development is multidimensional. The major dimensions/domains of development are physical (changes in height, weight, nervous system, illness, etc.), cognitive (changes in thinking, perception, memory, intelligence, language, etc.), social (interpersonal relationships with family, peer, etc.), emotional (changes in emotions, their expression, and regulation), and moral (development and changes in morality) dimension. These domains influence each other, which shapes the development accordingly. For example, when an adolescent experiences emotional changes due to rapid physical development, it also affects his/her social relationships with the family as well as peer group.

Development is multi-directional. Early stages of development are usually characterized by growth and later years are marked by decline or loss of functioning. However, changes in any direction can happen at any stage, and can occur combinedly also. Multi-directionality is shown not only in each stage of human life span but also in each domain of development, e.g., cognitive development in older age may exhibit poor memory, but improved language ability. Adolescents gain in abstract thinking but still lag behind in emotion regulation.

Development is multi-contextual. Development occurs in many contexts and is influenced by multiple, interacting forces such as biological, historical, social, and cultural forces. Three specific contextual influences are normative age-graded, normative history-graded, and non-normative life influences (Baltes, 1987). Hence, while studying adolescents in terms of their typical development, one needs to consider the

influence of specific experience and contextual factors also, e.g., the loss of parents of an adolescent.

Development is characterized by plasticity. Plasticity refers to the ability of human beings to change and adapt to situational demands reflecting resilient attitude. However, if the capacity and opportunity for change are reduced, for instance, in the case of adolescents from disadvantaged backgrounds, development gradually becomes less plastic. This has implications for developing resilience in adolescents by providing them adequate resources and skills to be resilient. There are, however, individual differences in plasticity as determined by their nature and nurture aspects.

Adolescence Stage: Definition and Nature

Adolescence is an important developmental period of transition which psychologists have long been interested in. It is a key stage which sets the basis not just for adult life but all stages to come. It brings in enormous changes not only in physical aspects (growth spurt and sexual maturation), but also in cognitive, social, and emotional aspects. In this period, the young are expected to attain physical, mental, and emotional maturity. They are required to make serious efforts at vocational and civic responsibilities.

The roots of the word **adolescence** lie in the Latin word (adolescere) meaning "to grow up" or "to grow into maturity" (Muuss, 1982, p. 4). Adolescents have been defined as those between 10 and 19 years (WHO, 2012; UNICEF, 2005). This definition has been accepted by the Ministry of Health and Family Welfare, Government of India (GOI). The United Nations Educational Scientific and Cultural Organization (UNESCO) described the term 'youth' as more smooth than a definite age group and refers to *"young people within the period of transitioning from the dependence of childhood to adulthood independence and awareness of their independence as members of a community"* (UNESCO, 2017). According to World Health Organization, *"one in five individuals in the world is an adolescent, aged 10–19 years and most adolescents live in developing countries which represent up to a fourth of the population"*. The literature on the period of adolescence has witnessed a paradigm shift across ages and interestingly varies from region to region not just in terms of definition but also the age of onset. This has been an area of concern for behaviour scientists, developmental psychologists, and even lawmakers to revisit their conceptions based on recent research in the area.

The UNICEF's report on "The State of the World's Children 2011" has emphasized certain complexities in defining 'adolescence' as different individuals experience the period differently, and there are differences in the developmental patterns of boys and girls. The factors like "age of voting rights" marriage, joining military, ownership of property, etc., vary widely in different countries. In India, attaining 18 years is legally considered to be an adult. The Juvenile Justice; Care and Protection Act, 2015, and POCSO—Protection of Children from Sexual Offences Act,

2012, define child who is below 18 years of age. Yet there are many instances where youth-related policies are fixed at different standards rather than on a particular fixed threshold. For instance, persons below the age of 14 years are prohibited from child labour. Integrated Child Development Scheme recognizes 13–19 years age group for boys and 11–18 years for girls under youth development policy. Moreover, many other government policies and interventions cover the extensive age group of 10–24 years in adolescents and youth. The outcome of such unclear policy in terms of age determination has lead to many flaws in the formulation of different acts and legal provisions. For instance, sex under 18 years of age is prohibited but mostly girls are married underage, and there are no legal provisions to secure such adolescents. The abandonment of babies due to illegal sex practices has led to many psychological ramifications in orphanages and shelter homes resulting in social stigma and disgrace.

Although there are international standards for determining the age of adolescence which is considered as 12–19 years, it differs across societies, cultures, and even in countries with respect to factors like urban and rural, tribal and technological society, poor and rich socio-economic levels of the family, etc. In contemporary India, most of the policies and initiatives regarding youth are governed under the universally popular threshold of 18 years.

The nature of adolescence varies in different historical periods. The contemporary concept of adolescence appears to have emerged in cross cultural research in the latter part of the nineteenth century. Great emphasis has been given to adolescence during the twentieth century because of the huge increase in school enrolment of 14–17-year-old adolescents. The current global pandemic of COVID-19 in this twenty-first century has also affected the development of adolescents differentially across economic and cultural conditions. The massive disruption has happened in the education systems, affecting nearly 1.6 billion students in more than 190 countries (WHO, Regional Office for Europe). Their health and well-being have also been severely impacted.

Thus, one needs to consider the historical context as well as the socio-cultural–economic context in understanding adolescent development. For instance, the average age of puberty has gone down by 3 years over the past two centuries largely due to health and nutrition (UNICEF, 2011). There has been a rise in challenges related to reproductive health, sexual behaviour, substance use, the spread of sexually transmitted diseases, and teenage pregnancies. Awareness of legal, social, and economic rights, and mental health issues and rights of adolescents have received a lot of attention from researchers. An increase in the use of technology and the rising of a digital world have revolutionized the life and experiences of adolescents, and have affected their developmental aspects in varied ways.

Development in Adolescence

Development is not a unitary dimension. It needs to be viewed in a cultural and social context so that it provides a genuine and practical perspective on adolescent development.

Adolescence as a psychological phenomenon is characterized by peer influence, delicate relationship with parents, insecurities, confusions, and at the same time having an '*everything possible*' attitude and high achievement goals. The adolescent tries to understand his/her 'identity' as he/she goes through this transition phase. Although physical changes determine adolescence, social forces also act to shape this phase of life. In a social context, adolescence observes increased independence from parents as the young person anticipates leaving home for education, to get into some vocation or employment, and to form sexual partners and marriage. Thus, it can be said that the beginning of adolescence is to a great extent a physical and physiological phenomenon, whereas the end of adolescence is mainly emotional–social. Therefore, while devising the legal, economic, and social regulatory policy for adolescents, it's imperative to consider the psychosocial needs of the adolescents not just the demographic and physical needs of adolescents.

The concept of age can also have different implications for adolescent development. The age by birth is usually referred to as the *chronological age*. However, one may feel older than the chronological age possibly due to illness or chronic stress. The *biological age* is defined simply as the pace at which the body is ageing. The rate at which the human body ages depends on several factors such as nutrition, physical activity, smoking, alcohol consumption, sleeping habits, how we handle stress, and the genetic history of our ancestors. On the other hand, the *psychological age* is the psychologically adaptive capacity as compared to others of our chronological age. It includes our cognitive capacity and emotional beliefs about our own age, e.g., the socio-economic context of adolescents may affect how the cognitive abilities manifest. Some may be more or less adaptive and excited to meet new challenges in comparison to other adolescents of their age. The *social age* refers to meeting appropriately the social norms and expectations embedded in one's culture and its expectations from the people of a particular age group. Our culture often reiterates us of our targets for attaining such social milestones as moving away from home, completing education, having children, and retiring from work. However, there have been arguments that "*social age is becoming less relevant in the twenty-first century*" *(*Neugarten, 1996). In the changing global scenario and its effect on varied aspects of our life including family, interpersonal relationships, and workplace, the developmental tasks of each stage of development have also undergone changes.

Aspects of Development

As is the case with other periods of development, adolescents also develop simultaneously with respect to development in other aspects and with reference to the context of family, school, and community. Other factors such as gender, sexual orientation, having a health condition, disability, and one's cultural and religious beliefs also have an influencing role on the various aspects of development in adolescents (Fig. 2.1).

Physical Development

Physical changes during adolescence are marked by puberty and associated changes. These pubertal changes are part of normal development, and yet marked by "*most profound biological and social transitions in the life span*" (Susman & Rogol, 2014), which may make adolescents susceptible to risky behaviour. The stage of adolescence is characterized by 'growth spurt', increase in muscle and fat, changes in the brain, and reproductive maturity. This general developmental process, however, gets affected by physical health factors related to the adolescents including their nutrition, exercise, physical activity, use of alcohol and drugs, illness, and disability; demographic factors such as genetic make-up, race, ethnicity, and socio-economic status; stressful life events and environmental-related factors.

The onset of puberty as well as response to puberty varies in different social contexts and ethnicities. This highlights the need for culture-specific interventions to prepare the children for adolescence. As adolescents attain sexual maturity, their neurons become more reactive to excitatory neurotransmitters. The excitatory neurotransmitters make adolescents react more vigorously to more rousing and stressful

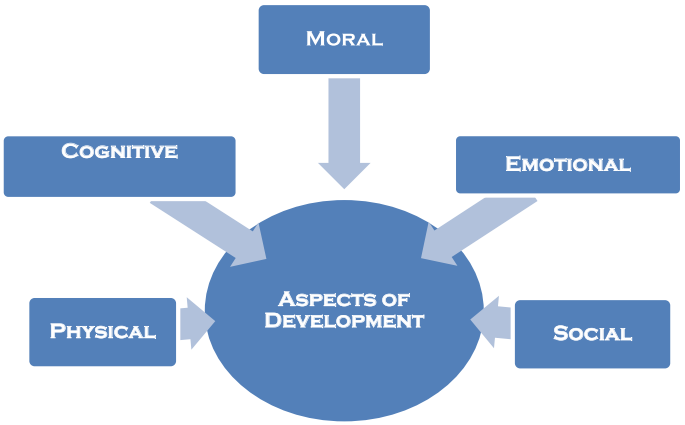

Fig. 2.1 Aspects of development

events. It also prompts them to intensely experience pleasurable stimuli. *But because the cognitive control network is not yet functioning optimally, most teenagers find it hard to manage these powerful influences* (Steinberg, 2010). These may be the reason for the adolescents' reckless driving or biking, sensation-seeking behaviours, experiencing excitement by drug taking, unprotected sexual activity, and delinquent behaviour. It also shows the vulnerability of the adolescents towards peer influences and risk-taking behaviours as a result of such influences.

Cognitive Development

Cognitive development in adolescence encompasses how a person thinks, perceives, and gains an understanding of the phenomenological world through an interactive mechanism of both genetic and acquired processes. They acquire formal operational thinking, engage in abstract thinking, decision-making, and meta-cognition skills, i.e., thinking about thinking. However, adolescents often show behaviour without caring for the consequences because of the reward system attached to risky behaviours like smoking, unsafe sex, drug addiction, and more importantly health-related vulnerabilities. These activities give them emotional satisfaction and much required sensation seeking.

Moral Development

Moral development is related to the cognitive and social development of adolescents that affects the development of their moral reasoning, moral values, caring morality, and prosocial behaviour. The earlier theories, e.g., psychoanalytic approach, have emphasized the early childhood experiences arising from parental practices and socialization processes as influencing the moral development of children. Kohlberg's theory of moral development suggests that *"young children exhibit moral behavior based on probable consequences whereas older adolescents base their moral reasoning on social conformity, intuitions and sense of justice"*. The cognitive theorists (e.g., Piaget) focused on the development of moral reasoning in children.

Later, Gilligan proposed a caring morality exhibited in the case of women influenced by prosocial behaviours, honesty, and altruism. Thus, it emphasizes caring and altruistic behaviour in matters of moral judgement, whereas justice-based morality puts emphasis on laws and rules to be conformed to as moral values and justice. Gilligan's theory of moral development while emphasizing the sex differences in the approach to morality does not claim that one is better than the other. Rather, both the care orientation to morality and justice orientation to morality need to be integrated to understand effectively the moral development in human beings.

Recent theories conceptualize morality from a social-constructivist framework, highlighting the influence of social interaction and social experiences in moral development (Smetana, 2018). The focus is on facilitating the rights and well-being of others, treating them in a fair and just manner, and avoiding any harm to others.

Studies indicate that dispositions towards feelings of care and concern for others lead to prosocial behaviour and avoid aggressive behaviour in children (Jambon & Smetana, 2015). This has implications for the way children are raised. Positive parenting practices can facilitate the development of a theory of mind in children. They are able to show empathy, considering things from other person's point of view. As a result, they are able to consider the intentions and motivations behind people's behaviour related to moral violations.

Variations in cultural practices also influence morality in children. For instance, Indian culture emphasizes interpersonal relationships and complies more with the duties and responsibilities related to it as compared to the American culture though the latter also views family and friends as important (Miller & Bland, 2014). Thus, socio-cultural influences can shape the development and expression of moral judgement as well as moral behaviour.

Recent research has focused on the evolutionary perspective on moral development highlighting the neurobiology aspect of it (Hamlin, 2013; Young & Dungan, 2012). The altruistic dispositions are marked by innate tendencies and such people are intrinsically motivated for this as it helps in maintaining harmony and peace. Thus, it can be said that although there may be a biological predisposition towards caring and prosocial behaviour, the early year experiences of the child, the socio-cultural practices and expectations together in dynamic interaction with the former, determine and shape the moral development of children as they grow into adolescents and adulthood.

Emotional Development

The development of emotional competence helps in laying the foundation for social competence, which helps adolescents to develop meaningful relationships with other people. More specifically adolescents need to learn to identify, use, and manage emotions. Self-regulation of emotions is an important life skill for adolescents. Attainment of puberty and increased level of hormones during adolescence can make the adolescents high on emotion. Hence, they need to learn to manage their emotions, use adaptive and reasoning skills, avoid snap judgements, and consider long-term consequences of behaviour. The skills related to self-awareness, self-management, social awareness, and social skills (which together refers to emotional intelligence) are particularly important in determining the efficiency of adolescents to develop harmonious and effective interpersonal relationships. Youth without relationship skills are at greater risk for a number of problems, including dropping out of school as compared to their peers who have these skills (Olweus, 1996). These skills of emotional intelligence affect both personal and professional life success. These can

be fostered through parenting practices, training of life skills, and other intervention measures.

An important part of the process of emotional development is developing a sense of identity and awareness of oneself. This process of identity formation is the central task of adolescence and continues after the stage of adolescence is over too (Erikson, 1968). The cognitive and affective evaluation of sense of self and the ability to think about the possibility of becoming is the striving for uniqueness during adolescence.

Increasing cognitive development of adolescents facilitates greater sensitivity in them to their own complex emotional states as *well* as those of others (Kirkbride, 2018). However, in the absence of proper ability to deal with these emotions, they may get overwhelmed and turn to negative ways of coping such as playing video games excessively, uncontrolled use of the Internet, and taking drugs and other substances.

Social Development

Social development in adolescents takes place in group settings like peer groups, family, school, work, and community. They mark a process of separation from parents and family leading to individuation where the adolescents form their own identity. All these settings influence and shape the identity development of adolescents.

Peers occupy a special place in the social development of adolescents, marked by a shift from the family to their peer group. However, drifting away from the family or decrease in the frequency of family contact does not mean that the family assumes less importance for the adolescent (O'Koon, 1997). In fact, family closeness and attachment have been associated with not smoking, less use of alcohol and other drugs, later initiation of sexual intercourse, and fewer suicide attempts among adolescents (Resnick et al., 1997). At the same time, the peer group provides the much needed support to explore oneself and develop a sense of identity.

Although peer relationships are important sources of support, they have the potential to play a double-edged sword in that the dynamic interaction among the adolescent, the peer characteristics, and the contextual factors will determine whether the peer is going to have a positive or negative influence on adolescent development. Peer groups provide acceptance, popularity, status, and prestige. It is also an important source of information to the adolescents about the world outside of the family and about themselves (Santrock, 2001). Peer acceptance has long-term implications for adjustment.

Early adolescents tend to have a peer group having homogeneous psychobiological characteristics and are characterized by acceptance and conformity to peer group norms. However, during middle adolescence (ages 14–16 years), adolescents prefer more gender-mixed peer groups in which less conformity to standards is accepted. By late adolescence, peer groups have often been replaced by more intimate dyadic relationships, such as one-on-one friendships and romances that have grown in importance as the adolescent has matured (Micucci, 1998).

The twenty-first century characterized by technology and online communication has implications for the social development of adolescents. It can facilitate as well as pose challenges and risks for adolescents in the digital world.

Family Relationships play an important role in development in adolescence. A strong sense of bonding and attachment to one's family helps them to be more self-reliant, emotionally mature, have better school grades, and decreased prevalence of high-risk behaviours such as drug use and delinquent behaviour (Perry, 2000; Steinberg, 2001). However, in the backdrop of the globalized world giving rise to various forms of families going beyond the prevalent joint family and nuclear family system, it has implications on adolescent development who are moving towards more independence.

School is another important source of influence on adolescent social development. School provides a sense of belonging, security to the child and serves as a platform to develop in all aspects. However, school can also be a traumatic experience if the adolescent faces bullying, abuse, and aggression by peers which becomes more pronounced when the adolescent is going through the process of identity development. Further, the school organizational culture, teacher fairness, as perceived by the adolescent also affects her/his school adjustment and performance.

Community has the potential to impact the development of growing adolescents either in a positive or negative way. The neighbourhood atmosphere, available infrastructure, services, facilities, socio-economic status of people, and institutions such as schools, religious organizations, and media create the ethos of the community and impact people living there. Communities rich in resources, both material and human, positively impact the development of their adolescents, whereas adolescents from poor rural areas or low socio-economic and deprived status may manifest behavioural problems, engage in delinquent activities and substance use. Adolescents positively influenced by spiritual and cultural values tend to have a great hunger for meaning in life. However, it is crucial that they are exposed to appropriate role models, open discussions of moral values, prosocial values, civic responsibility, and larger meaning of life.

Media has a profound influence on the social development of adolescents. Adolescents spend an estimated 6–8 h per day exposed to some form of media (Roberts, 2000). The social development of adolescents who literally live in a 'virtual community' is now more influenced by the adolescent's online presence, online behaviour, and online engagement.

The portrayal of explicit content, violence, and aggression in various media can have serious negative influences through social learning and particularly in the absence of any positive role models. Unrestricted access and lack of monitoring mechanism may lead the adolescent to cyberbullying, sexual abuse, pornography, and misinformation on various matters. Virtual relationships are more intimate than in-person relationships (Bargh et al., 2002). There is less inhibition which may also lead to problematic situations. On the other hand, media can provide a plethora of opportunities to the adolescents at their doorsteps, ranging from education to work

to providing information and knowledge on sensitive yet important matters such as substance use, bullying, negative peer pressure, healthy diet, depression, relationship issues, and other health-related matters.

The ubiquitous presence of the Internet and various interactive social media in the lives of adolescents makes it imperative that measures are taken to maximize the positive possibilities and minimize the negatives.

Theories of Development

Let us now discuss various theories of development and how they explain development during the adolescence stage. The theories can be classified into historical theories and contemporary theories of development as given in Table 2.1.

Historical Theories of Development

The earliest view on development is the Preformationist view, which considered child as merely a little adult. This view resulted in a belief that children possess sensory abilities, emotions, and mental aptitude at birth, and these abilities unfold as children

Table 2.1 Theories of development

Theories of development	Historical theories of development	Jean-Jacques Rousseau	
		Charles Darwin	
		G. Stanley Hall	
		Arnold Gesell	
	Contemporary theories of development	Psychoanalytic theory of development	Erikson and psychosocial theory
			Anna Freud
			Peter Blos
		Cognitive theories of life span development	Jean Piaget
			Socio-cultural theory of Lev Vygotsky
			Information processing theory of development
			Jerome Bruner's Theory of Cognitive development
		Ecological systems theory of Urie Bronfenbrenner	
		Learning theories of development	Social learning theory

continue to grow but these abilities unfold on a predetermined schedule (Thomas, 1979). On the contrary a well-known British philosopher, John Locke (1632–1704), refuted the idea of the innate presence of the capabilities and held that children are predominantly shaped by their social environments. Locke argued that the child's mind is a clean slate "Tabula Rasa", and the social environment shapes the knowledge and behaviour of the children particularly in their early life. It highlighted the nurture aspect in the nature–nurture debate on human development.

Jean-Jacques Rousseau (1712–1778): Although Rousseau did not agree to Locke's clean slate preposition, he approved the idea that children were not mere little adults. He believed children developed according to a natural plan which unfolded in different stages (Crain, 2005). He emphasized the idea of freedom for children to think by themselves according to their own ways and an inner, biological timetable which was unique to every child instead of instructing the correct way to think. This overemphasis laid by Rousseau on biological maturation was the precise reason for him being called the father of classical developmental psychology. Gesell, Montessori, and Piaget followed the developmental perspective of Rousseau.

Charles Darwin (1809–1882): The beginning of the scientific approach into the field of development witnessed improved methods and observations. One such theoretical explanation to the process of development is that of the British naturalist Charles Darwin. He propounded the well-known theory of Evolution, which emphasized two related principles: *natural selection* and *survival of the fittest.* He elucidated how some species survive in specific environments due to their characteristics to survive in that environment; whereas other species die off because of the lack of the characteristics required to survive in that particular environment. His clear emphasis on the adaptive value of human behaviour became the reference point for important theories of development.

G. Stanley Hall (1846–1924): Stanley Hall is considered as one of the most influential American psychologists of the early twentieth century and is also regarded as the founder of the child study movement (Hogan, 2003). He was influenced by Charles Darwin's and Rousseau's works and is regarded as the pioneer of his first textbook of adolescent psychology. He regarded development as a genetically determined process that unfolds automatically, much like a flower (Gesell, 1933; Hall, 1904).

Arnold Gesell (1880–1961): Based on his enormous experience at the Yale University and the Gessel Institute of Child Development, he and his colleagues believed that development unfolds in set sequences and concluded that the child's development was activated by genes which he named the process of maturation (Crain, 2005). Since he believed in the maturational perspective, he was averse to any efforts of teaching children ahead of schedule and argued that children will eventually engage in behaviours when their nervous systems sufficiently matured according to a prearranged and naturally occurring plan of growth.

Gesell strongly recommended sensitivity to children's cues (Thelen & Adolph, 1992). His books on child rearing along with Benjamin Spock's *Baby and Child*

Care were important sources of information on child development. His views were critically evaluated for neglecting human individual differences in development, yet he got acknowledgements of being highly scientific.

Thus, the historical theories highlight the nature and the nurture aspect of human development whereas, contemporary theories focus on other aspects such as socio-cultural factors and the dynamic interplay between the child and the system, influencing development.

Contemporary Theories on Development

Psychoanalytic Theory of Development

Among the most influential theories on human development, psychoanalytic views laid great emphasis on instinct-driven early childhood experiences in shaping human behaviour and personality. During childhood, we strive to become social beings by managing our instincts into socially approved reconstructions. His views on development and psychopathology dominated the field of psychology and related sciences until the arrival of behaviourism.

Freud held that there is a constant conflict between biological drives and social expectations as people progress through different psychosexual stages. While striving for gratification in each stage, fixation may occur due to over or undergratification, which severely affects the child's adult personality. If balanced gratification is ensured, children develop into well-adjusted adults and productive members of society.

Freud's extreme emphasis on sexuality or focus on the dark side of human nature has been the most criticized aspect of his theory. Second, this theory is very difficult to test scientifically (Crews, 1998). Yet, Freud's theory still remains a powerful view which not only emphasized the influence of the early parent–child relationship, but also provided a framework for later theories of development especially in the 1930s and 1940s.

Erikson and Psychosocial Theory

Erik Erikson's (1950) theory proposed eight developmental stages covering the entire life span and emphasized more on the importance of social factors in development.

Erikson advanced the view that humans experience or face challenges in every period of life which he called ***psychosocial crises***. The way an individual deals with challenges, goals, and demands of the crises determines his/her successful development. For instance, if a person does not develop a sense of trust in the earlier stage, s/he may find it challenging to form a positive intimate relationship as an adult. His concept of crises resembled Freud's 'fixation', but the crises represented a much wider term to reflect it into a challenge rather than psychopathology.

Adolescents face the crisis of identity versus role confusion which requires them to develop a well-defined and positive sense of self in relationship to others so that they can function effectively and progress smoothly to the next stage of development.

However, the theory has been criticized for the assumption that the completion of one crisis successfully is a precondition for moving to the next stage of development. The second criticism is that this theory concentrated on the social expectations that may be found in some cultures but not in all the cultures of the world. Adolescents being a diverse group reflect variations in their socio-cultural context and expectations which influence their development.

Anna Freud (1895–1982)

Anna is one of the first clinicians to write about adolescence and adolescent behaviour in her famous book, *The Ego and the Mechanisms of Defense* published in 1936. She extended the theory of her father in her discussions on the use of defence mechanisms by adolescents to ward off their anxieties caused by the onset of puberty. Humans defend themselves when faced with anxiety-provoking impulses and situations by using various psychological mechanisms of defence. Defence mechanisms as they are called revisit the situation in a less distressful way, for instance, adolescents turn away from indulgence and temptations by exerting extreme self-control and thus avoid the risk of their impulses getting out of control. This defence mechanism is called ***asceticism***. Their modus operandi is to counter more urgent desires with more stringent prohibitions. Anna listed many such defence mechanisms to explain the highly complex nature of adolescent behaviours. The theory has implications for adolescent psychopathology.

Although the psychoanalytic perspective is no longer the mainstream of the theoretical basis in developmental psychology research, it forms the basis for the understanding of life span development even today.

Cognitive Theories of Life Span Development

The cognitive theories stress how our mental processes change through the life span. Adolescent thinking is directed towards the use of abstract ideas rather than concrete ones, multidimensional rather than single ideas, reflective rather than absolute, Keating (1990). Further, the complexity of their thinking affects the complexity of their self-identity, image, and their efficiency to understand interpersonal relationships. Three important cognitive theories are Cognitive theory by Jean Piaget, Theory by Lev Vygotsky, and Information-processing theories.

Jean Piaget (1896–1980):

Jean Piaget, the Swiss psychologist, was an influential theorist of cognitive development. *He was one of the first to recognize and map out the ways in which children's intelligence differs from that of adults* (Piaget, 1929). The central theme here is

how the growth and changes in thought processes enable children to acquire and use knowledge about the world. Children develop knowledge structures or schemas through the process of adaptation. Piaget further describes that the process of adaptation consists of two mechanisms as assimilation and accommodation. Assimilation refers to integrating the new knowledge into the existing knowledge or skills, and accommodation involves changing one's own knowledge structure to accommodate or integrate the new information or knowledge. Intellectual development thus includes developing a more complex schema through the progress in the accumulation of knowledge.

Piaget's views have been criticized for describing tasks with confusing abstract terms, underplaying the role of culture, and overemphasizing the role of physical maturation. Cultural considerations have been neglected in emphasizing the key developmental processes since culture reveals considerable variation across children as to what children are able to do at various ages.

Socio-cultural Theory of Lev Vygotsky (1896–1934): This theory primarily stressed the importance of culture and social interaction in the development of cognitive abilities. His divergence with Piaget's view reflected his belief that an individual also has a set of 'potential abilities' in addition to a set of abilities that can be envisaged if proper guidance is given to them. His views represented a well-structured base and are used widely by educational planners.

The key theme of this theory is, "social interaction is the basis for the development of cognition in an individual". Every child's cultural development witnesses two levels; first, at the social (interpsychological) level and then at the individual (intrapsychological) level. Similarly, learning too occurs first through the interaction with others and then merges into the child's mental structure. These principles of two levels in learning and development are applied to other cognitive processes like memory, concept formation, attention, etc. (Vygotsky, 1978, p. 57).

Vygotsky's one of the potent concepts in his theory is "zone of proximal development" (ZPD) which refers to what a student can do on their own and what they can accomplish with the support of knowledgeable others. *This 'zone' is the area of exploration for which the student is cognitively prepared, but requires help and social interaction to fully develop* (Briner, 1999). The guidance and encouragement from a skilled and knowledgeable partner, a teacher, or a peer can help the student to achieve more in a 'proximal' zone which is the skills and tasks the student is close to master. The guidance and encouragement are similar to what Bruner called 'scaffolding' to support the student's evolving domains of not only knowledge but also complex tasks and skills.

Although the major contribution of his life was focused on studies of the infant and child, Vygotsky turned his attention to adolescent development nearly to the end of his life. His social constructionist approach recognized 'higher psychological functions' which emerge due to the integration of interpersonal networks and functioning in specific social and cultural settings. This life space within different contexts includes language; interaction modes, culture, and society represent a holistic psychological theory to adolescent development. In order to fully understand the diversity and

the context of adolescent lives, openness is highly important for understanding the interaction between adolescents and the unique environmental setting in which they live.

The chief concerns related to Vygotsky's views include the impreciseness of Zone of Proximal Development and emphasis on interaction which underscores the individuality of a child.

Information Processing Theory of Development

This theory is based on the information processing model of Atkinson and Shiffrin (1968) and the works of many other cognitive psychologists. It focuses on the processing of information received through three main components: information stores (sensory register, short-term and long-term stores), cognitive processes (coding, perceiving, and retrieving information and the subsequent processing like attention, storage, retention, analysis, interpretation, and other mental processes), and executive cognition (meta-cognition in which the individual is aware of the ways and means s/he processes the information and the amount of control one exerts over processing of information.

Information processing theory has developed further into different fields to enhance our understanding of human development. It has combined knowledge in biology, medicine, and neuroscience to form the field of Developmental cognitive neuroscience. Psychoinformatics which integrates the knowledge of psychology with computer science to handle large data sets derived from computer devices, smartphones, networking sites, and other gadgets fitted with automatic sensors which transfer data to remote servers helps in tracking the humans or to deeply probe into developmental stages by analysing the computer data of adolescents like movement patterns via GPS, reaction times, eye movement, sleep, and waking behaviours. This approach to the study of adolescence in particular and development in general is going to get a major paradigm shift in the near future.

Ecological Systems Theory of Urie Bronfenbrenner (1917–2005)

Bronfenbrenner's ecological systems theory which emphasizes contextual influences on development represents a distinctive explanation of an individual developing in a complex system. His postulates are based on the argument that the child's biological disposition does not work independently but joins with the forces of the environment in order to shape development. According to Bronfenbrenner, it is imperative to understand the ecology of development which is the scientific study of the continual growth and reciprocated adjustment between the developing person and settings in which s/he grows or lives.

The environment, according to Bronfenbrenner, comprises five layers or dimensions as follows:

Microsystem: The innermost layer of environment includes the individual's immediate surroundings, such as parents or siblings. Moreover, the restrictions, inhibitions, support, and child rearing directed towards young ones and the interaction styles of the elders have a direct impact on the behaviour, which in turn influence systems operating on him or her.

Mesosystem: It includes extended settings like *school, family, and religion.* These institutions impact and revolve around the micro-systems mentioned above. The child's problems of academics or the philosophy of the school system, day-to-day engagements, and other characteristics can affect the child's sense of accomplishment and self-image. Thus, the interacting influence of family, school can affect the development of a child/adolescent.

Exosystem: This includes larger contexts like workplace or community and their value system, health, and economic system. Exosystem represents the external support system, the informal interaction modes, the emphatic approach of the employers, parents' friends' and contacts of paternal and maternal extended relations.

Macrosystem: It represents the outermost layer of Bronfenbrenner's model which is composed of resources, cultural values, technological advancements, quality of public health and welfare, and welfare for marginalized sections of society. These systems incorporate positive and favourable experiences in the children.

Chronosystem: Humans have been viewed as dynamic organisms by Bronfenbrenner, who keep on assimilating the roles and settings across 'time' with a proper weighing of the roles and settings. These roles and settings can either be modified or created by the individual themselves according to opportunities in the environment or by individual virtues and attributes developed over time (Fig. 2.2).

Bronfenbrenner's theory, later known as a ***bioecological model*** (Bronfenbrenner & Evans, 2000), proposes that the environment represents a chain of connected loops from home and beyond. These connections extend from home to workplace, neighbourhood, school, community, etc. Thus, the theory has great implications for adolescent development. It highlights the combination of both the environment and the people who together form a network of interdependence. This theory has also been questioned on certain grounds like it is a bit difficult to apply due to less denied ecological detail, difficulty in empirical evaluation of its postulates, and its possibility of change in the definition of 'system'.

Jerome Bruner's Theory of Cognitive Development

In 1966, Bruner put forth his stage model of cognitive development emphasizing the merger of thinking and reason into a single continuous process. He proposed three prominent modes of learning such as enactive, iconic, and symbolic. The **Enactive** mode represents learning through actions. In the **Iconic** mode, the child gives meaning to the earlier experiences as a result of thinking which amounts to the visual

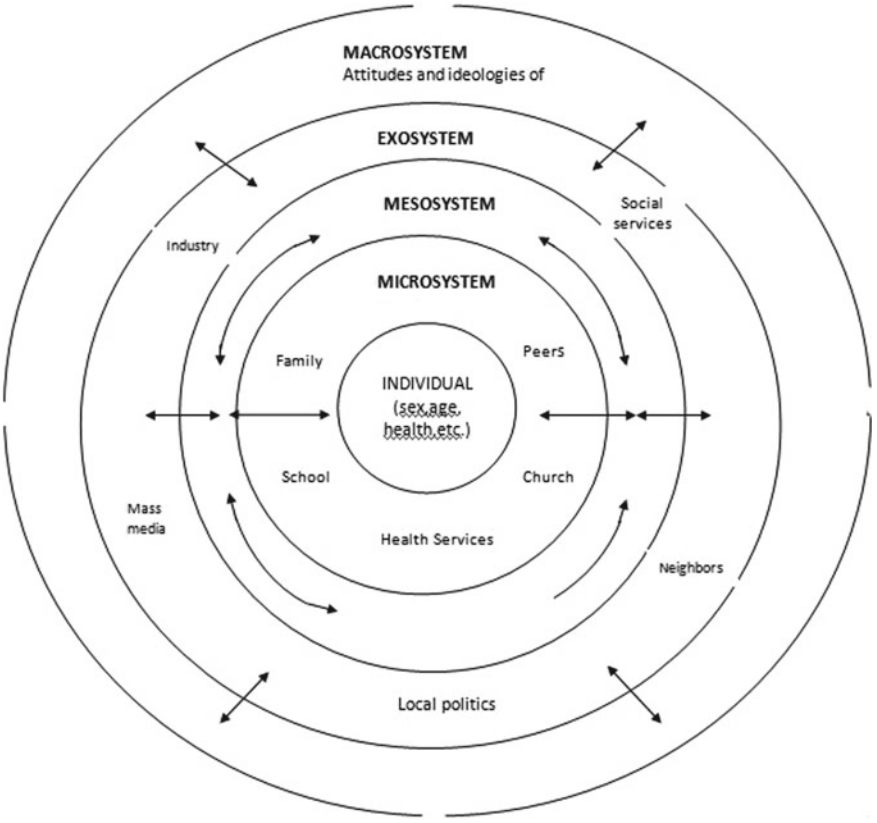

Fig. 2.2 Ecological systems theory of Urie Bronfenbrenner

encapsulation of images. The **Symbolic** mode indicates that the child uses symbols to describe his/her experiences. It is considered as the culminated form of thinking through which a child attaches meaning and prescribes names for the objects around them.

Bruner advocates that intellectual development and learning are not just memorization of concepts as human beings are active processors of information. The child must be able to comprehend, construct, and extract meanings from learning tasks. This can be arrived at by involving the child in problem-solving activities through collaborative tasks or peer learning through programmed guidance. He talked about 'scaffolding' to introduce an instructional process of making the child experience things through one of the three modes/stages. Here as the student progresses through task learning, the instructor reduces the amount of assistance during the process to encourage the student to experience things himself/herself.

The theory has implications for adolescent learning and development, especially those from disadvantaged conditions. They will need to have stimulating and encouraging learning opportunities so that they will be able to bring out and realize their potential. They need to be scaffolded by a meaningful parent–child interaction.

Learning Theory of development: This theory is also known as Behaviourism was first described by B. F. Skinner in 1953 and later furthered by Sidney Bijou and Donald Baer (1961). Learning theory states that mental processes can be objectively inferred from the behaviour of a child. The principles of learning can be applied not just to the study of development but also for various behavioural interventions in maladaptive behaviours as well as developmental disabilities. Skinner argued that the general principles of behaviourism could be used to develop theories about how best to teach children and how to create societies that were peaceful and productive (Skinner, 1972). Although this theory has greater acceptance due to the fact that the principles of development as a result of learning act uniformly and are common, it's termed as the reductionist approach to development. That is why this theory is also called the mechanistic perspective of development.

Social Learning Theory

This theory, put forth by Albert Bandura (1977), emphasized observational learning or learning through imitation as the most powerful determinant of development. He referred to social learning theory as a social cognitive approach because of its importance in the development of cognition, i.e., how children think about themselves and that of others. There is an interaction between the individual and his/her environment. The interplay between our personality and the way we interpret events and how they influence us is called reciprocal determinism. Bandura's theory has metamorphosed the field with its implications in resolving the adjustment and behavioural problems of adolescents, and revisited the field of developmental psychopathology. However, social learning theory has been criticized for being a reductionist view of environmental influences explained in terms of mere rewards and punishments and neglected individual capacities of each human being as well as the natural endowments in development.

All the historical and contemporary theories extensively discuss the period of adolescence in accordance with their basic assumptions and tenets.

Stages of Human Development in the Light of Indian Traditions

Development is always contingent on the dynamic interplay of the developing person and the socio-cultural environment and context. Hence, a cultural perspective on development is very important.

The Indian contextual traditions of life span development are based on the classical schools of Indian philosophy and the Hindu traditions. The life span of an individual is guided by the compendium of laws known as '*Dharmashastras'* that cover the spheres of the religious and social life of the Hindus. Dharamashastras have given much importance to adolescence as a phase of life and describe specific codes of conduct for adolescents to grow successfully into the adult stage of life. Even today, the traditional codes of conduct continue to influence the cultural practices towards adolescents.

The Hindu social life condition is determined by the '*karma'* one accumulates, (i.e., performing one's duties faithfully as laid down primarily in the caste *('Jati')* rules which are of utmost importance) for reaching the goal of liberation from the cycle of '*samsara' (attaining moksha).* The deeds done in the former life are reflected in one's present social conditions, suffering and satisfaction, and membership in a particular caste. This interpretation of the life cycle has rendered the Hindu society stabilize its elementary structures for thousands of years. The four purposes of life according to Hinduism, viz.—*dharma:* righteousness, responsibility, and moral conduct in conformity to the scriptures which also include individual, social, and religious duties; *artha*: wealth and power or attainment of economic success required for raising a family and maintain a household; '*kama':* gratification of the desires of the mind and body, basal drives, and passions; moreover, the satisfaction of authentic human desires such as creative work, food, sports, love in defined relationships, parental affections, jewellery, and embellishment; and the fourth '*moksha':* release from '*samsara',* all form the basic tenets of the indigenous development model which best explain the life span development in general and adolescence stage in particular.

These tenets can further be understood by four consecutive and essential life goals, according to the Hindu model of ideal human development—***asramadharma***:

1. The *brahmacharya ashrama:* This period is a period of apprenticeship in which the *shisya* lives with the guru. *It starts* when a child or student (*shisya*) enters school and continues under the guidance of a guru until he or she completes schooling. The prime goal is character building, knowledge acquisition, and skills training through regulated teachings and practical life experiences so as to attain the capability of shouldering the responsibilities in adulthood.
2. The *grhastha ashrama:* This is the phase of adult householder which starts at the marriage of a person. The goal of this *'ashrama'* is to pay three obligations—serving God, the saints, and ancestors, and relishing noble things in life in conformity with *artha*, *kama,* and the goal of *moksha.* The chief objective is to seek spiritual progress through service, compassion, and righteous living. The essential part of this stage is that an individual must have a son who can perform certain religious rituals which only a son can perform within the life cycle of a person. These ceremonies are essentially confined to male relatives.
3. The *vanaprastha ashrama:* This is the period of sequestered life in the forest with extreme discipline and self-containment. It starts when the responsibilities of *grhastha asrama* are complete and is only attained when one's children have reached adulthood. During this stage, an individual starts gradually withdrawing

Table 2.2 Four stages of Hindu model of human development—*Asramadharma*

Stage of development	Life goals
The *brahmacharya ashrama*	• Period of apprenticeship • The student (*shisya)* lives with the guru till completion of school • Focus is on character building, knowledge acquisition, and skills training
The *grhastha ashrama*	• Period of adult householder after marriage • Enjoys *artha*, *kama* (material things and sexual pleasures) • Goal is to pay three obligations—serving God, the saints, and ancestors
The *vanaprastha ashrama*	• 'Ascetic or hermit stage' marked by severe discipline and austerity • Devotes more time to the study of scriptures, contemplation, and meditation • Stage of preparation for abandonment, that is, sannyasa
The *sannyasa ashrama*	• Final stage of complete detachment from all worldly objects or *anashakti* • Lives on *biksa* and parts from the family completely to become a mendicant • Goal is to quintessential self-knowledge or *atma gyana* and spirituality

from active life and devotes more time to scriptures, self-contemplation, and meditation. Therefore, this stage is also called 'ascetic or hermit stage' or a stage of preparation for renunciation, that is, sannyasa.

4. The *sannyasa ashrama*: The final stage which is marked by complete detachment from all worldly objects or *anashakti* in which an individual spends most of the time self-relating, contemplating and meditating, and deeply ruminating over the mysteries of life. During this stage, an individual lives on *biksha* and parts from their family completely to become a mendicant. The *sanyasi* seeks transcendence from the limits of human existence and realizes quintessential self-knowledge or *atma gyana* and spirituality (Table 2.2).

In Hindu tradition, certain *'samaskaras'* are performed during an individual's entire life but certain rituals have significant relevance to the four-stage development model discussed above (Kakar, 1981; Saraswathi & Ganapathy, 2002). These rituals are not universal to all the Hindu tradition but can be seen in context to the region, caste, and gender.

1. *Garbhadhara* (impregnation) ritual is performed to ensure the healthy birth of a child.
2. *Pumsavan* rite is carried out during the third month of pregnancy to foresee that the child is a male.
3. *Simanta* is the parting of the expectant mother's hair between the fourth and eighth month, to prepare for the event of the birth.
4. *Jatakarman* includes various rites associated with the delivery; elder and experienced mothers massage the pregnant woman; in order to stimulate the sensory

and organic functions, warm and cold water are sprinkled onto the newborn's body and stones are rubbed together near its ears. Saltwater is given in order to make the newborn regurgitate amniotic liquids that may have entered during the delivery.

5. *Namakarana* is the ceremony of giving the child a name; it takes place between the tenth and twelfth day of a newborn's life.
6. *Nis-kramana* is the first outing, which occurs during the fourth month. The child is carried out to the sound of conch shells and the chanting of various prayers and hymns. This rite is also known as the *surya-darsana* or sun showing, as the child is placed facing the sun.
7. *Anna-prasana* is the food eating ceremony, which occurs when the child is between 5 and 8 months old and is fed with solid food for the first time.
8. *Chuda-karana* (tonsure) is held during a male child's first and seventh year of life. This entails the shaving of the boy's head.
9. *Vidyarambha* (beginning of knowledge) is performed when the child commences his education. It takes place in the fifth year at the child's home. The gods are invoked and addressed. The child then pays homage to the teacher. The teacher writes the Sanskrit characters and recites them one by one as the child repeats them consecutively.
10. *Upanayana* (thread ceremony) takes place during the child's eighth year. In ancient times, both girls and boys were admitted to this ceremony, but it was later restricted to boys of the traditional first three castes. The night before the ceremony is spent alone and is the first night spent without the mother. The next morning the boy eats together with his mother for the last time; from this time on, he will eat with the male members of the family. The ceremony symbolizes the boy's readiness for receiving sacred knowledge. The boy wears a sacred thread consisting of three strands which symbolize the three *Veda*s, representing moral discipline in thought, word, and deed.
11. *Vivaha* (marriage) ritual is a major ceremony and the only one permitted for the lowest castes, too. It is a binding between a man and a woman, not only in this life but for the life hereafter. The father of the bride gives his daughter along with a sufficient dowry to the bridegroom, who accepts the daughter by invoking a fire and tying a necklace around the girl's neck. The ceremony ends with *samapana* or consummation, when the bride and the groom feed each other symbolically and are also fed by the groom's mother.
12. *Antyesti* (final ceremony) is performed after death and includes the *shraddha* rites that cannot be performed by *sannyasins* or women. They are a means of paying homage to departed ancestors. Prayers are offered to gods, while the deceased ancestors are called upon to consume a large feast prepared by the grieving family. Brahmins perform the ceremony and they are paid well to represent the ancestors. It is assumed that whatever is given to them is received by the ancestors.

The above-listed rituals are associated with all the developmental stages and hence this argument that the Hindu tradition excludes adolescence is not valid as claimed

by some researchers like Thomas, (1990). However, the Hindu model of development does not provide a stage synchronous to the Western concepts of development. In terms of sexuality, the Western concepts place the highest emphasis on sexual development as compared to the puritan attitude of the parents in the Indian context. The emphasis is placed on acquiring ideal Hindu life rather than prominent sexual orientation and manifestation during adolescence as in the Western models of development.

The Buddhist Tradition

The Buddhist tradition has a great contribution to life span development in particular and psychology in general. The teachings of Lord Buddha's dharma are about the way human beings ought to live. These teachings are grounded in human existence that is pervaded by impermanence, unsatisfactoriness, and non-self (*Anatta or anatman-non-self or substanceless*). Lord Buddha promoted the idea of the development of an individual which occurs when a possible way out for the end of suffering is found. His conception of *avijja*—existential ignorance of *'meta-physical reality'* reflects an individual's inability to witness reality in its manifest form. Indeed, avijja means 'not seeing' or failing to be aware of the deep interdependence among all (Herschock, 2006, pp. 44–45).

Vajrayana Buddhism, for example, maintains that human experience of themselves occurs through three gateways: body, mind, and speech. The main basis of development according to Lord Buddha's teachings through Vajrayana Buddhism about *behavioural, verbal, and mental* actions results in human well-being and happiness. The advancement of these dimensions thus forms foundations of development.

Development in the Buddhist tradition is explicated as the development of an individual with reference to his/her spiritual and psychological aspects after securing an adequate livelihood.

Development is a result of the fulfilment of livelihood needs. The development of an individual is contingent upon the development of the human spirit. The underdevelopment and associated sufferings are thus due to the underdeveloped humanoid spirit. Buddhist education and development are intended to enable people to have *vijja* or true knowledge through the ability to see reality correctly (Smith & Whitaker, 2016, p. 529).

Any model of human development requires a comprehensive approach which not only includes global dimensions to the concept of development but also considers social and cultural dimensions of development. These core systems with multicontexual and multicultural perspectives will have to be integrated into theoretical contexts.

With the advent of globalization, a drastic need was felt to mainstream the multiple contexts and cultures into the field of psychology. It is also imperative to understand that any cultural specificity may not be suitable to explain the process of development

if incorporated in isolation, but an integrated approach may be the best solution wherein theories and models are reshaped and assimilation of standalone prominent influences of the traditions taken into account.

Thus, the development of adolescence needs to be considered in the context of specific culture and religion. However, there is also a counter-argument that the social and cultural construction is no longer confined to indigenous contexts due to the influence of globalization, the cybernetic revolution, and other scientific and technological interventions which exert powerful influences on interaction patterns, socialization, and the parenting styles in the systems. More exposure to social media, upbringing in a nuclear family environment and other emerging forms of family, and living in a world where the whole world culture is at your fingertips has far-reaching implications for understanding the dynamics of life stages and forces the professionals to revisit the very basic concept of development stages.

Conclusion

The present chapter focused on a very salient topic of development in adolescence. It discussed different aspects of the development of adolescents. Further, major theories of development were discussed that explain adolescent development from different perspectives. The crucial issues in adolescent development were highlighted that focuses on the role of multicontextual and multicultural contexts. A special focus has been laid down on stages of development with reference to human life span development in the Indian traditions. The implication is not to brand all the adolescents as a group though they belong to an age range, but to view adolescents as unique individuals whose aspects of development get influenced by varied socio-cultural contexts of the community and the country.

Time to Reflect

Adolescence is a stage in the human life span which has huge implications for later years of life in terms of attitudes, perceptions, and values formed at this stage. The life skills that they acquire from home, school, and community shape their own future as well as the country as they are the future generation of any nation. Definitely, the diversities arising in adolescents due to socio-cultural and economic contexts such as class, caste, economic status, deprivation, marginalization, living conditions, availability of resources, abuse, and traumatic conditions need to be kept in mind while talking about development in adolescents and forming frameworks and policies related to adolescents. The digital age of the twenty-first century though uniting adolescents in a sense also creates a digital divide and puts new demands and challenges for adolescents to smoothly sail through it. This scenario, reflects on how can we have a uniform concept of adolescence; if not, how do we take into account the

diversities in adolescence; and how do we prepare adolescents to function effectively in the future world and lead a good life.

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Chapter 3
Identity Development in Adolescents

Parul Bansal

Abstract This chapter focuses on the process of identity development in adolescents. This assumes significance in the context of adolescence being a transition stage from childhood to adulthood. This transitional process is influenced by the socio-cultural context that needs to be taken into account to fully understand the adolescents and their issues. The chapter highlights the role of sociocultural contexts in adolescent development and in the process of shaping the sense of identity in adolescents. The influence of various macro contexts and micro contexts on the behaviour, personality, and experiences of adolescents is discussed.

Keywords Adolescent · Youth · Identity · Contexts · Development · Sociocultural factors · Peer relations · Family

Introduction

Adolescence is a transitional stage in the human life span which is marked by major changes in all the aspects of development including physical, psychological, cognitive, moral, and emotional. It starts with the obvious pubertal changes and involves changes in thinking, reasoning, morality, altruism, emotion regulation, etc., which impact the growing sense of identity of the adolescent. There are changes in the body, mind, emotions, and the way the adolescent relates to parents, peers, and others in their environment. How the adolescent perceives and receives these changes is mediated by how the adolescents are 'situated' in different contexts and environments. This consequently influences the identity development in adolescents. Hence, it cannot be a uniform experience for the adolescents, but the multiplicity of situations and contexts of adolescents affecting their experiences need to be taken into account when considering adolescent identity development.

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Sociocultural Context of Adolescence and Youth

Famous Indian Developmental Psychologist, Saraswathi (1999) raised a pertinent question "Is adolescence a myth or a reality?" on the basis of an ethnographic study of children and adolescents in Gujarat, an Indian state (Saraswati and Dutta, 1988). The spontaneous answer to this question appears to be "Of course! Adolescence is a reality". While there are cultural variations in formal recognition of adolescence as a distinct stage of life, it is certain that almost all cultures distinguish between young people and adults. Furthermore, most cultures institutionalize a period of preparation/apprenticeship for adulthood which draws upon the biological, cognitive, and emotional development attained by persons in this stage. Notwithstanding the two decade old question, if we try to probe what made T. S. Saraswathi pose this question, we will understand that there is no kinescopic conception of adolescence. Instead, there is, socially and culturally, wide variation in the structure and experience of adolescence and youth.

The Kaleidoscope of Adolescence and Youth

In the context and culture of Gujarat, a study conducted by Saraswati and Dutta (1988) showed that the transition of children into adulthood seemed smooth, almost invisible. This was especially true for the rural adolescent girls who assumed the roles of wives, mothers, and home managers in their early teens. The notion of 'storm and stress' (Hall, 1904) associated with the development task of identity formation in adolescent and youth is not a dominant psychological experience in cultures where the 'rites of passage' are clearly tied to biological markers like puberty and social milestones like end of apprenticeship, schooling, taking over the family's occupational role, and marriage. In such societies (usually simpler with less differentiated economy), skills and tasks of adulthood are gradually acquired by young ones over the course of childhood. By the time of puberty, they reach adulthood, they have many competencies needed to function successfully as adults. In industrial–technological societies, in contrast, children reach puberty long before they have the requisite level of social and technical competence necessary to fulfil the complex social and economic roles. Thus, in such societies, multiple other events, rather than puberty, more accurately index readiness for adulthood. These milestones include—completion of education, entry into full-time employment, moving out of the parental household, and becoming financially independent (Elliott and Feldman, 1990). In most societies, marriage marks the end of adolescence and the beginning of adulthood (Schlegel & Barry, 1991). Unlike traditional societies where marriage is tied with biological maturity, in modern societies, marriage is linked with full-time employment and financial independence. In sum, the choice of key developmental markers and the age at which particular milestones can be attained affect the length, temporal boundaries, and psychological experiences of adolescence.

In complex societies world over, more and more people have been entering an extended period of adolescence termed as 'Youth' (Keniston, 1971) or 'Emerging adulthood' (Arnett & Taber, 1994) owing to the extended demands of education, preparation for specialized employment, and consequently delayed age of marriage. Youth/Emerging adulthood is distinct demographically and subjectively from adolescence (roughly from ages 10–17) and adulthood (beginning mid to late 20s). Most adolescents do not feel that they have the requisite skills for adulthood, and the majority of people over 30 and older are of the opinion that they are adults. Thus, most people in their 20s feel that they are in between adolescence and adulthood: The majority answer "in some respects yes and in some respects no" when asked whether they feel they have reached adulthood (Arnett, 1997). They occupy the stage of youth/emerging adulthood.

The adolescents and youth are differentiated with regard to their experiences, their perspectives, and hopes for the future. They may respond to their social landscapes with enthusiasm, passion, idealism, indignation, protest, silence or apathy. On one hand, they are represented as reckless, irresponsible, and uncommitted; on the other hand, as dedicated, deferential, and conformist. They invite love, respect, and admiration for their deep sense of honour, energy, and passion along with feelings of hatred, fear, and panic because of their often disruptive relation with the adult society. Adolescents are lauded as a symbol of hope for the future as well as scorned as a threat to the existing society.

There cannot be a singular understanding of adolescence and youth worldwide. There are 'adolescences' rather than the adolescence. This is not to deny that global youth culture has emerged due to the rapid spread and use of satellite television, information technologies, and social media. Appearances, interests, and concerns of adolescents and youth have converged. But underlying these similarities are distinct and diverse realities. The commonalities of biological, cognitive, and psychological development and the challenges brought on by the new global world of the twenty-first century are transformed and given distinctive meanings within diverse cultural and institutional systems. The forms that adolescence take vary not only across cultures, but also within a given culture. The lives of adolescents show differences across the wide variations of geographical, economic, and social indicators.

The Contexts of Development for Adolescence

India has one of the largest youth populations in the world. About 1/5th of its population is in the age group of 15–24 years. The lives of this mass of individuals vary according to their gender, class status, caste standing, religious identity, geographical location, and various such parameters. Human beings develop within the psycho-social context in which they are located. Much of the research literature in the field of developmental psychology has been devoted to the study of 'person-in-context'. A wealth of cross-cultural research and findings stemming from investigations of ethnically and socio-economically diverse communities indicate the

influential role played by socio-cultural experiences in the development of various psychological capacities (moral, social, emotional, cognitive, and linguistic). The environment consists of not only the events and conditions immediately surrounding the person, but extends beyond home, school, and neighbourhood settings to broad cultural values, laws, customs, and institutions of culture. A complex system of relationships among multiple levels of the environment influences the growth of a person. The negotiative relation between person and environment is instrumental in shaping and organizing the experiential reality and developmental potential of the human individual.

Sinha (1979) adapted the ecological model of development proposed by Brofenbrenner (1979) to highlight the context-dependency of development in the Indian context. In this model, Sinha states that the Indian child grows within an ecology that consists of two layers—the upper layer and the surrounding layer. The upper layer consists of visible factors such as nature of home and its facilities like availability of space and technology; schooling and peer interactions. The surrounding layer is more pervasive, less clearly visible but constantly interacts with the upper layer. It consists of geographical conditions such as density of population, caste and class status, availability of general amenities like sanitation, health care, electricity and water facilities, etc.

The meanings, norms, ideals, values, ideologies, opportunities, and choices characterizing the maturational environment are transmitted to the person from a very early stage in a subtle and/or obvious manner through the child-rearing practices, signs, symbols, and messages that are present in cultural/historical/economic/religious dimensions of society and day to day social interactions that occur between people. Against such an ecological view of human development, let us reflect upon the influences from the wider cultural context on the adolescents and youth of India.

The Macro Contexts of Development

The Brahmanical-Hindu Time Table of Human Development

The life cycle of human beings is usually understood with reference to western notions and theories. Shakespeare (1623) talks of the seven ages of man in his play ‘As you Like it’. Sigmund Freud, the founder of Psychoanalysis, in his psychosexual theory of development (1905) maps human development in terms of progressive maturation of sexual and aggressive drives giving rise to characteristic psychological traits. Erikson (1950), an ego psychologist, provides an elaborate time-table of human development in which development is the outcome of a dynamic relationship between the individual’s growing capacity to interact with an ever-expanding radius of people and institutions—from ‘mother’ to ‘mankind’—and the readiness of society to welcome, invite, and influence this interaction.

In the Brahmanical-Hindu culture, there is an indigenous life span model of human development called the Ashrama system. Ashrama system is an ethical theory of Hindu philosophy, where it is combined with four proper goals of human life (*Purushartha*) for fulfilment, happiness, and spiritual liberation. These four goals are: Dharma (moral duty, right action, alignment with truth of things), Artha (wealth, power, and fame), Kama (fulfilment of desires, pleasure of senses, aesthetic enjoyment of life, affection), and Moksha (liberation, salvation).

Here we will describe the four periods of human life span under the *Ashrama system* in the light of how these affect the development of identity in adolescents.

1. *Brahmacharya (student life)*—This stage roughly corresponds with the adolescence and youth stage. In the Hindu cultural imagination, young boys take on the role of students and apprentices in this stage. It marks the formal start of education. Upanayana is a traditional rite of passage that marks the acceptance of the young boy by the guru for teaching him all knowledge to lead an effective life. It symbolizes the 'second birth' of the young boy as the child will now shift from his earlier indisciplined and unregulated life to understanding the intricacies of life with spiritual and secular knowledge and know-how under the care, supervision, and guidance of the guru or teacher.

They take the vow of 'chastity, obedience, and austerity' necessary to build their character, knowledge, and skills through a deep identification with and emulation of the guru (teacher). The growing boy is trained to discipline his impulses and desires, both material and sensual, and pursue knowledge through concentration and single-minded determination. The guru imparts the knowledge of science, philosophy, scriptures, and logic. The disciple works to earn dakshina (alms) to be paid to the guru and learns to live a life of Dharma (righteousness, morals, and duties).

2. *Grihastha (householder stage)*—This stage begins with marriage. The young man now enters the stage of a householder with all the training of his mind. The tasks of this stage are to earn a righteous living, look after all family members, including the elderly, children, and guests. This stage allows one to acquire wealth and power (Artha) and fulfil desires (Kama). This is also the stage where he is in direct contact with society and serves the society. This stage lends support to the other three ashramas. In this stage, the three Purusharthas, viz., Dharma, Artha, and Kama are cultivated and practiced. The three rinas (debts), such as the paternal debt, debt towards the teachers, and debt towards gods can also be repaid in this stage.
3. *Vanaprastha (retired life)*—This is a stage where a person begins to develop more mental abstinence and detachment from familial and worldly affairs. The vanaprasthin gains greater spiritual maturity and takes to solitude for meditation and contemplation. Kalidasa has described a vanaprasthin as a 'muni', who observes silence, talks less, hears more, and renders service with a sense of duty and smile. A transition stage between the householder phase and sannyasa, this stage holds special significance for a person. The emphasis of life shifts from Artha and Kama (wealth, pleasures, and desires) to Moksha (spiritual

liberation). The person exercises discipline of the body (such as reducing the need for physical comfort and giving up cravings for material goods, celibacy, etc.) which allows for the sublimation of his instinctive and material life as well as widen the scope of sympathy from family and village to humanity at large.

4. *Sannyasa (renunciation)*—This is the highest stage in the Hindu timetable of human development. In this stage, man renounces the material world. He becomes one with the universal soul—Brahman. The world is his kin. He serves the poor, consoles the bereaved, heals the sick. He maintains equanimity and is beyond the pale of anger, greed, sorrow. The sannyasi is a homeless beggar-saint.

Thus, in this stage model, Brahmacharya is the stage for learning of Dharma, Grihastha is the stage for pursuing Artha and Kama within the framework of Dharma, Vanaprastha is the preparation for pursuit of Moksha and Sannyasa is about observing Moksha. It is the solid secular-spiritual foundation laid out during adolescence and youth and ripened during adulthood which leads to the attainment of the highest ideal of Hindu life—Moksha. In such a cultural imagination of human life, adolescence and youth are believed to be full of potential which needs to be harnessed for personal and collective evolution and to sustain harmony and order in the world.

Kakar (1979) has compared the traditional Brahmanical-Hindu view of human development and Eriksonian psychosocial theory of development and suggests a possible convergence between the two. Both the frameworks view human development in terms of stages of life, each building on the previous stage and bestowing a specific strength to human life. The individual in each stage is seen in the context of his psycho-social environment and in interaction with the sequence of generations. Specifically, with regard to the adolescence stage, both theories opine that it is a preparatory stage wherein the individual builds the foundation of skills, habits, character, and values which pave the way for life ahead.

At this juncture, it is important to highlight that the spiritual-philosophical ideas of human development embodied in the ancient Brahmanical-Hindu worldview take a largely upper caste (the Brahmans, the Kshatriyas, and the Vaishyas), male centric view of life span development. They do not reflect the possibilities and constraints characterizing the lives of women, Shudras, and Dalits. Traditionally, education and opportunities of spiritual evolution have remained the prerogative of upper-caste men. Formal education was theoretically available to members of the Dvija (twice born) castes, viz., Brahmans, Kshatriyas, and Vaishyas. The Brahmanical centres of learning were open to all the Dvija castes but they "appear to have attracted mainly the Brahmin students" (Thapar, 1978). A Shudra who dared to listen to the recitation of the Vedas must be severely punished as per the injunction (Thapar, 1978). The exclusion of women from this discourse also served to minimize the educational opportunities for women and served to establish motherhood as the highest role for them.

Cultural Messages in Classical Texts and Popular Narratives

The stock of folklores, legends, and myths in a culture are repositories of ethnotheories of human development. They reflect as well as construct the dominant value orientations, parenting practices, cultural goals which influence the nature of growth and development in that particular community. In ancient Hindu epics and legends of Gods, we find characters like Prahlada, Devvrata, Shravan Kumar, Krishna, etc., that become exemplars of boy childhood and adolescence in the Indian context. Their stories provide important cultural messages about relevant development goals set up for male adolescents to learn in order to become 'mature adults'. The story of Prahlada exemplifies courage to withstand the filicide of his demon father Hiranyakashyap, in order to uphold his spiritual devotion to God Vishnu. Devvrata, the original name of Bhishma in Mahabharata, took the vow of lifelong Brahmacharya (celibacy) and of service to whosoever sat on the throne of his father to enable the latter to marry a woman of his choice. He showed the path of subjugating personal desires to paternal wishes and getting rewarded in return. Shravan Kumar is a popular metaphor of a dutiful son in the Indian context who served his blind parents selflessly till the end of his life. Krishna provides a multitude of images for Indian boys to emulate. These include: playful and mischievous cowherder, enchanter and lover of gopis, and the protector.

The Indian Oedipus *Devvrata was the eighth son of Kuru king Shantanu and the river goddess Ganga. In his adolescence, King Shantanu fell in love with a fisherwoman, Satyavati. When he expressed his deep desire to marry her, her father demanded the throne for the child of Satyavati. Since, Shantanu has already promised the throne to his beloved and very capable son Devvrata, he sorrowfully declined the demand and became despondent. When Devvrata came to know of his father's reason of sadness, he took the vow of lifelong celibacy, thus forgoing his claims as the 'heir apparent' and denying himself the pleasures of conjugal love. In return of his sacrifice, Shantanu blessed him with the boon of Ichcha Mrityu (control over his own death).*

*Indian cultural tales, folklore, and myths show that the direction of aggression in the Indian father-son relationship is reversed. Unlike the Western Oedipus myth, the Indian son doesn't wish to overthrow the father. Rather, the father suppresses the son. In both the Ganesha myth or the story of Devvrata (later known as Bhishma), both sons win power, honour and titles as rewards for submission to the father figure. In both the legends, the power of the father figure is never overthrown (*Ramanujam, 1983*). After a fight or willingly, the son submits and identifies with the father. The Indian Oedipus provides an important caveat to the assumption that adolescence spans out in a uniform way across cultures. It provides a significant insight in the way paternal authority is negotiated by the growing son in the Indian cultural milieu.*

We notice an absence of youthful female characters in Indian legends and mythos. Hindu mythological stories are replete with images of Mother Goddesses and/or Apsaras (beautiful enchantresses) as symbols of cultural imagination about mature women. But, rarely do we find descriptions of female adolescence. This highlights the gendered nature of adolescence. This ties up with what Saraswati and Dutta (1988) found in their fieldwork in Gujarat with respect to the girl child. Kakar (1978) opines that the anticipated 'adult roles' of homemaking and motherhood are made clear to the growing girl rather early in her life and she is socialized for the same, limiting her mobility and exploration of self. Cultural notions like girls being the carriers of family honour, chastity, and virginity as important virtues for their marriage adversely affect girls' access to education. Parents are often reluctant to send girls to co-educational schools where they can interact with boys, be harassed by boys and men while travelling to and fro from school/college and form relationships with them. Girls usually have lesser freedom than boys to meet with friends outside home and to move about independently in the community. Constant pressures to be submissive, docile, and uphold family name also undermine their ability to voice their opinions, take their decisions, and develop their agency. Unlike boys, who experience less parental authority during adolescence, girls live under the scrutiny and overprotection of their families. This is soon exchanged with living under the protection and patronage of the husband after marriage.

In popular narratives like novels, short stories, and movies, we find the dynamic interplay of tradition and modernity shaping the lives of ordinary people. The protagonists, male and female, provide examples of resistance against the sociopolitical order (the 'angry young man' trope popularized by Amitabh Bachchan,[1] the 'ambitious career woman'), reclaiming dignity and freedom for self by women (in films like 'Arth', 1983, 'Thappad', 2020 and 'Secret Super Star', 2017),[2] and of masculinity in touch with emotions (the 'metrosexual' hero exemplified in the 'Complete Man' image in the well-known series of advertisements for a leading garment brand Raymonds). Such constructions of human subjectivities by literature and media open out life's distinctive complexity and indeterminacy allowing the adolescents and youth from across social-religious groups to dream and desire alternative realities. Gokulsing and Dissanayake (1998) suggest that the song and dance routine in Indian films, expressing a degree of intimacy, sexuality, and vulgarity not generally

[1] By the 1970s and 1980s, the joyful optimism in the immediate aftermath of independence had waned in India. Domestic politics was in turmoil, corruption levels were high, social and economic inequality was rampant. This found representation in the iconic film Zanjeer (1973) in which Amitabh Bachchan epitomized a new kind of hero—angry, brooding and despondent—existing in a world where injustice was a daily reality. He was driven by the desire for revenging against the narcissistic injuries meted out to him by the unjust, unequal world and the desire to set the wrongs right.

[2] In commercial Hindi films, women are either portrayed as hero's love interest, successful homemaker or as a vamp. In Arth and Thappad, we find women opting out of faithless, loveless marriages and taking decisions to live their lives without the men. They feel complete and happy within themselves. In Secret Superstar, we find an adolescent school going Muslim girl's struggle to achieve her dream of becoming a singing sensation and giving a better life to her mother who suffers from domestic violence and emotional abuse at the hand of her father.

found elsewhere in the script, enables a safe mediation between traditional, parental standards, and the individual romantic impulses of the young protagonists.

Opportunity Structures of Caste, Class, and Geographical Location

Indian society is fragmented by caste system. Varna and jati are two terms commonly found in Indian languages denoting caste. Varna is a more abstract and scriptural term indicating the four broad groups into which castes are supposed to be divided (Brahmin, Kshatriya, Vaishya, and Shudra, with the varna-less 'untouchables' or Dalits regarded as outcaste outsiders); while jati is a more locally situated and ethnographically relevant category, varying in its hundreds, if not thousands, across the length and breadth of not only India, but the whole of South Asia. Caste is a system of rigid social stratification into ranked groups based on descent. It is hereditary. Caste is at the same time economic (in that it has consequences for how wealth is distributed), political (how power is distributed), and social (how status is assessed). Caste divisions of various caste systems across the world also regulate life matters such as access to housing, marriage, and general social interactions. Caste divisions are reinforced through the practice and threat of social ostracism, economic boycotts, and even physical violence.

Since independence, the affirmative policies and social and political mobilization of scheduled castes and Dalits have had some positive impact on the economic and social status of these marginalized sections of Indian society. Reservation of seats for scheduled castes in educational institutions, government jobs, legislature, and local bodies has resulted in an increased representation of these previously discriminated sections in education, employment, and politics. Social and political mobilization of scheduled castes has furthered their process of achieving equality of status and opportunity in society. It has also resulted in a change in their public image in the society. Now perceived as vote banks and political actors, they are becoming a political force to reckon with in Indian polity. This allows the adolescents and youth belonging to the marginalized caste sections of society to sense the opportunity to get ahead in life, to have role models among their communities whom they can emulate, to debunk their stigmatized identities (Sinha, 2020).

While much has been gained, much still remains. The benefits of reservation policy are being reaped by the better off among the scheduled castes. Prejudice, discrimination, and violence against them still prevail in wider society. Poverty is rampant among these sections of society. The chilling suicide note of Rohith Vermula, the Dalit Ph.D. scholar which stated—"*My birth is my fatal accident. I can never*

recover from my childhood loneliness. The unappreciated child from my past….."[3]— is a testimony of continuing exploitation and dehumanization of backward castes in India.

Thorat (1979), a famous Indian Economist and a Dalit thinker, reminiscences his experiences of growing up with a stigmatized identity. He shares, *"During this period I was in school from the sixth to the eleventh standard. By then I had learned that I was untouchable by caste and therefore not allowed into the village temple, the caste Hindu homes, or into the common village dinner. Aware of the limits on my social relations, I used to try to stay within these limits; but whenever subjected to discrimination, I used to oppose it. This reaction to the stigmatized identity was associated with a conscious desire for equal treatment. The reaction was mainly emotional: I would either scold the caste Hindu or develop feelings of hatred"* (p. 74). Such humiliating experiences are shared across members of the lower castes.

Class divisions are yet another reality of social life. In middle and upper-class homes, the continuity between childhood and adulthood is disrupted (Verma & Saraswathi, 2002). Increased income allows teenagers to remain outside the labour force and there is little productive role that they are involved in. There is a segregation of the adolescent world from the adults. Adolescents in these sections of society attend formal schools and college. The educational environment, teachers, and peers exert a strong influence on their development. As digital natives and as consumers, they participate in the adult world at ever younger ages. Growing up in individualistic culture, middle and high-class adolescents define their own lifestyles and emphasize on their own needs, motives and interests. They have a more open-ended vision of the future. Their globally linked lifestyle also precludes the possibility of their being rooted in the culture of their family and caste community for all their lives.

While the urban middle-class young persons now have greater opportunities for personal fulfilment through self-determined identity explorations and commitments, a larger sense of purpose and meaning is usually lacking among most young people belonging to this section in America (Cote, 2019). Cote (2019) discusses the affluence-purpose paradox, which has come to dominate the lives of young persons in well-off sectors of societies, world over. Proactive identity formation which requires self-regulation, self-discipline, and self-reflection is undermined by the instant gratification culture of consumerism and narcissism fueled by the materialistic culture.

While rural adolescence does differ from urban adolescence in terms of greater continuity between childhood and adulthood due to involvement in familial/caste/tribe-based occupations and community participation at younger ages, the youth culture characterized by hedonism, consumption, fashion, and technological absorption is increasingly becoming a significant feature shared among youth across class and geographical locations. A teenager dressed in T-shirt and jeans carrying a mobile phone has become a ubiquitous feature of the Indian landscape.

[3] (2019, 17 Jan). My Birth is My Fatal Accident: Rohith Vemula's Searing Letter is an Indictment of Social Prejudices. *The Wire.* Retrieved from https://thewire.in/caste/rohith-vemula-letter-a-powerful-indictment-of-social-prejudices.

In the recent season of a highly popular Indian television show—Kaun Banega Crorepati? (Who will become a Millionaire?)—one of the contestants, Tej Bahadur Singh, a farmer's son, shared his life conditions which are reflective of a large majority of young people living in rural areas in India. He described how fragmenting landholding and declining returns on investment in agriculture have forced young people to look at government jobs and urban cities for their livelihood. He himself had aspirations of becoming an IAS officer (a prestigious government job in India) and confessed to being ridiculed by his kith and kin for 'daring to dream rich children's dreams'. Education is increasingly being viewed, especially for boys, as a route to become financially stable and give their families a better life. Youth who are denied access to higher education, on account of their family background and material constraints, and those who fail to find suitable jobs, often face frustration and alienation (Verma, 2000). Adolescents and youth from economically weaker and rural sections aspire for materially prosperous, urban living. But the desperate flight towards modernization, westernization, and urbanization creates cultural and psychological upheaval and fragmentation in people, restless and rootless cosmopolitanism, resulting in a sense of nostalgia and loss (Nandy, 2001).

The Changing Indian Village *In Indian cinema, the chasm between town and village, or between India and Bharat, has been a familiar theme. City was simultaneously perceived as the site of opportunities and alienation. The classic film 'Do Bigha Zameen' (1953) is a moving account of a poor peasant eking out a living in the harsh environs of a metropolis as a rickshaw puller so that he can pay back the loans. In many films, the village was presented largely as a homogeneous community where the moral economy thrives. The farmer was hailed as the true 'Bharatwasi' (inhabitant of India) and village land as yielding food for the teeming millions of the city. The hit song, 'Is Desh ki Dharti' ('the fertile land of the country') exemplified this sentiment. In contrast, to the simpleton villager, the city dweller was portrayed as corrupt.*

Today, the rural characters of the Indian village rarely attract viewers any more. It is hard to recall a film made since the 1990s, when India began to liberalize its economy, that glorifies the Indian village. In fact, these counter positions no longer seem to resonate. Indian villages are changing perceptibly. Not only do the poor, landless farmers have urban aspirations in order to build a more secure life, but even prosperous landowners seek a future outside the village or in nonfarm enterprises.

Religious Rites, Values, and Identities

Religion is an important basis of identity for mankind. The core of religious identity is a personal identification of oneself with a social collective (group) characterized by a particular cultural—historical—religious tradition (Ashmore et al., 2004). Religious values and practices influence people's lives from birth to death. Religious rituals mark important life transitions and events. In Hinduism, Jātakarman (birth rites), Nāmakaraṇa (naming ceremony), Annaprāśana (first eating of solid food) Karṇavedha (ear piercing), Cūdākaraṇa or Caula (first haircutting), Upanayana (initiation of brahmacharya), Samāvartana (conclusion of brahmacharya), Antyeṣṭi (offering of body to fire) are few of the important rites of passage. In Islam, the new baby is welcomed into the world as the father whispers a call to prayer—adhann—into his or her right ear and a call to worship—iqama—in the left. So, the first words the child hears are God's words. Bismillah is the celebration around the child's fourth birthday when he or she begins formal religious education. Zakat, an 'obligatory charity' is an important pillar of Islam, an act of worship and spiritual investment. Baptism, Confession, and Anointing of the Sick are important sacraments in the Catholic Christian tradition.

Growing individuals, the world over, feel the presence of religious faith during challenging circumstances as well as during celebratory occasions. Religious faith becomes the basis of abiding hope in life for people everywhere. Religious values provide a worldview to guide one's life. Every form of religion provides the 'right way' of living life. Concepts like 'Nishkaam Karma'(selfless action), 'Dharma' (moral duty), 'Samskars and Punya Janam' (psychological impressions carried forward through a cycle of birth, death, and rebirth), 'Paap-Punya' (sin and good deed), 'Anasakti' (non-attachment to material pursuits), Brahman-Atman (universal soul vs. individual soul) are ever-present in the collective psyche of Hindus. Mishra (2012) illustrates how the collectivist values exemplified in the traditional Hindu religious texts are mediated by socialization agents such as schooling to influence youth identities.

Religions also have the tendency to become fundamentalist and periodically erupt in bouts of individual and collective violence against people, groups, and symbolically charged symbols. The fundamentalist mindset draws upon distinct religious and ethnic identity and erects strict borders towards other groups, a tendency called totalitarianism by Erikson (1968). The success of fundamentalism depends upon the creation of a historical account by giving a new meaning to the culturally rooted representations and symbols (such as swastika, saffron colour in the context of Hindu fundamentalism, and Jihaad in the context of Islamic fundamentalism) or rejecting their significance altogether (such as rejection of satyagraha in modern-day politics). Youth who feel systematically excluded/alienated from the dominant trends of the world on the basis of their birth circumstances (ethnic, caste, class considerations) are recruited into the fundamentalist ideology because the shared myths, memories, values, and symbols help them to reclaim a personal sense of identity and heal the feelings of loss.

To take an example, Nandy et al. (1995) provided a brief analysis of the activities of Bajrang Dal (a religious and youth organization belonging to the right-wing group of political organizations in India). They showed that the youth members of Dal are mainly drawn from the poor, upper caste population of the smaller cities and semi-urban areas. They have some education and aspirations to enter the expanding modern sector of India, but they are unemployed. The Vishwa Hindu Parishad (the parent organization of Bajrang Dal) assuages their anxieties and gives them a place in society by handing them a cause to fight for—restoration of lost honour and pride to the Hindus. As if out to prove their worth to society and themselves, the Bajrang Dal youth have been involved in some of the more violent incidents that have taken place as part of the Ramjanmabhumi agitation.[4] In defense of the Dal, Vinay Katiyar, its chief, drew an analogy with the incident in the Hindu Epic Ramayana where Hanuman burns down Lanka. According to him, Hanuman had no other choice after the demons tied a burning rag to his tail to reduce him to ashes. Similarly, they followed Hanuman's footsteps by engaging in violence against the new set of demons who have put a torch to the hearts of the youth.

Neoliberalization, Social Media, and Formation of Youth Identities

The new economic dispensation of liberalization in India, in 1991, threw open the gates to new technologies, business ventures, foreign media, consumption goods. The new ideological messages are of imagination-backed initiative and guiltless indulgence. The adolescents are growing up with access to opportunities—educational/professional/consumption—their parental generation never had. The general mood of consumerist buoyancy and optimism about the emergence of India as a global giant is adding to their confidence and ambitions for material betterment. The youth are entering enterprise culture where they have to meet ever-increasing demands of productivity, competitiveness, and efficiency. In return, they are compensated with huge pay packets, foreign assignments, performance-linked promotions, and café culture. Multinational companies give many opportunities to their employees to learn and work abroad. Thus, employees are required to have skills such as sensitivity to nuances of different cultural norms and etiquettes, world knowledge, and an international lifestyle to fit in the global economic order. A large number of young Indians are expressing a form of 'individualized Indianness' (Bhatia, 2018) by engaging in specific cultural practices of watching American media, shopping at malls, visiting bars and pubs, and having romantic/sexual liaisons on the sly.

The enterprise culture places a great premium on social prowess, confidence, exuberance, initiative, risk taking—characteristics necessary for effective networking

[4] The agitation is regarding the history and location of Babri Mosque and whether a Rama temple existed at the site which was demolished to build the mosque on the orders of the Mughal King, Babar. It has been an issue of intense communal conflict between Hindus and Muslims in India.

and self-presentation that are in turn necessary for success in the competitive employment sphere. Autonomy is expressed through choice (mostly as consumers). Identities are defined by the brands one consumes—Nike shoes, Starbucks coffee, buying an iPhone, and driving BMW. Branding is not limited to commodities but extends to self as well. Tom Peters in his 1997 article 'A Brand called You' in Fast Company magazine encourages us to think of ourselves "every bit as much of a brand as Nike, Coke, Pepsi, or Body Shop". He counsels, we must envision ourselves as "CEOs of our own companies: Me Inc." and to recognize that "our most important job is to be head marketer for the brand called You".

Social class, caste, and gender create different experiences and engagements with neoliberal norms, ideas, and values (Sayer, 2005). The lives of poor, rural, and low caste youth reflect how conditions of scarcity exclude them from the discourse of neoliberalization. They do not have the access to the social and educational opportunities to fashion themselves as neoliberal selves comprising of a set of skills and attributes which need to be continually developed and projected like a brand. Their cultural values and practices are also undermined and treated contemptuously by the neoliberal ideology eroding their self-worth. Such youth are at risk of developing a negative identity (Erikson, 1968). According to Erikson (1968), forming a negative identity compensates for a lack of identity. Excluded from the possibilities of adopting socially accepted identity options, adolescents from marginalized sections adopt negative identities (e.g., lazy, angry, violent, delinquent) to resolve extreme identity crisis.

Social media (e.g., Facebook, Twitter, Youtube, Flickr, Instagram) is a new social environment for adolescents to network, to express, communicate, and spend their leisure time. Besides these benefits, it also creates the dangers of cyberbullying, online stalking, sexting, internet addiction, social isolation, identity confusion, and sleep deprivation.

Violence, Political Mobilization, and Civic Engagement

Violent conflicts between nations and groups, state and group terrorism, rape as a weapon of war, the movements of large numbers of people displaced from their homes, gang warfare, and mass hooliganism—all have become common occurrences around the world. Because of the ubiquitous nature of violent conflicts, it is a significant social contextual factor to be taken into consideration in relation to human development. They take a heavy toll on health in terms of deaths, physical illnesses, disabilities, and mental anguish. The growing individual experiencing violent environment have diverse understandings and memories of such events. Recchia and Wainryb (2011) found distinct dominant trends in how youth who are exposed to violence make sense of the violence. For some youth, these experiences carry personal or cultural significance. Others see them as frightening and so challenging to their sense of self that they feel very powerless in their memories of violence.

Khan and Majumdar (2017) report that young men and women of Kashmir have experienced several direct and indirect forms of violence which include direct physical beatings, being body checked, interrogated as well as witnessing torture, arrest or detention of neighbours and family members by armed forces, witnessing the searching and forceful occupation of their house and witnessing the destruction of the town. Their study further suggests that living in a conflict zone where movie theatres are shut, phone services are periodically prohibited, transportation is unavailable when curfews are in effect, movement is restricted and the military is heavily deployed—the sociopolitical self of youth is adversely impacted. They experience unfreedom, bondage and hopelessness which can lead them to turn towards violent retaliation.

The extent to which adolescents and youth of a country are involved in constructive political processes such as volunteer work, activism, civic movements also shape the potential of youth to become engaged citizens and voters. When from a young age, children are seen as responsible and capable to be a part of the solution, especially for problems that affect them such as environment, AIDS, substance abuse, unemployment, they emerge as agents of transformative social change. At Barefoot College Night Schools in India, children have far-reaching rights to directly participate in school affairs. Opportunities for civic and political participation of young men and women meet their needs for social inclusion, to drive social change through their energetic initiatives, as well as also enhance youth employability.

Micro Contexts of Development

Familial Context, Parental Authority, and Social Change

Family casts a long shadow on the psyche of Indians. Widely conceived as a collectivist society, Indians exhibit a high degree of familism. Familism is a dimension of collectivism that has two important normative dimensions (Mucchi-Faina et al., 2010). One is 'support obligations' which includes the obligation to provide material, economic as well as psychological support such as affection, reassurance, and care to family members. The other is 'adherence to traditional norms' which includes the obligation to conform behaviours and ideas to traditional moral values and to adhere to parental authority. The first dimension focuses on the function of the family to meet the needs of individual family members, the second dimension focuses on the interests of a family group.

With respect to the first dimension of support obligations of the family towards the growing individual, there is a strong trend of increased economic investment in children. Even poor families make personal sacrifices to invest in children's education. In middle-class families, costs to parents increase as years of education rise and extras such as tuitions, extra-curricular activities, leisure, and entertainment—all become integral to adolescents' lives. Because of few children and rising prosperity among

middle and upper classes, children receive more parental attention and supervision. Excessive parental supervision takes the form of 'Helicopter parenting' (Cline et al., 1992) which has become more plausible due to the availability of mobile phones and parental presence on social media sites. With respect to obedience, conformity to familial values and prioritization of family interests over self-interests, studies have consistently found that these behaviours are considered more important by Asian and Hispanic people than by European and American-European people (e.g., Fuligni et al., 1999; Suzuki & Greenfield, 2002). However, there is variation by gender, social class, and rural–urban location. An India wide Youth study conducted by KAS-CSDS in 2009[5] reveals that the extent of perceived parental control by youth vary with socio-economic status and gender. Nearly half of the youth sample of the study endorsed experiencing strong to very strong parental control. Most of these responses came from men and women from villages and towns. Youth in metros reported fewer experiences of strong to very strong parental control. Gender difference also shows a similar variation. More women youth as compared to male youth reported experiencing high parental authority in villages and towns. In case of metros, the gender difference was marginal. Geldard et al. (2016) point out that over-protective and over-anxious parents affect negatively the sense of agency and autonomy in adolescents which are important factors in progressing towards adulthood.

Kapadia (2008) in her study found that parental control was balanced by parental responsiveness towards the feelings and welfare of their adolescent offsprings. In scenarios of disagreement over marital partner selection and intersex mingling, neither party (parents and children) appeared to want to assert their views on the other. As a result, they tried to mutually accommodate each other's wishes. In contemporary Indian society, there is a rise in parental tendency to defer to the adolescent's wishes driven by the concern for children's happiness as well as by the concern to avoid unpleasantness in case children do not accept the parents' view readily. Additionally, parents are also realizing that the world in which their children are coming of age is very different from their own and thus, they are the ones who may need to follow the child's lead.

Kapadia (2008) also argues on the basis of her findings that Indian adolescents too welcome their parents' views on important life decisions. They accept their parents' role of not only knowing what was best, but also as having a responsibility to guide their children. They were trusted to do/advise what was good for the adolescent. Thus, when Indian adolescents accommodate their parents' wishes, they do not feel that they are relinquishing their personal interest in the service of family goals. Rather they trust that their parents wish well for them and by following their wisdom and authority will benefit them personally as well as the larger family.

[5] Lokniti, Centre for the Study of Developing Societies (CSDS) and Konrad Adenauer Stiftung (KAS) conducted a youth study. It is a sample survey-based study seeking to answer key questions about how India's youth thought and lived. The survey was conducted in April–May 2016 in 19 States of India among over 6000 respondents aged 15–34 years. The findings were published in 2017 as 'Indian Youth in a Transforming World: Attitudes and Perceptions', edited by Peter Ronald DeSouza, Sanjay Kumar, Sandeep Shastri and published by SAGE.

Bansal (2012) found in a psychoanalytically informed study of urban Indian youth that whenever parental demands for achievement and personal conduct are imposed on the growing individual without dialogue, the adolescent feels emotionally controlled. It often leads to reactive rebellion and/or false self-organization.

Indian families are changing. Family units are becoming psychologically nuclearized. Obligations towards distant kin are contracting. This has resulted in less rigid and flatter hierarchical structures in the Indian scenario allowing children to participate more effectively in the decision-making process of the family, especially in matters that concern them. It has resulted in changing the role definitions of womanhood/motherhood and manhood/fatherhood too. There are greater possibilities of a more companionate husband–wife relationship where homemaking responsibilities are more equitably shared and affection can be more openly displayed. The woman/mother in such a household is freer from restrictions imposed on her by elderly members of the family. The father can also be more involved with his children rather than maintaining a distance from them as is expected in joint families. It is suggested that the early experience of having emotionally accessible fathers will reduce the power distance in institutions and alter the expectations that young India will have of its leaders (Kakar & Kakar, 2007). Fathers' support in daughters' education and vocational aspirations also lay down the foundation of a strong identity for women.

Importance and Inclusivity of Peer Relations

The exclusive hold of family and caste anchored identity is getting weakened for India's urban elite. Exposure to the global world has made the young realize that they cannot rely only on the traditional customs, values, and lifestyle of their parental figures and caste grouping as the basis of their own lives. Peer group is emerging as a powerful source of direction for the young. The peers are important not only as the reference group for fashion, food and travel preferences, entertainment, etc., but are also instrumental in shaping the quality of one's inner experience. They serve as important sources of information, support, and companionship to make sense of the world whose signposts are unfamiliar to the parents. Thus, peer authority is contending with parental authority.

The new age value of 'Networking' is found to be important for young people today (Bansal, 2012). Youth want to connect to diverse people from different walks of life in order to be in the knowledge of the opportunities and developments in the larger world. No longer parents and family/caste members suffice as role models. So, young seek inspiration from people beyond the family. Internet aids networking and enlarging adolescents' world of peers. It opens new paths of communication and interaction with people outside their immediate community, and across barriers of caste, class, ethnicity, gender, sexual orientation, language, and nationality. It provides new opportunities for love, romance, and sexual exploration too.

Schooling plays an important role in taking adolescents away from their families and into a peer society for the better part of the day. In traditional sectors of Indian society, involvement with peers and friends tends to be much greater for boys than for girls. Among both school-going and non school-going adolescents, adolescent girls spend more time with same-sex adults learning and performing household tasks, while boys often congregate in the evenings to play and talk.

The KAS-CSDS study mentioned in the earlier section provides an important finding of the inclusivity of peer relations of Indian youth. It reveals that only 11% of sampled Indian youth reported having friends from all three categories—opposite gender, from other castes, and from other religions. About 25% of the sample didn't have any friends from any of these groups in their immediate friend circle. As compared to the rural youth, urban youth showed more inter-category interaction highlighting that making friendships across social groups is not a matter of choice, but of constraints and when these constraints are removed due to education and urban setting, then people are more willing to cross borders. 30% of women as compared to 19% of men reported having no interaction with the opposite sex and persons of other castes and religion and 38% of women as compared to 47% of men reported having moderate interaction with other people. Thus, young women do have more limited experiences of peer relationships.

While peer relations are often a source of information and emotional support, they also become the basis of continuous self-other comparison along the axes of perceived superiority and inferiority. The constant exposure to comparisons with agemates and judgments by superiors lowers self-esteem, creates self-conscious doubt about 'how good one is', and gives rise to a sense of shame over one's inadequacies and failures.

Educational Contexts

Population studies in India show a decline in labour and work participation rates, especially among younger age groups. This is reflective of the withdrawal of youth from labour force or postponement of entry into the labour force in order to pursue education. More than one-third of the youth population in India has attended educational institutions during 2009–10. Figures show that the attendance rates are higher among the male and urban youth when compared to their female and rural counterparts, respectively (Dev & Venkatanarayana, 2011). However, the female youth, especially the urban female youth, followed by rural female youth have shown the highest increase in the attendance rates between the 1980s, 1990s, and 2009–2010. While increase in school enrolment and literacy rates among females and rural sections is a marker of the success of educational policies of Indian state, it is equally important to pay attention to what kind of education is being imparted in the Indian school system.

Colonial investment in schooling in erstwhile colonies like India was inspired by two factors: cheap labour to run the colonial government and to enlist the support of dominant sections of Indian society for the British empire. British intellectual

Thomas B. Macaulay in his infamous Minute on Education (1835), advocated that colonial funds for public education in India were better spent if deployed "to form a class who may be interpreters between us and the millions whom we govern—a class of persons, Indian in blood and colour, but English in tastes, in opinions, morals and intellect". However, colonial education was also instrumental in revealing the contradictions of British rule, thereby leading to the resistance movement.

Educational sphere, including schools, technical education, and higher education, are simultaneously touted as the site of social preservation and social transformation. Along with family and caste/religious community, schools play a complementary role in socializing the child in the ethos of the society. Through authority structures, curriculum design, pedagogy, and other formal/informal practices, schools often replicate dominant sex role, class, caste, religious, nationalist values in their environment. For example, research on the educational experiences of scheduled caste (SC) and scheduled tribe (ST) students voices the concern that the school curriculum doesn't do enough to expose all students to an understanding of how oppressive structures operate to exclude sections of society. Additionally, the assimilation of middle-class values via schooling creates fissures between the educated and uneducated among the marginalized communities. While a small minority may be able to complete their education against all odds, many drop out with an internalized sense of backwardness that society ascribes to them. It is telling that in a study conducted by Indian Express[6] on 86 toppers of two national boards in India (CICSE and CBSE) between 1996 and 2015, there was only one student from the OBC (other backward) category and no student from SC and ST categories.

The class and gender divide among young learners are quite obvious from the mushrooming of private schools in India which are managed by private trusts, religious organizations, etc. There is a steady abandonment of government schools primarily by the urban upper and lower middle class. This tendency has led to the overrepresentation of students from poor and marginalized communities in government schools across India (Nambissan, 2012). When confronted with a choice due to limited economic means, parents often send the girl child to the government school and the male child to fee charging private school, for 'better' educational experience. The Indian Express study highlighted an important characteristic of schooling in Indian context which impacts the growing child—competence in English. All the toppers sampled in the study came from English medium ICSE and CBSE schools. One of the most important reasons for the increasing popularity of private schools in India is the provision of English in these schools. Competence in English in India is not only a status symbol, but also "a socially understood shorthand for general ability" (Kumar, 2005; p. 59). The English medium schools ride on the ambitions and aspirations of Indian parents for a better future for their children. Kapil Dev, an Indian cricketing icon, was the brand ambassador of Rapidex English Speaking course in 1980s. In an interview with Hindu newspaper,[7] he recounted his experience of being ridiculed by a Cricket board official for not being able to speak in English.

[6] Chopra (2019).

[7] Lokpally (2014).

He elaborates further that he realized that in order to address the media of different countries, he had to learn proper English. Recently, a contestant in a popular Indian television show Kaun Banega Crorepati shared how he devoted himself to learn English by watching American movies and TV series.

Familial and educational spheres collide in impressing upon the child from a very young age the importance of academic achievement in India. Education is widely perceived by Indian parents as the sole means of upward mobility in the highly stratified social order of India. In most cases, the focus is on treading the well worn paths of engineering and management as they provide smooth access into the world of well paid work. Higher education is prized in vocational terms, as passports for upward mobility in the expanding service sector of liberalizing India. Government jobs continue to be highly coveted in India and are seen as a source of social status par excellence.

Competition is a ubiquitous feature of the educational life of Indian children. The English medium schools have a selective intake of students on the basis of merit. Entry into institutions of higher education is also marked by aggressive competition and/or by hefty fees which many middle and lower class parents are not able to afford. The curriculum driven, information dissemination approach and examination-oriented nature of the Indian educational system don't encourage the students to select and combine courses of their choices, get excited about ideas, and challenge their taken for granted assumptions.

Conclusion

The young in India have to deal with the contradictions of 'traditional' and 'modern', 'family culture' and 'peer culture', 'parochial culture' and 'global culture', 'old values' and 'new ideals' throughout their socialization which often create inner conflicts in them. This can also apply to the young generation across cultures also in the global world. The need of the hour is for the socio-cultural contexts to provide socialization experiences that will add to the psychological capacities and skills of the adolescents to function effectively as adults. Socialization, thus has to provide inputs for healthy individualism which allows them to make flexible adaptations to diverse settings and values. The immediate contexts of family and educational institutions must go beyond the culture of conformity and obedience and encourage youth to encounter and dialogue with differences, develop creative thought, action, and social critique, participate in decision-making in family/collective affairs and contribute to community building. Very importantly, more intensive efforts to build a strong sense of caring community, confidence, competence, and prosocial action need to be directed towards the vulnerable sections of youth who feel marginalized in the neoliberal world.

Time to Reflect

In the lives of Indian adolescents and youth, what constitute the 'traditional' sectors of personality and what constitute the 'modern' aspects of self? How does tradition and modernity co-exist together within the identity of contemporary Indian adolescents?

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Chapter 4
Peer Relations in Adolescence

Nandita Babu and Chhavi Mittal Goyal

Abstract The chapter discusses peer relations in adolescents which has a significant impact on their life. It colours and shapes the perception and behaviour of adolescents to a great extent. Peers and friends play an important role in the socialization process of children and affect various developmental aspects. The shifting influence of family to peers as children grow leads to generation gaps and may create negative parent–child communication and other behavioural problems including risk-taking behaviours. The chapter explains the development of peer relations, romantic relations, and the various factors affecting peer relations such as social media. Peer victimization affects the adolescent development and interpersonal relationship in a significant way. Finally, the chapter deliberates on managing peer relations so as to make a positive impact on the adolescent development.

Keywords Peer · Peer relations · Friends · Family · Peer victimization · Romantic relations · Identity development · Media

Introduction

Rahul, a 13-year-old boy was very excited to go to a new big city school when his parents shifted from Madurai to Delhi. In his first class, when his teacher asked him to introduce himself, he started off with eagerness. He had a regional dialect in his speech, although he spoke clearly and fluently. When a few students giggled while he was speaking, he became conscious. He felt that all his classmates were staring at him and he is being judged and made fun of. He did not speak much for the next two classes. During recess time, he was wondering if he would be able to have any friends and how he will survive in this new school, when suddenly he saw two boys from his class approach him. He was scared. Shardul and Binoy introduced themselves and sat down next to him, keeping their hands on his shoulders. They too had a regional dialect as one of them was from Jammu and the other one from

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Kolkata and had recently joined this school, just like Rahul. He felt relieved that he had found someone who could understand what he was going through.

The above case demonstrates how the behaviour of peers impacts teenager's thoughts and behaviour. The influence may be direct or indirect. Nevertheless, peers occupy an important place in adolescent's life. The nature of peer relations changes from early childhood through adolescence to adulthood across the entire lifespan. But it plays the most influential role during adolescence affecting their development and identity formation. Globalization and digitalization have significantly affected peer relations, as they have impacted every other aspect of life. It has facilitated peer relations and at the same time contributed to negative peer relations such as peer victimization and risk-taking behaviour. It is important to understand this crucial aspect of adolescent's life that has the potential to provide support and contribute to adolescent development in a positive way.

Peer Relations: Key Terms and Related Concepts

Peers are people who are similar to the individual in terms of age or grade level. *Peer group* refers to a group of individuals in a shared context and having similar biological age, e.g., Rahul's classmates were his peer group. A person may or may not know her/his peers very well, though they may be spending a lot of time together doing shared activities such as studying in the same classroom. The interpersonal interactions between these peers are termed as *peer relationships*. Since there is a shift from family to peer group as children enter into the adolescence stage, there is increasing independence and peer relationships often go unsupervised by adults.

Globally, schools provide easy access to peer groups for forming peer relations. In India, in the backdrop of joint family systems, the first peers a child comes across are within the family by way of same-age cousins. On the contrary, the person one chooses to spend time with and knows very well about is called a *friend*. For instance, Shardul and Binoy might become friends with Rahul. Friends seem to provide support and care, similar to what parents and family do at home. Friendship during childhood centres mostly around shared activities, however, it increasingly involves sharing of thoughts and emotions during adolescence. Peers may or may not share the same views, they may also be ethnically, racially different. However, such is not the case in case of friends. A person may not be able to select his or her peers, but can definitely choose who to be friends with, and this choice of companionship says a lot about the person in question. Thus friends provide a sense of psychological closeness mainly characterized by emotional support, and with whom one can share anything.

Peers and friends are an integral part of the socialization process of the developing adolescent, influencing not only the way one talks, walks, eats, and dresses up; but also the thoughts and beliefs one holds about the self and the world. Unlike the western cultures, in India, the majority of adolescents (even in late adolescence years) tend to stay with their parents only, while very few move out of their homes to stay with relatives or in a hostel (Palaniswamy & Ponnuswami, 2013). However,

adolescents coming from nuclear family report higher peer group influence than their peers from joint family systems (Palaniswamy & Ponnuswami, 2013). Adolescent friendships are defined by mutual liking, closeness, and loyalty, while in the earlier years, friendships were based on shared activities, reducing feelings of loneliness, and reciprocal interactions between peers. Adolescent peer relations are marked by reciprocal equality wherein they mutually learn behaviours and skills from their peers which helps them to deal with typical crises faced during adolescence (Kasaralkar & Jogi, 2016). Recent research shows that peer relations during early adolescent years such as ages 10–14, significantly predicted their current happiness levels (Caroline et al., 2018). Another cross-sectional study with middle school graders from American adolescents revealed that having supportive parents and peers helps in enhancing the overall satisfaction with life experienced by them (Siddall et al., 2019).

Throughout our life, we tend to form close interpersonal connections with individuals on a one-to-one basis, known as dyadic relations. However, during early adolescence, *cliques* which comprise of small cluster of closely connected individuals on the basis of close friendships and interests, develop (Rohrbeck & Garvin, 2014). For example, 'jocks' is a commonly used term in media, to denote the clique of athletic teenage boys who are part of their high school sports team and enjoy a relatively high status in their peer group. Another example could be a group of academically inclined students who get together to solve problems of their respective subjects. Members of a clique tend to be similar ethnically, racially, and/or behaviourally. This results from homophily- a condition where adolescents form groups based on their similar characteristics and also influence each other's thoughts and actions on account of their group affiliation. Adolescents are more likely to be influenced by their peers (and/or) friends with whom they share a mutual bond, have close reciprocal interactions, and spend most of their time (Piehler, 2011).

Adolescents tend to view themselves in accordance with the views held by the clique they are a part of. As they move into late adolescence, cliques are replaced by *crowds*, i.e., large reputation-based peer collectives that encompass several cliques linked through direct/indirect ties. It moves from the dyadic relationship of friendships to close-knit groups of cliques to a crowd where there is less actual interaction and members may not even know each other. For example, a classroom or entire cohort of students in a particular grade can be called as a crowd. Crowds influence and also help developing adolescents from their social identities. Also, a movement from dyadic relations to cliques to crowds is indicative of the increasing need to form social connections and to be a part of social networks (Rohrbeck & Garvin, 2014). It helps them to place themselves in a social context, to define themselves, and facilitate their identity development. In the current context of COVID-19 induced pandemic, adolescents seem to be particularly affected due to the restrictions in movement and socializing in person. Even though internet has made it possible to stay connected with friends in the virtual space, it is difficult for adolescents who have been marginalized previously, thus making them feel isolated and constricting the opportunities to explore and express their identities, which is a crucial part of the age of adolescence (Settersten Jr et al., 2020).

Shifting Influence from Family to Peers

Adolescence is the time when the individual starts to spend more time with peers and is more likely to conform to their ideas and judgements as compared to parents and family (Vranda & Rao, 2011). Having someone who is similar in age and experience, makes it easier for the person to share their thoughts and feelings and to confide in. This also makes the situations seem less threatening for the adolescent because the peers/friends are also more likely to be facing the same situations, making the adolescent feel less alone, as they are able to relate well with their peers and friends who share the same experiences. This is probably one of the reasons behind the shift in the relative importance of family during adolescence. Often, the parents and adolescents struggle to understand each other's perspectives, leading to the commonly used phrase 'generation gap', which refers to the gap in communication between the young and the old, stemming from the differences in perspectives. It is marked by the insistence of parents to guide/direct the actions of their children using their wisdom and experience to avoid taking risks, while the adolescents seek an open, flexible and adventurous approach (Sukhabodhananda, 2012). "*You will never understand*" is the common phrase used by adolescents for their parents.

Recent research examined the social anxiety symptoms in adolescents in the context of their relations with their parents, teachers, and peers. The research revealed that for the adolescents who do not have very positive relations with their parents and feel less supported by their teachers, the only source of support available is through their peers. For this reason, these adolescents are likely to comply with their peers which are associated with an increased level of social anxiety symptoms (Weymouth & Buehler, 2018). Additionally, exposure to conflict between parents predisposes adolescents to perceive stress and vulnerability in the context of relationships. This perceived threat manifests in the form of social anxiety experienced by the adolescents which has implications for adolescent friendships, as they are more likely to feel lonely and unsupported by their friends (Weymouth et al., 2019).

Open and positive communication with parents can act as a buffer against the experience of peer victimization at school. On the other hand, poor parent–child communication can put the adolescent at risk for bullying and victimization, both in offline and online settings (Salmon et al., 2018). When children hold a fear of punishment, they often refrain from seeking advice from their parents, which can have negative consequences as parents would often remain unaware of what their child is going through, and thereby are unable to monitor/protect/guide their actions, leaving the adolescent vulnerable to negative experiences (Pells et al., 2016).

Recent research evidence (Llorca et al., 2017) hints at the link between parenting styles and subsequent peer attachment shown by adolescents and their academic achievement. For instance, a longitudinal study in Spain that traced the relationships of adolescents with their parents and peers from early adolescence years to late adolescence highlighted that when both parents, particularly the father adopts an authoritative parenting style, adolescents are less likely to engage in aggressive

behaviours or get victimized by their peers, and rather have positive peer attachments and bonds. On the contrary, permissive parenting style was not found to be effective. This research also added that adolescents who had more positive peer relations, tend to show higher academic self-efficacy and later academic achievement. According to Llorca et al. (2017), peer relations and the adolescents' belief about their own academic ability acts as a mediator between the parenting styles and academic achievement.

Qualitative research with 54 parents revealed that most of the parents provide ineffective advice to their children who are either victims of bullying or are bystanders. They either ask their child to inform an adult at school, avoid the perpetrator, or in case of bystanders, they advise them to take a stand for the victim. The research also suggests that adolescents are often reluctant to inform adults about their experiences of peer victimization because they feel that their parents, just like their teachers may not consider it to be serious, or may not be able to help them (Stives et al., 2018). This research highlighted the need to educate parents regarding more effective strategies to help them develop more friendly, frank, fair, flexible communication with their children.

Development of Peer Relations

Peer relations affect significantly various aspects of development, adjustment, and functioning of children and adolescents in different spheres. Bronfenbrenner (1979) remarks that peer relationships do not occur in a vacuum, but are embedded in the multiple contexts of youths' lives, extending from the most proximal (micro-system) to the most distal (macro-system) levels. Further, the factors at the micro level (family system, peer relations, school culture) also get affected by macro level contexts including cultural and political ideologies, stereotypes, and belief systems. Thus, the nature of peer relations and their development through the stages is influenced and informed by the socio-cultural factors around the individual.

During infancy, although the typical friendships may not be observed, infants do socialize with other infants, as they tend to smile at, vocalize or pay more attention when in the presence of another infant. As infants grow older, their sociability tends to increase with age. Playing social games like 'peek-a-boo' or imitating other infants, are important for the learning and development of social exchanges that require children to invite a response from others and subsequently react to them. This kind of social exchange between infants lays the foundation for learning new behaviours as well as their cognitive development, and it tends to persist even when they grow old (Feldman & Babu, 2018).

During pre-school years, one can see the early signs of friendships developing between peers. Around three to four years of age, pre-schoolers become 'friends' with their peers with whom they engage in shared activities. During this time, the development of theory of mind plays a reciprocal role in facilitating social interactions through make-believe play, which further enhances the development of

theory of mind (Babu, 2008). Gradually, as they get older, they learn to differentiate between peers and friends on the basis of abstract concepts like trust, support, and mutual interest. In middle childhood, different factors influence the development of friendships and peer relations across ages: reciprocal liking and time spent together doing shared activities (4–7 years); mutual trust, expectations, personal qualities of others (8–10 years); and lastly psychological closeness, i.e., intimacy and loyalty (11–15 years) (Feldman & Babu, 2018).

As children move towards adolescence, their 'popularity' or 'status' in the peer group determines their friendships as well as their overall adjustment in school. Adolescence is the age where the individual is dealing with a lot of changes physiologically, socially, and psychologically. It is at this time; the adolescent sees a shift in the relative influence of family (especially parents) to that of their peers (Rohrbeck & Garvin, 2014) in shaping the way they form their own identity.

Ecologically speaking, the family context, the peer group, the school, and (if applicable) the adolescent's workplace, together form the immediate social contexts of everyday life that deeply influence the development of the adolescent (Palaniswamy & Ponnuswami, 2013). Having a high status in peer group, i.e., adolescents who are evaluated as playing a significant role in the peer group by their peers, tend to be the popular kids who are also more likely to have higher quantity of social interactions, which in turn can account for their relatively higher number of friends, than their lower status peers. Popularity seems to be contingent upon social competence like being helpful, cooperative, funny, effective communicators, and ability to understand others' emotions well (Ladd et al., 2012). Whereas for the not so popular school kids, lower social competence tends to escalate into a vicious cycle as their apparent difficulty in relating well to others, leads to less chances to interact and form close association with their peers. This can further diminish their chances to regulate their own social skills by interacting with well-adjusted peers, which can thereby maintain their lower popularity.

Similarly, it is difficult for adolescents with disabilities to form healthy relations with their peers. Research suggests that for these adolescents to form relatively healthy peer relations, the ability to communicate and positive family interactions are crucial (Lygnegård et al., 2018). Further research with adolescents with long-term health problems and those with disabilities highlights the preference for positive relations with peers over the ability to engage in domestic chores. This research also adds that even though the adolescents with relatively poor health status and impairments would want to have more positive relations with their peers, the opportunities to do so are often limited due to their restricted participation in routine activities (Lygnegård et al., 2019).

Stereotypes related to gender, class, race, and ethnicity also influence the formation of friendship with peers among adolescents. Patterns of friendships among adolescents seem to be determined by the type of school, gender as well as the culture in which they are raised. For instance, research that compared adolescent friendships from American and Australian samples found that adolescents from American schools were more likely to emphasize upon closeness and assertiveness in their friendships as compared to their Australian counterparts. Likewise, girls preferred to

have more proximity and closeness while boys preferred more assertiveness. Similarly, adolescents from private schools were also more likely to be assertive than close with their friends as compared to students from Catholic and public schools (Bank, 1994). Stereotypes are widely held cultural beliefs, expectations, generalized attitudes, or evaluations about individuals who share a social position, such as ethnicity, race, gender, social class or nationality (Stangor & Schaller, 1996). They affect how adolescents and youth perceive themselves as well as others (Niwa et al., 2016). The significance of stereotypes as a macro-factor influencing adolescent peer relationships (Niwa, 2012; Way & Rogers, 2014) points out that though adolescents use the stereotypes to form boundaries with peer groups and peer discrimination, they also resist these stereotypes and peer victimization (Chu, 2014; Way et al., 2013). The fact that the youth both accommodate and resist stereotypes has implications regarding undertaking measures for challenging the stereotypes and forming cross-ethnic friendships.

Romantic Relations in Adolescence: A Special Case of Peer Relations

It should be noted that early adolescence, i.e., 11–13 years of age is the time when children hit puberty, and this is the time when a special kind of peer relationship, involving mostly the opposite sex comes into the picture—the romantic relationships. Empirical data confirms that the first stage of romantic development is triggered by puberty (Friedlander et al., 2007) and at this time adolescents become highly interested in matters of romance, and this is the main discussion and interaction topic among friends as well as internal fantasies (Tuval-Mashiach et al., 2009). This new, common interest in romance moves adolescents away from having only same-sex friendships, as is typically the case throughout childhood, towards the formation of mixed-group peer groups, which provide an opportunity to interact with romantically attractive others (Connolly et al., 2004). Having a romantic relationship is associated with enhanced self-esteem, popularity, social acceptance, and feelings of competence in managing day-to-day interactions with both friends and romantic partners (Grover et al., 2005).

However, there is a flip side to it as well, as romantic relationships are also associated with negative social and health outcomes. Research shows that social group norms and opinions of peers also influence the course of teenage romantic relationships and the impact it has on the development of problematic behaviours. Adolescents' idea of who is a desirable dating partner, whether to get involved in a romantic relationship, and how to proceed in the relationship are largely influenced by their peers. Additionally, when adolescents engage in relationships that contradict their peer norms, then boys and girls tend to develop externalizing and internalizing problem behaviours, respectively (van Zantvliet et al., 2020).

Just like peer group norms, culture also impacts the romantic relationships in adolescence. While it is relatively a routine in the Western countries for adolescents to be dating their peers and having open conversations about it with their parents. The adolescents in India have an opposite narrative about it as adolescent relationships are largely looked down upon in the Indian context. The situation seems to be far more complicated for adolescent girls in India. They face additional pressure from their parents and society at large that condemns their involvement in romantic relationships. They are also at risk for teenage pregnancy, running away from home, dropping out of school, and disturbed familial relations (Manjula et al., 2018). Also, just like in adult romantic relationships, when there is a failed romantic relationship, it impacts the young mind severely, and the impact is for both the partners involved. The partner who has feelings for the other, which are not reciprocated, feels rejected and may lead to low self-esteem; whereas the partner who rejected the other person's advances, is likely to be made fun of and may also experience guilt in some cases for having done so. However, more research is required to explore these claims in the Indian context.

Peer Relations and Adolescent Identity Development

Peer relations can affect adolescent identity development through peer pressure in both positive and negative ways. Peers can be the source of affection, fun, and emotional security, yet they can also influence the adolescent to try out drugs and alcohol (Rohrbeck & Garvin, 2014). Similarly, positive peer relations can provide a safe haven to explore and expand one's self-concept, making the individual more confident, better adjusted, altruistic, and less aggressive. It can also enhance their social skills while at the same time limiting the adolescent's internalizing problems and protecting them against difficult relationships at home and/or school, in turn making the adolescent more involved in school and showing greater work orientation than their peers who do not have positive relations with peers. The findings of a study by La Greca and Harrison (2005) indicate that various aspects of adolescents' peer relations and close relationships contribute to feelings of internal distress in a snowballing fashion.

Adolescents' peer crowd affiliations, positive interactions with best friends, and the presence of a dating relationship appear to 'protect' adolescents against feelings of social anxiety, while relational victimization and negative interactions in best friendships may contribute to feelings of social anxiety. In contrast, adolescents' affiliation with a high-status peer crowd appeared to afford some protection against depressive affect, but relational victimization and negative qualities of best friendships and romantic relationships were key factors associated with depressive symptoms. In particular, relational victimization was a substantial predictor of both social anxiety and depressive symptoms. Research indicates that adolescents' identity development and relations with peers are closely interlinked (Ragelienė, 2016). According to Ragelienė's (2016) systematic review of literature, there is a positive

link between adolescent identity development and attachment to peers. Research with 100 early adolescents (10–14 years of age) showed that those who show secure attachment patterns with their peers are more likely to report higher levels of happiness. This kind of close relationships with peers have important implications for healthy adjustment for the adolescent, along with relatively higher self-esteem and life satisfaction and less distress (Sharon et al., 2018).

Peer experiences significantly shape human development and the development of psychopathology. There is a general agreement among psychologists that children come to view themselves at least partly from how they are treated by peers. For instance, the relationships with peers provide rich opportunities for learning social skills like cooperation, gaining support, or developing interpersonal skills, whereas continuous difficulty in forming healthy and stable peer relations are linked with difficulties with others later in life and in some extreme cases, it may also lead to clinically significant behavioural and affective disorders (Parker et al., 2005). Also, having better quality relationships with peers was associated with a lower tendency to experience feelings of loneliness.

The relationship between adolescent identity and peer relations is bidirectional, as having reached a sense of personal and social identity is implicated in less nervous or competitive behaviour in interpersonal relations, more satisfaction in romantic relations, less controlling behaviour, and the ability to reflect on one's interpersonal relations. This could also be attributed to the fact that when an adolescent enjoys positive relations with his/her peers which are built upon mutual cooperation, negotiation, mutual understanding, it becomes less threatening to their self-image which subsequently gives the adolescent a chance to freely explore and commit to their goals and beliefs. Thus, adolescents' self-esteem is enhanced and these positive interactions with peers serve as a buffer against the anxiety related to the developing identity. When adolescents believe that their peer relations can be improved over time, i.e., they are malleable, or in simpler terms when they hold incremental beliefs about peer relations (and not fixed), they tend to focus more on fostering positive social relationships and improving themselves in the social realms.

Impact of Social Media on Peer Relations

In the age of internet, social media applications like Facebook, Myspace, Twitter, Instagram, etc., have dramatically altered the nature of peer relationships as they provide increased opportunities and contexts for peer relationships. Social media platforms are providing avenues to adolescents to make new friends, express themselves, and stay connected with their friends while simultaneously mitigating the barriers of physical space (Lenhart et al., 2015). These platforms make it possible for the adolescents to connect (virtually) with their peers whom they cannot encounter physically (Rohrbeck & Garvin, 2014). This increased 'availability', 'permanence', and 'publicness' of social media has created new avenues for both positive and negative encounters with peers (Nesi et al., 2018). During adolescence, feedback from

peers about one's likeability is an important determinant of the individual's reputation in terms of visibility and status in the peer group hierarchy. In this context, social media tends to create a heightened awareness of one's own as well as others' popularity or status among peers. Adolescents seem to be particularly concerned with how they are viewed by their peers and often resort to manipulated self-presentation means in order to fit in with their peers (Chua and Chang, 2016). They can also use social media to expand their 'popularity' beyond their immediate physical location and possibly attain 'celebrity' status (Nesi et al., 2018).

For example, current global star Justin Bieber initially became famous because of the content he shared on video sharing platform YouTube during his teenage years. Teenagers are also likely to alter their real-life behaviours in order to look more appealing virtually. For instance, many social awareness campaigns are now making use of popular 'hashtags' (example-#IceBucketChallenge) so that they 'trend' online. In order to get featured in these 'trends', many adolescents also join these social causes, to be able to post content with the 'hashtag' and get noticed and popular in the virtual world. However, maintaining one's social media popularity is like walking on a double-edged sword. On the one hand, social media is providing opportunities to express and maximize their potential and reach, and on the other hand, social media also leaves the adolescents vulnerable to new forms of peer victimization like cyberbullying and victimization. Also, adolescents who otherwise enjoy a relatively higher peer status stand a chance to gain more from social media as it can give them opportunities to enhance their popularity and social connections (social enhancement hypothesis). On the same lines, adolescents who are socially anxious, lonely or unpopular, also get a chance to enhance their social connections and peer status online (social compensation hypothesis). This change in adolescents' peer status because of social media is termed as the transformation framework (Nesi et al., 2018).

The loss of time and space restrictions on the development of peer relationships in the virtual world is seemingly responsible for the increasing instances of cyberbullying and aggression worldwide. Now bullying experiences are no longer restricted to school hours, as with social media, adolescents can pick on their peers in the virtual world whenever and wherever they want. This has led to an increased frequency and immediacy of peer victimization instances (Nesi et al., 2018). Additionally, it is believed that cyber victimization experiences are relatively harsher and more uncontrollable for the victims because of the anonymity of the perpetrator, minimal adult supervision, easy accessibility, as well as fear of being humiliated in front of a larger 'audience'. While the researches carried out so far have been inconclusive about the exact prevalence of cyberbullying, but researchers agree that if appropriate measures are not adopted, then cyberbullying poses a great threat to the well-being of adolescents. Also, there is a possibility that even individual isolated incidents of cyberbullying/victimization are prone to repetition as other students may help circulate, copy or share the hurtful online content that was posted by the perpetrator (Wachs et al., 2018).

Research shows that the availability of internet access at home has led to a significant reduction in the time spent communicating with the family (Varghese & Nivedhitha, 2014). This family time could have otherwise provided a buffer against the potentially negative experiences with peers both online and offline. However, in India, mobile phones and computers are generally shared between family members, and for most Indian children, physical spaces have not been completely replaced by digital or virtual ones (Banaji, 2015).

Initial evidence from India suggests that the majority of 17–23 years old who are active users of social media applications, showed more helping behaviour towards their friends. They are also less likely to try to maintain a healthy and positive interaction with their parents. These youth are also apprehensive that 'non-friends' may get access to their personal information online or others may use their information against them (Rajeev & Jobilal, 2015). Thus, research in the Indian context on the impact of social media on peer relations is still in its nascent stages. Another potential reason for worry is the increased vulnerability of the adolescents due to excessive data sharing online as the majority of teenagers tend to not only share their private pictures, but also contact information and live locations which poses threat to their safety. While most of them report having control over who can access their content, a survey report from the US suggests that over 90% of adolescents do not really bother much about third-party applications accessing their data (Madden et al., 2013).

However, as was mentioned in the beginning of this section, social media is not all bad. Research shows that in order to avoid awkward conversations such as matters pertaining to sexual health, adolescents often turn to online information sources, preferably ones that ensure confidentiality, presenting the desired information in a humorous way (Byron et al., 2013). This helps destigmatize the issue on one hand, at the same time there is a risk of information overload and misinformation due to limited control over who can access what information. It can be said that if used correctly, social media platforms have great untapped potential to spread awareness among youth, to reach out to the community. Spreading awareness about social media literacy and best practices for safe use of the internet can be an important agenda for the policymakers today.

Dark Side of Adolescent Peer Relations: Peer Victimization

As indicated, peer social experiences differ in multiple ways across individual adolescents. Having actual or perceived social support from peers and family is related to lower levels of reported victimization among adolescents (Chopra et al., 2017).

Adolescents with objective peer difficulties experience subjective distress due to their circumstances. It is clear that adolescents, who are liked by their peers, enjoy acceptance in their group, conversely, when a group rejects a particular individual, a consensus is formed among members about that individual being undesirable. Thus, having friends in the classroom and the features of these relationships has an important bearing on the adolescent's success in school (Ladd et al., 2012). Research with

50 adolescent girls from Mumbai with regards to their peers by Kasaralkar and Jogi (2016) showed negative notions held by the participants with respect to their peers. They reported being dominated by their peers and being forced to conform to peer group norms so as to gain their acceptance and approval. Research evidence suggests that peer group rejection has adverse consequences for adolescents' engagement and achievement in school, thus making them poorly adjusted to school. And these adverse peer relationships can lead to the extreme form of peer harassment, i.e., peer victimization. 'School bullying' and 'peer victimization' are used interchangeably in the literature, to denote a phenomenon that involves intentional negative actions that are repetitive in nature, with an underlying imbalance of power between the perpetrator and the victim. This phenomenon has been defined as, *"Bullying occurs when a student, or groups of students, say or do bad, nasty or unpleasant things to another student. It is also bullying when a student is teased repeatedly in an unpleasant way or when he or she is deliberately left out of things. It is not bullying when two students of about same strength or power argue or fight or when teasing is done in a friendly and playful or fun way* (UNICEF, 2017, p. 38)."

Peer victimization instances can be either carried out directly or indirectly. Direct peer victimization is a relatively open attack on a victim which involves overt behaviours (physical and/or verbal), observable by others. Such instances typically involve a face-to-face encounter between the bully and the victim. The student who indulges in bullying may choose to attack the victim through the use of physical or verbal aggression, or may simply scare the victim by staring, laughing at or making inappropriate gestures towards the victim. Indirect peer victimization is relatively subtler and more difficult to detect. It usually takes place in the background, with rarely the bully and the victim coming in direct face-to-face confrontation. Social bullying/Victimization and Cyberbullying/Victimization can be considered as examples of indirect peer victimization instances. Social isolation, intentional exclusion, manipulating the victim's social relationships, spreading of rumours, etc., are all examples of indirect ways of peer victimization (Chakraborty, 2018).

It should be noted here that not all forms of peer victimization are equally damaging for the students, some of them lead to scars on the outside, and some hurt the student internally (Skrzypiec et al., 2011). Adolescents who are rejected by their peers tend to cope by engaging in risky behaviours. They do so as to gain recognition from their peers or to establish a nonconformist identity (Forman-Alberti, 2015).

Peer Relations and Adolescent Risk-Taking

Research shows that adolescents are more likely to engage in risk-taking behaviours even if explicit information about the probable rewards and costs is available, in the presence (real or perceived) of their peers (Smith et al., 2014). This increase in risk-taking behaviours in the presence of peers is known as peer effect. Neurobiological

evidence also confirms the peer effect as fMRI studies have shown increased activation of the brain regions involved in prediction and valuation of rewards (orbitofrontal cortex and ventral striatum), and increased risky behaviour among adolescents when in presence of their peers (Chein et al., 2011). Experiences of social exclusion among adolescents who report having poor resistance to peer pressure are associated with enhanced behavioural risk-taking as confirmed by neuroimaging studies which show increased activity in temporo-parietal junction which acts as a mediator in this case (Peake et al., 2013). Adolescents' engagement in risky behaviour seems to be contingent upon the quality of their friendships. The positive quality friendships which are marked by high levels of support can serve as a protective layer and help promote socio-emotional competencies as well as prevent engagement in delinquent and risky behaviours. The friendships which are marked by high levels of conflict are known as negative quality friendships and are linked with delinquency, risky sexual behaviour, and substance use (Forman-Alberti, 2015). Similar results were obtained in a longitudinal study that required 46 adolescents to keep a track of their peer conflicts and support for a period of two years. Later on, fMRI scans revealed greater activity in striatum and insula regions of brain among adolescents having high levels of conflicts with their peers and received less peer support were more susceptible to risk-taking behaviours as was also indicated by their performance in a risk-taking task. On the contrary, adolescents having relatively healthier peer relations seemed to have developed a kind of stress buffer which diminished their tendency to engage in risky behaviours (Telzer et al., 2015).

Research has shown that life skills education or training in psychosocial competencies can help the adolescent in times of uncertainty, self-doubt, and disappointment, thereby help reduce the likelihood of their involvement in risky behaviours (Vranda & Rao, 2011). According to Kotwal et al. (2005), friends play an important role in adolescents' initial tobacco use and subsequent continual usage which leads to dependence on tobacco later on. They also suggested that adolescents tend to engage in substance use (especially tobacco and alcohol) due to peer pressure (Ghosh et al., 2014; Tsering et al., 2010).

Managing Peer Relations

When adolescents believe that their peer relations can be improved over time, i.e., they are malleable, or in simpler terms when they hold incremental beliefs about peer relations (and not fixed), they tend to focus more on fostering positive social relationships and improving themselves in the social realms. Given the importance and influence of peer relationships on the adolescent development, it is necessary to know the ways to foster good peer relationships. The benefits associated with positive peer relations are not limited to better social adjustment and personal growth of an adolescent. Peers can also help bridge the gap in adolescents' knowledge and subsequently help solve some of the common dilemmas faced by the young mind. For instance, the National Adolescent Health Programme launched by the Indian government in 2014,

also referred to as the Rashtriya Kishore Swasthya Karyakrama, emphasizes upon the physical, sexual, mental, and social health of adolescents. It has a peer education system as one of its key components. Under the rubric of this peer education model, four adolescent boys and girls are selected and trained from each village to conduct one-on-one sessions and activities targeting adolescents' sexual and reproductive health, nutrition, well-being, substance misuse, and so on. Frequently, group outreach programmes are also planned within this scheme to provide networking opportunities to the adolescents. These peer educators are called as 'sathiya' who reach out to adolescents in their respective communities and help empower the adolescents of that region (National Health Mission- Peer Education Programme, 2021). On the same lines, in the era of Covid-19, advocates of public health profess the idea of harnessing the power of peer influence on adolescents to influence each other to follow social distancing norms and help curtail the spread of the virus (Andrews et al., 2020).

The dual role of peer relations in being both a source of stress as well as comfort in terms of social support for the adolescents has been highlighted by research studies. While a lot of adolescents report feeling stressed about being accepted by their peers, they are equally likely (if not more) to open up about their problems with their peers and seek social support from them (Camara et al., 2013). Preliminary evidence from intervention-based researches that employ support from peers as a factor influencing adherence to behavioural interventions for depression shows promising results (Ho et al., 2016).

At the same time, the adolescent needs to know the ways to handle negative peer pressure. Since acceptance by the peer group and conforming to peer group norms is paramount in this stage, it is important to distinguish between positive and negative peer influence. Peers provide a sense of security and belonging during this transitional phase where they may get confused and anxious by drastic and vast changes at all fronts—physical, emotional, cognitive, and social. It may lead to the developmental crisis of identity confusion. Hence, it is important for the adolescents to fulfil this developmental need to form peer relationships and derive benefits from it, but at the same time to safeguard from the harmful effects of negative peer relations.

Two aspects can be mainly looked into with regard to managing peer relationships: (a) parental management of peers, and (b) social skills of adolescents.

Parental management of peers refers to the role of parents in the peer relationships of adolescents. The goals and beliefs held by the parents towards peer relationships in their adolescents affect the relationship positively or negatively. Mounts (2011) reported in a longitudinal study that the caregivers' goals and beliefs affect parental management of peer relationships, which in turn can lead to positive or negative outcomes. A greater number of caregivers' goals of improving peer relationships and higher beliefs about parental authority over peers were related to higher levels of consulting, guiding, and conflict about peers. This led to lower levels of assertion and responsibility in peer relationships over time. However, when parents were having greater number of goals of improving peer relationships without the beliefs about parental authority, it resulted in adolescents reporting higher levels of social skills such as cooperation, responsibility, assertion, empathy, and self-control over time.

Thus, higher beliefs about parental authority and conflict about peers put a barrier in parent–adolescent relationship that hampers effective communication and the development of social skills in adolescents. Hence, there is a need to look into the beliefs about parental authority and avoid peer conflict to improve peer relationships.

It highlights the importance of the type of parenting style adopted by the caregivers. Adolescents' perception of parental management of peers differs significantly across the parenting styles (Mounts, 2002). Parenting style was found to be a significant moderator between parental management practices of monitoring, guiding, prohibiting, and supporting, as well as the drug use outcomes. Further, parents' knowledge about adolescents' peer relationships and their direct involvement in peer-oriented activities shows a difference between the parents, with mothers reporting higher level of knowledge and most peer-oriented activities with their daughters (Updegraff et al., 2001).

Thus, parenting practices and parent-adolescent relationships play an important role in adolescent peer relationships and can facilitate the development of proper social skills to manage peer relations in an effective way. Adolescents can also learn social skills through the life skills education programme in schools.

Conclusion

As stated by Erikson (1968, p. 23), individual development is a constant "interplay between the psychological and the social, the developmental and the historical". There is a significant influence of the macro-contexts on the micro-contexts of the adolescents leading to a dynamic nature of their development in various aspects. Peer relationships as a part of the micro-contexts of the adolescent's life develop and get affected by the factors at the macro level. This interaction determines the impact of peer relationships as positive or negative on the adolescent development. This underscores the importance of making concerted efforts by all stakeholders mainly the family and school system to provide conducive environments for building positive peer relationships. The present chapter discussed the concept and development of peer relationships and explained its role in adolescent identity development.

Peer relationships form an important milestone in the development of adolescents. It provides assurance, affirmation, confidence, and support to explore one's identity—the crucial developmental task in this stage. The challenge, however, lies in peer rejection, peer victimization, conformity pressures which may give rise to behavioural problems and negatively affect the personality and psychological well-being of the adolescents as they grow. Hence, there is a need to focus on this crucial aspect of adolescent development.

Time to Reflect

Peers occupy an important place in adolescents' life across cultures. They have a significant impact on adolescent development and behaviour in this transitional phase of life marked by developmental transition as well as shifting from family to peer influence. It is a universal power struggle between parents and peers where the adolescent finds peers more approachable and aligned than parents; although parents are always for the well-being of their adolescents. How do we take care of this situation where all the three stakeholders—the adolescent, parents, and peers can complement each other towards achieving the common goal of adolescent positive development?

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Part II
Concerns and Challenges

Chapter 5
Adolescents and Issues Related to Learning and Academic Achievement

Subhash Chander

Abstract The chapter focuses on the learning experiences of adolescents in the education context. The concept of learning and academic achievement are differentiated and the implication of various theories on learning are highlighted. The issues and challenges related to learning and academic achievement in adolescents are discussed. Further, various ways and strategies to facilitate learning experiences of adolescents are discussed.

Keywords Learning · Academic achievement · Adolescents · Education · Identity development · Learning experiences

Introduction

Case A

Abhay studies in class 9th. In the parent–teacher meeting, his class teacher complained that his grades are very poor in all subjects compared to his last year's performance. His parents came to know about several unit test results which they were not aware of recently. His teachers showed their signed report cards, which upon querying Abhay, they found that these were signed by him only. Parents got angry and started scolding Abhay in front of his teacher and other students. Abhay's class teacher stopped them and suggested talking to the school counsellor about the matter.

Accordingly, when they first talked to Abhay's close friend, they came to know that Abhay had stopped talking to him a few months back because of some conflicts. It was further known that, since few months, Abhay had started to 'bunk' classes and was interacting with a new student from a higher grade who lived nearby his home. He has started smoking and doing things not permitted at home. And, as Abhay was forcing his friend also to participate in these activities, they stopped talking after

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some time. Abhay's parents and teachers have now started meeting more frequently withr the counselling.

Case B

Bharti was not a high achiever in school till her 7th class. As she joined the 8th class, she got exposure to astronomy through a workshop in school. She got fascinated by astronomy and ideas related to the universe. She started to get interested in learning basic ideas related to astrophysics. She tried to ask questions to her teachers about pursuing a career in astronomy, but she did not get much information from teachers. She was also not finding it interesting the way teachers were teaching. She started to look for information through the internet and started reading books by eminent astronomers and scientists on her own. After some time, she was not able to get any direction to do more related to astronomy and started to lose interest in her studies further.

Abhay and Bharti are just two of the cases in the Indian context, which shows the diversity of challenges and opportunities related to learning and academic achievement during adolescence. In Abhay's case, various factors may have been responsible for the deviation of the child from his focus on academics and learning. The onset of puberty, and the growing curiosity and experimentation nature may have been the reason. Or as Abhay grew, his observation and interpretation about his relations with family might have started to change. It may even be due to discord in the family or, any other reason. The consequences also included him resorting to lying and hiding things. The way parents and the school would handle this situation with awareness and sensitivity, would affect Abhay's state of mind. However, given the diversity of contexts in which adolescents live and function across society, cultures, and nations, the accessibility and availability of support systems is very critical at this point of time. Parents and teachers play a crucial role in dealing with such situations.

Bharti's case can also be a typical example of how our existing structures in educational institutions do not allow exploration of students' potential as well as their aptitude. The initiated self-direction, motivation, and self-exploration of Bharti could not be sustained in the absence of any guidance. So there was a timely exposure to her but without a well-defined and systematic follow-up. This raises implications for the education system which needs to put emphasis on going beyond the classroom instead of focusing mainly on the prescribed syllabus and marks attained by students only. It needs to recognize and fulfil the creativity and potentials of the students so that 'learning' can truly happen in our classrooms.

Adolescence presents a significant period for both learning opportunities as well as risk for students. As the brain prepares for adulthood, its development depends strongly on the learning environment and experiences provided during adolescence. Consequently, during the middle and high school stage of education, students must practice the types of complex cognitive and interpersonal skills necessary for postsecondary success (Alliance for Excellent Education, 2018). As we see, adolescence is

a complex, multi-system transitional process involving progression from the immaturity and social dependency of childhood into adult life with the goal and expectation of fulfilled developmental potential, personal agency, and social accountability (Greenfield et al., 2003).

The notion that adolescence is a heightened period of vulnerability specifically because of gaps between emotion, cognition, and behaviour has important implications for our understanding of many aspects of both normative and atypical development during this period of the life span (Steinberg, 2005). Sudden changes in physical, cognitive, and emotional aspects during adolescence affect the adolescents as well as their family members. Some adolescents bloom and achieve things during this stage, whereas some face adjustment problems and show deviation in their focus and behaviour. They may engage in harmful experimental behaviour, develop a defiant attitude or go into depression.

Hence, we cannot assess adolescents based on their age only. But the practices and the structure in educational institutions are mainly guided by the criteria of age. Adolescents not only bring the age-related experiences and developmental characteristics to the classroom situation, but also a variety of other experiences related to the multiplicity of adolescent context and background that affect their development and behaviour. This affects their receptivity to learning and other classroom transactions in the school context. Further, learning and achievement in academics are areas that are linked mainly to examinations in the Indian educational system. All these make it imperative that we understand the nature of learning experiences in the context of adolescents and discuss the factors, issues, and challenges to the learning of adolescents.

Learning, Academic Achievement, and Adolescents

Adolescence is a phase of development that leads to adulthood. We need to see it as a continuous phase rather than a disjointed and discrete spurt in individual growth. Although changes in physical and cognitive growth are more observable during these years, some of the changes are also covert in nature. As a stakeholder, we have to understand that each individual is different and any attempt to classify their development into fixed structures would not be a good idea. While we appreciate adolescent characteristics and take care of them while planning for learning, it is important to understand the adolescent as an independent entity trying to make sense of the environment and self during the changes happening within.

The changes in the early stage of development have direct implications on learning which are well presented in different theories of learning from behaviourism, cognitivism to constructivism, and other theories of learning.

Piaget's theory (Piaget, 1962) of cognitive development emphasized one of the most important changes during adolescence, which was the ability to systematically explore and manipulate the environment. The focus is on thinking processes

becoming more and more developed in a way that abstraction is better comprehended and applied. **Vygotsky's ideas** (Vygotsky, 1962, 1978) related to the impact of language development and socio-cultural context on individual cognition have equally important implications on learning. Constructivist theories emphasized on the active role of individuals during learning. As also seen in **Bruner's theory** (Bruner, 1966), where he talks about enactive, iconic, and symbolic modes of cognition and highlights that as we grow in age from childhood to adolescence our thought becomes more and more symbolic in nature. The information procession learning theories have emphasized on increased ability in storage, retrieval, and processing of information as we grow. With the ideas of **Siemens and Pepart** paving the way for new age learning theories based on **constructionism and connectivism**, implications for learning during adolescence need to be considered by educationists and other stakeholders more carefully. **Bandura's ideas** of social cognitive learning theory and how observation influences learning is a key concept while planning learning experiences for children and adolescents.

The emergence of the internet, particularly Web 2.0 has provided access to the views and opinions of a wide range of individuals opening up opportunities for new forms of communication and knowledge formation. Previous ways of navigating and filtering available information are likely to prove ineffective in these new contexts. (John Gerard Scott Goldie, 2016). The exponential increase in the usage of internet and web 2.0 among adolescence ihas major implications on the way they learn and what they learn in coming times. It would require a lot of research in the coming time to determine this relation but connectivism needs to be one of the major theories which teachers and other stakeholders associated with adolescents need to refer to.

Planning for learning experiences at micro level in schools requires a much deeper and wider analysis. It needs to take into account a host of factors related to personal, psychological, economic, social context. For instance, the relation between various aspects of development such as physical, emotional, social, moral development during adolescence has implications for learning. It's not just related to the ability to learn, but much beyond it. The changing emotional situation of the adolescents can influence their learning in many ways, and it may have implications beyond their cognitive development, affecting their development as a whole (Fig. 5.1).

Learning and academic achievement are related. Learning is an intrinsic process, whereas academic achievement is an outcome of it reflected in terms of marks, grades, certificates, awards, and distinctions. Academic achievement aims at achieving set educational goals, short term or long term. Learning is a lifelong process, the foundations of which are laid down in childhood and schooling years. It is crucial that the child develops an interest in learning which affects academic achievement, school success, and future life also.

Academic achievement is also affected by many other factors such as home environment (Dev, 2016), students' motivation (Steinmayr et al., 2019), and approaches to learning (Hermann et al., 2017). Learning approaches or strategies can be at a surface level as well as a deep level. Surface learning involves just acquiring the information and remembering it for the purpose of passing an examination; and one may forget it later. However, deep learning involves understanding the relation between

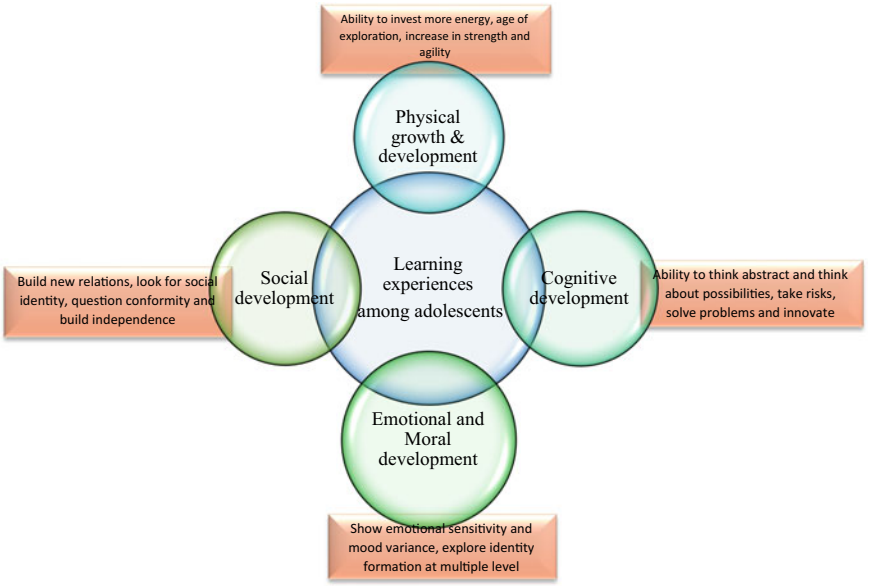

Fig. 5.1 Learning experiences among adolescents

concepts, analyzing it, and learning it for the sake of learning. Thus, it reflects an internal interest in learning. Further research (Veresova & Foglova, 2017) indicates that self-efficacy beliefs of adolescent students affect the autonomous evaluation of academic achievement, that is, when the student self-assesses and expects a certain standard of performance for herself/himself. It motivates the students to use deep learning strategies.

It is pertinent to reflect if our schooling system promotes learning or achievement only. One of the basic challenges in the Indian education system is the emphasis on academic achievement in schools. During the years of growth and development, students not only require learning opportunities through different modes, but also require the environment to share their emotions, channelize their physical energy through games, participate in different activities to develop their process skills. This is the time when they are not only exploring their identity but as part of it, they are also exploring themselves and the world. Hence, although academic achievement is important and influences the identity development of adolescents, creating conducive learning experiences for adolescents is more crucial which not only leads to achievement, but also facilitates the holistic development of children and adolescents.

Identity Development and Learning During Adolescence

Identity in adolescents is important as they try to understand their physical development, cognitive skills, and social expectations in order to construct a viable pathway towards their adulthood (Devi & Jyotsana, 2016). This process affects their learning and cognitive development.

Erikson's theory (1963) talks about the crisis of identity vs role confusion in the process of identity development among adolescents. He highlights the importance of a positive sense of self and relationship to others which helps in identity formation in the absence of which adolescent is faced with role confusion. This has important implications on adolescent learning. The role of parents, teachers, and other stakeholders responsible for providing learning opportunities and experiences to adolescent need to take this into account. Though the majority of the adolescents resolve the conflict and are able to have a sense of identity, there are multiple factors that are contextual and can be more prominent players in identity development and also influence the what and how of the learning. The diversity in the Indian context with respect to caste, class, gender, region, religion, disability is very high. All these factors contribute to the diverse nature of adolescents and influence their identity development which in turn affects the learning experiences of adolescents in school.

Like Erikson who emphasized on a continuous struggle to resolve the crisis which might lead to role confusion, Marcia (1966) also focused on a continuous effort by the adolescent to resolve the crisis during this stage. She talks about four statuses characterizing the adolescent development towards a mature identity: Achievement, Moratorium, Foreclosure, and Diffusion. These statuses are arrived at based on the two dimensions of exploration and commitment exhibited by adolescents in their search for identity. When the adolescent has the opportunity to explore things and takes own decisions, it results in the attainment of a committed identity. Whereas the influence of parents, peers, and others in choosing the career path for adolescents leads to foreclosure status. In moratorium status, the adolescent is engaged in exploring, but has not yet arrived at any clear path. Finally, adolescents in the diffusion status are neither exploring options nor have committed to anything. These four statuses can affect the way adolescents approach learning and their experience out of it.

Most teens eventually succeed in developing a stable identity, however, some teens may simply adopt the beliefs of their parents or the first role that is offered to them, perhaps at the expense of searching for other more promising possibilities (foreclosure status). Other teens may spend years trying on different possible identities (moratorium status) before finally choosing one (Lally & French, 2018).

Thus, identity development forms a critical component in the development of adolescents. The diversity in the Indian context related to gender, class, status, etc., exerts a huge influence on their identity and self-concept, and affects the learning experiences during adolescence. "The pattern of adolescent self-concept development with an increasing emphasis on personal traits and qualities is seen to hold best for the males from the elite social class in India" (Reddy & Gibbons, 1999).

Further studies have shown that socio-economic status affects academic achievement and cognitive development through a series of family environment variables such as parents' educational expectations, parenting ideas and behaviours, and the parent–child relationship (Bradley et al., 2001; Yeung et al., 2002). Parents' future expectations and aspirations for the education and careers of their children were low for Indian parents from the low socio-economic status in India, but it changed as we go to the higher economic status families. Thus, the role of parents and family in the learning of adolescents becomes crucial. Families stimulate and support the development of distinctive points of view; peers offer models, diversity, and opportunities for exploration of beliefs and values (Bosma & Kunnen, 2001).

Basak and Ghose (2008) found that adolescents with identity achievement status have higher self-esteem, whereas identity moratorium, identity foreclosure, and identity diffused adolescents have lower self-esteem. Thus, there is a significant role of identity achievement on developing higher self-esteem that would directly have implications on many factors that are critical for learning. For academic achievement and learning with efficiency, it is very important that students have confidence, positive self-concept and are well supported by the peer group also. The role of teachers in this context is equally important, where a teacher can help the learners to look at situations positively, assess the possibilities of life more effectively, create more interactive circles, guide and counsel them and also work collaboratively with professional counsellors for optimum learning by adolescents.

Ajay, who is studying in class 11th often has a conflict with his science teacher. He feels that the teacher deliberately asks questions to him in the class to humiliate him because he is irregular in his studies. He feels insulted in front of the class. He has lost interest in studying the subject and started staying absent from the class also. In one such instance, he was very upset and angry with his teacher and started shouting in the class itself. Later on in the corridor, when the school was over, he threatened the teacher with bad consequences.

Ajay is at an age where he is very sensitive about his identity. He is sensitive about being questioned in front of the whole class and relates it with a deliberate attempt to humiliate him. His attempt to defend his self-concept were directly related to his sensitivity towards his perceived perception of himself among his peer also. Although the instance may be analysed from various dimensions, one of the most prominent points emerging from it is that Ajay has strong views about his identity and gave strong reactions. Also, it has impacted his learning in many ways.

One of the most sensitive parts of learning in schools is the teacher–student relationship. The authority and respect which comes almost automatically to primary school teachers from the students starts getting challenged in higher classes. It may be due to their confusion about the role they play in life (Salinas et al., 2008) as they are in the process of developing a strong sense of identity. The socio-cultural context

of school and home can also have an influence on adolescent identity development and learning experiences.

Identity development among adolescents in the Indian context is an outcome of multifactor and multidimensions of society and culture. Thus, the learning experiences of adolescents get impacted by this which may hinder or facilitate depending on the particular context of the adolescent.

Challenges Related to Learning and Academic Achievement During Adolescence

Challenges related to learning during adolescence are too many and some of them are linked with each other. They range from nutrition to lack of guidance and motivation from parents and family to the education system itself. The assessment process at the school level and rigid system of schooling in terms of pedagogy and subjects influence the adolescent's interest and achievement.

Drop Out of Adolescent Students in Indian Context

One of the prominent indicators of challenges for adolescent learning and education is dropping out of school.

The following data regarding adult literacy rate (15+ age group) as given in Table 5.1, and the dropout rate among girls and boys in India (see Table 5.2), indicates that although there is an increase in the overall literacy rate for the 15+ age group, the number of students not achieving literacy by that age is still very high. Also, the dropout rates at secondary level school education are significantly high as compared to other levels.

The high number of learners who dropout of school may be due to various reasons. One of the prominent reasons of dropout during adolescence is lack of motivation from parents and family side. Research points out that academic motivation is an

Table 5.1 Adult literacy rate (15+ age group) in percentage

	2001			2011		
	All	SC	ST	All	SC	ST
Total	61.0	44.1	40.8	69.3	60.4	51.9
Male	73.4	59.3	54.8	78.8	71.6	63.7
Female	47.8	28.5	26.7	59.3	48.6	40.2

Date source Office of the Registrar General & Census Commissioner, India (website: http://censusindia.gov.in/)

Table 5.2 Average annual dropout rate in school education (all categories of students)

Classes/year	Primary			Upper primary			Secondary			Senior secondary		
	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total
2011–12*	5.89	5.34	5.62	2.13	3.20	2.65	NA	NA	NA	NA	NA	NA
2012–13*	4.68	4.66	4.67	2.30	4.01	3.13	14.54	14.54	14.54	NA	NA	NA
2013–14*	4.53	4.14	4.34	3.09	4.49	3.77	17.93	17.79	17.86	1.48	1.61	1.54

Data source
For school education: National University of Educational Planning & Administration, New Delhi (website: http://dise.in/)
*Figures related to School Education are provisional

important psychological factor that helps predict whether students dropout of school (Caprara et al., 2008).

Many adolescents depending on their socio-economic context are expected to contribute very early towards the income of the family. This is considered as a developmental task for such adolescents where the expectation is that they leave school at an early age and start working. It seems that one promising strategy for dropout prevention would be to devise efforts intended to improve students' educational expectations through the promotion of their academic motivation (Fan & Wolters, 2014). Such students even if they are high achievers, dropout from schools as their family expects them to start earning and contribute to family income. Various schemes of the Govt of India, e.g., the mid-day meal scheme which provides food to the students during school time have been initiated with varied success to address the attendance and academic achievement of learners. Efforts for retention of students in education are very difficult even after improved parent–teacher interaction.

Asif was the eldest of the four brothers and sisters. He completed class 9 in a government-run school. He was good in studies and was always full of curiosity and interest to learn new things. Arti, his language teacher was always in praise for him and has planned to include him in an important school project work after the summer vacation. However, Asif did not join back the school. When she checked on Asif's parents, she got to know that they want him to join them in the polythene packing work they have been doing for earning. They said, "Madam, padh likh kar bhi kya kar lega. Humaare yaha bahut saare college padhe hue bacche he colony me, uske baad bhi kisi ke paas koi acchi naukri nahi he" (Madam, what will he achieve after studying. We have many college pass out kids in our colony and none of them has a good job.)

Arti was heartbroken to see another learner of hers dropping out of school at an early age but there was nothing else she could do apart from counselling his parents.

Asif's case is an example of the perceived non-importance of education in fulfilling the economic needs of the family, which leads to dropout. The financial support

available in the form of scholarships is very few and inadequate for motivating the parents to send their wards to school. During childhood, mid-day meal and free uniform usually bring students to school but as they reach the higher secondary stage where these provisions are no longer continued, parents usually withdraw their growing children and expect them to contribute to the family earnings.

Ameeta was in class 8th when she decided that she would join the police force and work for the country. As she reached class 10th, her motivation level to work towards achieving her goal was missing. She had always looked up to Ms. Mala who is now her class teacher in 10th, as an idol who has motivated her a lot. When Ms. Mala asked about her frequent absenteeism from school for the last one month, she got to know that Ameeta is getting married in the coming two years and she has been engaged with someone whose family is not interested in her education. Ameeta has lost her hope and aspiration to become a police person. She said that next week her family may ask her to stop going to school completely.

Early marriages and lack of interest in girls' education has been a matter of concern for long in India. Schemes like '*Beti Bachao, Beti Padhao'* of the Government of India aimed at encouraging parents and families to support the education of girls. The support is not just financial, it is also related to the scope of subsidized higher education. But it requires the involvement of different stakeholders to come together and address this major concern. The challenge is equal in rural, as well as urban areas, but the challenges in urban areas are also due to lack of access to higher secondary schooling near the vicinity of their homes. Adolescent girls and boys are the strengths of our future India. If they dropout early and do not achieve their potential, it would lead to a loss for the individual student as well as the nation.

Many of the students dropout because of non-achievement also in schools. Those students who fail in their early years themselves loose interest in education as well as do not find encouragement to continue from parents. In such cases, these students silently dropout of the schools.

Theoretically, well-adjusted students who develop a positive affiliation, or social bond with their school are more likely to remain academically engaged, and less likely to become involved in school misconduct and other antisocial behaviours, than students who develop a negative affiliation with school (Hawkins & Weis, 1985).

The financial aid and scholarships that are given to students would not be the only solutions to motivate these learners and their families. The problem is much more deep-rooted in society and schools. There is a need to have more accountability in terms of student achievement in schools. The school administration and teachers need to be better educated to address the contextual challenges in schools as well as gear up their methodologies to suit the students they are teaching. Although, it may seem difficult to involve parents in this process of addressing the issue, increased collaboration and dialogue among teachers, administration, and parents is required.

Community sensitization needs to be done in a way that is more contextual. The teachers need to be well educated to observe early signs of such challenges and require a scope of flexibility in school to deal with such issues.

Many programmes and policies have been framed from time to time such as The Adolescent Reproductive and Sexual Health Strategy (ARSH) (2005–2013) and subsequent Rashtriya Kishore Swasthya Karyakram (RKSK) or National Adolescent Health Programme (started in 2014) in India, which reflect the government's commitment to protect and support adolescent health and well-being (Barua et al., 2020).

It is important to address the various reasons because of which students during their adolescent years dropout of schools. They may be very specific to the students such as health problems, inability to cope with assessment procedures, poor financial condition, etc., and may also be general issues like lack of understanding about the importance of education, lack of assured earning after completion of education, etc.

However, guidance and counselling of students and parents may bring some positive results in the majority of the cases (Okita, 2014; Gatua et al., 2015). It can help to address the issue of dropout as well as to check other issues in learning which arise during adolescence.

Overemphasis on Grading in Academic Achievement

> When we consider the practically universal use in all educational institutions of a system of marks, whether numbers or letters, to indicate scholastic attainment of the pupils or students in these institutions, and when we remember how very great stress is laid by teachers and pupils alike upon these marks as real measures or indicators of attainment, we can but be astonished at the blind faith that has been felt in the reliability of the marking systems.
>
> –I. E. Finkelstein (1913)

The contemporary school system generally puts a premium on scoring marks and achieving high grades. However, frequently reported academic stressors by adolescents include tests, grades, homework, expectations about school, career, and future life plans (de Anda et al., 2000). Even though education policies advocate for demystifying overemphasis on grades and marks, academic pressure is too high to ignore by the students and the parents. This leads to competition among students as the marks become criteria for selection or rejection into higher class, coaching institutes, choice of subjects, etc.

Learning environments marked by competitions exclusively create anxiety, fear, and feelings of inadequacy and insecurity among students. Studies (Marubu et al., 2015) point out that high expectations from parents and teachers negatively affect the motivational level of the students. There are also cases of suicides and attempts of suicide among school-going students, especially during examinations. National Crime Record Bureau of India (NCRB, 2012) reports failure in examinations as one of the main reasons for suicide in different states of India. This highlights the undue

pressure on adolescents to achieve academically. It is important for the education system and society as a whole to reflect on the causes behind such extreme steps taken by students during adolescence.

Academic achievement is limited to attainment of high scores and grades in the examination which puts undue and unwarranted pressure on the adolescent especially when they are at the crossroads of selecting subjects of study and career stream. Can the grades only really reveal the full understanding and aptitude of students? The narrow focus on grades affects their overall development, and their unique abilities and strengths are ignored and neglected. There is a need to focus on the adolescents 'own need and motivation' for learning and achieving. Lacking this, adolescents may perform to conform to parental pressure or may rebel or may get stressed out and frustrated at not being able to keep up with the competition. This requires a rethinking of the whole assessment and evaluation system in schools. Schinske and Tanner (2014) advocate exercising scepticism about the meaning of grades and suggest strategies for making grading more supportive of learning.

Health and Affective Aspects in Learning During Adolescence

Learning is not related to only getting good grades in school, but is related to the overall development of the child, enabling her/him to realize the potentials within and empowering the adolescent to grow into a mature and healthy citizen with critical thinking, logical analysis, creativity, and purposefulness. A healthy adolescent will be able to focus more on the learning endeavour and have a more focused approach in life.

Health issues related to physical as well as mental health among adolescence are major concerns that affect the learning and academic achievement of adolescents. Lack of proper nutrition is a factor that affects the cognitive development of growing children and results in poor academic performance. Issues like anaemia are common among children from low social-economic and disadvantaged backgrounds. On the other hand, adolescents in cities face problems related to being overweight and being obese which leads to health issues. It is also associated with reduced cognitive capabilities (Carnell et al., 2012; Hoeman, 2007) and impacts their learning. Serious illness in childhood can result in impaired educational and employment outcomes (Gledhill et al., 2000).

The intrinsic relationship between health and education suggests that health should be part of the core business of schools. The focus needs to be on physical health and also ensuring the good mental health of adolescents during their schooling process. Studies point out remarkably large mediating effects of truancy and suggest that screening for mental health problems among young people who play truant may be an important initiative to disrupt trajectories towards educational exclusion and low attainment (Hale & Viner, 2018). Mental health issues of adolescents affect the learning of adolescents and result in low performance, dropout and acquisition of age appropriate developmental skills. The issues and challenges related to mental

health are not just the cause of concern in urban areas, but they are equally visible in rural areas.

Adolescents are at a crossroad moving from childhood towards adulthood aspiring for more independence, autonomy, and understanding of their concerns. Early adolescents engage in pseudomature behaviours in a misguided attempt to look and act older/adult. They may go out with opposite sex, put on make-ups, drink and smoke, drive-in speed, and so on described as 'cool' by their peers. They are more driven by gaining peer popularity. In a longitudinal study (Allen et al., 2014) on a community sample of 184 adolescents from ages 13 to 23, early adolescent pseudomature behaviour was found to predict long-term difficulties in close relationships, as well as significant problems with alcohol and substance use, and elevated levels of criminal behaviour. In the absence of a supportive school and home environment, the growing adolescents may be misguided and their mental health is impacted. The resulting psychological distress and conflicts hamper their learning and lead to poor school achievement.

Health in adolescence strongly predicts academic attainment and has long-term impact- resulting in unemployment after controlling for childhood attainment, adult health, and sociodemographics. The identified mediators for these associations, including social exclusion, school behaviour, truancy, substance use, and long-term absences inform interventions for improving life chances for young people with poor health and reducing health inequalities (Hale & Viner, 2018).

Teachers can act as guides and important influencers in the impact of health-related aspects of learning. It is not just the dialogue that is important to be maintained between teachers and students, but also the pedagogy and curriculum need to be designed in such a way that it addresses the physical and mental health concerns of students from the beginning. As health includes physical, mental, and social well-being, learning needs to take into account all these aspects. Effective learning will depend on achieving optimally on all these aspects of health.

Affective aspects of learning focus on the learner's feelings, emotions, interests, aspirations, and values. It also highlights the attitude to learning, motivation, and enthusiasm to learn. Fulfilment of the emotional needs of the adolescent will lead to their involvement in learning. Unless they feel motivated to learn, learning will not happen or learning will be poor which in turn will affect their academic achievement.

According to Krathwohl's taxonomy of the affective domain of learning (Krathwohl et al., 1964), students need not only to receive information, but also to actively respond and value these by characterizing themselves in terms of those information or ideas or material, etc. Focus on affective aspects in teaching–learning process will draw the students in and hold their attention, engage themselves in learning. Affective knowledge has an enormous contribution towards improving cognitive learning (Kuboja & Ngussa, 2015). However, the affective domain is mostly neglected in the education system which has a negative impact on effective learning and achievement among students. There must be a '*need to learn'* for the students. This is found lacking many a time in case of students from lower socio-economic status, poor and deprived sections in the society.

Thus, a significant challenge in adolescents' learning pertains to their health—physical, mental, social, and emotional health. Since the burden of poor health falls disproportionately on adolescents in deprived households, poor academic and professional attainments resulting from poor health may further serve to entrench socio-economic health inequalities (Due et al., 2011). Special attention needs to be paid so that it leads to better inclusive growth and development of the learners from the disadvantaged sections. In considering the health concerns of adolescents related to their learning and achievement, the diversity of adolescents need to be looked into.

Learning Among Adolescents: Role and Expectations of Parents

There is a huge population in India that never gets a chance to complete their school education even after the right to education and provision of free education. The huge dropout rate (discussed earlier) is an indicator of the challenges this age group faces. Parents' attitude and aspiration play a crucial role here in the educational achievement of adolescents.

> *Astha was 15 when she shared with her close friend Archana that she is getting engaged soon. She also told that she would not be studying any further after school as that would be her 'in laws' decision. She and her friend had planned to study science and become a scientist. But Astha was sad now. Archana's parents, however, were supportive and have told her that they would save for her coaching and she can study whatever she wants to.*

Astha and Archana's cases here are two poles of how parents can play a critical role in the education of adolescents directly. How parents facilitate the aspirations of their children can be the main factor in helping them achieve in different fields including education. Adolescents in the Indian context are dependent on their parents not just for the financial aspect, but also on taking decisions for what they will pursue in the future. For instance, there is a lot of parental influence and pressure also in choosing subjects at the school level, though the pattern is changing to some extent at least in cities with more exposure and awareness.

Involvement of parents is critical for students who get marginalized or do not continue education after a particular level. Girls, especially in the Indian context, need more support from parents to continue with their educational endeavour. Encouragement, mentoring, and parental support can play a crucial role not just in continuing their education, but also in the choice of the subjects they want to pursue.

Children with disabilities face a lot of challenges regarding parental involvement with their academics and learning (Rajeswari & Saxena, 2014). Access to schooling is a major challenge for adolescents with disability. Further, many of the students

do not get subjects of their choice or are discouraged to take subjects like science and mathematics in the higher class (Chander et al., 2016). Thus, parents can play a pivotal role in not just providing access to schooling, but also in creating an inclusive environment for children with disabilities in school. There needs to be more involvement of parents in the education of children with disabilities and also more awareness about related policies and programmes.

Collaboration among stakeholders—the parents and teachers and various agencies—is crucial in dealing with the many challenges faced by children with disabilities in their learning and education (Kumar et al., 2018). Parents can be an important link in this collaboration who can play a more participative role at different stages of learning of children and adolescents with or without disability.

Media and Technology: Impact on Learning During Adolescence

The exponential increase of software, hardware, and social media platforms along with accessibility and availability of internet and handheld devices have increased the access of information and created networks among individuals. Social networking sites like Facebook, WhatsApp, Instagram, YouTube, etc., are used extensively by adolescents. Internet is being used for access to information through mobile phones from remote villages also. The Over The Top (OTT platforms) have become popular among adolescents in recent times with access to entertainment that is global. All these have led to getting addicted to their preferred internet applications, like online games and pornographic sites (Tsai et al., 2009).

There are positive sides as well as challenges with any new development. Digital development has made some adolescents well-known names in the households because of their talent, whereas it has put some adolescents to the perils. Online bullying and aggression among students are very common in schools (Chander et al., 2016). Online gaming is another challenge for adolescent learners as it leads to obsessive behaviour due to involvement in gaming.

Rajat, a class 11th student, was good in studies and participated in various school activities and competitions, and also won laurels for the school. He was extremely popular among teachers. However, his classmates had mixed reactions to his achievements. Suddenly in mid-term examinations, his performance went down and he refused to participate in any school activity. He told his teacher that he wants to focus on his studies as he would be going to class 12th now.

After two months Rajat's parents came to school with a concern that he has stopped talking to family members and remains secluded in his room. It was then the teachers came to know that there is some other reason for his recent behavioural change. When they inquired from some of his friends and probed with his sister, they came to know that Rajat was bullied online by some other students of the class who even threatened him with consequences if he would not stop participating in school activities. With help of the counsellors, teachers and parents of the students got involved and the issue was addressed.

Thus, there is a greater need for collaboration and communication among teachers and parents. It needs to go beyond the occasional parent–teacher meetings and needs to be more natural and child-centred.

The technology of internet is omnipresent in the society and has become even more embedded into our daily lives and learning of children due to the current COVID-19 pandemic. Adolescents are being affected by this pervasiveness of internet and social media in their lives which has the potential to negatively impact their learning and development unless used judiciously and consciously.

What are the impacts of such developments in the education and learning of the adolescents? With the increased use of artificial intelligence and virtual learning platforms, the institutionalized learning environment needs to evolve itself to remain relevant.

Further, Information and Communication Technology (ICT) is also used extensively in schools these days with the increased use of internet-based tasks and the use of digital boards to show multimedia content in school. Students also need to learn these twenty-first century skills to stay relevant and contemporary in the digital world. So, it becomes imperative that technology is used effectively in schools for learning and achievement among students. Hence, it is definitely a challenge to harness the positive aspects of ICT in learning and education of adolescents, and at the same time to protect our future generation from the dangers and misuse of technology. It points out the need to have frequent dialogues between the adolescent learners, parents, and teachers.

Facilitating Learning Among Adolescents

Adolescence is the age when the adolescents are ready to explore the world and expand their horizons. Thus, it becomes imperative to accordingly provide them learning opportunities and experiences that will help them realize the possibilities.

Designing Learning Experiences for Adolescents

Teachers need to be aware of how adolescent learners learn as well as the implications of their changing learning styles. The learning experiences need to be in sync with the contextual factors and experiences of adolescents. Assessment and feedback regarding learning also needs to be well planned and appropriately given to the adolescent learners.

According to Piaget, the formal operational stage (11–16 years) marks the ability to think at the abstract level. Hypothetical thinking and abstract reasoning are developed during this period. Learners at younger age understand more with concrete experience which later on changes to the ability to comprehend abstract concepts more easily. Although, learning through experience remains a more appropriate way of presenting concepts initially during adolescence also. Early adolescence gives the opportunity to develop more experiential ideas and consolidate them with more discussions. Howard Gardner's concept of multiple intelligence also emphasizes on different patterns of intelligence which again has huge implications for adolescent learning.

Creating learning opportunities for adolescent learners is an important task in the education system. Learning opportunities for the development of critical thinking and logical abstract thinking among adolescent learners need to be part of the overall design. To design learning opportunities that are appropriate for adolescent learners, the following points need to be considered:

- Design learning opportunities for exploration of concept beyond the given material. This is the time when students get engaged with ideas and concepts which fascinate them. They get motivated by areas that relate to their own mental frame of reference. With more opportunities to engage with new ideas, they would have more chances to connect.
- Create a challenging environment to help them expand their learning. It would help them to channelize their curiosity and eagerness to participate in those activities which challenge them.
- Facilitate and provide direction to new and innovative ideas. Even if those ideas appear to be not leading to practical solutions, students need to be encouraged to work on them and take risk. When these learners take risk with their ideas, they would be able to create solutions for all.
- Encourage group work among learners. Mixed group work also needs to be encouraged during learning so that students learn to shed their inhibitions.
- Be patient with their ideas, level of participation, actions in class, peer interactions and guide them during their deviations from the expected behaviour. It is important to understand that these deviations may also be the result of their critical analysis and reasoning which may have logic of their own.
- Give opportunities for communication of their ideas during learning experiences. It would help them present their ideas and thinking which would not only help those who want to present, but also those who need to come out of their shell.

- Novelty in the concepts should be brought while teaching so that they get more exposure to the concepts and in different ways. It would encourage them to be engaged with the concept and relate to the concept.
- Encourage ownership during learning as it is the time which suits best to create a connection with ideas, concepts, subject areas which motivates them individually also. When they feel ownership during learning experiences, they have more chance of exploring their own potential and doing well.
- Relate learning with future opportunities and their aspirations. This would help them in getting direction about the ideas they are already exploring. These explorations are generally not well guided when they incubate among the individuals. Thus, it is important that they get guidance during their learning experiences so that they can test their ideas and aspirations in a more practical manner to work on them in the future.
- Give scope for alternative expression. Alternative expression needs to be encouraged at all stages of learning, including assessment also. As we are aware that individual learning styles are there among the learners, there is an individual preference to express their ideas also. The majority of the learners do not get a chance to explore their talents and express their ideas in their own way.
- Create bridges between the outside world and the learning experiences. Exposure of students outside the world needs to be in sync with the learning experiences in the schools. This would help them in analysing and assessing their ideas on the basis of conceptual understanding also.
- Learning experiences need to include how to deal with the challenges of adolescence like the use of drugs, early exploration of sexuality, HIV, etc., so that they are educated about these issues.

Further, different levels of cognition (as discussed by Bloom and later on revised by Anderson, 2001) have implications for designing learning experiences for adolescents.

Level of thinking	Some factors to be considered during designing learning
Remember	Decision about important concepts to be dealt and ways to deal with them without overstressing on need to remember everything
Understand	How will they comprehend the different aspects of the concept and at which level they need to be given experience and opportunity to understand
Apply	Search for opportunities to apply their concepts. Let them bring more situations where they can apply. Give open problems and issues
Analyze	Create opportunities to develop ability to look at finer details. Plan more and more opportunities for diverse observations
Evaluate	Develop rubrics for evaluation. Give opportunities to discuss and evaluate. Let there be more platforms for brainstorming and assessment of events, situations, etc.
Generalize	Create spaces for large scale brainstorming. Wider platforms and concept development with new people and experts. Guided global and higher level exposure for generalizing ideas

(continued)

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Level of thinking	Some factors to be considered during designing learning
Construct	Give opportunity to take risk. Encourage and facilitate new ideas and initiatives. Support steps to make things and ideas
Create	Give encouragement to build on their ideas. Experiment with their ideas and present

Also, co-scholastic activities have a very important role to play during the growing up stage of adolescence. Co-scholastic activities give a lot of scope to the learners to explore their alternate expression as well as get engaged with groups and people who are pursuing a similar path. These activities can be critical to the learners during their times of stress and challenges. Further, opportunities need to be provided to learners where they can build their relations with people who can help them navigate through their challenging times. It also helps them in being motivated towards their goals.

Teachers can play an important role in this. Teachers of different subjects need to go beyond their subject boundaries and give exposure to the students during adolescence. Learning experiences in different subjects have scope for every area provided the teacher is sensitive enough to show direction to the learner.

Thus, teacher education also has an important role to play in this area. Teacher education programmes (In-service as well as pre-service teacher preparation programmes) need to deal with these areas. In view of the myriad challenges faced by adolescent learners, one important aspect of teacher education programmes is to develop understanding about guidance and counselling among the teachers.

Role of Guidance and Counselling in Effective Learning of Adolescents

Guidance and counseling is a crucial part of teaching–learning process in schools. It can provide proper pathways and directions to adolescents not only in their learning aspects, but also in their development process. Teachers are described as role models for the young students who can be trained in providing guidance and counseling to students. Teachers do not just teach in schools but they guide and counsel their students whenever required. Although teachers can resolve the issues faced by adolescents with training in guidance and counseling, professional counselling is required for certain issues.

Various issues faced by adolescents relate to their learning, choice of subjects, and career selection. The transitional nature of this stage also creates socio-emotional issues such as fear, anxiety, aggression, interpersonal conflicts, bullying, adjustment problems, and so on. Significant changes in physical, cognitive, and emotional aspects of development along with the pressures of academic achievement/performance create behavioural and emotional issues among adolescents. This highlights the need

for guidance and counseling for the adolescents to facilitate their learning experiences and also enable them to achieve well. Professionally trained counsellors can help deal with various problems and issues related to academic, career, personal, and social aspects of development.

Adolescence is a phase where children feel that there is nobody with whom they can share their thoughts and concerns. Peer groups can have both positive and negative impacts on the learning experiences of adolescents. Selection of subjects and academic aspirations in alignment with their friends, peer, and parental pressure becomes a major issue of conflict for the adolescents. With social networking reaching every corner of the world, adolescents are exposed to global trends and a huge web of opportunities as well. Guidance can help them to evaluate these opportunities carefully and protect themselves from the wrong influence of the digital world.

There is a challenge of fixed stream selection and rigid higher education system which do not allow for diversification. Although with the National Education Policy (NEP, 2020) of the Government of India, the situation and scenario may change with respect to the choices and flexibility in education. However, there is a need for using proper assessment and counselling related to the aspiration and aptitude of the adolescent under expert guidance.

Guidance and counselling can thus play an important role in the development and schooling of adolescents. Future opportunities and aspirations of adolescents are linked directly with the learning experiences they have. Schools in present times need to be in sync with the trends and future opportunities. Traditional pedagogy and assessment methods would not be able to do justice with the changes happening in the twenty-first century. However, too often schools overlook opportunities to capitalize on early adolescents' innate motivation to engage in activities they experience as relevant (Eccles & Roeser, 2011) during adolescent years. Guidance and counseling need to be a necessary feature of schooling that must seem relevant to adolescents. They need to realize its significance in their learning, development, and achievement.

Conclusion

The present chapter discussed the issues related to learning and academic achievement in adolescents. The learning opportunities and experiences play an important role in shaping the identity of adolescents. Challenges to adolescent learning and academic achievement are discussed including dropout, overemphasis on academic achievement, health issues, lack of emphasis on affective aspects in learning, parental expectations, and influence of media and internet. The role of guidance and counseling was highlighted in addressing these issues and facilitating an optimum learning experience for adolescents. The chapter also described ways about designing learning experiences for adolescents that will help them realize their potential. How we design and implement learning experiences for adolescent learners during these years has a critical impact on their life. It is a challenge to help them not be deviated from their

goal by various distractions such as media, internet, the lure of the virtual world, and at the same time offer learning opportunities to help them bloom and bring fresh ideas to the world.

The world needs creative ideas and energy of the youth to take it forward in the future. Possibilities need to be created as part of their learning experiences to facilitate their growth and development. Policy and programmes need to be geared up for their future participation as well as schools and institutions need to give them the opportunity to address their potential. Those who need guidance and support should not be left behind and we need to have structures for doing these things at large scale. We need adolescents to be engaged in such a way that their journey doesn't remain a turbulent one, rather they are equipped to face the challenges and explore new ways and possibilities.

Time to Reflect

> The system manufactures students who are smart and talented and driven, yes, but also anxious, timid, and lost, with little intellectual curiosity and a stunted sense of purpose: trapped in a bubble of privilege, heading meekly in the same direction, great at what they're doing but with no idea why they're doing it.
>
> –Phillips, 2014

Does our education system produce robots or human beings? Do we provide adequate and proper learning experiences to adolescents to harness the possibilities? Are we making our adolescents just intellectually bright or focus on their socio-emotional-moral development also which will make them real human beings?

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Chapter 6
Adolescents and Career Development

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Abstract This chapter explains career and career development in today's adolescents and youth. In the process, various factors influencing career choice and decisions are discussed highlighting the dynamic interaction between intrinsic factors related to the individual, external factors associated with careers and the sociocultural processes. The chapter explains the theories related to career development and explores the issues and challenges that the young generation faces while making their career choices given the context of cultural diversity, intergenerational conflict, and technology integration into the life of adolescents. Finally, the chapter discusses the career development process and intervention for adolescent career development.

Keywords Career · Career development · Career choice · Career decision · Career exploration · Theories of career development · Adolescents

Introduction: Career and Career Development

Adolescence stage is characterized by major and sometimes dramatic changes in different aspects of development. All these affect the adolescent identity development. She/he starts assuming adult roles involving individual and social responsibilities. Deciding about career is a step in this direction. Adolescents especially at the higher secondary education stage (around late adolescence stage) are concerned about selection of academic subjects and consequently the related careers they can enter. Career guidance forms a major part of counselling services provided to adolescents at this stage. This is crucial as it is going to be a major decision in the life of the adolescent. A careful and planned approach will enable the adolescent to progress into a successful career planning.

Career is not just a choice made by an individual to work in a particular profession at one point in time. It involves a decision process which can be understood as a complex phenomenon. "Career" and "Job" are terms which are interchangeably used but are significantly different from each other.

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Job can be defined as work position offered by an organization that we choose to do in order to earn mainly monetary benefits. While, career is a plan which includes a series of connected decisions to work in a particular area or field and thus choosing a particular educational training and a particular profession. Though a profession is also where monetary benefits are involved but this is more to be related to individual's self-concept, life goals, motivation, interest, and attitude. Career is thus more of a subjective construct that is objective in nature (Super et al., 1996, Savickas, 2002; Reardon et al., 2009).

Work has also been a term which is interchangeably used by many. Work has been defined by many researchers and theorists as a means for need fulfilment, thus indicating the objectivity as compared to career which is more subjective in nature (Blustein, 2006). Work is a productive activity leading to achievement of some goals. Various motives including internal and external motives govern the individual's engagement in work. Work thus has a physical, psychological as well as sociological orientation to it.

Super (1976) has defined career as "the sequence of major positions occupied by a person throughout his pre-occupational, occupational, and post-occupational life; includes work related roles such as those of student, employee, and pensioner, together with complementary vocational, familial and civil roles." In short it can be defined as "the pattern of influences that coexist in an individual's life over time" (Patton & McMahon, 2006). It is more comprehensive and broader than work and consists of all the life roles and related work activities. As Geysbers and Moore (1975) indicated, career identifies and relates all the life roles (citizen, family member, learner, and worker), the interaction settings (family, friends, school, community, and workplace), and life events (entering school, job, divorce, marriage, retirement, etc.) in which individuals find themselves. Thus, called as Life career development, it includes the non-occupational as well as the work roles of the individual.

Career Development

Career development is a lifelong process that can be understood as making a choice furthered by decisions to prepare and train oneself to achieve and pursue professional goals (Ginzberg et al., 1951). Sears (1982) defines career development as "the total constellation of psychological, sociological, educational, physical, economic and chance factors that combine to shape the career of an individual over the life span".

Adolescents are exposed to the world of work from early years in different ways, through their studies, television, media, friends of their parents, family members, and society. As they are developing their self-concept and identity, they also develop a concept of self at work or *vocational identity* (Skorikov & Vondracek, 2007) which derives from the question "Who will I become at work?" (Porfeli & Lee, 2012). This worker identity gets influenced by various factors such as gender, exposure to different professions in school and outside, peer pressure, and family expectation.

Further, it is a continuous process of forming a vocational identity where the adolescent first explores the world of work, explores oneself, and then tries to fit in or match both. Thus adolescent's vocational identity moves from a fantasy oriented and non-distinct perception to a more realistic, logical, and clear sense of self at work. The adolescent considers other social, economic, and environmental factors in addition to individual factors to gradually refine her/his vocational identity throughout life. Porfeli and Lee (2012) describe a "developmental model of vocational identity development" which consists of three stages—**career exploration, commitment, and reconsideration** which affect the adolescent career development.

Career Exploration

In Erikson's development theory, childhood is characterized by the crucial developmental task of establishing a sense of industry where the child takes pride and derives pleasure from doing work. Achieving of this sense of industry will facilitate the vocational identity development during adolescence. The first step in this process involves career exploration. This includes exploring oneself—one's abilities, skills, interests, attitudes, and aptitudes. It includes knowing one's thoughts, emotions, liking, and disliking. Further, it involves exploring the world of work to know about the various jobs in terms of educational qualifications, working conditions, personality requirements, promotion facilities, work avenues, career prospects, perks, and other facilities including any job hazards. Thus an individual's career path also involves exploring the self and the professional world to obtain an understanding of the general structures of the self and learn about potential career choices that might ensemble these structures (Patton & Porfeli, 2007). The adolescent assesses the work features, its nature, and responsibilities in terms of her/his abilities, skills, interests, etc. She/he also takes into account the family conditions and environmental factors while taking a decision on the career. The main focus of the career exploration stage is to explore and know about the diverse work available in the world of work and evaluate their suitability in relation to oneself.

The exploration of careers moves from a general looking around different work areas to a more focused search of specific careers that interest the adolescent. Thus there is a progress from in-breadth exploration of careers to in-depth exploration of self and career. Adolescents who are yet to establish a sense of identity will benefit from in-breadth exploration as it will help to explore things before planning their career. However, once there is a sense of self and identity formation, in-depth exploration will lead to more career planning and more career commitment.

Career Commitment

There are two components in career commitment, shortlisting a career and identifying with it (Germeijs et al., 2006). The search regarding careers in the previous stage leads to selecting a particular career and identifying with it. This choice of a particular

career is influenced by many factors, mainly gender, social class, economic status, media and celebrity influence, peer group impact, etc. However, unless the adolescent gains a strong sense of self, her/his choice may get biased by other factors leading to a pre-mature foreclosure of career choice, e.g., choosing a career similar to their parents or other family members or peers. Hence it is important to achieve a sense of identity first which will help the adolescent to go for proper career planning.

Career commitment indicates a person's connection to the career as well as the decision she/he takes regarding the career (Porfeli & Lee, 2012). The adolescent decides on a career and makes choices or behaviours as per these decisions, for instance, pursuing related education or training, and develops a vocational identity (forming a personal connection to the decisions and choices of oneself). Commitment to a career thus leads to career planning and career maturity. However, in the context of multiplicity of adolescence stage and individual variations, adolescents may vary in attaining a sense of identity and also in terms of the major influence of factors impacting their career choice. In such cases, there may be unfavourable outcomes in regard to career adjustment and career satisfaction.

Career Reconsideration

In such scenarios where the career commitment do not reflect the sense of self/identity, it may lead to re-examining of such commitments and search for suitable career alternatives. Career reconsideration has both advantage and disadvantages. It is advantageous in the sense that it reflects flexibility in career choices and long-term satisfaction. However, it may also lead to self-doubts and career indecisiveness and diminished well-being (Gordon, 1998).

Marcia's theory of human development suggests four identity status such as achieved, diffused, foreclosure, and moratorium. Applying these to the vocational identity development, it can be seen that when there is more career exploration and more career commitment, it leads to 'achieved' status, i.e., there is vocational identity, career planning, and career maturity. Career reconsideration is not required here. On the other hand, less career exploration and commitment leads to a 'diffused' status of identity where the adolescent has neither explored careers nor committed to any. When the adolescent has explored more, but not able to commit, it is called 'moratorium' and signifies the need to look into personal characteristics in order to make a career choice. Finally, if the adolescent has committed to a career without exploring, it leads to 'foreclosure' as the career choice here is influenced by parental, peer, and other such influences. This may lead to career reconsideration at a later time (Table 6.1).

The three processes of career exploration, commitment, and reconsideration interact in a dynamic way across adolescence and affect the development of a vocational identity of adolescent. A proper career planning highlights more career exploration and commitment and less career reconsideration. However, in the current scenario of job market fluidity and impact of technology and globalization in the career world, career reconsideration may be the norm rather than deviation. This

Table 6.1 Four identity statuses of Marcia (Milsom et al., 2021)

		Career commitment	
		High	Low
Career exploration	High	Achievement	Moratorium
	Low	Foreclosure	Diffused

will help lead to more adaptability in one's career decision and planning. It will also add to the dynamics of one's vocational identity.

Factors Affecting Career Choice and Decisions

Various factors contribute to the planning and decision of a career. During the adolescence stage it mainly pertains to career planning. Formal job/work/profession is sought at much later age in the Indian context, though it may start early during adolescence and even childhood in case of disadvantaged, poor, and lower socio-economic group. Career related planning and decisions are affected by various individual and environmental factors. Among some of the individual factors that play an important role in career decisions are personality, values, interest, abilities, aptitude, academic achievement, age, gender, and career expectation. These interact with prevailing environmental circumstances (Howard & Walsh, 2011) to affect career choices of adolescents.

Factors Related to the Individual

Personality is a characteristic way of an individual to respond to people, situations, and environment around oneself. It influences and shapes the career choice and career success of adolescents. Majority of theories of career development are based on personality in relation to career choice. For instance, an extrovert (someone who likes meeting and talking to people) will be more comfortable in a profession which requires this skill and will not be comfortable to be involved in a work where talking to people is limited or not allowed. On the contrary an introvert will be interested in such working conditions. Some other important personality related variables are self-concept, self-identity, self-esteem, self-efficacy, and locus of control which influence career decisions and career satisfaction.

Value system and value development also play an important role in career development of adolescents. Every individual is born and brought up in a certain culture which is driven by a set of ethics and values. Adolescents find it comfortable to work and choose a profession and career which fits into their value system. Thus, cultures, values, and ethics influence the adolescent career choices.

Adolescents have varied interests. Interest in different professions motivate them to explore possibilities of career prospects in those areas. This can be a first stage towards career planning.

Abilities enable an adolescent to experience success in task undertaken and thus motivates them to work in the field of the ability and plan career in it. It is an important aspect of an individual that contributes to career choices made during adolescence.

Aptitude is defined as potential or "talent" of an individual to perform a particular task. Along with interest, the adolescent needs to have aptitude to work in a particular field, e.g., aptitude for music or design things. Thus, aptitude is crucial in career choice and development.

Academic achievement also influences the career decision of adolescents as it motivates or demotivates adolescents to study and pursue a career based on their grades/marks.

Gender stereotypes are another factor affecting career decision and choices of adolescents. Pursuing STEM (Science, Technology, Engineering and Mathematics) subjects is largely dominated by males. However, globalization, societal, and attitudinal changes and women empowerment have brought in changes in the choice of careers. Females are venturing into varied career paths now. But largely gender stereotypes governed by culture impacts the career decisions and planning during adolescence.

Factors Related to the Environment

Parents and Family:

Career choice made by individuals in India differs from that in other countries and cultures. Most of the decisions in the middle and upper economic status are affected by family and parents (Levine & Hoffner, 2006; Millward et al., 2006). Parents' personality, career, and attitude also have an effect on the adolescent career planning and decisions Howard et al., 2009). Many adolescents especially in the collectivistic society, plan their career in accordance to their parents' choice and attitude towards particular profession (Sawitri et al., 2014). Parental pressure and family obligations influence their career decisions (Polenova et al., 2018). Higher career similarity with parents increases the career self-confidence and self-efficacy among the youth (Sawitri & Creed, 2015).

Physical factors such as environmental conditions also affect the choice of one's career and decisions related to it. Many career are environment, region, or climate specific. Largely, unorganized sector employment is affected by environmental factors.

Social factors such as socialization, socio-economic status, family, friends, school, and teachers also have a significant impact on career choice of individuals.

Technological environment decides and defines job and career prospects across the world; thus, technological changes and advancements also have an effect on career decisions and choices made by individuals.

Factors such as government policies, which foster the career development and schemes for adolescents, also have an impact on career choices. These policies can be related to age, gender, or catering to specific groups who belong to a selected region, caste, socio-economic status, or cultural background.

Factors related to the individual and environmental factors interact to affect career development process of adolescents. Integrating all these factors, Carpenter and Foster (1977) have proposed a three-dimensional model to classify the factors influencing career choice. These relate to **(a) intrinsic factors, (b) extrinsic factors, and (c) interpersonal factors**.

Intrinsic factors derive from the individual factors and how these relate to the profession or career. It highlights if the person is finding the profession interesting, enjoyable, and personally satisfying (Gokuladas, 2010; Kunnen, 2013). It includes personal interests, self-efficacy, and how does the person expect to grow in the profession. *Extrinsic factors* refer to the external benefits and facilities provided by the employment or career (Shoffner et al., 2015), for instance, promotional opportunities, perks, financial benefits, job security, and job accessibility (Bakar et al., 2014). *Interpersonal factors* relate to the influence of family and significant people around the individual such as peer, teachers, and community leaders (Bossman, 2014; Gokuladas, 2010; Guan et al., 2015).

It may be noted that dimensions under each factor vary in the degree of their effect on career decisions, for instance, job accessibility (nearness to employment locations) is a deciding factor for career decisions of youth in a collectivist society (Atitsogbe et al., 2018); however, it has less predictive value for career explorations than personality traits (Fan et al., 2012). Thus the factors interact and affect career decision taking into account the socio-cultural context of the individual.

The cultural values prevalent in the family and the society influence on the career choice and decision of the adolescents (Hui & Lent, 2018). Hofstede's (1980) individualism-collectivism cultural dimension has implication for the career choice of the individual. Individualistic cultures focus on the desires and choices of the individual; it emphasizes autonomy and an 'independent identity' that influences the career planning process. Collectivistic cultures on the other hand, put premium on societal interdependence and communal benefits (Sinha, 2014). Here, career related planning and decisions are influenced by the family, significant others, and peers. The individualistic versus collectivistic dimensions of culture influence the career decisions among youths (Amit & Gati, 2013; Sinha, 2014). In a systematic review study (Akosah-Twumasi et al., 2018), it was found that youth from collectivist cultures mainly gets influenced by the family expectations whereas they were more independent in career decisions and were governed by personal interest in individualistic settings. Further, higher career resemblance with parents led to more career confidence and self-efficacy among them.

However, given the culture of migration today, we can find inter-influence of cultures on each other. This has both benefitted these bicultural youths and also

resulted in conflicts as when there is a tussle between traditional older generation of parents with an in-group focus and the younger generation of youth having a more flexible and adaptive approach to take up not so traditional careers.

Thus career decision-making is a complex process which reflects a dynamic interaction between intrinsic factors related to the individual, external factors associated with careers, and the socio-cultural processes.

Theories of Career Development

Career development has been explained by many theorists from different perspectives. While some theorists have explained it in relation to factors affecting career choice while others have explained it as a process. Some theorists have emphasized on amalgamation of both.

- Content theories envision career development as being influenced by certain factors which are either from within the individual or are related to the environment in which the individual lives in. Major theories that focus on the 'content' of career development are trait and factor theories and psychodynamic theory (Holland, 1973; Parsons, 1909; Bordin, 1990).
- Process theories underline the various stages and changes in a career that take place in an individual's life. Theories of Ginzberg et al., (1951) and Super (1953) are some examples.
- Content and Process theories reflect an amalgamation of the individual and the surroundings (content theories) and the developmental stages (process theories). Theories like Social Cognitive Theory (Bandura, 1986) and Mitchell and Krumboltz (1996) are some examples.

Holland's Theory

The theory emphasizes the person-environment interaction that shapes vocational choices of individuals. Advocated by Holland, it states, "The person making a vocational choice in a sense searches for situations which satisfy his hierarchy of adjustive orientations" (Holland, 1959, p. 35). Individuals usually seek environments which helps them to make use of their skills and abilities; match with their values and beliefs; and offer appropriate roles and responsibilities. The theory talks about interaction between individual's personality and the environment resulting in six vocational personality types that can help in career planning and choice. This is described as RIASEC (Realistic, Investigative, Artistic, Social, Enterprising and Conventional).

Finding out the particular personality type of individuals will indicate the tentative careers suitable to them. Assessment through different scales (e.g., The Career Attitudes and Strategies Inventory, Holland & Gottfredson, 1994; The Self-Directed Search, The Vocational Preference Inventory, VPI; Holland, 1985) aims at finding

out the personality type and interest type of the individual and is expressed as a three letter code (e.g., SIA, RIA) which symbolizes and summarises an individual's career interest. The first letter of the code indicates the primary interest type of the individual, which is likely to play a major role in career choice and satisfaction. The second and third letters indicate secondary interest types, which also significantly affect the career choice process though to a lesser extent.

Bordin's Psychodynamic Model of Career Choice

Bordin's (1990) theory focuses on the development in early childhood, especially development of personality, as a deciding factor of work motivation in later life. Principally, Bordin had suggested that individuals look out for work that they "find intrinsically interesting or from which they can derive pleasure" (Lent & Brown, 2013, p. 3). The basic proposition of the theory is that individuals seek to enjoy their work as they do in other spheres of life. They want to include play in their work so as to enjoy their work because play is intrinsically satisfying. Play and work are perceived as one during childhood, and it is only through aging and socialization that these two are viewed as separate.

Various factors including parental pressure, biological-related, economic, and socio-cultural aspects impact the development of personality of growing children. Thus both internal and external factors influence the personality development and consequently the career development and career choices of the youth. While making career choices, individuals carry out a self-assessment and analyze the chances of success based on intrinsic satisfaction, such as "curiosity, precision, power, expressiveness, and concern with right and wrong and justice, as well as … nurturance" (Bordin, 1990, p. 114).

Parson's Trait Theory of Career Development

Frank Parson is considered to be the father of vocational and career psychology. Parson's (1909) process involved a careful examination of the individual and matching them with career choices available; hence it was also called the trait and factor theory. The theory advocates three elements important for appropriate career selection: (a) understanding of individuals in terms of their values, weaknesses, strengths, abilities, skills, interests, aptitude, and other such qualities, (b) awareness of the conditions of work and resources needed to succeed and limitations in the desired field of work, and (c) emphasis on reasoning skills with regard to the previous two for appropriate career selection decision. Analysing and being able to compare and contrast in terms of individual qualities and work requirements is crucial in career choice and decisions.

Ginzberg's Theory of Occupational Choice

Ginzberg et al., (1951) describes the career development of individuals in three stages such as Fantasy, Tentative, and Realistic. *Fantasy* stage which is from 6 to 11 years of age signifies the playful nature of children when they engage in various playful acts such as firefighters, race car drivers, and police officers. In this stage children gradually progress from just imitating and dressing up to actually mimic the key roles and responsibilities of the particular occupation.

The next '*Tentative'* stage ranges from 11 to 17 of years where children develop further ideas related to different occupations. This period is further divided into four stages—the first stage is of 'interest' wherein the child develops feelings of liking and dislike to certain occupations. The second stage is 'capacity', referring to how much of the child's interests and likes are in sync with his/her abilities. The third stage is 'values' wherein the child discovers how different occupations may fulfill his/her personal values. The final stage is known as 'transition' wherein the child starts to feel independent and makes choices.

The final stage 'Realistic' ranges from 18 to 21 years of age to early twenties. Here, the child develops more concrete plans for his/her career and often develops a backup plan. This stage is further divided into three stages—the first stage is of 'exploration' wherein the young adult has chosen a career path yet seeks other options. The next stage is called 'crystallization' in which the young adult becomes more and more engulfed and engrossed in a particular career path. The final stage is called 'specification' in which the young adult becomes more focused about her inclination towards a certain occupation in the desired career path.

Super's Self-Concept Theory of Career Development

Super's (1969) theory of career development emphasizes the role of individual's self-concept in career choice and development. According to Super, self-concept results out of a dynamic interaction among various factors such as physical growth, mental development, personal experiences, stimulation, and characteristics related to one's environment. The theory states that a relatively stable self-concept becomes more concrete in the late adolescence, and this guides the future career choice and development of the adolescent. It is essential to note that self-concept is dynamic in nature and it evolves throughout the course of one's life when interacting with different situations and environment.

Self-concept keeps on evolving and when it is applied to occupational and other life roles, it results in work and life satisfaction. Super (1990) has proposed a life stage developmental framework which consists of five stages to explain the career development process: growth (0–14 years), exploratory (15–25 years), establishment (25–45 years), maintenance (45–60 years), and decline (60+ years). In each stage, an individual has to act on the work task according to the socially acceptable norms

and rules, of that particular age. For instance, the exploratory stage requires the adolescent to cope with the vocational developmental tasks of crystallization (it refers to a cognitive process where one develops an understanding of one's skills, interests, and values and looks for a career path as per these), specification (refers to making tentative yet specific career choices, based on one's likes and dislikes), and implementation (refers to the individual undertaking relevant training to move ahead in their career choices). Super (1990) also hypothesized a mini-cycle within each of the above five stages. This mini-cycle consists of again from growth to decline or disengagement. Furthermore, individuals would also experience and undergo a mini-cycle of the stages when they are required to make expected and unexpected career transitions, for instance, being fired, unemployed, or personal factors.

Super's theory thus provides a comprehensive approach to delineate and explain the career development process which can aid in the vocational counseling and training.

Gottfredson's Career Choice Theory of Circumscription and Compromise

This theory focuses on gender and socio-economic status differences in career choices. It offers a developmental model of career selection in which adolescents go by the process of circumscription where they make the decision of eliminating those occupations not matching with their self-concept and zero in their career path search on to the most congruent one.

The first stage is known as "orientation to size and power" (ages 3–5), wherein the child perceives occupations to be the roles performed by the 'big people' (adults).

The second stage, "orientation to sex-roles" (ages 6–8), points out the importance of the sex-role norms and attitudes in defining the child's self-concept. The child analyses and evaluates the different occupations based on the assumption of whether a particular occupation is relevant to a sex role or not. Those occupations which face sex-role conflict are ignored.

The third stage is known as "orientation to social valuation" (ages 9–13). It focuses on the social class and status in impacting our self-concept further. The value of prestige in the selection of occupation is high at this stage. The child ignores those occupations that are below his status and too above his status or prestige.

The fourth stage is called "orientation to the internal, unique self" (ages 14 and above). Here the focus is on the internal and personal traits of the adolescent's self-concept, like personality, skills, interests, and values which influence and guide the career choice of the adolescent. External situations and factors such as economic hardship of the nation, family commitments, unfair selection, and recruitment procedure also affect career choice preferences of adolescents. They modify their choices accordingly to make it realistic and attainable.

Brown's Value Based Theory

The central theme of Brown's theory of career choice is values. Based on Rokeach's work (1973), Brown (2003) defines values as "beliefs that are experienced by the individual as standards regarding how he or she should function" (p. 49). His theory highlights the trend of shifting to a more holistic view of understanding career choice. His theory has two integral parts—the role of values in career choice and career counseling. As per Brown (1996), individuals constantly compare their performance with those of others on the basis of certain values which are crucial in determining the life roles as well as the satisfaction from those life roles. Brown (1996) was of the view that motivation of decision-making is drawn through the outcomes and consequences of the comparison and the values. Brown identified values as being crucial to career choice decision-making and focus on values since prior theories had not paid much attention to this aspect.

The basic proposition of his theory is that every individual develops a small set of values, which "dictate cognitive, affective, and behavioural patterns" (Brown, 1996). Values are believed to have developed through an individual's interaction with the environment (such as family, friends, and media). We receive value-laden messages from time to time and therefore, develop them over a period of time. With the passage of time, values become crystallized in the individual's mind and the degree to which this occurs is related to the individual's cognitive clarity. As per Brown (1996), it is essential that our values are crystallized and prioritized for effective decision-making. Those individuals whose choices are congruent with their values are believed to be more satisfied. Another crucial aspect of Brown's theory is the life roles and their interaction with one another. He was also of the view that different set of values may cater to different life roles; "the result of role interaction is life satisfaction, which differs from the sum of the marital, job, leisure, and other roles satisfaction indices taken separately" (Brown & Crace, 1996, p. 217).

Social Cognitive Career Theory

The social cognitive career theory (SCCT) by Lent et al. (1994) is based on Albert Bandura's social cognitive theory. According to this theory, three social cognitive processes determine individual's career development behaviours. These are self-efficacy beliefs, outcome expectations, and career goals and intentions. These aspects interact with gender, culture, ethnicity, socio-economic status, social support, and any perceived barriers to influence a person's educational and career trajectories (Blanco, 2011; Lent et al., 2000).

Self-efficacy can be defined as personal beliefs of an individual regarding his or her own capabilities and aptitude to perform specific tasks and behaviours. Thus they may exhibit different levels of self-efficacy related to job specific behaviours required in various occupational sectors. For instance, an individual may be extremely confident

in carrying out scientific tasks, yet may not be as comfortable and competent about a task concerning sales. The theorists believe that individuals will be interested in and be successful in carrying out a task when they have the self-esteem for that task while also possessing the essential knowledge, skills, aptitude, etc. The belief about one's self-efficacy is influenced by four aspects, namely personal performance accomplishments, vicarious experiences, social persuasion, and physiological and emotional states.

Outcome expectations is essentially the anticipatory belief of the consequence that would follow upon completion of a task (for example, what will happen if I do this?). The choice of engaging in a task, persistence in the task and the will to complete are dependant on the self-efficacy of the individual and the outcome.

Goals refer to intentions of an individual to carry out an activity or to attain a specific level of performance. The theory talks about two types of goals, namely, performance goals and choice goals. The aim of setting goals is to keep the individuals on track to complete their tasks in time when an external feedback is missing.

Thus personal interests and aspirations interact with the external environment to influence career choices. Self-efficacy, outcome expectation, and career-related interests together influence the individual's educational and occupational choice goals. When goals are clearly stated, specific, held dearly, and stated publicly, it becomes more intriguing for the individual to act on them. The theory also views that the kind of goals individuals set for themselves reflects the harmonious interaction between their abilities, self-efficacy, and outcome expectations. In order for individuals to be successful in academics and career, the goals should be realistically set according to their abilities, such that their self-efficacy also improves. It also results in positive outcome expectations and higher levels of success.

Various theories of career development described above point out that personal characteristics of the individual alongwith the contextual and environmental factors are important in determining the career choice and aspirations of the young generation. This has implications for career intervention measures to focus on development of effective personal qualities and career-related attitudes in the adolescents and also generating conducive environments to facilitate career decisions.

Adolescent Career Decisions: Issues and Challenges

Adolescents are a growing stage characterized by various significant changes in different aspects of development. Additionally, they need to take important decisions related to their choice of subjects and careers. Many a times adolescents feel the pressure to choose subjects at their higher secondary stage as it impacts their pursuing of related subjects and careers later on.

Thus one crucial issue in adolescent career decisions relate to the adolescent feeling uncertain and less prepared in their subject choice and career choice. This highlights the need to start the career decision process early so that the adolescent will feel better equipped to take decisions related to their career. It can focus mainly on

career exploration and acquiring career related values and attitudes in the early years. Early to late childhood can be considered as the ideal time for career exploration as there is relatively less burden of making an immediate commitment (Porfeli & Lee, 2012); although children from deprived and marginalized sections may not have this opportunity to explore. In general, however, children do get exposed to the world of work through various means. This can be utilized to make them aware about different career avenues, career features, and conditions vis-à-vis personality requirements. In-breadth exploration will facilitate in-depth exploration of careers during adolescence and will lead to career maturity and career commitment.

A second challenge pertaining to adolescent career decisions involves the impact of culture. Role of cultural differences in relation to interpersonal factors affecting career choices need to be examined as it may create tension and intergenerational conflict. Bicultural youths who were more acculturated to their host countries reflected more intrinsic motivation in their career decision-making (Akosah-Twumasi et al., 2018). The study also points out that further research needs to highlight the role of parental influence and cultural diversity for the career path of bicultural youth.

Thirdly, career aspirations and career development of girls are other major issues. Prevalent gender norms limit the career choices and expectations of females. Socialization process affects the achievement motivation and self-efficacy of females. The socio-cultural norms also lead to occupational sex-stereotypes, i.e., generalized views of appropriateness of occupations for males and females. Although the female participation in the workforce has increased over the years, still the crucial issues of equal participation and recognition in work responsibilities, promotional avenues, and attitudinal changes are prevalent and need to be addressed.

Fourth, the process of career development of adolescents now needs to consider the significant role of technology in career. In the advent of online era now and as highlighted by the fallout of COVID-19 pandemic, adolescents need to learn new online skills to make them relevant in the new age workforce. There are also new avenues of employment open to youth for which they need to be ready. Hence employability skills have acquired a new dimension in the advent of integration of technology in all areas of our life.

Interventions for Adolescent Career Development

Career choice, decision, and development during adolescence require proper guidance and counselling which can shape and motivate the adolescent towards good career planning and vocational identity development. This will enable them to develop accurate understanding of themselves and choose appropriate careers. Intervention programmes for career development can focus mainly on development of a vocational identity of the adolescent. Focus needs to be in which stage the adolescent is currently—career exploration, commitment, or reconsideration. Accordingly, intervention measures can be provided keeping in mind that intervention in one stage will impact the status in the other stages also. Further, the identity status of the

adolescent can be assessed and accordingly measures can be provided to facilitate increase the commitment and in-depth exploration by adolescents, and decreasing the in-breadth exploration and reconsideration over the long-term (Porfeli & Lee, 2012).

Adolescence is an age where a lot of psychological changes are accompanied with physical changes. This is the time when self-concept and identity develop which have a great implication in adolescent career planning. Guidance and counselling services will help the adolescents develop a proper self-concept and avoid confusions and anxieties, enabling them to progress effectively in their career development. Parental involvement needs to be an important aspect of adolescent counselling especially in the collectivistic society.

Career counselling and guidance need to be integrated into school guidance program. Instead of being a one-off activity or session, it needs to be permeated in all the activities and curricula of the school.

There also needs to be linkage of the curricula with the outside work environment and job market. Linking school curricula to world of work and employment opportunities will increase the relevance and applicability of what the students are learning in the school.

Further, a creative schooling system will motivate and promote ability and aptitude of various types. This will help adolescents discover their abilities and interests and develop a better self-understanding, thus facilitating their career decisions.

Mentoring can also support the students in their career choices through interaction with the alumni of schools and colleges. Sharing of first hand direct experiences of alumni will help the students develop better understanding of the process of career development and facilitate them in making appropriate career decisions.

Life skill development is another important aspect that enables students to become better professionals. These skills occupy an important role as most of the professions require social skills and life skills to effectively interact with people, manage their self and emotions and perform to optimum level at workplace.

Conclusion

This chapter provides an understanding of career development process in adolescents. It explains the factors and theories of career development having implication for career planning and career choices among adolescents. Career development and counselling for adolescents is a crucial need across the globe. It may start at different stages in different societies and cultures, but it has great implications for the future success and satisfaction of the adolescent. In Indian context of education, important decisions regarding career are made when a student is required to make a choice after tenth grade to choose between various disciplines broadly science, commerce, and humanities/arts stream. With the advent of changing paradigms in the education system within these streams varied choices are offered to the students. And this choice defines the future career of the students. Thus, it is very necessary that at this

stage these students are guided through systematic career assessment and guidance and counselling based on scientific tests and facts related to the attributes of these students based on their personality, attitude, aptitude, and interest.

The issues and challenges related to career decision need to be looked into and intervention measures provided. Awareness of various provisions, schemes to extend support to the adolescents from the disadvantaged group, and deprived sections of the society are crucial for the utilization of these services for their benefit. School-industry partnerships enable students to learn through internships and apprenticeships which later on help in providing wider placement opportunities to students. The initiatives under National Education Policy (NEP, 2019) of the Government of India guides and promotes bridging of gap between skills and employability. Thus the policy encourages skill based courses and focus on applicability of education in the industry.

Adolescent career planning and decisions need to be given utmost importance as they form a major chunk of human resource of any country, and a proper career choice will play a key role in adult career success and satisfaction.

Time to Reflect

Career is one important aspect of human being's life and adolescence stage is the crucial stage to decide on one's career path. New career avenues and paths have arisen in twenty-first century due to advancement in the field of knowledge and technology. Adolescent needs to be ready for these careers in terms of attitudes, skills, and values. At the same time there is a need for the adolescents to focus on the local and indigenous aspects of work and vocations and turn these to successful employment opportunities, thus bringing in the inclusivity and sustainability dimensions into the career field. Adolescents need to find out their 'Ikigai'—the purpose and meaning—in relation to their career, this will enable them to achieve success as well as happiness in whatever their career pursuit may be.

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Chapter 7
Aggression and Violence Among Adolescents and Youth

Swati Patra

Abstract The chapter defines aggression and distinguishes it from related terms of anger, violence, and anti-social behaviour. It focuses on explaining aggressive behaviour and violence among the young generation through different theoretical perspectives. Factors affecting youth aggression and violence are also discussed in relation to individual as well as environmental factors highlighting the socio-cultural context. Further, the chapter explains the impact of aggression and violence on the young generation and deliberates on the prevention and intervention strategies to deal with this challenging issue.

Keywords Aggression · Aggressive behaviour · Violence · Youth · Adolescents · General aggression model

Introduction

> Jatin, a 27 year old, was going in his car to the office and had stopped at a traffic red light. There was another car in front of him. A two-wheeler suddenly came from the left and crossed to the right in front of his car in the small space between the two vehicles. In the process, the scooter hit the front light of Jatin's car and it got broken. When Jatin shouted at the scooter to drive properly and told them to stop, the two young persons in the scooter threw abusive languages and sped away. When Jatin was nearing the next traffic light and stopped again for the red light, the same scooter came suddenly and the person on the back hit the driver side glass of Jatin's car with a stick, broke it, hurled abusive languages, and went away speedily.

As we see in the above example, aggression has been increasing in the society and is exhibited even for small non-issues also. It is known that violence and aggression has existed in the society since time immemorial. Human beings in the earlier times engaged in aggression for survival. The need for food, mate, shelter, and protection required them to show aggressive behaviour and defend their territory.

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Darwin's survival of the fittest involved being aggressive and ensuring one's continuity. However, as the civilization progressed, societies developed, and human beings advanced in various fields, aggression was not required for survival. In fact, it can hamper the progress of the individual as well as the society. For instance, the false notion of aggression being related with masculinity has led many young persons to extol it and adopt an aggressive stance to feel in control of things. The patriarchy system of our society has also since long supported this wrong notion which affects negatively our young generation. The adolescent and the youth because of peer pressure, gang culture and misplaced values and other factors take it as a way of asserting their presence in the society. As is seen in the example above, the society of late has been witnessing such violent acts to a greater extent in the younger generation—the adolescents and the youth. This is a genuine concern and needs to be understood in terms of its dynamics. Youth is an important resource of our nation as it constitutes a major portion of our population. If we want to progress and advance as a nation, we cannot afford to lose this demographic dividend to the casualties of aggression and violence.

The youth population (15–32 years) consists of 35% and 32% of the urban and rural population respectively (Jayaraman, 2013). In urban India, every third person turns out to be a youth, and India is soon going to be the youngest nation in the world (Patel, 2013). This rich source of our young population needs to be utilized for the good of the nation. India needs to make this demographic transition of youth from being a demographic burden to demographic dividend by focusing on their skill building, employment opportunities, and the most important, taking care of their mental health and well-being.

An important aspect of adolescent and youth mental health deals with the anger and aggression issues which typically characterize this stage of life. Aggression in this chapter has been discussed in the context of social interaction, involving a perpetrator of aggression and a victim of aggression. It also focuses on aggression by seemingly 'normal' persons who resort to serious and violent assaults against others. WHO (2002) reports that violence is a major public health problem and talks about various types of violence, their impact, the risk and protective factors, prevention strategies, and recommendations for dealing with violence in its 'World Report on Violence and Health'. In 2014, WHO brought out a status report called the 'Global status report on violence prevention 2014' which includes data from 133 countries. It highlights the national efforts to deal with various types of violence, including youth violence as it can be a financial burden to the nation in addition to being a serious societal issue.

Aggression Among Adolescents and Youth

Violence rates are highest during adolescence. Eaton et al. (2009) based on a national school-based data report that almost 1 in 3 high school students are engaged in a physical fight in the last 12 months and about 1 in 10 students are victim of violence

from a dating partner. Further, around 1 in 7 were electronically bullied through texting, Instagram, Facebook, or other social media (Kann et al., 2018).

Indian studies have also reported adolescent violence as an emerging challenge (Mahajan et al., 2011). In a study by Munni and Malhi (2006) on 1500 high school students, 69% students had witnessed violence in real life out of which 28% were severe; and the prevalence rates were 27% and 13% respectively for victims and perpetrators. Sharma and Marimuthu (2014) found that about 17.7% of the youth in a national sample of 5476 participants with a mean age of 20.2 years had high mean aggression score; and aggression was more in case of younger age group (16–19 years) than older age group (20–26 years).

Hence it is crucial that we focus on understanding the dynamics of aggression and violence among adolescents and youth. The issue needs to be treated in a sustainable and efficient manner so that precious resources in terms of time, money, energy, and lives are saved.

Defining Aggression

What exactly constitutes aggression and violence? Children while playing with each other may hurt each other or engage in fighting. The youth due to various reasons may cause injury to others and may end up in verbal abuses. But can these be called aggression and violence? It depends on the nature, extent, and severity of the act and behaviour displayed.

Aggression is any behaviour that harms and hurts other people. It can be physical, e.g., pushing, hitting, kicking, or throwing; and verbal, e.g., teasing, name-calling, making fun of. Violence goes more severe and involves destruction of things and causing severe injury, hurt, and killing. Both aggression and violence involves the violation of the rights of others. Violent behaviour in adolescents and youth can include various behaviours such as fighting, extreme temper tantrums, hurting others, threatening to kill, physical aggression, using weapons, cruelty towards animals, setting fire, destroying things, ruining properties, engaging in vandalism, bullying, and using abusive language.

The term aggression has been used in various ways in various contexts. For instance, take the example of a goon attacking a couple on the road in the night and looting them; or a businessman employing goons to kill his rival in the business; or a youth injuring his girl friend's lover. These are cases of violence. Now what about the case of a soldier killing the enemy in the war? Or a wrestler showing aggression in a wrestling match? Or a surgeon doing a surgery on the patient which causes pain and suffering to the latter? Do we consider these as violent acts? So one needs to be clear what exactly constitutes as aggressive and violent behaviour.

Aggression can be defined as intentionally inflicting harm/injury on the other person. However, not all intentional behaviour are aggressive behaviour as in the example of soldier and the surgeon above. The soldier is doing it for the protection of his country, and the surgeon is doing it for the benefit of his patient. The wrestler

is doing it as part of the requirement of the sport. Hence we need to focus on the causal attribution of the behaviour before it can be termed as aggressive and violent behaviour.

Baron & Richardson (1994) have defined aggression "as any form of behaviour directed towards the goal of harming or injuring another living being who is motivated to avoid such treatment". This definition has the following aspects:

(a) aggression as a behaviour: the perpetrator behaves in an aggressive and violent manner. It involves an action.
(b) aggression involves an intention: the perpetrator has an intention to cause some harm or loss to the victim; so it is goal-oriented.
(c) aggression causes harm or injury to the other person: the victim undergoes some suffering, loss, or injury.
(d) aggression involves living beings: the perpetrator and the victim. It happens in a social interaction context.
(e) Aggression involves an avoidance-motivated recipient: the victim always wants to avoid the suffering or the harm caused to him/her.

Thus human aggression can be characterized as a social behaviour involving interaction between at least two people, where one person has the intention to cause harm to another person, a reasonable expectation in being successful in inflicting harm, and the other person in turn is motivated to avoid that harm (Berkowitz, 1993; Bushman & Huesmann, 2010). It includes provocation and retaliation in a social context which can be distinguished from aggression directed towards self in the form of self-injury and suicide.

Aggression can also be differentiated from violence in the sense that violence is a subset of aggression. Thus aggression as a broader term includes violent behaviour, implying that all aggressive behaviour are not violent behaviour. The World Health Organization (2002) defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation." This definition focuses on the following:

- Intentionality: the definition excludes those that are unintentional or accident, e.g., traffic accident, injury, etc. as being violent.
- It highlights that there is an intention to use physical force in violence. However, it may be noted here that an intention to use force does not necessarily translate to an intention to cause injury or death, e.g., when two children engage in a fight in the school playground, they use physical force intentionally, but they do not mean to injure the other person.
- Violence is attributed not only to physical force but also to inequalities in power relations; thus, it includes physical aggression and also psychological abuse, sexual abuse, suicide, intimidation, threat, etc.
- Aggression can be actual/physical or threatened, intimidation, bullying.

- Self-directed or other-directed (includes self harm, suicide, interpersonal violence, community violence, wars)
- Outcome can be physical, psychological, and social. It is not limited only to physical harm, injury, disability, or death. Violence can have a substantial and long-term impact on varied aspects of the individual's life.

Source: WHO global consultation on violence and health, 1996 (4).

Types of Aggression

Aggression is a complex behaviour with several subtypes. It can take various forms such as hitting, beating, verbal abuse, depriving, withdrawing something of valuable to the victim, punishing, and so on. Let us see the various ways in which aggression has been categorized.

- *Buss's Categories of Aggression*

Buss (1961) has provided a framework for conceptualizing various aggressive acts. He has categorized aggressive acts along three dimensions, physical-verbal, active–passive, and direct–indirect.

(i) Direct physical aggression: murder, rape, assaulting someone with body parts (e.g., hands, legs, teeth) or weapons (guns, knife, etc.)
(ii) Indirect physical aggression: stealing or damaging other's property, hiring an assassin to kill someone, and setting a bobby trap for someone
(iii) Direct verbal aggression: criticizing, derogating, cursing someone, threatening
(iv) Indirect verbal aggression: spreading vicious/malicious rumours about someone

- *Childhood-onset and adolescent-onset aggression*

Aggression can start in the childhood or in the adolescence. Aggressive behaviour having onset in childhood is usually more persistent than adolescent-onset aggression. There is also adolescent limited and life time offenders. The former refers to aggression shown during adolescence period only whereas the latter continues beyond adolescence into adult life also.

- *Hostile aggression and Instrumental aggression*

The primary aim in hostile aggression is to cause pain, injury, or suffering to the other human being; whereas instrumental aggression is a means to achieve another goal, e.g., a thief hurting a passer-by in a bid to steal wallet/purse from him. Here the main goal is to steal money and in the process, if it requires, the thief hurts and injures the person. Thus in hostile aggression the proximate or immediate aim is to harm; whereas the main goal in instrumental aggression is achieving something else

via causing harm to the other person. Instrumental aggression is also called cognitive aggression as it involves intention and planning and is differentiated from emotional aggression which is more impulsive and based on emotions. However, all types of aggression can be instrumental to different extent as they satisfy some underlying need of the aggressor and thus can be viewed on a continuum.

- *Typology of violence proposed by the WHO*

The World Health Organization (WHO, 2002) has proposed a typology of violence that includes three main categories such as self-directed violence, interpersonal violence, and collective violence. Self-directed violence is directed towards the self and includes suicide, self-harm, and self-abuse. Interpersonal violence includes violence within the family and involves known persons, for instance, domestic violence, intimate partner violence, rape, child abuse, and abuse of the elderly. Collective violence is at a larger scale involving people who are strangers to each other. Examples of such violence are mob violence, youth violence, riot, communal violence, hate crimes, violent conflicts, terrorist attacks, and war.

It is pertinent here to distinguish aggression from some related terms which has implications for intervention measures.

Aggression and Anger

It can be noted here that aggression is different from anger. The latter refers to a feeling state whereas aggression is a behaviour. Aggression needs to be distinguished from any feeling or emotional state or attitude. It is a behaviour with an aim to cause harm to the other person. When the harm caused is extreme, leading to extreme injury or even death, it is called violence. Hence violence can be a subtype of aggression. However, more often the two terms are used synonymously in the literature and they have been used so in the present chapter.

Aggression and Anti-social Behaviour

Aggression involves violating the personal space, boundaries of another person and causing harm, or injury to the person; whereas anti-social behaviour involves violating the accepted social standards and values. Anti-social behaviour is a broad construct that encompasses not only delinquency and crime but also disruptive behaviour of children, such as aggression, below the age of criminal responsibility (Pulkkinen, 2001). It causes harassment and distress to other persons in the community which goes against the accepted social norms. Aggression may or may not involve violation of the societal norms and standards. When the anti-social behaviour

by the young violates the laws and considered as criminal acts, it is called as juvenile delinquency.

Aggression and Assertiveness

Assertiveness can be described as being in the middle of a continuum where the two ends are characterized by aggressiveness and passiveness. In assertiveness, one conveys one's things in a clear, concise, and confident manner while being respectful of the other person. In contrast, an aggressive person has little regard for the other person and has his own ways of talking, behaving and acting, causing harm, and suffering to the other person. An assertive person behaves in a way so as to achieve one's purpose and thus considers the situation and the context. There is no question of hurting anyone in assertiveness, neither the other person nor oneself. It involves a respect and consideration of the rights and views of others; whereas aggression functions from a place of fear. One becomes aggressive because of the perceived fear of losing one's status, respect, or objects.

Theoretical Perspectives on Aggression and Youth Violence

Since aggression is an interdisciplinary concept, it is studied from a multidisciplinary viewpoint. In psychology itself, it is explained from various perspectives such as learning theories, observation, and cognitive theories. However, before seeing aggression as an acquired and learned response due to the influence of environmental factors only, it is also important to consider an innate biological determined instinctual drive. Along with situational and biological factors, presence of provocation is necessary for aggression to manifest itself.

Thus the role of biological, psychological, and social factors needs to be considered. However, all these theories focus on different aspects which may not explain aggression in totality. The latest General Aggression Model (GAM) attempts to combine the different approaches and takes a comprehensive approach with inputs of bio-psycho-socio factors to explain aggressive behaviour.

Instinct Theory

This theory puts emphasis on the biological factors for aggressive behaviour. This is one of the earliest theories that uses the analogy of tightening a spring until it forcibly unwinds to refer to the building up of aggression instinct in the individual until it is expressed. It can be expressed in the form of aggressive behaviour towards others or released through socially acceptable channels such as games and sports. However,

this theory has little support in the scientific community as there is no evidence of natural aggressive feelings or innate biologically aggressive behaviour.

Psychodynamic Theory

Freud has proposed two types of instincts, namely, Eros (the life instinct) and Thanatos (the death instinct). The conflict between these two leads to the build-up of tensions and the resultant aggressive behaviour. Thanatos usually involves self-destruction tendencies but may get directed to others through the defense mechanism of displacement. Sometimes, aggression is also vented through a constructive and socially acceptable way (sublimation), e.g., sports or gardening. This has implication for the aggressive behaviour and the self-destructive behaviours among adolescents and youth when they take up to alcohol, drug use, or gang wars. Engaging the young in some personally meaningful and enjoyable activities such as playing football or volunteering to some cause for the community help facilitate the constructive utilization of their anger and aggression inside.

The Frustration-Aggression Hypothesis

The Frustration-aggression hypothesis (Dollard et al., 1939) is the earliest social psychological theory which explains aggression in terms of frustration that results when the person's goal-directed behaviour is blocked (Aronson, Wilson & Akert, 2014). However, the relationship between frustration and aggression may be moderated by so many other factors. The developmental experiences of adolescents related to their diverse socio-economic-cultural contexts may play a role in causing frustration among them. Presence of risk and protective factors in their environment will influence the manifestation of aggressive behaviour among the adolescents.

Learning Theories

According to Pavlov's classical conditioning and Skinner's operant conditioning theories, reinforcement of a behaviour results in the strengthening of that behaviour. Thus an aggressive behaviour, if rewarded in any way, becomes conditioned and the likelihood of repeating it in future increases. For instance, when the child has engaged in some verbal abuse or physical fighting in the neighbourhood, and parents or the peers encourage and tell him to give tit for tat to the other child, they are rewarding the child's aggressive behaviour. Thus positive reinforcement can lead children to behave aggressively through rewarding aggressive behaviour. Removal of a painful consequence after aggression (negative reinforcement) can also strengthen

the aggressive behaviour. Learning of aggressive behaviour also gets generalized to similar situations. In the above instance, the child may carry it to the school situation also. However, not all learned aggressive behaviour could be explained though conditioning and reinforcement.

Bandura later on proposed observational learning which explains that aggression can be learned by observing others engaged in such behaviour. Children learn social behaviours including aggression by observing and imitating others in social situations. The classic Bobo doll experiment (Bandura et al., 1961) shows the powerful effect of observation and imitation in acquisition of aggressive behaviour where children displayed aggressive behaviour after seeing a film in which an actor was hitting the Bobo doll. Children also learn aggressive behaviour in a vicarious way (vicarious learning) when they imitate people whose aggressive behaviour is rewarded.

In social learning theory (later called social cognitive theory), Bandura (1986) places emphasis on how people mentally construct their experiences. People not only observe aggressive behaviour but also make inferences about observed aggression which increases the likelihood of reacting aggressively in that situation and also generalized to other situations. This has made it easier for the adolescents to engage in aggressive behaviour online because of the anonymity and accessibility of the online world.

They are also exposed to online aggression and bullying either as victim or perpetuator. As a perpetuator they exercise their need to have power and autonomy through the anonymous online world. Given the exposure of the present generation to the virtual world and their engagement with various gaming activities, they are constantly observing aggression in these games and get rewarded also by earning points, thus increasing the likelihood of aggressive behaviour in them.

Excitation-Transfer Theory

Zillman (1979) has proposed the excitation-transfer theory which says that the excitation or arousal gets transferred. Any physiological arousal dissipates slowly. So, when two arousals occur within a short span of time, we usually label the second one and the cognitive label given to the second one is misattributed to all other arousals. Thus arousal from the first event gets added to the second one and cognitive labelling is done for the second arousal only. For instance, if the person is in an arousal state because of exercise and comes across an angry individual and is provoked, then s/he misattributes his arousal to anger and this determines his behaviour. This self-generated label of angry influences his aggressive behaviour.

Information Processing and Script Theory

With the emphasis on information processing approach and rise of cognitive psychology, aggression was also explained in these terms—the Social Information Processing (SIP) theory of Dodge (1980) and Script theory from Huesmann (1982). The SIP theory talks about hostile attributional bias which predicts our aggressive behaviour. It says that people attribute wrongly about the motives of other people. Thus people perceive the seemingly innocuous behaviour of others in a serious way, e.g., bumping into a person as intending to cause harm.

Script theory assumes that an individual acquires scripts of various situations/events based on their learning and experience. These scripts then determine their subsequent behaviour in such situations. A script tells how to behave in a particular situation. If the script involves aggressive behaviour in response to a situation and the script is enacted in response to that situation many times, it becomes automatic and generalizes to similar other situations. This has an implication in case of adolescents who get addicted to internet and video games involving aggression.

Cognitive Neoassociation Theory

The theory developed by Berkowitz (1993) focuses on the associative network models of memory linking aggressive thoughts, emotions, and behavioural tendencies in the form of schema. Further, cues presented during the aversive/unpleasant event or situation also gets associated with the particular situation and the subsequent negative emotions. For instance, the presence of a weapon can act as a cue and influence the aggressive behaviour, known as the 'weapons effect', (Turner et al., 1975) even after controlling for various other factors related to aggressive driving, e.g., gender, age, urbanization, census region, and driving frequency (Hemenway et al., 2006).

Cognitive neoassociation theory also includes higher order cognitive processes such as appraisal and attribution. The individual in a particular aversive situation can assess and appraise the situation, makes causal attributions of his feelings, decides how to respond, and thinks through the consequences of his action. Thus it explains the cause of aggressive feelings and behaviour.

General Aggression Model (GAM)

The above specific theories of aggression address aggression from their own specific viewpoints but do not give a unified whole explanation of the aggressive behaviour. Various factors ranging from biological, social, and psychological to environmental factors influence if the person engages in aggression and violence. Hence an integrative theoretical framework, General Aggression Model (GAM) was proposed by

Anderson (1996) to explain aggressive behaviour in a comprehensive way. It is a bio-social-cognitive model of aggression, which integrates all these theories in a single umbrella framework to explain aggression based on multiple motives (Bushman & Anderson, 2001), leading to better forms of intervention. Consequently, it will also help us adopt preventive measures with regard to aggression and violence among the adolescents. Further, it has implications for parenting practices, family interaction, and environment.

A key component of the GAM is *knowledge structures* (Anderson & Bushman, 2002). Knowledge structures are based on our experiences. These knowledge structures affect our perception, interpretation, affective states, and behaviour. They influence our response and action in different social situations.

Three specific subtypes of knowledge structure are (a) perceptual schemata, which are used to identify phenomena. These phenomena may be as simple as everyday physical objects, e.g., chair, table, or person or it may be as complex as social events, e.g., personal insult, etc.; (b) person schemata which refers to beliefs about a particular person or a group; and (c) behavioural script, which includes scripts regarding how people will behave in different situations.

Further, knowledge structure also includes *scripts* about affective experiences. It tells us about specific emotions to be experienced, when to experience these emotions, how the emotions influence our behaviour and decisions.

The main focus of GAM is the person, called an '*episode*' in a social interaction situation. It consists of three main parts: (a) the input which includes the person and the situation, (b) the routes, the cognitive, affective, and arousal routes through which the inputs exert their influence, and (c) the outcome of the appraisal and decision-making processes by the individual (refer Fig. 7.1).

(a) **Inputs**: Inputs consist of person and situation variables. The factors related to these personological and situational input variables represent the underlying processes that explain the aggressive behaviour. These factors affect the cognition, affective, and arousal of the individual which in turn influences the aggressive behaviour.

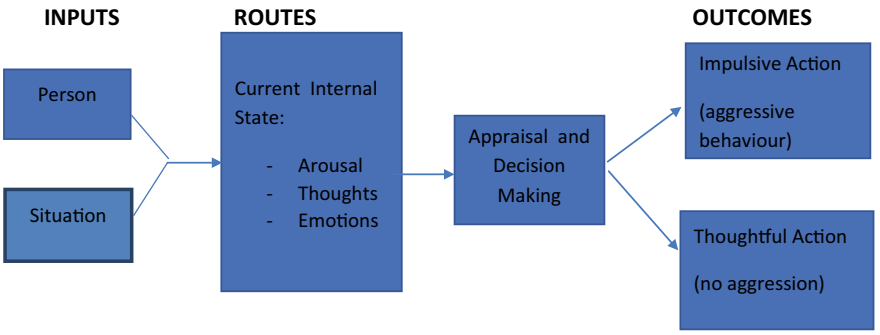

Fig. 7.1 General aggression model by Anderson and Bushman (2002)

Person variable includes various factors related to the person, for example, traits, attitudes, values, beliefs, age, gender, etc. These factors may be temporary like moods or stable like personality traits. Consistent use of particular schemata, scripts, or knowledge structure leads to stable personal factors. Certain traits make the person more aggressive like biases, hostile attributions, etc. (Dill et al., 1997). Sex differences are also observed in the expression of aggression, with males preferring direct aggression and females preferring indirect aggression (Oesterman et al., 1998). White (2001) points out that these differences can mainly be attributed to the socialization process. Beliefs of the individual also contribute to the aggressive behaviour. If the person believes that aggressive behaviour will help her/him achieve desired goals (self-efficacy), s/he will engage in such behaviour. Aggression-related beliefs will lead to aggressive behaviour (Huessman & Guerra, 1997).

Attitudes also play a significant role in aggressive behaviour. Positive attitude towards aggression will make the individual behave in an aggressive way. This may also be towards specific group of people, e.g., women, scheduled caste, etc. which increases aggression towards such group of people. Men who have positive attitude regarding violence against women exhibit more sexual aggressiveness against women (Anderson, 1996; Malamuth et al., 1995).

Values refer to one's belief system about what is right or wrong. In some communities, violence is accepted as a way to deal with wrongs or to preserve one's self-respect, e.g., the honour killing prevalent in some societies in India in Haryana and Punjab.

While person factors are related to the preparedness/predisposition to behave aggressively, the situational factors act like the spark and actually ignite the aggressive behaviour. Situational factors or environmental inputs refer to the features or cues present in the particular environment that influence the expression of aggressive behaviour. For instance, exposure to aggression and violence in the media such as television, movies, and video games may lead to aggressive behaviour (Anderson & Dill, 2000). Further, frustration and provocation in the environment also act as situational cues for aggressive behaviour. Extreme temperatures, noise, and aversive conditions like pain, use of drugs, etc. may also act as situational triggers for aggression.

(b) **Routes**: Routes refer to the internal states through which the input variables of personal and situational factors exert their influence on the outcome. The internal states refer to the arousal, affective, and cognitive aspects.

Cognition. Input variables like engaging in violent video games can prime aggressive thoughts. Priming refers to increased accessibility of aggressive thoughts. When one engages in frequent media violence on television etc., it leads to increased accessibility of aggressive thoughts in memory. These aggressive or hostility-related scripts become available depending on the input variables and influence the aggressive behaviour.

Affect. Input variables also exert their influence on feelings, emotions, and mood of the individual. For instance, pain increases state hostility or anger

(Berkowitz, 1993). Extreme temperatures make the person irritable and uncomfortable, thus producing negative affect.

Arousal. When a person is in arousal state, it may affect aggressive behaviour in three ways: (i) provocation or instigation during the arousal state can lead to aggressive behaviour; (ii) arousal elicited by irrelevant sources (e.g., exercise or any intensive manual activity like digging earth) can be wrongly labelled as anger in situations involving provocation, thus producing anger-motivated aggressive behaviour. This mislabelling process has been studied by Zillmann (1983, 1988), who named it as excitation transfer, which we discussed earlier in this section; and (iii) extreme high or low level of arousal may act as aversive and painful stimuli leading to aggressive tendencies.

(c) **Outcomes**: The input variables affect the cognition, affective, and arousal of the individual. The appraisal and decision-making processes are then activated and the individual's behaviour and action is influenced by the outcomes of these appraisal. Thus the outcome refers to the final action after the appraisal and decision-making based on the influence of the input variables on the cognition, affect, and arousal of the individual. The outcome may include automatic information processing or heavily controlled information processing (Robinson, 1998). The former is called immediate appraisal, and the latter is called reappraisal. Immediate appraisal is automatic, relatively effortless, and occurs immediately, e.g., if you have been thinking of aggressive thoughts, then the appraisal will be influenced by these thoughts. Thus the present internal state immediately influences the appraisal process. But when you think about these again consciously, it involves reappraisal which is effortful and aims at searching for an alternative view of the situation and looks for more information about the present situation. As a result, reappraisal leads to more considered and thoughtful outcomes whereas immediate appraisal results in impulsive action.

If the outcome of the immediate appraisal is not satisfactory and the outcome is important for the individual, the individual is having resources like time and cognitive capacity, and s/he engages in a more effortful reappraisal process. In the absence of all these, impulsive action results which may be aggressive or non-aggressive depending on the immediate appraisal.

This whole cycle of input variables, routes of cognition, affect, and arousal, and outcome is called an episode. The final outcomes of this episode then influence further social interactions by becoming the input variables for the next episode.

General aggression model is a useful and comprehensive model which takes into account the several domain specific aggression theories and presents a unified model that addresses successfully the various aspects of aggression. It has great implications, especially, for the prevention and intervention of aggressive behaviour by focusing on the factors which influence the development and sustenance of aggressive behaviour. It highlights the maladaptive knowledge structures that are learned from different social environments.

Risk Factors of Aggressive Behaviour and Youth Violence

Violent behaviour is manifested through two types of pathways: (i) life course persistent developmental pathway (life-time offenders) and (ii) adolescence-limited offenders.

Life course persistent developmental pathway suggests that there is a fair level of stability in the extent of aggression shown by one person relative to others of the same age over the life span. Children who are aggressive are likely to become adolescents and adults who are more aggressive than their peers (Bushman & Huesmann, 2010). This indicates a considerable continuity from childhood aggression to juvenile and adult violence. It indicates that there is a greater underlying tendency for aggression and violent behaviour in them. There are other factors though that may moderate this continuity and the final expression of aggression.

Adolescence limited offenders show aggression only for a shorter duration during the stage of adolescence. Adolescence is a stage characterized by a lot of physical changes in addition to psychological and social changes. Unless handled appropriately, it may cause disturbances, conflicts, stress, and aggression in the adolescent.

The reasons for engaging in aggression and violence are complex and interplay of many factors such as physical abuse in childhood, substance abuse such as alcohol and tobacco, negative peer influence, family violence, academic disturbance, and psychological problems like attention deficit-hyperactivity disorder, suspiciousness, loneliness, mood disturbance, negative childhood experience, and excessive use of television and media (Sharma & Marimuthu, 2014).

The various causes and risk factors for aggression can be described under **Individual/person factors and Environmental/situational factors**. Interaction between individual and environmental/situational factors play a significant role in aggressive behaviour. Individual risk factors may be high impulsivity and low intelligence; family risk factors may include broken family, violent family, abusive parents, child abuse, harsh parenting, domestic violence, strict disciplining, and poverty. Other social factors may include delinquent peer group, high crime/anti-social neighbourhood, gang membership, living in slums and extreme poor conditions, and low social status.

In discussion of these risk factors, one needs to focus on the culture-context-development framework of adolescents (Kapadia, 2017). The factors highlight as well as reflect the impact of the way adolescence stage is viewed and interpreted across cultures and contexts. The cross-cultural variability is a crucial factor that define adolescence as a socio-cultural construction (Kapadia, 2017) and needs to be emphasized in explaining the issues and concerns of adolescents.

Now let us discuss the individual and environmental factors related to aggression in adolescents.

Person Factors

Genetic predisposition—Although aggressive behaviour involves a considerable influence of learning, genetic factors also play an important role and account for perhaps a quarter to a third of an aggressive predisposition (Tuvblad et al., 2009). However, rather than directly accounting for it, genetic predispositions mainly interact with the environmental influences in causing aggressive behaviour. The early environment of the child and the parental interaction patterns and other situational factors exert a role in aggression. For instance, as reported by Kim-Cohen et al. (2006), aggression and anti-social behaviour are most likely to occur in those who have the related genetic trait and also experience childhood maltreatment.

Temperament—Research studies have pointed out the role of temperament which are relatively stable across time and contexts, in the development of aggressive behaviour in children and adolescents (Moore, Hubbard & Bookhout, 2018). Temperaments can be defined as biologically based individual differences in the domains of motivation, affect, inhibitory control, and attention (Rothbart & Bates, 2006). Aggressive behaviour of children can be linked to their early temperaments.

Hormones—The biological make-up of boys with higher levels of testosterone especially in the adolescents and young males can be a possible risk factor for aggressive behaviour. However, we need to keep in mind the socialization of males in our culture that may create this risk. It reflects the nature-nurture interaction in causing the manifestation of a particular trait/potential within the individual. The socio-cultural environment (e.g., lack of appropriate role models or improper social learning, Kosterman et al., 2001) in which boys grow up has been linked to a culture of violence and cruelty. Hence the socialization process and the child-rearing practices play an important role rather than simply the presence of a particular hormone.

Research has also pointed out the role of neurotransmitters like serotonin in aggression. Higher levels of serotonin leads to less aggression. However, as indicated earlier, this relation between neurotransmitter and aggression is also complex as the environment plays a key role in regulating neurochemistry.

Gender—Gender difference in aggression is influenced by the social and cultural practices and norms that govern the way a boy or a girl develops, e.g., males show direct and physical aggression while females engage in indirect and relational aggression (Ostrov & Crick, 2007). Gender socialization expects the boys to behave aggressively, and it is also allowed in some cultures, the boys grow up believing it to be an appropriate behaviour. However, we need to raise questions against such practices that are not in interest of the society.

Personality traits—Research by Barlett and Anderson (2012) on the 'Big Five' personality traits and aggression point out that people low in agreeableness and high in neuroticism are more aggressive and violent. Trait anger characterized by extreme sensitivity to provocation leads to aggressive behaviour under slightest of provocation. Other traits like irritability, hyperactivity, and impulsivity also predispose the individual to aggression. Impulsive people are not able to have control over their

aggressive impulses. In contrast, people having greater self-control to inhibit their impulses are less aggressive (Moffitt et al., 2011).

Overriding inhibitions—We usually are governed by inhibitions or self-regulation in our interaction and functioning in the society. However, these may get ignored in certain situations and make us engage in aggressive behaviour (Bandura, 2001; Staub, 1998).

This is exemplified in cases of terrorist attacks or mass killings. In such cases, the perpetrator justifies the violence by saying that the victim deserves it and that it is good for the society. Even at the individual level, for instance, parent abusing the child or in cases of intimate partner violence, the perpetrator of violence goes beyond their inhibitions and moral standards and feel justified in behaving aggressively.

Environmental/Situational Factors

Physical Environment

The physical setting of the environment around us, e.g., temperature, noise, foul smell crowding, etc. may also affect the aggressive behaviour of the individual. Increased temperature may cause the individual to behave aggressively. However, since aggression is caused by a multiplicity of factors, we need to consider these factors in conjunction with other contextual aspects. For instance, the issue of global warming has implications for rise in aggression and needs to be taken seriously. Loud sound in the environment may also aggravate/heighten the tendency to aggress. Crowding which leads to transgression of one's personal space may cause one to behave aggressively. Further, crowding leads to deindividuation where the person feels that he cannot be identified and thus get away with aggressive behaviour. This explains the vandalism and the mob violence that we experience in the society. Anonymity increases the likelihood of aggressive behaviour. However, it can be noted that personal space encroachment may not be a problem for some people and also in some culture where close proximity is accepted.

These environmental stressors—heat, noise, crowd, even strong foul odour, and physical pain—leads to physiological arousal. As we have seen earlier in the theories of aggression, arousal state may lead to aggression, though it will depend on how the individual interprets the arousal. Thus unpleasant stimuli or even aversive events in the environment can lead to aggression. Aggressive cues in the surrounding in the form of images, words, or objects may lead to aggression-related cognitions that result in aggressive behaviour. For instance, presence of weapons in the environment has been found to increase the chances of aggressive behaviour (Barrett, 2017), known as the weapons effect as described earlier in the chapter. Weapons are such a stimulus that has been conceptually linked to violence and whether it is present in real or virtual, it leads to aggression related thoughts primed in semantic memory, and the individual becomes more likely to behave aggressively.

Provocation—Aggressive behaviour can be triggered by provocation from another person (Bettencourt et al., 2006). Provocation may happen in different forms such as directly instigating someone, spreading ill words about someone, neglecting/isolating the person in a social situation, teasing, insulting, or physically hurting. Adolescence being a sensitive stage with so many changes, such provocation may lead to aggression.

Frustration—Human behaviour is always goal-directed. If this goal-directed behaviour is thwarted or blocked, the individual becomes frustrated which then causes aggression, e.g., if one wanted to win the game, but lost to the opponent, it yields frustration. However, in reality, a host of other factors mediate this relationship between frustration and aggression such as personality traits of the individual, the source of frustration, if the frustration was due to genuine reasons, if the situation was in control of the person or not etc.

Social class, caste, and culture—Social class and caste exerts a major influence on the social interaction. In the society, the gap between the haves and have-nots has always led to tension and conflicts. People from socially disadvantaged groups feel deprived in comparison to others and may engage in aggression arising out of the feeling of being left out. Their frustration over unequal treatment by the society spirals into aggression.

Caste system, especially in India, is a major determinant in the functioning and behaviour of the individual. Even in the era of globalization, caste system is still ingrained in many social interactions and practices such as rituals, marriage, and other intimate relationships. Inter-caste love relationships and marriages have witnessed a lot of aggressive behaviour by the families of both the boy and girl. When a person feels rejected by others in the society, it leads to social pain, creates frustration and anger, and generates aggression and violence. For example, when a girl rejects the romantic advances of a boy, the latter faces social rejection. This, in turn, may lead to abuse, stalking, rape, acid attack, and even killing of the girl. Of course, various other factors may mediate here. The instances of honour killings happening in some parts of India are also examples of caste intolerance and aggression. Barrett (2017) defines the term 'culture-of-honour' as a society in which people, especially males, are highly protective of their reputation and very sensitive and reactive to personal insults, humiliation, and other threats to their honour.

Culture influences our cognition, affect, and behaviour. Socialization process in a culture affects which traits are valued and appreciated in a culture and so on. If the culture permits aggressive tendencies, the child develops a predisposition to aggression. This also explains the gender socialization in our culture where boys are allowed to show some aggressiveness and is considered to be permissible by the society.

Media—Influence of media can lead to aggression and violence. Depiction of aggression and violence in various forms of media ranging from print to television, films, online/video games, etc. leaves an impact on the impressionable young minds. Seeing aggression on media also leads to physiological arousal which predisposes the individual to be more aggressive. Repeated exposure to such violence makes one desensitized and accepting of such violence. As reported by Warburton (2014),

violent media exposure increases the likelihood of aggressive behaviour and causes desensitization to violence in both the short- and long-term. There is a strong relation between watching TV violence and aggressive behaviour, as strong as that between studying and academic grades (Bushman & Huessmann, 2010). Further, exposure to media violence leads to hostile biases in thinking, increased aggressive thoughts and feelings, and decreased empathy and prosocial behaviour (Krahé et al., 2012).

Media impact operates through observational learning and modelling. Repeated exposure leads to creation of aggression related knowledge structures and scripts. In the presence of the situational cues related to aggression, these aggressive scripts may be played by the individual. The classic study (Bandura et al., 1961) regarding the role of imitation and observational learning in the aggressive behaviour of children was the Bobo doll experiment. Here children from 3 to 6 years of age observed a human adult model acting aggressively towards a Bobo doll (a toy like doll). It was found later that children who were exposed to the aggressive model showed more physical aggressive behaviours than those who observed the non-aggressive model.

Playing of video games has also been a major concern in the present times. The young generation today is faced with new games from time to time like 'Blue whale', 'PUBG', etc. which they succumb to and then the games start controlling their lives. Violent video games also have a negative impact on the youngsters. People are more active while playing the video games. They control and operate the things and achieve targets/goals in the game. When one is active, one is more involved and learns things better. When people get involved and identify with a violent character, they are more likely to behave aggressively themselves (Konijn et al., 2007). Further, they get rewarded by points or such things as 'nice shot' when they shoot the enemy. Thus the thought and behaviour related to shooting and killing the enemy get rewarded and strengthened. When it occurs repeatedly, there is likelihood that it gets reflected in the real life situations also. Polman et al. (2008) found that playing violent video games has more impact than simply watching others playing violent video games. They found that children tended to show more aggressive behaviour after playing violent video games as compared to their counterparts who only watched others playing it or the non-violent video game control group.

Studies (Anderson et al., 2010) have linked playing of violent video games to aggressive behaviour among the adolescents and the youth. The thrill of engaging in shooting actions in the video games gets transferred to shooting spree and other aggressive behaviours in real life situations (Bartlett et al., 2008). Prescott et al. (2018) conducted a meta-analysis of 24 studies from around the world from 2010 to 2017 on the influence of video game violence (VGV) on aggressive behaviour. It included 17,000 participants comprising of various nationalities and ethnicities with mean ages from 9 to 19 years. They concluded that playing violent video games is associated with greater levels of overt physical aggression over time, after accounting for prior aggression.

Media related violence also includes incidences of violence related to online harassment, stalking etc. which can be described under the umbrella term of cyber-bullying. Cyberbullying involves perpetration of aggression through the use of online media by using the electronic devices of computer and mobile. Whitty and Young

(2017) define cyberbullying as intended and repeated harm caused by communication via use of computers, mobile phones, and other electronic devices. Harassment and trolling through social media causes agony to the victim and may lead to cases of suicide also. Easy accessibility and anonymity in online media have resulted in the increase in cases of cyberbullying. One can conveniently engage in aggression against someone from the safe confines of his/her home without being physically aggressive.

Substance use—Use of substance which causes impaired judgement on the part of the individual may lead to aggressive behaviour. Frustration may lead the person to use substance and frustration may also lead to aggression as discussed earlier. Impaired thinking, judgement, and lessening of moral standards under the influence of substance use lead to aggression. Adolescents may take to substance use due to various reasons including peer pressure. Their still developing cognitive and affective system make them vulnerable to aggressive behaviour related to substance use.

Family environment and parenting style—The nature of interaction within the family, the degree of closeness among the members, the problem solving, and communication approaches used in the family affects the development of the person to a great extent. The child acquires the faulty conflict management styles of the parents and learns the aggressive ways of interaction. Family exerts its influence through the socialization process involving discipline, social norms and impositions, and parental injunctions. Harsh and strict parenting may lead to aggression in the children which may be manifested or stay latent. However, emotion regulation by children can also mediate the effect of harsh parenting on child aggression (Chang et al., 2003).

Family disturbances, maladaptive family functioning, substance abuse, abusive parents, and child abuse may lead to aggressive behaviour in the individual. In addition, psychiatric disorders in the parents may also play a role in aggression and violence in the young.

School and peer influence—Since children spend a major chunk of their time at school, the school environment can substantially influence, either negatively or positively, aggressive tendencies (McEvoy & Welkar, 2000). Peer relationships can also increase risks for violence regardless of neighbourhood types and socio-economic condition (Beyers et al., 2001). The influence of peer group on aggressive behaviour of the child operates through presence of deviant peer group that reinforces and encourages aggression in the child. But how does a child get into the anti-social peer group? It may start with peer rejection. Rejection by the peer group may lead into the process of affiliation with the anti-social peer (Loeber & Stouthamer-Loeber, 1998) and increase the likelihood of aggressive behaviour (Miller-Johnson et al., 2002).

Thus multiple factors in interaction with each other determine the risk and protective factors in case of aggression. A predominance of risk factors and insufficient protective factors may lead to aggression.

Impact of Aggression and Violence on Youth

Aggressive behaviour adversely impacts one's personal development, social relationship, and work life. Rising incidences of aggression among the youth has led to impact on the individual as well as the society. At the individual level, it affects their school achievement by negatively affecting their cognition, school attendance, and school connectedness (Basch, 2011). Feelings of insecurity leads to avoidance of the school by the students and staying absent.

School related aggression and violence affects the teaching–learning atmosphere in the school. Exposure to disruptive and aggressive behaviour in school affects the psychological well-being of the children. They face difficulty in adjusting to the school and their peer. Youngblade et al. (2007) in their study found that school violence was associated with internalizing behaviours (e.g., depression, anxiety, sadness, withdrawal) and externalizing behaviours (e.g., problems with conduct, getting along with others, bullying).

At the society level, the impact of aggression and violence operates on a large scale and affects the health of the community and society in a negative way. Mass shootings, terrorist attacks, public riots, and violence create an atmosphere of fear and insecurity, lack of trust, and helplessness. Some individuals will have direct exposure to such violence whereas others will have an indirect exposure and effect on their development and quality of life.

Thus aggression and violence not only results in physical destruction of properties but also impacts the mental and emotional well-being of people. It may also result in depression and other mental disorders, disability, and loss of life.

Intervention and Preventive Approaches

Aggression and violence is growing in alarming rate in the present times at a global level such that the WHO has declared it as a public health issue/problem. However, violence can be prevented and its impact can be lessened. Further, violence is commonly perceived as related to physical aggression and to be addressed by the police and criminal justice system. There is lack of awareness about the prevalence and magnitude of various other forms of violence which need equal attention and action. Several strategies and approaches can be used to tackle such varied types of aggression and violence.

Aggression in the adolescents is also associated with other kinds of problem behaviour such as substance use, rash driving, bullying, lying, stealing, school dropout, and truancy. Though it may not be said which one causes the other, it is important to recognize these associated problems when we talk about the prevention and intervention for aggression. There are different types of violence such as spousal violence, domestic violence, media violence, and violence in the society. These exposures make the youth conditioned and desensitized to violence and they

accept aggression as an expected way of behaviour. Approaches for intervention need to take a holistic view of the situation of the youth engaged in violence.

As discussed earlier, aggression is caused by a multiplicity of factors operating within various ecological systems like family, school, and peer group. Hence the intervention approach also needs to be multifaceted, focusing on different aspects. Further, it has been reported that childhood aggression leads to violent juveniles (Farrington & Loeber, 2000). However, not all cases of childhood aggression continue to violence in adolescence and adulthood. So, what are the protective factors that protect some children from turning into violence?

Overall, preventive and intervention strategies can be described under the following three categories (Domitrovich & Greenberg, 2003):

- Child-focused interventions that attempt to reduce risk by improving social, emotional, or cognitive skills.
- Parent-focused interventions that improve parental functioning, parental child-rearing skills, or the quality of the parent–child relationship.
- Multi-component interventions that integrate several interventions and target multiple contexts.

Some specific strategies/techniques for the intervention and prevention of aggression include behavioural interventions, social skills training, cognitive interventions, school interventions, parent training programmes, anger management, breathing, and mindfulness.

Behavioural interventions make use of reinforcement and aim at reducing the inappropriate or undesirable behaviours. Examples of two such techniques are token economies and contingency contracts. Token economies refers to providing tokens to the individual when s/he shows desirable behaviour. The tokens can be exchanged later on for some rewards. This method is based on the famous behaviourist Skinner's theory of operant conditioning. Skinner's theory has also given rise to contingency contract which as the term implies is a contract between the parent or teacher and the child or between the counsellor and the client. The contract specifies the goals (it may be behavioural or academic targets) to be achieved and the consequences received in case of either achieving or not achieving the set goals. Thus the consequence or reward is contingent upon whether the child achieves the targets. Since it is called a contract, the child should be involved in the contracting process, and it should be mutually agreed.

Social skills training (SST) It is based on the premise that children engaging in aggressive behaviour lack the necessary skills for an appropriate social interaction. Hence training in various social skills such as communication skills, conflict management, and managing emotions will help to reduce their aggressive behaviour and improve their social interaction.

Influence of family and peer group plays a major role in learning aggressive behaviour. If the socialization processes within the family have not been conducive to the child's development, s/he will not acquire required social competence. This may lead the child to adopt undesirable, aversive, and aggressive behaviours which

then transfer to the school context and peer group. As Pepler et al. (1995) have suggested, aggressive children's dysfunctional behavioural, affective, and cognitive processes are initiated at home and transferred to the peer group, where they may be fostered, maintained, and exacerbated.

Hence, aggression prevention and intervention programmes need to aim at enhancing the social skills of such children.

Cognitive interventions focus on changing thinking or cognitive skills and social problem solving. Studies have found out the effectiveness of various techniques, e.g., Denson (2015) provides evidence for the effectiveness of four psychological interventions such as cognitive reappraisal, self-control training, cognitive control training, and mindfulness to reduce reactive aggression. Cognitive approach to management of aggression focuses on the restructuring of one's thought processes. The thought that 'how the other person can tell me to drive proper, I know better' leads one to act aggressively. Hence changing the dysfunctional thoughts is the key in cognitive interventions.

Effectiveness of behavioural interventions such as parent management training (PMT) and cognitive-behavioural therapy (CBT) has been studied in randomized controlled trials with regard to anger, irritability, and aggression in children and adolescents (Sukhodolsky et al., 2016).

Other intervention programmes like **anger management** and **mindfulness training** can also be used for reducing aggressive behaviour.

Wilson and Lipsey (2007) based on a meta-analysis conclude that **school-based intervention** programmes can have a crucial role to prevent and reduce aggressive behaviour.

Preventive strategies can also be implemented in the schools to deal with the rising aggressive instances. These can include (a) surveillance (e.g., metal detectors, security guards); deterrence (e.g., disciplinary rules, zero tolerance policies); and psychosocial programs.

Public health approach (PHA) is a crucial strategy to follow given the magnitude and impact of violence across the nations at a global level. Public health approach implies steps for prevention and intervention at the individual as well as general public/community/society level. It concerns the health and well-being of the people as a whole. Examples are polio eradication campaign, eradication of tuberculosis, etc. by the Government of India. The PHA advocates an interdisciplinary approach deriving from health, education, law, etc. It underlies a collective action towards dealing with a particular issue/problem. It addresses the problem at three levels: *primary prevention, secondary prevention, and tertiary prevention.* In primary prevention, the issue of violence is addressed before it occurs, e.g., training the children in social skills, enhancing emotion regulation skills, mindfulness training, school-based prevention strategies, etc. Secondary prevention refers to addressing the immediate needs after the violence, like providing health service, counselling, etc. Tertiary prevention is long term, addressing the long term impact of violence related to disability, rehabilitation, etc.

Public health approach follows a *four-step process*: (i) Building the base-knowledge acquisition about basic aspects of aggression, e.g., prevalence, nature, scope, etc. of aggression; (ii) knowing the 'why' of aggression, i.e., causes and risk factors; (iii) developing intervention and prevention strategies; and (iv) implementing strategies and improving the effectiveness.

Many school-based programs have been developed which aim at reducing and preventing aggression. The most widely used are the Blueprints for Violence Prevention, the Collaborative for Academic, Social, and Emotional Learning (CASEL), and the National Registry of Evidence-Based Programs and Practices (NREPP) administered by the Substance Abuse and Mental Health Services Administration (SAMSHA) in USA.

In India, organizations like Yuva Parivartan, TARSHI, Bharti Foundation, Youthreach, Youth services for peace NGO, etc. address different aspects concerning youth like skill development, reproductive, and sexual health, providing educational opportunities and so on. Expressions India is also a national life skills, value education, and school wellness program which aims at promoting positive behaviour and holistic development of children and adolescents.

Aggression is not a straight forward outcome of a single factor. The manifestation/expression of aggressive behaviour and violence is an interplay of individual characteristics as well as the risk and protective factors present. Hence a multi-pronged approach is necessary for prevention and intervention of aggression. Early recognition of at-risk warning signs by the parents and family members, physicians, schools, and teachers is crucial. Starting the intervention as well prevention at an early age is also important to get the required benefits. Family and significant others in the life of the adolescent need to be involved in any program for reducing aggression and violence. A general approach as well as a contextual approach need to be followed. As Loeber (1990) puts it, given that aggressive children comprise a heterogeneous group, interventions need to be formulated with both a central tendency and an individual difference perspective.

Conclusion

The increase in youth violence and aggression in the past 50 years has been called an "epidemic" (Glicklich-Rosenberg, 1996). The economic impact of youth violence is huge which necessitates focusing on the primary prevention of aggression and violence (Bastiaens, 2006). The chapter discussed the meaning of aggression and various risk factors that may lead to aggression. Further, it discussed the theoretical perspectives that explain aggressive behaviour and youth violence. Intervention strategies were highlighted with an emphasis on the prevention of aggression and violence. Engagement in aggression and violence by the adolescents and the young is ultimately a great loss of human resources and productivity. Hence a multi-pronged approach with various stakeholders needs to be implemented for addressing this crucial concern in the society in any nation.

Time to Reflect

> Guns not only permit violence, they can stimulate it as well. The finger pulls the trigger, but the trigger may also be pulling the finger.
>
> —Leonard Berkowitz, Emeritus Professor of Psychology, University of Wisconsin. (Berkowitz & LePage, 1967)

The above quote highlights the interplay of environmental factors and personality factors in determining the expression of aggressive behaviour. When an adolescent, especially a male, is told that he is aggressive because of his being in the adolescence stage, e.g., his bullying of a classmate in the school, are we not overlooking the other factors? Further, when an adolescent starts believing in it and thinks it is okay and normal to be aggressive, does a self-fulfilling prophecy operate here? Aggressive behaviour and violence always needs to be viewed from a plurality of approaches.

The bio ecological model of Bronfrenbrenner is a pertinent theory in this context that views a child's development in the context of the systems of relationship that constitute the child's environment. He places the child/individual as surrounded by four levels of ecosystems: (a) micro-system, the immediate surrounding consisting of family, sibling, school, work, and peer group; (b) mesosystem, interaction among the above units; (c) exosystem, refers to the extended family, neighbourhood, parent's work environment, mass media who have an indirect effect; and (d) macrosystem refers to the larger system, the socio cultural values, customs, history, laws, and social conditions. Interaction among all these levels has an influence in shaping the behaviour and personality of the child and needs to be taken into account while understanding the aggression and violence in the youth.

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Chapter 8
Psychological Trauma, Adolescence, and Post-traumatic Stress Disorder

Sujata Satapathy

Abstract The chapter provides a comprehensive overview of the link between traumatic events, adolescence, and post-traumatic stress disorder among them. It provides an introduction to traumatic life events, why adolescence is a high-risk period for trauma, multidimensional trauma impacts, the factors determining trauma impacts, and key signs of trauma in adolescents. Further, the chapter discusses how traumatic incidents affect the biology of the adolescents, key theories that explain the link between trauma and post-traumatic stress development, and finally covers specific risk and protective factors in post-traumatic stress disorder (PTSD). It talks about diagnosis, assessment, and treatment for PTSD.

Keywords Trauma · Adolescence · Post-traumatic stress · Post-traumatic stress disorder · Psychological assessment · Interventions · Role of parents

Introduction

Originating from Greek language, the word "trauma" means "wound" (Webb, 2004). It is experienced at a biological level even though it starts from a psychological source. Pavlov (1960) described it as a lasting psychological alteration within the brain. According to van der Kolk (2000), trauma occurs when an individual feels helpless and loses the sense of having a safe place to retreat to and process the emotions or experiences.

Psychological trauma generally refers to any incident/experience/exposure that is a threat to an individual's existence, a violation of basic survival rights, an intensely stress producing event that overstrains the individual's existing resources, a sufficiently intense event to defeat defense mechanisms (Brette, 2004), and shatter fundamental assumptions one has about oneself and the world (Janoff-Bulman, 1992). A traumatic stressor is a broad term that encompasses a variety of experiences and situations ranging from an observable threat of death, disease, disability, and disasters

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to less observable threats such as abuse, violence in family, and detachment from attached figures.

Psychological trauma is the unique individual experience of an event or enduring conditions in which the individual's ability to integrate his/her emotional experience is overwhelmed and the individual experiences (either objectively or subjectively) a threat to his/her life, bodily integrity, or that of a caregiver or family (Saakvitne, et al., 2000). It is a multidimensional socio-cultural context. Nevertheless, when a particular experience is beyond a normal human experience, it is regarded as traumatic across cultures (Rajkumar et al., 2013).

Trauma is considered *acute* when it is a single episode of traumatic event such as a car accident, major theft, and witnessing a violent event but severe enough to have a significant impact on the child. *Chronic trauma* refers to the experience of same traumatic event occuring repeatedly for a long period of time, e.g., long-term child abuse, ongoing sexual abuse, living in a violent environment, neglect, etc.

The stress arising out of the trauma experienced is called **Post-traumatic stress (PTS)** which is a common and often adaptive response to any stressful situation. Physiological and mental signs and symptoms may include racing heartbeats, shaking hands, sweating, or feeling scared and nervous, tensed muscles, and breathing faster. These are usual "fight-or-flight" responses of General Adaptation Syndrome (GAS) where the body stops non-critical functions like digestion and diverts more blood and oxygen to the muscles to deal with the emergency.

Since this fight-or-flight response is a normal reflex, post-traumatic stress is considered a normal reaction and not a mental disorder. Treatment is not required as the symptoms are likely to subside on their own. However, if adolescents are troubled with the symptoms, there is a risk that they may develop maladaptive coping mechanisms such as drinking alcohol or using drugs. Further, it may lead to **Post-traumatic stress disorder (PTSD)** which is a debilitating, commonly chronic, and diagnostic mental disorder. Repeated and prolonged exposure to trauma in childhood severely exacerbates the symptoms of PTSD—often referred to as complex PTSD (cPTSD) (Cloitre et al., 2009).

PTS and PTSD:

- While PTS symptoms improve or resolve within a month, PTSD symptoms are more severe, persistent, can affect biological and socio-occupational functioning, and can last for more than a month.
- Most people with PTS do not develop PTSD. People can develop PTSD without first having PTS.
- PTS requires no medical intervention, unless symptoms are severe. However, psychological healthcare support can prevent symptoms from worsening.
- PTSD is a medically diagnosed condition and should be treated by clinicians.

Trauma, Biological Foundation, and Adolescence

Adolescents typically are at high risk for experiencing traumatic events. Several factors contribute to this in an interactive way ranging from biological, typical developmental characteristics of adolescents to socio-cultural influences. Since adolescence is a growing stage, all the aspects of development are affected by trauma. Adolescents are more vulnerable to physical, social, emotional, and cyber bullying in and outside the school, peer group violence, sexual abuse during dating, involvement in high-risk behaviours such as substance use, and high-risk sexual behaviour (Norwood et al., 2000). It can result in declining school performance, behavioural and socio-emotional problems and other issues that can affect the daily functioning of the adolescent, their quality of life and future.

Trauma experienced during adolescence is particularly important due to the significant brain (neuro-cognitive) development that occurs at this age (Hales & Yudofsky, 2003). Traumatic events can change major structural components of the central nervous system and the neuroendocrine system (Shaw, 2002) leaving a lasting effect on learning and information processing capability. It affects the cell production in brain and the secretion of hormones. It also might delay the development of the prefrontal cortex leading to heightened domination of amygdala resulting in emotional dysregulation.

"Some Interesting Facts About Adolescent Brain"

"Use it or lose it" cells

Adolescent brain is characterized by a huge increase in cell production, which indicates a rich potential to develop new skills. Lack of proper stimulation and guidance leaves these additional brain cells unused leading to their eventual decay. Though adolescents may learn these skills later on, this can greatly delay the process.

Neural Highway Repairs

There needs to be communication among different parts of the brain to function effectively. Myelin, a coating that speeds up communication on the neural highway between parts of the brain, grows in adolescence. To make this possible, the production of serotonin, a hormone that enhances mood, is slowed down. This explains the mood fluctuation experienced by adolescents frequently.

Prefrontal Cortex and Amygdala (Cognitive Brain and Emotional Brain)

Prefrontal cortex part of the brain controls impulsivity, decision-making, prioritizing, displaying appropriate behavior, empathy, etc. However, as the prefrontal cortex is developing in adolescents, the amygdala—the more emotional part of the brain may dominate which explains adolescents more often interpreting situations through an emotional mind rather than a rational one. This has implications for emotional regulation skills in adolescents.

Brain Development in Adolescence and Role of Trauma

Myelin development in the brain has been found to be important for adolescent learning, cognition, and behavior (Corrigan et al., 2021). Myelination process occurs from caudal to the rostral (i.e., back to front). Thus, prefrontal areas related to reasoning and judgment mature later as compared to the sensory and motor regions of the brain in the back. Further, depending on individual's life experience and the use of brain pathways, only the active neuronal connections are strengthened, whereas other inactive neurons result in cell death. This decrease in gray matter (cell bodies) occurs due to a process of "pruning." This implicates the inability of adolescents to think through the consequences of their behaviours and acting rashly and impulsively.

The body makes a number of profound physiological changes in case of traumatic life experiences. A highlight on the body's nervous system and endocrine system, which are the regulators of the body's physiological stability or homeostasis will be helpful here to understand how a child experiencing trauma processes it.

(a) ***The Nervous System***

The nervous system has three core functional roles in the communication networking of the brain: (a) detect information received by sense organs and internal organs, (b) organize that information, and (c) activate appropriate and adequate responses. The autonomic nervous system (ANS) oversees involuntary bodily functions or responses including our capacity to socially engage, trust, and intimacy. It evaluates events and people for their survival significance and prepares the body for appropriate response/action. While the sympathetic branch initiates actions or mobilizes physiological responses for either fight or flight under stressful circumstances, the parasympathetic nervous system modulates these physiological responses, e.g., heart rate, etc., to conserve energy. When both branches move in a flowing and reciprocal manner, the body's internal state is regulated and the body feels stability and at ease.

Here, let us know about the **Polyvagal theory** to understand the complexity of ANS in its capacity to switch between defensive strategies and a socially engaged sense of safety and connection (Porges, 2001). The phylogenetic emergence of dorsal vagus (which is an older, more primitive, reptilian and vegetative structure and emphasizes on the brainstem's involvement in the defensive strategies of immobilization e.g., fainting or dissociation) and ventral vagus (limbic-based system that modulates sympathetic arousal through social engagement to defuse aggression and tension) as explained by this theory throws light on evolutionary changes in the adaptive nature of the body's physiology. When the body experiences trauma at an early age, the dorsal vagus' defensive strategies of immobilization come to operate leading to freeze, faint, and even dissociation. As a result, the ventral vagus fails to adequately develop, hence, child's social development is impaired and the body automatically favours withdrawal from social engagement to control state of arousal. On a physiological level, the impact of early trauma on the vagus nerve, the 10th cranial nerve of the body which renders to larynx, pharynx, heart, lungs, and gut, leads to a variety of physiological responses thus, impacting myriad psychological,

social, and behavioural symptoms consequent to the traumatic experience (Heller & LaPierre, 2012). As the brain does not have a central processor, through a process called **Reentry** the brain weaves together the information entering into different regions via their respective quale (discrete attributes of the reality and storing that in a specific region. For instance, colour is stored in visual cortex and sound is stored in auditory cortex separately to create a coherent whole of the circumstance.

This crucial function of the brain to integrate and blend the quale—that is the process of reentry, fails when there is early trauma. And this failure of reentry process results in unprocessed sensory information remaining in disconnected fragments or interferes with the brain's capacity to organize information together to produce a coherent narrative. Neural plasticity of the brain can also be affected during the sensitive phase of adolescence.

(b) ***Endocrine System***

The endocrine glands produce a chemical network of signals that keeps the entire body under control by regulating vital metabolic. Growth and maintenance of our body depends largely upon the coordinated functioning of the nervous and endocrine systems—often referred to as neuroendocrine system. If the stress-induced hormonal changes remain chronically high, the body loses its capacity to adapt and recover which leads to adrenal fatigue and exhaustion (Selye, 1956).

Early traumatic stress affects the *Hypothalamic–Pituitary–Adrenal (HPA) axis* that regulates cognitive, immune, and behavioural responses to stress (Lupien et al., 2009). Severe trauma during childhood also contributes to increased HPA axis activity and higher cortisol production. This affects the smooth functioning of the neuroendocrine system that can lead to various disorders including post-traumatic stress disorder. For example, interpersonal trauma affects cortisol regulation and the corresponding decrease in brain volume (Carrion et al., 2010). In the case of severe trauma and resulting PTSD, high levels of cortisol can cause cell damage and even complete shutdown of hippocampus risking memory impairment (Heller & LaPierre, 2012).

The Sympathetic-Adrenal-Medullary System indicates that in the event of chronic traumatic stress, adrenal medulla releases adrenaline (epinephrine) and non-adrenaline (non-epinephrine) hormones leading to key physiological changes in the body, e.g., increased heart rate, increased blood sugar, constriction of blood vessels, pupil dilation, etc.

Since cortical and limbic systems of the brain are inseparably interwoven and the thinking brain is built upon the foundation of the emotional brain, the excessively high levels of emotional arousal can impair memory in case of constant threat. Derailment of normal bio-chemicals can have negative effects on immunity and may cause mental disorders.

Multidimensional Impact of Trauma

Almost all children and adolescents experience some kind of psychological distress or behavioural change, e.g., nightmares, difficulty in sleeping, anxiety, irritability, anger, etc., after trauma exposure (American Psychological Association, 2015). Most children can successfully overcome this and be resilient in the face of adversity. However, some may end up having mental health problems such as post-traumatic stress disorder (PTSD) that can affect their overall daily functioning (Fairbank & Fairbank, 2009).

Physical Effects

Traumatic events such as a high magnitude earthquake can impinge loss of limb/vital body organ; sexual abuse can lead to unwanted pregnancies, sexually transmitted diseases, anal/ vaginal itching, etc.; and physical abuse may result in grave injuries and burns. Other physical impacts of traumatic incidents can be exhibited in having problems in sleep, appetite, controlling bladder and stool, unspecified body pain, headache, pseudo seizures, loss of memory, etc.

Risk of Mental Illness

Severe and prolonged exposure to traumatic events in adolescents along with lack of proper treatment and presence of other risk factors can result in the development of psychiatric illness such as post-traumatic stress disorder, acute stress disorder, somatization, adjustment disorder, eating disorder, and obsessive–compulsive disorder. Common comorbid disorders in adolescents with PTSD include mood disorders, behavioural disorders, anxiety disorders (Copeland et al., 2007), and PTSD with/without dissociative disorder (Choi et al., 2019). It is important to understand the comorbidity of PTSD in adolescents as it can influence the diagnostic process, the course, prognosis, and treatment (Burgic & Burgic, 2010).

Behavioural Effects

Trauma can impact adolescent behavior in the following ways: anger, aggressiveness, mood swings, substance addiction, self-harming, suicide, disruptive behavior, conduct problems, hyperactivity, withdrawal, regressive behaviours, and inappropriate sexual behaviour (e.g., in case of sexual abuse).

Effects on Interpersonal Relationship

Trauma may affect the quality of interpersonal and peer relationships of adolescents. Important social consequences of traumatic life events may include poor social competence, reduced peer attachment, delinquent or antisocial activities, and increased risk of trafficking.

Effects on Academic and Non-academic Performance

Sudden deterioration of academic and non-academic performance, attention and concentration difficulties, difficulty in remembering, and retention are some key performance-related issues that adolescents may encounter in the post-trauma phase.

Effects on Emotions

Apart from fear, anger, low mood, guilt, shame, and self-blame, adolescents may experience low self-image, lack of self-esteem, and feeling of hopelessness.

The extent of impacts of any traumatic incident depends largely upon the type and gravity of the trauma, and the risks and protective factors present in the life of the adolescent.

Factors Determining the Impact of Traumatic Events

The followings are a few key factors that play in determining the impact of any traumatic event on an adolescent:

- Age**:** Impact of trauma, particularly intentional or interpersonal trauma could be very damaging in the early adolescence as compared to late adolescence due to continuation of physiological, cognitive, emotional, and social development.
- Sex**:** Female adolescents are more vulnerable to trauma as well as developing psychopathology after trauma if not dealt with appropriately. Boys will be more vulnerable to developing aggressive, deviant, and conduct problems.
- Gender stereotypes and culture: If the society at large, wherein the adolescent lives, has a lot of gender-related stereotypes and stigma in its culture, then social stigma, shame, insecurity, and isolation for the adolescent will increase. And this in turn may contribute to developing psychological problems and may affect their resilience negatively.
- Frequency: Chronic and complex traumatic events have more harmful impacts than a single event.

- Relationships**:** Positive relationships with healthy caregivers help the children recover faster.
- Coping skills: Children having better emotional intelligence, physical health, resilience, optimism, and self-esteem cope well and faster.
- Perception: Cognitive appraisal of the incident and the emotions the adolescent is attaching to trauma-related thoughts and memory influence the development of PTSD or any psychopathology.
- Sensitivity: Every adolescent is unique in that some are more sensitive and emotional than others. Some have a higher stress tolerance threshold than others. Some are expressive and brave to face the challenge they faced but some are not.

A majority of adolescents are resilient and can deal with trauma with minimal amount of careful and sensitive support. It is always crucial to analyse the risk, maintenance, and protective factors in the adolescent so that effective steps can be taken for prevention and intervention.

Signs of Trauma in Adolescents

The following signs can be considered as red flags subsequent to the traumatic incident.

- ***Thought and Cognition***
  - Talks about the trauma incident constantly, or denying that it happened
  - Stays absent mindedness for a significant period and on many occasions
  - Remains disoriented and disinterested
  - Talking about meaninglessness of life, death, suicide, etc.
  - May talk about revenge in specific traumatic incidents
  - Excessive negative thoughts which break the attention and concentration

- ***Behaviour***
  - Refuses to follow rules, or being argumentative frequently
  - Gets involved in risky behaviors such as indication of smoking, alcohol, drug, disinhibited behaviour (over familiarity with known and unknown people, quick to fall into a relationship even after knowing the risk, running away from home, getting involved in illegal activities, etc.)
  - A general increase in aggressive behaviours and may get involved in physical fighting over petty issues
- ***Mood and Emotions***
  - Frequent mood fluctuations
  - Increased agitation and irritability
  - Crying incessantly without any provocation
  - Losing interest in activities enjoyed earlier
  - Being tired all the time, sleeping much more (or less) than usual, having nightmares
- ***Social and Performance***
  - Avoids spending time with friends or sudden social withdrawal from peers and family members
  - Shows lack of interest in studies and/or sudden deterioration in academic performance
- ***Perceptions***
  - Often may scream during sleep
  - May talk with someone who does not exist in real
  - May see or hear something/somebody when actually things/people do not exist in real
- ***Other Red Flag Signs***
  - May harm self or even attempt suicide
  - May lose consciousness or faint or have unresponsive spells, which was not there before the incident.
  - In severe case, may remain in a particular position for long hours.

In a nutshell, caregivers need to be vigilant at least till three months post-traumatic event to notice any significant change in thoughts, emotions, perceptions, behaviours, and performance of the adolescent. Nevertheless, red flag signs and signs of perceptual abnormality require immediate medical attention. The list of signs provided here is not exhaustive rather indicative. Depending on the risk and protective factors, the signs and symptoms vary among adolescents even having same traumatic experience.

Key Theories on Psychological Trauma and PTSD

Some of the key theories linking the impacts of traumatic life incidents and PTSD are stress response theory (Horowitz, 1986), conditioning theory (Keane et al., 1985; Mowrer, 1960), the theory of shattered assumptions (Janoff-Bulman, 1992), information processing theory, and cognitive model (Ehlers & Clark, 2000).

Stress Response Theory: Horowitz (1986) offered a sequence of loss and trauma-related human responses ranging from outcry in the beginning in response to the trauma to active and passive coping mechanisms such as deep-rooted psychological defense mechanisms and assimilating trauma information. While the first response is to avoid memories of the traumatic incidents happening at an unconscious level, the need to integrate the new and old information drives the individual to organize the trauma memories by actively breaking these into intrusions, flashbacks, and nightmares at a consciousness level. As these two opposing processes (one trying to suppress the trauma information and the other trying to process it by bringing it to the conscious level) work simultaneously, there is avoidance of the trauma by the person as well as intrusions of the trauma. This fluctuation helps the person to work through the trauma, leading to reduction of the intensity of traumatic memories (in terms of emotions, thoughts, images, sounds, etc.). Absence of such processing of trauma information results in mental health problems.

Conditioning Theory: This theory explains the role of conditioning response mechanisms of developing fear and anxiety responses. For example, in an adolescent rape case, an unconditioned stimulus (coming back from a friend's house alone) gets associated with an unconditioned fear, intense emotion and anxiety response (rape trauma experience), and may result in strong anxiety and PTSD response (unconditioned response) whenever the adolescent goes out of home alone. Although this theory was initially credited to Mowrer (1960) for his two-factor learning theory, this was expanded by Keane et al. (1985) by explaining the mechanism of maintenance of PTSD reactions. They highlighted processes of stimulus generalization and higher order conditioning emphasizing the role of various associated stimuli in arousing fear. Avoidance of the conditioned stimuli by blocking out the traumatic memories or through distraction will provide short-term relief to the individual, but over long term, it would lead to maintaining of PTSD symptoms as the exposure to traumatic information was incomplete. Extinction could have occurred with repeated exposure to spontaneous memories of the trauma.

Information-Processing Theory: While behavioristic and learning theories primarily focused on the traumatic event and fear conditioning, the information processing theory (Lang, 1979) focused on how the failure of appropriate processing of wider memory or information associated with the personal and social context of that traumatic event could be risk factor for developing psychopathology. Lang proposed that the memory associated with frightening events consists of a fear network consisting of (a) stimulus information about the traumatic event, such as sights and sounds, (b) inputs regarding the emotional and physiological response of the person to the event, and (c) meaning information, regarding the degree of

threat). This fear network stays continuously activated in PTSD resulting in high levels of arousal and persistent re-experiencing (Chemtob et al., 1988), thus making it different from specific phobias. Further, the effects of individual perceptions and subjective meaning on the fear network in PTSD are different from other anxiety disorders (Foa et al., 1989). For example, someone who was raped on a dark and less crowded road would form stronger generalized associations between the characteristics of the road with fear and its behavioural and physiological responses. Now having to walk down on another such road would selectively activate the fear network in memory resulting in (a) the arousal symptoms of PTSD (e.g., making the person hypervigilant, (b) the intrusion symptoms of PTSD (e.g., information in the network entering into the consciousness, and (c) the avoidance symptoms of PTSD (i.e., trying to avoid and suppress the intrusions).

The Theory of Shattered Assumptions: This theory (Janoff-Bulman's, 1992) focuses on shattering of a set of fundamental assumptions of the individual about themselves and the world, in the event of a trauma. It challenges and rejects the deeply held global beliefs and values such as benevolence and worthiness of the self. Coping here involves rebuilding a viable assumptive world.

The theory highlights two aspects: firstly, the *pre-trauma risk factors*, for example, rigidity in one's belief system may increase the risk of PTSD. Rigid positive views or rigid negative views about the self and the world in terms of safety and competency, etc., can be extremely dangerous. Secondly, *negative appraisals of responses and behaviors* related to the traumatic event can intensify the risk factors.

Cognitive Model: Ehlers et al. (2002) focused on the cognitions related to the traumatic event. They highlighted the nature of the trauma memory and the negative cognitive-affective appraisals of the trauma. These are characterized by overgeneralization of danger (e.g., 'I am the only victim') or negative appraisal of own actions (e.g., "whatever I do, it results in negative things'), a sense of numbness ('I can no more form relationship with people') thinking about other people's reactions ('others' think I am no good, and cannot cope on my own') and so on. The prior beliefs and experiences of the person will influence the negative appraisals of the person during and after the trauma.

PTSD in Adolescence

The evidence-based research focusing on the association between trauma and post-traumatic stress symptoms among adolescents has largely stemmed from studies on natural disasters, war, political conflicts, terrorism, trafficking, and maltreatment. The risk factors for PTSD in adolescents are comparable to adults, including the level of exposure, magnitude of loss, extent of disruption of social support systems, and pre-trauma levels of psychopathology (Caffo & Belaise, 2003). These risk factors during adolescence could be a complex set of bio-psycho-social-ecological risk factors operating in various contexts namely self, family, school, peer group, neighbourhood, and virtual world. Risk factors for PTSD in adolescents can be categorized into several

clusters: (i) pre and post-trauma variables, (ii) aggravation of risk factors, and (c) characteristics of the trauma, the child, family, and socio-political-legal systems.

(i) **Pre-post-trauma variables**: Studies point out at the various pre-post-trauma variables such as poor family interaction, low social support, comorbidity of psychological problem, and perceived life threat which determines the development of PTSD in the child after traumatic experience (Trickey et al., 2012).

(ii) **Aggravation of risk factors**: Adolescent experience of trauma can be affected by various potential risk and protective factors such as community context (e.g., poor and low socio-economic condition in neighbourhood), family risk (e.g., dysfunctional family), behavioural maladjustment (e.g., adolescents having internalizing symptoms), cognitive vulnerabilities (e.g., low intellectual ability), and interpersonal problems (e.g., poor/lack of social support). Presence of such factors can aggravate the likelihood of trauma occurrence and experiencing trauma symptoms.

(iii) **Specific Characteristics of the Event, Survivor, Family, and Larger Social Support System**:

(a) ***Characteristics of the Trauma Event***

Studies report that traumatic events such as family violence, death of someone close to the child (McClosky et al., 2000); physical and sexual abuse by caregivers (Alisic et al., 2014); displacement and being refugee (Attanayake et al., 2009); and war (Trickey et al., 2012) increase the risk of PTSD in children. Further, cumulative and complex traumatic events that pose serious life threat are most likely to cause PTSD (McLaughlin et al., 2013).

(b) ***Child Specific Characteristics***

Among the specific characteristics related to the child are female gender (McLaughlin et al., 2013) who may experience certain traumatic events such as rape and sexual assault, which increase the likelihood of post-traumatic stress disorder. Other specific risk factors for PTSD among adolescents are low intelligence, low education level, multiple disability, lower socio-economic status (Margoob et al., 2006, Margoob et al., 2006; Ahmad, 2007). Further, children and adolescents having pre-existing mental disorders such as anxiety and mood disorders are more likely to develop PTSD following a traumatic event than those without a prior mental disorder (Alisic et al., 2014; McLaughlin et al., 2013).

(c) ***Family Specific Characteristics***

Studies have pointed at poor family functioning (La Greca et al., 1996) and parent mental disorders as risk factor for PTSD in children exposed to trauma (Koenen, et al., 2008). However, a good family environment with non-abusive parents reduces the risk of PTSD (Ditlevsen & Elklit, 2010). Secure and healthy attachment patterns with caregivers increase resilience in children which equips the child to deal with

stressful experience (Masten et al., 1990). Social support from parents, teachers, and peers is also another crucial protective factor that can prevent PTSD (Morris et al., 2012).

(d) ***Socio-political-legal Systems***

The first step in institutional support is a well laid out legal framework in any country for dealing with various traumatic exposures, such as providing psychosocial support after natural and manmade disasters, protection of women at workplace/public place, protection of children against sexual abuse, juvenile act, etc. The organizations following a trauma informed environment protocol, ensuring social security and safety, a non-stigmatizing neighbourhood and institutions, less cumbersome legal and administrative hassles to deal with such case, etc., are a part of a supportive social-political and legal system. School as a larger social system can also provide support to adolescent through positive experiences with peers and teachers, and in general creating a positive school experience.

Diagnosis, Assessment, and Intervention for PTSD

Diagnosis

PTSD diagnosis requires the following: presence of a traumatic event, reporting of the trauma event by the child, or other compelling evidence regarding occurrence of the trauma event (e.g., evidence from police, forensic or medical evidence), specific trauma symptoms, passage of at least one month after exposure to the index trauma. Acute PTSD is diagnosed if the symptoms are present for more than one month but less than three months after the index trauma, it is called acute PTSD; whereas chronic PTSD is diagnosed when the symptoms persist beyond three months.

PTSD diagnoses in DSM-5 (APA, 2013) and ICD-11 (WHO, 2018) have been placed under "Trauma & Stress Related Disorder", highlighting changes from the earlier versions of these classification systems. Behavioural symptoms accompanying PTSD have been emphasized with a new symptom cluster 'persistent alterations in mood and cognitions'. The addition of Preschool and Dissociative subtypes of PTSD (specifically for children 6 years younger) is one key change in the DSM-5. Compared to the earlier DSM-IV, the diagnostic criteria for Further, DSM-5 provides details of what constitutes a traumatic event, e.g., sexual assault is specifically included.

Problem Magnitude and Population Profile: International Scenario

The incidence and prevalence of traumatic life incidents has witnessed a sharp increase globally due to the legal frameworks and mandatory reporting of incidents

in many countries in the last few decades. A review of 200 longitudinal studies (Fryers & Brugha, 2013) reported that among other factors, psychological disturbance; adversity; child abuse or neglect; disrupted and dysfunctional families were the significant childhood determinants of adult mental illness.

Exposure to trauma is common among adolescents of 15–16 years of age. Studies indicate that 56% of 6,700 Swiss adolescents experienced at least one traumatic event and more than a third had experienced multiple traumas (Landolt et al., 2013). In the US National Comorbidity Survey for Adolescents (NCS-A) including over 6,400 adolescents, the rate of trauma exposure was just over 60% (McLaughlin et al., 2013). While the point prevalence of PTSD was 4.2% in the Swiss study, the American study reported the lifetime prevalence of PTSD as 4.7%. Both the studies reported the prevalence rates to be significantly higher in girls. In a meta-analysis of 72 cross-sectional studies from North America, Europe, Australia, and Asia, Alisic et al. (2014) reported higher rates of PTSD associated with interpersonal or sexual trauma than exposure to non-interpersonal trauma (25% and 10%, respectively). Hiller et al. (2016) in another meta-analysis of 27 longitudinal studies, estimated PTSD rates of 21% in the acute (1 month) post-trauma phase, spontaneously declining to 15% at 3 months, to 12% at 6 months and to 11% at 1-year post-trauma.

Stephanie et al. (2019) with 2064 young adults in UK and Wales born between 1994 and 95, reported that 31·1% participants reported trauma exposure. Further, trauma-exposed participants had high rates of psychopathology (29·2% had major depressive episode, 22·9% had conduct disorder, and 15·9% had alcohol dependence), risk events (25·0% attempted self-harm, 8·3% had suicide attempts, and 6·6% committed violent offences), and functional impairment. The risk factors for PTSD in trauma-exposed participants included being of female gender, having lower IQ, and disadvantaged socio-economic conditions. Childhood victimization and direct interpersonal index trauma such as physical or sexual abuse can act as significant independent predictors of PTSD with rates as high as 58% (Makley & Falcone, 2010).

Problem Magnitude and Population Profile: Indian Scenario

The prevalence of PTSD among adolescents in India is limited to studies done on disaster-affected adolescents. While post-super cyclone in Odisha, 30.6% of adolescents had a PTSD and 13.6% had a subsyndromal PTSD diagnosis (Kar et al., 2007), one year post-cyclone PTSD came down to 27% but more importantly with a higher comorbidity mental illness in 39% of adolescents (Kar & Bastia, 2006).

While the National Crime Records Bureau (NCRB) every year reports crime against children below 18 years, it includes crimes such as rape, molestation, murder, and suicide separately, thus does not cover trauma or trauma impacts as group of events. The Government of India (2007)'s nationwide survey on child abuse and maltreatment in the age group of 13–18 years in 13 States reported the following: Among the out of school children, 23.2% of faced physical abuse, and 26.5% faced emotional abuse in family settings; whereas among the school-going children, 30.5% faced corporal punishment at school and 49.9% reported sexual abuse. However, this

study was only about indication or trend of child abuse extent in a few States. The study did not assess point or lifetime prevalence rate of trauma, or the extent of mental health impacts of abuse on children below 18 years. There is a requirement to generate a State/city specific or national specific data on traumatic life events among adolescents and the prevalence and course of mental health, particularly PTSD among them. PTSD needs to be defined in terms of contextualization and culturally appropriateness of PTSD manifestations in India (Gilmoor et al., 2019). Majority of studies have explored PTSD with existing western tools that too mainly in natural disasters.

Margoob et al. (Margoob, Khan, et al., 2006; Margoob, Rather, et al., 2006) reported PTSD to be common in children (who reported killing of their parents or they had witnessed death of their relatives, and had exposure to traumatic events) living in orphanages of Kashmir. Almost 50% had psychiatric morbidity and among that 40.62% had diagnosis of PTSD. In a sample of 411 Indian 9th graders with a mean age of 14.15 years, Rasmussen et al. (2013) found 70% of the females and 85% of the males had been exposed to or witnessed at least one traumatizing or negative life event. The prevalence of PTSD was 10%.

Differences in prevalence estimates for PTSD may be due to varied assessment methods and tools used, sample size and sampling methods, the lack of developmental sensitivity in diagnostic frameworks; lack of cultural sensitivity in diagnostic criteria of PTSD symptomatology manifestation; and the changing diagnostic criteria for PTSD in different time periods.

Assessment of PTSD

Given the importance of early diagnosis and treatment for PTSD, the clinician needs to routinely ask the child and explore possible exposure to commonly experienced traumatic events (such as child abuse, domestic or community violence, or serious accidents) and then assess for the presence of PTSD symptoms in case of reported trauma experiences.

In cases of specific trauma-related referral, an inclusive clinical assessment of PTSD among adolescents will include three key features—initial screening, detailed clinical evaluation, and treatment planning. Following are certain important points to be noted during assessment:

- Obtaining reliable information through multiple informants/sources is important in making a holistic assessment, accurate diagnosis, and consequently, comprehensive treatment planning.
- Objective observation of congruence between verbal and non-verbal body language of the patient and other informants is very crucial to understand clinical as well as other psychological aspects of the illness.
- Informed written consent is crucial for interviewing or assessing. Further, refusal of assessment or treatment should also be documented/recorded.

- Confidentiality and limit setting rules should also be explained to the adolescents.
- The purpose of any assessment and how would that help in patient's treatment and recovery should be explained before any formal assessment.
- The clinical assessment should comprise detailed history taking, observation, clinical interview, and application of some clinical screening scales or PTSD severity measures.
- Selecting a screening tool or PTSD severity measure or comorbid mental illness should be culturally compatible and psychometrically tested tools. Language compatibility is also very important to improve the diagnostic/screening accuracy.

The clinician thus needs to proceed with sensitivity and establish adequate rapport with the adolescent before assessment.

What Needs to Be Assessed?

If the screening assessment suggests PTSD, then a detailed assessment to outline the severity has to be done. The assessment is aimed to facilitate the treatment, both pharmacological and psychological.

PTSD can comorbid with other mental illnesses such as depression and anxiety disorders. Careful assessment of externalizing and internalizing behavior problems, and suicide or self-harm risks is also required. Impairment in daily functioning and self-care needs to be noted. PTSD symptoms may be similar to the characteristic of oppositional defiant disorder and attention deficit and hyperactivity disorder in that there may be irritability, anger, hypervigilant motor activity, and hyperarousal symptoms. Sensorium impairment and fluctuating levels of consciousness should also be carefully assessed and differentiated from psychosis. Assessment of somatic symptoms, cognitive appraisal of the trauma incident and people associated will be helpful in charting the psychological intervention sessions. Exploring the strengths and potentials of adolescents is also beneficial in this.

Adolescents who re-experience thoughts/emotions, it is important to frame open-ended questions before the interview/assessment. For instance, a question which yields a yes/no should be avoided (e.g., "Do you have distress at reminders of your past event?"). Reframing the question such as "When you went past the house where the event occurred, what thoughts came to your mind and how did you feel?" would yield more information on psychopathology.

Various tools can be used for screening of PTSD along with the diagnostic interviews. Juvenile Victimization Questionnaire (Finkelhor et al., 2005) validated for ethnically diverse samples of children 2–17 years of age is an important tool to determine whether children have been exposed to qualifying traumatic experiences.

Self-report measurements for PTSD such as the University of California at Los Angeles (UCLA) Post-traumatic Stress Disorder Reaction Index (Steinberg et al., 2004); the Child PTSD Symptom Scale (CPSS- Foa et al., 2001, 2018); Trauma Symptom Checklist (Briere, 1996) can help in PTSD screening and also monitoring

response to treatment. The CRIES-8 (Perrin et al., 2005) and the Impact of Events Scale (Horowitz et al., 1979) can be used for detailed clinical assessment, and also as an outcome tool.

The choice of an appropriate tool for PTSD screening needs to be based on the cultural compatibility, need, and other suitability factors. It is important that assessment is broad-based (assessing symptoms of other psychological problems also), multimodal (using both interview and questionnaire), and multi-informant (collecting information from the child/adolescent and the caregiver) so that it can result in effective psychological intervention.

Evidence-Based Intervention/Treatment

Counselors and psychotherapists dealing with adolescent trauma survivors need to keep in mind two specific points: (a) trauma can affect several developmental domains during adolescence namely, attachment systems, neurobiology, emotion regulation, behavioural control, cognitive aspects, personality, attitudes and self-concept, and (b) adolescence is a favourable stage for any therapeutic activity to reduce symptomatology and restore normal developmental domains.

Psychotherapy can be a stand-alone therapy or can be an adjunct therapy with medication for mild to moderate symptoms of PTSD. Medication can be given when there is severe anxiety, fear, and hopelessness so that the adolescent feels calmer to apply the coping strategies learned in therapy. The objectives of psychotherapy for an adolescent with PTSD are to identify trauma-specific thoughts, emotions, behaviours, specific coping strategies, and self-efficacy. It aims at helping adolescents to identify and regulate various emotions related to trauma, process the trauma-specific memories, learning not to engage in self-blame or guilt, consciously adopt positive coping mechanisms, and restore trust in people around. The focus of any psychotherapy can be customized depending on the adolescent's symptoms, his/her priority, nature of trauma, and other considerations. Family psychotherapy can also be planned along with individual psychotherapy, in case intrafamilial trauma or trauma has a link to family members or for wellness of family members.

In fact the choice of type of psychological intervention will largely depend upon the type of trauma, stage-specific symptoms, target outcomes, and suitability of setting where an intervention will be carried out. The intervention can be clinic/hospital, school, or community based. The format can be individual, group, and combination of both, if required. It can also be done online.

Trauma treatment for adolescents is broadly of two types: trauma counselling and psychotherapies in general along with trauma-focused psychotherapy. Trauma-focused psychotherapies are the first line of treatment for children and adolescents with PTSD. With a moderately robust empirical support, Trauma-Focused Cognitive Behavioural Therapy (TFCBT) is the preferred and widely used non-pharmacological treatment for children and adolescents who encounter traumatic life events. It is a structured conjoint parent–child psychological treatment protocol (Cohen et al.,

2000), which predominantly follows cognitive-behavioural-cum learning principles and exposure techniques to prevent and treat psychological trauma and its associated problems. Rational emotive behaviour therapy (REBT), dialectical behaviour therapy (DBT), eye movement desensitization therapy (EMDR), and abuse-focused therapies are also gaining empirical evidence in PTSD symptom reduction.

In the developing countries like India, childhood trauma is overlooked, underestimated and underreported, but at the same time it is very much prevalent in the form of exposure to child abuse, rape, trafficking, domestic violence, natural and man-made disasters, death and accidents of significant family members. Frequency of disasters in the country, poor socio-economic background, and chronic illness in self or family can result in multiple traumas in children. Although many evidence-based therapeutic models are available, cultural adaptation of these models according to the needs of Indian adolescents with PTSD is very important as the symptom manifestation and other key socio- cultural- and familial variables are very different in India as compared to the West. Customization and validation is recommended.

Role of Parents

The role of parents is very significant in recognizing and normalizing adolescents' thoughts, emotions, and behaviours exhibited after the traumatic life experiences. They can facilitate the post-traumatic adjustment of the child/adolescent. Parents are able to influence the engagement of the child with trauma-related material (Cobham et al., 2016). They provide a sense of security and model adaptive coping (e.g., Marsac et al., 2016).

Parent–child relationships affect the trauma memories and the appraisal of trauma events by the adolescent. Authoritative (warm and democratic) parenting style is negatively related to post-traumatic symptoms in adolescents, whereas authoritarian (restrictive and hostile) parenting is positively related to it (Zhai et al., 2015).

Hence, parents need to provide a healthy family environment to the growing adolescent and adopt principles of positive parenting. They need to control their own overwhelming emotions by not reacting, rather responding to the situation. Further, being available and acceptable to your child/adolescent is pertinent for discussing trauma-related distress. Listening to your adolescent and being extremely vigilant about any self-harm behavior is very important.

Finally, parents need to be loving, warm, and supportive, rather than being overprotective towards the adolescents. As parents, just behave the way you used to behave with the child before the trauma incident. The adolescent may have stigma related to seeking professional mental health support and parents play an important role in reducing it. Offering professional help seeking as immediately as possible in case anything goes beyond your management/control/handle.

Conclusion

Adolescence is an important stage of brain, body, and personality development. Traumatic life events are potential threats to disrupt these developmental processes. Both traumatic life incidents and the post-traumatic stress/reactions are common during adolescence. Post-traumatic stress is normal and adaptive response while PTSD/cPTSD is a complex mental disorder affecting functioning of adolescents, their quality of life, and well-being. Young people with PTSD can have complex comorbid psychopathology, particularly depression and panic attacks, which could mask the diagnosis of PTSD in trauma-exposed young people, and thus require comprehensive psychiatric assessment and treatment (Lewis et al., 2019).

The chapter discussed the diagnosis, assessment, and intervention for PTSD. Trauma-focused psychotherapy is considered the first line of treatment for adolescents with PTSD. Early identification and prevention is one critical issue that needs to be addressed in research on PTSD. Parents and other caregivers play a significant role not only in adaptive processing of such experiences but they are also crucial in the early identification of PTSD signs and treatment seeking.

There is a need for integrating enquiry of trauma exposure in adolescents in regular clinical practice. This will help in timely identification and intervention. Research also needs to focus on appropriate efficacious intervention for PTSD prevention, especially finding out the maintaining of the treatment effects in long intervention studies. Keeping the skewed ratio of mental health specialists and adolescents needing help, large-scale evaluations of treatment effectiveness of established interventions in nonspecialist community settings are needed (Smith et al., 2019).

Another critical issue is that although the trauma exposure of adolescents in low and middle-income countries is high, the evidence for clinical practice of established interventions (such as TFCBT, or adapted CBT) is almost non-existent. Hence, cultural adaptation of such intervention at research level can be facilitated if such interventions are clinically applied first. Since research and clinical practice in the area of adolescent PTSD is extremely limited in India, various issues described here need to be addressed urgently by Indian clinicians and researchers.

Time to Reflect

Adolescence is a crucial stage of development which marks the process of identity formation. Traumatic stress at this stage negatively impacts their development in all aspects. The key is preventing avoidable traumas and ensuring availability of proper resources and support measures in case of trauma exposure and experience by children and adolescents. Collectivistic societies and cultures offer a variety of support and are characterized by socialization process different from individualistic societies. Collectivistic societies offer support to the vulnerable group of children through the close-knit system of family and society. However, many cases of trauma, e.g., child

abuse including physical, sexual and emotional, domestic violence impacting children, cyber victimization, etc., are also rising in such societies. Reflect on what are the implications of collectivistic versus individualistic societies on trauma occurrence, experience, and processing in adolescents?

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Chapter 9
Depression and Suicide: An Interrelated Mental Health Challenge Among Adolescents

Archana and Updesh Kumar

Abstract The chapter focuses on depression and suicide among adolescents, a major concern and challenge faced by the young generation. Risk factors associated with both depression and suicide are discussed at length. The chapter further explores the linkage between depression and suicide. Various psychological strategies and preventive measures are described for depression and suicidal behaviour in adolescents.

Keywords Depression · Suicide · Risk factors · Cognitive behaviour theory · Family systems theory · Interpersonal psychotherapy · Adolescents · Integrative model of depression

Introduction

Depression is a most common mental illness that affects the well-being of adolescents. Untreated depression can lead to multiple consequences affecting various domains of one's existence that includes health at physical, social, emotional, and mental level. It also acts as one of the most significant risk factors for suicidal behaviour among teens and adolescents (Galaif et al., 2007). Suicide being a most serious public health issue is affected by numerous interacting factors that include socio-economic conditions, genetic endowment, psychological functioning, and environmental situations of the individual. Adolescence is an important phase towards the progression of mental health.

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Adolescence is a key developmental period of life that is marked by changes in human functioning in day to day life. This period demands developing individual identities and forming meaningful relationships. As compared to other phases of life, adolescence is characterized by more psychological difficulties in terms of adjustment that affects their mental health and well-being. The adolescence period is marked with invariable apprehensions between rising proficiencies on one hand and striving for autonomy on the other. While trying to create one's existence in this challenging world, adolescents are likely to face many adverse situations, anxiety, and impediments with a much greater intensity than before. Although the life experiences and the intensity of these emotional states vary from person to person, but they tend to be an essential aspect of each adolescent's life. Adolescents require appropriate care and ample monitoring by parents and caregivers, since they show greater prevalence of depression and mental illness as compared to people of any other age group because of their unique developmental characteristics.

Aditya, who just completed his XII standard exams, was preparing for the entrance examinations to get admission into reputed medical college. His parents had spent a lot of money on his coaching with high expectations regarding Aditya that he gets into a reputed medical college. Aditya was always an average student though he studied hard. He started complaining of having headaches, getting tired, and felt pain in his eyes while reading. Upon medical check-up, his eyes were found normal. Gradually, his headache intensified and he started facing difficulties in falling asleep at night.

Aditya appeared for the exams but could not clear. This resulted in his parents getting angry and upset with his performance. They were feeling bad for spending so much money on his coaching and keeping high expectations from him. Aditya was also disturbed on his poor result. He was frustrated, withdrew socially, started feeling worthless and guilty for not fulfilling his parent's expectations.

Adolescent Depression

According to Walker et al. (2015), depression leads to 2.74 million deaths globally. Depression is a mental health problem that affects people of all ages. Depression progresses through age: being low in childhood with a subsequent increase in middle adolescence and reaching at the peak in late adolescence (Avenevoli et al., 2015). The overall prevalence rate of childhood depression in India varies between 0.3 and 1.2% (Malhotra & Das, 2007). As per National Mental Health Survey of India (2015; 16), the prevalence rate of depression among adolescent is 0.8%. A mental health survey by National Institute of Mental Health and Neuro Sciences (NIMHANS, 2016) reported that the incidence of depression is roughly 1 in every 20 Indians or 5% of the population. Depression is a normal manifestation of adolescence stage that requires timely diagnosis and intervention.

Adolescent depression is reflected by depressed mood, depressive syndromes, and clinical depression (Cantwell & Baker, 1991).

Depressed mood reflects depression as a symptom along with other negative emotions like sadness, unhappiness, social withdrawal, anxiety, and worry. These emotional states may exist in response to any situation that involves one's failure in attaining a desired goal, dealing with difficult life situations and coping with loss of relationships. For instance, in the case example of Aditya, after failing in entrance exams, he felt guilty for not being able to fulfil his parents' expectations. Consequently, he withdrew himself socially, spent most of his time alone contemplating over what had happened and became frustrated at the uncertainty. He was sad that he could not accomplish his goal and, at the same time, felt anxious about future (as he did not think of any alternative goals).

Depressive syndromes are syndromes of complaints with associated symptoms like feeling lonely, worthless, fearful, unloved, and imperfect. The symptoms are assessed on the basis of their frequency, duration, severity, and impact on daily functioning. The case study of Aditya shows that although his symptoms were more evident after his entrance exams, their onset could be seen somewhere during school years. He was constantly under pressure to perform well and even had to take up science (against his wishes) to overcome his parents' expectations. This resulted in experiencing of stress which intensified after he could not clear his entrance exam.

Clinical depression includes major depressive disorder and dysthymic disorder. In order to be diagnosed under major depressive disorder, an individual must experience at least five of the following symptoms during the same 2-week period—frequent depressed mood, reduced interest in pleasurable activities, disturbed sleep, reduction in psychomotor activities, inability to make decisions, and presence of suicidal tendencies. On the other hand, under dysthymic disorder, an individual must experience frequent depressed mood for at least 1 year with the symptoms pertaining to lack of energy, inability to sleep, low self-esteem, feelings of helplessness, and hopelessness.

Depression is one of the strongest significant risk factors for suicide and incorporates feelings of depressed mood, weight loss, psychological impairments, frustration, and fatigue. Depressed adolescents display cognitive, motivational, and somatic symptoms (Clark et al., 1999).

- Cognitive symptoms occur when adolescents struggle in making decisions. These adolescents have low self-esteem as they hold a strong belief about being inferior to others and frame negative perception about self, environment, and the future. The cognitive processes that change during depression include feeling of pessimism, distorted view of self, finding faults in oneself, and considering oneself responsible for everything that goes wrong in life. For example, even though Aditya's interests were different from his parents' expectation, he found it difficult to take a stand or express his views in front of his parents. It can be said that he had the need to be accepted and loved by his parents.
- At the motivational level, depressed individuals find it difficult to perform any activity on routine basis and are likely to act at a very slow pace. After his entrance exam, instead of looking at alternate options, Aditya spent his time in social isolation, felt helpless, and worthless of him.

- Somatic symptoms are observed in the form of loss of appetite, insomnia, weight loss, feeling tired, and lethargic. When Aditya was preparing for his entrances, he was under so much pressure that his eyes started to burn even though there was no probable cause. It was later accompanied by persistent headaches and sleeping difficulties.

Depression diagnosed in the early stages of life has been found to be consistent over time (Merikangas & Angst, 1995). The question still remains unanswered as to why few adolescents suffer from depression and others remain healthy even in the presence of multiple risk factors in their life. There are gender differences in terms of psychological processes related to depression in preschool students. Research findings indicate depressive symptoms to be greater for girls as compared to boys (Kandel & Davies, 1982). Depression in girls is related to low self-esteem and negative body image (Allgood-Merton et al., 1990). Also, early maturing girls are at higher risks to depression and other internalizing problems. Puberty in girls bring more challenges in their behaviour as compared to boys. Both men and women follow their own styles of coping behaviour while dealing with life situation.

Risk Factors in Depression

Depression has always been a major cause of concern for researchers in India. Various scholars have focused their attention on studying the epidemiology, symptomatology specific to cultural context, comorbidity, risk factors, protective factors, and treatment related to depressive disorder. Depression is associated with biological, psychological, and social variables that pose significant risk factors and affect an individual's level of functioning. Both individual traits and environmental factors together lead to depressive disorders. Factors like alcohol abuse, insomnia, family income, and striving for perfection in academia not only affects an individual's performance but also serves as a greater risk factor for developing depressive symptoms (Cheng et al., 2015). A review study by Hyde and Mezulis (2020) using a vulnerability–stress approach points out affective vulnerabilities, biological vulnerabilities, and cognitive vulnerabilities.

Genetic factors play a significant role in adolescent depression. Genes–environment interplay has implications for gender with regard to the risk of depression and the gender gap in depression (Zhao et al., 2020; Kuehner, 2017). According to Weissman et al. (1984), affective disorders run in families. Depressive disorders get transmitted from parents to their children. Children of depressed parents are vulnerable to develop depressive symptoms as compared to children of non-depressed parents (Weissman, 1990), which may be due to emotional unavailability of parents (Lee & Gotlib, 1991), dysfunctional parent–child interactions (Burge & Hammen, 1991), and marital conflict (Downey & Coyne, 1990). They are also found to score high on temperamental traits like distractibility and short attention span (Chess et al., 1983).

Risk factors for depression also include low socio-economic background, unemployment, poor nutritional status (Mohandas, 2009), low educational level, and living alone (Jain & Aras, 2007). According to Chandran et al. (2002), depressed patients experience higher proportion of life events related to death of a family member, bereavement, personal health-related events, and interpersonal and social events. Low family bond, parental divorce, and disturbed interpersonal relation among family members magnify the intensity of depression among adolescents (Graber, 2004). Research by Sund and Wichstrøm (2002) reveals that adolescent's insecure attachment to their parents is likely to result in depression.

Poor peer relationship and peer rejection are likely to magnify depressive symptoms. Due to being isolated, the depressed adolescents lose confidence in self, express failure in having a control over their environment, which affects negatively their school performance, and may also lead to mental illness. Mental illness enhances the risk of depression and maladaptation in later lives (Hou and Ng (2014). Adverse experiences such as parental loss, family disruption, bereavement, and academic problems, etc. are some of the factors causing depression (Harrington, 1993). Lack of social support in this context may precipitate depression as stated by Lewinsohn's (1974) theory of depression.

Various life events like financial problems and death in the family, failure in examination, serious illness, stress at school and family as well as family history of mental illness, poverty etc. are associated with risk of developing depression (Barua et al., 2007; Patel et al., 2002).

Thus, the risk factors for depression arise out of a complex interaction between multiple genetic and environmental factors (Cao et al., 2018). It highlights the diathesis–stress model, which explains depression in terms of a dynamic interaction between a vulnerability predisposition or diathesis and the stress arising out of the environment/life events. This model focuses on the negative environment to study the effect of genetic and environment ($G \times E$) on depression. Whereas, the differential susceptibility model states that individuals with certain genetic predisposition are also more susceptible to the effects of positive growth environments and can perform well or the opposite (Belsky & Pluess, 2009; Zhao et al., 2020).

The risk factors operate in conjunction with the protective factors that the individual has, e.g., peer support, healthy bonding with parents, good academic achievement, high self-esteem etc., which can protect adolescents and reduce the risk of depression. These can moderate the effect of risk factors depending on the variety and extent of protective factors the adolescent has. Thus, the implication is to work towards reducing the risk factors and increasing and strengthening the protective factors in the life of adolescents. It is also pertinent to look into the sociocultural factors in this context.

Integrative Model of Depression

An integrative model of adolescent depression involves certain factors that are associated with each other. These factors consist of temperamental factors, which are accountable for interactions between children and significant others; environmental factors that take into account an individual's life experience; acute stress that activates depression and chronic development of depressive symptoms. The model explains that the presence of risk factors will not generate adolescent depression if an individual gets adequate social support from family and is capable of using apt coping skills in order to deal with problematic behaviour patterns. The model elucidates why some adolescents turn out to be depressed and perform suicidal act; whereas others are able to cope well under depressed feelings.

One of the most well-established models of depression emphasizes on the **cognitive behavioural theory**. This theory focuses on the cognitive triad that involves thoughts, behaviour and emotions as an important framework for depression. This theory proposes that the thought process of an individual affects his/her emotions and behaviour. The cognitive-behavioural models take into account the attribution theory of depression by Seligman (1975). It states that the cause of any bad event results in a feeling of hopelessness among adolescents. Also, they tend to attribute their failures to internal traits. An association between depression and attribution styles as presented in most of the reviews suggests that negative attributional style is a state-dependent symptom of depression (Harrington, 1993). According to Beck's cognitive theory (Beck, 1976) when an adolescent experiences adverse life events like parental neglect and peer rejection then these attribution styles and other cognitive biases are likely to increase the risk of getting depressed. The dysfunctional schemata and cognitive bias act as a triggering force towards the emergence of depressive symptoms. Rejection by others gives rise to a feeling of worthlessness leading to depressive disorder. Lewinsohn (1974) states that individuals low on social skills generally experience less positive reinforcements, resulting in depression. According to this model, Aditya, in the earlier case example, rated his worth on the basis of his school performance. He interpreted his average performance as his inability to score well, resulting in lowered self-esteem. His parents' negative response to his school performance reinforced Aditya's negative chain of thoughts.

Family system theory of depression focuses on the dysfunctional family environment, wherein depressive symptoms are found to be associated with lack of family support and enmeshed family boundaries (Stark et al., 1990). Aditya was most affected by his inability to make his parents feel proud of himself.

Suicide in Adolescents

Suicide is a growing concern of humankind in today's world. According to WHO (2014), suicide has been found to be the second leading cause of mortality among

females and the third leading cause among males aged 10–24 years. Further, over 90% of the world's children and youth reside in low- and middle-income countries and account for over 75% of global suicide deaths (WHO, 2014).

The CDC's 2019 Youth Risk Behaviour Survey from 2009 to 2019 (Ivey-Stephenson et al., 2020) reported an increase in the prevalence of suicide attempts among females, 12th-grade students, and overall. Another study (Campisi et al., 2020) covering 118 surveys on adolescents of 13–17 years of age from 2003 to 2017 across 90 countries, also indicated a significantly higher prevalence of suicidal ideation among girls than boys.

The National Crime Bureau, India reports that the year 2019 witnessed 381 suicides daily (10 Sept 2020, Times of India.com). It is a leading cause of death, as the highest rates are among those < 30 years old, attributed mainly to having a primary mood disorder and/or substance use (Samuel & Sher, 2013).

Adolescents going through a major transitional period face many stressful situations starting from dealing with physical changes, peer pressure, desire for autonomy to studying well, getting into good careers, adjusting to people and dealing with emotions. Suicide is a serious mental health problem that has long-lasting damaging effect on individuals, families, and society as a whole. Suicidal acts are often followed by stressful life events that may be either acute or chronic in nature. In the current COVID-19 pandemic, it is increasingly affecting the lives of adolescents devoid of peers, decreased activities, closure of schools, limiting of travel, and pursuing outdoor hobbies. It is also creating stress in them regarding pursuing higher education and career prospects. With the increasing complexities in our life style, the level of stress has been rising at a phenomenal rate. The intensity of stress varies depending upon the context and the capability of the person to cope with it. Some are able to handle these tough times and make the best out of it, whereas there are others who find it difficult to deal with such challenges.

The reasons that people choose to take their own life are very complex. Both instant and enduring factors contribute towards suicidal behaviour. The *instant factors* are the precipitants to suicide, for example, severe depression, death of a loved one, job loss, and drug or alcohol intoxication. The *enduring factors* indicate the cumulative effect of factors that occur over a long-term period such as parental neglect and trauma in childhood, dysfunctional home environment, family history of suicide, absence of support system.

Suicidal behaviour can be in the form of (a) suicide ideation (the idea or thought regarding committing suicide), (b) suicide planning (preparing plans for committing suicide), and (c) suicide attempts (carrying out self-injurious act with an intention to end one's life, but which are non-fatal).

O'Connor (2011) has proposed an integrated motivational volitional model of suicide involving three stages, namely—pre motivational, motivational, and volitional. The *pre motivational stage* focuses on biological and personality factors such as social perfectionism and self-criticism leading to the risk of suicide. There is a lack of appreciation for one's own success, rather there is negative self-appraisal or evaluation. Further, individuals with low socio-economic positions are more vulnerable to suicidal behaviour than those from affluent group (Tomlinson, 2012). Existing

psychiatric disorders also enhance the intensity of suicidal behaviour (Haw & Hawton, 2011).

The *motivational stage* of the model includes forming the idea and intentions regarding doing suicide. When the individual fails to achieve a set goal, it results in a feeling of failure and a sense of lacking. There can be rumination, which refers to being engaged in brooding or passive problem-focused thought. It can develop feelings of entrapment leading to suicidal behaviour (Morrison & O'Connor, 2008).

The *volitional stage* refers to the act of planned behaviour. Certain factors may increase the likelihood of suicide, e.g., a detailed action plan by the person and the availability of lethal means for self-harming behaviour increases the chances of committing suicide.

Differences in the methods employed for suicide pertains to socio-economic factors, availability of lethal means, and firearms legislation, rather than differences in the nature of the behaviour, per se. Some of the common modes of suicide used in developed countries include firearms, car exhaust asphyxiation, and poisoning whereas in developing countries, pesticide poisoning, hanging, and self-immolation lead the list. According to NCRB report (2010), consumption of poison (33.6%), hanging (31.5%), self-immolation (9.2%), drowning (6.1%), and jumping from buildings (1.5%) were common modes of suicide during 2009 in India.

Gender differences are found in suicide attempts and committing of suicide. Males use more lethal means, which also results in a higher rate of suicide commitment. They prefer to use violent methods as it would help them to be successful in their attempt (Canetto & Sakinofsky, 1998). Whereas females use less lethal means that results in a higher rate of suicide attempt, and it may not lead to actually ending the life. Differences in the lethality of means used lead to completed suicide in case of males (Hawton, 2000) whereas it may be more of self-harm behaviour in case of females. Males are more likely to use firearms and hanging to commit suicide, and females resort to drowning and self-immolation as a means for ending their lives (Kanchan et al., 2009).

Risk Factors in Suicide

Adolescence stage is the most sensitive period of heightened risk for suicidal behaviour and suicide rates among young people are increasing tremendously as they are the most vulnerable group, especially with the age range 20–24 years (Chandran et al., 2002).

The most significant risk factors contributing to suicidal act include: thwarted belongingness, perceived burdensomeness, and acquired capability for suicide (Joiner, 2005). *Thwarted belongingness* refers to the absence of meaningful relationships with others. Factors like bullying, discrimination in the peer group and in the school are likely to lead to thwarted belongingness (Romero et al., 2014). *Perceived burdensomeness* refers to the feeling of being a burden on others by the individual and not being able to contribute significantly to the society. *Acquired*

capability for suicide refers to the capability of the individual to undertake a lethal suicide attempt. It includes a reduced fear of death and a higher level of tolerance for physical pain.

Rudd et al. (1995) have proposed fluid vulnerability theory, which indicates a certain baseline level of risk for each individual which along with the personality traits of the individual and static factors that include mental illness in the individual or in family history determine the vulnerability to suicide.

The risk factors for suicide, thus, involve a complex interaction between psychological, social, environmental, genetic, and neurobiological factors, which differ according to what part of the suicidal process they predict. The prevalence of all these factors predisposes an individual to behave in a specific manner that varies from situation to situation or changes as per the circumstance change. It also depends upon one's capability to grow and learn from challenges of life. Under such circumstances, the main challenge is to identify those adaptive strategies that help in coping with stressful life events.

Suicide is commonly reported in low-income and middle-income countries (McKinnon et al., 2016). However, diversity in the social, economic, cultural and religious aspects contribute to the variation in the factors causing suicidal behaviour, suicidal ideation, attempt and commitment of suicide (Page et al., 2013; Wasserman & Wasserman, 2009). According to Srivastava et al., (2004), some of the risk factors associated with attempting suicide include: unemployment, presence of a stressful life event in the last 6 months, suffering from physical disorders and having idiopathic pain.

Suicide is determined by the presence of multiple vulnerable factors that predispose an individual to higher risk of suicide. For instance, not all individuals who are unemployed are at the risk of suicide. Unemployment coupled with the feelings of hopelessness, inability to take care of the needs of family and a thought that others would be happy in their absence, heightens the level of suicide risk. Some of the factors that increase the suicidal risk include: feelings of hopelessness, impulsivity, alcohol/ drug abuse, cognitive rigidity, depressed mood, thwarted belongingness, perceived burdensomeness, lack of problem-solving ability, deficits in social connection, pessimistic approach towards life and mental illness.

Hopelessness, a state where an individual remains pessimistic for the future life, increases the likelihood of suicidal behaviour. Literature reports a strong relationship between hopelessness and suicidal behaviour (Brezo et al., 2006). Hopelessness creates more risk for multiple suicide attempters than for single attempters (Eposito et al., 2003). It turns out to be more risky in situations where an individual internalizes anger rather than externalizing it. Suicide is considered to be an impulsive act. Impulsivity, which can be related to suicide attempts and deaths, is characterized by impaired self-regulation, sensation seeking, more risk-taking behaviour, poor planning, coordination, and immediate reward-seeking behaviour (Gvion & Apter, 2011). These are all characteristics of adolescents and youth. Research also suggests that reactive aggression marked by impulsive responses in stressful situations leads to suicide in the young (McGirr et al., 2009). Impulsivity along with maladaptive coping skills is also associated with suicide attempts (Chandrasekaran

et al., 2003). Although impulsivity is a significant risk factor for suicide, however, at times it becomes difficult to understand whether people act impulsively or they try to attempt suicide without giving any warning signs to others.

Loneliness, which refers to a sense of social disconnectedness, can increase the risk of suicide (Wiktorsson et al., 2010). Social relationship with others, even if it is only with one person, can help the individual in overcoming the feelings of loneliness.

The presence of genetic and familial factors like strained family relationship, family history of suicidal behaviour, mental illness in family and disorders like schizophrenia and alcoholism increases the likelihood of suicidal behaviour (Gould et al., 1996). Mental illnesses are characterized by irrational behaviour, mood swings, impaired judgement, distorted perceptions, troubled emotions, and inability to deal with the challenges of life. These illnesses may range in severity from being short in duration to being persistent and prolonged in nature. Physical illnesses and physical disability can also result in suicide attempt. In high-income countries, majority of the suicidal cases are observed among people who are suffering from mental disorders (Cavanagh et al., 2003). However, this trend seems to be less prevalent in few Asian countries like India and China (Radhakrishnan & Andrade, 2012).

Suicidal individuals fail in their ability to regulate emotions. Self-regulation is characterized by the capability of an individual to keep a check on their anger and repetitive thoughts of self-destructive behaviour and minimization of negative rumination. Deficits in self-regulation lead to impulsivity, negative self-appraisal, and negative attributional style (Schwartz et al., 2000). Pessimistic approach towards life is often related to suicidal behaviour. Inability to attain a set goal affects one's well-being. Drugs and alcohol abuse are likely to induce mood swings and make an individual more emotional and sensitive towards breakdown in interpersonal relationship and further diminishes their ability to deal with the adversities of life. Substance abuse is perceived as a masculine way of handling with stress. The excessive use of alcohol/drugs can make one impulsive and likely to engage in suicidal behaviour. It also increases the feelings of hopelessness and helplessness, leading to depression.

According to NCRB report (2009), in India, the top 10 causes or correlates of suicide in 2009 were family problems (23.7%), illness (21%) [including insanity/mental illness (6.7%)], unemployment (1.9%), love affairs (2.9%), drug abuse/addiction (2.3%), failure in examination (1.6%), bankruptcy or sudden change in economic status (2.5%), poverty (2.3%), and dowry dispute (2.3%). Research by Sharma et al. (2008) revealed that adolescents had significantly higher levels of depression, hopelessness, lethality of event, and stressful life events. It was also found that the prevalence of suicide risk behaviour was quite high with almost 16% having suicide ideation and 5% having attempted suicide. Females were also seen as being more vulnerable.

Linkage Between Depression and Suicide

Depression and suicidal tendencies have been found to be associated with parental deprivation, recent bereavement and family history of suicidal behaviour, severity of depression, being married, employed and less than 35 years of age (Srivastava & Kulshreshtha, 2000). Relationship between anger and suicidality has been studied and depressed patients with anger attacks exhibited more suicide-related phenomena in comparison to depressed patients without anger attacks (Painuly et al., 2007).

Depressed mood is related to suicide risks in adolescents. A sense of helplessness arising out of inability to control one's life can lead to thought of ending one's life. Blatt (1995) identifies two dimensions of depression: self-critical depression and dependent depression. Self-critical depression includes severe self-scrutiny, inferiority, and unworthiness feelings. Dependent depression includes a fear of being left out and deserted by others and is marked by a desire to be loved by others. Studies indicate that people with self-critical depression are rated high on lethal suicide attempts whereas those with dependent depression are likely to resort to low lethality suicidal gestures (Blatt et al., 1982).

Adolescents have shown the highest rate of prevalence of depression as compared to people of any other age group. Both suicide and depression are associated with each other and display similar confounding variables like anxiety and stress (Hou & Ng, 2014). Depression has emerged to be the most significant risk factor for suicide in adolescent, and recent research has shown a high rate of depression among those who have tried to attempt suicide (Serocznyski et al., 2003). Severe depression has been found to be related to suicidal behaviour that varies from suicidal thoughts to plans to attempts (Greening & Stoppelbein, 2002).

Both risk and protective factors play an influential role during this stage, as the level of depression heightens during this particular age group (Fero et al., 2015). The mental health issues during adolescence are dependent on the combination of both socio-economic conditions and psychosocial factors (like traumatic stress events, anger, criticism, and bullying) that can increase the level of risk for both depression and suicide (Dooley et al., 2015). Also, external factors like alcohol abuse and negative social stigma remain significant risk factors towards the occurrence of depression and suicidal behaviour (Glasheen et al., 2015).

Adolescents having a tendency for committing suicide generally have a poor perception of themselves, feel helpless, display poor impulse control, show low tendency for dealing with stressful events and often feel depressed. The feelings of depression may arise due to disturbed family background, abuse or parental neglect. Although depression remains a major risk factor for suicide, but not all individuals with depression commit suicide. Why some adolescents suffering from depressive disorder die by suicide, whereas others being diagnosed with the same disorder do not commit suicide, still remains a question to be explored by researchers. Higher family cohesion and positive parental relationship have emerged as the strongest protective factor against suicide. On the one hand, friendship dimensions like quality of friendship and traits possessed by a friend enhance peer relations and on the other

hand, poor quality friendship and unsupportive peer relationships increase risk for suicide ideation among adolescents (King & Merchant, 2008).

Intervention Strategies

Due to an increase in mental health issues, more care is required to be rendered to adolescents so that they become capable of handling challenges affecting their day to day functioning. During adolescence stage, pressures develop when individuals face difficulty in dealing with social lives and academic pressures. By promoting positive relationships and social support the risk for depression can be reduced (Lee et al., 2001). Intervention studies show that social connectedness with family and friends helps in reducing suicide ideations (Oyama et al., 2008). Since the risk for developing symptoms of depression and suicide is highest during adolescence period, therefore extensive training methodology needs to be developed for screening mental health issues among youths. Maintaining mental health and well-being are the most important aspects that leave a positive impact on the overall functioning of adolescents. However, stigma related to mental illness often makes it difficult for adolescents and their family to seek help. This has the implication for enhancing accessibility of mental health services at the academic institutions for the students.

Attitudinal barriers need to be addressed in order to reduce the negative stigmas pertaining to mental health treatment. Students often display confused opinion on seeking mental health care. For example, mostly student support those who require care for mental health issues, but when it comes to their own personal level, then they feel reluctant in seeking help. Mental health services can be promoted by addressing stigmas associated with both depression and suicide. The problem of suicide needs to be addressed at the stage of ideation itself. For preventing suicide, one also needs to lay emphasis on embracing personal strengths and virtues. The approach of positive psychology towards suicide prevention is considered as a significant means for adapting positively to stressful events. At times, it may not be possible to prevent all the risk factors for suicide, but certain principles of positive psychology may be instilled in an individual that may help in preventing suicide.

Psychosocial interventions like cognitive behaviour therapy (CBT) and interpersonal psychotherapy (IPT) are important in treating depression. CBT makes the assumption that by changing the thought processes, one can reduce symptoms of depression and improve functioning. The aim of therapist in CBT is to trim down the symptoms of sadness and enhance social skills. This approach helps depressed clients in examining their moods, developing social competence, eliminating negative thoughts, and gaining contentment by effectively dealing with stressors. The procedure of CBT involves identifying negative thoughts, helping the client reflect upon how such patterns were formed, unlearning those patterns and finding alternative ways to solve problems. This therapy follows a goal-oriented approach to deal with symptoms of depression. CBT consists of various techniques to help the client

overcome their state of misery. These techniques primarily focus on reframing cognitive distortions into healthier and realistic thoughts ("I feel worthless that I could not clear the entrance exam" to "I couldn't score well but at least I know the areas where I need to work on. I will perform better next time"). CBT further helps the client in keeping track of their thoughts so that they can be managed well in future.

Interpersonal psychotherapy (IPT) is another kind of psychosocial intervention that focuses on improving the interpersonal skills among adolescent. IPT shares many aspects with cognitive behaviour therapy, like they both aim at providing psychoeducation about depression and altering maladaptive communication patterns. However, unlike CBT, IPT focuses on the struggling interpersonal relationships of the client and its impact on the current symptoms. According to IPT, problems in interpersonal relationships occur due to complicated bereavement (when someone of high significance passes away), role dispute (interpersonal disputes among family, friends, colleagues, etc.), role transition (which may occur as a result of some significant life changes attributed to biological, social, or contextual developments) and interpersonal deficits (an absence of major life event or simply not feeling the required depth in relationships).

Mindfulness techniques are also used in the treatment of depression. In this technique, individuals pay attention to their present moment by recognizing their feelings, thoughts, and bodily sensations. In most of the situations, antidepressant drugs are used for treating depression. These drugs may be effective for treating depression among adults, but they may be risky for young population, especially children and adolescent. Although antidepressants produce positive results in the short term, but in long run, it fails to serve the purpose. Although advancements have been made regarding the identification of depressive moods and suicidal thoughts, but still sufficient diagnosis and intervention methods for dealing with such mental illness need to be further explored.

Conclusion

Depression accounts for 10% of the total non-fatal disease burden worldwide, which falls disproportionately on girls and women, making it a global health priority (WHO, 2016).

Depression in adolescent is a significant disturbing problem, undermining the quality of life and day-to-day functioning. The developmental changes experienced by adolescent pose severe challenge if they are not addressed appropriately. Research has uncovered multitude of factors associated with onset and management of depression. Depression appears to be a complex interplay between biological vulnerabilities and factors related to one's environment. Depressive symptoms are characterized by feelings of unhappiness, persistent sadness, anxiety, negative thoughts about oneself, the world, and the future. Depression is a strong contributing risk factor towards the development of suicidal behaviour. Given the vast research on depression among adolescents, it has been observed that those treated with depressive symptoms are

more likely to display lower level of risk for attempting suicide. By applying preventive measures in the form of decreasing stigma, promoting healthy relationships, practising psychosocial strategies (through cognitive behaviour therapy and interpersonal psychotherapy) and increasing availability of mental health care services, the psychological well-being of adolescents can be enhanced, thereby reducing the likelihood of suicidal thoughts and behaviours in adolescents.

Time to Reflect

The incidence of depression and suicide has greatly increased among adolescents and youth. The growing phenomenon of cyber addiction and cyber suicide is also an emerging concern and challenge among the youth. It is really disturbing to think about young people taking away their own life; their life is at the mercy of a click of a mouse. What is it that makes them so powerless and succumb to a non-human being? You can do a survey of the personal, psychological, family, and environmental factors playing a role here.

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Chapter 10
Adolescents and Substance Use

G. S. Kaloiya and Geeta Singh

Abstract The chapter talks about the epidemiology of substance use among adolescents which is a major concern for this age group. It highlights the bio-psycho-social factors contributing to substance use among adolescents. Stages of substance use are described starting from experimentation to dependent use. The chapter describes the harmful consequences of substance use and the comorbidities associated with it. Finally, it discusses the assessment and the psychological interventions for the management of addiction in adolescents.

Keywords Adolescents · Substance use · Psycho-social risk factors · Psychological assessment · Management

Introduction

Adolescence is a stage of life where the behaviour of adolescents is mostly guided by their curiosity and eagerness to explore new things. At this stage, adolescents indulge in a number of risk-taking behaviour, and also do experiments with many new things. Hence, this stage seems full of energy and enthusiasm. Channelizing this energy in an adequate way is crucial. Proper channelization may result in innovations, whereas improper or wrong guidance may lead to harm and destruction aimed towards oneself and/or towards the society. Use of drugs and other substances by adolescents also starts from curiosity and experimentation. Searching for an identity and wanting to feel like adults may lead to use of substances. Further, the risk-taking nature of the adolescents also engages them in such kind of behaviour. There are cases of adolescents who take to smoking and alcohol for the thrill of it in their peer group.

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Coupled with inadequate guidance, substance use turns into a major problem having serious negative consequences.

Key Terminologies Related to Substance Use

A 'substance' refers to anything that can change a person's mood or cognition, bringing in a 'high', i.e., a very pleasurable feeling. It includes drugs such as cocaine, alcohol, cannabis, hallucinogens, inhalants, opioids, stimulants, tobacco, and other or unknown substances.

We all take prescribed medicines or drugs. However, when these drugs are used in ways different from that as advised by the physician/doctor, it refers to misuse of the drugs, i.e., not using it in a proper way. For instance, self-medication of prescription drugs or taking more amount of medicine than what is prescribed by the doctor can be termed as *misuse of drugs.* Thus, misuse refers to problematic use of prescription drugs and legal drugs. When the misuse of drugs (both legal and illegal drugs) results in adverse physiological and psychological consequences and negatively impacts our personal, social and work life, it is termed *drug abuse or substance abuse.*

However, these terms are no longer used as they may lead to stigma for an individual. The proper term used at present is "substance use". Inappropriate use of drugs over a longer period of time develops *tolerance* in the individual, i.e., she/he needs more amount of the particular drug/substance to achieve the same result. Thus, the individual has to increase the dosage of the substance to get the same effect. Further, she/he also becomes *dependent* physiologically as well as psychologically on the substance, which leads to *addiction*. There is a *craving* for the drug and the individual uses all her/his resources to have the drug. When the individual develops addiction, a sudden discontinuation or stopping of the drug leads to *withdrawal* symptoms, which are severe physiological and emotional disturbances in the individual. To avoid such severe discomfort, the individual again resorts to taking the drug so that s/he gets relief.

Treatment of substance use includes *detoxification*, which is a medical procedure of clearing the toxins from the body and other psychological therapies. *Relapse* refers to starting to use the substance again after treatment period is over.

Thus, *substance use disorder* refers to when the individual continues to take substances despite its adverse impact on his/her health, relationships, and other aspects of life. The terms substance abuse and substance dependence are no longer used by the DSM-5 (Diagnostic and Statistical Manual, 5th version, 2013), which is a key classification system for mental disorders including addictions. Dependence refers to physical dependence on the substance, whereas addiction includes both physical as well as psychological reliance on the substance. Dependence may start with abuse of the drugs/given substance. Thus, abuse and dependence refers to the time period and extent of use of the particular substance. Over a period of time, dependence usually leads to addiction which results in biochemical changes in the brain,

marked by tolerance and withdrawal. The person continues taking the substance even if it causes suffering to oneself and others around.

In DSM-5, the terms substance abuse and dependence were replaced by the term "substance use disorder" or simply abbreviated as SUDs as it conveyed more inclusion. Further, the terms abuse and addiction convey a negative connotation. The current term substance use disorder gives a scope to identify people ranging from low, moderate to high severity and accordingly provide treatment to them. It is viewed on a continuum from the beneficial use of a substance to harmful use.

Prevalence of Substance Use Among Adolescents

The substance use by youth is increasing gradually at a younger age with decreasing age of onset. Substances used by adolescents go by various names. Table 10.1 given mentions the substances used by the adolescent population and the street names or commonly used names for these substances.

Let us now see the prevalence of substance use among adolescents in India as well as across the world.

Studies using nationally representative samples of U.S. youth revealed that the lifetime prevalence of alcohol use disorders was approximately 8% and illicit drug use disorders were 2–3% (Merikangas et al., 2010; Swendsen et al., 2012). In a study conducted by the European School Survey Project on Alcohol and Other Drugs (ESPAD, 2015) in 35 European countries, including 24 EU Member States, a decline in both tobacco smoking and drinking habits has been observed among 15–16-years-old school going children; however, the burden has not lessened yet as this age group is more likely to use newer substances with their newer modes of administration due to their experimental nature. This poses great challenges in front of the whole scientific community.

The Global status report on alcohol and health by the World Health Organization (WHO, 2014) highlights the following data:

Table 10.1 Substances commonly used by adolescents and their street names

Substance	Street names
Alcohol	Whisky, Rum, Vodka, Beer, Tadi, Desi, etc.
Cannabis	Bhaang, Ganja, Charas
Opioids	Smack, Brown sugar, Proxyvon, Afeem, Dodda, etc.
Inhalants	Fluid, Iodex, Petrol, etc.
Nicotine	Bidi, Cigarette, Gutka, Pan-masala, Khaini, Kuber, etc.

- Worldwide, more than a quarter (27%) of all 15–19-year old are current drinkers.
- Rates of current drinking are highest among 15–19-year old in Europe (44%), followed by the Americas (38%) and the Western Pacific (38%).
- School surveys indicate that, in many countries, alcohol use starts before the age of 15 with very small differences between boys and girls
- Alcohol is consumed by more than half of the population in three WHO regions—the Americas, Europe, and the Western Pacific.
- Worldwide, 45% of total recorded alcohol is consumed in the form of spirits. Beer is the second alcoholic beverage in terms of pure alcohol consumed (34%) followed by wine (12%).

A national drug use survey conducted by NDDTC, AIIMS (Ambekar et al., 2019) to find out the prevalence of substance use in Indian settings included a representative sample of 10–75 years old from 186 districts of the country, who used at least one of the substances like alcohol, cannabis, and opioids. It reported alcohol as the most commonly used substance (14.6%), including the problem users (5.2%) and dependent users (2.7%). Cannabis is the second most widely used substance (2.8%), and opioids are the third most widely used substance (2.1%) in the country. Moreover, tobacco is also one of the most commonly used substance in Indian settings. The overall prevalence of tobacco is about 28.6%, among which 42.4% are men and 14.2% are women. A study (Daniel et al., 2017) on male adolescents in New Delhi regarding the prevalence and pattern of substance use found that about 44.26% of the adolescents started to use substances before 13 years of age and reported 'to be liked by friends' (57.38%), 'to feel like an adult' (24.6%), and 'liked the feeling of substances' (13.11%) as reasons for taking substances. In most of the cases (85.25%), they got the substances from their friends. Common substances used by the participants were any kind of tobacco (77.05%), inhalants (26.23%), and alcohol (11.47%). The findings indicate an early onset of substance use and point out that peer group and friends are the key factor in starting and maintaining the use of substances.

Katoki et al. (2016) reported peers playing a major role in substance use initiation and supply source of it among the adolescents in urban slums in Guwahati, India. Tobacco and alcohol were found to be the most widespread substances among school going children in the age group of 14–16 years who initiated it during 8–13 years of age and mostly belonged to the lower socio-economic strata having a family history of substance use.

Kamate et al. (2017) studied 600 (505 boys and 95 girls) aged 10–19 years from the urban slum of India. The prevalence of substance use was 11.8%, in which prevalence among females was 17.9% and males were 10.7%. The smokeless form of tobacco was the most common substance use (78.87%) followed by the smoke form of tobacco (15.49%). The least prevalent substance was alcohol and Ganja. Studies indicate that by 2020, tobacco will account for 13% of all deaths in India (Bate et al., 2009). Smokeless forms of tobacco use (e.g., gutkha) were found more

popular than smoked forms (e.g., cigarettes and bidis) in all the surveys among urban Indian school children.

A representative national survey of children with substance use in India (Dhawan et al., 2017) revealed that the pattern of drug use shows a progression from licit to illicit/illegal substances with the use of tobacco being the highest, and then alcohol, cannabis, inhalants, pharmaceutical opioids, heroin/smack, and sedatives in that order. The average age of initiation of tobacco use was lowest (12.3 years) followed by inhalants (12.4 years), cannabis (13.4 years), and alcohol use (13.6 years). Opioids and pharmaceutical drugs were initiated at 14–15 years of age followed by injectable use (15.1 years).

The data thus indicates that worldwide including India, substance use is starting early and is increasing. The easy availability of the particular substance and the socio-cultural context of the individual may influence the use of substance by the individual. In India, it is more prevalent and problematic in some States, e.g., Punjab and North-Eastern States (Gururaj et al., 2016).

Ambekar et al (2019) in a national survey in 36 States and UTs found that out of the eight categories of psychoactive substances such as alcohol, cannabis, opioids, cocaine, Amphetamine type stimulants (ATS), sedatives, inhalants, and hallucinogens, alcohol was the most common (14.6%) psychoactive substances used by the Indians, followed by cannabis (2.8%) and opioids (2.1%). States with the highest prevalence of alcohol use were found to be Punjab, Goa, Tripura, Arunachal Pradesh, and Chhattisgarh. The North-eastern States of Sikkim, Manipur, Mizoram, Nagaland, and Arunachal Pradesh reported the highest prevalence (more than 10%) of opioid use in the general population. The Report also found the prevalence of inhalant use is more in children and adolescents (1.17%) than adults (0.58%), particularly in Delhi, Haryana, Maharashtra, Uttar Pradesh, and Madhya Pradesh.

The diverse conditions of adolescents such as social group, education, and economic status of household need to be considered influencing the use of substance.

Bio-Psycho-Social Factors of Substance Use Among Adolescents

A variety of factors may contribute to the initiation of substance use among the adolescents, leading to problematic use and addiction or dependence over the substance. It is important to understand that substance use has a strong association with the individual's biological, psychological, and social factors. There is an interacting influence of these factors in initiating or maintaining substance use.

Hawkins et al. (2002) have explained that these specific risk factors may be understood at two levels—societal/community level and at individual level. The societal/community risk factors include availability of substance, policies, laws, norms, and marketing strategies adopted by governmental agencies to curb the substance use in a particular society, for instance, the minimum regulatory age for drinking and

smoking in India is 21 years and 18 years, respectively. The personal characteristics are considered to be occurring at the individual level which might include temperament, low harm avoidance, poor impulse control, personal and familial history of substance use, levels of family conflicts and support, lack of and/or inconsistent parental discipline, academic achievements, aggression, and antisocial traits, etc.

The underlying contributing factors can be categorized into the biological, psychological, and social factors that are linked with substance use among adolescents.

(1) **Biological Factors**

Strong evidence from studies on twins, siblings brought up separately and adoptees demonstrate the role of genetic vulnerabilities in development of substance use. It has been noticed that adolescents with a positive family history of substance abuse are more prone to develop substance use disorders due to their genetic predisposition. Apart from genetic factors, researchers have also focused on the neurobiology or the biochemical base of substance use. There is a reward pathway in the brain which gets activated when the individual takes alcohol or other drugs. It explains the 'high' feeling reported by the individual consuming alcohol and drugs. It produces an intensely pleasurable feeling. Human beings tend to repeat those behaviours that are rewarding. Thus, when substance use leads to a pleasurable feeling, it activates the reward pathway in the brain, and the intake behaviour of substance is strengthened. Researchers have also identified particular neurotransmitters involved in this process such as dopamine and GABA (Gamma-aminobutyric acid) system. As Sadock and Sadock (2007) point out, the reinforcing effects of the psychoactive substance through reward circuit of brain maintain the substance taking behaviour of the individual. Continued use of alcohol and other drugs leads to 'neuroadaptation', progressive changes in the structure and function of the brain. This produces cravings for the drug, the individual takes the drugs, and it gets reinforced again. Such changes in the brain neurocircuitry also convey long-term vulnerability to relapse (Koob & Simon, 2009).

However, this does not mean that the use of substance is affected by the biological factors alone. Rather, a combination of risk and protective factors present for the particular individual will determine if the substance use will turn into addiction.

(2) **Psychological Factors**

A number of psychological factors play a significant role in substance use among adolescents. It is important to establish a good rapport with adolescents to know more about these psychological issues. There are some common dysfunctional beliefs among substance users that contribute to maintaining the substance abuse, for example, 'cannabis enhances school or work performance and it is not at all harmful'. In addition, parenting styles is known to affect the overall psychological development of the child. Parents with uninvolved, permissive, and authoritarian parenting styles are known to hamper the growth of their child. This affects the overall psychological integrity of the

child and may push her/him to the substance use under the influence of peers or other factors.

Following are some of the psychological factors that can play a crucial role in adolescents' substance use.

(i) **Poor Academic Achievement**: Studies (e.g., Mekonen et al., 2017) point out poor academic behaviour among the substance users; though mediating factors such as self-discipline, willpower, and determination (Bunch, 2002) may play a role here. However, the inability to perform well in studies may cause frustration among adolescents leading to substance use as a denial strategy to deal with their failures.

(ii) **Negative Mood State**: Negative affect has been considered universal risk factor across the development of substance abuse (Baker et al., 2004) and use of substance help individuals to cope up with affected mood state. When a person experiences negative events, or any kind of loss and trauma, it may result in anxiety, stress, and depression. To cope with such negative emotional states, the person may resort to substance use.

Case example: One of the 12-years-old boy with cannabis dependence lost his mother at 4 years of age, attributed his addiction to the feeling of emptiness.

> (I feel lonely, I don't share my problems with anyone. I feel that I don't have any problem but still, I feel boredom. There is no harm in taking a substance, and I feel happy with it.)

(iii) **Personality Disposition**: It has been noticed that certain type of personality dispositions also contributes to substance use among adolescents. Mitchell and Potenza (2014) have reviewed some studies showing link between addictive behaviours, impulsivity, and sensation-seeking. Hopwood et al. (2011) found higher levels of negative temperament (particularly self-harm) and disinhibition (particularly impulsivity) in patients with SUDs. Aggressive tendencies have also been linked to substance use. Children who indulge in frequent fights with parents and others, with the aggressive and rebellious attitude, are most likely to develop addiction at the later stage. Studies have also pointed out the moderating role of poverty and socio-economic status in the relationship between substance use and personality traits (Sutin et al., 2013).

Case example: (an account of a father for his 16-years-old son who was dependent on inhalants.

> He is aggressive since starting, anytime he goes out of the home anytime and doesn't inform anyone at home. He gets angry on asking about it. He argues with teachers too. He has been doing this entire thing even when he had not started taking the substance, he always demands different things.

(iv) **Sensation Seeking**: Higher levels of sensation seeking are associated with substance use (Pokhrel et al., 2010). It refers to an individual's very high need for novelty seeking, the desire for novel and unusual

experiences, risk-taking attitude, and a high level of curiosity. Such behaviours depend on various cultural factors including the city culture, and family type or structure.

Case example: (an account of a 15-year-old boy dependent on cannabis).

> I love to experiment with different things and I know that I'll stop it myself. How will you know the pleasant effect of Ganja unless you have tried it? I take it just for a mood change. I feel I am too mature to decide the right and wrong for me.

Majority of adolescents want a sense of personal autonomy, and to feel grown up which may lead them to do experiment with substance. It thus has an implication for developing adequate self-control among adolescents in social and interpersonal situations.

(v) **Anxiety and Self-Esteem**: Adolescents treated for addiction also report mood and anxiety symptoms. Social anxiety is a very common contributing factor in substance abuse which lowers the self-esteem of an individual and generates a feeling of inadequacy and insecurity. Current western trends of social aloofness in our country are also responsible for enhancing levels of anxiety and an overall reduction of self-esteem in children, adolescents as well as adults. Studies have indicated that low self-esteem and psychological distress were important factors in the substance use, theft, and prostitution among adolescents and adults (Alavi, 2011; Khajehdaluee et al., 2013).

Case example: (an account of 18-years-old boy diagnosed with alcohol harmful use who was taking alcohol to reduce his social and performance anxiety)

> (I feel that I stutter while interacting with others and that seems funny in front of others. Once I drink alcohol, I get a confidence that I can manage my studies and my entire work appropriately.)

(3) **Social Factors**

Children and adolescents raised in a family environment with lack of proper guidance are most likely to develop undesirable behaviour including substance abuse. Peers become an increasing influence in the lives of adolescents. Home environment along with peers play a major role in the initiation and maintenance of substance abuse.

(i) **Peer Substance Use**: Influence of peer substance use is a leading factor for substance use. In some cultures, the adherence to family rules and regulations is of utmost importance and sometimes, this might make the adolescents detached from their families and succumb to the peer pressure for use of substance. Adequate guidance by parents here is crucial to make youth aware of the harmful consequences of substance abuse.

Case example: (account of a 13-year-old boy attributing his inhalant use to peer circle).

> I saw one of my friends was taking inhaler. He was the person who taught me to consume inhaler, then I got habituated to it, I didn't know that consumption is harmful.

(ii) **Adult Substance Use**: Children learn through modelling of their parent's behaviour. Substance use by family members have a significant impact on its use by their children (Tsering et al., 2010). It also poses an increased risk for children to develop a substance use disorder (Zimic & Jukic, 2012).

Case example: (account of a 16-year-old boy smoking 10–12 cigarettes who started to use because of his uncle).

> Sometimes my uncle used to tell me to get bidi and sometimes to light it for him, and that time I also felt like smoking. Initially, I was taking it without knowledge of others but now everyone knows about it.

(iii) **Disturbed Family Environment**: Poor relationship with parents is an important risk factor for adolescent substance abuse. It has been widely observed that interpersonal relationship problem within the family system such as parental conflict, etc., play a very significant role in the development of substance use in the youth. Many times practice of authoritarian parenting by any of the parents proves harmful to their children and pushes them towards substance abuse.

Thus, risk factors related to the family and the peer group play a major role in substance initiation. In a nationwide survey of nearly 4000 children under 18 years of age, using substances (school-going, out-of-school as well as street children) across more than a hundred cities/towns, fairly representing all the parts of India (Dhawan et al., 2017), peer pressure was reported by 40% as the reason for continuing drug use. Substance use by family member/s accounted for 57%, family conflicts (47%), and abuse (46%) towards substance use by the children.

Harmful Consequences of Substance Use

In general, the physical consequences of taking substance are mostly highlighted while neglecting the associated psychological and social consequences. However, it is important to understand that substance abuse not only damages our physical health but also leads to a diverse set of negative psychological as well as social consequences. A huge number of substance users develop HIV infections and hepatitis due to use of infected syringes.

Apart from the physical problems, the chronic use of substance also hampers the cognitive functions of an individual such as thinking, memory, decision making, attention, concentration, and problem-solving. Substance induced brain damage

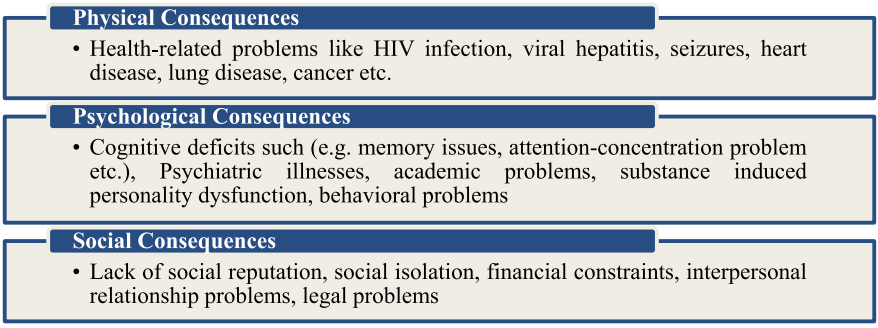

Fig. 10.1 Harmful consequences of addiction

mostly leads to forgetfulness, attention and concentration difficulty and poor planning ability. In addition, the occurrence of a number of psychiatric conditions such as depression, anxiety disorders, and personality disturbances such as intense aggression, disregard of social rules, and lack of social conformity has been linked with prolonged substance use.

Thus, use of substance affects negatively different aspects of an individual's life, resulting in emotional burden, economic burden, relationship problems and medical and legal problems. They also suffer from lack of social reputation. These individuals are not accepted by the society easily, and are labelled as addicts and at times their families also withdraw financial and emotional support from them. The neglect of the society and their own family further generates social isolation and depression among these individuals.

Besides the social isolation, the presence of the legal problems due to physical fights, rash driving, etc., in intoxicated condition are also very common negative consequence among substance users.

The physical, psychological, and social consequences of substance use among adolescents can be seen in Fig. 10.1.

Stages of Substance Use

An individual goes through a long process before it results in addiction. The pattern of substance use from experimentation to dependence is divided into several stages. An individual can move through these stages quickly or in several years. Keane (2005) in his handbook, Understanding Substances and Substance Use, has talked about these stages represented (Fig. 10.2).

Stage One: Experimentation—Mostly substance use starts with experimentation. At this stage, adolescents need a very small amount of substance to have a high or satisfaction and they return to normal condition. The experimentation starts out with curiosity and risk-taking attitude. Some adolescents experiment with substance

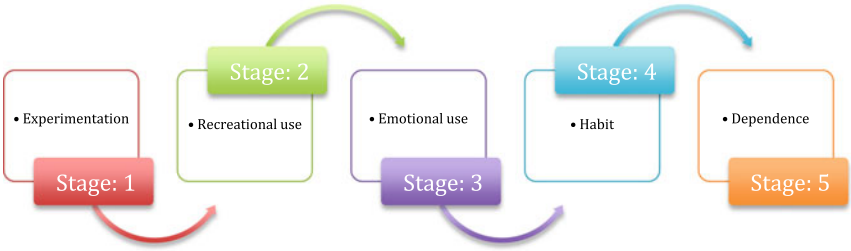

Fig. 10.2 Stages of substance use

and then stop using it but there are a majority of others who struggle life-long with substance abuse after their first time experiment with substance.

Stage Two: Recreational use—The social acceptance remains the primary motive of this stage. Therefore, the context of substance use always remains in the group setting. An individual usually doesn't recognize that their consumption has become regular gradually because now they use the substance in a company of other people as well. Substance abuse starts hampering adolescent's life such as falling grades in school.

Stage Three: Emotional use—At this stage individual generally starts taking a substance to manipulate their feelings, emotions, and behaviour. They consume substance to have fun and to feel good. The purpose remains to elicit pleasurable feelings, to cope with stress and negative emotions.

Stage Four: Habitual Use—In this stage, the adolescent's substance use starts impacting their life. Individual starts remaining preoccupied with the thoughts of procuring the substance. Sleep and concentration difficulties, withdrawal symptoms may occasionally be experienced, tolerance and craving may increase. Certain behavioural problems such as dropping the school, poor school performance also starts taking place with significant mood swings.

Stage Five: Substance Dependence—The stage includes all the features of habitual use. Besides, at this stage substance use becomes persistent. Despite the consequences of individual's risky behaviour, the substance consumption continues. Relationship problems with family members and peer group, health issues, legal problems and academic degradation becomes evident and prominent. The substance use problem becomes chronic, often relapsing, recovery becomes comparatively difficult but treatable.

Awareness of these stages of substance use is necessary for adolescents and their family members to know how the use of substance turns into problematic use.

Common Psychiatric Co-Morbidities with Substance Use

Substance use in many cases is not a standalone problem. It is commonly seen with other co-occurring psychiatric disorders. Comorbidity refers to when two or more disorders occur in the same individual. This co-occurrence of two psychiatric disorders can be simultaneous or successive, and it poses a major challenge for the individual and the family. Srivastava et al. (2010) have provided a review on the psychiatric comorbidity research in India based on the data published in the last six decades and found the reported comorbidity to be as high as 60%.

Let us see below some common psychiatric comorbidity associated with substance use.

Depression: Depression consists of core symptoms of low mood, fatigability, lack of interest and withdrawal. Depression and other mood disorders were found to be the most common psychiatric comorbidity (46.2%) among those with alcohol dependence (Darshan et al., 2013). In most of the cases, the substance use disorder follows the psychiatric disorders. Further, the patients having dual diagnosis belonged to a younger age group (Vohra et al., 2003). Other studies have reported additional psychiatric disorder in 92% alcohol dependent individuals, whereas it was only 12% in the healthy controls (Heramani et al., 2005).

Anxiety Disorder: Anxiety is basically a feeling of apprehension and nervousness. Anxiety disorders are clinical diagnosis having specified signs and symptoms. Anxiety disorders, particularly social anxiety disorder and post-traumatic stress disorder (PTSD), may be related to the risk of substance use disorders in adolescents (Kilpatrick et al., 2000). In a review study, Brady et al. (2013) indicate the association between anxiety disorders and substance use disorders. Specific anxiety disorders including generalized anxiety disorder, panic disorder, and post-traumatic stress disorder have all been associated with substance use.

Conduct Disorder: The presence of conduct disorder is a strong predictor of early initiation of both licit and illicit/unlawful drugs among adolescents. The disregard and serious violation of social rules is the most common feature of conduct disorder. A longitudinal study by Hopfer et al. (2013) revealed greater risk for initiation of all substances, especially illicit substances among adolescents with conduct disorder as compared to those without conduct disorder.

Attention Deficit Hyperactivity Disorder (ADHD): The inability to pay attention and excessive activity are core symptoms of ADHD. It has been noted that 50–60% of adolescents with the substance use disorder have co-morbid ADHD and the association between the two conditions among adolescents is moderated by other factors such as level of cognitive functioning. Individuals with lower cognitive functioning are more likely to develop substance dependence in response to their hyperactivity compared to adolescents with higher cognitive functioning (Dawes et al., 2000). ADHD in childhood also has been found to be significantly associated with early onset of alcohol dependence (Sringeri et al., 2008).

Screening and Assessment of Adolescents with Substance Use Disorder

A detailed clinical evaluation helps one to find out patient's substance related history, associated psychosocial factors maintaining the use and related consequences. A comprehensive case work up helps to determine the good and poor prognosis of an individual. It also helps to find out the core conflicts of the individual and plays an important role in formulating the adequate management plan. Further, psychological assessment determines the severity of the problem and also facilitates to uncover the latent issues not revealed in clinical interview.

1. **Detailed Case History Taking**: Case history taking is the first step followed when someone visits for treatment of substance use. It basically includes a clinical interview by a trained professional in a systematic manner. The interview focuses on diverse area of the individual's life, e.g., substance use history such as the type of substance used, amount of use, the frequency of use, last use, if any abstinence attempts, the frequency of relapse, reason for relapse, withdrawal symptoms, tolerance related information, per day expenditure on substance and biological, psychological and social consequences of taking substance, etc. Further, the professional also explores patient's treatment history, past history of physical or psychological illness and family history of substance use, medical and psychiatric disorders.

Personal history is also collected, with a focus on the detailed evaluation of patient's childhood history, parenting style, attachment style, temperament, school behaviour, sexual history, marital history, and the general pattern of living, etc. Individual's perspective towards their substance use and willingness for treatment are considered important to evaluate. All these elicited information help in effective case formulation and treatment planning.

2. **Psychological Assessment**: After the case workup, another important step is the psychological assessment using psychometric test measures. It is pertinent to choose the appropriate measure based on the purpose of testing and considering the contextual background of the individual. These psychological tests are divided into the two broad categories based on their psychometric property, i.e., objective test and projective test.

   (a) **Objective Tests**: The objective tests are the structured type of instruments such as questionnaires and inventories, etc. These are paper–pencil tests in which individual's response are recorded as true/false or yes/no or on a Likert type rating scale. The tests assess the particular psychological aspect associated with substance use and the severity of the problem. A few of the commonly used tests are as follows:

   - Teen Addiction severity index (Kaminer et al., 1991)
   - Adolescent Drug Abuse Diagnosis (Friedman & Utada, 1989)
   - Adolescent Diagnostic Interview (Winters & Henly, 1993)

- The American Drug and Alcohol Survey (Oetting et al., 1989)
- Personal Experience Inventory (Winters et al., 1989).

(b) **Projective Tests**: Most adolescents have associated underlying conflicts which they don't reveal easily even after a number of clinical interviews. Projective tests help to explore the unrevealed underlying conflicts, personality and family dynamics, and hidden feelings through unstructured or semi-structured test materials. The most commonly used projective tests for adolescents with substance use disorder are as follows:

- Thematic Apperception Test (Murray, 1943)
- Sentence Completion Test (Sacks & Levy, 1950)
- Word Association Test (Mednick et al., 1964)
- Draw A Person Test (Short et al., 2011)
- Picture Frustration Test (Rosenzweig, 1976).

Management of Substance Abuse in Adolescents

Managing substance use is the most crucial part which requires support from family and the peer group. It is important to always keep in mind the adolescent's cultural background, context, environmental factors such as peer influences, belief system, their age, gender, ethnicity, disability status, and stage of readiness to change, etc., while planning for adequate intervention. There are certain principals that should be taken care of by professionals while dealing with adolescent substance users.

Principles for Treatment of Substance Use in Adolescents

- The gender, family dynamics, and surrounding of the adolescent needs to be considered.
- It is essential to involve the adolescent's family and community in the treatment process as their support is an important element of treatment and various issues present in the family needs to be handled carefully through treatment.
- It is necessary to identify substance use in adolescents as early as possible.
- Intervention should be started even for a less severe stage of addiction, i.e., substance use.
- Many a time adolescents do not think treatment is required and rarely go for treatment. In that case, legal or family pressure may be an important way to involve them in the treatment process.
- Treatment should not focus on just substance use rather should also include issues associated with the adolescent.
- Behavioural therapies can effectively treat substance use disorders.

- Mental health conditions need to be addressed in order to effectively treat substance use.
- Follow up should be essential for adolescents to ensure the change or improvement.
- There should be the investigation for sexually transmitted diseases and hepatitis as adolescents are at high risk for these illnesses.
- The frequent relapse should be considered seriously as it indicates the need for intensive treatment for the adolescent's substance use.

There are two broad treatment modalities available to treat adolescent's substance use; one is pharmacotherapy, i.e., treatment through medication and another one is non-pharmacotherapy, i.e., psychological intervention. The medication mostly targets the management of intense craving, withdrawal symptoms such as restlessness, tremors and physical complaints which occur in the absence of psychoactive substance, and works on biological irregularities. Psychological modalities of intervention for substance use among adolescents are centred around the individual and their environment.

Psychological Intervention

(a) **Psycho-education**: Psycho-education is one of the most significant parts of intervention process that includes delivering information and educating adolescents about the substance use disorder, co-occurring mental health problems, related biological, psychological and social causes, adverse consequences of substance use, and it also emphasizes upon the need for treatment with available treatment modalities for substance use. In the process, the individual is made aware of their problems and provided an opportunity to ask questions. Sometimes they have a tremendous guilt feeling for their substance use which is mostly caused by stigma about addiction present in our society. Individuals with substance use disorder also commonly face humiliation and are frequently blamed by their family members and outsiders for their substance use. Psycho-education process deals with the negative feelings of these individuals by assuring them that addiction is a disease which needs proper treatment. Recent studies have found psycho-educational process effective to treat adolescents' substance use behaviour (Kaminer et al., 2002).

(b) **Motivational Enhancement Therapy (MET)**: MET developed by Miller and Rollnick in 1991 is basically used for the individuals with low motivation to change their substance-taking behaviour. Majority of patients with substance use come to the de-addiction centre either with pre-contemplation or contemplation stage of motivation who deny the use of any substance. The Motivational Interviewing approach targets ambivalence toward behaviour change in regard to substance use, emphasizes on self-efficacy of an individual, develops discrepancy between the present behaviour and future goals. Therapist always

Table 10.2 Decision balance sheet

Behaviour: reducing drinking		
	Pros	Cons
Short term	• Makes me relaxed • I feel comfortable around people	• I spend huge money on it • Family don't like me
Long term	• Relaxed in long term? • What about comfort?	

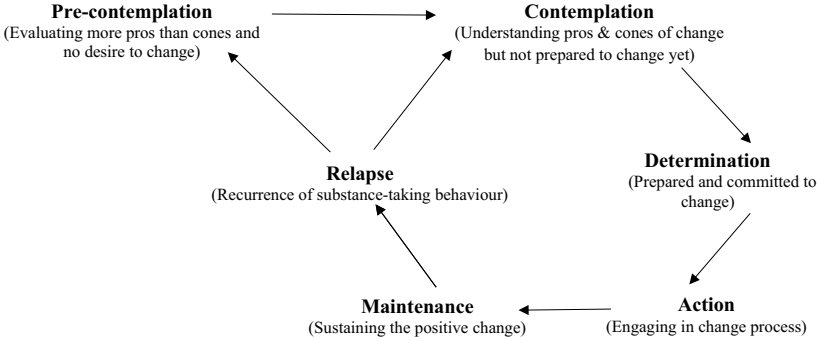

Fig. 10.3 Stages of motivation to change

avoids arguments with the patient through rolling with resistance and clarifies the free choices for the patient. The studies have found efficacy of MET for treatment of alcohol use problems and illicit drug use problems (Hettema et al., 2005).

The preparation of decisional matrix is an essential procedure of MET to build up a motivation to change. An essential step of MET is to jot down on the decision balance sheet in client's own words to build up the motivation for change. Table 10.2 depicts an example of drawing the balance sheet.

It is important to know that during the therapy process an individual may go through several stages of change. There are total five stages of motivation to change that has been described below and shown in Fig. 10.3.

Stages of Motivation to Change

- **Pre-contemplation Stage**: This is the first stage of motivation where an individual is aware of the costs and benefits of taking substance but they are not interested in change and have no plan or intention to change. These individuals generally deny taking treatment.

- **Contemplation Stage**: At this stage, people are aware of problems associated with substance use. However, they are ambivalent toward change. Generally, they have the desire to change but they lack the commitment to change their behaviour.
- **Determination Stage**: At this stage, people made a decision to change as they outweigh the harmful consequences compared to benefits and accept responsibility to change their behaviour. People start making plans to make the needed changes and evaluate techniques for behavioural change.
- **Action Stage**: At this stage, people actively engage themselves in behavioural change by using certain skills and making efforts. An individual at this stage come to the treatment centre willingly for the cure of their problem.
- **Maintenance Stage**: People in the maintenance stage sustain new and desirable behavioural change. They now start coming for regular follow up to the treatment centre, take medicines on time, and follow the doctor's advice.

(c) **Contingency Management (CM)**—Contingency management (CM) approaches are based on operant conditioning of learning theory. It works on the principle that substance taking behaviour can be changed by controlling relevant environmental contingencies. CM programmes focus on enhancement of desirable target behaviours such as drug abstinence, attending counselling sessions, and compliance towards medication regimes. Reinforcing or punishing consequences occur when the target behaviour is not achieved.

There are four basic processes to design CM interventions.

- **Positive reinforcement**: It involves delivery of a desired consequence contingent on meeting a therapeutic goal such as providing increased privileges, tangible goods or praise as positive reinforcers when patient shows compliance towards medical staff, attends counselling sessions regularly, takes medication timely, etc.
- **Negative reinforcement**: It involves removal of an aversive stimuli contingent upon meeting a therapeutic goal, e.g., lifting criminal justice supervision, early curfew, grounding, etc., may result in an increased pro-social behaviour.
- **Positive punishment**: It involves addition of an aversive or painful stimuli contingent upon an undesirable behaviour such as positive test results for the presence of cotinine in saliva.
- **Negative punishment**: It involves reduction or removal of desirable stimuli contingent upon an undesirable behaviour, e.g., reduction of the privileges and rewards.

The effectiveness of CM interventions is mostly influenced by five variables: the schedule used to deliver consequences, the magnitude of the consequence, the choice of the target behaviour, the selection of the type of consequence, and the monitoring of the target behaviour (Sulzer-Azaroff and Mayer, 1991). There are several ways to implement the contingency in substance use. These techniques are illustrated as below

i. **Differential reinforcement of alternate behaviour**: Providing reinforcement when an individual performs any other activity except for taking substance such as watching TV in evening in place of going outside to procure substance.
ii. **Differential reinforcement of incompatible behaviour**: Providing reinforcement when an individual performs a behaviour which is completely incompatible with substance use, e.g., indulging in deep breathing exercise at the time of craving.
iii. **Differential reinforcement of low rate of behaviour**: Providing reinforcement when an individual decreases the frequency and quantity of substance intake.
iv. **Differential reinforcement of high rate of behaviour**: Providing reinforcement when an individual performs a high rate of desirable behaviour, for example, concentrating on studies.

One of the biggest challenges of the therapist is to counter the reinforcing effects of the substance.

(d) **Relapse Prevention Therapy (RPT)**: Developed by Marlatt in 1985, RPT is based on cognitive behavioural approach and emphasizes a functional analysis of cues for substance use and the development of alternative responses to these cues. This approach focuses on the identification and prevention of high-risk situations such as environmental contingencies (e.g., conditioned drug cues), emotional or cognitive states (e.g., negative affect, diminished self-efficacy), and/or physiological states (e.g., acute withdrawal) which are responsible for precipitating the substance use. Some high-risk situations are nearly universal across addictive behaviours, e.g., negative affect (Baker et al., 2004), whereas others vary from person to person, across behaviours, and even within the same individual over time (Witkiewitz and Marlatt, 2011). Individual's expectation of perceived positive effects of use is challenged and therapist psycho-educates them and helps the patient to develop skills for alternative choices of behaviour in the high-risk situations.

(e) **Craving Management**: Craving is basically our desire and wishes to have substance, and it is said to increase in the absence of using the substance. Hence, craving is one of the significant predictors of relapse and therefore management of craving needs to be given special attention. Graham (2004) has discussed two of the strategies to be helpful in managing craving:

I. ***Psycho-education about Craving***

- Craving is the result of long-term substance use and can continue in abstinence state as well.
- Craving can be triggered by anything like people, place, feelings, etc., that was associated with substance use in the past.
- Craving remains stronger when you stop substance and gradually it fades away over time.

- If an individual consistently does anything other than taking substance during craving, the craving starts losing its intensity. This is known as extinction.
- Craving loses intensity if an individual has control over himself and hence craving is not reinforced by taking the substance.

II. ***Behavioural Strategies to Cope With Craving—The 4 D's***

- **Deep Breath**: Deep breathing exercises help in which you inhale deeply, hold it for a couple of seconds, and then release it slowly. It helps an individual to relax and make the craving manageable.
- **Drink Water**: Drinking water at other times and during craving helps to remove the toxins out of your body system.
- **Distract**: Distraction helps in changing their surrounding environment which finally helps to forget their urge to consume the substance.
- **Delay**: Craving is not permanent, it comes and goes quickly. Individuals are told to delay their urge, wait for some time to deal with craving.

(f) **Cognitive Behaviour Therapy (CBT)**: CBT is centred on the notion that thoughts cause behaviours, and these thoughts determine the way in which people perceive, interpret, and assign meaning to the environment (Beck & Weishaar, 1989). Eliciting and identifying patient's problematic thoughts and beliefs that maintain substance use is most essential part of the treatment regime. CBT facilitates the development of self-regulation and coping skills among adolescents by teaching them to find out the internal and external cues preceding substance use. It helps adolescents to practice a number of strategies to deal with situations that may trigger the craving, and to enhance skills of problem-solving (Barrett et al., 2001). Cognitive restructuring is also one of important element to identify and challenge the dysfunctional thoughts either in self-reference or related to individual's substance use. The dysfunctional thought record diary and/or substance use diary can be used for cognitive restructuring among these individuals.

I. **Dysfunctional Thought Record Diary**: The diary helps to identify the situation or antecedents which precipitate substance use, the mood in that situation, automatic thoughts related to that situation and patient's behaviour following that situation.

Case Vignette: Mr Y is 18-years-old boy working salesperson, reported with current use of alcohol for one year and six months. He was brought up in a nuclear family with financial constraints. His mother was a housewife and father was a back office worker. The parenting style of father appeared to be authoritarian. There was the frequent conflict between the parents on trivial issues and patient always used to feel alone. He never used to share his problems with his parents or anyone, was mostly remaining to himself and never used to express his true feeling of anger, disappointment or love to anyone. The patient started taking alcohol initially with one of his friends just for enjoyment but later on took it regularly to get rid of the negative mood state, etc. Initial 5–6

sessions mostly focused on rapport establishment and collection of case history with the patient. Further sessions focused on identification and modifications of cognitive dysfunctions of the patient using cognitive restructuring techniques. The table given below highlights a few of the patient's dysfunctional beliefs.

Situation Where were you? Who were you with? What were you doing?	**Mood** What did you feel? Rate each mood (0–100%)	**Automatic Thoughts** What thoughts were you having before you felt this way?	**Evidence supporting automatic thoughts**	**Evidence not supporting automatic thoughts**	**Alternative/balanced thoughts** What would you rate on a scale of 10 about believing the alternative thought
I was with my Colleague who told me that boss allotted my client to someone else	Ager 90% Frustration 100% Upset 70%	I am useless, it is annoying, Let's have a drink as I want to calm down myself	I was working on that client but I couldn't convince him	I have convinced many of my clients in this job and for that I got appreciation	I had many clients but my colleague had no clients to handle with, maybe that's the reason boss allotted my client to him (8)

II. **Substance Use Diary for Functional Analysis of Substance Use**: Substance use diary is based on the same principle as thought record diary but the focus remains in terms of functional analysis of substance use behaviour. The patient is asked to record the contextual antecedent, thoughts and feelings, behaviour and consequence.

Case Vignette: Mr X, a 16-year-old boy, studying in class 11th was brought up to De-addiction centre with cannabis use for 2 years. Initial sessions with this boy basically emphasized on rapport establishment. After initial two sessions of intervention, therapist proceeded to implement functional analysis for his substance use. Given below table shows how the analysis was done using patient's account.

Day	Time of taking substance	Substance amount	Type of cannabis	In company or alone	Where took place	Feelings before and afterward	Effects of consumption

(continued)

(continued)

Day	Time of taking substance	Substance amount	Type of cannabis	In company or alone	Where took place	Feelings before and afterward	Effects of consumption
Monday	5–6:00 PM	4 Cigarettes with Cannabis	Gamma	In friend's company	At a friend's home	I was feeling boredom before taking and afterward it was pleasurable	Makes me relaxed, I feel good
Tuesday	9 AM	1 cigarette with cannabis	Gamma	Alone	In my room	Restless before taking and peaceful later on	Pleasurable to me

(g) **Family Intervention**: The basic goal of family intervention is to maximize the support gained by family and community and utilizing it to aid the patient in achieving complete abstinence for longer periods. Hence involving the family members in the treatment process is a very important step while planning management for adolescents. The common factors of substance use among adolescents are dysfunctional communication pattern within the family, inadequate family dynamic, interpersonal relationship problems, parental conflicts, and inadequate parenting style. The family intervention plan emphasizes on developing the insight of family members to understand how the family dysfunctions are maintaining substance use in an individual and thereafter how to modify the family dynamics. Some common strategies that are extensively studied among adolescents for treating SUDs are as follows:

(i) **Brief strategic family therapy**: This approach conceptualizes that the adolescent's substance taking behaviour develops due to an unhealthy family system. The therapist observes the interactions of family members and deals with the negative interactions existing in the family. As positive changes begin to take place in the family system, the adolescents' undesirable behaviours automatically will improve. The therapy is implemented over 12–16 sessions in different treatment settings.

(ii) **Family behaviour therapy**: Family behaviour therapy involves contingency management, behavioural contracting, and other interventions based on the adolescent and his/her family's preference. Here, the therapist involves adolescent and one of the parents in the therapy process. The family is encouraged to practice the skills learned during sessions in their everyday lives.

(iii) **Functional family therapy**: It is based on behavioural approaches for the improvement of counterproductive family interactions which

are responsible for contributing to the problematic behaviours among adolescents. The therapist works in close proximity with family members for improving communication, parenting styles, and problem-solving skills.

(iv) **Multidimensional family therapy**: This is one of the most widely used comprehensive modality to address substance use among adolescents. It considers both familial and community systems such as the school for an effective treatment process. Sessions are conducted over a period of 12–16-weeks at various locations such for instance, home, schools, and courts. Sessions are held once or twice a week.

(v) **Multi-systemic therapy**: It also considers familial and community systems with a view that both intrapersonal and external factors (familial and community based) are responsible for the adolescent's substance use (e.g., characteristics of the adolescent, influence of peers, school, family, and neighbourhood, etc.). In this therapy, multiple evidence-based treatments such as contingency management and CBT are used depending on the gravity of the problem in adolescents. The sessions are held over a course of approximately 4–6 months.

(h) **Community Reinforcement Approach (CRA)**: CRA attempts to alter the contingencies present in the environment and include such activities in the patient's daily life that are more rewarding than substance use. Family members are trained in the implementation of reinforcement strategies which they practice at home regularly while dealing with the substance use behaviour or other undesirable behaviours of the adolescents. Adolescents-CRA mostly focuses on development of problem-solving, communication skills in adolescents and their engagement in positive social and community activities so that relapse is prevented.

Conclusion

In this chapter, we saw that substance use among adolescents is a common though serious problem that starts due to a number of biological (e.g., genetic vulnerability, reinforcing effects of drugs, etc.), psychological (e.g., personality disposition, mood and anxiety symptoms, etc.) and social contributing factors (e.g., authoritarian parenting, interpersonal relationship issues in the family, peer pressure, etc.). Inadequate parental guidance is also responsible for substance use which may start with experimentation use and gradually lead to recreational use, emotional use, habitual use, and dependent use. The chronic substance use is found to be linked with a number of adverse physical (e.g., health problems), psychological (e.g., cognitive impairment, psychiatric disorders), and social (e.g., loss of social reputation, social isolation) consequences among adolescents. The diagnosis of depression, anxiety disorder, conduct disorder, and attention deficit hyperactivity disorder (ADHD) are common psychiatric comorbidities associated with adolescents' substance use.

Hence careful clinical assessment including taking a detailed case history and psychological testing are crucial elements for the management of substance use. The psychological management of substance use has been described in detail. It is always important to follow a holistic approach in the management of substance use. The sociocultural background, context, and environmental factors such as peer influences, etc. always need to be considered while planning for treatment. Involving family members is an essential part of adolescents' substance use treatment regimen.

In conclusion, adolescents' substance use disorder has far-reaching psychological and social consequences and is also a matter of great public health concern. A few of the important areas of interventions for associated common problems in adolescent substance users are anger management programme, social skills training, coping skill training, and lifestyle balance.

Adolescents must be approached in a different way compared to adults due to their unique developmental considerations. Adequate guidance by parents is the key to prevention of substance use among adolescents and professionals must be careful about not labelling them as an addict. Psychological intervention must also involve the family of the adolescent. A holistic approach (i.e., assessment and management taking into consideration the unique aspect of an individual) is an essential milestone for treatment of adolescents with substance use disorder.

Globally, India has one of the highest proportions of children and adolescents (aged < 18 years: 45% of the population; 5–19 years: 35.3% of the population) as per the Census of India, 2011. However, around 70% of the children had never sought any treatment for substance use, and only a mere 7.7% were in contact with NGOs working in this field (Dhawan et al., 2017).

As the Substance use report in India 2019 (Ambekar et al., 2019) point out, protection of the adolescents and youth is of paramount importance because they are the future of the *Atmanirbhar Bharat*. For ensuring this, several policies are enforced to prevent the substance use (*Rashtriya Kishor Swasthya Karyakram* or National Adolescent Health Policy, 2014) Furthermore, foundation of such prevention programmes can be placed on the common goals of addressing risk factors prevalent in the community so that adolescents do not get attracted to substance and maximize their growth for becoming productive members of the society.

Time to Reflect

Adolescents are brought to de-addiction centre by their parents for treatment of substance use. Parents come to know about their child's substance use behaviour when a child starts showing disinterest in studies or/and start remaining detached with everyone in the family. The chief reason for consultation remains the problem of substance use that is caused by a diverse set of other issues. Unfortunately, it has been noticed that majority of parents keep on blaming the child for their substance use and many times they behave harshly with the child. Therefore, the core problems that require professional's special attention remains completely untouched by family

members which as a result maintain substance use directly or indirectly. The irony is that majority of the family members remain unaware of these issues of their child. This is the high time to consider the fact that nothing happens without reason. If an adolescent starts taking a substance, then it should be our responsibility to explore the untouched and painful reality of that individual.

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Chapter 11
Adolescents and Digital World

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Abstract The chapter focuses on adolescents as the netizens in the twenty-first century. With changing ways of relating to people, working, and functioning, the digital world has become a new world for the adolescents which can be both a boon as well as a danger depending on how effectively they navigate the digital world. The chapter discusses the threats and opportunities of the virtual space. The implications of online education and identification with the social media world by the adolescents are discussed. It also explains the impact of the tech world on the adolescent development and the family highlighting the need for a family digital strategy. Risk factors contributing to the negative impact of adolescent digital engagement are discussed. Prevention and intervention strategies for digital addiction are also described.

Keywords Adolescent · Internet · Media · Social networking sites (SNS) · Digital world · Online education · Risk factors · Internet addiction

The Realm of Digital World

The advent of the Internet has opened up multiple channels for communication and information sharing for the entire population which is remarkably faster and flexible as compared to our traditional modes of communication. The digital world is invading adolescents' micro-systems, their homes, classrooms, social interaction, and all other activities, thus, significantly altering their affective, behavioural, and cognitive aspects of functioning. The evolving technology has made it possible to offer engaging online information, images, videos, games, and the use of social media—all of which have the potential to make the individual hooked to the online world. Adolescents today are born into this virtual world, using smartphones and laptops from an early age. Although factors related to necessity, convenience, status, etc., contribute to this early engagement with the virtual world and consequent behaviour of netizens, this may affect functioning and adjustment in different aspects of life and have serious consequences.

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Studies on the prevalence of Internet use show that 92% of American adolescents go online everyday and 24% reported to be online 'almost constantly' (Lenhart et al., 2015). Data regarding dysfunctional use of interactive media report 0.8% in Italy (Poli & Agrimi, 2012) to 14% (Wu et al., 2013) in China. In a study on 987 adolescents in India (Goel et al., 2013) with a mean age of 16.82 years, 74.5% were found to be moderate or average users and 0.7% were found to be addicts using Young's original criteria. In another study by Bhat et al. (2016) on 1763 participants with a mean age of 19.73 ± 1.4 years using Young's original criteria, it was found that 10.4% were moderate problematic users and 0.8% were severe problematic users. Further, 35.5% of participants felt that they are addicted to the Internet. In a study sample of 724 students from class 8–11th, the prevalence of Internet addiction was found to be 8.7% (Prabhakaran et al., 2016). Further study (Kumar et al., 2019) on 3973 respondents from 23 engineering colleges across India reported 25.4% indicating problematic use of the Internet. A recent study by Hassan et al. (2020) on 454 participants in Bangladesh reported the overall prevalence of Internet addiction as 27.1%, and the addiction rate was 28.6% in the 19–24 years age and 23.5% in the 25–35 years age group.

Adolescents are the most frequent users of the Internet. The activities of present generation adolescents are no longer bound by the strict physical demarcations of home, school, and neighbourhood. Adolescents have a broader set of opportunities than ever before and classrooms of universities and schools can interact with their counterparts from any part of the country and world through online services provided by apps such as Google Meet, Zoom, Microsoft Teams, and Webex. These applications help create digital proximity through which ideas and knowledge can be shared, and teaching and instruction can happen by audio-visual mode. Research by Cifuentes and Murphy (2000) in elementary schools has found that such interactions can deepen multicultural understanding across international borders which ultimately promote an increasingly global society. The advancements in technology and Internet-mediated facilities have made it a lot easier for the adolescents to accomplish several things at once which is commonly understood as multitasking.

However, every technological change brings some advantages, disadvantages, and challenges. Similarly, the use of digital technology that pervades almost every aspect of an adolescent life ranging from education to information, entertainment, and social relationships also produces challenges for the adolescent in different aspects of development and functioning. For example, the printing press was invented in the fourteenth century and people at that point of time feared the loss of oral traditions and our capacity to memorize long narratives. However, printing facilitated the stage for the scientific revolution. Gradually people learned skills to adapt to the changes which were created through printing and converted them into opportunities.

The digital landscape has drastically increased its space among adolescents and demonstrated distinct patterns of media consumption by the age group. Thus, the impact of digital media gadgets on adolescents' behavioural metamorphoses varies with the influence of several contextual factors such as instructive mediation or restrictive mediation by the parents. People in general and parents in particular are faced with the dilemma of negotiating with the digital behaviour of their children.

There seem to be paradoxical situations such as how much screen time a child should be permitted, how to keep media gadgets out of children's bedrooms, or what rules should be set for media usage by adolescents. Technology has invaded our life to such an extent that it has hugely impacted our lifestyle and daily functioning. It has become difficult to demarcate how much use of screen time is sufficient and healthy and what is unhealthy.

In an agrarian society like India, spending time with children was considered valuable but with the advancement of digital technology, joint activity between older and younger generations is gradually disappearing. In the past few decades, technological tools and media gadgets have become so entrenched in our daily routines that even parents, adults, and adolescents are not what they used to be a few decades back. We must understand how these digital contexts have altered the family and social interaction patterns. Cultural values of parents and teachers as role models have changed due to increased media interaction and its influential role in learning, motivation, cognition, and socialization. Excessive digital media involvement further leads to passive orientation among the adolescents.

Turkle (2011) has documented that the cell-phones are playing a crucial role in delaying the parent–child separation. Earlier, there used to be a moment in child's life when he used to take the first unaccompanied step into the world beyond home and school (e.g., navigating the city alone by urban kids). Whereas, now it is not uncommon for the college students to still text their parents about their whereabouts and other matters just as they might have when they were in elementary school with cell-phone. Turkle (2011) writes, "everyone important is on speed dial" (p. 173).

The rules of social engagement have changed drastically with the preponderance of digital media interaction, affecting the identity development of an adolescent. On the flip side, this has led to social withdrawal and social anxiety in adolescents arising out of frustration in personal companionship. Further, the emergence of narcissism among the adolescents is becoming more evident with the growing digital networking, urbanization, and nuclearization of the families. The relationship between parents and the adolescents has undergone a dramatic shift in terms of perceived responsibilities. Digital ecology platforms provide huge opportunities for self-promotion by engaging in self-descriptions in different social media, catering to one's vanity and pride by posting photos of oneself, and trying to increase the 'friends' list online (though shallow relationships), all of which may be related to 'trait narcissism'. A growing proclivity of sexting as flirtations and normative relational aspects of adolescents' interactional experiences can have pronounced social implications.

Digital media and Internet-mediated communication are reshaping and restructuring patterns of social interaction and everyday aspects of our personal life. The technology-mediated communication of this digital age has far-reaching psychosocial implications. The digital media interaction helped in establishing a global village where media tools are inextricably woven into our lives. Along with the benefits, this has opened up many difficulties and challenges that adolescents experience with online navigation that need to be explored. For example, the challenges experienced

with the replacement of traditional classroom settings by online educational platforms, connectivity issues, intergenerational conflicts regarding engagements with media, cyberbullying, sexting, undue exposure to unhealthy sexual materials, and myriads of entertainment opportunities have made this platform far more complex and challenging.

According to Takeuchi and Stevens (2011), the vast expanse of media use has redirected our focus on joint media engagement where people can interact and use media together rather than the earlier notion of using media as isolated individuals. This is especially visible in the case of young people who engage in multiple forms of media. Hence, it is important that we may better take advantage of the unique capacity of human beings to work, learn, think, and make things together (p. 5). This highlights the need to understand the adolescent's behaviour, experience, and functioning in the digital world so that it will enable the stakeholders to harness the benefits and opportunities of the online world while taking care of the threats or the negative impact of the interactive media use.

Uncontrolled or excessive use of the Internet has been found to be problematic affecting negatively physical and psychological well-being of the user. Adolescents who are avid users of the Internet are especially vulnerable who are still developing in their cognitive and emotional–social aspects of development.

Internet addiction is commonly used to highlight the ill effects of Internet use leading to addictive behaviour and consequent dysfunctioning in various areas of life. The term 'Internet addiction' was used for 'pathological compulsive Internet use' by Dr. Ivan Goldberg in 1995 (Ivan, 1995). It is marked by excessive or poorly controlled preoccupations, urges, or behaviours regarding computer use or Internet access, leading to impairment or distress (Shaw & Black, 2008). Mark (2000) has specified six 'core components' of addiction, i.e., salience, mood modification, tolerance, withdrawal, conflict, and relapse. Davis (2001) points out that since addiction refers to a dependency on psychoactive substances, pathological Internet use (PIU) is a better term to use than Internet addiction. However, Caplan (2007), based on his studies, advocated the term 'problematic Internet use' instead of 'pathological Internet use' as social isolation plays a greater role in behavioural symptoms of PIU rather than psychopathology. Though Internet addiction has not been included in DSM 5, gaming disorder has been included as a diagnosable mental disorder in DSM 5 and also International Classification of Diseases 11 (ICD) by the World Health Organization (World Health Organisation, 2018). Prevalence of gaming disorder has been reported to vary from 0.7% to 27.5% across studies (Mihara & Higuchi, 2017). A pooled analysis of four large international surveys estimated the prevalence in the general population to be between 0.3 and 1% (Przybylski et al., 2017).

Impact of Digital World on Adolescent Development

The media-saturated environments may have psychosocial consequences for the developing child and adolescents. Online platforms such as YouTube and Google

provide a larger degree of connection among their peers. But what are the threats and opportunities these digital technologies and the social media world offer to this connected generation?

Bronfenbrenner's ecological systems theory proposed that the surrounding environment of the children including human–human, human–environment, and environment–environment interactions shapes media effects on learning(Bronfenbrenner, 1992). It is difficult to isolate the media–children interaction effects without simultaneously taking into account characteristics of contextual and environmental factors. A better understanding of the media interaction dynamics of the adolescents can be achieved by analysing how an adolescent learns at school, parent–child interaction time, other community spaces, and other ecological transition processes from natural territories to digital territory. Adolescents today are being bullied not only on the school playground, but also being bullied online on social media platforms and smartphones, where messages may reach them even while being at home, once considered as safe sweet home.

Earlier Internet was mainly for infotainment—information and entertainment. Now it has also become an important medium for gaming and social networking through the use of various social media and also used for the purpose of learning and education. Smartphones and various social media devices have contributed a lot to the use of social media by offering infinite access and connectivity (Goggin, 2014). Smartphones also make it easy to engage in online games and have redefined how the young are spending their leisure time. Peer pressure and having various social media accounts as a status symbol make the adolescent vulnerable to develop an addiction to smartphone use.

The digital world has offered a lot of opportunities in terms of easy reach, access, connectivity, and impact. It has brought the whole world to our fingertips. Anything, anywhere, and anytime is the buzzword of the online world. However, the constant engagement in the virtual world and web-based interactions can have a negative impact on the growing adolescents. It may also pose threats to the development and well-being of the adolescents. It can affect the physical health, mental health, social relationships, and academic achievement of the adolescents. Excessive use of the Internet and social media also impacts one's work performance and family relationship and interaction negatively. Overuse of the Internet to engage in chatting, playing video games, and surfing the web may affect the eyesight (Bener & Al-Mahdi, 2012) as well as the weight (Murray et al., 2016) of the adolescents. Since most of the time is spent sitting only or lying down, it leads to a sedentary lifestyle and obesity which further may lead to other physical health issues.

Mental health is also affected as the constant and excessive use of the Internet gives rise to stress and anxiety (Goel et al., 2013) in adolescents. It is associated with three psychological health pointers comprising of poor self-rated health, subjective unhappiness, and depressive symptoms (Ha & Hwang, 2014). Pathological Internet use and depression have been found to be correlated (Young & Rogers, 1998; Ha et al., 2007).

Relationship difficulties arise in the peer group and in family (Lakshmana et al., 2017) due to preoccupation with the social media, gaming, and other Internet use.

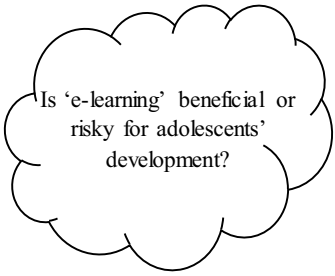
Adolescents may have increased virtual relationships, but decreased real contact relationships which have an adverse impact on their development and acquiring social skills. Their social world and social relationships are characterized by 'like', 'comment', 'friend', etc., which may affect their socio-emotional development. Social media is a top venue for flirting (Lenhart et al., 2015). Adolescents' social media interaction in the Indian context has resulted in problems of cyberbullying, problematic Internet use, and development of depression among the adolescents and young adults. Mental health-related problems were found to be more in those with Internet addiction (Kuhu et al., 2017).

Uncontrolled use of the Internet impacts negatively the studies and daily life routines of the addicts (Chou & Hsiao, 2000). It, thus, affects all aspects of the health and development of adolescents.

Online Education

One of the key benefits of the digital world is online education. In the current COVID-19 pandemic, online education has become the panacea for taking education to the students. Although online education existed earlier also, it has now become an increasingly widespread medium, especially in India for delivering knowledge and teaching the students who are physically separated from the teachers and instructors. Traditional classrooms have been substituted with virtual classrooms for teaching. Virtual campuses have technologically enabled systems making possible interactions between different stakeholders of the university without the necessity for sharing the physical proximity. The use of technology in learning and education has witnessed exponential growth in the past few months in India. Students in India experienced a rapid and disruptive change in the educational landscape with the sudden outbreak of the COVID-19 pandemic in the year 2020.

The extent of the digital divide in the Indian context came to the fore during the COVID-19 pandemic times which was influenced by household income, gender, rural residence, or urban residence. It had serious limitations for the students and teachers in terms of training to handle Internet-mediated learning. Access to the Internet has a major issue owing to 3G/4G connectivity problems in the remote parts of the country. The late adopters of Internet-mediated learning also hampered the effective use of digital learning.



Prosperio and Gioia (2007) argued that in response to changing learning styles of the virtual generation, teachers need to evolve to become a guide for teaching students the ways to search for and recombine information and knowledge. The interaction of students in online course and engagement in the class vary with instructors' ability to generate and facilitate interest among students. The lack of availability of smartphones and laptops in rural areas, erratic electricity supply, and intermittent Internet connectivity make the process of online education very difficult for the students. Further, teachers' lack of proficient use of pedagogically sound technology affects the quality of learning outcomes despite good intentions. The definition of digital learning is vague and ignores the nuances involved in preparing teachers and students for digital education. A mere possession of any digital gadget without learning the art of engaged online conversation with context sensitivity is likely to make e-learning a passive mechanical activity. Social processes of identification, intimacy, and warmth among users, eye-contact, body language, and other non-verbal cues important for effective communication are largely missing from online education.

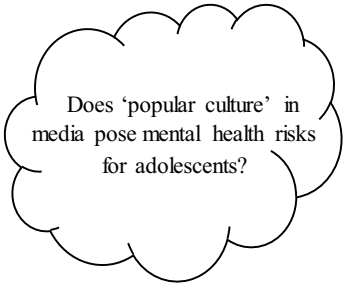
The theory of attentional social presence highlights four options as important for the construction of social presence to enhance communication and secure audience interaction: budgeted, entitled, competitive, and invitational (Turner & Foss, 2018). Further, the social identity theory of deindividuation effects explains the effects of anonymity and identifiability on group behaviour. It proposes that situations in which individuals act in groups do not see themselves as individuals, thereby, facilitating anti-normative behaviour.

In the Indian context, online education at a wider level is at the experimental stage and a variety of factors need to be considered to use this medium. In view of the lack of adequate Internet facilities, the diverse nature of the Indian society, and the demographic variations, traditional classroom teaching cannot be and must not be replaced in haste. An important aim of education is the emancipation of our social problems. Classroom teaching and interactions can greatly help in cultivating the relational qualities of empathy, sensitivity, and influence beyond individuals at all social levels.

Use of Social Media

A majority of adolescents access social networking sites (SNSs) multiple times by engaging in self-presentations by posting updates and photos. Exploration of 'self' has been understood as one of the primary objectives of adolescents, and hence, social media networks act as a significant medium to express identity and self-concept. Presentation of self on social networking helps them in the development of one's sense of self and identity.

Adolescence is the crucial period in the life span of an individual characterized by the freedom to define their own values, breaking away from parental views and values. Literature on adolescence shows that self-exploration can manifest itself visibly as teens express changing attitudes through their use and adoption of current fashion and style. The majority of global and Indian adolescents use digital platforms to socialize and hang out with friends. Many teens use profiles on SNSs which have several features on affordances that provide rich and varied opportunities to digitally post biographical information such as age, sex, location, interests, hobbies, books, and movies.



In his seminal work, Erikson (1960) argued that the process of coming to understand one's identity has a normative peak during adolescence. It is important to highlight that teens tend to express who they are and wish to experiment with others' reactions towards them through social media posts. In this context, the Marcia (1966) theory of identity statuses also emphasizes about the need for exploring one's identity. For instance, the foreclosure status in her theory occurs when an individual commits securely to an identity that is never truly explored. From a development point of view, adolescents who have not been able to define their identity can suffer psychological and social consequences.

Interpersonal interaction is crucial to young person's identity formation. The control theory of identity highlights the integration of interpersonal feedback, i.e., the communication and feedback received from others, into the adolescent's identity exploration (Kerpelman et al., 1997). Although adolescents still interact in face-to-face social situations, still there are a set of teenagers constantly 'plugged in' to SNS technology.

A positive and supportive environment created by the parents facilitates teens' exploration of identity and influences their self-concept development. Self-concept refers to having a clear sense of oneself—'who and what of oneself', whereas self-complexity indicates the diversity in the content of the self. The development of self-concept with the use of SNS helps in social connections, hobbies, and maintaining relationships. However, it is important to ascertain what adolescents are doing on SNSs in addition to assessing the time spent on it. Digital profiles provide the architecture for digital self-representation. Social interactions influence the development of the self. As Goffman (1959) points out, people's sense of self is the "product of scene and is not a cause of it" (p. 253). Much of the social interactions of individuals involve managing the impression that others will have of them (Goffman, 1959). This might impact the self-esteem of adolescents also which refers to an individual's positive or negative attitude towards the self as a totality (Rosenberg et al., 1995; p. 141).

Thus, several factors like time spent, the content of the interaction, parent–adolescent communication, and varying patterns of usage and context patterns of usage and context factors can play a crucial role in the identity formations of adolescents. The 'storm and stress' that is often associated with adolescence can be significantly influenced by their digital activities and engagements.

Theories on the Effects of Media

Various theories have explained the effect of media on the individual. An understanding of the online behaviour of adolescents will help design appropriate strategies for maximizing the benefits and minimizing the threats or risks of the online world.

Media Effects Theory

In order to understand the effects of digital media on adolescents, it is desirable to know about important theories of media effects. Historically, media effects are characterized by three- or four-phase model with its boundaries defined by emerging media technologies, the overall cultural context, and ideological perspectives used by the prominent researchers and theorists. The first phase of this model is characterized by 'magic bullet' or 'hypodermic needle' metaphors symbolizing that 'medium' shoots the messages and creates impact into its receivers. Thus, it focuses on the content of the media affecting the development of the individual. In the initial stages of mass media expansion, the printing press, newspapers, films, and radio intruded into everyday life and played a significant role in shaping the opinions, attitudes, and behaviours.

Cultivation Theory

This theory was conceptualized by George Gerbner in 1969 and has still remained a powerful theory of mass communication in the constantly changing media environment. Cultivation theory proposes the ability of television to influence and shape the people's values and beliefs about the world. This theory argues that people acquire knowledge in the form of stories. Television disseminates stories of three types namely fictional stories (how things work), news stories (how things are), and stories of values (what to do) which ultimately shares the opinion of its viewers.

Globalization has caused fusion among the cultures. Most of the dominant media messages have flowed towards the cultural centre of gravity, i.e., the most common homogeneous, dominant stream in the society rather than towards conservative views or liberal views. Our value systems—ideologies, assumptions, beliefs, images, and perspectives—are cultivated to a great extent by television portrayals of right and wrong. Cultivation impact is determined by the repetition of messages of a particular type, exposure time (heavy viewing or light viewing), and knowing about users' viewpoints. While evaluating the impact of TV portrayals, variations in age, sex, socio-economic status, minorities, and occupational factors also play an important role.

Uses and Gratifications Theory

The uses and gratification theory (Katz et al., 1974) advocates that people use mass media for deriving gratifications. This theory's assumptions also apply to digital media usage of people who use it to satisfy various needs including cognitive, affective, personal, and social needs. People and especially adolescents use social media for social interaction, information acquisition, sharing, and self-expression. Digital media platforms also enable adolescents to participate and interact on various issues of public importance. They also use social media for entertainment, gaming, and viewing trolls and humorous content.

Children, adolescents, and young adults use social networking sites (SNSs) to express their views. Whiting and William (2013) discovered that 56% of their respondents used social media to express their opinions and thoughts by liking and sharing posts, photos, and comments. Some of the adolescents join professional online sites like LinkedIn to seek the promotion of their career prospects. In fact, surveillance is also one of the motives of the young population to use social media. In Whiting and William's (2013) study, 32% of respondents used social media to spy and monitor what other people are doing. Therefore, on the basis of this theory, it can be reasonably assumed that adolescents derive various types of gratifications by the use of different digital media platforms.

Third-Person Effect Theory

According to Davison's (1983) theory, people believe that other people are more influenced by the media messages than they themselves indicating a perceptual bias resulting from the third-person effect. Mass media messages are generally attributed as having powerful effects on the attitude and behaviours of the mass audience. This self-serving bias to believe that other people are more vulnerable than oneself may be applicable in the online usage of anti-social media messages such as violent rap lyrics, pornographic content, or media violence (Paul et al., 2000; Perloff, 1993). Media perceptions such as the third-person effect seem to be a cross-cultural phenomenon but socio-cultural factors may moderate the impact.

Though the magnitude of the third-person effect may vary on the basis of individual differences it has certainly some behavioural consequences depending upon the media types and adolescents' willingness to support the imitation of controversial contents such as violence and pornography. Social networking sites (SNSs) have indirect behavioural consequences on the adolescents. Unlike traditional media, SNSs have turned out to be very influential media platforms for the adolescents.

Framing Agenda Setting and Priming

Framing research is a strategy of constructing and processing news discourse (Pan & Kosicki, 1993) that examines 'individual frames' (Scheufele, 1999) or 'mentally stored clusters' (Entman, 1993, cited in Scheufele, 1999). This internal structure of mind perspective has two broad foundations, i.e., sociological and psychological. Users of mass media do not usually encounter messages with a blank mind. They use schemata or initiate expectations that lead one's exploration in a particular direction while ignoring others. There are differences in terms of semantic and schematic activation. This varies on the basis of information stored in memory and external cues, respectively.

Agenda Setting Theory

Agenda setting theory developed by McCombs and Shaw (1972) refers to the creation of public awareness and concern of issues through media influence and attempts to establish a preference in the minds of people. The setting of agenda refers to the effect and transfer of media agenda to the society in a reciprocal way. Media activities do not operate within a vacuum. Further, the agenda of media also exerts a subtle form of control on 'how' and 'why' of the public opinion.

During the times of digital media expansion and availability of heterogeneous media, the situation has changed through fragmentation of audiences. Digital media

platforms may influence agenda setting through the social media sharing to a large audience. The traditional power of mass media has led to the reduction in the influence of political agendas due to the personalized use of digital media. Adolescents and children nowadays prefer entertainment in comparison to news and political knowledge. In the contemporary times, mass media is losing its grasp on the public agenda due to increased selectivity and audience fragmentation. On the contrary, digital online platforms for social networking and entertainment such as Instagram, Facebook, and WhatsApp are growing in popularity leading to customized information through filters which limit exposure based on past searches and interests. Bulkow et al., (2013; p. 59) suggested that …agenda setting, aims at homogenizing the public opinion by bringing in live positive judgments of involved and uninvolved persons for issues which are regarded as important by the media at a certain point in time, thus covering the society as a whole.

Priming Theory

The priming theory of media is based upon the cognitive psychology model of human memory which assesses the effect of priming on public opinion. According to this theory by Iyengar and Kinder (1987), exposure to one stimulus influences a response to a subsequent stimulus, e.g., the word 'student' is recognized more quickly following the word 'teacher' and then by the word 'bread'. Priming can be perceptual, associative, conceptual, affective, or semantic.

Media may prime goals and behaviours within their audience by providing information about 'significant others' embedded in media content. These may trigger motivational and behavioural responses in the audience, e.g., celebrities can be shown repeatedly in the media leading to priming aspects of an individual's self-concept. Another example is the role of media in the form of movies and video games in the formations of aggressive thoughts and emotions among children and adolescents. However, the priming effect may be moderated by chronic media exposure, personal salience of issues, and the need for cognition.

Co-construction Theory

With a plethora of social media and digital environments available such as chat rooms, instant messaging, text messaging, and social networking sites, users construct and co-construct their environments (Subrahmanyam et al., 2010). It is, thus, a dynamic environment where the users co-construct and use various digital platforms and tools in varied ways. The critical issues in the life of adolescents concerning their identity and social development get reflected in their online interactions also. Co-construction theory suggests that adolescents help to create the content of digital communication influencing their lives and pointing at a strong continuity between

adolescents' offline and online lives (Subrahmanyam et al., 2006). Thus, Internet as a cultural tool (Greenfield & Yan, 2006) creates online cultural spaces and norms that affect the well-being of adolescents.

Risk Factors

Risk factors for Internet addiction may range from physical, psychological to socio-cultural factors. Lam (2014) based on a systematic review of longitudinal studies pointed out three broad categories of variables: psychopathologies of the participants, family and parenting factors, and others such as Internet usage, motivation, and academic performance. Internet use time, neuroticism, and life impairment were found to be the three main predictors of Internet addiction (Hassan et al., 2020; Wu et al., 2015) which indicate multiple factors interacting to lead to addiction.

In the contemporary digitalized societies, the breakdown of social support and increase in self-centeredness have contributed to the emergence of excessive dependence on social media platforms. Family satisfaction, the first familial factor studied by researchers (Ko et al., 2007) among Asian adolescents, indicated a negative relationship with Internet addiction. A detached family relationship significantly contributes to Internet addiction (Hassan et al., 2020).

Using the Internet for playing games was found to be related to at risk for Internet addiction in around 5% of school personnel in a rural area in Japan (Tsumura et al., 2018).

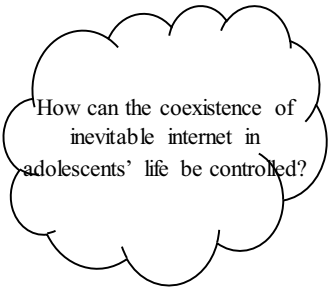
In the recent COVID-19 pandemic during the lockdown period, 50.8% of the participants reported increased gaming behaviour (Balhara et al., 2020). It indicated the use of gaming behaviour by adolescents as a coping mechanism against stress. This highlights the need to develop awareness about appropriate coping strategies which can be a protective factor for the adolescent. For instance, parental use of excessive Internet may be imitated and seen as acceptable behaviour by the growing children in the family. Effective parent–child communication and a cohesive family environment (Hassan et. al., 2020) are protective factors for the proper development of adolescents.

Implications of Adolescent Digital Engagement

The adolescence stage is characterized by novelty-seeking, curiosity, and experimentation. The digital world offers them an exciting opportunity to form friends and look out for new things. This is also a 'cool' thing and a very much 'in' thing for the adolescents to engage and be a part of the social media world. However, this may raise concern for adolescent well-being because of their characteristic impulsive nature and risk-taking behaviour of adolescents and also the fact that their ability for self-regulation and other executive functions are still developing.

Everyday life activities of adolescents in the contemporary time period are construed and constructed around the paramount reality of online socialization. The diverse range of activities, public and private, rational and irrational, their interpersonal bonds, their meeting place, conflicts, and the sum total of relations are guided, shaped, and influenced through interactions on digital platforms.

Phenomenological, interpretative, critical, and social identity perspectives are necessary for understanding the complex role of the Internet in everyday life. High usage of the Internet by different types of adolescents and different ways of using along with changing familial and cultural contexts would bring about widely divergent consequences. Adolescents engage in active sense-making, sometimes threaten and undermine the privacy of their friends, and don't hesitate to participate in acts of aggression and possible oppression. As with the growing infrastructure of the Internet and the number of Internet subscriptions rising phenomenally everyday with dangling wires across the open spaces between apartment buildings, wireless connections entering our tiny bedrooms, the cyberspace has become a vehicle for responsible and irresponsible behaviour.



The world of the Internet has opened up a wide range of activities, new patterns of behaviour in the new contexts where expectations of autonomy, privacy, and ethics are at risk. Several instances of misuse of Internet platforms in the form of cyberbullying, trolling, dating, sexting, and privacy violations are taking place frequently. The problems of identification due to anonymity and pseudonyms often pose threat to the peace and happiness of adolescents and pose a serious challenge of tracking the IP address and public Internet terminals to the law-and-order agencies. Cyberspace can't be depicted as a coherent unambiguous whole rather it consists of a wide range of activities, and the onscreen performances engaged by adolescents are embedded in everyday social practices. The possibilities of playfulness and deception had been the dominant themes of gender and sexuality in digital cultures. Identity deception in different forms is a common practice on Internet sites ascertained through verification that lets other members 'verify' that you actually are who you actually claim to be. Further, the online world can create and recreate the body in so many ways through image text and sound that can create a problem for the adolescent.

There are issues related to dissolution and fragmentation problems, and options of creating embodied persona have increased on digital interaction of adolescents.

Many value-based ethical practices are compromised in Internet-mediated communication contexts, and balancing privacy, accountability, reliability, self-expression, and security always remains unstable owing to situational and contextual factors.

There are various readings of Butler's theory (1990, 1993) of gender performativity in cyber-spatial contexts. Many Internet researchers have explored the connections between Internet games and sexuality (e.g., Consalvo, 2003). Taylor (2009) has made important contributions to the area of embodiment and gaming.

Risky Encounters

The extraordinary rapidity of Internet diffusion and the development of digital platforms online have led to increased risks for adolescents in the recent years. Public anxieties and the anxieties of parents in the Indian context have also increased manifold times. There is a typical paradoxical situation that poses a moral dilemma for the parents that opportunities and risks are inextricably interwoven in the engagement of online technology. The design and content dynamics of online materials are such that it becomes difficult for the parents to draw the boundary lines between safe use and risky encounters. Advertisements related to pornographic content keep flashing while children use the Internet. The offline conduct of adolescents can be socially regulated by parents and teachers while this factor goes unregulated on the online platforms. Mancheva (2006) reports that one in three Internet users in Bulgaria have met in person somebody whom they met online, and one in three have experienced continuous attempts to communicate with them (often about sex) against their will. A 2006 survey in Poland reported that two in three Internet users make friends online and share personal information, almost one in two had met someone whom they encountered online and half of them went alone, and one in four of these described the behaviour of the other person as suspicious (cited in Dreier et al., 2013).

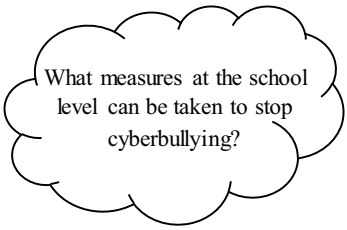
In the Indian context, we also very commonly experience cases of polyvictimization by children and adolescents' bullying in schools and in our day-to-day social life. In anthropological parlance, a relationship is called a 'joking relationship' (Radcliffe-Brown, 1940), where the person in such a relationship can throw abuse and banter against each other.

Cyberbullying involves harassment by teasing or insulting victims using modern digital platforms. Bullying among children generates from healthy socialization turning into ugly and hostile manifestations of interactional dominance. Based on evidence from research, there are immediate and long-term detrimental effects of school bullying on the educational, psychological, and professional lives of the students.

Cyberbullying is more prevalent than traditional bullying owing to the anonymity offered through digital platforms as it is easy to harm without physical interaction. It requires little planning as the threat of being caught is less and lack of supervision also acts as a contributory factor in committing cyber offences. Victims of cyberbullying can be reached at any given point of time whereas traditional bullying occurred during

school hours. Relational aggression is a very common form of bullying where the bully uses their social network to spread rumours or indirectly attacks or threatens relationships in order to produce a particular outcome (Jackson et al., 2009).

Adolescent age seems to be a more vulnerable group as it is a transition from the innocent world of childhood into the mature world of adulthood. Psychological problems like depression and lack of interest in school activities are some of the symptoms experienced by cyberbullying victimization. In some situations, prolonged bullying may lead to eating disorders, suicide, and homicide as a consequence of persistent anxiety, low self-esteem, and feelings of anger and revenge. Some of the normative factors of socio-cultural acceptance of anger as acceptable means for solving problems are shown in the media such as violence shown in Bollywood movies and use of force to achieve a goal, caste, and gender-related stereotypes and aggression used as a suitable strategy for getting something they want. The power and performance of the written word and textual attacks often carry a heavier emotional impact than that of verbal attacks. It is difficult to establish simple cause and effect relations for the prevalence of cyberbullying owing to the influence of a complex set of factors contributing to this process. The dominance of consumerism, nuclearizing family system, low–high-income gaps among the household, lack of parental support due to strict and extended working time schedules, urban anonymity, lack of communication ethos of helping each other, marital discord, rising divorce rates, and high pressure to perform to get a job are some of the factors relevant in the Indian context.



Problematic Internet Use (PIU)

The Internet has dramatically increased in the world and in India. Research in this area has used various terms like ‘Internet addiction’; ‘Internet dependency’; ‘cyberaddiction’; ‘virtual addiction’; or ‘compulsive’, ‘problematic’, ‘excessive’, and ‘pathological Internet use’, all being similar to problematic Internet use. (Breslau et al., 2015; De Cock et al., 2014; Kuss et al., Kuss, Griffiths, et al., 2014, Kuss, Shorter, et al., 2014; Richter et al., 2016). The reasons for the use of variable terms are lack of internationally agreed unanimity on this issue and lack of agreement to call it independent pathology. Currently, gambling disorder is the only accepted behavioural addiction

in the Diagnostic Statistical Manual of Mental Disorders (DSM 5). Some of the researchers use the term 'problematic Internet use' (PIU) while others use 'Internet dependence' with no necessary notion of disorder per se. It would be more apt to explore the dynamics of Internet usage and discuss the relevant concepts related to this field. Preston (1941) cited in Tokunga (2015) was among the first who described media addiction as "giving oneself over to habit forming practice very difficult to overcome, no matter how the after effects are dreaded."

Television addiction has been conceptualized as a multidimensional phenomenon consisting of three key elements: (a) loss of control that results in too much time spent in front of the TV; (b) unsuccessful attempts to reduce its use; and (c) functional impairment such as professional and social problems (Kubey, 1990). It is also an important aspect to understand and analyse that at times moral panics or exaggerated reactions are highlighted whenever there is a lack of concrete empirical evidence at a large scale and at a longer period of time. Internet nowadays has become an integral part of adolescents' life activities and it has become extremely difficult to dissociate offline from online.

In 1996, Kimberley became the first to publish a detailed case report of a 43-year-old female homemaker with addictive use of the Internet, similar to an alcohol addiction. However, other researchers disagreed with this and concluded that an addictive behaviour could exist among certain Internet users. Several other studies published later showed that addictive Internet users can in fact experience similar symptoms as were traditionally found for substance use disorders, i.e., salience, withdrawal, mood modification, conflict, and relapse. (Kuss & Griffiths, 2012; Kuss et al., Kuss, Shorter, et al., 2014; Widyanto & Griffiths, 2006).

A systematic literature review conducted by Kuss and Griffiths (2012) concluded that on the molecular level, Internet and gaming addiction is characterized by an overall reward deficiency that entails decreased dopaminergic activity. The Internet can have beneficial effects on the users in many situations; hence, many researchers are cautious enough not to label it as addiction. In a variety of situations, Internet use may become a saviour for alleviating the real-life problems and individuals may feel a strong desire to connect to it but to suggest that this is a mental disorder seems to be a stretch.

Mitchell (2000) had commented that the question of Internet addiction having a diagnosis of its own is debatable as it is difficult to know whether Internet addiction develops on its own or occurs as a result of underlying comorbid psychiatric illness. After more than a decade, this debate still remains open as reflected by its non-inclusion in the DSM 5.

Cognitive–behavioural perspective considers PIU as a multidimensional syndrome having cognitive and behavioural symptoms leading to negative social, academic, or professional consequences (Caplan, 2005). PIU is considered as an outcome of deficits in online relationships and relationship-building resources (Tokunga & Rains, 2016). Hence, such adolescents may prefer online interaction over face-to-face interaction as they may suffer from psychosocial problems like loneliness and depression. Relational resource deficit indicates uncontrollability over Internet use and mood alteration. Similar to the central characteristics of substance

use disorder and gambling disorder, it highlights impaired control, interpersonal problems related to use, neglect of major roles, restlessness when not allowed to use, and withdrawal from important activities.

DSM 5 includes Internet gaming disorder (IGD) as a potential behavioural disorder, explicitly referring to the Internet as not yet an acceptable disorder, rather it is included as a potential disorder needing further research prior to consideration for inclusion as an official disorder. The central symptoms of IGD include preoccupation, withdrawal, and tolerance, along with unsuccessful attempts to control its use. Deception, escape, jeopardized relations, and job or career opportunities are some of the other symptoms of gaming disorder. Though complete unanimity and consent statements are lacking for Internet use disorder, there is no denying the fact about its problematic aspects. The problems related to gambling behaviour also have similarities for Internet-dependent persons. The umbrella term 'Internet use disorder' is used commonly with its subtypes, e.g., related to gaming, social media, or sex.

As compared to other concepts such as 'compulsive Internet use' or 'excessive Internet use', the term 'problematic Internet use' is commonly used relying on measures of the amount of time spent online. Another unifying description is Problematic Interactive Media Use (PIMU) which is a syndrome describing behaviours characterized by compulsive use of, increasing tolerance to, and negative reactions to being removed from interactive screen media use, which impairs the individual's physical, mental, cognitive, and/or social function (Rich et al., 2017). The researchers have proposed four variations of PIMU, gaming, social media, pornography, and information seeking/surfing the web which includes uncontrolled online searches of anything.

The Internet addiction test (Young, 1996) is one of the most used scales for Internet addiction, and other important scales are the compulsive Internet use scale (Meerkerk et al., 2009), the Internet addiction diagnostic questionnaire (Young 1998b), the generalized problematic Internet use scale-2 (Caplan, 2010), and the problematic Internet use questionnaire (Demetrovics et al., 2008). Different adolescents using excess of the Internet have different reasons and stories to justify their behaviour. Their exploration to digital pathways leads them to develop various adaptive strategies to balance offline and online activities. In the Indian context, adolescents' excessive Internet use leads them to neglect daily routines and may result in an academic downfall, aches, sleeplessness, and parental conflicts.

Prevention and Intervention Measures

Given the crucial nature of issues related to Internet use, a comprehensive measure at various stakeholder levels needs to be adopted. The beginning is at home in the family where parents and family members need to understand the vulnerability of children and adolescents to the dark side of the virtual world and take necessary steps.

Clark (2011) urges that 'participatory learning' be added as a fourth parental mediation strategy that recognizes the utility of newer media to engage in interpersonal relationships and collaborative creativity.

Schools next have a crucial role to create awareness about the safe use of the Internet and a zero-tolerance policy for bullying, aggression, and cybersex-related issues. The focus needs to be on building resilience and adopting effective coping strategies.

A community approach is important which will offer opportunities and scope to adolescents who may otherwise engage in cyber surfing or social media use or gaming.

Steps also need to be taken at the policy level and adoption of various measures so that the future generation is able to navigate and function in a digital safe and healthy environment.

The most commonly used treatment approach for Internet addiction is the cognitive behaviour therapy (CBT) (Widyanto & Griffith, 2006). CBT has been widely and successfully used in other addiction and impulse-control disorders such as eating disorders, compulsive shopping, and pathological gambling (De Abreu & Goes, 2011). Studies (Li & Dai, 2009) have found that CBT has good effects on adolescents with Internet addiction.

A multimodal treatment approach combining pharmacotherapy, psychotherapy, family counselling, and motivational interviewing is also used to deal with Internet addiction and problematic interactive media use.

Conclusion

As mentioned in the McKinsey report (2019), India is one of the largest and fastest-growing markets for digital consumers, with 560 million Internet subscribers in 2018, second only to China. The digital divide is reducing and the country has the potential to be a truly connected nation by 2025 (McKinsey Global Institute, 2019). Digital ecosystems are reshaping transactions in various fields including agriculture, healthcare, business, microenterprises, retail, logistics, and other sectors.

The adolescents are born into this ecosystem and will grow and function and work in this only. So it is important to inculcate good digital health in the adolescents from the beginning who are the future generation so that they can effectively harness the benefits while avoiding the risks and pitfalls of the digital world which can be so addictive.

The present chapter highlights the realm of the Internet as a new way of communication and a new era with diverse characteristics regarding the transfer and speed of information. There are numerous advantages related to the Internet in terms of education and social reforms but its dark side cannot be ignored. The chapter deals with media effects theories and important conceptual foundations related to the functioning of media and digital platforms. Online education is a new reality of the pandemic times posing threats and opportunities to the pedagogical infrastructure of

our own country. It would be unwise to ignore the importance of the Internet but it will be extremely dystopian to believe that it can be a replacement for our age-old traditions of learning and teaching in the physical classrooms.

A comprehensive understanding of the digital medium can minimize its disadvantages for adolescents and the society in general. There are huge differences in the access and usage patterns among the adolescents of the country, and a mindful road map is needed to use this platform for the advantage of the adolescents. One must not ignore the fact that in today's globalized world, our adolescents can't be kept away from the paradigm shift of medium. Thus, strategies should be developed aiming to improve its effectiveness for its users; hence, more researchers in the Indian context are needed to understand the problems and reasons associated with this medium, and a great deal of sincerity of efforts is required to know about its complications. Lastly, it can be said that there are different perceptions among the scholars about its usage and effects but as a developing county, we cannot afford to escape this powerful medium on the basis of our subjective perceptions. Attempts need to focus on the use of the Internet for enriching our younger generations for the development of a powerful nation.

Time to Reflect

The use of the Internet and social media platforms has revolutionized the way adolescents today learn, play, socialize, and work. Everything is at the tip of their finger—through using mobiles and laptops or computer systems. This has created a sense of instantness and need for immediate gratification. How is it affecting adolescents' value system and well-being? Reactivity, anxiety, abuse, and violence are some of the fallouts for adolescents of the present generation leading mostly a digital life. Being constantly online has also its impact on their human relations. Since the digital or online world is the new normal now, how do adolescents strike a balance between their online and offline world to function effectively and live happily?

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Chapter 12
Adolescence and Disability

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Abstract The chapter talks about disability in the context of adolescents. It highlights the issues and concerns of adolescents with different types of disabilities. The experience of disability during this stage of life poses additional challenges and difficulties for these adolescents over and above negotiating their regular tasks of adolescence. The chapter further discusses the challenges and aspirations of adolescents with disability related to their quality of life, body image, identity formation, social self-perceptions, sexuality, abuse, violence, sports, recreation, and well-being. Cross-cultural issues in the development of adolescents with disabilities in our country also need to be considered. There needs to be an all-round emphasis on optimizing their inclusive living.

Keywords Disability · Adolescents · Deaf culture · Body image · Delinquency · Handicap · Human rights model · Inclusion · Integration · Multiple disabilities · Psychoeducation · Quality of life · Well-being

Abbreviations

APA	American Psychological Association
ASL	American Sign Language
BSL	British Sign Language
DALY	Disability-Adjusted Life Years
dB	Decibel
DSM	Diagnostic and Statistical Manual
DQ	Developmental Quotient
HoH	Hard of Hearing
ICD	International Classification of Diseases
ICF	International Classification of Functioning, Disability, and Health

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IQ	Intelligence Quotient
ISL	Indian Sign Language
QALY	Quality-Adjusted Life Years
QOL	Quality of Life
SQ	Social Quotient
UNGA	United Nations General Assembly
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Introduction

> Sarita, 16-year old, the elder of two siblings, was born out of a difficult and prolonged labour. The child's first few years of life were troublesome. She had fits with high fever many times during the first three years and was put on anti-epileptic medicines until the age of ten. Her development milestones, the parents recalled, were delayed when compared to her younger brother. During the school years, it was a daily ordeal for the mother to sit with her with books and complete home assignments, class tests, and project work, till she eventually completed school as a repeater. She was not allowed to participate in cocurricular activities at school although she loved and did fairly well in different craft work. It was found on the clinical assessment that she has a mild hearing loss in one ear and has below-average intelligence (slow learner). She did not have any friends or companions, mostly watched television, snacked excessively, and indulged in no exercise which has led her to be overweight.

The above case highlights the various issues, concerns, and challenges faced by Sarita as she enters adolescence with the disability. Why do you think she had to face such difficulties and rejections? Like any other adolescent of her age, she also must be having her own desires, likings, and disliking. Why were her interests and aspirations not considered by the school, the curriculum, and the teachers? Does the society not have any role and responsibility towards such adolescents having a disability? What could the school have done to address the various concerns of Sarita as she was studying and make Sarita feel belonged to the school? This could have helped her life more comfortable and happier.

Disability is definitely challenging at any stage of life. However, disability during the adolescence stage makes it more challenging. There are significant changes in various developmental aspects such as physical, emotional, and social during adolescence. The varied expectations from the significant others coupled with the rapid and vast changes in the physical development as well as peer pressure and relationship issues with parents make an adolescent confused about his/her identity.

Hence, first, one needs to understand the adolescent; second, the adolescent with a disability needs to be understood. Having a disability affects various aspects of life, and when it occurs in the adolescence stage, it adds to the already existing pressures and stresses of the adolescence stage and may result in mental health issues. Thus, it is a double challenge that these adolescents with disability face, and the same is true for the parents also to understand and manage them.

Successful completion of specific developmental tasks in each stage of human life facilitates a smooth transition to the next stage of development. In the case of adolescents having a disability, their developmental tasks must be continued over and above managing their condition, working towards acceptance by peers, integrating body image and self-concept, establishing sexual identity, and a personal sense of independence. The example of Sarita above shows it is not easy to be an adolescent with a disability. They are a vulnerable group who often experience social exclusion and discrimination. They do not have the same access to the opportunities and privileges, and this violates their human rights such as equal opportunity and accessibility without any discrimination. This differential access and treatment affects their physical, cognitive, social, and emotional spheres of life with repercussions on their siblings, parents, and family.

Two important terms that need to be understood here are (a) Quality-Adjusted Life Years (QALY) and (b) Disability-Adjusted Life Years (DALY). QALY describes health as a function of the length of life and quality of life combined into a single index. It refers to different health states expressed in terms of some unit called utility. Thus, if the person has perfect health in a year, it will be one QALY. So, one QALY equals one year in perfect health. DALY indicates how society measures the burden of disease as indicated by time lost due to disability, ill-health, or early death. The two leading causes of DALY in 2010 for adolescents in India are road injury and self-harm (Reddy, 2016).

Various types of disability are described in the section below followed by concerns, issues, and challenges pertaining to the adolescents with disability in the subsequent section.

Types of Disability

Disability can be described as a multidimensional experience for the individual. It can affect the body part, functioning, and participation of the individual. Accordingly, the International Classification of Functioning, Disability, and Health (ICF; WHO, 2007) states three dimensions of disability: body structure and functions (and impairments thereof), activity limitations (of the individual), and participation restrictions in life situations. Negative terms like handicap are avoided. Further, social, physical, and environmental factors that affect disability outcome are recognized.

Disabilities can be congenital (since birth) or acquired. It can be physical, sensory, or mental; mild or severe; and solitary or multiple. Thus, there can be physical, sensory, cognitive, or intellectual impairments and various conditions of chronic disease. In the case of acquired disability, it may be due to chronic ill-health conditions, road injury, HIV, depression, suicide, diabetes, asthma, and interpersonal violence. Adolescents are also at increased risk for disabilities resulting from road traffic accidents, sports-related injuries, violence, and drug-induced calamities. The experience of the adolescent in each of these cases may be different.

Regarding the prevalence of the disabilities, census 2011 reports that 2.21% of the total population of 121 crore population was having a disability. Census 2011 collected data for eight types of disability in seeing (19%), hearing (19%), speech (7%), movement (20%), mental retardation/intellectual disability (6%), mental illness (3%), any other (18%), and multiple disabilities (8%).

Broadly, disabilities can be grouped into physical, sensory, and intellectual disabilities and mental illness. Specifically, the prevailing Rights-based Persons with Disabilities Act 2016 in India recognizes 21 types of disabilities: Blindness, Low-vision, Leprosy Cured persons, Hearing Impairment (deaf and hard of hearing), Locomotor Disability, Dwarfism, Intellectual Disability, Mental Illness, Autism, Cerebral Palsy, Specific Learning Disabilities, Multiple Sclerosis, Muscular Dystrophy, Chronic Neurological conditions Speech and Language disability, Thalassemia, Haemophilia, Sickle Cell disease, Multiple Disabilities including deaf–blindness, Acid Attack victim, and Parkinson's disease.

Let us now discuss the following types of disabilities and how these affect the development and aspirations of the adolescents.

1. Chronic Illness
2. Physical and Locomotion Disability
3. Hard of Hearing, Hearing Loss, and Deafness
4. Visual Impairments and Blindness
5. Intellectual Disability
6. Chronic Mental Illness classified as Mental Disabilities
7. Borderline Intellectual Functioning
8. Learning Disabilities
9. Multiple Disabilities.

1. Chronic Illness

> Veena, 17-year old, diagnosed with type 1 diabetes showed early warning signs like increased thirst and bathroom breaks which were first misread and chided by her teacher as being done deliberately to disturb the class. Her increased appetite and stealthily eating at the back bench during class were further misunderstood as a distraction. She faced difficulties when her parents placed restrictions on her partying with friends or staying overnight with them. She did not want to see herself as being 'different' from her classmates. Her mother's frequently given well-meant advice and reminders to check the blood sugar levels were irritating and often ended up in a negative dialogue between them.

There are disagreements regarding which ill-health conditions must be included and what must be their duration or age of onset to be recognized as chronic illness during adolescence. There are questions on whether it must be congenital or acquired, visible or invisible, what must be its expected course or chance of survival, amount of mobility and physiological functioning it permits, or whether it leads to communication, cognitive, emotional, and social impairment (Wijlaars et al., 2016). There are formal and informal methods of identifying adolescents with chronic conditions. The Chronic Conditions Short Questionnaire (CCSQ; Mazur et al., 2013) is one such instrument. The medical conditions that can affect the adolescent in the form of disability are asthma, diabetes, rheumatoid arthritis, congenital heart defects,

epilepsy, blood disorders (like haemophilia, anaemia, and sickle cell disease), infectious diseases (HIV, and hepatitis), and cancer (Yeo & Sawyer, 2005). Many diseases that were once considered fatal are now life-threatening with long-term survival or even cure also can be possible. Chronic conditions that used to necessitate long-term hospitalization are now treated primarily on an outpatient basis. The focus of intervention is based on causes and how they affect their Quality of Life (QOL). Their life adjustment and well-being vary by the severity of their disease and choice of treatment. However, such youth have a tendency to develop secondary psychiatric symptoms, somatic complaints, and depression (Suris et al., 2004). It may harm their attainment of age-related developmental tasks like forming friendships or romantic relationships with peers and gaining autonomy (Pinquart & Shen, 2011).

As we know, the early adolescence is centred on physical changes, middle adolescence is marked by 'individuation' or the establishment of identity whereas in the late adolescence stage, they move towards acceptance of their condition. These developmental changes common for all the adolescents also need to be considered when dealing with adolescents with disabilities. Such a developmental perspective will help in understanding and providing appropriate intervention for these adolescents. Diagnostic disclosure, psychoeducation, understanding the course and prognosis, and open discussion on their condition will help in the acceptance of the disability by the adolescent as well as the family members including the parents. Peer support also plays a crucial role in many such instances (Sawyer et al., 2007).

2. Physical or Locomotion Disability

> Vinay, 18-year old, a student of first-year degree at a graduate college was affected by post-polio residual paralysis of the lower limbs. His most frequent problem was fatigue having no energy or being too tired to do any physical activity. The muscle strength in his legs was poor. It was a huge effort even to complete small or routine activities like getting on or off the toilet, getting out of the chair, rolling over in bed, putting on shoes, carrying a pail of water, etc. Other problems included aches or pain all over the body, inability to tolerate cold places, and swallowing problems.

Adolescence is that time of life when one takes pride in physical independence or in the show of one's physical strength, speed, agility, and coordination. The adolescent loves to show off through performance or participation in games and sports. However, if their mobility inside or outside the home is restricted, and they have to remain dependent on others, then it can affect their self-concept, self-esteem, and self-image.

Locomotor disability is a heterogeneous group. It affects the limbs and extremities. It results in the person's inability to execute activities involving moving oneself or objects from one place to another. They appear in many forms, since birth or acquired, and affect one or more limbs to various degrees of severity. The source of difficulty could be an affected nervous or muscular–skeletal system. The site of involvement may be spinal, cerebral, nerve lesions, skeletal, or multiple. The common physical disabilities seen in adolescence can be amputation, deformities and contractures, cerebral palsy, muscular dystrophy, post-polio residual paralysis, spina-bifida, and spinal cord injuries (Venkatesan, 2004).

Adolescents with minor physical anomalies like clumsiness or developmental coordination problems are more seriously affected on different domains of self-esteem than those with major physical disabilities (Miyahara & Piek, 2006). Studies (Hussain, 2006) report significantly low scores on the self-concept of physically challenged adolescents compared to their unaffected same-age counterparts though there are mixed findings on this (Ratra, 2007). A part of their poor self-concept may be attributed to their isolated, often secluded, sedentary, and stationary lifestyle. For example, youngsters with cerebral palsy have a less gross motor function. Obesity is a common secondary consequence of their sedentary condition which may add to social stigma (Hammar et al., 2009) as well as health risks like fatigue, pain, and difficulties in performing activities of daily living (Rimmer et al., 2007). Their experience, feeling, and attitude about their own bodies also affect their well-being (Talepororos & McCae, 2002).

In sum, adolescents with physical disabilities form a highly heterogeneous group. They face added challenges depending on how their social universe views them. The physical disability by itself may not necessarily lead to psychological difficulties. The contextual issues that confront each adolescent and varying social experiences shape their gradual reconciliation, adjustment, and acceptance of their bodies over time.

3. Hard of Hearing, Hearing Loss, and Deafness

> Asha was diagnosed as having a hearing loss only after she joined college. She was advised a hearing aid which she was not ready for. There were many times when she looked puzzled in trying to make out what others were telling her. When she did not hear and answer, some of her friends misunderstood that she was arrogant. She felt hurt and almost cried when one of her classmates called her 'deaf'.

Hearing loss occurs when there is a loss of 60 decibels (dB) or more in better ear for a conversational range of frequencies. However, there are various severity levels of this disability in terms of dB, based on audiology evaluations of the better ear. Their degree of hearing loss is to be accurately ascertained by an ENT doctor and audiologist. The types of hearing loss are distinguished based on the site of lesions, such as sensory–neural hearing loss, conductive hearing loss, mixed hearing loss, central auditory disorder, and retro-cochlear pathology. Hearing loss can result in adolescents from damage to the outer, middle, or inner parts of the ear; untreated ear infection; and head trauma. There is also an increase in the incidence of noise-induced hearing loss in the teen years (Marques et al., 2015; Sekhar et al., 2014).

Hearing level (in Db)	Severity of hearing loss
0–25	Normal
26–40	Mild
41–55	Moderate
56–70	Moderately severe
70–90	Severe

(continued)

(continued)

Hearing level (in Db)	Severity of hearing loss
91+	Profound

Does deafness affect adolescent development? Studies indicate that their adaptation, self-concept, identity development, and quality of life are affected (Brice & Strauss, 2016). Their vocabulary levels are relatively lower than age-matched unaffected controls. They learn at concrete levels more easily than abstract words. They may not hear their own voice when they speak. They have high rates of emotional and behaviour difficulties (Stevenson et al., 2015). The inability to communicate freely with peers can create a loss of self-reliance, confusion, doubt, suspicion, isolation, or avoidance behaviour in such adolescents. Gambling is reported to be frequent in these adolescents (Geidne et al., 2016). Their level of adjustment was found to decrease with age (Mohanraj & Selvaraj, 2013). However, despite such difficulties, we cannot say that adolescents with hearing issues are in any way intrinsically different in seeking social affiliation and career self-decision-making self-efficacy than their hearing peers (Michael, Cinamon & Most, 2015).

Like vision, the hearing also ranges from excellent, good to poor, or non-existent. Some adolescents are hard of hearing, others are moderately deaf, and still others may have a profound hearing loss. A few are not able to hear when there is too much of interfering background noise. There are misconceptions that the deaf can hear if only one speaks to them very loudly or that all of them know or use sign language. One of the reasons for the inattention of deaf adolescent student in the class may be because s/he is not able to see or lip read the teacher who is speaking while writing on the board. Resistance of the adolescent to use a hearing aid in the company of non-using peers needs to be dealt with sensitively. The use of hearing aid, either body-level or behind the ear, carries a stigma. Cochlear implants and inside-the-ear devices are unaffordable to average Indian families although there are now government-subsidized schemes made available for the poor people. Although sign language may be chosen, there is no single standardized or universal Indian Sign Language as American Sign Language (ASL) in the USA or British Sign Language (BSL) in a few European countries.

Further, it may be convenient for these adolescents to use sign language within their deaf communities or as part of their deaf culture. However, the challenge remains in the broader and bigger culture which typically views spoken language as valuable and deafness is perceived as a disability. Should the adolescents with a hearing disability grow in the deaf community and share a deaf culture or should they be mainstreamed by regular schooling is a critical question that cannot be easily answered and poses a challenge for parents.

The role of psychologists and counsellors is crucial here in fostering a healthy sense of self in the affected adolescent and guiding their parents also.

4. Visual Impairments and Blindness

Rashid is a teenager with partial visual impairment. He faces difficulty while moving about in school and has fallen down while negotiating objects or flower pots in the school corridor.

He needs an amanuensis or reader facility to prepare or write examinations. His friends have been helpful since school days to help him all along. He has availed a certificate that has allowed him to secure extra time during public examinations. He faces various challenges and stigma from peers and even a few teachers who appear insensitive to his requirements such as being given a special question paper with an enlarged font size.

Visual impairments are conditions of the eye that cannot be corrected by using a pair of spectacles, contact lenses, medicines, or surgery. There could be a total absence of sight or reduced visual acuity not exceeding 6/60 or 20/200 (Snellen) in the better eye with correcting lens. They have limitations in their field of vision subtending an angle of 20 degrees or worse. Some persons can have partial sightedness, low vision, legal blindness, or total blindness. Some common causes of this condition are cataract, corneal ulcer, glaucoma, optic atrophy, nystagmus, trachoma, xeropthalmia, astigmatism, short sight, or long sight. Although blindness or visual impairments may begin at birth, the experience of being a blind teenager with its onset during adolescence is not uncommon. It may result from conditions like retinitis pigmentosa or an accident.

Visual impairment affects the activities of daily living of the adolescent. Whether from birth or acquired later, it results in depression or distress symptoms in their relationship with parents and siblings (Koenes & Karshmer, 2000). At the same time, for most of them, parents are the most important source of social support (Kef et al., 2000) because of having restricted and fewer personal networks and social supports as compared to the matched sighted adolescents. They have more peer and emotional problems such as anxiety (Bolat et al., 2011; Pinquart & Pfeiffer, 2012). However, studies have also shown that blind adolescents on an average have better pragmatic abilities, superior tactile sense, and skills to undertake non-verbal communication (French, 2017).

In India, a common misconception is that the blind are paying for the sins in their past birth. Owing to the stereotypes about visual impairment conditions, they are feared, avoided, and rejected especially in intimate relationships. Hence, the adolescents need to be made aware of such stereotypic attitudes and how to counter them in their social dealings (Sacks & Wolffe, 2006) so that they develop a positive self-concept.

Rehabilitation helps facilitate the inclusion of the blind adolescent in society. Adjusting to an acquired visual impairment in adolescence is different from one's gradual adaptation to a similar birth defect. The identity shift from a 'sighted self' to the 'blind self' requires extra skills to cope with negative societal messages about blindness. Factors like education, the degree of residual vision, expectation, or support from family and friends shape their attitude towards the acceptance of their condition (Roy & MacKay, 2002). Lessons may be required to improve their Braille literacy, use of audio or talking books, enrol into radio-reading or digitalized talking newspaper services, and develop prosocial skills by reducing their blindisms—a common tendency in such individuals to indulge in strange actions like eye pressing, hand flicking, and rocking back and forth or side to side.

5. Intellectual Disability

> Anil is a 12-year-old boy whose developmental milestones were slow. He was not able to acquire the basic three Rs—reading, writing, and arithmetic. His intelligence was found to be below average on clinical assessment. He is clumsy and is not able to carry out the daily activities adequately. He remains locked at home all day long since everyone else is busy and out at work. He loves visitors at home. He gets excited so much that he hugs them, touches them inappropriately, interrupts when they are talking, and signals repeatedly to go out with them outside the home. Sadly, no one seems to have the time or inclination to take notice of him.

Although things are changing for the better nowadays with free and compulsory education for one and all, adolescents with severe to profound intellectual disabilities continue to be a neglected lot. They do not have colleges to attend, a community except their nearest family members, and no leisure or community-based entertainment as exemplified in the case of Anil above. Intellectual disability was earlier known as mental retardation, mental deficiency, oligophrenia, idiocy, imbecility, moron, dullard, or dunce. Such insulting terms are now discarded to eliminate the stigma linked with this condition. The core element in the identification and classification of intellectual disability is the concept of intelligence. Intelligence refers to the global capacity of an individual to think rationally, act purposefully, and effectively solve problems in life. It is measured using standardized psychological tests and is expressed in terms of Intelligence Quotient (IQ). The diagnosis of intellectual disability takes into account social competencies measured as Social Quotient (SQ). These persons show a typical slowness in development since birth or immediately thereafter but definitely not beyond the developmental period of eighteen years. Therefore, technically, no one can become intellectually disabled beyond this age (AAIDD, 2010). Given below is the classification of Intellectual Disability (ID) in terms of IQ.

IQ range	Severity level
90–109	Average
70–89	Below average/slow learner
50–69	Mild ID
35–49	Moderate ID
20–34	Severe ID
Below 20	Profound ID

*below average/slow learner and average levels are given for purpose of continuity and comparison

Adolescents at the level of mild intellectual disability have mental ability equivalent to that of 11–12-years old. While adolescents in the range of *mild-to-moderate* intellectual disability may complete regular middle schooling albeit with concessions and educational support, they may only show functional literacy skills, speak in short narratives, and can gain small-time unskilled or semi-skilled remunerative employment under supervision. They respond well to therapeutic interventions like social skills training (O' Handley et al., 2016). Those in a *severe to profound* range

of intellectual disability seldom cross the primary level of academic achievement. They may have minimum phrase-level speech and even require frequent prompts to undertake activities of daily living like personal hygiene, handling money, negotiating unfamiliar routes, or helping in household chores. They may often have associated medical issues related to hormonal imbalances, fits, or mental illness thereby requiring regular medication (Munir, 2016).

Thus, given the above condition, these adolescents require intensive individualized training, incentive-driven mentoring, and target-oriented behaviour change programmes on a continual basis (Carter & Hughes, 2005). However, the understimulation of these adolescents is noted by many studies with minimal or absence of hobby, amusement, leisure, and recreational engagements (Jin-Ding et al., 2010; Venkatesan & Yashodharakumar, 2016). The nature and extent of their interactions with peers are also dismally low (Carter & Hughes, 2005). The prevalence of mental illness, especially depression, has also been reported to be at least five times than normal controls (Emerson & Hatton, 2007). All these may lead to self-stimulatory, violent, or aggressive behaviours in such adolescents (Dekker et al., 2002). Unfortunately, however, these emotional-problem behaviours are misunderstood as due to their primary intellectual condition.

6. Chronic Mental Illness classified as Mental Disabilities

> There is often confusion between mental illness and mental retardation. While they are both being recognized or classified as a disability, they are different. However, in rare instances, they can occur together in the same person. Usually, when they co-occur, you may see symptoms like sleep and appetite disturbances, mood swings without any apparent reason, irrelevant or incoherent speech, seeing or hearing things that others cannot perceive, drop from the pre-morbid level of functioning, and poor personal hygiene. Lancy is an example of this type of clinical picture. Although slow in mental development since birth, suddenly during adolescence, he began turning violent without any provocation, crying excessively for some time and then laughing uncontrollably for some more time. He has been started on antipsychotic medication after which the parents found some control of the acute symptoms.

Mental illness refers to mental health conditions that affect your thinking, emotions, and/or behaviour. It results in distress or problems in functioning in the family, social, and workplace and the inability to cope with life's ordinary demands and day-to-day functioning. Mental illness may range from mild to severe and include, for example, depression, anxiety disorders, schizophrenia, mood disorders, eating disorders, and so on.

According to an earlier classification, adjustment disorders are passing conditions; neurotic disorders are a little more serious; and psychotic disorders are far more serious, recurring, and long-lasting. According to the recent laws passed in our country, only chronic mental illness beyond a specified duration after psychiatric treatment is classified or certified as a mental disability. Schizophrenia and bipolar disorders are two major forms of chronic mental illness that typically have their onset in adolescence. Alcohol and recreational drug use can add to the seriousness of these conditions in teens. Suicide as an outcome or in association with depression is one of the leading causes of death in adolescents. Apart from treating mental illness in the early stages, health promotion is important for young adults. Unfortunately,

owing to stigma, they resist consulting mental health professionals or adhering to the prescribed treatments (Hazen et al., 2011).

7. Borderline Intellectual Functioning

> Sony, a 19-year old diagnosed as functioning at the level of borderline intellectual functioning with mental age corresponding to twelve years (IQ: 75) completed her class ten-level equivalent examinations through open schooling under the category of students with special needs. Her two elder sisters were in college, owned, and maintained their own two-wheelers and smartphones. She insisted on her own gadget and the vehicle which her parents denied by holding that she was to come of age. However, their undisclosed apprehension was whether she would be able to handle them on her own. Sony was good at cooking routine dishes and housekeeping although lacking in negotiating money, community orientation, or life skills and soft skills needed for maintaining non-exploitative interpersonal social relations. Her parents thought that an early marriage for Sony will set right all the problems.

The above case of borderline intellectual functioning represents a lifelong condition which is an invisible clinical entity. They are not easily recognized even by trained mental health professionals as well as by laypersons. There are no benefits and concessions for them as is available for persons with disabilities. This is because they do not fall above the minimum cut-off percentage earmarked for receiving such provisions.

Although such cases of borderline intellectual functioning whose IQ ranges from 70 to 89 are not officially recognized as having a disability by any national or international systems of disease classification, consideration about this sizeable but neglected adolescent population is important (Venkatesan, 2017a). This condition refers to a group of persons who fall within the boundary between average intelligence and intellectual disability. Some authors divide them into two sub-groups, the 'dull normal' (IQ: 80–89) and 'borderline' (IQ: 70–79). Not to be confused with a borderline personality disorder, their typical behaviour profile may seem like they are independent in their daily routines, but actually, they are not. They require subtle cues, verbal prompts, and reminders without which they are stranded, cheated, or victimized.

As adolescents, they are nick-named as 'childish', 'immature', 'gullible', 'fixated on routines', 'incorrigible duds', or ridiculed for 'over-eating'. Their cognitive–intellectual profile shows the difficulty in abstract thinking, reasoning, visual–spatial reversal, general knowledge, comprehension, planning, processing, analysis, and synthesis. They show the history of repeated school failure (Karande et al., 2008), unemployment or underemployment (Seltzer et al., 2009), mental health problems (Wieland et al., 2014), alcohol/substance abuse (Chapman & Wu, 2012), homelessness (Van Straaten et al., 2014), poor health (Emerson, 2011), symptoms of conduct disorder and hyperactivity (Van der Meer et al., 2008), involvement in violent crime (Jones, 2007), and increased sexual offences (Lindsay et al., 2007). In India, they are labelled as 'slow learners' (Dasaradhi et al., 2016; Kalaivani, 2016; Vini, 2016).

8. Learning Disability

> Basheer is a 15-year-old, class tenth student of an elite English medium school. He is recognized as a state-level swimming and taekwondo champion for which reason alone his school

has retained him. In academics, he is a failure. Although fluent in spoken English, he cannot read or write even 4–5 letter words and cannot solve 3-digit additions involving carry over or subtractions requiring borrow operations. He cannot write 2–3 line answers. The teachers who do not know or understand his problem think he is 'lazy', 'stupid', or 'naughty'. The parents blame the school and the teachers as ineffective. Basheer hates books, academic work, and examinations.

There is no single common term or definition to explain this condition (Venkatesan, 2017b). The ever-changing course of symptoms and their presentation across ages even within a given child through adolescence and later into adulthood make it difficult to draw a common denominator for understanding this problem (Venkatesan, 2017c). A noteworthy feature of this disability, which is described as specific learning disabilities officially recognized only last year in our country, is that it is 'invisible'.

During adolescence, while they are in their search for identity and independence from parents, the experience of this disability can be frustrating. With their difficulties in reading, writing, spelling, and arithmetic, they feel incompetent and inferior. Many of them experience anxiety, depression, anger, and aggression (Daniel et al., 2006). They may also show symptoms of anti-social or passive–aggressive, or some such personality disorders (Venkatesan & Swarnalatha, 2013).

We may note that many of these adolescents have exceptional creativity, skills, aptitude, or talents in other non-academic areas. However, given the value attached only to securing of marks and academic achievements, they may be disallowed to venture into such non-academic pursuits. In school settings, wherein many teachers are not knowledgeable about this condition, they may dub them as slow, incapable, or incompetent. Learned helplessness is the understandable response of such students during adolescence. In order to deflect negative social perceptions, some of these students adopt 'masks' whereby they take up roles, such as class clown, trouble-maker, good-Samaritan, martyr, or victim (Deshler, 2005).

9. Multiple Disabilities

The co-existence of two or more disabilities in the same individual is called as multiple disabilities, e.g., a person may have an intellectual disability with hearing loss, blindness, and epilepsy. Like the single disability condition, individuals with multiple disabilities also differ in the degree or severity of their problem. Also called poly-handicap or pluri-handicap, the extent of their problems depends on how many disabilities the person has and what is the severity of each of them. Almost half of the population of adolescents with cerebral palsy has below-average or borderline intelligence. There are also conditions like deaf–blindness and intellectual disability combined with chronic mental illness (such as Pfropf or Engrafted Schizophrenia).

Many such affected adolescents may show limited self-care; experience difficulties in interpersonal relationships; become fearful, angry, impulsive, upset, or sensitive for no apparent reasons; have poor motor coordination; and have associated physical or health problems like fits or heart defects.

Research on multiple disabilities in general and especially during adolescence is a neglected area. However, early identification, training, and empowerment and also

technology-assisted enablement techniques have shown positive outcomes (Lancioni et al., 2007). Left unattended or unoccupied, there is a high probability of them developing greater numbers or severity of challenging behaviours (Poppes et al., 2010).

Concerns, Challenges, and Aspirations of Adolescents with Disability

The difficulties and challenges faced by adolescents with disabilities are typically related to their quality of life; health, hygiene, and well-being; community living; indulgence in sports, recreation, entertainment, and leisure activities; involvement in bullying, victimization, crime, and conflict with the law; and religion and spirituality.

You already know that the transition from adolescence to adulthood involves challenges of moving from school to workplace or home to the community. They have their own future expectations, uncertainties, and aspirations. Any setback could result in dependency, unemployment, segregation, loss of vocational skills, and employability. In the case of an adolescent with a disability, there are additional barriers of accessibility, support, and availability of up-to-date information on life options, choices, and possibilities. With little or no past experience of social life, their restricted communication competencies, and over-dependence on their family for support, their transition problems are aggravated (Pandey & Agarwal, 2013). Parents of adolescents with intellectual disability particularly are more concerned with themes like dependency, their future capacity to be independent or have one's own things especially regarding their health, getting oneself to and from the doctor when ill, moving from child health to adult health system, handling anger and related problem behaviours as they grow older, and/or providing for their social supports (Tucker et al., 2011).

Adolescents across various disabilities face challenges in the following aspects:

1. **Quality of Life (QOL)**

This social construct refers to the general well-being of individuals and societies. It covers the overall experience of life satisfaction, physical health, family, education, health, productivity, wealth, employment, religious beliefs, and the environment. The WHO has developed two instruments for measuring QOL: WHOQOL-100 and WHOQOL-BREF used across various cultural settings (WHO, 1997). However, it is pertinent to note the model of human functioning and disability (magical–religious, medical, or human rights) which is adopted to understand or explain the QOL in adolescents with disability (Buntinx & Schalock, 2010). All the domains of QOL may not apply for all types of disabilities. For example, the domains related to emotional well-being, interpersonal relations, self-determination, and social inclusion are more relevant for adolescents with **intellectual disabilities** than 'freedom' and 'boundary limitations' (Morisse et al., 2013). Therefore, it is recommended that

different perspectives must be used in QOL assessments of this population (Brown et al., 2013; Simoes & Santos, 2016).

Attempts to develop exclusive QOL measurement tools for youth with **hearing impairment** (HEAR-QL-28; Patrick et al., 2011; Rachakonda et al., 2013; QOLM-DHOHY) have studied levels of social support from their families and friends (Reyhani et al., 2016). They report anxiety, depression, social withdrawal, somatic complaints, rule-breaking behaviours, attention, and thought problems than age-matched normal controls (Brown & Cornes, 2015). Meyer et al (2013) found better QOL with respect to social participation, self-acceptance, and stigma for adolescents with severe to profound sensorineural hearing loss using hearing aids or cochlear implants than those with no such devices. In another study, adolescent girls than boys, who attended mainstream than special schools, and those with mild than severe hearing loss (Borujeni et al., 2015) reported better QOL. Use of hearing aids by such adolescents has been shown to enhance their QOL scores (Adibi et al., 2013).

Similarly, **visual impairment** can limit an adolescent's ability to perform everyday tasks, move about unaided, and can affect their QOL and ability to interact with the surrounding world.

A comparison of reported QOL between adolescents with physical, visual, and hearing disabilities showed poor scores especially in domains of 'psychological', 'environment', and 'social relationships' (Torres & Vieira, 2014). Similar trends are reported for adolescents with chronic illness (Sawyer et al., 2004). QOL measures were affected by the need for frequent medical attention, difficult communication skills, poor educational opportunities, and deficient problem-solving skills in adolescents with cerebral palsy (Hoon & Stashinko, 2015).

Research on QOL and community living experiences of adolescents with disabilities is meagre. Adolescents with disability have challenges in going around, e.g., for shopping, participating in social recreational activities or sports, or indulging in friendships and relationships without support. Caste, gender, the area of residence, rural or urban, and belonging to minority religion may add to their stigma especially in our country. They suffer double discrimination with limited friendships, fewer intimate relationships, and lack meaningful leisure activities.

Hence, it needs to be ensured that the living place of the adolescent with a disability is barrier-free. Facilitative infrastructure, social support, and an encouraging environment in which the adolescents with disabilities live, learn, and play can significantly enhance their sense of self-determination and autonomy. Thus, it is important to value their dignity, strengths, and intrinsic worth. Family members and the family environment have a vital role to play here.

2. Health, Hygiene, Grooming, and Well-Being

Adolescents with disabilities experience more health challenges than their unaffected peers. They suffer intentional or unintended injuries and violence, road traffic accidents, communicable and non-communicable diseases, substance use, or HIV/AIDS. While everyday personal body and facial hygiene matters like washing hands, covering mouth while coughing, and keeping clean may seemingly come spontaneously to all, there is a social side to all of these things like hair, nail, and foot care,

handling body odour, smelly feet, and bad breath. Hygiene behaviours are linked to mental health status. Owing to their poor manual and cognitive skills, they may have poor oral hygiene compared to those with other disabilities.

Managing menstrual hygiene for adolescent girls with intellectual disabilities may require extensive teaching (Grover, 2011) just as boys require straight talk on wet dreams or washing one's private parts (Jeffery et al., 2013). Several misconceptions related to these natural body changes need to be openly discussed and clarified. There are ethical issues about maintaining privacy and confidentiality while discussing such sensitive matters with the adolescent. Another frequent issue in clinical practice is the role of surgical options for the management of menstruation in the adolescent girls with disability. Adolescent girls with epilepsy on certain anti-epileptic drugs are at greater risk for irregular periods or reproductive endocrine disorders like polycystic ovary syndrome. Owing to their relatively sedentary lifestyle, obesity or increased body mass index with its related problems become a common health concern.

3. **Sexuality**

Human sexuality covers knowledge, beliefs, attitudes, values, and behaviours of individuals towards sex. It includes the capacity for sexual feelings, one's sexual orientation or preferences, and the activity of indulging in sex. A related concept is 'sexual health'. This indicates a positive approach to sexual relationships as well as having pleasurable or safe sexual experiences, free of coercion, discrimination, and violence (WHO, 2011). The issues on how 'sex' is defined or understood, sexual intercourse, perceived risks of pregnancy, treatment-seeking behaviours for unintended pregnancies, or sexually transmitted diseases are experienced both by typical adolescents and their peers with disabilities. Preadolescents require information on differences between male–female bodies, rules about public and private behaviours, 'good–bad' touch, acquisition of secondary sex characteristics, menstruation for girls, wet dreams in boys, use of contraceptives, what sex is all about, or how babies are made. Since adolescents with a disability are likely to participate in fewer intimate relationships, inadequate information on matters related to marriage, reproduction, parenthood, birth control, and sexually transmitted diseases are issues that are uniquely confronted by them (Balen & Crawshaw, 2006; Murphy & Elias, 2006).

Many of us think adolescents with disabilities are asexual creatures always needing support and protection (Murphy & Young, 2005). Sometimes, they are viewed as aggressively sexual and uncontrollable. It is sometimes assumed that marriage is a 'cure' for epilepsy and intellectual and mental disabilities. Parents are often shocked, frightened, or even offended by such emerging behaviours. Despite their physical maturation, many of us consider them as ineligible for marriage and bearing children. On their part, they are in no position to have their say on where or with whom they will live. They are denied the right to marry or build families of their own. Without a social acknowledgement of their sexuality and with no sex education, they get placed at risk for unwanted pregnancy and sexually transmitted diseases. While some young men with disabilities may be secretly married off to unsuspecting girls in the hope or pretext of seeking a 'cure'; in communities or families wherein men are allowed to keep mistresses or additional wives, teenage girls with disabilities

are often taken to fulfil this role. Instances of physical or psychological abuse, rape, domestic violence, victimization, crime, and exploitation are higher in these groups (Greydanus et al., 2002; Kef, 2006).

> Kumar, aged 18 years, last of three siblings, preceded by two elder unmarried sisters, diagnosed as functioning at the level of moderate intellectual disability, was brought with complaints of an intermittent outburst of rage, temper tantrums, and violent behaviours. Interview with family members brought up the issue of masturbation indulged by the adolescent much to the embarrassment of his female siblings. The unmanageable behaviour problems were understood by the siblings as due to his diagnostic condition and the consequence of their stopping or chiding him for the act. Unable to censor or stop the brother's misdemeanours and for fear of public shame, the sisters had to silently bear with the experience.

Adolescents with disabilities, especially women, are twice more likely to be sexually abused than their unaffected same-aged peers. Given this situation, they are not likely to report or seek assistance from elders or legal experts. More often, parents hide or close the matter for fear of public shame. Adolescent girls with borderline intelligence or mild intellectual disability are frequently implicated in sexual, financial, and behavioural crimes. Adolescent boys get arrested for theft, acts of a public misdemeanour, or voyeurism—even as their more intelligent unaffected peers plan such acts and escape (Venkatesan, 2015).

4. Violence, Abuse, Victimization, Crime, and Delinquency

Adolescents with disabilities can be agents as well as victims of bullying, violence, abuse, victimization, and crime. Traditionally, Indian mythology and movies have sought to portray the person with a disability as shrewd, sly, or sadistic agents of crime. A hunchback in the Indian epic Ramayana was instrumental in poisoning the mind of one of the queens of Dasaratha to seek a share of the throne for her son. A limping Shakuni in Mahabharata, another epic, was a villain par excellence. Western movies have depicted baddies as one-eyed jacks or a limping gangster with a wooden leg.

At another extreme, they are shown as gullible, innocent, and simpletons, who need pity or sympathy for their being duped (Venkatesan, 2015; Venkatesan et al., 2015). There is also bullying of young people with disabilities, which may manifest as marginalization, by patronizing, speaking slowly, treating them as dumb. They may be ignored or shunned. They may be goaded to do something wrong. Their mannerisms could be mocked. There can be name-calling or intimidation by taunting, threatening, teasing, tripping, or hitting (Holzbauer & Conrad, 2010; Martin & Stubbs, 2012).

> Ravi, a 19-year-old person with mild-to-moderate hearing loss and borderline intelligence, was taken on rolls of a book-binding unit. His simple routine and repetitive sub-job required applying glue on a cover continually through an eight-hour schedule every day for six days in a week. Apart from a few initial interpersonal skirmishes with co-workers, who used to tease, joke, or make fun of him, there was no complaint regarding his work. Notwithstanding all this, he was paid only half the salary under a presumption that the job was given to him only on 'humanitarian grounds' and therefore one could not expect more!

Surveys show that institutionalized women adolescents with disabilities are doubly at risk for physical and sexual abuse. They tolerate abuse for long periods because they may fear abandonment or reprisals. They lack privacy. The power differential can help the perpetrators who are sure that these victims cannot get help and are often not believed when they report the crime. Myths that persons with disabilities are insensitive to pain or that they are less human add to their victimization (Horner-Johnson, & Drum, 2006; Reiter et al., 2007). Many times, they may wittingly or unwittingly become perpetrators or partners in crimes such as stealing, destruction of property, attack, or selling drugs (Grigorenko, 2006; Mcgillivray & Moore, 2001; Shandra & Hogan, 2012).

5. **Sports, Recreation, Leisure, and Entertainment**

How many adolescents with disabilities do we see in the park or malls or clubs engaged in some sports or leisure or fun activities? Although termed as non-obligatory activities, sports, recreation, leisure, and entertainment activities are as much important as are sleeping and eating. They are intrinsically motivated, non-serious, freely chosen, imaginative, spontaneous, joyful, and actively engaging activities. It may lead to the development of their competencies, achieve mental and physical health, learn about self, enhance their decision-making skills, have therapeutic value, and establish meaningful friendships and relationships.

However, adolescents with disabilities tend to have diminished physical activities and reduced opportunities for participation in sports, recreation, leisure, and entertainment activities (Block et al., 2013; Carlon et al., 2013). It is shown that adolescents with mild intellectual disabilities indulge in predominantly passive and solitary leisure activities (Buttimer & Tierney, 2005). Youth with cerebral palsy have fewer friendships, lowered participation in leisure activities, or prefer home-based games and recreation (Shikako-Thomas et al., 2008). In another study, it was found that those with intellectual disabilities had near to nil (Mean: 0.83) leisure activities as well as opportunities for community exposure as compared to those with visual impairment (Mean: 3.20), hearing loss (Mean: 5.10), and unaffected age-matched peers (Mean: 11.87) (Venkatesan & Yashodharakumar, 2016).

The Paralympics event provides opportunities for athletes with physical, vision, and intellectual impairments to participate. In the recently held Tokyo Paralympics 2021, India showed an impressive performance with 19 medal winners. However, there needs to be still more awareness and action regarding sports and leisure activities of people with disability at the community level.

6. **Religion and Spirituality**

It is one thing to study the religiosity or spirituality in parents, it is quite another to examine these aspects in the adolescents with disabilities themselves. Adolescence is the phase when individuals understand different religions, their denominations, beliefs about the nature of gods, the meaning of worship and prayer, and the activities of daily life (Elkind, 1999). Unlike in the early stages of childhood, the adolescent represents an increased level of understanding about religion and its tenets. A prayer,

for example, may be understood as a regular ritual or as the personal and private experience of communion with God.

Fowler's theory of faith development recognizes four stages commensurate in the context of interpersonal relations along with their growing levels of cognitive development. Beginning primal faith during infancy, intuitive projective faith during Piaget's preoperational stage, the child reaches a stage of mythical–literal faith during elementary school years. By adolescence, one reaches the stage of synthetic-conventional faith coinciding formal operational thought, ego identity versus identity diffusion, and the establishment of a healthy sense of personal identity. Adolescents with disabilities or their families also undergo the same stages of religious development and its related concepts as their typically developing peers. It promotes the same sense of well-being; serves as means for social support, health promotion, and improvement of prosocial behaviours; and provides purpose and meaning to life (Ault et al., 2013; Jacober, 2010; O'Hanlon, 2013). In a related study, it was found that the psychosocial well-being of adolescents with visual impairments increased following psycho-spiritual yoga-based breathing practices *(pranayama)* and meditation as compared to matched controls (Mishra & Kotnala, 2016).

7. Body Image, Social Self-Perceptions, and Identity Formation

Some disabilities are outwardly visible like an acid attack victim (now recognized as disability) or adolescent with cerebral palsy, or Downs' anomaly; while others are invisible like epilepsy, thalassemia, juvenile diabetes, and haemophilia. All these can affect the body image, self-perception, and identity formation of the adolescent. If short height, pimples on the face, or a bulky body can make a typical adolescent feel wretched, how will the adolescent with disability feel having these in addition to her/his disability, especially when the disability is there for life? It may affect their sense of identity, ego development, and lead to negative self-image and lowered self-image (Adamson, 2003). The greatest impediment in their lives is social and self-perceptions like stereotyping, prejudice, misconceptions, social isolation, and discrimination. Programmes for persons with disabilities, wherever they exist, ignore the adolescent. They are alienated, unattended, ignored, neglected, overlooked, or invisible groups (Nosek et al., 2003).

> Anita, the 16-year-old student with hearing loss since birth, completed her regular mainstream school in the first division with educational benefits and concessions as is made available for students during class tenth public examinations. Problems started weeks after she started going to the college. She refused to use the behind-the-ear hearing aid since no one else was using it. She suspected her college mates might be making fun of her behind her back. At one point, she refused to go to college complaining of a headache without any organic basis as ruled out by the family physician as well as a neurologist.

The unaffected perceive their peers with disabilities not as individuals but in terms of their disability, which affects the growth and development of the concerned adolescent. The view that adolescent with deafness cannot undergo regular college results in the lack of accommodation or other disincentives that prevent the deaf student from studying. Many youngsters with disabilities are viewed as persons always in need of control, management, and guidance. Sometimes, the able-bodied

are asked to indulge in exercises in which they 'try on' a disability for a short time, such as a blindfold game or using a wheelchair. Note that these simulation exercises may affect the self-esteem of the few students who have real disabilities. Unless it is done with a focus on creating awareness and understanding of the disability, it may lead to having pity for the adolescents with disability (Murugami, 2009). Social isolation and stigma attached to their condition become serious concerns even if they have the close emotional support of their family or friends (Marini & Stebnicki, 2012).

Identity formation, also called as 'individuation', in adolescents involves the development of a distinct personality of an individual. The role of one's family, friends, culture, religion, caste, and peer relationships is important in the identity formation during adolescence. A failure to achieve this will result in identity diffusion. When an adolescent is having a disability, the identity development begins with the passive awareness that one is different from the others. Based on one's experiences, the individual may learn to deny disability, develop a dependency, or shy away from public attention. By middle adolescence, they may begin to realize and view the self as disabled. This may lead to a sense of anger, denial, or self-hate, with concerns on how others might perceive their appearance or condition. Eventually, by adulthood, the focus shifts from 'being different' in a negative light to embracing or accepting self as relevant, no more or less than others. It is only then, they are ready to get involved in disability advocacy and activism.

Gill (1997) viewed disability identity development through four types of integration: (1) 'coming to feel we belong', (integrating into society); (2) 'coming home',(integrating with the disability community); (3) 'coming together', (internally integrating our sameness and differentness); and, (4) 'coming out', (integrating how we feel with how we present ourselves). A successful resolution of these stages alone can lead to personal empowerment and disability rights activism.

On the whole, the person with a disability has the challenge of accepting their condition as a reality without losing their sense of self. Disability is incorporated into their identity. A person with a disability sees himself or herself as a person first and disability as just one of the characteristics in his or her personality (Prout et al., 1992).

8. Future Aspirations and Expectations

Adolescents with or without disabilities share the same life aspirations and expectations with regard to love, marriage, vocation, or employment (Arnold & Chapman, 1992). The areas of contemporary concern were keeping fit, seeking to improve their job skill, having a successful career, making money, having friends, saving income for the future, getting higher education, developing hobbies and sports, having long-term relationships, travelling, getting married, and having children. By contrast, parents aspire that their wards live in the family home than independently. They have their share of worries about whether their children would be able to live independently, have their own family, work, or earn a living after their demise (Cussen et al., 2012; Rojewski et al., 2011).

In conclusion, adolescents with a disability share the same themes of problems and concerns along with their unaffected peers, whether they are related to their quality of life; health, hygiene, and well-being; community living; indulgence in sports, recreation, entertainment, and leisure activities; involvement in bullying victimization, crime, and conflict with the law; and religion and spirituality. However, the extent and the expression of these concerns depend on how their family members and the peer group reflect upon these issues. The three stakeholders here are

- the adolescents with disability themselves—how do they perceive themselves with a disability?
- the parents and family members—how do they perceive the adolescent with a disability?
- the community and society in which the adolescents with disabilities live—how disability is viewed by the society and what are the facilities and opportunities provided to them?

Issues and concerns related to disability and the intervention and facilitative measures need to be addressed both at the micro as well as macro level.

Conclusion

The crucial question is how the individual, family, and society view adolescents with disabilities—as 'assets' or 'liabilities'? The many barriers, discrimination, stereotypes, misunderstanding, misinformation, and misconceptions that are prevalent in the society are demolishing to give place for viewing the adolescent with a disability as individuals in their own right and as positive symbols of promise, hope, beauty, potency, vigour, and strength as reflected increasingly in the achievements of such people in the Paralympics movement. Even as the myths of a sound and perfect body, physical attractiveness, independence, and achievement are cherished, the attribution of disability as something that is not necessarily ugly, tragedy, asexual, and invalid needs to change.

Adolescence is a period of extensive physical, biological, and psychological change, emerging sexuality, expanding socialization and networking, and opening opportunities for employment and education. The experience of disability during this stage poses additional challenges and difficulties over and above negotiating the regular tasks of adolescence. This chapter outlined the spread, prevalence, and magnitude of different types of chronic ill-health conditions and disabilities among adolescents before elaborating the typical themes of concern, problems, and issues faced by them. These adolescents undergo almost similar inner and outer challenges as their unaffected same-age peers. They negotiate matters related to teenage transition, change in body image, identity formation, expanding interpersonal relationships, emerging sexuality, and their unfolding notions of morality, religion, and spirituality. All this has to come with extra effort to meet their aspirations, given the difficult situations and surroundings imposed on them by an uncomprehending

although well-meaning ambience of friends, family, and fraternity. Cross-cultural issues in the development of adolescents with such affected conditions in our country also need to be considered. There needs to be an all-round emphasis on optimizing their inclusive living.

Time to Reflect

Disability and happiness—can they go together? Disability is usually associated with feelings of sorry, pity, and sympathy. People with disability are thought to be miserable, dependent, frustrated, depressed, and not living a happy life. But do all the so-called normal people live a happy and contented life? Research shows that people with disability consistently report a quality of life as good as, or sometimes even better than, that of people without a disability. This is called the 'disability paradox'. This means that we wrongly associate disability with suffering and misery. Disability need not be a tragedy. It points out the importance of the environment in determining the happiness of persons with disability. This attitude needs to be changed. Ignorance and prejudice need to be removed. Stereotypes must be pulled down. Environmental and attitudinal barriers need to be destroyed. Participation needs to become the keyword. When all this happens, empowerment of the persons with disability will be a natural outcome.

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Chapter 13
Mental Health Problems and Mental Disorders among Adolescents

Vimala Veeraraghavan

Abstract The chapter discusses the mental health problems/mental disorders faced by adolescents in the Indian as well as global context. Factors related to mental health problems in adolescents are explained. The many trends in mental health problems, such as stress, suicidal tendencies, substance use and abuse, etc., in adolescents are discussed highlighting the symptomatology, diagnostic criteria, prevalence of the disorder, causes, and treatment measures. Further, emotional and behavioural disorders, risk-taking behaviours, eating disorders, anxiety disorder, and schizophrenia are also discussed.

Keywords Mental health problem · Mental disorder · Depression · Suicide and attempted suicide · Emotional and behaviour disorder · Childhood behaviour disorders · Oppositional defiant disorder · Conduct disorder · ADHD · Learning disability · High-risk behaviours · Eating disorders · Anxiety disorder · Body dysmorphic disorder and schizophrenia

Introduction

Harish, a 17 year old boy, was extremely concerned about his poor performance in school. He has been struggling with academics and was worried if he would be able to clear his 12th class Board examination. He was fidgety, restless, stressed and felt unmotivated and disinterested in studies. He was also anxious about his inability to control his negative thoughts and fear of failure in school. He was not listening to his parents and started arguing on the slightest of things.

Leena, a 13 year old girl, shifted school as her father got transferred to a new city. She was very shy child and found difficult to adjust in a new environment. She missed her friends in the old school. She started to stay alone and withdrawn. She also performed poorly in the class test. This further affected her self esteem and she felt her classmates and teachers see her as a poor student.

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As it can be seen above, the two cases exemplify mental health problem. Harish is faced with examination stress, fear of failure, and anxiety. He was restless and not able to concentrate. These are some indicators that Harish is facing some mental health problems. Leena also faced problems of adjusting to the new school and it affected her school performance. It can be noted here that mental health problems can be manifested even in normal school going youngsters. In fact, any one at any stage of development may get affected by mental health problems. At the less severe level, it affects the adjustment and efficiency of the individual. Unless properly diagnosed and intervened at the earliest with suitable therapeutic methods, the mental health problems may become severe leading to mental illness or disorders, seriously impairing the cognitive, affective, and other aspects of the individual. In the examples given above, the problem in both the cases was relatively milder and with support from parents, teachers, and professional help from psychologists and counsellors, the problem can be taken care of.

Thus the mental health problems may vary from mild to moderate to severe levels. Further, mental disorders or mental illnesses can affect a person irrespective of age, gender, class, and race.

Defining Health and Mental Health

Health consists of both physical health as well as mental health. Both complement and supplement each other. As stated by the World Health Organization (WHO,), "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Though this definition has contributed a lot in creating awareness and understanding about different aspects of health including mental health, it has also been criticized that it excludes those who are living with disease/infirmity or disability and managing their life well. The absoluteness of the term 'complete' in the definition is criticized in relation to well-being (Machteld et al., 2011) as 'complete' is neither operational nor measurable (Jahad & O'Grady, 2008; Smith, 2008). The requirement for complete health "would leave most of us unhealthy most of the time" (Smith, 2008).

It is possible that individuals with disease or infirmity can manage and adapt to the situation/their health conditions and live well. By successfully adapting to an illness, people are able to work or to participate in social activities and feel healthy despite limitations (Machteld et al., 2011). Hence, definition of health needs to include the ability to adapt and self-manage.

This has an implication for the definition of mental health also. Mental health has been defined by WHO as a state of well-being in which an individual realizes his/her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his/her community. It is more than just the absence of mental disorders or disabilities. This indicates an attempt at ongoing and continuous emotional and mental well-being. Thus, good and positive mental health means that the individual is able to effectively use his or her mental functions such as thinking,

feeling, and reacting appropriately in his or her interactions with people and situations and live his or her life in a balanced manner. On the other hand, poor mental health renders a person relatively incapable of using his mental and cognitive functions appropriately. His thinking, feeling, and reacting become considerably decreased or non-functional.

Adolescence (10–19) years are a critical phase in the entire life span. Since they are the future of the nation, well-being of the adolescents needs to be promoted so that they can make use of their full potential. As reported by the WHO, around 20% of the world's children and adolescents have mental disorders or problems. This makes it all the more significant to protect the adolescents from adverse experiences and risk factors and build up the protective factors so as to ensure a sound mental health and increased productivity among the adolescents.

Key Facts regarding Mental Health of Adolescents (WHO, 2018).

- One in six people are aged 10–19 years.
- Mental health conditions account for 16% of the global burden of disease and injury in people aged 10–19 years.
- Half of all mental health conditions start by 14 years of age but most cases are undetected and untreated.
- Globally, depression is one of the leading causes of illness and disability among adolescents.
- Suicide is the third leading cause of death in 15–19-year-olds.
- The consequences of not addressing adolescent mental health conditions extend to adulthood, impairing both physical and mental health and limiting opportunities to lead fulfilling lives as adults.
- Mental health promotion and prevention are key to helping adolescents thrive.

Adolescents are passing through that stage of development where they experience physiological and psychological changes as well as changes in their cognitive abilities and social relationships including the relationship with peers. All these changes can lead to an identity crisis and create a certain degree of confusion, discomfort, and imbalance, that manifest in the adolescent's behaviours. The socio-cultural environment also plays an important role here. In the absence of appropriate care and support, some adolescents may develop severe problems leading to mental/ psychiatric disorders. A mental disorder is a distressing condition that affects adversely the individual's cognition, emotion regulation, and behaviours causing dysfunction in the psychological, biological, and developmental processes. These problems are of varied types affecting adversely the growth and development of adolescents that result in emotional disturbances impacting their academic performance, work life, and social life.

World Health Organization (WHO) defines mental disorder as behavioural or psychological and of clinical significance and is accompanied by a concomitant distress and/or a raised risk of death, or an important loss of freedom and involves unexpected cultural response to any situation (WHO, 2003).

Diagnostic and Statistical Manual (DSM 5) defines mental disorder as a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning (American Psychiatric Association, 2013).

International Classification of Diseases (ICD 10) states that "'mental disorder' is not an exact term, although it is generally used. It implies the existence of a clinically recognizable set of symptoms or behaviours associated in most cases with distress and with interference with personal functions" (ICD, 1992).

Mental illnesses are medical conditions that make it difficult for the individual to cope with the ordinary demands of life (CEC, 2018). As indicated by The National Alliance on Mental Illness (NAMI), "Mental illnesses cause disruption in a person's thinking, feeling, mood, ability to relate to others and daily functioning". Similar to physical illness, mental disorder also has interacting causes ranging from heredity, brain dysfunction, neurological factors to family pathology and socio-cultural factors. Thus mental disorders/illnesses need to be taken seriously and appropriate steps need to be taken for its treatment.

Increasing Trend in Mental Health Problems of Adolescents

Mental health problems and mental disorders are increasing among the adolescents the world over due to changing socio-cultural context and a host of other factors (Michaud & Fombonne, 2005). The rise has been driven by social change, including disruption of family structure, growing youth unemployment, and increasing educational and vocational pressures.

The prevalence of mental health disorders among 11–15 year olds in Great Britain is estimated to be 11%, with conduct problems being more common among boys, and depression and anxiety more common among girls (Mental Health Foundation, 2016). In the United States of America, based on eight studies and a sample of 3104 children, Bronsard et al. (2016) reported a prevalence rate for mental disorders among adolescents as 49%, that is almost one adolescent for every two persons has a mental disorder. The more commonly obtained mental disorders were disruptive disorder (27%), conduct disorder (2%), oppositional defiant disorder—ODD (12%), and ADHD (11%). The prevalence of anxiety and depression was reported to be 18% with PTSD showing the lowest prevalence of 4% (Manchia et al., 2016).

In India, studies (Anita et al., 2003; Srinath et al., 2005) reported a prevalence rate for depression, conduct disorder, social anxiety, and panic disorder to be 12–16.5% among adolescents. Discussing the trends in mental disorders among adolescents, Ahmad et al (2015) pointed out that the prevalence of mental health problems in children and adolescents (5–15 years of age) showed an increase from 13% in 1996 to 19.4% in 2006 and 20% in 2011.

The National Mental Health Survey (NMHS) of India, 2015–2016, conducted by the National Institute of Mental Health and Neurosciences (NIMHANS) Bengaluru reported that the overall prevalence of any mental morbidity among the adolescents (13–17 years) was 7.3% (Gururaj et al., 2016). The prevalence was similar for both the genders (males—7.5% and females—7.1%). Further, the prevalence of mental morbidity was higher in urban metro areas (13.5%), followed by rural (6.9%), and urban non-metro areas (4.3%). Anxiety and mood disorders were found to be the most frequently occurring mental disorders in adolescents.

In a study by Sagar et al (2017), the 12-month prevalence of common mental disorders was found to be 5.52% (anxiety disorders—3.41%, mood disorders—1.44%, and substance use disorders—1.18%). Males (49.3% of the sample) had a higher prevalence of substance use disorders, and lower prevalence of anxiety and mood disorders as compared to the females.

The survey revealed a huge treatment gap of 95%, with only 5 out of 100 individuals with common mental disorders receiving any treatment over the past year.

Thus the increasing prevalence of mental health problems is a matter of great concern, especially among the young generation who are the economic force and future of the nation. Young persons are more prone to a number of health impacting conditions leading to mental health problems, due to personal choices, environmental influences, and life style changes including communicable and non-communicable diseases and injuries (Singh and Gururaj (2014). In their study on health behaviours and problems among young people in India, Singh and Gururaj (2014) point out that the youngsters engage in substance abuse and are often victims of road accidents, injuries and victims of HIV, STD, etc. All these may create a susceptibility to mental health problems in the young generation and add to the mental health burden of the nation.

As mentioned in the UN report, many of the health-related problems including mental health, are compounded by economic hardship, unemployment, sanctions, restrictions, poverty, etc. (United Nations, 2004).

The following section examines various factors related to mental health problems in adolescents.

Factors Related to Mental Health Problems in Adolescents

Mental health problems arise out of a dynamic interaction among the bio-psychosocial factors. In most cases, it is a combination of biological, psychological, and socio-cultural factors that affect the mental health of adolescents and lead to mental health problems and mental disorders. The following factors are highlighted as related to mental health problems in the adolescents:

- Characteristics of the adolescents
- Disadvantaged background
- Socio cultural context
- Technology and media influence
- Chronic illnesses and disabilities.

The stage of adolescence is marked by huge physical as well as psychological changes. Failure of the adolescent to deal with this transition phase from childhood to adulthood successfully results in an identity crisis which may lead to mental health problems. Further, the stage of adolescence is characterized by a desire for autonomy, peer pressure, risk-taking behaviour, and increasing sexuality. All these affect their own development as well as their relationship with peer group, family, and the society.

The disadvantaged background, e.g., poverty, minority ethnic or sexual background, orphans, etc., may increase the risk of mental health-related problems. Abusive parents, harsh parenting, dysfunctional family, sexual abuse, violence are risk factors for developing mental health problems in the adolescents. Teenage pregnancy and early marriages may also affect their mental health.

Given the impact of technology in the lives of human beings today, adolescents are no exception. In fact, today's generation of adolescents use technology as their means of information, relationship, and entertainment. This impacts their adjustment and development negatively. Increased use of technology has a detrimental effect on mental health, leading to, for example, Internet addiction and suicide.

Adolescents suffering from chronic illnesses and disabilities are at greater risk of stigma, discrimination, and exclusion which affects their mental health. They lack support in terms of infrastructure as well as support from family and community that results in their isolation from the main stream.

Besides the above factors, we will highlight a few other important factors as observed in the recent trends in the mental health problems faced by adolescents. These are (i) Under nutrition and micronutrient deficiencies (ii) Stress (iii) Suicides

and attempted suicides (iv) Overweight and obesity and (v) High-risk behaviours shown to be associated with the development of certain mental disorders. These trending factors are discussed below.

(i) *Under nutrition and micronutrient*

Mental health problems of adolescents are related to the trend of undernutrition and micronutrient deficiencies, due to fast food or junk food consumption or similar eating habits. For instance, according to National Institute of Nutrition (2002, 2006), more than half the population between the ages of 10–18 years are undernourished. Similar findings were also reported by other researchers (Wasnik, et al., 2012).

In a school-based study, Haboubi and Shaikh (2009) studied the stunted growth in boys and girls, and reported that nearly 40% of adolescent boys and girls were stunted due to malnutrition. On the other hand, a community-based study among Madhya Pradesh tribals, relating malnutrition to stuntedness showed 51.7% of adolescents being stunted (Rao et al., 2003). Though stuntedness is a physical problem, it also affects the mental health of the individual who feels anxious and depressed due to his or her being very different from the normal adolescent individuals.

(ii) *Stress*

Another trending factor related to adolescent mental health problem is stress. While it is natural to expect certain increased levels of stress in adolescents due to physical and psychological changes, it has been observed that quite a few adolescents suffer from stress which by itself is a mental health problem and which also underlie some of the mental disorders. In a study by Sahoo and Khess (2010), 20% of the young adults reported that they experienced stress. Sharma and Sidhu (2011) studied adolescent girls in regard to their experiencing stress, and reported that 60% of the girls in the study expressed financial stress, whereas 85–90% reported moderate level of social stress, with 90.6% of the entire sample of adolescents expressed academic stress. Such stress over a period of time ends up in the development of mental disorders such as anxiety disorder, depressive disorder, etc.

(iii) *Suicides and attempted suicides*

Suicide and attempted suicide presents another trend in mental health problems among adolescents. Wasserman et al. (2005) examined global suicide rates among adolescents in the 15–19 age group using the World Health Organization (WHO) Mortality Database covering 90 countries. Findings showed that the mean suicide rate for this age group was 7.4/100,000, with suicide rates being higher in males (10.5) than in females (4.1). Further the analysis also showed that suicide was the fourth leading cause of death among young males and the third for young females. The researchers reported that of the 132,423 deaths of young people, suicide accounted for 9.1%. They also reported a rising trend in suicide rates between 1965 and 1999, covering 26 countries for whom the data were available.

In India, about 40 per cent of suicides are committed by persons below the age of 30 years (Vijayakumar, 2006). In a sample of 5115 attempted suicide, it was found that 2.1, 8.4, and 28.6% of individuals were in the age group 10–15, 16–20, and 21–25 years, respectively (Gururaj et. al., 2008). The study also showed that among the 912 completed suicides, 2.2, 16.2, and 21.6% were in the age group 10–15, 16–20, and 21–25 years, respectively.

The National Crime Records Bureau of the Ministry of Home Affairs, New Delhi, India (NCRB, 2012) indicates that age specific suicide rate among 15–29-year-old persons is on the rise, increasing from 3.73 to 3.96 per 100,000 population per year from 2002 to 2011.

Thus it may be stated that the trend of suicides and attempted suicides among adolescents and young adult have been reported to be on the increase, which is quite serious. Considerable efforts are needed by government and other agencies to reduce this rate of incidence and prevalence of mental health problems in youngsters.

(iv) *Overweight and obesity*

Another trend in the mental health of adolescents in the present day is one of overweight and obesity which render them anxious, worried as well as depressed.

In a research to review prevalence of overweight and obesity in adolescents, Bibiloni et al. (2013) took a total of 40 studies of which 25 were nationally representative of 10 countries. They concluded that the prevalence of overweight and obesity among adolescents worldwide is high, and obesity was higher among boys. The IOTF (International Obesity Task Force) criterion is the most frequently used method to classify adolescents as overweighed or obese in public health research. Binge eating, anorexia nervosa, which we will discuss in the subsequent sections, are some of the problems related to overweight, obesity, and adolescent's mental health. Research in this area has shown a prevalence of overweight among children aged 10–19 years to be 9.9–19.9% (Aggarwal et al., 2008; Deshmukh et al., 2006; Goyal et al., 2011; Khadilkar & Khadilkar, 2004; Kotian et al., 2010).

(v) *High-risk behaviours*

A major trend in mental health problems of adolescents is the high-risk behaviours. The onset of multiple risk behaviours, such as smoking, anti-social behaviour, hazardous alcohol consumption, substance abuse, unprotected sexual intercourse, etc., are associated with increased risk to develop various illnesses including mental disorders, morbidity, and premature mortality (Kipping et al., 2012).

The Center for Disease Control and Prevention's (CDC) Division of Adolescent and School Health (DASH), USA, routinely monitors youth health behaviours and experiences, so as to implement primary prevention of HIV, sexually transmitted diseases and teen pregnancy. The weekly report of the CDC's Morbidity and Mortality surveillance on the 2017 National Youth Risk behaviour survey (YRBS) provides data on health behaviours and experiences of high school students across the country

(CDC, 2018). According to its 2007–2017 report, the high-risk behaviours among youngsters in the year 2017, showed among various aspects, increase in the use of illicit drugs, injecting drugs, injury with a weapon, significant increase in students attempting suicide, etc., in 2017 as compared to 2007.

As for high-risk behaviour in adolescents in India, the National Family Health Survey-3 (NFHS) (2005–06) indicated that only 14.1% of unmarried sexually active adolescents used safe sex measures (IIPS, 2012). Kumar et al (2011) in their study of 2475 'never married' boys and girls, pointed out that in premarital sex, condom use by males was only 22.3% and by females still lower with 6.3%.

From the available data, Singh and Gururaj (2014), Gururaj et al. (2016) concluded that while prevalence of mental morbidity was 7.3%, prevalence of high-risk sexual behaviour among youngsters in India was high and varied across the different studies needing priority focus so as to prevent HIV and related diseases in them. Malhotra and Patra (2014) reported higher prevalence rate (23.33%) of mental disorders among adolescents in India. In regard to substance abuse, the National Household Survey (2002) by UNODC showed that approximately 43% of adolescents in India indulge in substance abuse (Saranghi et al., 2008) and according to Juyal et al (2006), 31.3% use one or more substances regularly.

It may thus be stated that the trend of mental health problems and mental disorders in adolescents varies considerably from study to study. Many trends, such as stress, suicidal tendencies, high-risk behaviours, etc., have been identified, studied and the prevalence rates have been reported. Mental health problems among adolescents appear to be increasing over the years and the severity of the problems requires immediate and urgent attention and measures have to be put in place to help adolescents overcome many of their mental health problems and become active and contributing members of the society.

Common Mental Health Problems/Disorders in Adolescents

It is reported by WHO (2014) that about 50% of mental disorders which develop during adolescent years remain undetected and untreated until adulthood or later years. It states that mental disorders and substance use disorders are major contributors to health-related disability in children and youth. Behavioural disorders have been found to be the sixth leading cause of disease burden among adolescents and affect their education and may at times lead to indulge in behaviours that are in conflict with the law (Erskine et al., 2015).

In addition to mental disorders which are severe in nature, reflecting psychiatric disturbance, adolescents are more commonly affected by mental health-related problems and issues. These can have a negative impact on their development and adversely affect their quality of life emotionally, socially, and vocationally.

Some of the common mental disorders suffered by adolescents include (i) Depression (ii) Suicide and self-injurious behaviours, (iii) Emotional and behavioural disorders (iv) Childhood behaviour disorder (v) Oppositional Defiant Disorder (ODD),

(vi) Conduct Disorder (CD), (vii) Deviant behaviours, (viii) Attention Deficit and Hyperactivity Disorder (ADHD), (ix) Learning Disability (LD), (x) Risk-Taking Behaviours, (xi) Substance Use Disorder, (xii) Eating Disorders (xiii) Anxiety Disorder (xiv) Body Dysmorphic Disorder (BDD), and (xv) Schizophrenia.

(i) **Depression**

Depression in adolescence is also referred to as 'teenage depression'. It is one of the most common global mental health problems, and in adolescents, it is one of the under-recognized problem that needs psychiatric help. The Diagnostic and Statistical Manual of Mental Disorders, 5th edition (APA, 2013), states that to be diagnosed as depression, following symptoms should be present: depressed mood**,** psychomotor agitation or retardation, diminished interest or pleasure, insomnia, fatigue or loss of energy, diminished ability to concentrate, significant weight loss, feelings of worthlessness or excessive guilt, and recurrent thoughts of death. Individuals exhibiting five or more of the above-mentioned symptoms meet the criteria for depressive disorders (APA, 2013).

According to WHO (2018), depression is one of the leading causes of illness and disability among adolescents, and suicide is the second leading cause of death in adolescents. Violence, poverty, humiliation, and low self-esteem can increase the risk of developing mental health problems. It is stated that globally, depression is the ninth and anxiety is the eighth leading cause of illnesses and disabilities in adolescents.

An estimated 9% of the U.S. population of adolescents aged 12–17 had reported one major depressive episode with severe impairment (NIMH, 2017). Prevalence of depression among adolescents in India varies between 10 and 60% (Jha et al., 2017; Nagendra et al., 2012). Major depression affects 3–5% of children and adolescents (Bhatia & Bhatia, 2007) negatively impacting their growth and development, school performance, peer or family relationships, and in certain cases may also lead to suicide.

Adolescent depression is often mistaken for boredom, irritation, and disinterest in school, which in reality is not so. Some of the features of adolescent depression that is based on a research study by Bahls (2002) include (i) irritability and instability, (ii) depressed humour, (iii) loss of energy and lack of concentration, (iv) lack of motivation and interest with psychomotor retardation, (v) feelings of guilt and hopelessness with low self-esteem, (vi) poor school performance, (vii) sleep disorders, withdrawal from friends and feelings of isolation, and (viii) suicidal ideas and behavioural changes. Other studies (Gururaj, 2013) showed that depression was associated with guilty feeling, pessimism, sadness, and past failures, inability to cope with academics at the school, problematic relationships and economic difficulty. He pointed out that youth with depression are at high risk for developing mental disorders such as anti-social behaviour and substance use disorders. Medication, psychotherapy, and cognitive behaviour therapy are some of the interventions that can help in depression.

(ii) **Suicide and Attempted Suicides**

Encyclopedia of Children's Health (2018) states that suicide is the act of ending one's own life. Suicidal behaviour is thoughts or tendencies that put a person at risk for committing suicide. It is the third leading cause of death among 15–19 year olds in the United States and the sixth leading cause of death among 10–14 year olds. Nearly 90% of the world's adolescents live in low- or middle-income countries but more than 90% of adolescent suicides are among adolescents living in those countries (WHO, 2018). Adolescent years are stormy and many major decisions regarding their future have to be taken as they continue to develop their newer identities. Faced with many challenges, they experience considerable stress which is one of the reasons for their contemplating or even committing suicide.

Data of suicides among persons of age group 14–30 years in India by the NCRB (2016), clearly indicates that the number of persons in the age group of 18–30 years, who indulged in suicidal behaviour, was 51,787. Within this, nearly 85% were between 18 and 30 years and the remaining were between 14 and 18 years of age. As of 2017 data, India's total population is 133.92 crores and the persons below 30 years constitute 25.578 crores. Within this, the percentage of young persons indulging in suicidal behaviour is 53,255.

Risk factors for suicide are multifaceted, including harmful use of alcohol, abuse in childhood, stigma against help-seeking, barriers to accessing care, and access to means. In a study by Im et al (2017), it was pointed out that the risk factors in adolescent suicide ideation include gender, academic performance, socio-economic status, and living with single parent. Communication through digital media about suicidal behaviour is an emerging concern for this age group (WHO, 2018).

As for the treatment of suicide attempters and those who contemplate suicide or have suicidal ideation, psychological counselling combined with cognitive behaviour therapy helps to remove suicidal ideas from their minds. Also family counselling and guidance to parents and close family members help in developing more.

Providing psychological counselling, guidance and supportive relationships between adolescents and family members is crucial in the prevention of suicide risk in adolescents. The Safety plan intervention (SPI) appears to be an effective brief intervention (Stanley & Brown, 2012). This includes evidence-based suicide risk reduction strategies such as lethal means reduction, brief problem-solving and coping skills, increasing social support and identifying emergency contacts to use during a suicide crisis, etc. Another preventive measure is the Crisis response planning (Bryan, 2010), which is a brief intervention in which individuals use a small card to write out steps for self-identifying personal warning signs, coping strategies, enlisting social support, and accessing professional services. Within a sample of high-risk active duty soldiers, crisis response planning was found more effective than contracts for safety in preventing attempts, reducing suicide ideation and hospitalization (Bryan et al., 2017).

(iii) **Emotional and Behavioural Disorders (EBD)**

Emotional disorders are characterized by increased levels of anxiety, depression, fear and somatic symptoms. Behavioural disorders, on the other hand, are an umbrella term that includes specific disorders such as Attention Deficit Hyperactivity Disorder (ADHD) and Conduct disorders, commonly seen in adolescents. Further, developmental disorders is also an umbrella term covering intellectual as well as autism spectrum disorders.

IDEA (Individuals with Disabilities Education Act, 2004) of the U.S. Department of Education defines emotional disorder or disturbance (ED) as a condition exhibiting one or more of certain characteristics, for example, (i) inability to learn that cannot be explained by intellectual or health factors; (ii) inability to build and maintain satisfactory relationships with peers, teachers and others; (iii) inappropriate behaviours under normal circumstances; (iv) a general pervasive mood of happiness or depression and (v) a tendency to manifest physical symptoms associated with personal or school problem. These disorders affect the adolescent's social, psychological, and physical skills (NICHCY, 2010).

As put by CEC (2018), children having an emotional disturbance show the following characteristics: (i) hyperactivity (short attention span, impulsiveness); (ii) aggression or self-injurious behaviour (acting out, fighting); (iii) withdrawal (not interacting socially with others (excessive fear or anxiety); (iv) immaturity (inappropriate crying, temper tantrums, poor coping skills); and (v) learning difficulties (academically performing below grade level). Those having serious emotional disturbances may exhibit distorted thinking, excessive anxiety, bizarre motor acts, and abnormal mood swings.

It needs to be noted here that even though many children may show some of the above symptoms, they may not have emotional and behavioural problems. The frequency, intensity, and duration of the symptoms along with the extent of their impact on the day-to-day functioning of the individual need to be considered while diagnosing as emotional and behavioural problems.

Prevalence of behavioural and emotional problems in adolescents across the world varies from 16.5 to 40.8% (WHO, 2001). In India, it varied from 6.3 to 12.5% (Srinath et al., 2005).

The causes for this disorder include lack of appropriate instruction in reading, writing, and mathematics as well as visual, hearing, and motor disability in the child, and certain cultural factors, environmental and economic disadvantage, and atypical education history. Also, chemical imbalances in the brain and body affect managing emotions. The biological factors include prenatal exposure to drugs or alcohol, a physical illness or disability, an undernourished lifestyle, brain damage and hereditary factors (NSODC, 2005, 2008).

An adolescent with emotional and behavioural disorder (EBD) whose problems increase in frequency and intensity to such an extent that it affects their daily routine and school life adversely, requires special educational services for recovery. Treatment requires early intervention targeting the

social–emotional development of the youngster, the stress factor that they go through, and the relationships based treatment involving their care givers (NSCDC, 2017). The relationship-based mental health interventions help to improve parent–child relationships leading the adolescent to diminish the risk for future mental health problems in adolescents (Zeanah et al., 2005).

(iv) **Childhood Behavioural Disorders**

Childhood behaviour disorders refer to repeated, severe and age-inappropriate behaviours such as destructive and challenging behaviours, aggression and violence, etc. It goes beyond the flouting of rules, crossing the limits imposed and breaking the boundaries built by parents and society which are typical characteristics of adolescence stage. According to Merikangas et al. (2009), childhood behavioural disorders are the sixth leading cause of disease burden among adolescents. These disorders can affect their academic performance and related areas, work life and at times may bring them in conflict with the law enforcement agencies due to violence or anti-social behaviours.

The causes underlying these disorders include biological factors consisting of physical illness or disability, malnutrition, brain damage, and hereditary factors. In addition, parental pressure, unhealthy, and inconsistent discipline, their poor attitude towards education and schooling as well as divorce between parents may all cause behaviour disorders in adolescents. Remedial measures include family counselling, behavioural, and multisystemic interventions.

(v) **Oppositional Defiant Disorder**

It is common to find adolescents to disobey, protest, defy rules, and show hostility towards parents, teachers, and authority figures. However, when they continue to show defiant behaviours with a degree of persistent stubbornness, showing an unwillingness to compromise or negotiate with others including their peers, it is a matter of serious concern.

Oppositional defiant disorder (ODD) is characterized by negative, defiant, disobedient, and often hostile behaviours most often directed at adults and people in authority. These children blame others for their misbehaviours and mistakes. In addition, they are argumentative, disobedient, resentful, and extremely sensitive. The prevalence of this disorder has been reported to be between 1 and 16% of children in the United States. As for India, there is a lacuna of studies on Oppositional Defiant Disorder (ODD). Mishra et al (2014) in their cross-sectional study of 900 school aged children of 6–11 years found the presence of ODD and CD in 7.73% of them.

The causes include the influence of similar behaviours in the family, parents, and other significant members, who reinforce the hostile behaviour in children as an acceptable means of interacting with others. There is no specific treatment but the role of parents in therapy is highly important, who are helped to reinforce the prosocial behaviours consistently, praise them, and reinforce the same (Mishra et al., 2014).

(vi) **Conduct Disorder**

Continuation of the aggressive and undesirable behaviours of adolescent may lead to conduct disorder under the following conditions such as (a) *it is of long duration*, (b) *violates the rights of others*, (c) *goes against accepted norms of behaviour and,* (d) *disrupts the child's or family's everyday life.*
Conduct Disorder (CD) is a frequently occurring serious behavioural and emotional disorder that has its onset in adolescence. It is characterized by a persistent pattern of aggressive and non-aggressive rule breaking anti-social behaviours, which brings the youngster in conflict with the law and norms of the society.
In DSM-5, there is an introduction of a specifier of CD with a callous-unemotional (CU) presentation which is a new type added to conduct disorder. Thus they lack empathy in their relationships. Symptoms of CD are of four categories, viz.,

- Aggressive behaviour: includes threats to cause physical harm, fighting, bullying, showing cruelty to animals and helpless people.
- Destructive behaviour: they are intentionally destructive, damages others' property and indulge in vandalizing public places, etc.
- Deceitful behaviour: they repeatedly tell lies, shoplift, break into people's homes or steal cars.
- Violation of rules: constantly violate rules of the society, play truant from home and school, play pranks on others which are injurious and harmful.

These youngsters are also sexually active at a very young age. Youngsters with conduct disorder cannot appreciate or visualize the hurt or harm they have caused to others. They never feel guilty or remorseful of their action.
Conduct disorder is differentiated from oppositional defiant disorder in that ODD is mainly about being defiant to the authority figures, especially the parents and teachers. It is refusing to obey rules and being disciplined. They resist being controlled. Whereas conduct disorder, which occurs in a little older children and adolescents, goes beyond and not only resists being controlled but also tries to control others. They exhibit aggression, deliberate destruction, cruelty and lack of empathy, exemplifying a callous-unemotional interpersonal style as specified in DSM 5. Prevalence of ODD has been found to be around 7–8%, whereas it is around 5–12% for CD (Cholakottil et al., 2017; Mishra et al., 2014, 2015).
No exact cause is available for conduct disorders, however the biological, genetic, environmental, psychological, and social factors together appear to cause this disorder. Treatment involves medication and psychotherapy. In addition, providing the youngster with a nurturing, supportive, and consistent home environment can ensure a balance of love and discipline, which in turn may not only minimize the disorder but may also prevent it from occurring in the future (WebMD, 2018).

(vii) **Deviant Behaviours**

Deviant behaviours refer to those behaviours that are not in conformity with the norms of the society. These behaviours cause harm and injury to people,

public property and damage to the existing system and bring the individual in conflict with the law. Deviant behaviour is different from aberrant behaviour in the sense that the aberrant behaviour would include traits like strangeness, eccentricity, and individuality, which are not harmful (Goode, 2016). On the other hand, deviant behaviour is any behaviour that is contrary to the dominant norms of society. While formal deviance refers to criminal violation of formally enacted laws, informal deviance refers to violations of informal social norms, which have not been codified into law.

One of the important signs of deviant behaviour in adolescence is social isolation and identification of self as 'deviant' by them. Some of the deviant behaviours indulged in by adolescents are playing truant from home and school, stealing, lying, cheating, and in more serious cases, assaulting, rape and murder. It is also known that adolescents are highly influenced by their peers either positively or negatively, and may indulge in deviant acts for the sake of conformity.

Analysing deviant behaviours in school setting, Nabiswa et al (2016) reported twelve types of deviant behaviours in varying scale of severity with a prevalence ranging between 3 and 21%. It is also reported that in case of sexually deviant behaviour, a victimized youth indulges and repeats deviant sexual behaviour (Burton, 2008).

Many theories explain the causes for deviant behaviour in adolescents, such as those of social control theory, social learning theory, differential association theory, etc., in addition to poor parenting, peer and school influence. Nkhata and Mwale (2016) pointed out that parenting techniques, peer group influence and school environment contributed to adolescent deviant behaviours. Further, they advocated that through counselling and by changing the school discipline and environment, the deviant behaviours could be reduced considerably. Treatment should focus on correcting deviant behaviours both by parents and professional psychologists, individually and in group. Counselling would help these youngsters to gain a better understanding of the root cause of their own anger and their need for power, control, and revenge. It also helps them to consider more appropriate replacement behaviours.

(viii) **Attention Deficit/Hyperactivity Disorder (ADHD)**

Attention deficit/hyperactivity disorder is a neurobehavioral disorder characterized by a combination of inattentiveness, distractibility, hyperactivity, and impulsive behaviour. According to DSM 5 (2013), ADHD is characterized as "a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals of comparable levels of development". The symptoms of ADHD include Inattention, Impulsivity and Hyperactivity. While causes for ADHD are not known, heredity, chemical imbalance and brain changes are stated to be some of the causes.

ADHD is prevalent worldwide and is also one of the emerging disorders in India. It interferes with school performance, self-esteem, family relationships, and predisposes teenagers to high-risk behaviours. According to Medicine Net (2018), current studies indicate that approximately 60–80% of patients diagnosed as children will meet diagnostic criteria during adolescence and adulthood. ADHD affects an estimated 3–5% of preschool and school-age children in the United States (Low, 2017). The majority of these children will continue to experience symptoms into adolescence and adulthood. In India the prevalence rate of 1.3% was reported in a study on 3120 children aged between 5 and 12 years from 18 schools (Ramya et. al., 2017). Adolescents with ADHD will commonly have problems with relationships (parents and peers), academic and nonacademic (for example, sports and employment) success, and self-esteem. As for treatment of ADHD, patient education is a vital part of treatment of ADHD. Cognitive behavioural therapy, insight oriented psychotherapy, and family counselling has been found to be useful along with medications.

(ix) **Learning disabilities**

Learning disabilities (LD) is most commonly observed among children and adolescents and also most misunderstood and under diagnosed. It is usually observed as difficulties in learning and using academic skills, specifically with regard to reading, writing, and arithmetic. DSM 5 uses the umbrella term of Specific Learning Disorder to include these specific disabilities related to reading, written expression and mathematics. These are key academic skills which need to be learned by the children. However, in case of learning disabilities, the child experiences difficulty in word reading, spelling, reading comprehension, arithmetic, and mathematical reasoning. Performance of such children in these areas is well below average for age.

However, we need to be more careful about defining and understanding it as it goes by the principle of exclusion. That is, it should not be due to any sensory handicap/impairment, intellectual disabilities, other mental or neurological disorders, emotional problem, socio-cultural disadvantage/adverse conditions such as inadequate instruction, lack of proficiency in the language of instruction or any psychosocial adversity. Thus, learning disabilities refers to deficiency in the basic processes of learning.

IDEA (2004) defines learning disabilities as "*A disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in an imperfect ability to think, speak, read, write, spell, or to do mathematical calculations*". It encompasses dyslexia, dysgraphia, and dyscalculia that refers to learning disability in reading, writing, and arithmetic, respectively. DSM 5 describes these subtypes under specific learning disorder as follows:

- Specific learning disorder with impairment in reading: includes possible deficits in word reading accuracy, fluency, and reading comprehension.

- Specific learning disorder with impairment in written expression: includes possible deficits in accuracy in spelling, grammar, punctuation, and clarity or organization of written expression.
- Specific learning disorder with impairment in mathematics includes possible deficits in number sense, memorization of arithmetic facts, accurate calculation and math reasoning.

Discussing the risk and protective factors associated with emotional well-being in adolescents with learning disabilities, Syetaz et al (2001) conducted a national longitudinal study with the purpose of finding out the differences in emotional well-being among adolescents with and without learning disabilities. In a sample of 20,780 adolescents, of which 1301 were learning disabled, they found that adolescents with LD had twice the risk of emotional distress, risk of attempting suicide, risk of violence involvement as compared to their peers without learning disabilities.

In a review study focusing on published articles in peer-reviewed journals since 2000, Kuriyan and James (2018) found that 1–19% of school going children in India have learning disability as reported by various studies. On finding the mean score, they indicate that 10% of children in India have LD. While learning disabilities are caused by genetic and hereditary factors, early intervention improves outcomes for most children with disorders of learning, attention, and cognition (Pratt & Patel, 2007). Parental attitudes and commitment, availability of resources would make for significant positive change in these adolescents.

(x) **Risk-Taking Behaviours**

Adolescents indulge in risk-taking behaviours such as smoking, alcohol, drug abuse, unsafe sex, very risky adventure sports, reckless driving, binge drinking, etc. With increasing alcohol and drug intake, the probability of sexual risk-taking behaviours also increase, leading to HIV and other such diseases (WHO, 2018). Perpetration of violence is another risk-taking behaviour among adolescents. With the growing recognition of youth violence as a major public health problem, there is increased pressure to develop effective and early intervention programmes (US HHS, Surgeon General's Report, 2001).

In India, Das et al (2015) listed out risk-taking behaviour in Indian adolescents as dietary behaviour (indiscriminate and fast food), physical activity (sedantry life style and lack of physical exercises), mental health issues (indifferent attitude towards mental hygiene), protective factors (not taking precautionary or protective measures while indulging in sexual relationships), violence and unintentional injury, etc., being either in the 'moderate' or 'high' risk grade. The study by Agrawal and Agrawal (2013) showed that the prevalence of chewing, smoking and drinking among adolescents was 3.3%, 12%, and 0.9%, respectively. Adolescents, who were school dropouts, were found more likely to indulge in risk-taking behaviour than their counterparts. However, female adolescents, adolescents belonging to scheduled

tribe, other backward classes as well as those belonging to slightly higher socio-economic status, were observed to be less likely to indulge in any risk-taking behaviour. The authors recommended comprehensive prevention and control programmes for all adolescents and in particular to those adolescents who were school dropouts or had never been to school, as the latter were more likely to indulge in risk-taking behaviours.

As for causes that lead adolescents towards risk-taking behaviours, it may be stated that at the individual level, risk factors may include a history of involvement in crime, delinquency and aggressive behaviour, hyperactivity and conduct disorder in the person. At the family and relationship level, poor parental supervision, parental involvement in crime and harsh inconsistent discipline are risk factors for youth violence. At the community level, the risk factors are crime filled neighbourhood, gangs that supply guns and illicit drugs, unemployment, income inequality, and poverty. Keeping these causative factors in mind, a number of measures have been suggested to curb the youth violence (WHO, 2015), for example, youth violence prevention programme through policy guidelines, evidence-based youth violence prevention programmes, building skills and competencies of adolescents to choose nonviolent, safe behaviours, etc.

(xi) **Substance Use Disorders**

The curiosity of adolescents combined with peer influence lure them to indulge in smoking, drinking, and trying out more powerful drugs that may harm the body and mind. Starting with occasional use of the substance concerned, the youngster graduates to more powerful drugs, and become addicted to them. The adolescents use substances for a variety of reasons, viz., sharing a special experience, relieving stress, seeking new experience, and for overcoming the symptoms of mental disorders such as depression, anxiety, etc. In addition, other reasons for drug use include lack of self-control, peer pressure, lack of parental monitoring, parents themselves indulging in alcohol and drug, and taking prescription drugs indiscriminately over the counter, etc.

Adolescence is the key period of development for substance use disorders. Findings from the nationally representative samples of U.S. youth reveal that the lifetime prevalence of alcohol use disorders is approximately 8% and illicit drug use disorders is 2–3% (Merikangas et al., 2010; Swendsen et. al., 2012). An interesting trend in the prevalence rate is that there are more adolescents (of 13–18 years of age) who are indulging in the drug abuse as compared to the lower age group below13 years.

In the context of India, a study by Kailash (2016) found that at the age of 5 years, many children reported that they were consuming drugs. According to Saxena et al. (2010), around 5500 children in India start consuming tobacco products daily and some children as young as 10 years of age, consume tobacco. The most common substance consumed, according to Rao (2010), is nicotine, in the form of 'bidis' and 'gutkas'. Other substances used include adhesive glue, petrol, and gasoline. The reasons for the prevalence of drug

abuse in children and adolescents are economic burden, poverty, ignorance, migration, child labour, etc. (Qadri et al., 2013).

Regarding causation, the genetic and epidemiological studies have consistently demonstrated that genetic factors have a major influence on the progression of substance use to dependence (Merikangas & McClair, 2012). The environmental factors unique to the individual also play an important role in the youngsters using the substances in the initial stages when they get exposed to the substance.

One of the important risk factors for adolescent smoking is that their own parents, their friends, and peers as well as persons who are their role models, smoke (Sargent et al., 2004). For addiction to drugs or alcohol, it is important to admit the youngster to treatment and deaddiction programme followed by psychological therapy sessions such as cognitive behaviour therapy, psychotherapy, etc. More than the treatment, prevention of drug use and abuse is to be given the highest priority (Dalton et al., 2002). The role of society and media in portraying drinking or indulging in drugs as acceptable and fashionable also needs to be considered. Parental role is extremely important in conveying clear expectations to the youngster in regard to drinking, setting limits consistently, and monitoring their behaviours.

(xii) **Eating Disorders**

You may have seen teenagers and adolescents go on strict dieting to the extent of starving themselves to look thin. On the other hand, there are also instances of eating excessively and indiscriminately. These are called eating disorders characterized by abnormal or harmful eating behaviours where the adolescent has an extreme and unrealistic concern about body weight and shape.

The most common eating disorders are anorexia nervosa and bulimia nervosa where the person is excessively concerned about restricting the calorie intake. Anorexia nervosa is starving oneself, and feeling that one is still over weight despite dramatic/abnormal weight loss. They fear gaining weight and becoming fat despite having a very low body weight.

Bulimia nervosa is characterized by excessive eating or binge eating and then self-induced vomiting or purging, and the cycle goes on like this. They have a high level of distress, guilt and self-disgust during such binge eating. Another eating disorder, called binge eating disorder involves excessive eating and a high preoccupation with food but does not involve any purging. Apart from anorexia, bulimia nervosa and binge eating, there are a few more eating disorders such as pica, rumination disorder and avoidant/restrictive food intake disorder. While pica refers to eating of non-food items, such as soap, cloth, dirt, etc., rumination disorder refers to repeatedly and persistently regurgitating food after eating which may result in malnutrition if the food is spit out or if the person eats lesser in order to avoid regurgitation. In case of avoidant or restrictive food intake disorder, the person fails to meet the minimum required daily nutrition as he or she has lost interest in eating; or these persons may avoid foods with certain colours, smell or taste, or may

even be concerned with consequences of eating, e.g., the person may fear that the food would choke him. In these cases, food is not avoided because of the fear of weight gain. Such eating disorders are injurious to adolescent health and is accompanied by depression, anxiety and substance abuse.

It is important to understand the causative factors for eating disorders which are multifaceted and can be biological, sociological, emotional, and environmental. One of the focuses in research on eating disorders is the study of the biological component. Researchers have shown that brain pathways in persons suffering from eating disorder are very different from those who have no such disorders (Ekern, 2018). Another study by Hicks and et al., (2018) related eating disorders to different types of trauma experienced by the study participants. The purpose of the study was to show the prevalence of various trauma types in a clinical sample of adolescents presenting eating disorder in an outpatient clinic. They concluded that 35% of the sample reported experiencing one or more traumatic events such as bullying, death or loss of a dear person, sexual abuse, etc.

A variety of therapies by a multidisciplinary team of physicians, psychiatrists, psychologists, nutritionists, and other specialists will help the youngster to achieve goals that include normal eating behaviour, coping skills for stress management, personal confidence, understanding the root cause of the eating disorder, appropriate views of body image, improved relationship skills, treatment for co-occurring disorders, relapse prevention, and aftercare plans. Prevention includes minimizing the common social, familial, and individual factors like pressures to be thin, self-esteem problems, which can lead to eating disorders. Parents, school counsellors, and teachers should become educated about the causes that perpetuate eating disorders. Individual factors such as low self-esteem can also be addressed by appropriate and timely counselling.

(xiii) **Anxiety Disorders**

Adolescents commonly experience anxiety related to their physical growth, psychological and emotional development and also due to the academic pressure. These are normal anxious feelings, worries, and fears that are common to all children and adolescents. However, when anxiety is excessive, irrational, persistent, all pervasive, over whelming, and debilitating, it signals mental health problem. As mentioned by Connolly and Nanayakkara (2009), anxiety disorders are one of the most common psychiatric disorders observed in children and adolescents but yet go undetected and untreated even though it is highly treatable.

According to Cleveland Clinic (2018), anxiety disorders share a few common features, viz., (i) anxiety is often an inexplicable or irrational fear which interferes with the adolescent's ability to enjoy life or complete their daily routines, (ii) anxiety is puzzling to both adolescents and to their parents, and (iii) anxiety does not reduce even after logical explanation, and cause the adolescents significant distress and affects their efficiency, competency and

their level of functioning. Anxiety makes the adolescents nervous, has unrealistic fears, suffers sleep disturbance, bothered by obsessional thoughts, etc. Physical symptoms include tremors, sweating, muscular tension, stomach aches and headaches, which all make the adolescent feel that he or she has no control over them.

Anxiety disorders is an umbrella term that includes generalized anxiety disorder, social anxiety/social phobia, separation anxiety disorder, panic disorder, and specific phobias. Regarding causes, a combination of biological, psychological and social factors are considered to cause anxiety disorders.

Treatment of anxiety disorders involves pharmacological treatment. A more recent one is selective serotonin reuptake inhibitors (SSRIs) and selective serotonin–norepinephrine reuptake inhibitors (SSNRIs). These have been found to be effective in the treatment of anxiety disorders in adolescents. Also among the psychological therapies, cognitive-behavioural therapy (CBT) has been found to be efficacious in the treatment of these conditions in youth. In cases where the combination of CBT + an SSRI are administered, the improvement has been highly significant (Wehry et al., 2015).

Preventive measure will involve educating the adolescents and the parents, relaxation training, skills such as communication, problem-solving, and managing emotions.

(xiv) **Body Dysmorphic Disorder**

This disorder has its onset during adolescent period, with a point prevalence of 0.7–2.4% (Bjornsson et al., 2013). The youngster is obsessed with his or her appearance, and overly critical and distressed and anxious about some of the flaws perceived by them in their own physique.

Body dysmorphic disorder (BDD) affects their academic performance, relationships with peers, family members and teachers in the school. Bullying is also observed which takes the form of body shaming that ends in more negative body image and very low self-esteem in the adolescent person. This negatively affects the social interactions of adolescents. Weingarden and Renshaw (2015) reported that 94% of youths with BDD expressed experiencing social difficulties due to their appearance.

As for causes, abnormalities in the brain structure, genes and environmental factors lead to this disorder (Mayo Clinic, 2018). Treatment consists of **Selective Serotonin Reuptake Inhibitors (SSRIs) and cognitive behaviour therapy**.

(xv) **Schizophrenia**

Schizophrenia is a psychotic disorder that often begins in late adolescence or early adulthood, and has serious impact on an individual's thought, perceptions of reality, and behaviour. According to DSM 5 (American Psychiatric Association, 2013), diagnosis of schizophrenia is made if two or more of the following symptoms (delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behaviour, and negative symptoms such as diminished emotional expression), last for at least a month or longer period of time

and at least one of them impairs the functioning of the individual in work, interpersonal relations or self-care with some signs of the disorder lasting for a continuous period of atleast 6 months.

Psychosis means "withdrawal from reality", and that's exactly what schizophrenia is—a mental disorder that is mainly characterized by difficulty distinguishing what is real from what is not. The prevalence rate for schizophrenia in India according to NIMHANS study is 0.41–1.42. (NMHS, 2015–16). International prevalence rate of schizophrenia is reported to be 0.33–0.75 (Kustner et al., 2018).

Schizophrenia is said to be caused due to structural and functional abnormalities in those regions of the brain that control and coordinate thinking, perceptions and behaviours (Karlsgodt et al., 2010). Another explanation for schizophrenia onset is the brain pathways that use the chemicals dopamine and serotonin. Schizophrenia also occurs due to genetic factors in quite a few cases.

Regarding treatment for schizophrenia, early diagnosis and appropriate treatment are critical. A comprehensive treatment programme should include medication and psychotherapy such as cognitive behaviour therapy. Family interventions including psychoeducation, that is, educating the family about schizophrenia and how to cope can play a crucial role.

Conclusion

The present chapter discussed mental health problems and mental disorders encountered in the adolescent stage of development. Major factors associated with the increasing trend in mental disorders were discussed. The different mental health problems/mental disorders among adolescents were presented, highlighting the symptomatology, prevalence rate global and India, diagnostic criteria, causes, treatment, and preventive measures. The disorders dealt with were: depression, suicide and attempted suicide, emotional and behaviour disorder, childhood behaviour disorders, oppositional defiant disorder, conduct disorder, ADHD, learning disability, high-risk behaviours, eating disorders, anxiety disorder, body dysmorphic disorder, and schizophrenia.

Time to Reflect

Adolescents are perceived in various ways across societies and cultures. In western countries, they are seen as individuals on their own right and expected to live independently and start off on their own. Whereas in collectivistic societies like India, they are mostly considered as dependent and are still seen as children; though in some aspects, they are expected to behave like grown ups. Overall, adolescents are still not full adults. They are not involved with adult tasks and life's myriad responsibilities

and expectations. So, it is important that they should have good mental health. At the most they are expected to have only small issues related to their studies, education and relationship with peers around which their life revolves mostly. Though children from under privileged backgrounds have other life concerns related to basic survival and supporting the family, still they are also not perceived to have mental health problems. But we need to take serious note of the research evidence that our children and adolescents across social class and economic backgrounds do face mental health problems and mental disorders which need urgent attention. They are our most valuable future resource, and if neglected, it will not only affect their own optimal development and leading a fulfilling and productive life, but also add to the economic and social cost of the nation. WHO (2017) points out that worldwide, 10–20% of children and adolescents experience mental disorders. Half of all mental illnesses begin by the age of 14 and three quarters by mid 20s. If this is not reason enough for us to focus on adolescent mental health, then what else is needed? Children with mental disorders are the worst sufferers of it as it not only limits their access to education and health care, but also exposes them to stigma and discrimination, thus violating their fundamental rights. It is really time to have a wake up call to focus on adolescent mental health.

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Part III
The Way Forward

Chapter 14
Promotion of Mental Health and Well-Being Among Adolescents

Swati Patra

Abstract The chapter highlights the importance of mental health in the multi-faceted context of adolescents. It explains the factors affecting adolescent mental health. Further, it discusses the promotion of mental health and well-being among adolescents in the backdrop that the positive effects of mental health promotion and preventive measures for the young people are cumulative and carry over across the life span. A concerted approach involving both prevention and intervention measures is important in achieving sustainable mental health among adolescents. Various measures at individual and group level for promoting mental health in adolescents are described. Finally, the chapter points out the challenges to mental health promotion in the socio-cultural context of adolescence and advocating a rights-based approach to mental health.

Keywords Mental health · Well-being · Adolescents · Counselling · Community · Prevention · Intervention

Introduction

Adolescence is a crucial period not only in terms of the various developmental transitions and their impact on the adolescents during this stage but also how it is going to affect their future life and adjustment depending on how they manage these transitions. Half of all mental health conditions start by the age of 14 (WHO, 28 Sept 2020). The way adolescents adapt to the physical, mental, and emotional changes at this stage and the societal pressures and expectations resulting from these changes determine their psychological well-being to a great extent. In fact, as per the WHO, 16% of the global burden of disease and injury in the age group of 10–19 years is accounted for by mental health conditions and in the context of the fact that one in six people are aged 10–19 years, it needs to be taken seriously. Various research

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studies report psychiatric morbidity in the range between 14.4 and 31.7% among Indian adolescents (WHO 2005).

Mental health problems are far more common in the young people than we think. Often, there is lack of adequate attention to the mental health aspect of the adolescents. There are ample policies and measures focusing on malnutrition, education, child labour, and child abuse, but serious focus on mental health aspect of the adolescents is still lacking (Hossain & Purohit, 2019). Research points out at the prevalence of stigma related to mental health problems among young people in India (Gaiha et al., 2020). The study indicates that one-third of young people have poor knowledge of mental health problems and express negative attitudes towards people with mental health problems, and 1 in 5 showed actual/intended stigmatizing behaviour. They were not aware about the symptoms, causes, and possibility of treatment for mental health problems. This is further reflected in the four main themes that emerged in a thematic analysis of mental health problems shared online by the youth (Gonsalves et al. 2019). The themes identified in these narrative descriptions were (1) living through difficulties; (2) mental health in context; (3) managing one's mental health; and (4) breaking stigma and sharing hope. It strongly highlights the need for anti-stigma initiatives and awareness activities at a community and society level.

Importance of Mental Health for Adolescents

Adolescence is a crucial stage in the life span where there is a transition from childhood to adulthood. Various developmental changes happen at this stage and establishing one's identity is one of the significant needs of this stage (Erikson, 1968). Adolescent may face an identity crisis in the event of not being able to achieve this important developmental task of the stage of adolescence. Developing a sense of self is influenced by their cognitive changes, emotional changes and most importantly, rapid physical changes. Added to this are the parental and societal expectations, norms and socio-cultural practices related to gender, caste, class, and religion. All these impact the mental health of adolescents which gets compounded because of the multi-faceted context of adolescents. Hence it is important to emphasize mental health and well-being of adolescents in this challenging stage of life.

World Health Organization (WHO) defines child and adolescent mental health (CAMH) as the capacity to achieve and maintain optimal psychological functioning and well-being (Herrman et al., 2005). Good mental health at the early stage will have long-term positive impact on multiple areas of functioning in life including personal, social, and work. It will facilitate adolescents' performance in the areas of learning, peer relation, social interaction, career, and most importantly, managing one's life effectively by using coping skills, problem-solving, critical thinking, and acquiring positive values and character strengths. On the other hand, poor mental health will impact negatively the development of competencies in adolescents to manage functioning in different areas of life. Mental health also impacts other aspects of development. For instance, there is a bi-directional relationship between physical health and

mental health. Poor mental health impacts recovery from physical health conditions and diseases. Poor physical health also contributes to poor mental health (WHO, 2003). Hence it is important to view health in an integrated manner and emphasize all the aspects of health. Mental health-related attitudes and habits affect our overall health and may lead to adjustment problems, stress, anxiety, and interpersonal relation difficulties (Choudhary et al., 2016).

Mental disorders are clinical conditions based on the diagnostic criteria indicated in ICD 11 or DSM 5. However, there are also sub-threshold mental disorders that do not reach the threshold of indicated clinical diagnosis of a mental disorder. This refers to mental health conditions that do not meet the diagnostic criteria of disorders but affect the functioning, adjustment and performance of the individual significantly. Mental disorders and sub-threshold mental disorders affect a large proportion of populations.

Studies indicate that globally mental and substance use disorders add to the disease burden in children and youth (Erskine et al., 2015). Depression is considered as among the leading causes of illness and disability among adolescents. Suicide is the third leading cause of death in older adolescents between 15 and 19 years. Childhood behavioural disorders including anxiety also affect the adolescents in a significant way. The data indicates the importance of focusing on the socio–emotional health of children and adolescents in addition to their physical health. These emotional and behavioural disorders in the adolescents affect their school performance and their relationships with peer and other members in the family and neighbourhood. Mental health problems have an ongoing and long-term impact and thus affect the adolescents' future life as adults also.

Although a life-course approach to mental health is required as mental health is important at each stage of life, evidence highlights the need to take steps to give every child the best possible start in life that will generate the greatest societal and mental health benefits (WHO, 2014). The positive effects of mental health promotion and preventive measures for the young people are cumulative and carry over across the life span.

Factors Affecting Adolescent Mental Health

The characteristic features of the adolescence stage coupled with the socio-cultural contexts of adolescents may make them vulnerable to develop mental health-related problems. For instance, the growing desire for autonomy in the adolescent may be compromised by factors such as gender, religion, physical illness, socio-economic background, etc. Adolescents go through key life cycle and developmental transitions such as entering into the world of work, doing paid work, leaving home for education or work, learning to be independent, forming relationships, handling responsibilities, etc. This makes these young people especially vulnerable to mental health problems (Carter, 2000).

The stage of adolescence is also characterized by risk-taking behaviour such as sexual risk-taking, use of substance, engaging in aggression, and violence. Involvement of adolescents in these risky behaviours further depends on the multi-faceted background and situation of the adolescent, such as marginalization, exclusion, discrimination, peer influence, dysfunctional family, and media exposure. The need for conformity to peer group values and culture exerts pressure on the adolescent to engage in harmful and maladaptive behaviours such as substance use, engaging in bullying, and violence. The adolescent may also abuse others or may get abused themselves, especially sexual abuse and violence. Further, adolescents may also engage in risk-taking behaviour as a way of maladaptive coping.

Adolescents today are exposed to the globalized world through the power of technology. They are living in a digital world which affects their perceptions, values, and aspirations. However, given the multiplicity of adolescents, this may create a disparity between an adolescent's lived reality and their perceptions or aspirations for the future (WHO, 28 September 2020).

Media influence plays a great role in shaping the perceptions and values of the adolescents with regard to the roles and expectations in the context of gender, peer, and social status. Increased access to and use of technology by the adolescents opens up a virtual world to the young generation about which their parents generation are not aware of and are also not comfortable in getting into it. However, the Net savvy generation of young people may develop mental health problems such as stress, anxiety, and depression due to problematic use of Internet (Goel et al., 2013; Gupta et al., 2018; Masih & Rajkumar, 2019).

Hence it is important to assess the risk factors in the life of an adolescent that may affect the mental health of adolescents. These risk factors may pertain to the adolescent themselves related to their developmental characteristics and competencies. It may also include the environmental factors and the socio-cultural context of the adolescent. These include the disadvantaged background, social exclusion, discrimination, harsh parenting, domestic violence, dysfunctional family environment, abusive parents, poverty, scarcity of resources or limited resources, etc. Singh et al. (2015) studied the psychosocial functioning of adolescents in relation to their demographic variables, self-concept, and prosocial behaviour. These were found to affect the mental health-related difficulties of the adolescents. Prosocial behaviour was found to be negatively correlated with depression, anxiety, and stress in adolescents. Further, perceived presence of relaxed family environment and positive perception of opinion and thoughts expression in front of parents and family members affected adolescent's prosocial behaviour.

Identification of the risk factors in the lives of adolescents that may predispose the adolescents to mental health conditions is a crucial step in the direction of promotion of mental health. The risk factors may vary in relation to '*who*' is the adolescent, '*where*' is the adolescent living and in '*which*' context the adolescent is functioning. When we discuss in terms of 'who', there is difference in terms of the age group in which adolescence is defined and factors vary according to the age. WHO and UNICEF define adolescence as those aged 10–19 years. Ministry of Health and

Family Welfare (MoHFW), Government of India has also adopted the WHO definition of adolescents and categorizes adolescents as between 10 and 19 years of age. However, within this age group also, adolescents vary in terms of their needs, developmental characteristics and societal expectations. Regarding 'where' is the adolescent living, we find adolescents living in rural and urban places, in slums and villages or on streets/shelter homes/juvenile homes, etc. These living conditions vary in terms of the types and severity of risk factors they are exposed to and the impact these have on their development. Further, it is also important to understand the contextual factors in 'which' the adolescent is functioning, whether it is a dysfunctional family environment, a 'gang' culture, deviant peer group, social discrimination, stigma, dogmatism, abuse, violence, political uncertainty, or oppression. The caste, class, race, religion, education, economic, and employment status of the adolescent also affect the development of adolescents in different ways. Hence it requires that we focus on the specific factors operating in the socio-cultural context of the adolescent while discussing preventive and intervention measures for promotion of mental health and treatment of mental disorders.

Promotion of Mental Health and Well-Being Among Adolescents

A discussion on the promotion of mental health requires a conceptual clarification of the meaning of mental health. WHO points out that mental health indicates going beyond the mere absence of disorders. However, the general perception relates mental health to mental disorders. Thus it focuses on only one aspect of mental health and neglects the other side. There needs to be prevention of mental disorders as well as promotion of mental health. However, the health professionals and health policymakers are often too preoccupied with the immediate problems of those who have a disease to be able to pay attention to the needs of those who are 'well' (WHO, 2004). Hence it is important that the planners and policymakers are oriented and aware of the conceptualization of mental health and the issues related to it. According to Keyes mental health continuum, mental health ranges from the presence of mental disorders through the absence of mental disorders to the presence of mental health.

Absence of Mental disorder

Presence of _____ * _____ Presence of

Mental disorder Mental health

It indicates that the absence of mental disorders automatically does not mean that there will be good mental health. It goes beyond the mere absence of disorders. Even with the presence of disease, infirmity or disability, for example, elderly with chronic illness or an individual with disability, one can achieve good mental health.

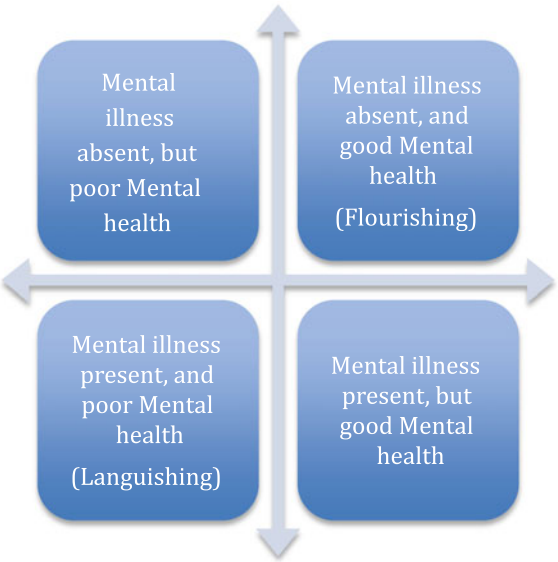

Fig. 14.1 Dimensions of mental health

Thus the key is to adapt and manage the illness or disabilities and achieve well-being (Machteld et al., 2011).

If we take a two-dimensional model with mental health (ranging from poor to good on horizontal axis) and mental illness (ranging from absent to present on vertical axis), we will have four quadrangles as seen in Fig. 14.1. So we can have presence of mental illness with poor mental health (languishing state), presence of mental illness but good mental health, absence of mental illness but poor mental health, and absence of mental illness with good mental health (flourishing state).

Thus it is important to understand that mental health and mental illness/disorders are two separate dimensions. One can have good mental health despite the presence of mental health conditions. On the other hand, one may not have good mental health even if there is no mental disorder. So prevention and treatment of mental disorders is one thing. But one needs to go beyond this and need to talk about the promotion of mental health and well-being so that one can achieve the flourishing state of being.

Physical health is visible and obvious whereas mental health is not that obvious unless one shares and expresses about it. Still then, this may not be understood and taken seriously because of lack of awareness about mental health in the society. The socialization process, the child-rearing practices, the family interaction also do not put that emphasis on aspects of mental health and are not openly communicated and discussed neither at home or school nor in the community. It is either neglected or under emphasized.

Mental health needs to be talked about widely in every forum because there is no health without mental health. However, there is a general discomfort with the term ‘mental health’ as it is equated with mental illness; instead ‘psychological and emotional well-being’ is a term more preferred (Victorian Health Promotion

Foundation, 2005). We need to consider the cultural contexts which can play a role in maintaining the stigma related to mental health issues.

Factors related to the individual and factors in our environment determine our mental health. A dynamic interaction between our thoughts, emotions, and behaviour influence our mental health. Further, various factors related to our family, school, workplace, relationships, neighbourhood, etc. interact and impact our mental health. The needs and demands of the particular developmental stage of the individual also interact with all these factors to affect the mental health of the individual. Since adolescence stage is a transitional stage with rapid developmental changes and challenges, the effects of these factors on the mental health become more pronounced. This needs to be recognized because there is the possibility that these may be thought of as part of the normal challenges of the growing adolescence stage.

Hence it is important to know and understand the adolescence stage itself and also the factors that affect the mental health of adolescents. This will facilitate in two ways, first, identification of mental health problems in the beginning itself which is a major challenge in the absence of proper knowledge. This will help in taking early and timely steps for addressing the problems in an effective way. Secondly, awareness about adolescence and factors affecting their mental health will enable one to take proactive steps for the promotion of mental health and well-being among adolescents. Thus mental health issues can be prevented beforehand and adolescents can grow up to live a happy, productive, and meaningful life.

Addressing mental health of adolescents requires prevention as well as intervention measures. Prevention is always better than treatment and rehabilitation. It is cost effective both from the financial, material, and human resource aspects. Moreover, it contributes to more productivity and efficiency in the targeted population in personal, social, economic, and other areas. Hence a concerted approach including both prevention and intervention measures need to be the focus of any comprehensive programme for the promotion of mental health and well-being among adolescents. There may be three approaches for developing programmes for mental health and well-being of adolescents.

(i) A comprehensive approach where a general programme can be developed covering the issues and concerns of adolescents in general, but is flexible enough to build into its ambit/ framework the contextual factors keeping in mind the multiplicity of adolescents.
(ii) Specific approach where specific programmes can be developed to address the concerns of the adolescence stage specific to the context of the adolescents.
(iii) Selective approach where specific components from different programmes can be taken which are relevant in the specific contextual background of the particular adolescent group.

Further, the focus of mental health promotion programmes can be two-fold: the individual and the group. At the individual level, one needs to work on enhancing personal skills, and developing the right attitude and beliefs. Thus it targets the actions/behaviour of the individual and her/his thoughts and emotions. At the group level, we need to work at the community and society level. Here the emphasis needs

to be on creating a conducive atmosphere, an enabling environment in the community that will promote the mental well-being of people.

Measures at the Individual Level

Working at the individual level requires that it take into account the developmental characteristics of the individual. Adolescents are growing at a physical level. Their cognitive capacities, social–emotional competencies are still growing. There are of course individual differences in the growth and maturity level of adolescents in different developmental aspects. Two regions of our brain are important here: amygdala and frontal cortex. Amygdala which develops earlier than frontal cortex is responsible for our emotions, affective responses, and instinctual behaviour. Frontal cortex controls our reasoning, decision-making, rational thinking, and judgement. Thus stressful situations may create confusion, doubt, and anxiety in the adolescent with regard to their self and make them impulsive and aggressive. Adolescents are still developing in different aspects including cognitive, social, and affective. They may have difficulty in inhibitory motor responses as adolescents still have limitations in implementing basic cognitive control (Luna, 2009). The added novelty and sensation seeking behaviour of adolescents, a characteristic feature of this stage, makes them to engage in risk-taking behaviour which impairs their decision-making and affect their psychological well-being.

Hence it is important to focus on the cognitive and affective development of the adolescents. Once the adolescents understand how their mental abilities, thinking, and emotions affect their behaviour and how these are interrelated, it will enable them to manage their emotions and avoid dysfunctional thoughts. Various methods and techniques are described below that are found to be effective in promoting mental health by focusing on the factors at the individual level.

Individual counselling works with the adolescent as an individual and focuses on making the adolescent work with herself/himself. The adolescent develops understanding about the self, the developmental changes, and the thoughts, emotions related to it. Since mental health depends to a great extent on cultivating right attitude and attributes by the individual, it is important to ensure that these are developed in the individual at an early stage. '*Catch them young*' is the key in ensuring good mental health among the adolescents so that they learn the 'how to' of mental health as they learn the 'how to' of physical health. One important parenting goal is to develop healthy habits in children and adolescents, but it mostly focuses on habits related to physical health. However, developing healthy social and emotional habits are also important for good mental health.

The focus needs to be all round development. There are several determinants of mental health at the individual level such as managing one's emotions, coping, interpersonal skills, and learning to communicate well which contribute to mental health (Singh et al., 2015). Factors such as empathy lead to social and emotional

competence (Allemande et al., 2014) and resilience also contributes to a healthy sense of identity (Dent, 2016) in adolescents. Empathy is the ability to understand things from the other person's point of view and accordingly take steps or make a decision. This helps in good interpersonal relationship and well-being. According to Gazzaniga (2008), empathy can enhance psychological well-being as it enables one to take on others' perspectives instead of an egoistic perspective of one's own self; which in turn, helps in reduction of selfishness and impulsive behaviour and contributes towards increased well-being. Empathy enhances an individual's self-image (Chung, 2014) and thus affects one's self-esteem and psychological well-being. Resilience refers to the ability of the individual to face any kind of failure or difficult situation and bounce back from it with new learning and new perspective. It helps the adolescents to adapt well to any kind of challenge or adversity. Various studies (Fabio & Palazzeschi 2015; Hasse et al., 2014; Nagle & Anand, 2012; Vinayak & Judge, 2018) have shown empathy as well as resilience related to promotion and enhancement of one's mental well-being. Resilience acts as a protective factor in case of adversities and traumas.

Various other factors such as self-esteem, and psychological capital have been found to contribute to good mental health in the adolescents. Gujar and Ali (2019) have indicated self-esteem as a significant predictor for emotional and behavioural problems. They also found a significant correlation between psycap and self-esteem. Psychological capital (PsyCap) is a positive psychological resource which consists of four aspects namely, hope, self-efficacy, resiliency, and optimism. Positive attributes in individuals affect their well-being. According to Lyubomirsky and Layous's (2013) positive-activity model, performing small intentional positive activities makes people happier and enhances their well-being. The person-activity fit in terms of the interaction between the features of the person (e.g., demographic status, motivation, personality type, etc.) and the features of the activity (e.g., duration, frequency, etc.) further predicts increases in well-being.

Enhancing mental health awareness in a democratic society like India will lead to advocacy, leveraging of political will, funding, and cross-synergies (Srivastava et al., 2016). They suggest six main platforms such as conventional media, Internet and social media, educational system, industry, crowd-sourcing, and govt programmes that can contribute majorly to awareness regarding mental health.

Focusing on thoughts

Our thoughts play an important role in our psychological well-being. Understanding the nature of our thoughts and modifying them suitably helps promote our mental health (Eagleson et al., 2016; Ford et al., 2018). One of the commonly used measures in this regard is the *cognitive behaviour therapy*. It focuses on our thoughts to create adaptive thought patterns, thereby ensuring mental health. CBT can be used as an intervention as well as preventive measure to develop appropriate mental health-related attitudes and beliefs among adolescents. However, the use and efficacy of CBT may vary depending on the educational and socio-economic background (Levi et al., 2018). Hence it is always important to remember that adolescence is not a unitary concept. It is a multidimensional construct and this needs to be taken into account while adopting various measures for mental health promotion.

Focusing on Emotions

Emotions are a crucial part of our life and it has the potential to make or mar our life. Adolescence is a time of greater emotionality (Verma & Larson, 1999) and the adolescents face many emotional upheavals due to their transitional stage. Hence it is important for them to learn to understand and manage their emotions in an effective way (Brown et al., 2019; Guerra-Bustamante et al., 2019). Creative techniques such as art, music, play, and dance have always helped the human being to express emotions. Adolescence, being a stage characterized by the desire to know and explore things, a desire to create and learn things have the natural characteristic of creativity in them. Hence these various mediums have been used to help adolescents express their feelings and emotional turmoil (Riley, 2001; Bosgraaf et al., 2020). Termed as expressive therapies, these include art therapy, play therapy, music therapy, dance, and movement therapy.

Developing Personal Skills

Individual level focus for mental health promotion also targets at building up personal skills in the adolescents so that they learn to engage in appropriate behaviours to ensure good mental health. The ten Life skills of WHO, namely, self-awareness, decision-making, problem-solving, critical thinking, creative thinking, empathy, interpersonal relationship, effective communication, managing stress and coping with emotions, focus on building the skills necessary for living an effective and satisfied life. Majority of the schools in India are imparting these life skills as part of their curriculum. Studies have indicated the effectiveness of these life skills education programmes (Vranda, & Rao, 2011).

Measures at Group Level

Adolescents are a part of various communities such as school, family, peer, neighbourhood, clubs, etc. In the digital era, they are also part of various online communities related to social media such as FB, Twitter, Instagram, etc. Mental health and many common mental disorders are influenced and shaped to a great extent by the physical, social, and economic environments in which people live (WHO, 2014). It is affected by the surrounding environments and interactions as we grow, learn, work, and socialize. The dynamics of how we function at home, school and work place, and other group settings determines our mental health. Hence it is important that we consider these environmental realities of individuals across life course so that effective strategies can be formulated at various levels for promotion of mental health and well-being and undertaking preventive intervention measures.

School mental health initiatives

Schools play a significant role in adolescent mental health (Long et al., 2019). The study on a sample of 1102 students in urban schools in India, pointed out the role

of factors related to school environment, home environment, and peer relationships in affecting the mental health of adolescents and emphasizes implementing school-wide mental health programme for students. School mental health programmes have a unique advantage to offer a comprehensive programme for enhancing mental health of children and adolescents. The school offers an apt setting for building up the academic, physical, behavioural, social and emotional competencies, and skills of all the children by taking a universal approach. These programmes can address all the stakeholders including students, parents, teachers, and all the staff of the school to create awareness about mental health in the young and how each individual and the school as a whole can contribute to the mental well-being of this future generation. Early measures will help reduce behaviour disorders in children and prevent adult psychopathology (Shastri, 2009).

Two most widely used evidence-based approaches for universal school mental health programmes are Positive Behavioural Interventions and Supports (PBIS) and Social–Emotional Learning (SEL). Main aim of these programmes is to prevent problems and promote well-being.

Positive Behavioural Interventions and Supports (PBIS) is a universal, school-wide prevention strategy. A longitudinal multi-level analysis of study conducted in 37 elementary schools on 2596 staff points out that the PBIS whole-school prevention model leads to changes in school organizational health, which can in turn be a potential contextual mediator of the effect of PBIS on student performance. (Bradshaw et al., 2009).

The Collaborative for Academic, Social, and Emotional Learning (CASEL) advocates evidence-based social and emotional learning (SEL). Focus on socio–emotional learning (SEL) is a key component in promoting positive mental health (Cook et al., 2015) in the school context. Five broad and interrelated components of SEL include self-awareness, self-management, social awareness, relationship skills, and responsible decision-making. The SEL competencies for students include various skills and attitudes that can be described under four groups: awareness of self and others; positive attitudes and values; responsible decision-making; and social interaction skills (Payton et al., 2000). Based on these components, various programmes/measures have been developed (e.g., Promoting alternative thinking strategies (PATHS) to develop these competencies and skills in children across different school stages.

Analysis of several SEL programmes (Jones et al., 2017) divides core SEL skills into three domains: cognitive regulation (includes attention control, inhibitory control, working memory/planning, cognitive flexibility), emotional processes (includes emotion knowledge/expression, emotion/behaviour regulation, empathy/perspective-taking), and social/interpersonal skills (includes understanding social cues, conflict resolution, prosocial behaviour). All these help in academic achievement, social–emotional skills, and proper adjustment and behaviour in different contexts and environments. SEL provides benefits in terms of improvement in students' social and emotional skills, attitudes, relationships, academic performance, and perceptions of classroom and school climate. At the same time, it also helps in decline of students' anxiety, behaviour problems, and substance use, and also improvement in prosocial behaviour of students (CASEL.org).

SEL as a universal prevention strategy has also been found to be effective in preventing social–emotional and behavioural problems and promotes well-being and success across the full spectrum of school students (Thayer et al., 2019). Such school-based preventive interventions involving socio–emotional component can have a positive impact on teachers' beliefs and perceptions, regarding their self-efficacy, burnout, and social–emotional competence. (Domitrovich et al., 2016). Results suggest that universal, school-based programmes can benefit the emotional health of youth in low income, urban settings (Lewis et al., 2013). SEL interventions on a school-wide basis can be the important first tier step, on which other universal interventions such as anxiety and bullying prevention, and targeted depression prevention could be developed in a multi-tiered fashion (Kuosmanen et al., 2019).

School-based mental health services have positive impact on student mental health (Ross et al., 2020). However, the crucial thing is the implementation. The programme features critical to the success of school-based SEL programmes emphasize curriculum design, coordination with larger systems, educator preparation and support, and programme evaluation (Payton et al., 2000). Further, necessary organizational structure, administrative support, and school leadership support act as facilitators for implementing the programmes (Langley et al., 2010). Studies point out significantly greater improvements in overall student mental health and reductions in externalizing behaviours when these measures were used combinedly rather than using them independently (Cook et al., 2015).

Community mental health

As Kurt Lewin has said individual's behaviour is a function of person and environment. $B = f\ (P \times E)$. Hence it is important to be aware of the interaction between the individual characteristics and personality with the contextual and environmental factors in impacting one's behaviour and decisions. Community-based support and interventions can play an important role in promotion of mental health. The VicHealth Mental Health Promotion Framework (1999) focuses on three socio-economic determinants of mental health:

(i) social inclusion—includes supportive relationships, community involvement and group activities, civic engagement
(ii) freedom from discrimination and violence—includes ensuring physical security, accepting and valuing diversity acknowledging and accepting the right to life, control of one's life
(iii) access to economic resources—access to education, decent work, employment, income, housing, and other basic facilities for living

Hence the community level measures need to take into account a varied number of factors influencing mental health of adolescents. Accordingly, primary, secondary, and tertiary prevention programmes and services can be developed.

Addressing mental health concerns of adolescents needs to be a shared responsibility with all the stakeholders working synergistically towards the common goal of promotion of mental health, prevention of mental health conditions, intervention and

treatment of mental disorders, and rehabilitation. From the top level officials framing policies to the health professionals focusing on the treatment of mental disorders to the bottom level health care workers facilitating information dissemination, offering mental health assistance, and providing psychological first aid—all need to work together for the promotion of good mental health among adolescents and spreading mental health literacy among the public.

Health care providers mainly are concerned with treatment and rehabilitation. However, they also need to equally emphasize on the promotion of metal health and prevention of mental health-related problems. Promotive and preventive measures addressing the mental well-being of adolescents will be a rich investment resulting in long-term returns.

The comprehensive mental health action plan 2013–2020 of WHO which has been extended to 2030 to align with the 2030 Agenda for Sustainable Development, propounds strengthening of effective leadership and governance for achieving objectives of mental health promotion and prevention of mental disorders. In addition it also emphasizes on developing a good network of community and social care services and creating awareness and dissemination of information and strategies for promotion of mental health. Hence global knowledge and evidence need to be integrated with local community resources to strengthen the services for mental health promotion and preventive interventions.

Challenges to Mental Health Promotion

Adopting a rights-based approach to providing mental health care and service to our children and adolescents is most crucial which will ensure focus on their mental well-being. Mental health at its fundamental level involves the right to live with dignity. It means living with basic amenities, infrastructural facilities, health and hygiene, opportunities to realize potential, having fulfilling relationships, and leading a meaningful life. When mental health is considered as a fundamental right of our children and adolescents, it has the potential to change the entire scenario of mental health service delivery and mental health-related policies.

For an Indian traditional society, a child remains a child even if s/he grows up to be an adult. It means that the family and the society in their role as the primary provider of care and nurturance to the young people seldom consider children as individuals in their own rights. Mental health can be considered the fundamental right of children and adolescents, and the approach to ensure the fulfilment of these rights so far has always been more need based rather than 'rights-based' (Shastri, 2009). In line with Indian collectivistic cultural values, even in today's time youngsters are expected to conform and adhere to family norms and group harmony (Fabes et al., 1999).

Sustainability is another key challenge in the mental health and well-being of adolescents. Mental health promotion should not be in a piece meal manner or just arbitrarily implementing strategies without having a well thought out comprehensive long-term perspective regarding mental well-being of adolescents. Goal 3 of SDG

indicates well-being for all. Mental health needs to be planned across life course and for this mental health plan and promotion at the early age will be the foundation. Investing in mental health at an early age will have long-term effect across the life span.

Measures for adolescent mental health needs to be built into the public health policies so that it can lead to sustainability. Viewing mental health from a public health lens will target all the adolescent population, not just the ones who need treatment. It will work at the prevention of mental health conditions and promotion of mental health. Public health policies attempt to identify factors that enhance or decrease health and well-being. And, importantly, they are driven by thoughtful engagement of communities in order to understand mental health issues as people define them—one size does not fit all (Michaels & Hagen, 2014). Further, the policies and practices regarding mental health of the young generation need to take into account the context and culture as multiple kinds of childhood exists in India (Saraswathi et al., 2017).

Conclusion

The young generation is the future resource of any nation and India has the largest adolescent population in the world with 253 million adolescents as per Census 2011 of the Government of India. They constitute 20.9% of the total population with every fifth person being in the age 10–19 years. Further, if we consider the youth 15–24 years of age group, it is 231.9 million and constitutes 19.2% of the total population (Census of India, 2011). This large population of young needs to be capitalized upon to yield rich dividend in economic, political, education, health, and social sector of the country. They can contribute to the health and wealth of the nation immensely. This highlights putting emphasis on the mental health and well-being of the adolescents on a priority basis.

The Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) by the World Health Organization (WHO) envisions a world in which every woman, child, and adolescent in every setting realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping prosperous and sustainable societies. It highlights that for the first time, adolescents joining women and children at the heart of the Global Strategy. It has three-fold aims (i) Survive: to end preventable deaths at the time of birth and during infancy and childhood; (ii) Thrive: to ensure health and well-being among the young people; and (iii) Transform: to expand enabling environments for the young so that they can contribute to their full for the development and progress of their own, the society and the country. As mentioned by Dr. Tedros Adhanom Ghebreyesus, Director General, World Health Organization in relation to the global strategy, "Universal health coverage is the centre of gravity of global health—but women, children and adolescent health is the centre of gravity of universal health coverage!"

This emphasizes the unique and specific concerns and challenges faced by the young generation. These need to be addressed on priority as it can affect their potential for optimal achievement in different sectors of education, economic, and functioning at their personal best and contributing effectively to the society.

Mental health promotion among adolescents requires building up resources at the individual as well as at the community/society level. The adolescent needs to learn to manage emotions well, form effective social relationships, cope with challenging situations and be resilient in adversities. It needs to be a multi-level approach with various stakeholders pitching in to address the mental health concerns of the young generation. A robust community approach to mental health will ensure the involvement of all in the promotion of mental well-being of adolescents. As it is said it takes a village to raise a child, similarly it involves the whole community to take care of the mental health of our young children and adolescents. Social support and a caring, nurturing, and enabling environment has a strong impact on the mental health of the young. Mental health needs to be an integral part of the public health policies. It needs to be an important part of the broader concept of health promotion so that we can truly achieve sustainable health that will address all aspects including physical, mental, and socio–emotional aspects of health.

Time to Reflect

If someone has got flu or a headache, we advise her to take some medicine or go and check with a doctor. But if someone feels low or sad or is not the usual self, we tell her not to worry, it'll go away, just take some rest. Why do we not give equal importance to our mental health related issues? Why do we not encourage the person to express and share her feelings, thoughts, concerns and worries? Why can we not tell the person to go and refer a mental health professional? Mental health literacy is the need of the hour and should start from home and school level itself. As we focus on the academic literacy, mental health literacy is also crucial to develop proper mental health related attitudes and beliefs in the young generation.

The importance of mental health and well-being has always been there but has increased significantly in the twenty-first century with the changing world, complex nature of relationships, need to equip oneself with adequate skills to function in the globalized world, dwindling social support and the struggling lives of the marginalized and disadvantaged sections of the society despite so much advances in the field of health and education. The adolescents are the worst sufferers as it impacts development of their full potential in all aspects. Hence mental health needs to be given equal priority and there has to be a concerted effort by all the stakeholders including the family, school, community, government agencies, non-governmental organizations and at the policy level.

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Chapter 15
Life Skills for Adolescents

Swati Patra

Abstract The chapter focuses on the importance of life skills and life skills education for adolescents that can help facilitate positive development in adolescents. Research in the field of life skills and the measurement of life skills are highlighted. Various initiatives regarding life skills programmes in India and globally are described. Further, the issues and challenges to life skills education programmes are analyzed with future suggestions.

Keywords Life skills · Adolescents · Life skills education · Life skills training · Youth · Thinking skills · Emotional skills · Social skills

Introduction

The twenty-first century adolescents are venturing into a world with new opportunities, challenges, and innovations. Individual aspirations, social relationships, and the work culture are changing with the advent of new technologies and advancements in the world. The future generation needs to be equipped with the know-hows to function effectively in this future world. This will require not only the skills related to academic learning but also the emotional and behavioural skills to relate to people, deal with problems and adapt to emerging situations. The focus needs to be on the overall development of the young generation including their mental health and well-being. Thus socio–emotional skills to address the adjustment and well-being of adolescents along with twenty-first century skills like creative thinking, decision-making, communication skill etc. would help them to have positive health, gain employment, and be empowered (IIPS, Mumbai, 2010; India youth development index & report, 2017). It will make them effective and productive citizens of the country. The society and the nation will also benefit and advance from one of the important human resource—the young generation, termed as the 'demographic dividends' of a country, especially in India where adolescents and the youth form a major

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chunk of the total population. However, a significant number of youth in India face challenges related to physical as well as mental health (Chavan et al., 2018; Gururaj et al., 2016) owing to disadvantaged conditions. As a result, it limits the opportunity to harness the benefits that can arise from this rich demographic resource. Hence, the young population needs to be empowered by imparting them necessary life skills so that they can thrive and contribute significantly to the society and the nation.

The focus of education system majorly has always been on the academic achievement of students. It is lacking in its ability to equip the youth with necessary life skills (Youth in India, 2017). Although there has been an emphasis from time to time through various national educational policies and frameworks on imparting skills other than academic-related skills, systematic and comprehensive approach to this is lacking. Education needs to develop the child as a whole and prepare her/him for a productive and fulfilling life. It also needs to make them future ready in terms of personal skills, socio–emotional skills, and work/employment skills. Life skills play a crucial role in this regard, which needs to be made the centre stage of school education as it has an impact not only on academic progress and achievement but also on personal social effectiveness and excellence.

Conceptualizing Life Skills

Life skills refer to skills and competencies related to our interpersonal and psychosocial aspects that help adolescents to adapt, adjust, cope, and live life effectively. Life skills are a range of psycho–social and cognitive abilities that equip children and youth to engage in informed decisions and choices, manage their emotional well-being, and communicate effectively (Singh & Menon, 2015). World Health Organization (WHO, 1994) defines life skills as "the abilities for adaptive and positive behavior that enables individuals to deal effectively with demands and challenges of everyday life". Adaptive indicates being flexible and adjusting to various life situations one comes across. Positive behaviour refers to having a positive outlook and looking for alternatives and possibilities even in the most difficult situations. Thus, it includes personal social competencies that can help achieve personal well-being, ensure good mental health, and function effectively in social settings.

Life skills are also considered as non-cognitive skills, socio–emotional learning, character traits, or personality traits, as defined by West et al. (2016), "skills not captured by assessments of cognitive ability and knowledge". Thus, life skills can be described as consisting of *Thinking skills* and *Social skills*. Thinking skills refer to cognitive abilities at an individual level. Social skills include emotional skills and interpersonal skills to identify emotions and to deal effectively with other people. It helps in communicating effectively and managing conflicts. Life skills sometimes are viewed in terms of workplace success. However, the importance of life skills is not limited to workplace only, but it goes beyond and indicates skills to function effectively in other spheres of life also as a whole. So life skills can be used to indicate life success. They can help adolescents deal with life's diverse challenges.

UNICEF defines life skills as "a behaviour change or behaviour development approach designed to address a balance of three areas: knowledge, attitude and skills". This has implications for adolescent mental health as changes in knowledge, beliefs and skills will reduce the likelihood of them engaging in risk and other maladaptive behaviours, deal with peer pressure and conflicts. This will facilitate their physical, mental, and socio–emotional well-being.

Ten Core Life Skills

The World Health Organization (WHO) emphasized on the need and importance of life skills education in 1998. It has suggested ten core life skills—self-awareness, empathy, critical thinking, creative thinking, problem-solving, decision-making, interpersonal relationship skills, effective communication skills, coping with stress and coping with emotions—to every school worldwide to incorporate into the mainstream academic curriculum. All these skills help adolescents develop awareness about themselves, be able to analyze and solve problems, think critically and creatively about challenges, build healthy relationships, and manage emotions and stressful situations. It helps them to be healthy, productive, assertive, and resilient through adolescent stage and in further life stages.

Self-awareness: It can be described as a key foundational life skill, which underlies the significance of knowing oneself. It includes developing an awareness about oneself in terms of one's thoughts, emotions, and actions as well as knowing one's interests, preferences, dis-likings, abilities and skills, and so on. Understanding oneself will help the adolescent explain their behaviour, choose correct path, and enable to take proper decisions in life. It will lead to interact effectively with their peer and others, and develop empathy.

Empathy: Empathy refers to the ability to develop 'other awareness', that is, one is able to think about things or situation from the perspective of the other person. This helps in improving communication and relates well with other people. It can help in good interpersonal relationships with peers and family as it conveys a sense of caring and understanding towards the other person. Empathy can help the adolescent to accept the differences and be sensitive to age, class, ethnic, and culture related diversity.

Critical thinking: It includes the ability to think and analyze a problem or situation from all angles, considering the pros, cons, and implications. The ability to think critically will help adolescents in recognizing the risk factors in a particular situation, avoid peer pressure, and media influence. It will help them to take a correct decision.

Creative thinking: Thinking creatively refers to a novel and useful way of thinking, which consists of fluency (number of new ideas), flexibility (seeing things from different perspectives), originality (newness of the idea), and elaboration (expanding ideas). Given the rapid developmental changes during adolescence stage and the

complexities of the twenty-first century global world, adolescents will need both critical thinking and creative thinking to achieve success and well-being.

Problem-solving: It refers to the ability to solve problems effectively in the given situation and context by taking a comprehensive view of the problem in all aspects. Adolescents need to see things objectively and use their critical and creative thinking to be able to solve problems effectively.

Decision-making: Adolescents need to learn to make effective decisions as they are faced with many crossroads in their life starting from subject selection at school to deciding on who to be friend with, choosing their career and life style. Decision-making skill helps them to be confident and deal with situations in a constructive manner without getting stressed.

Interpersonal relationship skills: Adolescents are at a growing stage where they need to learn to form effective relationships with their family members, peers, and others at school and in the society, e.g., as part of different clubs, associations, or workplace. This will help them to have good social relations and social support, which can contribute to better mental health.

Effective communication: The generation gap and other issues in growing adolescence stage may lead to more conflicts and anxieties, which can be constructively dealt with by effective communication. Rather than being passive or aggressive, adolescents learn to be assertive in their communication.

Coping with emotions: The transitional stage of adolescence generates a variety of emotions in the adolescents, which they need to learn to recognize, identify, and manage. Further, this skill helps them to know about emotions in others and learn to handle these properly. Coping with emotions helps adolescents to learn to respond to emotions and understand how emotions are affecting their mental health and relationships.

Coping with stress: This skill helps adolescents to recognize stress in them, know the sources of their stress, and use appropriate strategies for coping.

Importance of Life Skills

Adolescence is considered as a turbulent stage because of the progressive biological changes and consequent impact on other aspects of development. "The frontal lobes, home to key components of the neural circuitry underlying 'executive functions' such as planning, working memory, and impulse control, are among the last areas of the brain to mature; they may not be fully developed until halfway through the third decade of life" (Sowell et al., 1999). This has implications when viewed in the context of the characteristics of adolescents that include behaviours marked by novelty-seeking, risk-taking, and increased peer-based interaction and affiliation. As a result, adolescents may engage in substance use, mis-adventures, truancy, aggression and

violence, anti-social behaviour, and gang-culture. It also affects their interaction with parents negatively.

Further, the education system and the societal expectations, in general, are such that the emphasis by schools and family is mostly on the development of academic skills and career-related decisions. However, the mental health aspect, which is equally important, gets neglected or emphasized less. This results in anxiety, stress, and other emotional behavioural problems. Life skills training can play an important role in better adjustment, coping, increased self-esteem, empathy and pro-social behaviour (Bharath & Kishore, 2010; Yadav & Iqbal, 2009), and in promoting adolescents' daily functioning and mental well-being (van Loon et al., 2019). This consequently can have positive impact on school performance also. Teaching of life skills in schools leads to improvement in academic learning outcomes among adolescents (Subasree, 2015). Thus, research studies show that life skills programmes can help not only in academic outcomes but also developing psychosocial skills and competencies, and reducing risky behaviour (Bardhan & Nair, 2016).

Life skills will equip the adolescents to deal with the various challenges and concerns related to not only cognitive and physical development but also emotional, social, and sexual development. Adolescents need for autonomy, independence, creativity and desire to do things can be capitalized on to gear them towards constructive and productive things. Life skills is the key here that will enable the growing adolescents to realize their desires and dreams and steer their life in an effective way. Hence, life skills education needs to be emphasized in the school system (Prajapati et al., 2016). At early school stage, the emphasis is on acquiring basic reading, writing, and numeracy skills. In other words, the focus is on the three R's—reading, writing, and arithmetic. As the child grows and enters into adolescence, they need to learn various life skills to function effectively, adjust, and adapt to school life, peer group and life situations. In addition, the requirements of the twenty-first century make it imperative for all adolescents to have digital skills and literacy. Further, the adolescents need to learn vocational skills to be effective and productive at work.

UNICEF talks about four types of skills needed for success in school, life and work: *Foundational skills* (literacy and numeracy), *Digital skills* (using technology), *Transferable skills* (life skills/soft skills/socio–emotional skills), and *Job-specific skills* (technical and vocational skills). Transferable or life skills help adolescents to deal with emerging challenges, manage conflicts, learn interpersonal skills, and develop empathy. The demand of being a global citizen requires adolescents to learn skills that will help them to create a better future not only for themselves but also for their family and community in the long run. However, as per UNICEF, "By 2030, it is estimated that another 825 million children will not acquire the basic secondary-level skills—like transferable, digital and job-specific skills—needed to support lifelong learning and employment". This is a global challenge, and more pronounced in case of marginalized sections of the society.

The Jomtien Declaration on Education for All (1990) has highlighted life skills as essential learning tools necessary for survival, capacity development, and quality of life. The Convention on the Rights of the Child (1992) has also advocated for linking life skills to education as it will help in development of the child's fullest

potential, which is the main aim of education. Hence, it is very important to make life skills an integral part of adolescent's life by an exclusive focus on this and active implementation of life skills education in the school as part of curriculum. This will enable the adolescents to be employment ready as well as future ready to deal with the varied and emerging challenges/issues of future.

Life Skills Education: Policies and Initiatives

Life skills are generic skills, which can help adolescents in their optimum development and adjustment. At the same time, these skills can be aimed at specific issues and problems such as targeting adolescents with substance use or faced with abuse, violence, or HIV/AIDS etc. Life skills can act as primary prevention in various areas such as violence, child abuse, adolescent pregnancy, HIV/AIDS, suicide, substance use, accidents, injuries, conflict etc. (WHO, 1999). There has been varied initial focus in starting of life skills programmes in different countries. In USA, life skills programmes focused on prevention of violence and substance use whereas life skills initiatives in UK targeted child abuse prevention. In Mexico, it aimed at prevention of adolescent pregnancy; and in Thailand and Zimbabwe, it aimed at prevention of HIV/AIDS. South Africa has created a curriculum for education for life called Life Orientation Education and Columbia has termed it as Integral education which focuses on life skills training to students.

In India, Central Board of Secondary Education (CBSE), the apex body governing school education in India integrated life skills education as part of curriculum in 2010 (Behrani, 2016). It developed life skills manuals for teachers based on the ten core life skills of the WHO.

National Curriculum Framework (NCF, 2005) has emphasized on connecting knowledge to life outside the school and going beyond the textbooks, thus highlighting learning of skills other than academic by the growing children. It indicates the importance of constructive learning experiences, active engagement of children, interaction with people and environment around as crucial for building life skills to deal with the demands and challenges of everyday life. Another important initiative, Adolescence Education Programme (AEP) (MHRD & NACO, 2005) of the Govt of India, launched by the Ministry of Human Resource Development (renamed to Ministry of Education in July 2020) in collaboration with National AIDS Control Organization (NACO) focuses on strengthening the life skills of the young to deal with risky behaviours, preventing AIDS and substance use, and encouraging healthy attitude and behaviour.

However, concern for and focus on the adolescent issues and development had started much earlier in India when the National Council of Educational Research and Training (NCERT), an apex body in school education in the country, developed the General Framework of Adolescence Education based on the National Seminar it organized on Adolescence Education in 1993, 12–13th April. The Framework addressed three main aspects such as the process of growing up during adolescence,

HIV/AIDS, and drug abuse. Thus, it brought the issues and concerns of adolescence into the mainstream of the school education system. It aimed at empowering adolescents by developing life skills in them to deal with risky situations, reducing their vulnerability, enabling them to make healthy choices, and helping in their positive behaviour development.

NCERT also emphasizes on education for peace and acknowledges the purpose of education as promoting a culture of peace (NCERT, 2006a, 2006b). It also highlights a health and physical education curriculum at all levels of schooling and talks about special attention to vulnerable social groups and girl children (NCERT,). This has implication for learning of life skills and will contribute to the physical as well as mental, social, and emotional development of children. All these reflect the objective of preparing students for life and making them capable to lead an effective and good life.

Importance of life skills education for adolescents has also been emphasized in various international declarations such as the Dakar Framework for Action on Education for All: Meeting our Collective Commitments (2000) and the UNGASS Declaration of Commitment on HIV and AIDS (2001). WHO, in 1993, has prepared a document (later revised in 1997) outlining a framework for life skills programme development, both conceptually and practically. It includes life skills for developing psychosocial competence and also talks about development and implementation of life skills programmes. It targets teaching life skills to children and adolescents in schools, but it can be applied to those out of school also.

Life skills education (LSE) aims at providing awareness and training to adolescents in developing appropriate knowledge, attitudes, and skills to adapt to life situations and engage in healthy behaviour and functioning. Research studies have advocated the importance of life skills education for youth (Dinesh & Belinda, 2014; Singh, & Sharma, 2016). It plays a crucial role in youth health promotion, education, and overall development (Sangma, & Prakash, 2017; Vranda & Rao, 2011). Studies have also pointed out the need for training in life skills (Buvaneswari & Juliet, 2017).

Various initiatives have been taken in India regarding Life Skills Education (LSE) programmes. The Youth focused Life Skills Education and Counseling Services (YLSECS) program has been prepared by Department of Youth Empowerment and Sports, Government of Karnataka supported by Department of Epidemiology, Centre for Public Health, National Institute of Mental Health and Neuro Sciences (NIMHANS), in India for the promotion of mental health and well-being of youth in the State (Pradeep et al., 2019). The objective of this training program was to provide the knowledge of life skills to the participants and to train them to organize such trainings in their respective settings through facilitatory approach. Overall, 28 life skills training workshops were conducted. Each training workshop was planned for 5 days and two domains of life skills by WHO were covered each day, devoting 3–4 h per domain. Each workshop enrolled about 25–30 participants who were trained by master facilitators who were specialists in the field of psychology and social sciences and were skilled in conducting the training following a facilitatory approach.

YLSECS training program, thus, aimed at empowering the participants with requisite knowledge and skills for imparting life skills to college going youth. Findings

indicated that such training significantly improved participants' awareness about life skills and increased their level of confidence and capacity to teach life skills to students. Furthermore, the study highlighted the need for supportive supervision for participants to conduct life skills training themselves in their respective colleges.

A cascade model of life skills education has been developed by the Department of Psychiatry, NIMHANS Bangalore in India in collaboration with World Health Organization-South East Asia Region Office (WHO-SEARO), which focused on various developmental issues such as nutrition, hygiene, interpersonal relationships, substance use, academics, gender issues, career, and sexuality (Bharath et al., 2005). These modules were separately developed following a developmental approach separately for classes 8th, 9th, and 10th standards using a teacher as facilitator.

There are many non-governmental organizations (NGOs) also across India who are involved in providing life skills training. They cater to children from marginalized sections and disadvantaged backgrounds, focus on empowering girls specifically, attempt to build life skills through sports, art forms, and other multiple methods.

Life Skills for Adolescents Outside the School Curriculum

Many children and adolescents are out of school or drop out of school due to various reasons. Life skills are of crucial significance for such children and adolescents who are faced with life's stark realities and challenges. Such children include street children, working children, orphans, abused children, sexually exploited children, and victims of violence, war and trauma. Life skills will help them to develop psychosocial competencies to deal with the demands and challenges of their everyday life.

The local level organizations, self-help groups, NGOs, local governance and in-community functionaries, and leaders can play an important role in developing life skills in such children and adolescents. They can be provided orientation to be sensitive to the needs of these adolescents and trained to impart life skills to them through a participatory approach.

Whether it is in-school or out-of-school life skills training programmes, the role and involvement of community are crucial in success of the programmes. Community linkage provides support and helps the adolescents to transfer the life skills into actual practice, thus leading to sustainability of the life skills learned.

There needs to be a collaboration between various stakeholders at school, home, and community with a common objective to facilitate the growing up process of adolescents, develop psychosocial competencies in them to be resilient and face any life situations. This assumes more significance in that the adolescents in India are from diverse contexts and backgrounds. Hence, it is important to help them realize their strengths and empower them through life skills training. This highlights a right-based approach to the empowerment of adolescents.

Assessment of Life Skills

There is a need for measurement tools to assess the impact of life skills programmes. One such tool is Life Skills Scale (LSS) by Vranda (2009a, 2009b; 2007), consisting of 115 items on a 5-point Likert format, which is based on the ten life skills of WHO. The scale has been used effectively with adolescents in diverse contexts such as school, institutionalized, and street children (Vranda, 2009a, 2009b).

Another scale, The Life Skills Assessment Scale developed by Subasree and Nair (2014) is popularly used by various researchers (Dhingra & Chauhan, 2017) to assess life skills. This scale also is based on the ten life skills of WHO, having a total of 100 items.

The Dream Life Skills Assessment Scale (DLSAS) was developed specifically to measure life skills of disadvantaged children (Kennedy et al., 2014), which includes assessment by teacher/facilitator of five critical life skills in children such as interacting with others, overcoming difficulties and solving problems, taking initiative, managing conflict, and understanding and following instructions.

Various other tools are also used by the organizations working in the field. However, in general, there is a need to develop more standardized tools with a focus on measuring life skills as a whole which can be utilized across the age groups, and address the assessment of outcomes across the temporal spectrum, that is, immediate outcomes to long-term outcomes (Talreja et al., 2018).

The Indian Association of Life Skills Education (IALSE) in India plays an important role with regard to compilation and dissemination of knowledge and research in the field of life skills through organizing conferences and its journal called International Journal of Life Skills Education. On the international scenario, the Collaborative for Academic, Social and Emotional Learning (CASEL) focuses on the importance of integrating the academic learning with psycho–social aspects with an aim of achieving a balanced and effective personality. Towards this end, it has developed various grade-wise programmes to enhance social and emotional skills in students. Research and initiatives by CASEL have made social and emotional learning (SEL) at the centre stage of education in USA and have been used globally also. The SEL framework focuses on five components such as self-awareness, self-management, social awareness, relationship skills, and responsible decision-making, which can be taught across developmental stages from childhood to adulthood and also in diverse cultural contexts (www.casel.org).

Other tools on life skills have focused on specific skills addressing particular contexts. For instance, Korean Life Skills Scale for Sport (Lim et al., 2019) measures life skills in school physical education or sports fields. It assesses five factors such as teamwork, goal setting, time management, social skills, and leadership relevant for functioning in sports context and excelling in it.

One crucial aspect in assessment of life skills relates to measuring the outcomes of the training or intervention programmes. This requires a clear consensus on defining and identifying what life outcomes one is aiming at. The WHO Quality of life tool (WHOQOL) provides a measure of life outcomes mostly in terms of mental health

space, but it is not representative of different facets of life (WHO, 1998), which is the objective in any life skills training programme.

Challenges to Life Skills Education

Life skills education (LSE) has an important contribution to the overall development of adolescents. It aims at facilitating the practice and reinforcement of skills in a culturally and developmentally appropriate way. It, thus, helps contribute to the promotion of personal and social development, the protection of human rights, and the prevention high-risk behaviour and social problems. However, there are many challenges in the implementation of LSE that needs to be considered (Grover, 2019). The stakeholders here are the teachers/facilitators who provide life skills training, the adolescent themselves with their diverse background, the quality of the LSE programmes in terms of their content and methods, and the education system itself, how much weightage and priority it gives to LSE in schools.

- The education system usually focuses on the child as a product of the system (Singh & Menon, 2015), not on the process of development of child into a competent, effective, and healthy individual with a resilient and positive attitude to deal with any challenges of life. It is examination and grade-centric and ignores the natural free spirit and creativity of children. To date, the Indian educational system produces individuals in general who are not able to think for themselves or even acquire the ability to work independently, to take ownership and responsibility and to solve problems and take decisions (Subitha, 2013). The twenty-first century is moving towards a world where the adolescents need to be truly a global citizen for which they need to acquire the relevant thinking skills, vocational skills as well as the social and emotional skills. However, the school system prioritizes the cognitive skills and focuses more on imparting the scholastic knowledge. Even though co-curricular activities are there in school, development of emotional and social skills are mostly neglected. Further, life skills education is also confused with value education (Ramakrishnan, 2010) and with vocational education (Subitha, 2013). It has implications for understanding of the meaning, scope, and purpose of life skills for adolescents by the teachers and the school system. This will help the stakeholders realize the importance of LSE and give its due place by integrating it into the curriculum.
- Effective implementation of any programme requires adequate resources. Life skills education also needs good facilitators or teachers trained in imparting life skills training (Abobo & Orodho, 2014). Infrastructural facilities also need to be adequate. Thus, teacher education programmes need to focus on developing the awareness, skills, and competencies of teachers who will facilitate the life skills training for the students. The quality of LSE also needs to be maintained by structuring it and maintaining a uniform standard protocol for its implementation.

- The content of LSE programme and the method for delivery also are important factors. The modalities of LSE can include group discussions, role-plays, debates, games, brain storming, stories and case studies, and other interactive activities. Participatory strategy needs to be used in teaching life skills, focusing more on using an affective approach to life skills training. In the process, the teacher/facilitator needs to take into account the sociocultural context of the adolescent.
- Adolescent is not a unitary term with uniform experience and background. They have varied contexts and personal, social, and cultural needs, which influence their development and mould their attitude. Any life skills training programme needs to take into account the experiences of the adolescent and build upon it. Further, the decreasing traditional support systems, changing family structures and family relationships have created different kinds of issues and challenges for the adolescents. These can have different impacts related to their socio-economic status and background. The type of schools, the nature of peer group, the living environment etc. might also impact the receiving and understanding the importance of LSE by the adolescents themselves and their family and the community.
- Evaluating the outcome of life skills training programs is crucial as it will provide feedback about the effectiveness of the programme, delivery mechanism of the training, and practical difficulties in the contextual background of the participants.
- Assessing the effectiveness of life skills education/training programmes requires measurement of life skills through standardized tools. However, the challenge to measurement is the way life skills are viewed, as separate skills or as a whole. There is a need to develop more standardized tools and further research to study the efficacy and application of such tools in multiple contexts, with varied constructs and outcomes.
- A fundamental challenge to life skills education programmes relates to defining and a uniform conceptualization of life skills. Research studies in India indicate that life skills education is evaluated mostly through the lens of employment readiness rather than life readiness (Talreja et al., 2018). This highlights employability only in relation to adversity in the life of adolescents whereas focus needs to be more on preparing the adolescents for the future and developing psychosocial competencies in them to lead a good life. This requires taking a developmental approach to life skills and viewing these skills as lifelong. Hence, it requires emphasizing the role of life skills from early childhood years to school years and to young adults and then older years.
- Life skills education and training programmes can benefit from a strength-based approach. Discussions on adolescent brain development and maturity often use a deficit-based approach, but research in brain science has enormous opportunity to illuminate the great strengths and potentialities of the adolescent brain (Johnson et al., 2009). This can inform the policies and the programmes related to life skills education to better promote adolescent health and well-being.

Conclusion

The conventional emphasis on examination and academic success has given way to the realization in the twenty-first century globalized world about the importance of other pertinent skills in achieving success in life. The complexities of life and technological advancement require learning of various life skills to become successful in life. Life skills as the name suggests are skills for leading an effective and successful life. They provide important building blocks for adolescents to carve out their life. Hence, it becomes imperative that life skills are integrated into the curriculum (Schurer, 2017), this way it will be an effective strategy to strengthen adolescents' life skills.

The chapter discussed the concept of life skills and life skills education. It highlighted various initiatives in life skills education. The chapter also described the concerns and challenges related to life skills programmes, which need to be addressed so that the full benefits of such programmes can be realized by the adolescents. Life skills are very important and necessary life tools that the young population need to equip themselves with to survive and thrive in the global world. This is more pertinent for the adolescents struggling in the deprived and marginalized sections of the society. Life skills training will help them to adapt to difficult situations in their life and be resilient.

It is really counterproductive that, on the one hand, India has world's largest youth population (UN Report, Nov. 18, 2014), set to continue till 2030 (UNFPA); on the other hand, various reports indicate that majority of this youth population are facing poverty, malnutrition, and hunger (Ministry of Women and Child Development, Govt of India, 2013–2014; UNICEF, 2009). The resultant developmental delay affects various aspects of adolescent health and leads to poorer cognitive abilities, poor information processing, emotion regulation difficulties, neuropsychological difficulties, and behavioural problems such as self-harm and social withdrawal, among others (Kennedy et al., 2014).

The adversity and challenges faced by the young deprive the nation of the potential of this demographic dividend. In this scenario, it is the life skills that can address this challenge and enable the adolescents and youth to thrive in life, develop resilience, acquire psychosocial competence, be productive, and contribute meaningfully. The underlying emphasis here is to focus on the rights of these adolescents to live a dignified and productive life. Towards this end, life skills can act as the right tool to empower them to achieve their basic rights and dignity.

Time to Reflect

Life in earlier times was simple, more so for our young population. Play was integrated with their learning. But gradually with increasing complexities and competitions, learning got devoided of play and then we started talking about joyful learning,

playway method to refocus on the natural way of learning. The gap between play and learning needs to be bridged and education system needs to revisit the main aim of education, that is the holistic development of the child focusing on all aspects such as physical, mental, social, emotional,, moral and spiritual. Life skills education programmes can be the key to realizing this goal of education, equipping our young with the necessary skills to excel and thrive in their own life and also contribute to the society.

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Chapter 16
Expressive Therapy Techniques

Renu Kishore

Abstract The chapter focuses on expressive therapies and their importance for adolescents in addressing their mental health-related issues and promoting their well-being. It delineates the historical background of expressive therapies in counselling. Four main expressive therapies of art, music, dance, and drama therapy are explained in terms of their characteristics and stages of therapy. Techniques used in each therapy, their benefits, and application areas of each therapy are also discussed.

Keywords Adolescence · Expressive therapies · Art therapy · Music therapy · Dance/movement therapy · Drama therapy · Play therapy · Bibliotherapy

Introduction

Adolescence is known to be a period of 'storm and stress' as it involves rapid physical, physiological, cognitive, social, and emotional changes. Lack of clarity and guidance in most cultures make it a difficult period for the person in transition from childhood to adulthood. The lives of adolescents today are in greater turmoil due to marked changes in socio-cultural environment, in education and career options, in family structure and dynamics and an increased reliance on technology. Besides rapid physical and physiological changes, thoughts and emotions are two main aspects, which have an implication on adolescent development. The psychosocial problems faced by adolescents can have a serious impact on their everyday functioning (Bhosale et al., 2015). Thus, it reflects an interaction between psychological aspects of the adolescent's experiences with the wider social experience (Soliman et al., 2020), thus covering emotional, social, and behavioural problems. The significant changes during adolescence create disturbance in their emotions, and they may not know how to express these in proper ways. Consequently, it may lead to either suppression or aggression in the adolescents. Both the scenarios result in problem behaviour, psychological distress and impact their interpersonal relationships. These emotional, behavioural, and social problems often occur jointly (Ogundele, 2018). There are

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various psychological issues and disorders such as eating disorders and substance abuse during adolescence. Hence, it indicates an enhanced need for counselling, guidance, and psychotherapy for adolescents.

With an increasing number of youngsters facing stress and mental illness, it is important to ensure early identification, explore available resources, and take preventive measures. Traditionally, the interventions used for dealing with mental health-related problems in adolescents focus on the cognition or thought processes of adolescents, thus using related therapies such as cognitive behaviour therapy, and the parenting skills and strategies. It is necessary to provide support for adolescents and their families to enable them to develop resiliency and learn ways of coping with challenges. It is equally important to emphasize on learning socio-emotional skills to ensure a safe and healthy environment for our youth.

Children and adolescents often find it difficult to verbally formulate or express their experiences and feelings (Teel, 2007). Hence, expression-based techniques and therapies are important in addressing the mental health concerns of adolescents. It can help in reducing psychological distress, promoting emotional regulation and effective social skills. Adolescents need to learn to manage their emotions properly and express emotions in a safe and constructive manner, thus promoting their mental health and well-being.

Traditional verbal methods of psychotherapy and counselling are often met with reluctance or resistance. Adolescents may not also be receptive to adult intervention. Most adolescents do not appreciate 'advice' from elders. They like action and excitement. The typical teenager may not cooperate and shut off mentally during a traditional counselling session. In such cases, non-verbal methods and expressive therapies that require action may be more effective than the 'talking cure'.

Expressive therapies are therapies that focus on self-expression as a central goal using a different form of creative arts such as art, music, dance/movement, drama, creative writing, play etc. The art forms are used in a therapeutic way to help the individual explore and express inner feelings, fears, anxiety, emotional turmoil, and distress, thereby helping her/him to understand the emotions and gain perspective of the problems and issues. Expressive therapies basically include expressive art forms and creative art forms that facilitate the cathartic experience of the individual and release of pent-up emotions, which otherwise may lead to mental health-related issues and problems. They also facilitate in self-understanding, emotions management, conflict resolution, and promotion of well-being.

Historical Background of Expressive Therapies

Expressive arts have always formed an integral part of our culture as well as methods of healing throughout the history of mankind. Expressive therapies have been around since centuries and used by traditional cultures as the ancient Greeks who used drama and music for their healing properties. Healing applications of expressive arts are often mentioned in early texts of medicine, psychology, and anthropology.

The ancient Egyptians encouraged the "mentally ill to pursue artistic interests and attend concerts and dances" (Fleshman & Fryrear, 1981) to enable the release of negative feelings and become whole again. Greek philosophers like Plato and Aristotle emphasized the power of music in healing. The Greek god Apollo was the god of music and medicine. Early Hebrews also believed in the power of music and poetry in strengthening relationships.

The use of art as catharsis for suppressed emotions has been especially important in collective cultures. China has been using the artistic display of emotions in public for the sake of collective harmony for many centuries (Chen, 2000). Painting, music, and poetry have been used as an outlet for "buried emotions" and hidden feelings since ages in China (Chang, 2012).

In ancient India, arts and music were an integral part of holistic education. Extensive literature dating back to the fourth century B.C. can be found discussing science of music (*Gandharva tattva*). The renowned classical musician Swami Haridas was one of the many who used music for healing as early as sixteenth century. The ancient texts *Nada Yoga and Raga Chikitsa* are ancient texts of music therapy in India.

Though expressive arts had perhaps been used indirectly through the ages, it was only during the late 1800s to 1900s that it was formally conceptualized for use in addition to medical treatment in the western world. The founder of psychodrama Joseph Moreno (1946, 1959, 1969) suggested using enactment as a way to study interpersonal differences and restore mental health. Children's drawings were used as measures of cognitive development by Goodenough (1926). Creative arts therapies became more acceptable in the 1930s and 1940s.

The foundations of using expressive arts in counselling lie in psychoanalytic theory. The major underlying assumption is the psychoanalytic concept of 'catharsis', which refers to expression and release of pent-up emotions to achieve healing. The catharsis may be direct or indirect, real, or symbolic. It may be achieved through art, music, dance, drama, or play.

Importance of Expressive Therapies

> ...When words are not enough, we turn to images and symbols to tell our stories. And in telling our stories through art, we find pathways to wellness, recovery and transformation…
>
> —Malchiodi (2012).

Expressive therapies offer themselves as valuable diagnostic tools in addition to therapy and healing. Since expression in arts is subjective and symbolic, the person is free from the pressure of judgment. A trained professional can identify patterns in symbols used and then work upon them further.

Gladding (2014) uses the term "creative arts" to include both verbal and non-verbal art forms that encourage clients' involvement in counselling and helps them to grow and develop in functional ways. According to him, counselling is like art in its emphasis on creativity, uniqueness, and originality. Many of the creative art forms

such as music, poetry, and dance have been used in providing relief and healing since time immemorial, though their role is gaining professional recognition only recently.

Over the years, several expressive techniques have been used to complement a wide range of psychotherapy and counselling theories. They are applied not just with psychoanalytic, but also in cognitive-behavioural, humanistic, and other approaches (Malchiodi, 2005). They are being widely used in the fields of psychotherapy, counselling, rehabilitation and health care, either by themselves or as supplementary techniques. Expressive therapies are being found to be especially useful in working with children and adolescents. They are effective in clients with trauma, abuse or with very small children who have limited language capacity to express things clearly. It may be noted here that expressive therapies are not essentially non-verbal though they involve the use of mediums such as art, movement, or drama. Clients may use language later on to talk about their art products/outcomes and convey their thoughts and feelings. Thus, it can be both verbal and non-verbal.

Resistance to counselling and psychotherapy is typically high during adolescence, making traditional talking cures less effective with this age group (Riley, 1978, 1999, 2001). Riley found that though parents and teachers frequently refer adolescents to counselling, the efforts are met with resistance either through non-compliant or overly compliant behaviours, both of which are counter-productive to verbal counselling interventions. Riley recommends expressive techniques as the primary communicative channel over verbal intervention. According to McNiff (1981), expressive therapies are those that introduce action to psychotherapy. Traditional methods of communication in therapy and counselling have been largely verbal; hence, many therapists are now using action-oriented expressive techniques in therapy for adolescents and finding them valuable. The expressive techniques also take into account that communication involves other forms also beyond talking only. People communicate through visual, auditory, tactile forms also. Especially when adolescents find it difficult to express verbally the strong emotions, they are undergoing due to interpersonal issues, abuse, violence, trauma, or mental illness, expressive techniques help them to express their thought and emotions authentically and communicate effectively.

Types of Expressive Therapies

The different types of expressive therapies are inter-related but it is important to understand that a particular expressive therapy may be useful with one individual and not with another. Hence, choice of a particular technique must be done after assessing the client's interest level and suitability to the issues and problems at hand. Clients have different expressive styles—one individual may be more visual, another more auditory, while another may be more verbal. Accordingly, the selection of the expressive techniques needs to be done carefully.

Some of the major expressive therapies that can be used with adolescents are:

- Art therapy: use of art media, images and the creative process which can be considered as reflections of the individual's development, personality, concerns, and conflicts (American Art Therapy Association, 2004)
- Music therapy: use of music to facilitate positive changes in the psychological, physical, cognitive, or social functioning of individuals (American Music Therapy Association, 2004).
- Drama therapy: use of drama/theatre to help the client tell her/his story, achieve catharsis in the process, and explore inner experience and meaning (National Drama Therapy Association, 2004).
- Dance/movement therapy: use of dance or movement to achieve emotional, cognitive, and physical integration of the individual (NCCATA, 2004a).
- Poetry therapy and bibliotherapy: use of poetry, books, stories, and literature for healing and personal growth (NCCATA, 2004b).
- Play therapy: play techniques are used for children and adolescents to facilitate interpersonal processes, resolve psychological difficulties, and achieve optimal growth and development (Boyd-Webb, 1999).

Various expressive therapies can be used together or they can be used singly as required. Further, they can be used as a primary form of therapy or can be used as a complement to other verbal therapies depending on the individual characteristics, preference, nature of the problem, suitability of the particular expressive technique.

Art Therapy

Art therapy uses the creative process of art as a therapeutic technique to improve the physical, mental, and emotional well-being of individuals. Creating the art form is cathartic in itself. The symbolic expression through art forms is interpreted by the therapist and later discussed with the client. The use of creative techniques such as sketching, drawing, painting, colouring, sculpting, photography, and pottery helps people express themselves. Identification of psychological and emotional undertones in the artistic expression can help the individual to achieve insight and move towards healing.

Art therapy involves understanding the client's symbolic self-expression and then eliciting interpretations from the client. With the help of the therapist, clients can identify the underlying symbols, which could lead to a better understanding of their own feelings and behaviour leading to resolution of deeper issues(Slayton et al., 2011).

Procedure

It is not necessary for the therapist or client to have artistic talent, because the therapeutic process does not focus on the artistic value, but on associations between the creative choices made and a client's inner life, struggles, and conflicts. The artwork is simply used as a stimulus for uncovering memories, feelings, and narratives that may reveal deep-rooted complexes and aspects of the client's personality.

Materials required for art therapy may include easels, canvas, white and collared paper sheets, water colours, oil paints, brushes, colour pencils, crayons, felt pens and markers, glue sticks, cellotape, clay, potter's wheel, camera, and any other items in which a person can use to create or express himself or herself. The setting needs to be a safe distraction-free space with table and chairs or sitting arrangement on a carpet or rug.

Art therapy can be used alone, but it is also used in combination with other types of therapy. As with any other form of therapy, the procedure is as follows:

- The first session consists of establishing rapport and a counselling relationship.
- Identification of issues and mutual goals follow.
- Therapist and adolescent client then decide a plan that involves creating some form of artwork.
- Once the process of art creation begins, the therapist may initially observe without interference or judgment.
- Later he or she may ask questions to explore feelings about the artistic process and what thoughts or memories the person may have had while working, as well as feelings after completion. Discussion about symbolism of figures, colours, or symmetry may also take place.
- After a few sessions, the therapist and client may be able to identify patterns of feelings and thoughts, which have been expressed and those that need to be worked over in future sessions.
- The entire process can help the adolescent achieve insight and help in dealing with pent-up emotions and progress towards healing.

Moon (1999) described the role of the therapist as that of facilitator, teacher, guide, and participant in the therapeutic process.

Benefits

The assumption of art therapy is that artistic creation helps in self-expression, which has therapeutic value for understanding and healing oneself. According to the American Art Therapy Association, art therapists are trained to understand how the colour, texture, and various art media can reveal one's thoughts, feelings, and psychological disposition, and help in the therapeutic process.

Art therapy allows the adolescent to communicate what is sometimes difficult to put into words. It can help in understanding ambiguous emotions and underlying complexes hence providing a safe outlet for feelings such as fear, guilt, pain, shame, rage, and anger. It assists young clients in gaining newer and more objective perspectives on their stressors or difficult life circumstances. The client is encouraged to make positive choices and gain hope for the future.

Crawford (2008) reports a detailed qualitative case study using art therapy for a 16-year-old adolescent girl who was suffering from mild retardation and mood disorder. The adolescent was resistant when verbal communication was used during the weekly art therapy sessions, but she was receptive to the non-verbal, expressive channels of art therapy intervention.

In another case example, improved and productive behaviour, ultimately resulting in enhanced self-control and reduced impulsivity was reported in art therapy with a 17-year-old male with severe behavioural problems (Franklin, 2000).

Case Vignette A young adolescent, 14-year-old Ravi (name changed) had lost his mother and baby sister when their thatched house in a slum area was set on fire by the alcoholic abusive father. He was brought by the police to an institution for further care as the father was behind bars. The adolescent was having repeated nightmares and bed-wetting. Traditional methods of talking were met by silence and Ravi would not open up at all.

Taking the help of projective art therapy, he was asked to draw-a-person on a blank paper with crayons. He was hesitant at first saying he does not know how to draw, but finally did manage a figure. When asked the gender, Ravi described it as a boy. When asked how the boy was feeling, the answers were 'scared" and 'angry'. When asked to tell a story about him, Ravi proceeded to recount how the father used to hit them with rods and 1 day under the influence of alcohol set fire to the thatched hut. The mother and baby sister died in the fire but "the boy" escaped with slight burns.

He expressed fear of the father returning to take the boy back, as well as excessive anger at the father. He was then asked to draw a 'father' next to the boy and then asked how the boy was feeling towards him. The reply was spontaneous that he wanted to hit the father in the same way that he was abused. He was asked to take a black crayon and draw lines representing a rod to symbolically hit the father. The intensity of emotions on Ravi's face while 'hitting' with his symbolic rod was a sight to behold. When the energy was spent, he looked relieved but tired. Further therapeutic interventions helped Ravi finally get rid of his night terrors.

Art therapy was, therefore, successfully used in the above case in many ways: as a method for helping the adolescent come out of his reluctance and silence, to express his emotions, as well as help to heal through catharsis of pent-up emotions along with other therapeutic techniques.

Limitations

Art therapy must not be used without professional training in arts-based therapies. It is extremely important to consider the socio-cultural context from which the adolescent is coming to be able to use art therapy for diagnosis and therapy. A particular symbol may have different meanings in different cultures.

Applications

Art therapy can be used in many ways with adolescents, such as:

(a) To form rapport and break the ice.
(b) To assess and diagnose the problem and its roots.
(c) To achieve catharsis, insight and healing.
(d) As supplementary technique along with traditional methods.

Art therapy has been found to be beneficial in helping adolescents explore their emotions, to manage stress and addictions, improve self-esteem, decrease symptoms of anxiety and depression, and cope with physical illness or disability. It can help adolescents suffering from aggression, hyperactivity, body image issues, eating disorders, as well as family and peer issues.

Art therapists work with individuals and groups in a variety of settings, including private clinics, hospitals, schools, correctional institutions, and community organizations.

According to Riley (1999), art therapy encourages creativity, which is usually high during adolescence. Integration of art therapy into the therapeutic process has been found to help adolescents achieve greater control and clarity during this phase of life when they are often struggling with issues of identity and independence.

Music Therapy

Since time immemorial, music has been an integral part of all cultures, whether in the form of singing, drumming, tapping, or playing of instruments. Music is linked with all aspects of human life and emotions, both positive and negative. Whether it is a birth in the family or a wedding, a birthday or a heart break, music is always a part of the event. Nearly everyone likes music and it holds value at every stage of life, beginning from the foetus stage through infancy, childhood, adolescence, youth, middle and old age. Music is a part of cultures across the globe. India is a culture of festivities and music and dance occupy a central place in all the festivities and functions.

Music holds a special significance for adolescents. It helps in emotional expression and regulation. Peer bonding and influence of age-mates in choice of popular

music is very powerful. With further cognitive and socio-emotional development, the adolescent begins understanding the meanings of words in songs, identifies with the underlying emotions, and turns to music for relaxation and bonding with peers.

Though music has always been an important part of human life, music therapy as an organized profession only emerged in the 1950s with the establishment of the National Association for Music Therapy in USA. The American Association for Music Therapy came up in 1971 and these two associations merged in 1998 as AMTA (The American Music Therapy Association). The mission of AMTA was to advance public awareness of the benefits of music therapy. On the other hand, the formal establishment of British Association for Music Therapy (BAMT) happened in 2011, with the aim of providing information and promoting the highest standards of practice, training and research in music therapy.

Music has been an integral part of the multi-cultural Indian context with its rich historical background (Indian Music Therapy Association, IMTA). Chanting and music have been a part of ancient healing traditions of Yoga and Ayurveda. In India the Indian Music Therapy Association and Nada Centre for Music Therapy are among the active associations dealing with music therapy. Nada as a form of yoga has been used by Indians since long past to uplift one's level of consciousness to achieve 'relaxed alertness' (Indian Music Therapy Association, IMTA). Dr. Trimurthy V. Sairam, the founder president of these associations, believes that a trained music therapist can help select and apply appropriate music for effective treatment of each unique client (Sairam, 2012, 2014).

Modern medical science is now rediscovering the curative powers of music. Music therapy helps to maintain and improve all aspects of health: physical, psychological, and spiritual. Research shows that music stimulates the functioning of the pituitary gland, which affects the nervous system and the flow of blood. Music is a universal language and medium of communication. It provides a pleasant and therapeutic experience. Both listening and performing are beneficial.

Procedure

In music therapy, no musical background or training is required for the client. Music therapists are trained professionals who have knowledge about various types of music and application for specific purposes. Knowledge about the basics of music and psychology are required for the therapist.

Several types of music are available for music therapy ranging from vocal to instrumental, classical, and semi-classical to folk, ghazals, bhajans, sufi, pop, and rap. Drumming has found to be very beneficial for adolescents to release their pent-up energy. Both listening and performing can be therapeutic. Any style of music or instrumentation can be used, depending on the unique preferences and needs of the client.

Music therapy provides a safe non-threatening space and medium for adolescents to address their personal issues without judgment while guided by a trained therapist. Sessions can be one-on-one or in small groups. Music can be used in two ways:

(a) Performing: Singing or instrument playing or music composed on computer by the client. The performance can be recorded and reviewed by client and therapist to identify feelings and symbols.
(b) Listening to music, recorded or live, either vocal or instrumental. Choice of music would depend on the client's needs and interests.

Materials needed would depend on the mode of music being used for therapy. For performing purpose, the relevant instruments will be required, while for listening purpose, the music-playing device, speakers, and headphones would be necessary.

The steps of music therapy include:

- Rapport formation with client.
- Assessment of client's strengths and needs; nature of issues; personality, interests, preferences and familiarity with music; client's socio-cultural and environmental context.
- Setting mutually acceptable goals, both short-term and long-term, e.g., relaxation can be a short-term goal while higher self-esteem can be a long-term goal.
- Designing treatment plan.
- Choice of music keeping in mind the client's preferences, needs and problems as well as researched impact of the particular type of music.
- Intervention towards each goal: asking client to play, sing, hear selected music.
- Helping client express feelings and move towards healing.
- Summarizing progress and setting homework.
- Ending the sessions after joint evaluation with client.

Benefits

Adolescence can be a difficult period marked by search for identity, adjustment to rapid body changes, development of sexuality and integration into society. Adolescents are likely to experience mood changes, swings between hyperactivity and lethargy, impulsivity and vulnerability to experimentation with sex and substance abuse. Peer relationships take on extreme value while family bonding goes into the background. Hence, adolescents are at high risk for emotional disturbances and maladjustment.

An extensive research study conducted by Tervo (2001) focused on effects of music therapy for treating adolescents admitted to a hospital in Finland for problems ranging from depression, aggression and anti-social behaviour. Music therapy was used besides psychoanalytic therapy and community therapy. Tervo (2001) has worked extensively with children and adolescents over 20 years and concludes that music, in particular rock music, can help adolescents to express and share feelings of

anger, rage, grief, longing, and psychological disintegration. Music provides adolescents with opportunities to experience bonding and closeness as well as isolation and to explore sexual fantasies and feelings.

Three stages in music therapy with adolescents have been identified by Tervo (2001). These are the stages of (a) interest in music instruments, (b) learning to play an instrument, and (c) improvisation on the instrument to express own feelings. It was seen that many problems could be resolved through creativity, cooperation, and communication in music therapy for adolescents.

Reviews of research evidence suggest that music therapy helps improve mental health in children and adolescents with autistic spectrum disorder (Gold et al., 2004; Whipple, 2004). Music therapy has also been found to be helpful for adolescents and children with cerebral palsy and autism (Krakouer et al., 2001). It helps to enhance the individual's emotional well-being. It also encourages positive communication between the client and the therapist through musical interaction. It makes one more empathetic towards others while enhancing a sense of self-awareness and improving self-confidence. Medical research is continuously proving the benefits of music therapy in ensuring holistic health. It has physical, psychological, emotional, and social benefits for adolescents (Hegde, 2017).

Case Vignette Ankita (name changed), a 16-year-old girl, was referred for low grades, withdrawal from family and aggression. She lived with her parents who reported that she was obsessed with her smartphone, stayed confined to her room and had no friends. She would get into aggressive outbursts when her parents or elder brother tried to motivate her to study and keep her phone away. When brought for a counselling session, she remained withdrawn and made no eye contact. She would only give short one-word answers when prodded. In order to deal with her reluctance, the therapist asked her what kind of songs she has on her play-list. She opened up and soon they were not just looking at the play-list but actually playing a few of them. Her expression changed magically and made it easy to connect at a therapeutic level. In subsequent sessions, her love for music was explored, and she indicated how music helped her to cope with peer rejection at school. Over subsequent sessions, a schedule for listening to her preferred music was mutually established. Relationship skills and anger management were also worked upon. She was encouraged to listen to motivating and lively music to stay away from negative emotions.

The use of music therapy for adolescents must be carried out with total involvement of the individual. Choice of music as well as choice of singing/performing or listening should be in consultation with the adolescent, keeping in mind the suitability of the type of music, the words in verbal music, and above all the rhythm for the individuals' personality and the type of issues being dealt with. As a simple example, for a hyperactive person, some soothing music can be used while for a lethargic and de-motivated adolescent, some faster music would be beneficial.

Music therapy can use a diverse range of musical styles, instruments, or the voice, each of which can be used with improvisation at every step. Analyzing the meaning of lyrics in vocal music can help one delve deeper to seek insight as it is less invasive than talk therapy. Singing allows the person to indulge in free expression and ventilation of feelings. Rap music popular with teenagers and young adults helps them express surplus energy and intense emotions in a musical way. Listening to calm music engages the neo-cortex of our brain, which helps to relax the person and reduce impulsivity. Song writing gives helps by giving an opportunity for introspection and reflection while encouraging creativity hence providing a sense of fulfilment. Therefore, a variety of interventions can be employed in music therapy, which are highly beneficial to people especially adolescents.

As is well known, Indian classical music consists of a system of ragas where each raga belongs to a family and is bound not only by a prescribed use of certain notes but is also supposed to have a gender, a certain time of day and season suitable for rendering and an emotional impact called 'rasa'. Kishore (2020) studied the impact of listening to different types of Ragas in different tempos among late adolescents and young college students. Findings revealed that even musically untrained listeners perceived the general intended ethos of the raga. On the other hand, the same raga when played in slow and fast tempos evoked different imagery and meaning. It points out to the implication regarding selecting appropriate raga and tempo based on the interest and needs of the client in music therapy.

In conclusion, music has several benefits.

- As a relaxation technique.
- To enhance personality and productivity.
- As a therapeutic aid.

Limitations

The limitations of music therapy can be:

1. Use of music therapy by someone not having undergone training in music and counselling, thus not knowing how to use it properly can lead to waste of time and effort.
2. Choice of music needs to be done carefully. If a wrong choice is made it can lead to undesirable results.
3. It should be used in addition with other therapies if required.

Applications

Music therapy is being used widely all over the world and in India too. There are several applications of music therapy for adolescents:

- It can be used by itself or in addition to other forms of therapy.
- It can be carried out in individual or group settings.
- Performing or listening in groups helps greater bonding and improve communication between members. Collective signing, performing, and listening in a group can help motivate or calm the group members such as devotional music or patriotic music.
- It can be used as a curative technique as well as for preventive and enhancement of personal growth.
- It can be used for a variety of purposes: for relaxation, management of pain, anger, grief, anxiety and depression, helping persons with special needs, helping those with disorders of speech, autism spectrum, attention deficit hyperactivity (ADHD) and also for providing motivation and energy.
- It can be applied in health, recreational, educational, and work settings.

Dance Movement Therapy

Just as music is appreciated across ages and cultures, movement in rhythmic fashion is also universally pleasurable. Dancing is especially popular with adolescents and youngsters. According to American Dance Therapy Association (ADTA), dance movement therapy can be defined as "the psychotherapeutic use of movement to further the emotional, cognitive, physical and social integration of the individual". It focuses on movement as it emerges in the therapeutic relationship. Body movement is the basic component of dance. Both movement and dance provide the means of assessment and the mode of intervention for this therapy. The wonderful thing about dance therapy is that people do not need to speak the same language because movement reveals so much without words.

Anthropological studies show that cultural groups who had developed their unique dance forms and were able to share their feelings through dancing were more likely to survive. Music and dance are not only very useful for physical and mental health, they also facilitate social bonding. Dancing helps release of endorphins, which are hormones that can trigger neurotransmitters to create feelings of comfort, relaxation, fun, and power. Music and dance activate the sensory and motor circuits of our brain, and also the pleasure centres.

The magic of dancing cannot simply be reduced to brain chemistry. Dancing is also a social activity that allows us to bond with others, share experiences, and coordinate our body movements with those of others. This results in a very positive effect on our mental health. Moreover, as we move and dance to music, our muscles relax and we are able to get rid of the tension built up in our mind and body.

Dance movement therapy is useful with people across all ages, races, and ethnic backgrounds and also in individual, couples, family, and group therapy formats. Further, it is also effective for individuals with developmental, medical, social, physical, and psychological issues. It holds special significance for children and adolescents for whom dance is a beautiful way of self-expression.

Adolescence is known as a period of 'storm and stress' due to rapid biological and psychological transitions. Adolescents go through extensive changes in body size, structure, and muscle strength along with further cognitive development and emotional upheavals. These changes are out of their control, making adolescents find their growing bodies feel unfamiliar, and go through mixed feelings such as confusion, fear, guilt, shame, enjoyment, and pleasure (Engelhard, 2014). Dance movement therapy can be effective for adolescents as it focuses on the mind–body connection. It enables adolescents to express emotions related to their changing bodies in an active, behavioural form, thus helping to communicate more effectively (Engelhard, 2014).

Psychologists at the University of Orebro (Duberg, 2016) experimented with a group of teenagers who were suffering from stress, anxiety, and depression. Half of them were asked to attend two dance classes a week, while the other teenagers continued with their daily routine. In the dance classes, the focus was placed on enjoying the movement rather than on technique. After 2 years, the experimental group who was attending the dance classes showed a marked improvement in stress symptoms and reported being happier than the group not exposed to dance classes. Many other research studies across the world have shown benefits from dance.

A study by Jeong et al. (2005) revealed that dance movement therapy improves emotional responses and neuro-hormonal functioning in adolescents with depression. Anderson et al. (2014) found that dance movement therapy helps improve moods of adolescents in a psychiatric hospital. The inclusion of dance/movement therapy as part of the intervention program devised by Cohen and Walco (1999) for dealing with the psychosocial needs of children and adolescents with cancer helped enhance the integration of factors related to coping.

Dunphy et al. (2016) have developed a computer-based application that helps in assessment of progress in dance and movement therapy interventions for clients with disability, including intellectual disability. With potential for application in diverse contexts and client groups, it measures improvement across physical, cognitive, emotional, personal, and interpersonal domains. Strassel et al. (2012), based on the review of studies in dance movement therapy, noted the therapeutic benefits of dance therapy and suggested it as a relevant add-on therapy.

Procedure

The idea of dance movement as a therapeutic or healing tool lies in the basic assumption that the body, mind, and spirit are inseparable. It is known that body movement reflects inner emotional states, and, therefore, it can lead to changes in the mind, thus promoting holistic health and healing. It focuses on how our body holds emotional and psychological experiences in our body. There is no right or wrong way of moving or dancing.

The four stages of dance movement therapy are:

1. Preparation: warm-up stage, helps establish safety.
2. Incubation: helps relaxation, letting go of conscious control, movements express symbolic emotions.
3. Illumination: insight, meanings become clearer, leads to positive effects.
4. Evaluation: discussion about benefits of the healing process, preparing to end therapy.

Choice of form of dance, whether creative and free, traditional forms such as ballet, bharatnatyam, kathak, or folk dance such as tap dancing or bhangra, or popular social dance form such as waltz, salsa, popping, lyrical, or flush, should depend on the preference and therapeutic needs of the client. Decisions about individual or group setting must also be taken carefully. The therapist needs to have completed a certified training program in dance and movement therapy and have a strong background in psychology.

Freestyle techniques of dance and movement can help unlock and improve the body's capacity to communicate and express. Dance can be adapted to a wide variety of body types and personalities. It helps people to move away from habitual movement patterns and discover a new, dynamic body language. Group sessions may consist of enjoyable movement activities using music, props, body exercises, energizers, icebreakers, and relaxation routines interspersed with verbal dialogue. Participation in individual and group activities helps persons to remove inhibition, while enhancing self-awareness and social skills. The movements also help release physical and mental stress and improve self-confidence, emotional expression, and leadership qualities.

Benefits: Dance is pleasurable by itself, whether a person is dancing alone or in a group, whether the dance is classical or folk or creative, regardless of age and gender of the dancer. The goals of dance therapy for adolescents are not aimed at distracting them from their problems and giving them moments of pleasure, On the other hand, it is designed to help adolescents trying to cope with various issues related to anxiety and depression, eating disorders, issues about body image, low self-esteem, peer issues, and romantic and emotional issues.

Dance therapy has been found to be extremely beneficial with adolescents with special needs. Those with visual, auditory and speech disorders benefit from dance and movement therapy. Even those with orthopaedic disabilities enjoy dancing on their wheelchairs.

Research studies indicate that dance therapy helps those suffering from developmental, physical, medical, social, and psychological problems (Strassel et al., 2012, Pierce, 2014). It has also been found to be effective in reducing test anxiety in college students (Erwin-Grabner et al., 1999). For high school students, dance therapy is beneficial and developmentally appropriate as it provides an opportunity to communicate conflict and emotional turmoil in a physical format rather than verbally (Gladding, 2006). Dance movement therapy helps adolescents struggling with feelings of anger and confusion as they can express themselves in a safe and dynamic format usually accompanied by music. Adolescents are very conscious of their physical size and image as they are reaching sexual maturity (Rowley & Hart,

1998). Body size, shape, and image are big concerns for high school students. Dance and movement therapy facilitates exploration of the radical changes their physical bodies are undergoing. At the same time, dance therapy helps to explore the feelings of depersonalization and identity crisis typical of this stage (Emunah, 1990).

Dance and movement therapies prove to be especially beneficial due to the underlying factors.

- Provides catharsis of repressed emotions.
- Improvement of peer relationships as dancing together encourages trust, understanding the role of touch and awareness of their bodies and emotions.
- Enhancing positive body image.
- Helps adolescents with special needs to overcome inhibitions and express emotions.
- Enhancing self-expression and confidence in those who are socially anxious.
- Helps regulate and control overwhelming emotions and thoughts.
- Promotes resilience as it helps adolescents understand how their feelings are given form and expression through their actions.
- Dance therapy can work wonders with families facing problems by combining dance/movement concepts with family therapy concepts such as the need to work on non-verbal patterns of communication and interaction.

Case Vignette

Selissky (2017) *reports the case of a 14-year-old girl struggling with low self-esteem and difficulties in making social connections. The therapist made her explore movement patterns of the character of Elsa from Disney's movie Frozen, playing someone who managed to accept her 'abnormal' part and create a new self from a 'malfunctioning' one. Movement and dance therapy helped the adolescent to gain insight and to facilitate changes in her behavioural patterns. She was gradually able to express her feelings of isolation and move towards self-confidence.*

Limitations

As with other expressive techniques, there are certain limitations of dance therapy.

1. The therapist must be trained in this kind of intervention but training facilities are limited in the Indian context.
2. When, at what stage of counselling, which techniques, how and with whom dance therapy is conducted needs the skills and expertise of the counsellor.
3. If either the client or the therapist is formally trained in dance, it may hinder the therapeutic process in the client due to subjectivity and rigidity.
4. It is important to recognize that not every client may be capable or interested in dance or movement.

5. This therapy may not be fully applicable to those with physical disabilities as it requires the clients to express themselves both physically and emotionally through body movement. Any major physical disability may hinder a person's performance within the session.
6. Confidentiality may be a problem in group sessions. But when confidentiality is ensured, dance therapy can be used successfully in combination with other creative arts as well as with traditional psychotherapy to promote healthy growth and positive changes for adolescents.

Applications

Dance therapy is being practised across the world in areas of mental health, medical, educational, and forensic fields. It is being used in a variety of settings such as in clinics, rehabilitation centres, day care centres, health promotion programs, and in private practice. The situation in India shows that it is gradually being accepted and used but there is much progress to be made.

Dance and movement therapy has been found to be effective for individuals with developmental, medical, social, physical, and psychological impairments. It is being used with people of all ages, races, and ethnic backgrounds in individual, couples, family, and group therapy. It holds special significance for adolescent counselling and therapy as dance and movement are naturally attractive activities at this stage of life.

Drama Therapy

Drama therapy refers to the deliberate use of drama, role-playing, and theatre processes in a therapeutic way. It is an active and experiential approach, which facilitates the participants to tell their stories, express feelings, achieve catharsis, and solve problems. Through dramatization of one's own behaviour or of significant others or even fictional characters, the person may achieve insight into behaviour of self or others. On the other hand, drama therapy also includes watching drama as an audience member.

Psychodrama is a therapeutic technique developed by Moreno (1946, 1959, 1969) in which one or many individuals act out certain roles in the presence of a therapist. It was found that acting out one's own role or of another person helped achieve insight and move towards empathy and healing. Drama therapy grew out of the success of Psychodrama. Many other therapists later used drama techniques for helping clients. Virginia Satir used the techniques of role-play and family sculpting to help families deal with conflicts and dysfunctional communication patterns and coping stances (Satir et al., 1991). Family Sculpting technique (Miriounis, 2017) was devised in the late 60s by Duhl et al., (1973) where the arrangement of persons is done to express

family relations at a particular time. It helps family members recognize the emotions they are finding hard to express otherwise.

Theatre has a long history across the world, including India. From time, immemorial plays have been enacted to narrate stories and to convey social messages. In India, mythological dramas such as Ramayana have been enacted regularly on stage and on streets. Even today, street plays conveying social messages are very popular among adolescents and youngsters in schools and colleges. Theatre is different from drama in the sense that the former follows a set pattern, scripted and directed, and has less spontaneity than drama. The trend of drama on stage and streets continues but, in modern times, the field has moved onto videos and films. Cinema is a strong medium for influencing adolescents. It is easy for youngsters to empathize with certain characters and situations and learn new ways of dealing with circumstances. Those taking active parts benefit the most.

Drama techniques are very appealing to adolescents as they prefer active participation rather than simple talking. They also enjoy watching theatre and can learn values, different perspectives, and interaction skills from watching others' enact scenes.

Drama helps to actively explore the depth and breadth of inner experience and enhance interpersonal relationship skills. Through efforts at expanding and modifying one's roles, the individual learns how to strengthen own life roles. It helps development of empathy where one is able to look at the situation from the other person's perspective. Drama therapy offers a creative way to explore and solve personal problems and can be used in a variety of clinical and community-based settings. Besides helping the identified client, it benefits other group members too, as they are led to explore insights and links to their own lives from the roles being played by others.

Procedure

A drama therapist uses different techniques to help the client create a fictional story to portray in order to express emotions and achieve insight to move towards healing. Drama therapy includes various forms of intervention/techniques such as role-play, mime, theatre, puppetry and other improvisations. Drama therapy can be used in many ways:

(a) Active participation where the client plays a role or passive watching as others perform live or on screen.
(b) Participating individually or in group setting.

Techniques Used in Drama Therapy

1. Role-play: is one of the most common activities used in drama therapy. Role-playing refers to enacting the part of a certain character in a particular situation, e.g., playing the role an example of role of an adolescent or the parent in a

situation related to studying for the examination, and exploring the emotions expressed in the process.
2. Mime: Miming refers to relying only on body language to depict a certain emotion or scenario without using speech. This can help to think in alternate ways and discover feelings one may not have experienced earlier.
3. Speech: Sometimes the therapist may ask the client to speak in ways one normally does not speak, e.g., a client with poor self-confidence may be asked to shout; or may be asked to use words to describe their emotions.
4. Improvisation: It refers to creating a scenario and making the dialogue on the spot. It can be done by the client alone or in groups on the spot itself. Improvisation often helps bring forth underlying true emotions.

Stages in Drama Therapy: Drama therapy can take place in a range of different settings such as in schools, clinics, families, and peer group. Each drama therapy session plays out differently according to the therapeutic needs and context of each client. It is possible that each member of the group is facing a similar issue, or each may have different concerns. Once the therapist identifies the client/s' expectations and needs, the session can be planned. A typical group drama therapy session may proceed in the following manner:

1. Check in: This first step is important for the therapist to understand the present state of each participant.
2. Warm-up: Before beginning the actual drama scenario, the therapist needs to prepare the client/s for the session. A warm-up activity helps loosen inhibitions and stimulates imagination, e.g., an ice-breaking exercise can be initiated where each member of the group introduces himself/herself by telling one's name and enacting how they are feeling without using words.
3. The main activity: The main working part involves the use of various techniques such as role-play, mime, or improvisation to work through emotions that require insight and processing.
4. Closing: At the end of each session, the therapist asks for inputs about how the session went for each client and what has been learnt. De-briefing is then done by the therapist to let each client come out of the role and understand what has been achieved.

Jones (1996) states in his book *Drama as Therapy, Theatre as Living* that the two core processes at the heart of drama therapy are projective identification and dramatic distancing. *Projective identification* refers to the process of identification of the client with a character in the story. With the use of hypothetical situations and fantasy, clients try to work out their problems and achieve better insight into alternative perspectives. *Dramatic distancing* refers to creating a distanced relationship between the client and their feelings and problems so that these seem to belong to the character in the story, not the client, and thus are easier to tolerate. In real life, people avoid certain feelings as they are too painful. Drama therapy helps in projecting such feelings, attitudes, and opinions through masks, puppets, objects, or art. This helps the person to create a distance between himself/herself, and the problems and can deal with them more

easily without subjectivity or inhibition. Thus, in dramatic distancing, emotional and psychological problems can be easily accessed through the use of symbols or metaphors.

Benefits of Drama Therapy

Drama therapy allows the adolescent to explore emotional issues through drama, using a variety of activities such as creating and learning scripts, improvisation, as well as acting out a role or activities using puppets and masks. It could also involve watching a play or film on stage or on screen and then discussing the experience. It can help to:

- Find alternative perspectives and solutions to own problems.
- Achieve expression and catharsis of pent-up feelings.
- Explore truths about self.
- Understand and empathize with others.
- Get insight into memories and associations.
- Identify and modify unhealthy behaviour patterns and issues in interpersonal interaction.

Drama therapy proven to help adolescents deals with problems such as anxiety, depression, eating disorders, addictions, self-harming behaviours, relationship issues, and traumatic experiences. It works wonders with persons with special needs, autism, hyperactivity, and anger issues.

Case Vignette

An extensive intervention program using 20 sessions of group drama therapy with 6 adolescent girls in the age range of 12–13 years, living in poverty-stricken conditions in Cape Town, South Africa, has been reported by Koekemoer (2006)*, a master's student who worked under supervision of Heather Schiff, a trained drama therapist. Drama Therapy worked wonders with the girls who were struggling with poor self-concept and low self-esteem. Participants enjoyed the 20 weekly sessions with various activities involving mask making, myth work, and dramatic enactments. They developed a sense of self-control, mental strength, and resilience.*

Limitations

As with all expressive therapies, it is imperative that the therapist should be professionally trained in drama therapy with a strong background of psychology. Professional skill is required in choice of drama medium, in taking decisions about technique to be used, whether to use active or passive mode, individual or group mode and also for guiding the client towards achievement of goals. Helping the client achieve insight and acquire new perspectives and skills requires expertise.

Applications of Drama Therapy with Adolescents

Drama therapy can be used in a wide variety of settings such as clinics, hospitals, schools, and also for leadership training. Drama therapy exists in many forms and can be applicable to individuals, couples, families, and various groups. It has been found to be applicable in the case of a variety of problems and with different kinds of people, especially children and adolescents, for instance, studies have reported drama therapists successfully helping juvenile delinquents and children in conflict with law deal with their aggression and other negative emotions. Drama therapy can be used very effectively with adolescents with special needs (Balasundaram, 2007). It can help clients deal with anxiety, depression, eating disorders, addiction, low self-confidence, and relationship issues. By slipping into another person's role, the client is able to try out new ways of behaving without any consequences. Drama therapy is especially helpful for adolescents. It allows them to identify and express their emotions in a safe environment of anonymity, learn empathy, and acquire new coping skills.

Other Expressive Therapies

There are many other expressive therapies that are used for helping adolescents. Some of these are.

Play Therapy

Indoor and outdoor games provide an opportunity for adolescents to express their emotions in a non-competitive manner, helping them to channelize emotional energy into constructive channels. Adolescents usually have surplus energy and play can be a desirable activity. Play can help increase empathy with others, learn how to accept defeat and acquire social skills for teamwork. Sports are usually part of the school

curriculum. Extra-curricular activities also provide a change as well as exposure to various life skills.

Play therapy for children has been used since long but it is developing as new technique for adolescents and adults too. Green and Myrick (2014) devised a system of play-based therapy for adolescents who have experienced complex trauma and found it extremely helpful for them to process the emotions related to traumatic experiences. The approach includes the following phases: establishing safety, processing of trauma, and reconnecting with the world.

Bibliotherapy

Reading literature, whether fiction or non-fiction, prose or poetry, can help adolescents understand emotions and different ways of living and thinking. Fantasy and imagination can help the person move towards divergent thinking, leading to alternative ways of dealing with a problematic situation. Biographies can be inspirational. Reading helps the adolescents gain not only by learning from narratives but also by diverting their attention from their own problems (Shechtman, 2009).

Writing

Many adolescents go through overwhelming emotions along with rapid changes in the body, cognitive processes, and social interactions. Adolescents are often undergoing confusion and not good at verbalizing their thoughts and emotions to others. Writing down their thoughts and feelings helps them to express and clarify things for themselves (Utley & Garza, 2011).

Most teenagers enjoy writing prose or poetry, diaries, and 'journal therapy' is a highly recommended technique. It is a very helpful and creative way of self-expression. Writing helps achieve catharsis and leads to clarity of thinking about one's issues. Therapeutic writing can include poetry, story-telling, narratives, dialogues, humorous stories and journaling. It is important to understand that writing therapy is not the same as journaling for oneself. The therapist is trained to set topics for writing and then helping the adolescent move towards healing.

The therapist usually suggests writing exercises that focused on specific issues and problems. The adolescent is then guided to explore the issue in detail and more depth to try to come to a better understanding and hopefully a solution or alternative behaviour. Other exercises could include writing a letter to a person one is angry with or has been hurt by, writing about a particular issue such as sadness or anger, painful experiences, a past traumatic event or even experiences within therapy. Journaling one's thoughts, feelings and even gratitude is used widely by therapists during their interventions. Writing has been found to help relieve stress, understand the problems, process painful feelings, and to make connections between feelings and behaviour.

It can be easily adapted to the specific problem or situation that the client may be dealing with. Research has shown that writing is an effective technique for enhancing mental health.

Evaluation of Expressive Therapies

On the whole, the use of expressive therapies has been found to be extremely beneficial. Most expressive therapies are used in a complementary way along with traditional talk therapy, but today, there is a growing trend across the world to use them by themselves.

Expressive therapies are especially useful for those teenagers and youngsters who are inhibited and not able to express feelings and thoughts in talk therapy sessions. Many adolescents are going through an identity crisis, often overwhelmed with rapid changes in physical, physiological, cognitive, and socio-emotional changes. They often become distant from elders and those in authority. This leads to resistance in opening up to a traditional therapist who tries to make the individual talk. The use of expressive therapies makes the process of counselling easier. Art, music, dance, or drama seem to be fun activities where the adolescent can feel free to express emotions and conflicts.

Expressive therapies can be used both at individual level and in group settings. Since peers become more significant than family members, a group setting can work wonders. They can prove useful at all stages of the therapeutic process. They help to reduce inhibition and make a connection during the initial rapport formation stage. Emotional expressions during art, music, dance or drama can lead to better diagnosis. These expressive forms have proven helpful in healing the client as the major therapeutic intervention through catharsis, insight and moving on.

Choice of a particular expressive therapy and also its particular techniques needs to be done very carefully keeping in mind the psychological issues to be dealt with, the nature and personality of the adolescent and the social context involved. As an example if an adolescent who enjoys listening to music is suffering from low self-esteem and lethargy, he would benefit from listening to music with cheerful lyrics and fast tempo. A teenage girl who is fond of writing stories but has suffered rejection by peers, can be asked to write a story about a character dealing with such a problem and later discuss the story in a non-judgmental way.

Though simple to use it is imperative for practitioners of expressive therapies to have professional training and certification in both psychological counselling and psychotherapy as well as in the particular art form. Any wrong interpretation of symbolism in assessment, diagnosis, and treatment may lead to errors in conclusions and aggravation of problems.

Though expressive therapies are gaining popularity in the Indian context, there is a lack of professional training facilities except a few. It is imperative that there should be greater awareness, establishment of more certified training programs and

increased use of expressive therapies either along with traditional talk therapies or even by themselves.

Conclusion

Expressive therapies refer to techniques that use art, music, dance, drama, and other forms of creative outlets that help a person reveal feelings and emotions in a safe space. They are especially useful for adolescents who are going through a transitional phase in life and facing many difficulties in their physical, psychological, and social domains. They are often not able or willing to talk about their issues with adults. They often show reluctance and resistance towards traditional talk therapy. On the other hand, expressive therapies do not focus on talk but more on action and expression, which makes it appealing to adolescents.

Expressive therapies are used by themselves and also along with talk therapies. They are useful at all stages of counselling and therapy, beginning from the initial rapport formation stage, assessment and diagnosis as well as the major therapeutic intervention stages.

The chapter focused on major forms of expressive therapies such as art, music, dance, and drama therapy discussing their characteristics, techniques, benefits, limitations, and applications along with case vignettes. Other expressive therapies such as play therapy, bibliotherapy, and writing were also highlighted.

Evaluation of expressive therapies shows that they are very beneficial for adolescents dealing with relationship issues, depression, anger, hyperactivity, autism, self-concept, and body image issues. They are a boon for those with special needs. Though they appear very simple, it is imperative for the therapist to be professionally qualified and trained in using them for diagnosis and healing.

Expressive therapies have been accepted widely the world over not only as supplementary techniques along with traditional psychotherapeutic techniques but also as therapy on their own. In the Indian context, expressive therapies are gaining in popularity pointing to the need for establishing more certified training centres and organizations.

Time to Reflect

India is a collectivistic society where emphasis is on compliance and obedience to authority figures. This is especially expected from children and adolescents and also continues to reflect in adult interactions with also in relation to their elders/parents. Most adolescents are not very open and expressive with elders or authority figures. In this context, the goals of expressive therapies that focus on expression of feelings, emotions, and inner conflicts and turmoil may help the adolescent in emotional release and coping with the situation. But the adolescent will continue to live in

the same context and same socio-cultural context where freedom to express and individuality may not be encouraged. So how can the adolescent deal with it and how these can be integrated?

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Chapter 17
Cognitive Behaviour Therapy for Adolescents

Nitasha Borah

Abstract Cognitive behaviour therapy is one of the most well-known and empirically validated approaches to psychotherapy. This chapter provides a unique focus on therapeutic practice in cognitive behaviour therapy with adolescent clients. Adolescence presents distinctive cognitive processing and emotion regulation demands, which call for a tailored approach and a collaborator-coach stance from the therapist. Highlighting basic guiding principles of cognitive behaviour therapy, the chapter integrates them with specific developmental challenges that this group navigates. It discusses practical strategies for identifying problems, managing a therapeutic relationship and targeted interventions to help adolescent clients bring about change. Ethical and clinical issues with regard to involvement of parents in adolescents' therapy are also explored. Case illustrations, examples, and reflective questions have been included to facilitate application and understanding.

Keywords Cognitive behaviour therapy · Adolescents · Case formulation · Cognitive techniques · Behavioural strategies

Introduction

Cognitive behaviour therapy (CBT) is primarily thought to have emerged in response to two diametrically opposing points of view with regard to how human beings function, what creates psychological problems, and how to address them. The psychoanalytic view was the first to emerge from the work of Sigmund Freud and dominated discourse in this area for decades (Safran & Gardner-Schuster, 2016). The fundamental tenets of this school of thought were that individual problems originate in early experience with primary caregivers and lead to unconscious processing of psychological material. Recovery from psychological disorders would thus involve making the unconscious, conscious. The other dominant school of thought was birthed out of criticism for the psychoanalytic approach in that the unconscious was neither

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observable nor measurable and the mechanisms of change therefore could not be objectively studied or proven. Behaviourism emphasized that the human experience should be studied using units of behaviour-observable actions of an individual which could be studied objectively. However, this line of thinking also ignored what had until then formed the mainstay of the discipline of psychology—human emotions and thoughts which existed in the psyche but could only be inferred and not directly observed.

Cognitive behaviour therapy can be viewed as a more balanced view of the human experience which attempts to integrate all three elements to explain and intervene in this domain-thoughts, emotions, and behaviour. The most well-known articulation of this approach is Aaron Beck's cognitive therapy approach for depression (Beck et al., 1979) from which he derived most of the core principles of CBT that are in use even today. The approach itself has undergone many changes and has evolved significantly since then to take its current form. This chapter focuses on the basics of delivering CBT to a special group of clients-adolescents.

Principles of CBT

Cognitive behaviour therapy is guided by some fundamental principles which merit understanding so that effective application can follow.

1. **The Cognitive Triangle**: This principle states that our functioning in the world is determined by the integration of the components of the triad of cognitions, feelings, and behaviour (Fig. 17.1).

   Our thoughts, beliefs, interpretations, and values comprise our 'cognitions' about the world. These determine the lens through which we view our environment, our relationships, and even ourselves. The implications for this are that our cognitions play a very significant role in how we behave and react to stimuli in our day-to-day lives. For example, in response to a situation in which a friend does not wish you on your birthday, the following thoughts may arise:

   Maybe she forgot the date

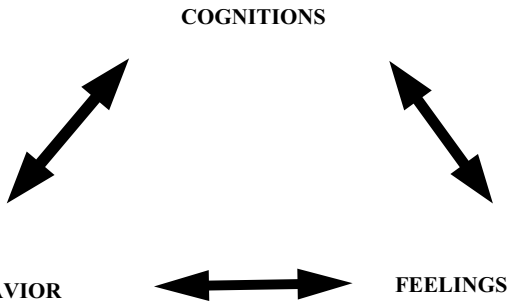


Fig. 17.1 The cognitive triangle

Maybe she doesn't care about me as much now
What if she's mad at me
I hope she's okay

Evidently, a range of *automatic thoughts* could occur in response to the same situation—all very different from each other. What one decides to do next will depend on which thought is prominent and what feelings arise. For example, in response to the first thought, one may feel mildly annoyed and reach out with a reminder—"Hey, you forgot my birthday!". The second thought about your friend not caring could trigger feelings of sadness and could lead to withdrawal from your friend. The other two thoughts would likely give rise to markedly different feelings and actions in the person having this experience and thus, map onto the cognitive triangle.

2. **Dysfunctional thought patterns are the source of psychological problems**: The cognitive model assumes that distortions in thought patterns are a common underlying source of distressing emotions and a correction in these dysfunctional thought patterns can lead to alleviation in depression, anxiety, or other psychological disorders. In the example above, the thought of your friend forgetting your birthday may lead you to further assume that your friend is on the verge of leaving you. While this may be true, there is an equal probability that your friend simply forgot your big day. However, without considering this at all, you may indulge in *catastrophizing* by giving greater weight to the former explanation, thus experiencing anxiety about the impending abandonment.
3. **Formation and maintenance of a sound therapeutic alliance is crucial to the success of therapy**: The therapeutic alliance is the shared, most significant factor in therapeutic success (Ardito & Rabellino, 2011) irrespective of the therapy approach applied. Like client- centered therapy, empathy, warmth, positive regard, and a non-judgmental attitude form the bedrocks on which cognitive behavioural interventions are built. A key differentiator in CBT is that the therapist is not meant to be a distant observer or expert in the client's problems. In fact, the client is encouraged to collaborate and take on an active part in therapy by deciding on which goals he/she would like to focus on, what they would like to discuss in a particular session, and ideas for between-session exercises, referred to as 'homework'.
4. **Therapy is intended to be time limited and goal oriented**: Early goal setting and continuous monitoring is one of the hallmarks of CBT. Therapy ends when the goals have been achieved to the satisfaction of the client and termination is discussed much in advance to prepare the client for the eventual cessation of work. This lends structure and transparency to the process and can be very 'containing' for several groups of clients such as adolescents.
5. **Present orientation and here and now formulation**: CBT is oriented to a client's current situation. When creating a formulation of how client's specific problems fit into the general understanding of human behaviour, attention is directed at the factors that may be maintaining the problem at present. These factors may not be the same as the ones that gave rise to the problem in the

first place. This is an important distinction. However, this does not mean that CBT disregards a person's past. In fact, the client's history is acknowledged as a critical contributor to the development of *core beliefs*-rigid, overgeneralized ideas about oneself from which one's current problems emerge.

While a person's early experiences are factored in, large swathes of therapy sessions time are usually not devoted to discussions about the past. Judith Beck in her authoritative book on the basics of CBT (Beck, 2011), however, clarifies two exceptions to this—the past is focused on when a client states that they would like to do so and when clinical judgment indicates that the early roots of a problem need to be resolved and processed in order for therapy to succeed in the present.

6. **CBT aims to educate the client and develop skills "to be their own therapist"** (Beck, 2011): The client is proactively educated about his/her symptoms, maintenance factors, the cognitive model, and how therapy will proceed. In addition, clients develop hands-on skills to identify, evaluate, respond, and modify their dysfunctional thinking patterns and self-defeating beliefs. Through certain techniques that will be discussed in later sections, clients are helped to design ways in which they may have opportunities to test out their old and new thinking patterns. Towards the end of the process, clients will have learned important tools and skills that they can use independently to achieve adaptive and balanced thinking and behaviour.

Developmental Sensitivity in Therapy with Adolescents

The World Health Organization (2014) defines adolescents as people between 10 and 19 years of age. On the other hand, it is also acknowledged that while age is a convenient way to define adolescence (UNICEF, 2011), "it is only one characteristic that delineates this period of development" (Canadian Paediatric Society, 2003). Given the vast range of physical, cognitive, social, sexual, and psychological changes that are seen in this period, an adolescent at the bottom of the age range and another who is 18 or 19 years of age are likely to be very different from each other, even though they may both be referred to as 'adolescents'. It can be useful to thus divide this range into narrower cohorts such as early (10–13 years), middle (14–16 years), and late (17–19 years) adolescence (Sawyer et al., 2012) with reference to specific developmental needs during each stage. This has important implications for delivering developmentally appropriate therapy.

As is evident from the basic principles of CBT elucidated earlier, this therapy approach makes certain basic assumptions about clients: that one has the ability to observe and identify thoughts and emotions, can differentiate between thoughts and emotions and among different kinds of emotions and also possesses the ability to evaluate these experiences. All adolescents may not be cognitively sophisticated enough to perform these tasks or even be verbally articulate enough to talk at length about them. This is especially true for early and middle adolescence.

However, perspectives on this vary. Piaget's systematic study of human cognitive ability yielded a cognitive model that proposes that cognitive development proceeds through four stages. In his model, during adolescence, a clear shift occurs from the third, concrete operational stage to the final formal operational stage in which one is able to 'think about thinking', and thus moves from thinking about the world in concrete terms to more abstract ways (Inhelder & Piaget, 1958). Some clinicians assert that since the concrete operational stage of Piaget's model of cognitive development is usually acquired during 7–12 years of age, most adolescents already possess the cognitive skills required for CBT (Stallard, 2019; Verduyn, 2000). Others suggest that skills training in CBT should be made fun and engaging so that adolescents and young people may learn skills better through repeated practice and demonstrations for enhanced learning and generalization (Young & Brown, 1996).

Selman's theory of role-taking (Selman, 1980) outlines another development need for this age group—that of being able to take another person's point of view. Early adolescent years overlap with Level 2 in his four-stage model wherein children are able to see themselves from another person's point of view and discern that others may have a point of view that is different from theirs. Between 10 and 15 years at Level 3, children can view themselves from a third person's perspective. At Level 4 from age 14 to adulthood, adolescents can view individuals in relation to social contexts and the influence of societal values on the perspective that one may take. In this way, the development of social cognition occurs, which underlies social awareness, empathy, interpersonal problem-solving skills, and self- knowledge. Perspective taking skills developed from Level 3 onwards can prove key in CBT interventions that require one to take an alternate view of thoughts and situations as a strategy to evaluate dysfunctional thoughts.

The final key domain of adolescent development is in the area of emotion regulation. Saarni (1999) lists the following skills for developing emotional competence:

1. Awareness of own emotions;
2. Ability to discern and understand other's emotions;
3. Ability to use vocabulary of emotion and expression;
4. Capacity for empathic involvement;
5. Ability to differentiate internal subjective emotional experience from external emotional expression;
6. Capacity for adaptive coping with aversive emotions and distressing circumstances;
7. Awareness of emotional communication within relationships; and
8. Capacity for emotional self-efficacy.

Along with brain development, social and family relationships exert profound influence on these competencies. Emotion regulation and goal-directed behaviour is thought to be localized in the prefrontal cortex, an area which shows rapid development during adolescence (Dahl, 2004). Family and interpersonal relationships also play a key role in emotion regulation skill development. The family environment, parental relationships, reward and punishment mechanisms, and discussion about emotional experiences all impact how these competencies develop (Howells, 2018).

Cognitive behavioural strategies can play an important role in facilitating these when the normal course of their evolution in adolescence is blocked or otherwise derailed, as manifested in risky behaviour, extreme emotionality, substance use, etc.

Effectiveness of CBT for Adolescents

CBT is one of the most extensively studied approaches for the treatment of anxiety and depression. In fact, several researchers (Kessler et al., 2005; Seligman & Ollendick, 2011, Kendall & Peterman, 2015) acknowledge that anxiety disorders are the most frequently diagnosed disorders in adolescents, with the period serving as the developmental phase during which most adults first develop an anxiety disorder. Cognitive behaviour therapy is the most evidence based (Hollon & Beck, 2013; Seligman & Ollendick, 2011) and recommended first-line treatment for anxiety disorders in youth (Connolly & Bernstein, 2007; Higa-McMillan et al., 2016). CBT has been shown to be effective in reducing anxiety symptoms across several common anxiety disorders (Ishikawa et al., 2007; Silverman et al., 2008). Long-term studies have yielded data that supports findings that post-treatment gains from CBT last long after treatment and follow-up studies suggest that many children who see benefits from CBT will maintain their treatment gains and continue to improve even after treatment has formally terminated (Nevo & Manassis, 2009).

CBT is an efficacious treatment for depression in youth as well (Rudd et al., 2001; Brent & Melhem, 2008; Sondhi et al., 2013; Idsoe et al., 2019). In general, a combination of pharmacotherapy and CBT has yielded superior results and better clinical response than either of these approaches alone (March et al., 2004; Brent & Melhem, 2008). A systematic review of 25 studies revealed that CBT had a significant impact on reduction of suicidal ideation and non-suicidal self-harm even though it did not impact suicidal attempts (Labelle et al., 2015). CBT has been found to be a cost-effective intervention for increasing self-awareness and reducing depression in non-clinical settings such as classrooms for ages 12–16 years (Stallard et al., 2013). Recently, internet and computer-based CBT have shown promise in treating anxiety and depression in adolescents and young adults (Ebert et al., 2015; Pennant et al., 2015).

CBT has also shown promise in the treatment of eating disorders and prevalent body image issues in the adolescent group. A 10-week CBT programme coupled with 10 weeks of phone contact was found to improve body composition of overweight adolescents (Margarita et al., 2008). In another recent study, a CBT group comprising 55 adolescents significantly improved their psychosocial health, physical activity, and health-related quality of life as compared to treatment as usual group (Miri et al., 2019). The effects of CBT have been demonstrated to be sustained at 12-month follow-up when employed as an intervention to improve health-related quality of life (Vos et al., 2012). Alcohol and adolescent substance use has emerged as another key diagnostic domain in which CBT has been applied successfully, especially in outpatient settings (Hogue et al., 2014).

Designing and Delivering CBT

The default steps for initiating therapy largely remain the same across therapeutic approaches. After a comprehensive case history and assessment has been conducted, a structured CBT approach proceeds through the following steps.

Creating a Cognitive Behavioural Formulation

A formulation can be viewed as a 'map' that helps the therapist and client navigate the process of therapy towards the goals that the client has set. It provides understanding, direction, focus areas and resolutions for stuck moments when therapists may be at a loss for what to do to emerge out of a stalemate. However, this is not set in stone and can shift dynamically as more information and data emerge during therapy. The formulation process begins right from the first session and flows from the cognitive model described below.

A central tenet of the CBT approach is this: "It is not a situation in and of itself that determines what people feel, but rather how they *construe* a situation" (Beck, 1964; Ellis, 1962). Therefore, depending on how an event is interpreted or viewed determines how one eventually reacts to it. To illustrate this, let's return to Fig. 17.2

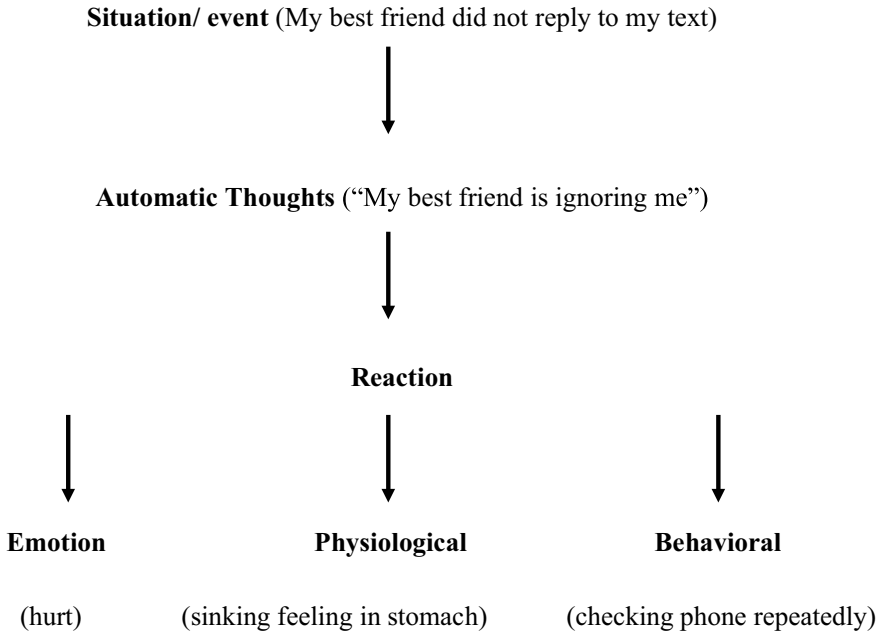


Fig. 17.2 The cognitive model

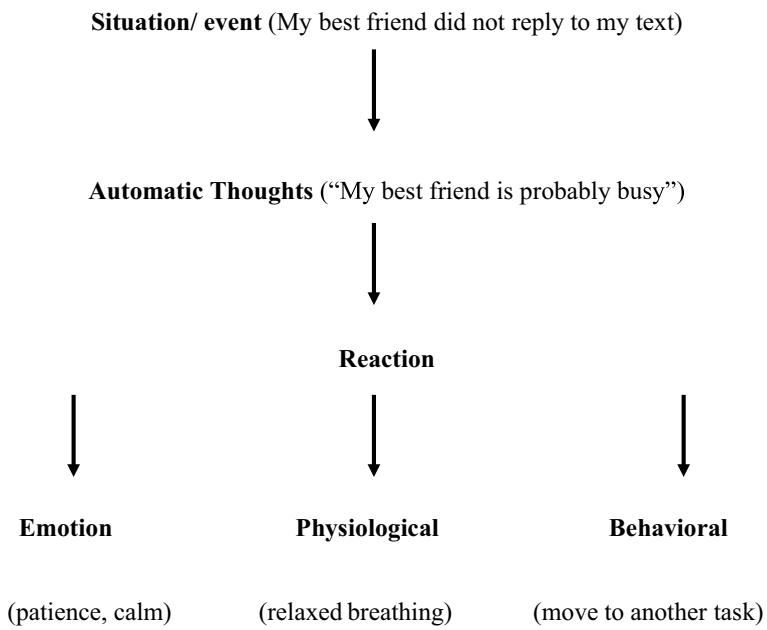


Fig. 17.3 The cognitive model with alternative interpretation

and see how the same situation may give rise to entirely different reactions if one's way of thinking about it changes.

As seen in Fig. 17.3, perception of a situation, rather than the situation itself is key. Automatic thoughts are 'spontaneous, rapid and brief' (Beck, 2011) and arise in response to events or situations, followed by a physiological, emotional, or behavioural reaction, even without individuals pausing to examine them. It follows then, that a critical evaluation of such thoughts can often reveal them to be biased and without evidence and offers an opportunity to change one's reaction by changing the thoughts themselves.

But what explains this difference in interpretation of the same situation between individuals? This brings us to an additional component of the cognitive model-beliefs. Beliefs are persistent and enduring ways of looking at the world, developed through one's early experiences and socialization in family and social systems. They possess the following characteristics:

1. Some beliefs are more 'core' and others could be more peripheral. The more central a belief is, the more likely it is to influence thinking when activated.
2. Beliefs can be activated by a triggering event—a person's words, non-verbal expressions, actions, etc.—or can even be operated without an identifiable cue. Either way, they serve as the dominant force in determining one's worldview.

3. They are treated as absolute truths by the person possessing them, and so the thoughts that they give rise to are also accepted unquestioningly, even if not supported by facts.
4. Individuals tend to attend to information that supports their core beliefs and disregard information that does not fit their narrative.
5. Core beliefs can give rise to an intermediate set of beliefs held in the form of rules, attitudes, or assumptions that impact automatic thoughts.
6. The information processing described above usually occurs without a person's awareness.

Integrating the above with the cognitive model described so far and the two examples discussed above, the expanded cognitive model now looks like this for two persons with distinct experiences and core beliefs (Fig. 17.4).

A case conceptualization is developed by gathering data about the presenting problems, assessment data, history of precipitating factors, early childhood experiences, developmental milestones, relationship history, common ways of thinking and responding to situations, and mapped onto the above model. This model is then revised and updated as more information becomes available and used to select and implement interventions.

Developing and Introducing the Treatment Plan

The provisional cognitive formulation described above will guide the treatment plan for a particular client. Using information gathered in Step 1, the therapist factors in the family circumstances, temperamental considerations, quality of support available, history of substance use, and socio-cultural factors to develop a unique plan for each child. Factors that may get in the way of delivering interventions will also prove to be important considerations while planning. For example, a child with obsessive thoughts that are followed by compulsions will have a different treatment plan involving exposure and other behavioural interventions than a depressed child with low self-esteem and self-doubt who would need cognitive interventions to manage thoughts.

It is generally recommended that adolescents be introduced to the treatment model the way adults would be (Beck & Beck, 1995). However some additional tools may be employed to enhance clarity of the process. For example, a standard thought record may be used to break down an experience into its components and then make connections between thoughts and feelings as in the figure below (adapted from Friedberg & McClure, 2015) (Table 17.1).

1. Step 1: Ask client to pick an important event from the last week. Enter that in the 'situation' column.
2. Step 2: Ask client to list all the feelings he/she might have felt when the situation occurred. Enter those in the column marked 'feelings'.

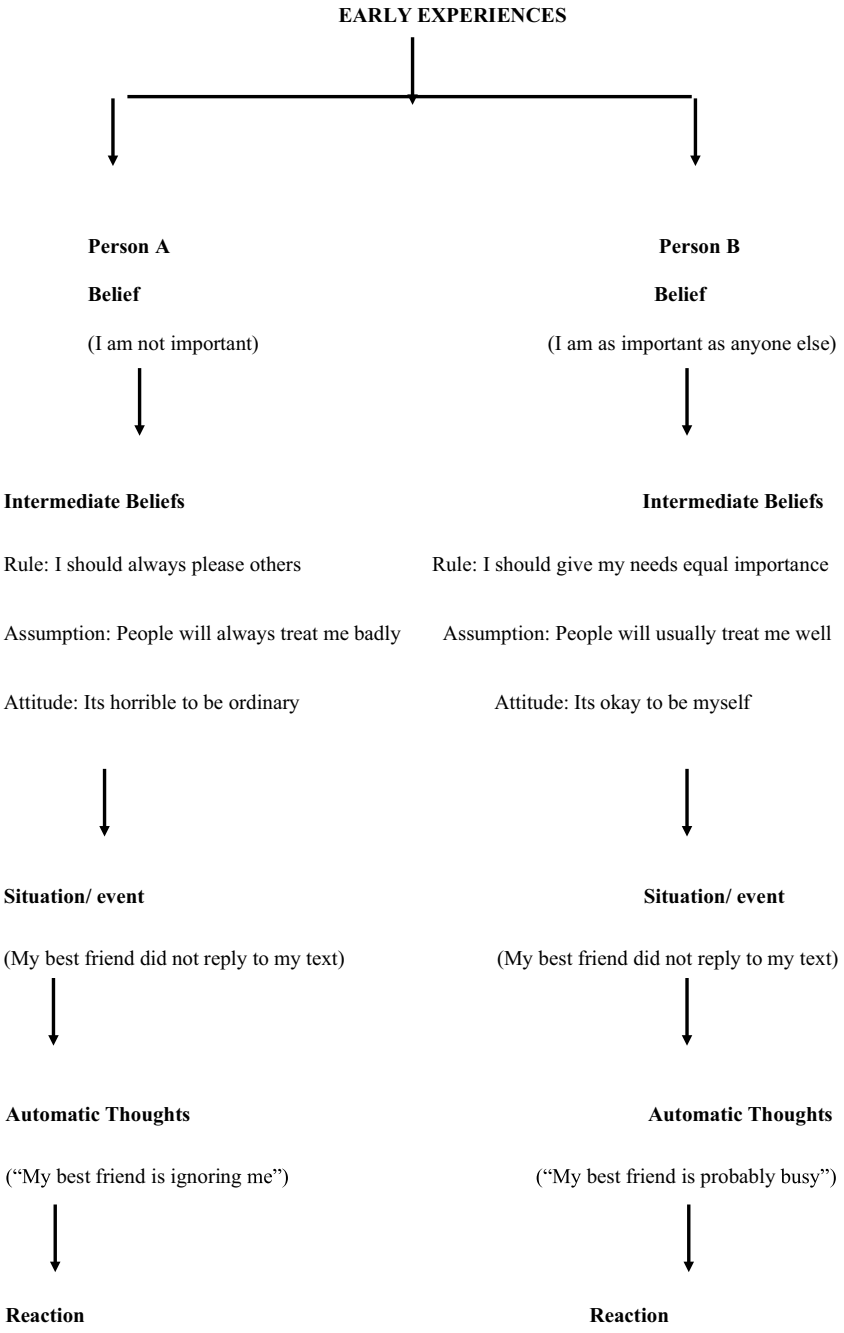


Fig. 17.4 Integrated cognitive model

Table 17.1 Use of thought record to explain treatment process

Situation	Thoughts	Feelings
My best friend did not answer my call	Hope my friend is okay	Worried
	My friend is ignoring me	Anxious
	My friend has never done this before	Confused

3. Step 3: The middle column is filled last. The client is asked to list out all possible thoughts/explanations/reasons/possibilities that might be associated with the situation.
4. Step 4: Make connections between thoughts and feelings explicit by stressing that each thought gives rise to a unique feeling. At this point, the therapist may use lines or colour coding to show these connections.
5. Step 5: Ask client "Which thought is accurate?" Young clients generally respond by saying that they don't know or they would have to find out. Either of these responses could be used as cues to explain that CBT helps them access ways in which they might find out how accurate their thoughts are so that what they feel is connected with what is actually happening rather than what they might assume or wonder about.

Creating a Session Plan and Structure

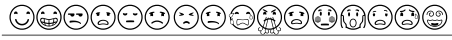
There are six elements of a standard CBT session (Friedberg & McClure, 2015):

1. Mood check-in.
2. Homework review.
3. Agenda setting.
4. Session content.
5. Homework assignment.
6. Eliciting client feedback.

The above session structure provides an organizing framework for coherent and focused work during each meeting with a client. A mood check-in is important so that progress is monitored and in case there is suicidal risk, there is enough time during the rest of the session to prioritize and attend to it. However, all adolescents may not be equally skilled at identifying their mood states or differentiating between intensities. Scaling questions and mood tracking worksheets may be used to elicit information. A scaling question often asks a client to rate a particular emotion on a scale of 1 to 10 or 0 to 100, wherein increasing magnitude reflects greater intensity. In this way, subjective ratings can also be compared across several weeks.

There are many variations on mood tracking methods. A sample tracker for use with younger adolescents is provided below (Table 17.2).

Table 17.2 Sample mood chart

Day	Morning mood	Evening mood
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday/Sunday		
		

It is also important to go through the homework assignment early in session. This has two functions—insights from the assignments can be utilized in session, and secondly importance of homework is emphasized due to consistent reviews. The session agenda is set collaboratively between client and therapist and may include items from the homework and mood check-in. Based on the main session content, relevant homework assignments are designed for the forthcoming week. Ongoing feedback from the client is another key ingredient of therapy—the client may be asked to share thoughts and feelings about the session experience or even the therapy process itself in order to help the therapist calibrate therapy and possibly prevent dropout. The predictability and consistent implementation of such a structure discourages unfocused conversations, utilizes session time efficiently, and provides adolescents with a sense of safety, containment, and control which may be absent in their environment outside the therapy office (Friedberg & McClure, 2015).

Selecting Session Content

This section describes selected CBT techniques that may be used to fulfill certain objectives in a particular session. The description of each technique is followed by its appropriate uses.

Cognitive Techniques

1. Socratic dialogue and examining evidence

A starting point in adopting Socratic dialogue is to start without the assumption that a particular thought is inaccurate or irrational. The idea is to use the spirit of discovery to examine thoughts to check their validity with an open mind like helping a child 'assemble a puzzle' (Overholser, 1993), as opposed to unchallenged acceptance of assumptions and distorted processing of facts.

Table 17.3 Examples of Socratic questions

Standard form	Modified form
1. What is the evidence for this thought? 2. What is the evidence against this thought?	Tell me how you know that your friend is ignoring you… What are the clues that they are not ignoring you?
1. What is an alternative explanation for this?	Let's see if there's another way of looking at this… Could another person (friend/parent/teacher) see it differently? What reasons might they give?
1. What are the advantages of thinking in this way? 2. What are the disadvantages?	In what way does this way of thinking help you? In what way is this unhelpful?
1. What is the worst that could happen? 2. What is the best that could happen? 3. What is the most realistic outcome?	(Use as it is in the Standard form))

Some examples of Socratic questions and their corresponding versions framed to be less threatening and interrogative for young adolescents are given in Table 17.3.

Use for:

- Evaluating automatic thoughts
- Framing alternative, balanced ways of viewing a situation.
- Coping self-talk.

During the stage of thought identification and eliciting beliefs, the therapist would have helped the client identify self- defeating and dysfunctional thoughts that may be seen as a sort of internal dialogue that gets amplified in certain situations. Replacing this internal dialogue with more balanced self-talk helps to break this cycle. For example, saying to self—"I'm never going to finish this chapter in time for tomorrow's exam"—may be more realistically stated as "I have finished half of this, I have the other half to go"; or "No one is going to talk to me in school today" may be reframed as "This is scary and new but I'm going to try and say hi to my deskmate". Self-statements could even be written on physical "coping cards" or digital notes saved on the client's phone so that statements can be prepared in advance and accessed as reminders when the situation arises. The latter may be welcomed as a less conspicuous and more accessible medium.

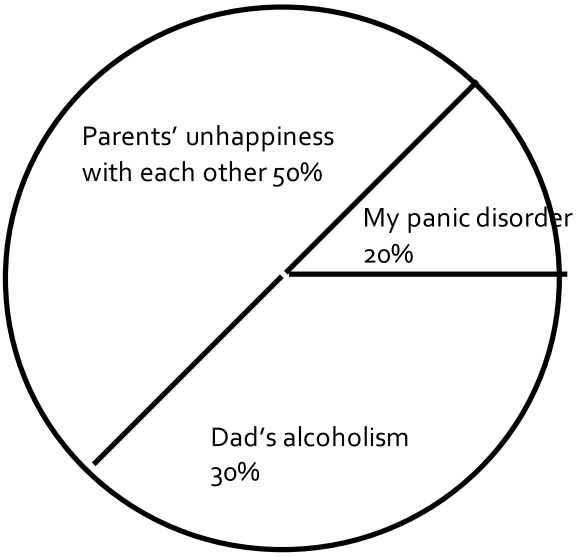
2. Worry time

Since worry is a common derailer for adolescents with anxiety issues, clients are encouraged to encapsulate the time they devote to worry so that they can focus on other tasks through the day, while not entirely dismissing worries either. The therapist and client decide on a 'worry time' of a realistic duration that the client will use each day for nothing but worrying. When worries arise at other times in the day, the client can write them down to be thought about later during the worry time and move back

to the task at hand. During worry time, he/she can look at the list and see which of the issues there are still problematic and need problem-solving and which ones are no longer relevant.

3. Responsibility pie.

This is a reattribution technique in which the client is encouraged to evaluate alternative explanations instead of owning a disproportionate amount of responsibility for something, especially when the situation involves events that they realistically have no control over. The process is begun by asking the client to list out all possible reasons for the occurrence of an event. The client's explanation is also taken into account but usually listed right at the end so that he/she has time to process all other alternatives first. Given the assumption that the total area of the pie is equivalent to 100% (as probabilities are), the child is facilitated to attribute each 'slice' of the pie to each of the listed reasons or factors on basis of the likely contribution of each to the overall event. A sample pie for a child who feels guilty and responsible for their parent's divorce might look as follows:



Use for:

- Reattribution of guilt.
- Challenging black and white thinking.
- Challenging overgeneralizations.

Behavioural Techniques

1. **Relaxation training**

This set of techniques has many variations with the common objective of reducing muscle tension and autonomic arousal. A simple, mindful breathing technique is described in Think Good Feel Good-A CBT-based workbook for children (Stallard, 2019; pg. 59). Progressive muscular relaxation or PMR takes a different approach wherein muscles are first tensed and then relaxed, often individually or in large muscle groups. While standard relaxation training scripts are extensively available, certain developmental considerations would serve the goal better. For example, inclusion of imagery helps the adolescent to focus. A case in point is the ten candles technique (Friedberg & McClure, 2015).

Use for:

- Anxiety.
- Anger regulation.

2. **Systematic desensitization**

This technique is based on the principles of counterconditioning derived from behaviour therapy—an experimental procedure in which an organism already conditioned to respond to a stimulus in a particular way, "is trained to produce a different response to the same stimulus that is incompatible with the original response" (American Psychological Association, 2020).

It works by reciprocal inhibition—since anxiety and relaxation are incompatible, inducing a relaxed state when being exposed to an anxiety triggering stimulus inhibits anxiety. Designing systematic desensitization involves certain steps:

1. Identify the fear or phobia.
2. Coach client in deep muscle relaxation.
3. Create a fear hierarchy in ascending order of intensity. A sample hierarchy for fear of dogs is provided below.
4. Starting at the item located at the least level of fear in the hierarchy, the client practices relaxation exercises as he/she is exposed to the corresponding stimulus. Once the client reaches a point where they do not experience unsafe levels of anxiety any longer for that item, he/she moves to the next item. This procedure is repeated for all items sequentially (Table 17.4).

Use for:

- Intense fears.
- Phobias.

3. **Role plays**

Role playing is a very common behavioural technique not only used independently but also often utilized as a part of a broader intervention such as social skills or assertiveness training described later in this chapter. Such simulations can be employed with adolescents to gauge their thoughts and feelings about a figure in their lives by inviting them to 'play' the person so that the therapist can assess how the client experiences him/ her. Gathering background information about this figure,

Table 17.4 Sample fear hierarchy

Behaviour	Fear intensity in subjective units of distress (SUD)
Think of a dog	20
Look at a picture of a dog	30
Look at a real dog on a leash	40
Stand within 10 m of the dog on a leash	50
Stand within 5 m of the dog on a leash	60
Pat a dog on the back of its head while it is being held by someone	70
Take a dog for a 5 min walk along with another person	80
Take a dog for a 10 min walk alone	90
Hug a dog	100

such as tone of voice, mannerisms, typical phrases used, etc., can help the therapist to create more realistic role plays wherein the therapist plays the figure (e.g., a bully) and the child practices how to respond to this person in the safe therapeutic space before trying out the skill in the actual situation.

Use for:

- Problem assessment, wherein a client models challenging behaviour for the therapist.
- Practicing social skills.

4. **Social skills training**

Social interactions and challenges therein contribute to common adolescent issues, especially among peers. This makes social skills training an important component of CBT for this group. The broad design of such an intervention includes identifying and defining the behaviour that needs to be developed or as in the case of aggression, reduced. The targeted skill is first taught to the child through direct instruction and demonstration. Age appropriate worksheets and material can be supplemented with the therapist demonstrating a particular technique or models of similar age as the client modelling a behaviour. Demonstration videos can also be utilized. Role playing as described above can be utilized next, to practice the skills and subequent repeated behavioural rehearsal often consolidates the skill further. Supportive feedback is provided to the young client in very specific terms so that he/she has a clear idea of what aspects of the skill worked well and which ones need further development. As a final step, the client is encouraged to practice the behaviour in 'real-world' settings and demonstration of targeted behaviour is positively reinforced to build confidence.

Videos can also be customized and created to demonstrate specific social skills or to record the client in action followed by constructive and supportive feedback.

Use for:

- Difficulty in making friends or initiating social contacts.
- Managing own anger and aggression.
- Learning to be more assertive.
- Requesting help.

5. **Contingency management**

Contingency management approaches are based on operant learning principles whereby behaviours that are followed by desirable rewards increase in frequency and those followed by negative consequences decrease in frequency and/or intensity. The first step would be to define the desirable behaviour in specific, measurable, and concrete terms. An example of such a definition would be: Anish will exercise for 30 minutes at a time on 4 days each week. This behaviour is then tracked through a week and Anish receives a reward when he performs this behaviour for the targeted frequency and time. In Anish's example, it could be a dinner outing or permission for a sleepover or anything else that is significant and carries value for him. It is important to remember that the reinforcement should only be delivered when the entire target is met and should be consistent in order to be used effectively.

Use for:

- Developing new, desirable behaviours.
- Extinction of problematic behaviours or non-desirable behaviours.

6. **Activity scheduling**

Activity scheduling is utilized to include pleasant and positively reinforcing activities in a client's routine. Continuing the collaborative approach that underlines CBT, the therapist works with the client to list out activities that he/she enjoys or would like to try and includes these at specific timings and days during a typical week. A sample activity schedule is presented in Table 17.5.

The key features of the above activity schedule are that it keeps some activities constant, while introducing variations in others, there is balance of 'fun' and 'achievement' which is a key component of behavioural activation and there is plenty of space for rest and recuperation so that the client does not feel overscheduled.

Use for:

- Behavioural activation for depressed clients.
- Establishing routines.
- Increasing positively reinforcing activities in daily life.

Other Techniques

1. **Problem-solving**

Problems and decisions are an integral part of our everyday experience as human beings. Yet, we seldom receive formal training on how to do these critical tasks. Most of us learn these skills as we go along, often through trial and error. However, not

Table 17.5 Activity schedule

Time	MON	TUE	WED	THURS	FRI	SAT	SUN
7–8 am	Wake up + bathe + eat breakfast	Wake up + bathe + eat breakfast	Wake up + bathe + eat breakfast	Wake up + bathe + eat breakfast	Wake up + bathe + eat breakfast	Wake up + bathe + eat breakfast	
8–9 am	Reach school + classes	Reach school + classes	Reach school + classes	Reach school + classes	Reach school + classes	Lab work	Wake up
9–10 am	Classes	Classes	Classes	Classes	Classes	Lab work	Leisure/choose activity
10–11 am	Classes	Classes	Classes	Classes	Classes	Lab work	Leisure
11–12 noon	Classes	Classes	Classes	Classes	Classes	Lab work	Leisure
12–1 pm	Classes	Classes	Classes	Classes	Classes	Lab work	Leisure
1–2 pm	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch
2–3 pm	Rest	Rest	Rest	Rest	Rest	Rest	Rest
3–4 pm	Tuitions	Tuitions	Tuitions	Tuitions	Tuitions	Tuitions	Rest
4–5 pm	Tuitions	Tuitions	Tuitions	Tuitions	Tuitions	Tuitions	Leisure/ choose activity
5–6 pm	Tuitions	Guitar class	Sports	Tuitions	Sports	Guitar class	Leisure
6–7 pm	Dance class	Sports	Dance class	Sports	Dance class	Theatre	Go out with friends/parents
7–8 pm	Free time	Free time	Free time	Free time	Free time	Free time	Go out with friends/parents
8–9 pm	Dinner	Dinner	Dinner	Dinner	Dinner	Dinner	Dinner
9–10 pm	Study/H.W	Study/H.W	Study/H.W	Study/H.W	Study/H.W	Study/H.W	Study/H.W
10–11 pm	Read + Go to bed	Read + Go to bed	Read + Go to bed	Read + Go to bed	Read + Go to bed	Read + Go to bed	Read + Go to bed

everyone acquires these skills successfully through experience, especially during the younger years when experience itself has been limited. Thus, acquisition of these skills in therapy is a common client goal. A significant chunk of problem-solving includes making decisions. The standard steps in problem-solving are:

1. Identify and define a problem in specific terms.
2. Brainstorm and list solutions.
3. Evaluate pros and cons.
4. Select a solution.
5. Implement the solution.
6. Evaluate its effectiveness.

(Adapted from Beck, 2011). The therapist's role is to enable the client to move through these steps by asking facilitative questions and encouraging analysis and reflection on the problem at hand.

2. **Behavioural experiments**

While cognitive techniques are very useful in identifying and challenging thoughts, learnings sometimes need to be consolidated by actually testing out conclusions through 'real-world' experiments. For example, an adolescent who has a fear of public speaking may consistently predict that his classmates may be able to see his sweaty palms and hear his shaky voice when he presents a class project. The therapist encourages him to predict these possibilities by assigning the degree to which he is certain that these two things will happen. Then, the client is encouraged to test this out by making the presentation and following this up by enlisting the help of two friends that he trusts, to get feedback on the degree to which they noticed these behaviours in him. This is followed up by re-rating the degree of certainty post-event.

Use for:

- Failure cognitions.
- Challenging catastrophic thinking.

There are some excellent CBT workbooks that therapists can integrate in their in-session work with an adolescent. A good option is 'Think Good, Feel Good' by Paul Stallard (2019).

There are several other CBT techniques that are employed in therapy with adolescents and this is by no means a comprehensive review. However, these are the most common and basic techniques utilized with this population. Moreover, techniques will vary with the type of issues that an adolescent brings to therapy. Specific formulations and techniques for various disorders are beyond the scope of this chapter.

3. **Homework**

Between session work is a key component of CBT. It allows clients to try out and gather feedback on how the CBT techniques they learn in session may be working for them and which aspects need more clarification or practice. This is often referred to as 'homework', a term which may bring up unpleasant associations for adolescents. It is

often useful to replace this term with 'assignments', 'skill practice', or ask the client what they would like to call it, thus developing one's own unique therapy language. Regardless of what it is called, there are several guidelines to using homework in a way that its maximum benefits can be reaped (many of these apply to adults as well):

- Homework tasks should be relevant to the presenting complaints and central issues that the client brings to therapy.
- Enough time should be devoted in session to ensure that the task is well understood so that the child does not experience difficulties later.
- It is helpful to ask the client what might get in the way of doing the homework. This helps both the therapist and client anticipate problems, and remove obstacles by planning ahead and problem-solving. For example, assuming that an adolescent can make their own activity schedule may lead to non-compliance.
- Homework is always collaboratively designed. Tasks that are imposed on clients may cue defiance and the therapist risks being associated with other authority figures leading to ruptures in the therapeutic alliance.
- It is often useful to demonstrate the task in session or even begin it during the session so as to begin in a graded way, giving the client a head start and getting a sense of what might be challenging for them to do on their own and problem-solve in advance (Freidberg & McClure, 2015).
- If homework is assigned, it should be reviewed without fail and early on in the session. Inconsistent monitoring of homework send out mixed messages about its importance in the therapy process and may lead to inconsistent compliance.

Despite using the strategies described above, it is possible that non-compliance still remains an issue in therapy. If so, it is never ignored. The therapist needs to work with the client in assessing what might be getting in the way and actively targeting it. For example, if fear of failure extends to not doing homework, a therapist may try and elicit automatic thoughts that are cued by the task and challenge them through examining the evidence or Socratic dialogue.

Critical Issues in Therapy Delivery for Adolescents

Many of the central tenets of CBT apply across age groups. Collaborative empiricism and guided discovery are employed with adolescents as well. Therapy structure, agenda setting, progress monitoring, and homework tasks are retained in adolescent work.

However, many features of standard CBT require adaptation to adolescent needs:

1. Not all adolescents enter therapy of their own volition. This is especially seen with externalizing problems wherein the adolescent client may be brought in by a parent who has 'had enough' or when the school has given an ultimatum to the parents to correct the behaviour. Similarly, several key decisions regarding how

often the client will come or when therapy will end could be made by parents, considering that they support the client financially.

2. The therapeutic alliance may be challenging to build at first. Adolescents who come into therapy will often report histories of mistrust and authority problems and this has ramifications for the adult occupying the therapist's chair as well. Even developmentally normative adolescents would be undergoing strivings for autonomy which could interfere in the formation and maintenance of a therapeutic alliance (Bennett et al., 2013). The therapist stance in CBT is that of a consultant-coach. Retaining the overall spirit of collaboration in which a CBT therapist facilitates and discovers strategies alongside the client without direct advice, the therapist centres their work around a collaborative orientation. Alongside this, the therapist offers some strategies that clients can try out to examine their thought patterns and solve problems systematically. A specific, therapist-decided solution is never enforced, except in the case of suicidal behaviour when crisis management strategies would need to be adhered to.
3. Some level of confidentiality will have to be maintained while working with adolescents to retain their trust and address issues from a non-moralistic or paternalistic frame. However, limited but timely parental involvement may improve outcomes. Their role could extend to implementing reinforcement contingencies at home, aiding their children in behavioural experiments or skill practice or encouraging autonomous decision-making to increase confidence and other such strategies, depending on the profile of presenting issues and degree of support available in the family system. In some cases, it may be advisable to even engage parents as co-clients if they are contributing in the creation and/or maintenance of problems of an adolescent client. Sometimes, even teachers may need to be involved. Engaging parents and teachers (where feasible) in the process by providing psychoeducation at the beginning of therapy may go a long way in improving engagement and overall outcomes.
4. Some small sample studies indicate that CBT with adolescents may not yield the same efficacious results as with adults because of developmental challenges and increased anxiety issues (Bennett et al., 2013; Pattwell et al., 2013). While formulating a therapy plan for children, a thorough developmental assessment of the child is vital to profile his or her adaptive capabilities for CBT (Halder & Mahato, 2019). Verbal and cognitive interventions would need to be tailored to the language and reasoning abilities of the adolescent to avoid the possibility that they might feel overwhelmed too quickly.
5. Therapists may benefit from transcending diagnostic labels while working with adolescents to reduce stigmatization and avoidance of internalization of such labels as part of their developing identity.
6. A thorough history and case work-up is very essential to identify co-morbidities early on so that therapy derailment is avoided in due course. Halder and Mahato (2019) identify adolescent co-morbidities as a significant challenge in therapy

and recommend that an eclectic approach integrating a suite of theoretical orientations and techniques be adopted for treating such conditions, instead of rigidly implementing the standard CBT model.

7. The adolescent should be matched with a therapist who is fluent in the language that the former understands and feels confident in communicating with. Cultural competence of the therapist would also be an important factor in establishing a strong and congruent therapeutic alliance not only with the client but also with the parents.
8. The therapist should be prepared to coordinate with professionals from various disciplines involved in caring for the child. Comprehensive treatment may include the participation of a psychiatrist, an occupational therapist, and a speech therapist instead of CBT being delivered in isolation by a psychologist.

CBT and Future Directions

Adolescents today, even in small towns in India, are quite technologically literate. This presents a valuable opportunity to deliver CBT through smartphones or computer-assisted technologies to those who reside in semi-urban areas where trained therapists are not available to deliver interventions. This approach also bypasses issues around embarrassment and stigma associated with going to a mental health clinic. SMARTTEEN is one such computer-assisted intervention for adolescents with depression which has been pilot tested recently (Srivastava et al., 2020). The study was conducted with 21 adolescents with unipolar depression who were assigned to either SMARTTEEN or treatment as usual groups. The groups were assessed at baseline, 6 weeks and at 12 weeks after completion. The SMARTTEEN group was significantly more effective in reducing depressive symptoms at 12 weeks and also showed better treatment compliance.

Technological innovations can also be used to augment clinic services, such as in the gamification of therapy. Donovan et al. (2013) describe the use of a computer game similar to Dungeons and Dragons Adventure by Clarke and Schoech wherein one must pass levels and rooms by using skills in problem-solving and impulse control. A recent meta-analysis of computerized CBT or c-CBT by Christ et al. (2020) revealed that the approach is effective in reducing anxiety and depression in adolescents and young adults, as compared to controls.

Although more evaluative studies are needed for this innovation, it certainly holds the potential to bridge gaps in CBT treatment delivery for this group. However, even if such modalities are scaled up, certain obstacles are likely to remain. If delivered through the Internet, poor connectivity in many parts of India may be a hindrance. Additionally, adolescents in rural areas may still not have access to such innovations unless the Government adopts these on a larger scale and provides supporting resources to families.

Indian Perspective

While the preceding sections describe the standard CBT approach, some additional considerations may apply while implementing the approach in the Indian context. The largest number of children and adolescents in the world reside in urban India (NIUA, 2020). Estimates peg the prevalence of high stress levels among school going urban adolescents at 1 in 5. Most commonly identified stressors in this population in order of salience are academic pressure, romantic relationships, and negotiating autonomy (Parikh et al., 2019). Estimates regarding mental health show wide variations across states and research methodologies but the National Mental Health Survey (2016) reported that the prevalence of mental disorders was 7.3% among children aged 13–17 and the prevalence among urban children was nearly double (13.5%) as compared to rural children (6.9%) at the time of the survey. Factors that impact the design and delivery of CBT interventions for Indian adolescents include the following:

1. Barriers in service access and delivery: Stigma about mental health and non-recognition of mental health problems by parents and caregivers act as barriers in accessing professional services (Nebhinani & Jain, 2019).
2. Lack of nationwide policy: There is no policy for child and adolescent mental health in India (Hossain & Purohit, 2019) which significantly limits access to evidence-based treatments such as CBT.
3. Limited applications of the standard CBT model: Halder and Mahato (2019) have identified that delivery of CBT is often limited to a focus on behavioural interventions rather than cognitive ones to restructure cognitions and correct cognitive errors. Selvapandiyan (2019) in his review has also observed that most CBT studies in India suffer from treatment fidelity issues. Further, he emphasizes a clear understanding of and training in the use of CBT therapeutic components to deliver it properly to adolescents.
4. Literacy and language barriers: CBT relies heavily on the assumption that the client is literate and is able to absorb and utilize a vocabulary for thoughts and emotions. This may not apply to adolescents who have co-morbid speech and language difficulties or even those who are based in rural settings instead of urban locations. This may limit the range of applicability of CBT interventions on Indian adolescents unless interventions are adapted to meet local needs without compromising on fidelity to the treatment model.
5. Affordability: Therapy fees in India, while much lower than global standards, can still be relatively high for parents of adolescents. There may be a tendency to view medication more favourably as a tangible, visible intervention as opposed to therapy which may be seen as ‘just talking’ and therefore not worthy of the fees charged. As a non-academic investment, parents may not value psychotherapeutic interventions including CBT, as much as disciplinary or coercive parenting techniques.

Conclusion

Cognitive behaviour therapy remains one of the most well-known evidence-based approaches to psychotherapy across various age groups. With its emphasis on tangible problem-solving strategies and time-oriented structure, it is used extensively with adults- a population which is able to articulate goals clearly and pursue change proactively. However, adolescence presents distinctive cognitive processing and emotion regulation demands, which call for a tailored approach and a collaborator-coach stance from the therapist. Basic guiding principles of cognitive behaviour therapy can be effectively integrated with specific developmental challenges in adolescence to deliver a therapy modality that is efficacious and effective for this group. This chapter includes contemporary perspectives from cognitive and emotion science to explain common adolescent issues and emphasizes how CBT with adolescents differs from the therapeutic approach to adult clients. It discusses practical strategies for identifying problems, managing a therapeutic relationship and targeted interventions to help adolescent clients bring about change. Innovations in the use of CBT, especially the use of technology, need to be emphasized and explored further as the digital world is the proverbial 'second world' for the present generation of adolescents and will continue to be so. Challenges of using CBT in Indian settings specific to the socio-cultural context require attention for the successful implementation of CBT for adolescents.

Time to Reflect

CBT is a widely used intervention having universal acceptability and validity. However, adolescence is a multidimensional construct having multiple influences on it. In this context, how can we adapt CBT further in the specific socio-cultural-developmental-economic context while keeping the basic tenets intact? Further, what is the implication of the fact that adolescent cognitive development is still in process whereas CBT focuses on working with cognition? Given the collectivistic culture of India where conformity to hierarchy is valued, how does it influence the emotional expression, emotion regulation, and emotional competence development of adolescents, which forms an important part of CBT? Reflect on the varied considerations to be looked into while providing CBT for adolescents in the diversity context of India.

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Chapter 18
Family-Based Interventions with Adolescents

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Abstract The chapter focuses on the role of families in adolescent development and the need for family-based interventions with adolescence, especially in the context of various disorders. Various family therapies, their key strategies, goals, and techniques are elaborated. Process of implementing these interventions keeping in view the special needs of adolescents and cultural factors has been highlighted. Since adolescence is a major transitional period, it is important to understand the adolescent in the context of family dynamics and relation that will help deal with the challenges of this stage of development.

Keywords Family · Family therapy · Adolescents · Family-based interventions · Parent-focused interventions · Interpersonal psychotherapy

Introduction

Family is a dynamic concept in a constantly changing and diversifying culture. The socio-cultural factors define to a large extent the definitional interpretation of the term. One of the most recent and comprehensive cultural understanding of "Family" in India has been that it is "*people related by marriage, birth, consanguinity or legal adoption, who share a common kitchen and financial resources on a regular basis*" (Sharma, 2013). In the context of children and adolescent, the definition can be specified further to refer to "*individuals who have regular contact with its children and assume the responsibility of meeting their developmental and emotional needs*" (Josephson, 2015). Thus, the definitions indicate that in a family, individuals live together, engage in a regular interpersonal interaction, and there is a mutuality in the relationship. These very characteristics define family to a large extent, and whenever there are any disruptions in achieving this state, it may lead to various forms of distress in family members. The dysfunctional interaction within the family impacts

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the development and adjustment of adolescents, indicating need for intervention at the family level.

'Family therapy' is the most commonly used term which is often associated with the notion of family members sitting together with the therapist and moving towards a common goal. However, Josephson (2015) points out that the notion of 'family as a system' is no longer the only key component of the intervention. Rather the definition has been broadened to include active therapeutic work on various specific aspects of the family, such as family communication, family environment, parenting practices, etc., which aims not only at symptom amelioration but to address factors that impede child and adolescent development (Josephson, 2015). Hence, the term 'family-based intervention' (FBI), which is the focus of this chapter, has been used as a comprehensive concept assuming that children and adolescents typically live in families and intervention incorporates range of approaches which assists them in being more effective in their environment (Rickerby & Roesler, 2015).

Need for Family-Based Interventions in Adolescents

Literature documents that the family plays an important role in the optimal development of adolescents (Baluster & Hammond, 2016; Fernández et al., 2018; King et al., 2018). The interpersonal context in which adolescents expand themselves mostly includes adolescents' own psychosocial development (biological, cognitive, and social developments), their significant familial and extra familial relationships, social institutions in their vicinity, and the larger zeitgeists within which they find themselves in. Some examples of these developmental contexts are adjusting to puberty, developing peer relationship, understanding one's sexuality, consolidating an identity, and preparing oneself to leave home (during late adolescents). Though the developmental tasks are often sequential and cumulative, the demands during this phase of transition to adulthood sometimes may overwhelm the adolescents' ability to cope, leading to manifestation of various adolescent pathologies. It is here when families can act as a buffer to the onset of mental health issues.

Family thus acts both as a protective factor and a risk factor for development of adolescents' difficulties. Family attachment, supportive relationships, extended family support, adequate socio-economic status, and acculturation are some of the important protective factors identified in the literature (Muchiri & Santos, 2018; Folger & Wright, 2013; Gregory et al., 2020). Similarly, the level of financial, emotional, physical, and medical support provided by parents enhances adolescents' executive, relational, vocational, and academic functioning. Parents act as scaffolding or safety nets for the emotional and economic development of adolescents (Suleiman & Dahl, 2019). Factors like absence of early separation, secure attachment, authoritative parenting, and involvement of father's in child rearing process have been associated with development of resilience in adolescence (Firoze & Sathar, 2018; O'Gara et al., 2020; Suizzo et al., 2017).

The familial risk factors are also of various nature, such as single parents, familial conflicts, parental strain, family history of psychiatric illness (genetic load), poverty, loss of a family member, etc., which lead to development of adolescents' mental health issues (Dhondt et al., 2019; Eiden et al., 2020).

Similarly, presence of parental psychopathology has been documented to interfere with effective parenting (Rasing et al., 2020; LeMoine et al., 2018). Parenting styles may not be effective due to the presence of psychopathology arising due to various disorders like psychosis, depression, substance abuse, and so forth resulting in detrimental effects on adolescent development. Presence of physical and sexual abuse, neglect, attachment problems, parental mental illness and family conflict, stress, and breakdown in the family environment are often linked to adolescent psychopathology (Daryani et al., 2016; Harold et al., 2017; Vezzetti, 2016; Lau et al., 2018).

Parenting styles have also been documented to be another crucial dynamic factor affecting the adolescent's developmental progression. It affects the development of autonomy in adolescents in terms of greater interpersonal boundaries, independent decision-making, and responsibility and self-regulation skills. On the other hand, greater parental authority, demonstrated through psychological and behavioural control may inhibit the development of autonomy and self-regulation in adolescent (Inguglia et al., 2015; Shen et al., 2018; Costa et al., 2016).

Overall, family processes play a pivotal role in the socio-emotional and cognitive development of adolescents, failure of which may lead to various kinds of distress in adolescents. When adolescent's efforts at individuation are encouraged within family system and an environment of emotional connectedness and support is provided, continued growth and development ensues. Though this forms part of a healthy developing family, often disruption in any of these processes may lead to significant difficulties and may need to be addressed through interventions that are family based (FBI).

Indications for Family-Based Interventions (FBI)

Since family factors are implicated in most clinical cases of adolescent, it is important to understand when exactly there is a need for specific and in-depth FBI. Josephson (2015) defines following four circumstances when FBI should be considered for referral. These are given as follows:

1. The clinical presentation of symptoms has underlying interactional dysfunctions. This includes range of presentations like aggression towards parents, running away from home, physical or sexual abuse, and other forms of behavioural problems.
2. When psychopathology in parents severely impacts parenting patterns and behaviour.
3. There is a clearly identifiable family contribution towards psychiatric presentation in adolescents (Diamond & Josephson, 2005).

4. Psychiatric disorders in adolescents, where even though family processes are not involved in the development of problem, but their role would be significant in ensuring holistic recovery (Diamond & Josephson, 2005).

Though these four factors should always necessitate an immediate referral for FBI, role of family, either as etiological or exacerbating factor, should always be considered during each clinical encounter of adolescents in clinical setting.

Goals of Family-Based Interventions for Adolescents

It's important to have well-defined goals in treatment prior to initiation of any family-based intervention. Therapist can help families to come up with achievable, straightforward, and measurable treatment goals. Adolescent's expectation and family's expectation from the intervention are asked separately as these might not be mutually inclusive. The more specific and inclusive the goals are, the more motivated will the families be to engage and participate in the sessions. The formulation of goals is dependent upon the nature of case presented as well as theoretical model of FBI employed.

Broadly, however, the approach of the therapist is to educate and emphatically support a family dealing with adolescent's illness or it could be to identify problematic interactions in family, explore issues, and challenge the family to change its pattern of interpersonal communication. A specific example in the case of an adolescent with depression undergoing family-based intervention would include goals like improving communication skills; problem-solving skills; resolving attachment issues, and disrupting repetitive, negative, and critical cycle of communication between parents and adolescents; and eventually help families to deal with adolescents symptoms of depression within home setting, including making plan of management in case of suicide risk. All these goals are achieved within the larger context of establishing trusting relationship, improving channels of communication and involving all members of the family. Liaisoning with other team members (for instance, with psychiatrist for medication or with other therapist taking individual sessions of the adolescent) must be part of the treatment design. Referrals to appropriate agencies are also undertaken while charting out the goals, whenever indicated.

Assessments in Family-Based Interventions for Adolescents Issues

Family assessment is a crucial parameter to conceptualize a case, prepare case formulation, and most importantly plan an optimal treatment. On the practical grounds,

it provides elaborate details about families, whether parents, or other legal custodians, have the legal power to initiate assessment and treatment, and information on provision of financial resources for continued clinical support. From a clinical perspective, family assessment helps in understanding the family strengths, the psychopathology or issues of other family members, and parenting styles. Most importantly, it provides clinician with an opportunity to understand family relationships, interactional patterns, and the presenting problems based on which decision is made if family's involvement in treatment would be beneficial. This is based on a comprehensive assessment which covers spectrum of methods ranging from structured testing, history taking, to observation of family dynamics.

Structured assessment varies widely depending upon the major theoretical approach employed for assessment. For example, Bowenian therapist completes elaborate three-generational genograms before beginning treatment while a behavioural therapist would employ a variety of questionnaire and checklists, whereas in other cases there would be those conducting little to no formal evaluation. *History taking* and observations provide details on family structure, family communication, family monitoring of child development, individual functioning of child and parent, marital functioning, and the stages of the family life cycle (Josephson & Moncher, 1998a, 1998b). *Observation reports* are of particular significance in family assessment. Simply observing a family interaction in consulting room is sometimes enough to provide details about family dynamics. For example, the harsh limit setting by parents, hostile or ambiguous communication patterns, avoidant, or over-involved parenting styles are some of the easily available observations in therapy room. And since observation is an ongoing process throughout therapy, it is crucial to make notes of significant observations to not only provide corroborative evidences in assessment but also to indicate which domains require further in-depth explorations.

One of the most helpful guidelines on comprehensive assessment of family is Practice Parameter for the Assessment of Family, which outlines 10 primary principles of assessment (American Academy of Child and Adolescent Psychiatry, 2007). These are given as follows:

1. The initial assessment of mental health of adolescents must include both the current as well as historical details about them, their family, and their family functioning.
2. Observation report on ways in which an adolescent is relating to their parents or caregivers.
3. Interview from multiple informants such as the adolescents, his/her individual family members, entire family together, caretakers, peers, and teachers.
4. Detailed interview with family members frequently interacting with the adolescents to enhance understanding on the context of problem behaviour.
5. Information on risk factors in the family for any specific disease or disorder.
6. Details of the family structure, communication patterns, interaction patterns, and socio-culturally family beliefs system.

7. Family history including details of its development, marital relationship of parents, and history of disease and disorders in the family along with in-depth history of each parents.
8. Multiple techniques of data collection should be used.
9. Sensitivity to socio-cultural background of the adolescent and their families.
10. Assessment should connect well to treatment with the purpose of not only alleviating disorders but promoting health and well-being.

Though these principles comprehensively cover most of the major domains of family assessment, it is in no way intended to define the standards of care or claim inclusiveness. Hence, a clinician's decision on assessment must always be guided by the needs of a particular presenting case. For example, the assessment for an adolescent with autism would focus on the stressors of care giving experienced by family members while assessment for an adolescent with conduct disorder would focus on nature of family's interactional sequences. And since assessment is a bridge to planning intervention, it is equally important to communicate essential components of assessment to parents and children in a simplified and empathetic manner.

Major Models of Family-Based Interventions for Adolescents

There are many theories of family-based therapies and all of them highlight the role of the family in resolution and maintenance of individual's symptoms. The models mentioned here vary widely in their focus on treatment, type of intervention planned, and nature of difficulties addressed. Addressing the immediate behavioural needs of children or parent management training comprises the core intervention in some therapies, while other therapies focus on the dysfunctional patterns in interpersonal functioning or communication as this is a core cause of adolescent's emotional distress. Since family includes various sub-groups with its own homeostatic functionality or dysfunctionality, family-based interventions (FBI) may often shift from child sessions to parent session for resolving their own conflicts or psychopathology, to conjoint parent–child sessions for improving parent–child interactions, and to most extensive family sessions dealing with larger issues pertaining to each family members. Thus, intervention is flexible and is tailored as per the needs of individual case.

Three important models of family-based interventions: (a) family therapy, (b) interpersonal psychotherapy—adolescents (IPT-A), and (c) parent-focused interventions are described here.

Family Therapy

Family therapy is a modality of family-based interventions, which works with the family rather than with individuals depending on different conceptual models. It is based on family systems theory originating in late 40s and early 50s with the study on schizophrenic patients and gradually further evolved with new science of cybernetics, circularity, and communicational aspects. Family therapy focuses on family relationships, interactions, and family systems in adolescents.

A number of approaches like psychodynamic, experiential-humanistic, strategic, systemic, structural, cognitive behavioural, psychoeducational, multisystemic, post-modern, etc. have been developed using different models of family therapy. Some of the common ones used for adolescents are listed below.

Bowens Family Systems Theory/Transgenerational Theory

Murray Bowen (1978), who developed the family systems theory, proposed that family is like an emotional unit, which has many interlocking relationships within itself. He emphasized on the significance of past family relationships on the individual and maintained a systemic perspective in that he focused on the current family unit and its interaction patterns. Simply put, family patterns tend to repeat themselves, unresolved issues are passed on from one generation to the next generation through parents to the adolescents (McGoldrick et al., 2008). Bowens theory, also known as *natural systems theory,* addresses emotional processes within and across generations in a family by focusing on eight interlocking theoretical constructs (Kerr, 1981). These are given as follows:

1. *Differentiation of Self*: It is a process by which adolescent develops a balance of independence (autonomy) and connection with their families of origin and with other important social-emotional system.
2. *Triangulation*: When negative emotions escalate between two members in a family, a third person may be brought into the relationship to restore its emotional balance, through a process called triangulation. The third person attempts to lessen the anxiety (by giving reassurances, advices, etc.), however the broader conflicts remain unresolved.
3. *Nuclear family emotional process*: This process looks into the symptoms that are present in the nuclear family and also which member it will affect the most or in which relationship it will manifest itself.
4. *Family Projection Process*: This process refers to the transmission of multigenerational emotional problems from the parents to the adolescent.
5. *Emotional Cut*-off: Extreme emotional distancing by a family member in order to break the dysfunctional emotional ties.
6. *Multigenerational Transmission process*: Refers to how the current family members functioning is a result of his/her previous generations stability and functioning.

7. *Sibling Position*: Describes how certain personalities are influenced by an individual's position in their sibling order.
8. *Societal Regression*: Refers to the society's response to events such as population growth and depletion of natural resources that impact families.

Bowen (1978) introduced the widespread use of *genogram,* which is a diagrammatic manner of understanding in depth the origins of the presenting problem over at least past three generations. Based on the above assumptions there are two basic goals in Bowen's systems therapy: (a) to manage family's anxiety and (b) to enhance each member's capacity for differentiation (Kerr & Bowen, 1988). Hence, a mature individual, while being able to remain in good contact with his/her family unit, is also able to retain his/her internal locus of control—*healthy separation and connectedness* (Bowen, 1978).

Using Bowens theory, many researchers have studied the role of identity development, differentiation from one's family of origin, and the role of autonomy and relatedness in parent–child relationship. Higher distress, problems in coping, adjustment to stressful situations (Parker et al., 2008), chronic anxiety (Knauth et al., 2006), depression, and drug use (Willemen et al., 2011) are commonly found in adolescents who fail to differentiate from their families of origin.

Structural Family Therapy

Salvador Minuchin's structural theory of family interaction is based on his interactions with families with delinquent children. Family is viewed as the social group within which these individuals exist. Much of the structural family therapy is aimed at changing the organization of the family, specifically targeting the family interactions. Three concepts that form the essential component of structural family therapy are given below:

(a) *Structure*—It refers to how family members interact in an organized manner with respect to their roles, communication patterns, etc.
(b) *Subsystems*—Individuals are the subsystems within a family, e.g., three subsystems commonly found across families are couple subsystem, parental subsystem, and sibling subsystem.
(c) *Boundaries*—It refers to rules regarding 'who' participates in the system and 'how', i.e., the degree of access outsiders have to the system. Boundaries can be clear/open, diffuse, closed, or rigid.

Structural family therapy suggests that the problems among adolescents mainly highlight the imbalance in their family structure, Hence, the whole family is included in the assessment and therapy session. Focus is on exploring presenting problems followed by exploration of family's response to it.

Based on assessment, structural family therapy progresses towards achieving two primary intervention goals—changing family structure so that family can solve their own problems (primary goal) and family members experiencing a change in their

subjective experience as a result of this structural change (secondary goal). These goals are attained by following these seven techniques, which are unique to the structural school of therapy:

1. *Joining and Accommodating*—to ease the anxiety of the family and to build alliance with all members.
2. *Enactment*—therapist observes the family's interaction within the session as they are asked to talk directly to each other.
3. *Structural Mapping*—here formulation of problems is made within the structure of the family instead of focusing on individual or past events.
4. *Highlighting and modifying interactions*—therapist focuses on modifying pattern of interaction between the members.
5. *Shaping competence*—positive assets in the family are emphasized to increase each member's competence.
6. *Boundary making*—boundaries are realigned and strengthened between the subsystems.
7. *Unbalancing*—here the goal is to change the relationship within a subsystem.

Strategic Family Therapy

Strategic family therapy has its origins in structural family therapy, communication theory of Gregory Bateson, and cybernetics theory of Don Jackson. In contrast to other forms of therapy, strategic family therapy tends to be brief (8–16 sessions), directive, therapist centred, and task oriented.

This therapy postulates that in a healthy family, hierarchies are more clearly defined, indicating that parents are in a higher position, taking majority of the families' decision. These families are characterized by their ability to move from one stage of life cycle to another, solving problems and making new rules as they move to meet the demands of the next stage.

In contrast, problematic families have unclear boundaries and lack flexibility. They show maladaptive behavioural interactions which refer to repeated family exchanges whose main intention is to achieve a particular outcome but ultimately no positive results are realized (Szapocznik et al., 2012). Here the problems are hypothesized to have particular role in maintaining the families functioning, and hence they have more resistance towards change.

Some of the examples of goals in strategic family therapy include: disrupt repetitive interactive sequences that leads to conflicts, change the way family members deal with each other, and to reorganize the family system. In simple terms, strategic therapist creates strategies to solve families presenting problems.

Stages of strategic family therapy:

1. *Social stage.*
2. *Inquire and solicit information.*
3. *Ask family to talk to each other.*
4. *Set goals and clarify changes.*

Strategic family therapy techniques:

1. *Positive Connotation*: Therapist alters the family member's view of the problematic behaviour by revaluating the problem within the broader context.
2. *Directives*: Therapist here provides direct instructions to the family as to what is to be changed and how the change has to be made.
3. *Covert Change*: Therapist praises desired behavioural change in the family and ignores all non-desired behaviour.
4. *Paradoxical Interventions*: This is famously referred to as prescribing the symptom so as to reduce the resistance.
5. *Pretend techniques/Reversals*: Family members are asked to act in a way that is different from their usual way of relating.
6. *Hypothesizing*: Therapist formulates case based on the information about the family.
7. *Neutrality*: Therapist does not align with any specific family member or behaviour.

Activity

Consider a teenage girl who is spending late nights in texting on cell phone or playing her favourite Internet game and the parents try to impose limit setting and ensuring timely completion of home work and getting to bed at a reasonable time. Like many teens, she often finds this imposition of a directive or demand to be aversive, unpleasant, or otherwise unwanted as it means she must stop an enjoyable activity to do one less enjoyable or even unpleasant activity. The teen may ignore this directive initially but, after repeated requests by the parent, will escalate by opposing, resisting, or escaping from the parental demand through defiant and other coercive behaviour. This leads the parent to withdraw from the interaction and so the behaviour that led to this withdrawal may delay having to do homework or go to bed and allows the teen to continue to resist and engage in her recreational activities. The teen thus is able to succeed in escaping, even if only temporarily, but it negatively reinforces her oppositional behaviour and strengthens its likely use in subsequent encounters of this sort. Here one can recognize the pattern of interaction between the parents and adolescence and the role it plays in maintaining problematic behaviour.

- Can you identify the structure of this family and who all constitute its subsystem?
- Which techniques from the above-mentioned models of family therapy will be useful in this situation

Cognitive Behavioural Models of Family Therapy

Cognitive behavioural family therapy (CBFT) was a result of the pioneering work of Gerry Patterson (1971) on behavioural parent training. The central assumption of CBFT is that our cognitions (attitudes, thoughts, beliefs, attributions, expectations) and behaviours which are problematic are learnt and maintained by the repetitive patterns of interactions. It states that family members having difficult relationships tend to have more of negative schemas, which are shared beliefs within the family.

The therapist undertakes behavioural assessment of family functioning which typically occurs at two levels (Falloon, 1991): (i) problem analysis and (ii) functional analysis. Here the therapist focuses on making changes to facilitate positive family interactions and also on helping families maintain this newly improved behaviour. In contrast, cognitive assessment involves functional analysis of *inner experiences*—thoughts, attitudes, expectations, beliefs, through self-report questionnaires, individual and joint interviews, and direct behavioural observations of family interaction (Epstein & Baucom, 2002). Once negative cognitions are identified, clients are encouraged to challenge these negative thought by finding evidence for/against them. Cognitive restructuring, rational analysis, thought diaries, behavioural enactment, and psychoeducation are the most common techniques used in this therapy.

Functional Family Therapy

Developed by Barton and Alexander (1981), functional family therapy (FFT) integrates systems and behavioural approaches and has been widely used for managing adolescent behavioural problems like violence, delinquency, and substance abuse (Alexander et al., 2013). It can be used as both prevention and intervention programme across culturally diverse client populations (Sexton & Alexander, 2000). It works as a short-term intervention, consisting of approximately 30 h of treatment and can be delivered in varied setting—clinical, school, or at home (Weisman & Montgomery, 2019).

The aim in FFT is to create a non-blaming relationship that seeks to explain the causes of all members' behaviours (Alexander et al., 2013). Behaviour serves an important function in relationships and is not seen as 'good' or 'bad' in themselves, rather they are seen as being adaptive. These are referred to as the relational functions, which has two dimensions—relational connection and relational hierarchy. The final aim then becomes to help families develop non-problematic relationships with each other and at the same time to be able to have the same relationship function as before. This helps families to find relatively adaptive ways to deal with the relational distance and relational hierarchy between people (Alexander et al., 2013).

FFT proceeds in three phases, each of which have separate goals and assessment objectives, each addressing different risk and protective factors, and each of these tasks require specific skills from the therapist providing treatment (Sexton & Alexander, 2000):

1. *Initial phase (engagement and motivation)*—Negativity, blaming, hopelessness, are lack of motivation are the risk factors associated with this phase while credibility, alliance, and treatment availability are the protective factors present. The aim of this phase is to reduce the risk factors and enhance the protective factors. The therapist tries to change the focus from individualistic to one of family as a mutually influencing system where members share responsibility for changing family behaviour (specific techniques include validation, positive interpretation, reattribution, reframing, and sequencing).
2. *Middle phase (behaviour change)*—The goal in this phase is to develop and implement intermediate and ultimately, long-term individualized behaviour change plans of each family within cultural context. They also provide specific behavioural interventions focusing on parenting, communication, and conflict management to make more specific changes in the behaviour. This involves modifying attitudes, expectations, cognitive sets, and affective reactions to create protective behaviours. The focus of assessment in this phase includes relational skills (communication, parenting), family's compliance with behaviour change plan, and relational problem sequence. Ultimately it requires enhancing the ability of family members to perform activities related to their risk factors in a way that matches their relationship functions.
3. *Late Phase (generalization)*—FFT therapist in this phase helps the families to implement the new positive changes into other area of life, maintain the changes made during treatment, and prevent any relapses. The primary goal of the generalization phase is to improve a family's ability to mobilize community support systems and modify deteriorated family-system relationships.

Booster sessions after completing the treatment are part of this form of intervention. Relapse may happen when, for instance, an adolescent violates law or engages in truancy. These sessions will then remind the family members about earlier learnt skills and their ability to attain good family functioning. The outcome of FFT includes less conflicts and improvement in communication in families and decline in offense and substance use among adolescents. As a result, adolescents are more likely to get connected with the family and school.

Multidimensional Family Therapy (MDFT)

MDFT is family-based intervention which is used most commonly in adolescent with substance abuse and associated mental health and behavioural problems (Liddle, 2010). It mainly addresses four domains: (a) considering the adolescent and enhancing their skills such as communication and social skills, e.g., saying 'No' to drugs; (b) parents focusing on their parenting skills and practices; (c) family environment, indicating the relationship and transactional patterns among members; and (d) the larger context of peer groups, school system, and juvenile justice systems.

MDFT thus adopts an ecological framework involving multiple systems such as the adolescent, parents, family, and the extra familial systems. The aim here is to

help the adolescent and their family progresses towards a more functional developmental trajectory. There are four premises on which MDFT is based—that problems are multidimensional; multidimensional problems require multidimensional conceptualizations; multidimensional conceptualizations yield multisystem interventions. Some of the major assumptions underlying MDFT includes understanding drug use as a multidimensional phenomenon, looking at day-to-day activities as opportunities for change, looking at changes as being determined by multiple systems, motivating adolescents and their parents to engage and change, therapist making alliance with each member in the family, and therapist's responsibility and attitude being emphasized and treatments being individualized to the person and his/her family (Liddle, 2010).

In this form of therapy, sessions are held one to two times a week and generally last for around 4 to 6 months. Overall treatment includes various phases with its corresponding goals. The first phase includes building motivation for change with the adolescent, family members, and external supports. In second phase, therapist makes request for changes in relationships and in different areas of functioning which were identified in the first phase of therapy, through the use of specific techniques like decision-making skills, communication skills, and problem-solving skills. Meanwhile work with parents is also done to improve their parenting styles. In the final phase, skills acquired throughout the sessions are generalized to newer situations. Discussions around the kind of challenges that are expected to occur once the therapy ends and how can the family navigate through these challenges are also part of the final phase of the therapy session.

Attachment-Based Family Therapy for Adolescents (ABFT)

Attachment-based family therapy (ABFT) is an evidence-based family psychotherapy developed for treating adolescent depression based on a central premise that the depressed adolescent needs both attachment and autonomy for healthy development. The fundamental principles and processes of ABFT have been derived from four major clinical model of psychotherapy: structural family therapy (SFT, Minuchin, 1974); emotion-focused therapy (EFT, Greenberg et al., 2007); contextual family therapy (Böszörményi-Nagy & Spark, 1973); and multidimensional family therapy (MDFT, Liddle, 2002).

ABFT proposes that there are multiple factors contributing to secure parent–child relationship which includes child factors (e.g., temperament, self-regulation ability, and genetic vulnerability); parent factors (e.g., parenting styles, their attachment history, and psychopathology); and environmental factors (e.g., poverty, victimization, and peer group). The adolescent faces the challenge of retaining attachment and at the same time acquiring more independence and autonomy, the successful resolution of which will ensure adequate growth opportunities. Inability to do so may lead to various forms of attachment injury and negatively impact the self-esteem and self-regulation of the adolescent, and also result in dysfunctional family-interaction pattern. All these make the adolescent vulnerable to depression. The

therapist attempts to help both adolescents and parents understand the attachment injuries and create a conducive environment to generate corrective attachment experience marked by emotional availability of parents and expression of vulnerable feelings by the adolescent.

Derived from the transactional model of change, ABFT consists of five treatment tasks, with each task requiring a single or multiple therapy sessions to complete. The description of the nature of each task and its goal is given in Table 18.1.

Case vignette below illustrates how an adolescent struggling with depression coped with severe suicidal ideations progressing through the five stages of ABFT.

Table 18.1 Description for five tasks of ABFT

Task number	Task name	No. of sessions	Goal
I	Relational frame	1	Establishing treatment contract Joining and understanding presenting problem Discussing attachment themes Contract for relational repair
II	Alliance with adolescents	2–4	Building alliance with the adolescent Understanding their problem narrative Identifying attachment ruptures Linking presenting problems with attachment narratives
III	Alliance with parents	2–3	Building alliance with the parents Identifying obstacles that inhibit healthy relationship development Identifying strengths that facilitates relationship building Exploring intergenerational attachment injuries and linking them to current parenting
IV	Attachment task	1–3	Facilitating conversations to resolve attachment ruptures Mutual responsibility and commitment to change
V	Promoting autonomy task	8–9	Promoting autonomy and competency in the adolescent Building competency in communication skills between parents and adolescents

Case Vignette

Case Background: Neha, a 15-year-old female from Delhi, presented with diagnosis of major depression and panic disorder. She was referred for psychological intervention following a recent suicide attempt by hanging.

Family Background: She lives with her parents, 40-year-old mother as a homemaker and 45-year-old father working in a government bank. Her elder sister is married and lives in Mumbai. Her brother has joined army recently and has been away for a year.

Pre-therapy Assessment: Upon interviewing she denied having any history of abuse. She has been facing bullying at school because of her weight and physical looks and her academic performance has also been impacted recently. However, she has not talked about her distress to her parents or siblings. She had started to remain low and engaged in wrist-cutting 2 months back. Perpetuating stressors for her thus has been bullying in school and loneliness due to siblings moving out. While recent stressor has been poor academic performance, social anxiety, and conflict with friend.

Upon assessment, Neha's pre-treatment scores indicated severe depression and severe suicidal ideations.

Treatment Summary at Each Stage

Task I—Relational Reframe: Therapist joined the family and identified various relationship ruptures which prevented Neha from sharing her distress with her parents. Focus was on eliciting the nature of parent–child relationship than exactly on the symptoms. While Neha kept on blaming herself for everything, parents were equally finding it difficult to understand that despite being so caring, they could not be with their child. Family acknowledged the conflict and agreed to work on improving parent–child relationship as a major goal of therapy.

Task II—Adolescents Alliance: Therapist joins with adolescent here to understand the nature of distress, especially the attachment experiences which fostered a lack of safety and comfort to receive caregiver's help. For example, since parents were still undergoing transition of separation from older siblings, she didn't want to trouble them more with her stress and wanted to be the strongest one. This left her to consider suicide as the only solution to all the problems. Therapist also prepared Neha to share these concerns to the parents.

Task III—Parent Alliance: Here therapist explored parent's own life with focus on eliciting stressors as well as intergenerational attachment patterns, to help them understand how these factors impact parent–child relationship and undermines Neha's willingness to seek parental support. For example, the impact

of marital conflicts, parenting differences, and their own relational patterns impacting Neha's coping. Her mother was anxiously overprotective while father was avoidant and both agreed to find middle grounds so that Neha could communicate openly and freely. They learned new parenting skills and worked on their interpersonal conflicts as well.

Task IV—Attachment Task: This phase focused on attachment repair. Some of the core fears of Neha were taken up in the session (e.g., fear of emotional indifference upon disclosure of distress) with changes in the way each member responded. While Neha tried to be more honest in her expression of emotions (ventilate her traumatic experiences of bullying and parting from siblings to her parents) or conflicts, parents could empathize a lot, listen carefully, and sensitively respond to her emotional pain. Thus, each member changed their perception of themselves as well as how they interacted with others.

Task V—Promoting Autonomy: With improved family-interaction patterns, Neha continued sharing current distress associated with poor academic performance and conflict with friend. Neha was encouraged to solve problem situation herself with parents as her support system. The family mutually agreed on various ways in which they handled the stress. Session further focused on encouraging Neha to discussed her career goals, making arrangement to meet Neha's siblings frequently, re-joining her favourite extra-curricular activities at school. At this stage, the family no longer required therapist in these conversations and therapy was subsequently terminated.

Re-assessment: Neha showed mild depressive symptoms and lessened anxiety on re-assessment. Her functioning at school and home improved. She even became a volunteer for the anti-bullying group at school. Overall family had better bonding, trust, and communication with each other.

Treatment Implication: Working on attachment injuries helps adolescent not only reduce the suicidal ideations but also assists family in providing safe and secure attachment patterns to better support the adolescent deal with their distress and support their increasing need for autonomy.

Family therapy over the years has undergone a significant change. Post-modern models of family therapy focused on ideas of constructivism and saw a shift of focus from interactional patterns to use of language as a relational vehicle to impact family members' lives within the cultural context. However, evidence does not point at any one modality of family therapy as being more effective. A review study (Berry et al., 2019) on 23 articles examined research of past 11 years and found inconsistencies in time frame, frequencies of session, and significant disparity in number of family members included in family sessions and outcome measures. Thus, it implies the need to adopt a contextual approach in determining which therapy to use.

Interpersonal Psychotherapy—Adolescents (IPT-A)

As psychosocial factors and various interpersonal deficits play an important role in adolescents depression (Hammen, 1999; Stader & Hokason, 1998), urgent need was felt to adapt interpersonal psychotherapy (IPT) as per the developmental relevance to the adolescent population.

While the overall goal and problem areas addressed in IPT-Adolescence (IPT-A) remains largely same as IPT, significant adaptations has been made in the module on role transition to address concerns specific to adolescent issues. Additionally, parent session has been added in IPT-A as an optional session at various phases of treatment, especially required in cases when it is crucial for parents or guardians to encourage the well-being of adolescents in addressing issues such as aggression, abuse, school refusal, or suicidality. Further, IPT-A has been tailored to be developmentally appropriate to the needs of adolescents such as attaining greater independence, achieving interpersonal effectiveness especially with romantic partners, managing stress due to bullying or peer pressure, and dealing with any significant personal life trauma.

The basic structure of IPT-A is designed as a 12-week treatment with two primary objectives: (i) ameliorating symptoms of depression and (ii) dealing with interpersonal conflicts related to the onset of depression. The treatment proceeds in three phases such as initial, middle, and termination phase. The beginning phase of treatment includes detailed psychoeducation followed by exploration of interpersonal difficulties which is then formulated as therapy goals. In the middle phase, adolescents learn about various specific strategies that can help them in dealing with each of the identified interpersonal difficulties. Some of the major change techniques include expression of emotions, communication skill learning, resolving interpersonal conflicts, and leaning new ways of relating to the people effectively. Termination phase focuses on discussion around implementational strategies and challenges of applying acquired skills in various contexts and future situations, and the need for further management.

Parent-Focused Interventions

The value of parent training programmes has been well understood as a significant part of treatment for children and adolescents since early times. For example, parent–child interaction therapy (PCIT, Eyberg et al., 1995) is aimed at developing effective parenting techniques and reduction in behavioural issues leading to a stronger familial relationship. PCIT has been found effective in children and adolescents with oppositional defiant and conduct disorder (Eyberg et al., 2001). Similarly, the ‘Incredible Years’, a social learning theory-based programme for reducing children’s conduct problems has been effective in reducing children’s conduct problems (Webster-Stratton & Hancock, 1998).

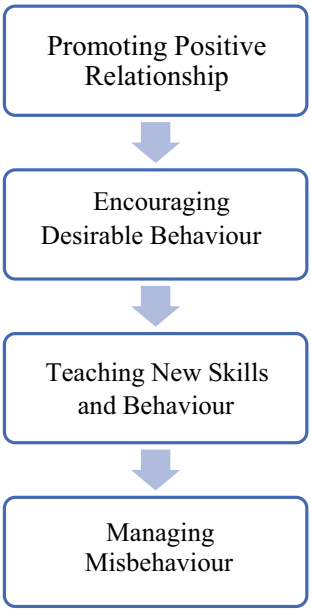

Fig. 18.1 Intervention continuum

Since these programmes had narrow focus and scope, the need was felt to broaden the focus on parenting-based family intervention to address wide range of issues across various age groups from children to adolescents. One such example is Triple P-Positive Parenting Program developed at a multilevel system of parenting support (Sanders, 2012). The approach aims to treat as well as prevent social, emotional, and behavioural problems in children and adolescents by enhancing the knowledge, skills, and confidence of parents. Thus, it provides a continuum of intervention ranging from treatment of misbehaviour to promoting positive relationships as shown in Fig. 18.1.

Empirical Evidence on Family-Based Interventions in Adolescent Disorders

Research indicates that different family-based interventions work in different problems. Role of family-focused intervention in adolescent *depression* has been implicated since family-related factors have been frequently associated with development as well as maintenance of adolescent depression (Hardt et al., 2008). It equally plays a part in preventing depression or *suicide* through providing parental emotional support, warmth, and family cohesion (Wagner et al., 2003). For example, multisystemic family therapy and CBT-based family therapy have been found to be effective specifically in reducing suicidal ideations (Brent el al., 2013). Evidences, however, have been strongest for attachment-based family therapy (ABFT) in strengthening

family cohesion to act as a buffer against both overall depression and suicidality (Diamond et al., 2010; Israel & Diamond, 2013). In fact, it has also been effective for severe cases with high suicidality, history of physical, or sexual abuse along with many other co-morbidities (Diamond et al., 2010, 2012).

Barkley's four-factor model (adolescent's characteristics, the parents' characteristics, the family environment/stresses, and parenting practices) of family interaction explains how the normal coercive interchanges that most families sometimes experience escalate to clinical proportions. Randomized trial studies by Barkley et al. (2001) using family intervention to deal with the coercive interaction between parent and adolescents with *Attention-Deficit Hyperactive Disorder* (ADHD) have been found effective.

In case of *Oppositional Defiant Disorder* (ODD), studies have established that parent training is the primary evidence-based family treatment (Lundahl et al., 2006; Reyno & McGrath, 2006). RCT studies indicate the efficacy of parent–child interaction therapy (PCIT) compared to the treatment as usual in adolescents with ODD across cultures (McCabe & Yeh, 2009). Family-focused intervention based on parent-targeted social communication training has found significant improvement in large-scale RCT study with regard to *Pervasive Developmental Disorder* (PDD) (Green et al., 2010).

Studies have also consistently reported the crucial role played by families in *substance use disorder* among adolescents. In a meta-analysis of 24 treatment studies of drug misuse, Baldwin et al. (2012) reported that Brief Strategic Family Therapy (Szapocznik et al., 2015), Functional Family Therapy (Alexander et al., 2013) and Multisystemic Therapy (Henggeler & Rowland, 2019) were much more effective than waiting-list control conditions and modestly more effective than treatment as usual or alternative treatments. Multidimensional Family Therapy (MDFT) has been proven efficacious across cultures and socio-economic status for non-residential treatment of adolescent substance use, delinquency, and mental health disorders (Dakof et al., 2015; Rowe et al., 2016; van der Pol et al., 2018).

Family-based intervention in *psychosis* primarily involves detailed psychoeducation to help families understand and manage the condition, medications, associated stress, and early warning signs of relapse (McFarlane Lynch & Melton, 2012). It has also been found to be effective for adolescents with high risk of psychosis (Miklowitz et al., 2014).

In a comprehensive meta-analysis of 16 studies from 1994 to 2013, it was found that family-based interventions for children and adolescents with *anxiety disorders* (diagnosed with specific phobia, social phobia, generalized anxiety disorder, panic disorder, and obsessive–compulsive disorder) were as effective as individually based interventions, such as individual or group cognitive behaviour therapy (Thulin et al., 2014). The crucial part of these intervention included detailed training for both the adolescents and parents in cognitive coping, conducting exposure exercises, and using relaxation skills which enhanced the treatment outcome.

Studies on family-based treatment for adolescents with *eating disorder* have reported significant benefits (Couturier et al., 2013; Sweeney et al., 2015).

Family-based psychological therapies have been found significant for children and adolescents with *chronic medical conditions* (such as asthma, cancer, cardiovascular disease, chronic pain, cystic fibrosis, diabetes mellitus, and epilepsy) (Law et al., 2014; Palermo et al., 2007; Wilfahrt et al., 2017).

Process Issues in Implementing Family-Based Interventions

Therapeutic Alliance with Family: Bringing a Balanced Approach

Building a clear and collaborative therapeutic alliance is crucial in family therapy (FT) as it enhances the likelihood that families will consistently attend and participate in treatment of adolescents. Thus, cross-cultural competency involving therapist's cultural sensitivity, warmth, empathy, competence, and therapist-client congruence is the most crucial element of building therapeutic relationship (Sue et al., 2019) and has a significant impact on the therapy outcome (Lee, 2011). Hence, the role of therapist is important in forming adequate relationship with both parents and adolescents. There is a need to shift the focus of therapy from fixing the patient to enhancing family relationships which necessitates healthy collaboration with each member of the family, indicating the systemic assumption that "whole is better than the sum of its parts".

Engagement and Retention in Therapy

Often children and adolescents referred for therapy do not turnup or dropout during the course of treatment (de Haan et al., 2013). Some of the most common predictors of dropout are related to demographic, interpersonal, therapeutic alliance, and contextual variables including parental stress, degree of child's presenting problems, parenting practices, parental psychopathology, economic factors, and referral source (de Haan et al., 2013; Robbins et al., 2006). Awareness of such variables will help the therapist address them in detail such that family members remain in treatment till completion.

Cultural Issues in Family-Based Interventions

The therapist needs to avoid making assumptions about a particular cultural background; instead they should respectfully inquire about the family's cultural beliefs and expectations. A person's culture is often fused with who that person is as an

individual. Discussions around cultural backgrounds and what meaning it holds for the adolescent can also foster conflict resolution and identity development in adolescents. Honest curiosity can be communicated through open-ended questioning by the therapist. Therapist needs to be aware of not only cultural barriers to treatment but also knowledge of different cultural beliefs need to be integrated in the therapeutic process so as to enhance acceptance to therapy by the family including the adolescent. The therapist should be aware of their own cultural biases and should discuss these within their supervision sessions.

Therapist Issues

The therapist must always assume a stance of respect and acceptance of the family. Blaming the family members for adolescent's difficulty might lead them to feel attacked and criticized, often resulting in families dropping out of treatment. Similarly joining parents in criticizing the adolescent would lead to poor therapeutic relationship with adolescent and eventually poor outcomes in therapy. Hence, therapist must maintain a neutral stance, respecting the views of each member of family member. In recognizing the family's desire to resolve problems, the therapist engages them in the hopeful process of assessment, education, and treatment. Hence, considerable skills and training along with supervision are essential to conduct family-based interventions.

Cultural and Contextual Factors in Practicing Family-Based Interventions in India

Cultural Fabric of Indian Families

Families mainly seek therapy because of academic difficulties of adolescents or parents' inability to deal with 'adolescent's symptoms' (Roy et al., 2017). Since in Asian societies, achievement and education are considered status symbols for parents and sign of successful parenting (Ranganath & Ranganath, 1997), poor academic functioning remains one of the prime concerns for Indian parents to seek consultation, though the underlying issues may relate to parents' high expectations, rigid beliefs, and inconsistent parenting practices (Thomas, 2012). Westernization has also influenced parenting practices, and many parents end up vacillating between permissive and authoritarian parenting styles which often creates family conflict, anxiety in adolescents, and increases the risk for behaviour and emotional disorders (Bharat, 1997; Carson & Chowdhury, 2000).

Barriers to Family Therapy in Indian Context

There are several culture-specific issues that may have implications in achieving goals in family therapy. Attribution of causation of illness and treatment to destiny or supernatural power has often been documented as one of the prominent causes for poor compliance to interventions and hence causing early dropout in therapy (Carson & Chowdhury, 2000; Carson et al., 2009). It often results in seeking help from faith healers (Bhargava et al., 2017). Further, even if they believe in medical model, the lack of 'psychological sophistication' hinders in the establishment of therapeutic relationship.

Further, children and adolescents often mask conflict in the couple subsystem. The tendency to avoid conflicts results in endless cycles of blaming each other for child's problems. Thus, entire family system resists change and as a result child assumes a '*sick role*' which is often difficult in therapy to overcome. Another barrier pertains to cultural beliefs held by family regarding illness model and therapy, e.g., "the family in treatment believed that their inability to do religious rituals has led to child's symptoms and hence only performing the rituals can cure this (OCD)" due to which any efforts at explaining the scientific nature of OCD symptoms were discounted by the family members and no significant therapeutic gain could be achieved in the case.

Many Indians believe in fatalism, that is, things do not really change, either within people or in family systems ("no matter what you do, the outcome will be the same") (Roy et al., 2017), thus rendering any counselling ineffective. Further, family matters are considered private and confidential to be solved within the family (Carson et al., 2009).

Lastly, though Indian families are generally 'collectivistic' in nature and concept of privacy does not even exist in Indian socio-cultural setting (Neki, 1992), however, in contemporary times, with changing values, adolescents' need for 'space' may become another contentious issue during family therapy sessions.

Family-Based Interventions for Adolescents in India: Moving Towards Integrational Model

The integrational model of family therapy shares common ingredients of therapy across models. It reflects the value of 'helping the families' as the primary goal. In fact, it has been pointed out that since Indian couples and families are often more in need of education and skill-training than therapy per se (or therapy secondarily), psychoeducational approaches that include, for example, components of parent training (e.g., positive discipline and behaviour management practices; effective communication with children and youth), and basic information about adolescent development and health maintenance, could be extremely helpful (Carson et al., 2009). Further, since learning by doing, seeing, story-telling, and narrating

is paramount in many Indian cultures, adaptations of experiential family therapy and narrative family therapy may find their rightful place. In addition, solution-focused therapy may also find its applicability due to its emphasis on brief duration of intervention and building on existing strengths (Carson et al., 2009).

Conclusion

Families play an important role in the social, emotional, and cognitive development of the adolescent. The turbulence caused by the physical changes is exaggerated by the dysfunctional interactional patterns within the family and social life. The chapter highlighted the crucial role of various family-based interventions (FBI) and indicated their goals and assessment procedure. Three main intervention models described were family therapy, interpersonal psychotherapy—adolescents (IPT-A), and Parent-focused interventions.

Family-based interventions (FBI) not only deal with various forms of adolescent's distress but also address their developmental needs of bringing forth smooth transition to adulthood. Though each model varies in its focus, mechanism of change, extent of intervention, and nature of difficulties addressed, the choice of intervention is often guided by the needs of each presenting case. Interventions are thus tailored as per both individual and contextual factors. Research evidences over many decades are promising but generalizability is limited because of different methodology and different outcomes assessed. Though some of the process issues and cultural barriers pose challenges in effective implementation of FBI, there has been escalating indigenous efforts at incorporating cultural factors into the FBI model and move towards a hybrid integrational model which shares effective ingredients across models than being universal in nature. Additionally, the need for training and supervision is important in the effective delivery of any of the family-based intervention.

Family forms the core component in determining adolescent's mental health. They are crucial in building resilience, providing instrumental support, and acting as the 'secure-base' for identity exploration and mirroring their conflict resolution skills. Hence, a clinician absorbed in any role (psychologist, psychiatrist, social worker, nursing, special educator) must keep questioning ways in which family ameliorates or exacerbates adolescent's presenting problem and continues incorporating the FBI in regular practice whenever indicated with an overarching purpose of providing healthy family functioning to all the adolescents.

Time to Reflect

Adolescents may have different beliefs, opinions, and choices as compared to their parents. Reflect on how the current socio-cultural context and global scenario affect adolescents' perceptions and values, and how these are different from the earlier

generations. Further, these may change for future generations also. So each generation will be shaped by their current context. However, family will always consist of many generations, with a minimum of two generations. Will it not be wiser to acknowledge and accept, and give space to each generation to function and interact in the integrated system of family with a common goal of harmony, peace, thriving, and well-being?

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Chapter 19
Role of Gratitude in Positive Adolescent Development

Pulkit Khanna, Kamlesh Singh, and Shruti Dua

Abstract This chapter focuses on positive adolescent development and the role of gratitude in particular in promoting adolescent well-being. A global view on the subject is offered, with a specific focus on the Indian cultural context. The chapter consists of three main sections. The first section offers various perspectives on adolescent development, emphasizing a strengths-based approach. It highlights empirical findings on how gratitude benefits adolescents. This section also presents the cross-cultural and indigenous Indian aspects of gratitude. The second part describes an empirical study involving gratitude journaling among Indian adolescents. Study findings and implications are discussed. The third and final section of this chapter presents both Indian and international scenarios towards positive adolescent development and concludes by proposing future recommendations.

Keywords Adolescents · Well-being · Gratitude · Character strengths

Introduction

The World Health Organization (WHO, 2012) defines adolescence as the maturation phase and transitional stage of human development between childhood and adulthood. It represents how an individual experiences physical and psychological development and encounters changes in perceptions, abstract and critical thoughts, sense of self-awareness, and social expectations. According to the United Nations International Children's Emergency Fund (UNICEF Adolescent Demographics, 2019), around 1.2 billion adolescents constitute nearly 60% of the global population. This number is estimated to grow by 7% to 1.3 billion adolescents in 2030 and peak

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by 2065 (United Nations Estimates of World Population Prospects Report, 2019). India is home to the world's largest adolescent population at 253 million (Census, 2011), and today every fifth Indian is an adolescent aged between 10 and 19 years (UNICEF India, 2017). These burgeoning numbers call for focused attention to address concerns of adolescent well-being.

Although the UN Convention of the Rights of Child (1991) protects adolescents' rights, the fulfilment of their psychosocial needs often remains unaddressed. Mental health problems account for 16% of the global disease burden among adolescents (10–19 years), and the onset of about 50% of mental health conditions occurs by 14 years of age (WHO, 2020). Thus, it is imperative to promote positive behaviours, healthy practices, and emotional well-being, which will enable adolescents to secure healthy and fulfilling adulthood (WHO, 2020).

Understanding Adolescence: Theoretical Perspectives

The defining criteria and experiences of adolescence vary across cultures, gender, and society. Nevertheless, many prominent agencies, including the United Nations, WHO, UNICEF at the global level, and the Ministry of Health and Welfare, Government of India at the domestic level, consider the period between 10 and 19 years as adolescence. Among all the developmental stages of life, adolescence is demographically the most dynamic (Mulye et al., 2009). *Biologically*, adolescence is primarily a function of physical maturation and hormonal changes. *Socially*, adolescence is viewed as the transition stage where adolescents are expected to increasingly take up adult roles and is marked by identity crisis. *Cognitively*, adolescence ushers in the ability to reason, abstract thinking, and logical reasoning. *Psychologically*, adolescence is characterized by identity formation and new roles and responsibilities which may lead to confusion, anxiety, and stress.

There are many different perspectives to conceptualize adolescence. The *biosocial perspective*, which includes Hall's (1904) theory, extends the recapitulation principle to a child's mental and behavioural development, suggesting that mental growth proceeds by evolutionary stages. This perspective views adolescence as a phase of '*storm and stress*' (Hall, 1904). The *organismic perspective* includes both Freudian and Neo-Freudian views. Freud (1905) views adolescence as a time of upheaval and explains it in terms of psycho-sexual development emphasizing the onset of puberty and the genital stage after that. At this point, the hormonal changes disturb the psychological balance leading to adolescents grappling with the resolution of psycho-sexual conflicts and restoration of equilibrium towards adulthood (Freud, 1905). Further, the Neo-Freudian perspectives, including Erikson's psychosocial development theory (1964), focus on developing ego to meet social demands, wherein adolescents need to successfully establish their ego identity to progress along the developmental ladder.

The theory of *cognitive development* (Piaget, 1954) emphasizes the shift among adolescents from concrete thinking to abstract and logical thinking, thereby

expanding their cognitive repertoire. Bronfenbrenner's (1979) *ecological perspective* regards adolescents as active agents who orient to transitions in their physical and social environment. Similarly, Hill (1983) focuses on the interplay between an adolescent's traits and the environment. Thus, the congruence between micro-system and macro-system influences adolescent behaviour (Hamburg & Takanishi, 1996). The *humanistic perspective* suggests that every human is a unique, growth-directed, and self-perfecting individual (Maslow, 1968). Therefore, an adolescent must adopt a positive development orientation. For example, Roger's (1959) theory of self-concept is critical towards adolescent development. It is vital to building positive self-concepts within adolescents through unconditional positive regard, and a person must be respected and accepted in every aspect (Rogers, 1959).

Beyond these classical theoretical views of adolescence, various contemporary perspectives have emerged over the years. There has been an emergence of process-oriented approaches involving interactions among individuals, people, and contexts (Lerner, 1981). The contemporary perspective recognizes adolescents' strengths and focuses on enhancing their competence and potential instead of furthering a pathological view, thereby emphasizing *positive youth development* (Damon, 2004; Lerner et al., 2009).

Positive Adolescent Development

Adolescent well-being can benefit from maximizing the association between their potential strengths (e.g., ability to change) and developmental assets (e.g., supporting relationship with family, teachers, or friends) within their environmental context (e.g., home, school, and community) (Catalano et al., 2002). Positive adolescent development is the outcome of this association, facilitating adolescents' growth during the course of development (Lerner et al., 2005). Capitalizing on the opportunities and resources for positive development during adolescence can contribute immensely towards setting young people on the path of positive adulthood and thriving (Lerner et al., 2005).

Positive adolescent development stresses the relatively plastic relations between adolescents, their context, and their strengths as contributors towards their progressive, positive development (Damon & Gregory, 2003; Steinberg & Morris, 2001). The emergence of positive adolescent development is an exemplar of developmental science, which may help policymakers and practitioners advance civil societies and promote positive development (Lerner, 2000). Many researchers have highlighted personal agency, growth, and positive changes for conceptualizing competence in adolescent development. Benson (1997) furthered the asset-building framework comprising 40 developmental assets, including internal and external criteria. Catalano et al. (2002) offered a systematic model highlighting 15 constructs of positive youth development. Lerner et al. (2009) recognized competence, confidence, connection, character, caring, and contribution as the bedrock of positive youth development.

This growing focus on positive adolescent development has spurred research and practice in the area. There is promising evidence for gains associated with identifying and nurturing diverse constructs from positive psychology among adolescents. These constructs can be categorized across intrapersonal and interpersonal groups which include different character strengths. *Character strengths* facilitate positive adolescent development (Proyer et al., 2017). The use of character strengths correlates positively with happiness (Seligman et al., 2005), life satisfaction, academic achievements and well-being (Park et al., 2004), and protects against various psychosocial issues during adolescence.

Intrapersonal positive psychological constructs

Literature suggests that the benefits of building *resilience* among adolescents include proactive coping strategies (Marriner et al., 2014), better emotional regulation and emotional balance (Kent, 2012), increased self-confidence to face future challenges (Cohen & Sherman, 2014), and better relationships with peers and parents (Laible et al., 2004). Cultivating *hope and optimism* among adolescents helps them handle difficult situations by fostering positive interpersonal relationships (Snyder, 2000). Further, *self-compassion* helps adolescents develop a sense of common humanity, self-judgment, and mindfulness (Gilbert, 2009). It is a notable predictor of mental health among adolescents (Neff & McGehee, 2010). *Grit and growth mindset* have emerged as significant predictors of adolescents' success at school and beyond (Duckworth & Gross, 2014). They are understood to contribute towards adaptive cognitive and behavioural outcomes (Yeager et al., 2012) and are connected with learning strategies, achievement, and school engagement (Farrington et al., 2012). *Flow* is a motivational outcome variable (Kuhnle et al., 2012) that helps adolescents to seek pleasure while engaging in the activities for their own sake (Nakamura & Csikszentmihalyi, 2002).

Interpersonal positive psychological constructs

Forgiveness helps decrease anger in young adolescents who experience stressful life events and interpersonal hardships, and it also teaches them to be kind and compassionate even to their opponents (Enright et al., 2014). It acts as a buffering factor among adolescents in safeguarding against suicidal ideation (Liu et al., 2013). *Prosocial behaviour* is a multi-faceted concept (Mestre et al., 2015), associated with benefits including self-esteem, academic success, and better relationships (Laible et al., 2004) for adolescents. Prosocial actions among adolescents elicit a positive interpersonal response, strengthening their self-image (Crocetti et al., 2016).

Another notable interpersonal strength is *gratitude*. It holds psychosocial benefits for adolescents (Froh et al., 2014; Tudge & Freitas, 2018) and is integral for their flourishing (Froh et al., 2009). It helps adolescents develop positive emotions, hope, love, forgiveness, empathy, kindness, humility, and a persistent attitude (Froh et al., 2009; Scales et al., 2004). Grateful adolescents are self-compassionate, caring, and less judgmental (Peng et al., 2020). Many of these constructs are highly correlated. Since the present chapter focuses on the role of gratitude, we examine this construct and its associated benefits for adolescents in greater detail in the next section.

Role of Gratitude in Positive Adolescent Development

Gratitude is a virtue, attitude, emotion, and trait (Emmons & McCullough, 2003). It is a social emotion experienced and expressed differently around the world (Appadurai, 1985). In fact, researchers conceptualize gratitude across various dimensions. The *behavioural dimension* describes gratitude as a benevolent response to receiving something of value (Froh et al., 2011). The *cognitive dimension* looks at it as an acknowledgement of gain, along with the realization that another person is responsible for it (Chen & Kee, 2008). The *affective dimension* entails a sense of delight in response to receiving a tangible or intangible gift (Froh et al., 2009).

Gratitude contributes to positive adolescent development, acting as a buffer against adverse school experiences, lessening the chances of mental illness (Masten, 2001; Seligman, 1995). Gratitude is also associated with resilience, which boosts adolescents' happiness, well-being, and life satisfaction (Kent et al., 2015). Further, gratitude contributes to better academic achievement (Wen et al., 2010). It promotes subjective well-being in adolescents (Tian et al., 2016), further stimulating the benefactor's prosocial behaviour (Weinstein & Ryan, 2010). Research suggests that gratitude reduces stress among adolescents over time (Krause, 2006; You et al., 2018). Moreover, gratitude leads to sound social support systems and a better coping style (Wood et al., 2007).

The multitude of benefits associated with gratitude has led to growing interest in gratitude-focused interventions among adolescents. Gratitude interventions usually involve contemplative writing exercises like making gratitude lists (e.g., Emmons & McCullough, 2003; Froh et al., 2009), maintaining a gratitude journal (Emmons & McCullough, 2003), writing a gratitude letter (e.g., Sheldon & Lyubomirsky, 2006; Watkins et al., 2003), and freewriting about events inducing gratitude (Duran & Tan 2013). These are connected with gains in academic and extracurricular domains (Ma et al., 2013).

Gratitude interventions in adolescents may facilitate engagement in self-improvement behaviours associated with long-term self-improvement goals instead of behaviours with more immediate rewards (DeSteno et al., 2014). Literature also suggests that young people assigned to gratitude interventions experienced greater happiness, positive affect, life satisfaction, and psychological well-being than those in control conditions (Davis et al., 2015; Dickens, 2017). Gratitude interventions help increase life satisfaction and optimism (McCullough et al., 2002) and the experience of happiness (Watkins et al., 2003). Such interventions may promote higher self-esteem among school children (Kong et al., 2015) and student's success (Mofidi et al., 2014). Gratitude interventions are also useful in clinical therapies (e.g., Emmons & Stern, 2013).

Notwithstanding this rich evidence base, Renshaw and Olinger Steeves (2016) meta-analysed gratitude interventions among youth and reported somewhat less dramatic effects, advocating the need for further research. It is also quite discernible

that the extant literature does not represent all parts of the world. The bulk of gratitude research has emerged from western, educated, industrialized, rich, and democratic samples (WEIRD; Henrich et al., 2010). However, research evidence suggests different pathways in the development of gratitude across diverse societies (Merçon-Vargas et al., 2018), thereby necessitating the need to understand the cross-cultural intricacies better.

Adolescence as a developmental stage is also influenced by the culture and context. Hence it becomes imperative to understand the role of gratitude in specific adolescent contextual backgrounds. This will enrich the extant literature and contribute to a comprehensive understanding of gratitude in the positive development of adolescents.

Cross-Cultural Aspects of Gratitude

People representing diverse cultures across the globe experience and demonstrate gratitude in varied ways. Culture subsumes values, beliefs and practices, and the broader socio-economic milieu (Tudge, 2008). Consequently, gratitude contains culturally ubiquitous and socially constructed facets that vary across cultures (Morgan et al., 2014). Social and cultural values influence the development of gratitude (e.g., Merçon-Vargas et al., 2018; Visser, 2009). For example, Wang et al. (2015) reported that Chinese children expressed more connective gratitude than American children.

Further, language influences gratitude expression by shaping people's understanding of social rights, duties, and mutual collaborations (Floyd et al., 2018). For example, native speakers of English and Italian explicitly convey gratitude more regularly than those using non-western languages like Lao (prevalent in Southeast Asia) or Siwu (prevalent in western Africa) (Floyd et al., 2018). Floyd and colleagues further discuss the established differences between a potentially global *feeling* of gratitude and more diverse *expressions of* gratitude.

In collectivistic societies where social norms of mutual help and role obligation prevail, people may benefit less from expressing gratitude than in individualistic cultures (Shin et al., 2020). This is understandable as people in individualistic cultures possess an independent self-view, whereas those in collectivist cultures have an interdependent self-view (Markus & Kitayama, 1991). Consequently, the practice of gratitude may benefit people from western cultures more than those from eastern cultures (Boehm et al., 2011; Layous et al., 2013). Indeed, Shin et al. (2020) observed cross-cultural variations in experiences and benefits accrued from gratitude among participants from America, Taiwan, and India. Clearly, gratitude which is the predictor of mental health and positive functioning varies across cultures on the dimension of people's varied experiences (Aghababaei & Tabik, 2013). Since this chapter focuses on gratitude among Indian adolescents, we discuss how gratitude is experienced and expressed in Indian society.

Gratitude Through the Indigenous Indian Lens

India espouses a rich cultural heritage and diversity, a hierarchical society where gratitude often manifests in *non-verbal expressions* (Appadurai, 1985). An emphasis on removing the burden of indebtedness is a common guiding principle in exchanges of gratitude observed in Indian culture (Shin et al., 2020). Traditionally, Indians express gratitude in various forms, including dance, music, drama, meditation, and yoga. Symbolic gestures like folding hands in greeting (*namaste* or *namaskar*) or bowing to touch another's feet as a mark of respect are also common in the Indian culture. People practice these symbols of gratitude in interpersonal relationships and divine worship (Shaules, 2007).

Appadurai (1985) describes the *focus on transpersonal gratitude*, which gives rise to personal gratitude as a common phenomenon in India. Interestingly, appreciation and gratitude are often directed towards nature and marked through religious celebrations and rituals. Some of these vibrant cultural traditions find mention in ancient texts and vernacular literature. Different manifestations across the Indian landscape include gratitude towards the sun (observed as *Chathh Puja* in Bihar) and the moon (observed as *Purnima* or full-moon night). Other related festivals and ceremonies include reverence towards rain (*Minjar* festival of Himachal Pradesh), clouds (*Pongal* in Tamil Nadu), rivers (*Pushkaram* in Andhra Pradesh), and stars (*Ahoi Ashtami*). These indigenous ideas are also embedded in folktales (e.g., *Panchtantra, Jataka tales*) that often narrate an individual's gratitude and respect towards nature (Dorji, 2009).

Further, Indians are known to feel connected and grateful for a wide and distant social network of people (Markus & Kitayama, 1991; Triandis et al., 1986). In fact, Titova et al. (2017) discuss how Indians are grateful to distant others for receiving emotional and moral support. This summary points at the nuances that characterize indigenous experiences and practices of gratitude. Clearly, cross-cultural research is an essential means to advance cultural sensitivity in the literature (Layous et al., 2013). It is equally essential to focus on relatively under-represented populations. The present chapter contributes to this emerging area by sharing findings from a study focused on gratitude journaling among adolescents from North India. The next section examines the background, details, and findings of this study.

A Study on Gratitude Journaling Among Indian Adolescents

Study Background

This study emerged from a more extensive project involving applying school-based positive psychology interventions among adolescents from North India. The overall project evaluated the impact of different intervention modules on participant well-being and other related variables. These interventions focused on gratitude cognitions

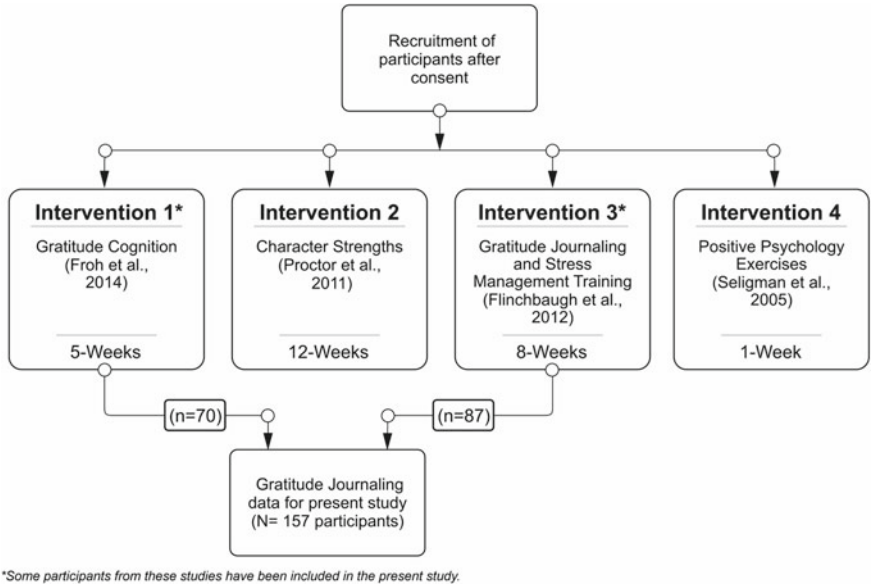

Fig. 19.1 Overview of Study Flow

(Froh et al., 2014), character strengths (Proctor et al., 2011), stress management and gratitude journaling (Flinchbaugh et al., 2012), and various positive psychology exercises (Seligman et al., 2005).

As part of two of these interventions, adolescent participants engaged in the process of gratitude journaling over several weeks. In the present chapter, we focus exclusively on the data that emerged from these student gratitude journals. Figure 19.1 depicts the context, setting, and flow of the present study. A detailed description of each section follows. To familiarize the reader with the study context, we briefly explain the two intervention programmes that subsumed gratitude journaling:

Study 1: This study looked at the impact of a gratitude building intervention (Froh et al., 2014) among Indian adolescents. We randomly assigned participating classrooms across intervention and control conditions. The intervention group attended 30-min-long weekly sessions spread over five weeks, based on Froh et al.'s gratitude curriculum. As part of this programme, students also maintained a personal gratitude journal. During the same time, the control group participants were offered sessions on an unrelated neutral theme. Detailed findings are available elsewhere (see Khanna & Singh, 2016).

Study 2: This study aimed to understand the effect of a gratitude journaling and stress management intervention (Flinchbaugh et al., 2012) among Indian adolescents. We randomized participating classrooms across four groups (stress management training, gratitude journaling, combined stress management and gratitude journaling, and control group). Among these four groups, students in two intervention conditions

engaged in gratitude journaling for eight weeks. Study findings of the intervention impact are presented elsewhere (see Khanna & Singh, 2021).

Participant Information

A total of 157 boys and girls from four schools across two sites (New Delhi and Chandigarh) in North India participated in gratitude journaling. Participants were adolescents aged 11–14 years from grades 6–9. The majority of them belonged to urban and nuclear households. Since the present study sample consists of participants from two independent studies described previously, group-wise participant information is as follows:

Group 1 ($n = 70$).

A total of 70 students of grades 7–9 from two schools participated in this study. Participant's age ranged from 11 to 14 years ($M = 12.29$ years, SD = 0.67).

Group 2 ($n = 87$).

Participants were 87 students of grades 6–9 from two schools. Their age ranged from 11 to 14 years ($M = 12.31$ years, SD = 1.27).

All these students were engaged in gratitude journaling and were considered together for the present study's purpose.

Procedure

Initially, we contacted schools authorities and obtained permission to work with students and collect subsequent data. As a next step, we sought parental consent through letters sent home with class teachers' help via students. Upon receiving parental consent, participating students filled the assent forms in their respective classrooms. We used a quasi-experimental design and randomized participating classrooms across conditions in each school. As mentioned previously, detailed information about interventions from where the current study emanates find mention elsewhere (see Khanna & Singh, 2016, 2021). The scope of this chapter precludes a detailed description of these studies.

Participants received hard-copy booklets titled "My Gratitude Journal". The researchers asked students to label their journals to avoid misplacing them and keep them safely for the intervention duration. The students' basic instruction was to note three good things (Group 1) and five things (Group 2) that they were most thankful for during that week. In the initial days, the facilitator (first author) helped students unpack the concept of gratitude by suggesting various examples of what one could be grateful for. The idea was to familiarize students with gratitude and its manifestations in everyday life.

The facilitator visited all participating classrooms every week. Along with each class's respective intervention curriculum, the facilitator reminded participants to make their journal entry for the week. The standard brief each week was '*recall the things you are grateful for this week*'. Confidentiality of participant data was assured. Although adolescents journaled in-class, we prompted them to engage in journaling after these sessions as well. While we did not expect students to share their journal entries with their peers, they were free to discuss anything or clarify any relevant doubts. The idea behind the regular reminders during the weekly classroom visits was to encourage and motivate them to keep up the journaling practice. At the same time, it also provided the students with an opportunity to discuss anything they wanted to, within the larger context of the ongoing intervention participation. The research team collected the journals after the completion of the last intervention session.

Data Analysis

We used inductive content analysis to interpret the textual data from student gratitude journals. This process enabled us to systematically quantify qualitative data (Krippendorff, 1980; Sandelowski, 1995). The analysis process involved the following main steps:

Step 1: The researchers read through the gratitude journals several times to immerse themselves with the data and develop an overall sense of it.

Step 2: Guided by an inductive approach (Elo & Kyngas, 2008), the research team engaged in open-coding and recognized any meaningful patterns emerging from the data. They went on to identify suitable response categories.

Step 3: Next, overlapping categories were merged. Similar categories were also grouped under higher-order categories (Burnard, 1991; Dey, 1993) to organize the findings better. At this stage, the research team had frequent discussions and moved back and forth between categories as required until they reached a consensus (Graneheim & Lundman, 2004).

Step 4: The researchers tallied the frequency of occurrence of each sub-category and higher-order category. Since we considered each participant's journal entries over a few weeks, multiple responses corresponded to every participant.

Step 5: Finally, an independent reviewer who was not part of the analysis process till this point verified all the identified categories (see Burnard et al., 2008; Miles & Huberman, 1994). The purpose of this was to minimize any subjective bias and improve the trustworthiness of the entire process. Minor revisions suggested at this stage were incorporated.

The next section describes the critical findings from this analysis.

Results and Discussion

What We Found

The gratitude journals reflected adolescents' sense of gratitude attributed to aspects emerging from three dominant categories: *emerging from self*, *emerging from others*, and *emerging from transpersonal sources*. Each of these is described ahead, along with the sub-categories encompassed in each higher-order category (refer Fig. 19.2).

Table 19.1 represents the frequency of responses under each category, supplemented with some exemplar responses corresponding to each.

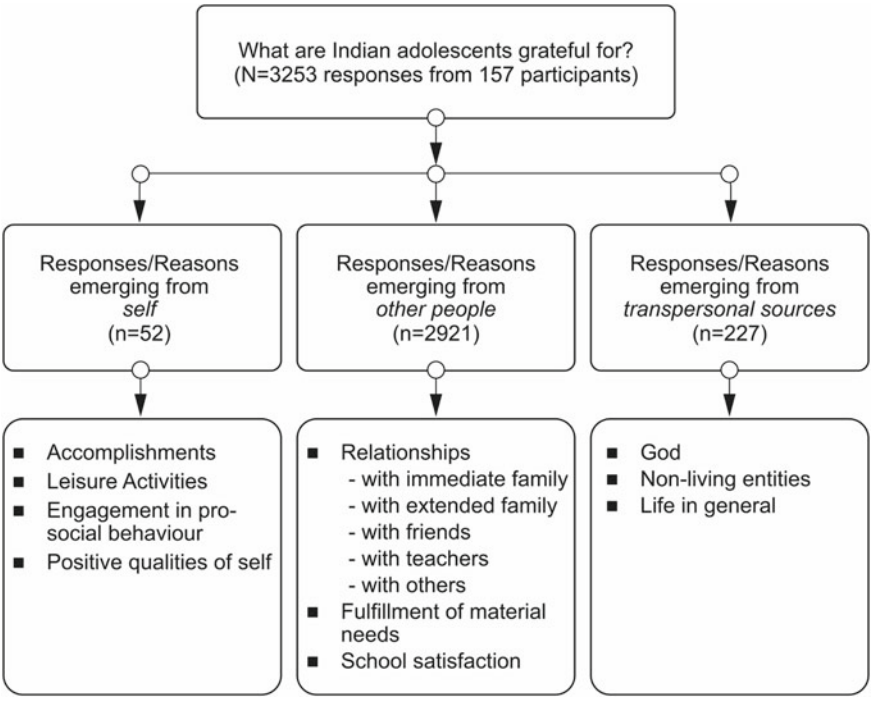

Fig. 19.2 Overview of response categories that emerged from gratitude journals

Table 19.1 Frequency of responses that emerged from student gratitude journals

Categories	Frequency	%	Examples
Emerging from self	**52**	**1.59**	
Accomplishments	16	0.49	'*First prize in bulletin board competition*' '*Good marks in unit tests*'
Leisure activities	13	0.39	'*I get to go out and play everyday*' '*Watching Kapil Sharma Show*'
Engagement in prosocial behaviour	13	0.39	'*Donated money in an NGO*' '*Helped an old man cross the road*'
Positive qualities of self	10	0.36	'*I am confident*' '*I am hardworking*'
Emerging from others	**2921**	**89.79**	
Relationships	2293	70.48	
With immediate family	960	29.51	'*My parents helped me get over depression*'
With extended family	118	3.62	*'My aunt helps me in studies.'*
With friends	840	25.82	*'Friends helped me in revision.'*
With teachers	274	8.42	'*My maths teacher always listen to my problems*'
With others	101	3.10	'*Neighbour helped me find my lost keys*'
Fulfillment of material needs	578	7.76	'*Mom gave me a remote control car*' '*Dad gave me new iPhone*'
School satisfaction	50	1.53	'*Lovely school to change all classes to smart classes*' '*School gave us good teacher*'
Emerging from transpersonal sources	**227**	**6.97**	
God	135	4.15	'*God gave me everything*' '*I feel thankful for God for giving me good friends*'
Non-living entities	62	1.90	'*My house*' '*Good planet*'
Life in general	30	0.92	'*Beautiful life*' '*Wonderful life*'
Miscellaneous	**53**	**1.62**	'*I forgot to sit in my exams today*' '*My dog bites my enemy*'

Bold represents the higher-order categories. These higher-order categories encompass sub-categories (not in boldface)

Emerging from Self. All responses where participants expressed gratitude for aspects of life, attributes, or situations that arose from themselves have been considered under this higher-order category. In essence, it includes all responses wherein adolescents' reason for feeling grateful emerged from themselves (as opposed to being received from others). Sub-categories subsumed within this category were:

Accomplishments. Entails all responses wherein the participants were grateful for their accomplishments in life. These accomplishments comprised academic achievements (success at school) and non-academic achievements (goals fulfilled in life outside school).

Leisure Activities. Includes all responses revolving around activities (unrelated to schoolwork) undertaken for relaxation and enjoyment, such as playing video games and outdoor play, among others.

Engagement in Prosocial Behaviour. Includes all responses wherein participants were grateful for their engagement in prosocial activities such as sharing, donating, helping, volunteering, and co-operating to benefit others.

Positive Qualities about Self. All responses in which adolescents' gratitude for their own positive attributes and behaviour (e.g., being hardworking, confident) was described have been considered here.

Emerging from Others. This higher-order category includes all the responses wherein participants' reason for gratitude was attributed to others and not limited to themselves. All responses indicated that participants were grateful for their relationships, interactions, and tangible or intangible benefits derived from other people. Sub-categories subsumed within this category were:

Relationships. Encompasses all responses where participants showed gratitude towards various relationships in their life. Prominent relationships were immediate family (parents and siblings), friends, extended family (grandparents, uncle, aunt, and cousins), teachers, and other community members.

Fulfilment of Material Needs. The responses under this sub-category revealed adolescents' gratitude towards others, specifically for attaining desirable material possessions. Participants enlisted a sense of appreciation and joy for receiving tangible things, including gifts, cash, and varied objects from their relatives.

School Satisfaction. Responses wherein adolescents shared positive attributes of their school in general or mentioned specific aspects contributing to their welfare had been considered here.

Emerging from Transpersonal Sources. This broad category includes all the responses wherein adolescents' reason for gratitude emerged from sources beyond self or interpersonal others. Sub-categories included entities like God, Nature, and other intangible aspects explained ahead:

God. Includes responses where participants expressed gratitude to God. The participants were grateful to the supreme power for specific aspects or multifaceted domains of their life.

Non-living Entities. All responses where participants described their gratitude for the inanimate and intangible (e.g., planet, nature, environment), and non-living things (e.g., house, city, books) accounted for this sub-category.

Life in General. Includes all responses wherein the participants expressed gratitude for life in general and described it using various positive adjectives.

Miscellaneous. All random and infrequent responses that did not fit into any previously described categories were considered under this head.

What These Findings Suggest

This study aimed to examine Indian adolescents' reasons for gratitude through their participation in gratitude journaling. Within the broader canvas of two classroom-based interventions, school-going adolescents from North India maintained gratitude journals over several weeks. Since a detailed discussion precludes this chapter's scope, we briefly discuss the prominent trends that emerged from our findings.

First, a sweeping majority of responses suggest that study participants were grateful towards their relationships (including family, friends, and teachers). This finding is on expected lines considering that gratitude is a predominantly interpersonal emotion (Emmons & McCullough, 2004). Since India is a collectivistic society, Appadurai's (1985) assertion that Indians tend to be grateful to an extensive and distant social network reinforces this trend. Froh et al. (2009) emphasize the connection between gratitude and social support. The most frequent response categories that emerged from our data were family and friendships. This is quite logical as gratitude is a significant motivator of relationships with benefactors (Algoe & Haidt, 2009).

Interestingly, adolescents frequently expressed appreciation for fulfilling material needs and receipt of material gifts from different people. Although materialism deters gratitude (Solom et al., 2017), it is also a favoured means of pursuing happiness (Emmons, 2014). Indeed, material possessions have a significant consumption value because young people use them to express their extended self (Belk, 1988). This seems understandable, considering that participants were young adolescents from urban India. Moreover, Chaplin and John (2007) assert that focus on material possessions is maximum during early adolescence and tends to decline with age. Another distinctive finding was adolescents' gratitude directed towards transpersonal sources and inanimate entities. This can be explained better through the general idea of gratitude as a transpersonal experience (e.g., Lin, 2014; Steindl-Rast, 2004) and the specific focus on this dimension in Indian culture (Appadurai, 1985). The well-established connection of gratitude with religion (Emmons & Kneezel, 2005; Peterson & Seligman, 2004) and spirituality (McCullough et al., 2002) renders support to these findings.

Further, relatively few responses indicated participants' gratitude towards events/causes emanating from themselves. Most of the response categories that emerged here tie in nicely with positive adolescent outcomes. These included

academic and non-academic accomplishments, leisure activities, engagement in prosocial behaviour, and positive personal attributes. Specifically, academic accomplishments are related to well-being (Quinn & Duckworth, 2007). Leisure activities also play an important role in adolescents' personal development (Larson & Verma, 1999). Interestingly, engaging in prosocial behaviour (a recurring response in student journals) emerges during early adolescence development (Brownell, 2013) and links to gratitude (McCullough et al., 2004). Weinstein and Ryan (2010) contend that gratitude could, in turn, motivate the benefactor's prosocial behaviour.

To sum up, this study offers insight into what adolescents from India are grateful for. It is beneficial as it adds to scholarship about a relatively under-represented demographic group. It is essential to understand the perspectives of Indian adolescents themselves to gather insight into their lived experiences. Nevertheless, future research could refine and expand both the subject and scope of such studies. A larger and more representative study sample, journaling in their mother tongue, and utilizing other innovative strategies could yield further insights. Indeed, Bono et al. (2020) emphasize the benefits of expressing gratitude to others beyond just feeling it within oneself. They also call for the use of modern technology in interventions of this nature. Considering the mixed evidence for gratitude journaling among young students (see Khanna & Singh, 2021), age-appropriate and culturally informed practices could offer a promising way forward.

Positive Adolescent Development: Current Steps and Future Roadmap

Different stakeholders, including the governments, private agencies, and non-governmental organizations (NGOs), have launched various policies and programmes to promote adolescent well-being across the world. We examine some prominent ongoing work in this area globally, with a detailed focus on the Indian scenario.

Ongoing Work by Various Agencies: Global Scenario

There are many strategic initiatives and programmes to support multidimensional adolescent development at the global level. For example, UNICEF (2018) delineated a strategic direction to advance adolescents' quality of life in line with the Sustainable Development Goals; and the United Nations (2018) put forth *Youth 2030* as a far-reaching blueprint for young people's empowerment and development. Further, the United Nations Major Group for Children and Youth issued a global *Call to Action* (2019), urging the international community and national governments for resolute action for adolescent health and well-being.

Among specific schemes, *the Adolescent Girls Initiative* by the World Bank (2008) is a multi-country public–private collaboration to enable adolescent girls' progression from school to gainful employment through skills training and interventions. *Global Accelerated Action for the Health of Adolescents (AA-HA!)* by the WHO (2017) supports governments and policymakers across countries in catering to their adolescents' health needs. Further, the WHO (2018) report on *Engaging young people for health and sustainable development* outlines a gamut of initiatives including *Adolescents 360* (to promote voluntary use of contraception among girls from marginalized communities), *Adolescent Youth Constituency* (a multi-partner capacity building programme for youth at different levels), and *All-In to End Adolescent AIDS* (a collaborative effort to destigmatize and combat AIDS among adolescents globally).

In the academic domain, the *Social, Emotional, and Ethical Learning Program* (SEE Learning), a collaboration between Emory University and His Holiness the Dalai Lama, expanded globally in 2019 to nurture social, emotional, and ethical competencies among school-going children. Similarly, *Collaborative for Academic, Social, and Emotional Learning* (CASEL, https://casel.org/) works extensively to instil scientifically backed social and emotional learning practices within the school education systems. *Gaia Youth Programme* (https://www.gaiaeducation.org/face-to-face/gaia-youth/) is a flexible curriculum that supports sustainable education for youth. The *California School-Age Consortium (CalSAC,* https://www.calsac.org/) enables an out-of-school time workforce led by strong mentors and highly skilled practitioners. Another leading initiative of this kind is *Support Advanced Learning and Training Opportunities for Youth (SALTO-YOUTH)* (https://www.salto-youth.net/), offering informal learning resources and youth training.

Among efforts focused on disadvantaged groups, the *International Organization for Adolescents* (http://iofa.org/) fosters effective community-level partnerships to impact vulnerable children. *Central Australian Youth Link-Up Service (CAYLUS) Mission* (https://caylus.org.au/) aids community efforts to enhance the quality of life and handle substance use issues among youth. One of America's largest positive youth development organizations, *4-H* (https://4-h.org/) takes a strengths-based approach to nurture equity, inclusion and empowerment among young people.

Following this brief overview of global work in the area, we take a more detailed look at diverse initiatives in the Indian context.

Steps for Positive Adolescent Development in India

The Government of India has pioneered some large-scale initiatives to advance holistic adolescent development over the past few decades. Among these, *Adolescence Education Programme* (2005), in association with the National Council of Educational Research (NCERT), Ministry of Human Resource Development (MHRD) and United Nations Population Fund (UNFPA), aims to empower adolescents with culturally relevant and age-appropriate information to handle real-life affairs constructively. The *Kishori Shakti Yojana* (2010) is a government scheme that

aims to enable adolescent girls to combat gender disadvantage and realize their full potential. The *Rajiv Gandhi Scheme for Empowerment of Adolescent Girls* (2011) or *Sabla* is a centrally funded initiative by the Ministry of Women and Child Development for adolescent girls' holistic development. *National Youth Policy* (2014) by the Ministry of Youth Affairs and Sports caters to the overall youth development needs. The multi-faceted programme *Rashtriya Kishor Swasthya Karyakram* (2014) under the Ministry of Health and Family Welfare prioritizes adolescent nutrition, sexual health, substance misuse, gender-based violence, and mental health. The *Atal Innovation Mission* (2016) seeks to nurture scientific temper and innovation among school-going adolescents.

Further, various state governments have also launched prominent programmes to facilitate adolescents' positive development and welfare. *Understanding the lives of adolescents and young adults-UDAYA* (2015), a novel collaborative endeavour of the Population Council in Bihar and Uttar Pradesh, is one example. Similarly, the Government of Karnataka and the National Institute of Mental Health and Neurosciences (NIMHANS) initiated *Yuva Spandana* (2015)—a youth mental health promotion programme to encourage a healthy lifestyle among the youth. The Delhi government's flagship programme *Happiness Curriculum* (2018), for school children, is based on Boniwell and Ryan's (2012) wellness curriculum and Nagraj's (1999) happiness triad model. It focuses on promoting students' social-emotional well-being through self-awareness, mindfulness, critical thinking, empathy, and overall personality enhancement. Recently, the Madhya Pradesh government and the UNFPA introduced the Umang Adolescent Helpline (2020), an anonymous tele-counselling service to assist adolescents in crisis management. This initiative also expands to include walk-in counselling centres and integrate the *Life Skills Education Initiative* (2017) to further a healthy learning environment for adolescents.

Various NGOs across India are also championing the cause of overall positive adolescent development. Prominently, *Sangath* (https://www.sangath.in/) and *Association of Adolescent and Child Care in India* (https://aacci.in/) are working for adolescents' holistic well-being. Others like *Dasra* (https://www.dasra.org/) and *Pravah* (https://www.pravahindia.org/) support initiatives for a youth-centric development ecosystem. Further, *Leher* (https://leher.org/) and *Child Rights and You* (https://www.cry.org/) work for child rights and protection. Another NGO, *Smile Foundation* (https://www.smilefoundationindia.org/), contributes towards adolescent education and healthcare.

Interestingly, private sector organizations also contribute meaningfully to this area, especially through their corporate social responsibility (CSR) initiatives. A notable example is the *Teen Coalition* by India CSR Network (https://indiacsr.in/tag/teen-coalition/), a collaborative endeavour that unites stakeholders across regional and digital divides to further the cause of adolescent welfare. Other eminent initiatives include Dabur India's *Sundesh-be the change* (https://www.dabur.com/amp/in/en-us/csr-be-the-change/sundesh), Procter and Gamble's *Parivartan-The Whisper School Programme* (https://www.smilefoundationindia.org/procter_&_gamble_outreach.asp), Nestle India's *Healthy Kids Programme* (https://www.nestle.in/csv/

individuals-families/nestle-healthy-kids-programme), and Mahindra & Mahindra's *Project Nanhi Kali* (https://www.nanhikali.org/).

While acknowledging all these steps in a positive direction, it is imperative to note that many of them rely on anecdotal evidence without being objectively monitored or backed via robust empirical evidence. Scientific research on positive adolescent development in India is still fledgeling. We offer a concise review of relevant scholarly findings spanning the past decade. There is rising interest in understanding the mental health status of adolescents from diverse parts of India (e.g., Harikrishnan et al., 2017; Halli et al., 2021) and the socio-demographic factors related to their mental health and wellness (e.g., Singh & Raina, 2019; Singh et al., 2015; Sood & Gupta, 2012).

Further, specialized interventions have attempted to address the diverse needs of this segment. For example, Bharat and Kishore (2010) evaluated the *Life Skills Education Program*'s impact among Indian adolescents. *CorStone* has conducted a rich body of work to strengthen resilience among Indian adolescents from underserved and marginalized communities (see CorStone, 2011, 2013). Singhal et al. (2014) developed and assessed a school-based coping skills programme for at-risk adolescents and affirmed a proactive intervention's value. Sundar et al. (2016) piloted *The Hero Lab*—a positive psychology programme set in a migratory Mumbai slum and documented statistical gains in participants' happiness, grit, empathy, and gratitude, demonstrating the relevance of such steps to address mental health needs. Carreres-Ponsoda et al. (2017) examined the effectiveness of a mindfulness programme among adolescents and encouraged its implementation to cultivate positive emotional and social skills. Shinde et al. (2020) evaluated *Strengthening Evidence base on scHool-based intErventions for pRomoting adolescent health (SEHER)*—a multipart, school-wide intervention to foster adolescent health. Michelson et al. (2020) also examined a short counsellor-led intervention targeting mental health issues in Indian adolescents from urban, low-income schools. Sharma et al. (2020) affirmed encouraging preliminary evidence for *Setu*, a school-based programme to prevent violence during early adolescence. Khanna and Singh (2016, 2019, 2021) have previously worked on classroom-based positive psychological interventions targeting adolescents from North India.

This snapshot of research and practice initiatives by diverse stakeholders offers an encouraging picture of the future of adolescent health and well-being in India. However, if we take cognizance of the challenges at hand, it becomes evident that there is no room for complacency. We conclude this chapter by proposing some ideas to guide future work in this area.

Future Directions

First, we reiterate the importance of moving beyond the pathological model towards a more strengths-focused perspective of adolescence. Since a positive psychology perspective informs this chapter, we note the evolution of positive psychology itself. Moving from the traditional focus on individual well-being to a more balanced

and existential focus in the second wave (see Ivtzan et al., 2015; Wong, 2011), we acknowledge the relevance of the emerging third wave in positive psychology (Lomas et al., 2020). This new movement urges a deeper understanding of contextual and cultural nuances, systems informed, and more inclusive approaches (see Lomas et al., 2020). Future work in the Indian context should be aligned with these shifts, recognizing inherent cultural best practices while keeping pace with current knowledge and advancements.

As an extension, future work would benefit from revisiting indigenous Indian practices and assimilating them into the present context. With the widespread understanding that seemingly universal phenomena may be interpreted differently across cultures (e.g., Rich & Sirikantraporn, 2017), there is a need to advance cross-cultural and localized research from non-western contexts. Bridging the gap between the local and the global would immensely benefit subsequent adolescent welfare initiatives in India.

Taking a cue from Bono et al.'s (2020) recommendation in gratitude literature, we support the potential of integrating a *top-down approach* with a *bottom-up approach* to further positive adolescent development in India. This entails combining policy-led initiatives with more grassroot-level steps that consider local factors, challenges, and intricacies. This is especially relevant to cater to the diversity inherent within the Indian milieu.

Further, Sheldon and Lyubomirsky (2019) advocate the importance of *person-activity fit* to derive more significant benefits from positive psychology interventions. We believe this idea is relevant across other types of interventions as well. Policymakers, educators, and academics must consider the compatibility between an initiative and its target recipients to ensure optimal acceptance and subsequent gains.

Finally, the magnitude of the adolescent population in India and the challenges they face call for sustainable and scalable steps. Drawing on models like *participatory action* and *peer mentoring* could help reach adolescents across diverse Indian communities and transcend the rural–urban divide. Numerous studies (e.g., Leventhal et al., 2018; Mathiyazhagan, 2018; Rath et al., 2020) establish the relevance of such strategies when working with Indian youth. Harnessing the benefits of modern technology and utilizing innovative web-based applications and platforms (e.g., Wasil et al., 2020) emerges as a favourable future step.

Multipronged and innovative steps towards positive adolescent development could ladder up to tremendous socio-economic gains for India.

Conclusion

The present chapter discussed positive adolescent development with a focus on the role of gratitude in promoting adolescent well-being. The cross-cultural aspects of gratitude are highlighted and the benefits of gratitude in different spheres are indicated. The chapter presented the findings of a study based on gratitude journaling among Indian adolescents. The study threw light on what Indian adolescents are

grateful for, pointing at the same time further scope of research in this area. Various initiatives and measures on positive adolescent development both at the global level and in India are described.

The chapter has adopted a strengths-focused approach to adolescent development, moving away from the traditional view of adolescence. The empirical study stresses the need to look into cultural aspects in using the positive psychological constructs. Emphasis on socio-cultural contexts and practices will help in better understanding adolescents' challenges, and subsequent steps to address these and promote their well-being.

Time to Reflect

> Let us rise up and be thankful, for if we didn't learn a lot today, at least we learned a little, and if we didn't learn a little, at least we didn't get sick, and if we got sick, at least we didn't die; so, let us all be thankful—Buddha.

From any early age, most cultures encourage their young ones to say 'Thank You', often touting this as one of the magic words. It is worth pausing to reflect that gratitude is more than the mere utterance of this powerful phrase. While nearly every language has its own words to express gratitude, the power of gratitude defies the need for language! If we look around with an appreciative eye, we will find so many deep-rooted cultural and spiritual practices across the globe that have the essence of gratitude at their core. The festival of 'Thanksgiving' in Western cultures, various harvest festivals in Asian contexts and diverse cultural practices are just a few prominent examples. Irrespective of the pathway you adopt, it is immensely beneficial to make gratitude a part of your life.

Try this out:

On a daily basis make it a point to recount something you are grateful for. Please select a time and routine that you are most likely to enjoy and sustain. You could maintain a gratitude journal (online or physically), a gratitude photo gallery (perhaps a folder with a collection of images that recount your gratitude). To pay it forward, try to give someone else a reason to be grateful. You could choose the frequency of this exercise and how any things you decide to recount/pay forward. The essence is to focus on making this part of your being.

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Chapter 20
Risk and Resilience Among Indian Adolescents: A Community Approach

Shilpa Pandit

Abstract The chapter presents a new approach to understand adolescent development in the pluralistic and diverse Indian context by integrating the recent developments in community psychology and resilience research. It focuses on a community approach to positive adolescent development in the Indian context. The chapter explains the social construction of adolescence and discusses the risk and resilience factors to understand and deal with the challenges pertaining to this stage of development. It highlights that community-led interventions can act as a strong protective factor to promote resilience among adolescents. The chapter showcases real-life examples related to this in the form of case studies that points out that larger context shapes adolescent development and concludes that community-led interventions are the way forward for positively building up the life of adolescents.

Keywords Adolescents · Ecology · Risks · Protective factors · Vulnerabilities · Community interventions · Resilience framework · Micro–meso–macro levels of context

Introduction

> Pratibha grew up in a small village near Jind, Haryana in North India. Girls were few in her village, and she found it difficult to find friends for her kho-kho and pitthu games, whenever she would find time to play. Anyways, she rarely had time to play games in the evening. She had to help her mother to take care of the cows, help prepare food in the kitchen, go to the jungle to fetch dry wood sticks, and also fetch water from the water-stream in the next village.
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> She went to school till primary level. At puberty, her father and other elders decided to take her off school and completely focus on household work. The boys in the village were aggressive and the girl needed to be protected, they said. Very soon, the elders in the family decided that she should be married. When Pratibha protested to her mother, her mother said, she should be happy that she is allowed to live. Girls are few in her village because most girls are either aborted from the womb or die immediately after birth. Pratibha protested and didn't

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eat for three days. She called her cousin aunt, one evening, on mobile, hiding in the evening twilight and cried. Her aunt worked in Rohtak as an ASHA worker in the Panchayat and decided to take charge. She visited her village two days later and there was a huge family fight. Her aunt fought hard with her brother (Pratibha's father), tried to convince village elders, and finally took Pratibha with her to Rohtak and enrolled her into a municipality school, though two classes junior.

This story highlights female foeticide or infanticide as well as the larger social and cultural structures, which constrain and facilitate the development of genders differently. Indeed, what do we mean by 'development' can have two sides of the debate. The elders in Pratibha's village might think that they are doing the 'best' for the girl. Girls in India face several challenges, right from conception. Foeticide and infanticide result from 'boy preference', even though it is illegal by law. Systemically, we see girls dropping out of the education system and lesser girls in higher education. When women enter the workforce, we see girls and women getting less pay than their equally skilled male counterparts. Economists say that if more women participated in the workforce and were equally paid, the countries would prosper and families would flourish!

The point that we see in this story is that culture itself acts as a constraint—as in the case of girls not being allowed to go to school after puberty and culture again can potentially act as a resource where it allows for diversity to flourish! We need to see, what cultures are we building and supporting—just like Pratibha's aunt!

The risk and protective factor framework gained prominence during the 1980s and 1990s (Masten & Garmezy, 1985; Rutter, 1985). **Risks** are generally understood as challenges arising from structures and the context, whereas **'vulnerabilities'** are understood as challenges arising from within the person (Krovetz, 1999). Some researchers have pointed out that this distinction between risks and vulnerabilities arose in the context of epidemics such as HIV/AIDS, where certain people were thought to be more 'vulnerable' than others. In this chapter, we take this technical definition as appropriate for our purpose. Similar to the fact that there are risks that arise from an environment, **protective factors** also exist in the ecological context that protects against adversity. These protective factors can be a strong attachment relationship, strong social support, access to a good school, a good teacher–student relationship, a strong and pro-people administration, etc.

There are places in our country having a very low child sex ratio, which means less girls seem to survive past 5 years of age in these districts (http://censusindia.gov.in/). Globally also this is a challenging problem for our society. Why does such a social practice continue and how knowledge of psychology can be applied here?

There are multiple levels of strengths and protective factors within ourselves, our families and relationships as well as communities. In India, due to the particular characteristics of the Indian social structure, community interventions have been used extensively. These communities—either formed due to our kinship groups, residential or geographical proximity or formed by our own selves—help us in multiple ways. They bring us affiliation, companionship, collective problem-solving, sharing activities and stress, and bring joy and trust in our lives. Research shows that community interventions among adolescents do show impact, even as studies show a variation in

results (Aggarwal & Berk, 2015; Arora et al., 2010; Mehra et al., 2018; Rath et al., 2020).

The basic premise discussed in this chapter is—can a resilience framework be used for understanding adolescence in the Indian context. Resilience is a key concept for us to understand. Werner in the 1970s was the first to introduce the term 'psychological resilience'. In a landmark study, she studied children from Kuai Island in Hawaii longitudinally from birth to adulthood for more than 30 years. The focus of early research was on vulnerabilities and adversities. The research identified lack of problems as one of the important outcomes of resilience (Werner & Smith, 1982). It is only in the past few decades that we see a strength-based salutogenic understanding of resilience. Resilience research has also been critiqued for primarily emanating from the western context and therefore Ungar (2008) has given a context-embedded definition of resilience after investigating youth and resilience in 14 communities across five continents. Ungar states that resilience is multi-layered and there are culturally specific as well as global dimensions of resilience. Researchers now also acknowledge that resilience is more than a personal quality or attribute but needs resilience at micro- and meso-structures, such as resilient families and communities, that channel resilience in culturally navigated ways. While resilience acknowledges the presence of adversity, the shift in focus is now on how adolescents and youth experience sustaining, enhancing pathways towards well-being, beyond the absence of problems (Theron et al., 2015; Ungar, 2008, 2011, 2013; Ungar & Liebenberg, 2009). Resilience is therefore defined in the context as, 'In the context of exposure to significant adversity, whether psychological, environmental, or both, resilience is both the capacity of individuals to navigate their way to health-sustaining resources, including opportunities to experience feelings of well-being, and a condition of the individual's family, community and culture to provide these health resources and experiences in culturally meaningful ways' (Ungar, 2008).

How do we translate this powerful revision into the Indian context? Firstly, moving away from the individualistic idea of resilience, this definition looks at risk and protective factors in the communities. Some of these risks and protective factors may be global such as the presence of strong attachment figures, etc. Some are specific to the context—such as the context of income poverty or access to schools. Thus, the role of communities in interventions is also emphasized. Secondly, it is emphasized that adolescents and young people negotiate with the relationships and systems as they navigate through their adversities and this dynamic negotiability, as you see in the case of Pratibha when she called her aunt for help is an important resource when we study adolescent development in the Indian context.

Thus, the chapter discusses the importance of social context, or the eco-system, in which adolescents grow and develop. In recent years, psychologists in India have also noted this change in the consensus about the role of culture and context in adolescent development (Misra & Babu, 2013; Saraswathi, 1999; Saraswathi & Oke, 2013). The socio-cultural context is both a strength or resource and a challenge. Certain cultural and social practices act as buffers, providing support and resilience. At the same time, certain contextual factors act as risks and adversities, deeply affecting the person throughout the life span. As goal-directed behaviour, the risks and strengths

can be put in the foreground and/or background (using gestalt principles) as we situate adolescence in the Indian context. The chapter highlights the risks and strengths as specifically located in the context of Indian adolescents. It emphasizes that creating communities and community-led interventions can act as a strong protective factor in working with adolescents.

Adolescence as a Social Construction

Social construct or construction means that society and the people who constitute the society create a certain meaning of an object, or an event, or a process such that this construction is taken as 'natural' and guides thoughts, feeling/attitudes, and actions of the members of the society. For example, in the 1980s, adolescence was constructed as a period of 'storms and stresses', especially, in the Euro-American context. Do all adolescents, in all contexts, face storms and stresses? Saraswathi, in her 1999 paper questioned this universal idea and indicated several pathways towards maturity. For example, several tribal societies lead their adolescents to mature adulthood through social and cultural processes. Now, once we have constructed adolescence as a period of storm and stress, then it is likely that such a construction in turn influences the thoughts, actions, and social relationships of the parents, teachers, and adolescents.

Adolescence can be considered a social construction. It indicates that even though people across the world and throughout history have grown, entered puberty, and experienced the changes in their body and mind to become full adults, the social meaning of what it is to attain puberty and become an adult has changed from time to time. About 200 years ago, there was the practice of child marriage in India, where children attaining puberty were more likely to be already married, and puberty meant taking adult roles in the family and community. Contrast this to the idea of 'emerging adults' (Arnett & J., 2000) for the millennials growing in middle-class and upper-middle-class urban clusters of India today. Persons in their 20s in several contemporary urban societies are not understood as 'full adults' but as 'emerging adults', as they have not yet settled in their occupations, completed their education, or started their families. The point to note is that as societies transition, the social meaning attached to the life span development trajectories also changes. This social meaning is constructed by the societies themselves.

The understanding of adolescence focuses on certain key themes. They are the onset of puberty and the physical growth, the endocrine changes and their impact on social relationships and emotions/mood states, clinical aspects of dysfunctions during adolescence, and the changes in personality and identity. Along with these individual-related factors, the social contextual factors also play a role in understanding adolescents. Hence it is important to discuss adolescents situated and embedded in their social context and ecology and how this eco-system shapes their development.

Multiple Social Contexts and Ecologies in India

We tend to assume that social contexts are homogenous in nature, especially in psychology, which is being increasingly questioned. For example, Saraswathi (1999), first raised the question of adolescence as a social construction, when she studied Gujarati adolescents and did not observe the stereotypical notions of storm and stress among adolescents. Saraswathi, thus not only questioned a universal idea of adolescence but also identified cultural and contextual factors that change the construction and lived experience of adolescence. If we merely focus on the individual and defocus on the context, that amounts to a reduction of the reality as stated by scholars such as Ungar (Theron et al., 2015; Ungar, 2008) and more importantly, as experienced by a vast majority of adolescents in the Indian context. There are some critical premises of this chapter related to this:

(1) **Role of Context**: Structure/context shapes individuals in a much stronger manner than it is thought, especially in the growing age. There is a multiplicity of contexts in the Indian diversity such as our villages and cities, languages, schools and colleges, workplaces far and near, different states, their cultures and their socio-demographic features, etc. Individuals, based on their goals, dynamically foreground and background the plural features of their micro, meso, and macro-context using the Gestalt approach.

(2) **Ecology**: Thus, there are layers of context; there is no single fuzzy homogenous context. Like the cells and tissues of an interconnected physiological system, changing one layer of the context can change the other layers as well. This layered context is addressed as **an ecology**. It implies interdependence and includes material and socio-cultural contexts.

(3) **Resilience framework**: The ecological context includes both risks/vulnerabilities and strengths/protective factors. Risks and vulnerabilities highlight the dangers and challenges that adolescents face, whereas the strengths and protective factors focus on the buffers and their capacity to offset or flourish/find new opportunities under adverse circumstances. Thus in the context of these premises, it can be emphasized that in the Indian socio-cultural context, finding communities or creating communities can and has acted as a protective factor and create resilience for adolescence (KHPT, 2015; Zimmerman, 2013).

The above ideas/premises are further explained below.

(1) Role of Structure/Context in Shaping Individuals

In the story of Pratibha mentioned in the beginning, the context doesn't allow girl children to survive, to 'play', and to go to school. The context facilitates hard physical work. It may also be noted that the context of Haryana is not the same as the context in Kerala or north-eastern part of India. However, families as micro-systems are embedded in the context, where village elders and family elders as meso-contexts may decide on rules that everyone agrees with. Many of the families and individuals may find hard to imagine any other way of life, which is unconnected to the context.

It is known that development is plastic and is a result of the interaction of nature and nurture (Santrock, 2016). Nature includes the genetic inheritance, consistent traits as well as genetic diseases that an individual inherits. Nurture needs to be understood as including but not limited to parenting, the role of mother, and early childhood experiences. In recent years, the focus has been more on relational elements especially when it comes to understanding relationships and communities as sources of strength and protection. The Indian philosophical, as well as lived, understanding of the context is much richer and more complex because of the diversity and commingling of contexts in the process of growing up. For example, even if the families are changing and becoming nuclear, the adolescent growing up in the Indian context is still aware of and interacts with extended families and community networks. The role and importance of other elders in the family are still significant.

Nurture apart from including the mother and parents, etc. includes the meso and macro-context which allows the relationships to get enacted in a particular manner. In a significant way, the social and economic context facilitates and constrains nurture and nurturing relationships and their expression/practice. For instance, in the above example, if the village has a significantly less number of girls, then Pratibha obviously cannot find girl playmates and as she is not allowed to play with boys, she is unable to play much.

There is contextual diversity in India, which is related to the different complex social structures and systems, different languages and cultural systems that commingle and intersect with the socio-economic, administrative, political, and geographical contexts. A tribal adolescent from Kendrapada district collecting wild bee honey in the forests and selling it in the markets on the day of bazaar is shaped differently than a student in a high profile private school/college in a city in India. This wide diversity, also resulting from and leading to economic and social inequality, means that the shaping by the context must create widely divergent aspirations and goals for the adolescents of the same historical cohort. The idea of an aspiration and a goal for life would perhaps be different for the shy tribal boy from Kendrapada or he would say, what appears feasible to him and his family, whereas a confident student, articulate in English, would struggle through his/her own challenges—academic pressure, job placements, paying back the education loan, etc.

So, in each context, there would be certain **risks**. In the context of Kendrapada, the adolescent boy faces certain risks—fear of destruction of forest, no or minimal education, the utter struggle to subsist, no opportunity to create wealth, and oppressive social structure. In the context of the student of a private school/college in India, there are risks—the intense pressure to compete; to be coerced into choosing subjects they cannot manage or have no interest in studying; and managing placements and getting jobs which are tough for beginners in the jobs hierarchy.

(2) The Ecological Context: Structure-Individual Dynamic/Interplay

Bronfrenbrenner (see Santrock, 2016) gave a conceptual model that viewed development as embedded in the **ecological systems**, where persons throughout their life span, especially children, are shaped by the dynamic interplay of the environment and the individual. There is a constant and dynamic interaction between the overlapping

structures that form the context—the social, economic, cultural, and administrative systems sharpening certain facets, making them prominent and levelling off some facets.

So, at different levels of analysis—micro, meso, and macro levels—protective factors in the environment can be identified. Similarly, individuals will have certain **strengths**—arising from within, out of their genetic and epigenetic factors, such as order of birth, a sense of self, ego-integrity, etc.

The individuals interact with both the risks and the protective factors in the environment. Ecology can be thus understood as the dynamic interplay between the risks and protective factors within the environment with the strengths and vulnerabilities in the individual.

The development of adolescents then needs to be looked into in the particular ecological context. This will help us build the resilience of the adolescents by examining the various factors present.

Let us see these in the Indian context.

Government Interventions for and By Adolescents and Youth

The Government of India has tried to engage with the adolescents and youth recognizing them as a separate group and a community. This intervention approach got prominence as part of the HIV/AIDS response. Adolescents and youth were viewed as target audiences for prevention and social and behaviour change communication. A similar intervention approach is also applied for alcohol and substance abuse demand reduction. Clubs and groups are created, such as rainbow club (for HIV awareness) and kishore and kishori groups (for adolescent health and sexuality) where several activities are conceptualized and implemented. Conducting awareness programmes about puberty, menstrual hygiene, safe sex and delaying the age of sexual debut, information about contraception, providing other opportunities for peer learning in a safe space, and conducting other training programmes on life skills are some of the activities under this approach, which are usually held in schools and colleges/universities. Most of these efforts are conceptualized and funded by multilateral agencies such as UNFPA and UNICEF, in collaboration with the state governments and implemented, either by the state or the local NGOs. This life skills approach was promoted by the UN agencies and utilized this delivery mechanism.

Can we call this approach a community-led approach? Well, maybe we can't. Without denying its relevance and functionality, this approach is driven by stakeholders, who are essentially outsiders. This is for the adolescents and youth, but rarely led by then youth and adolescents themselves. Nevertheless, in a resource-scarce context where adolescent and youth interventions are a few, it has shown impact. One of the important pivots in these interventions is the 'peer learning approach', which is theoretically premised on the fact that

adolescents and youth learn better from each other, than from adults, who may be viewed as outsiders (in terms of age and experience).

Review Questions: *Review the interventions done by UNICEF or UNFPA in your state and write an analytical report on its conceptualization, activities, and impact.*

Risks and Protective Factors for Adolescents in the Indian Contexts

So, what are the risks faced by adolescents in the Indian context? These can be discussed in terms of macro and meso-context.

Risks and Protective Factors in Macro Context

Administration and State

At the macro-level, all of us are impacted by decisions taken by the state and the district or municipality. The administration is thus a silent and pervasive influence. If, for example, data is not correctly captured by the administration, then too the interventions are misestimated and planned (Bhargava et al. 2020). Risks in the administration include non-provision of services and entitlement, corruption, and pilferage of the benefits due. For example, the mid-day meals scheme is a provision by the state government of India in the school system; however, in many village-level panchayats, it is seen that mid-day meals are not regular or not provided. It is not only an act of corruption but also has adversely impacted the development of adolescents and put them to risk of poor nutrition. This affects their learning, academic achievement, and development in other aspects. Similarly, several state governments have instituted scholarships and other benefits such as vocational training, skilling, etc. for adolescents and youth. Lack of monitoring by the administration and lack of awareness among adolescents can put students at many such risks. On the other hand, a proactive administration with strong monitoring and supervision can be a strong protective factor in the macro-context. Awareness of one's rights and entitlements through media can also be a protective factor, although more empirical research is required in this.

Law and order, as well as crime, is a state subject and there is an administrative variation that comes in terms of safety and trafficking of vulnerable adolescents. At the first level, social and legal protection of adolescents is

an administrative responsibility and several adolescents face risks due to lax administration. Adolescents, especially adolescent girls face immense risks due to trafficking. Other risks are crimes against children and adolescents, children and adolescents in conflict with law, and children who live on the streets—these adolescents face the highest risks to their safety and dignity (more data can be found from this report: https://censusindia.gov.in/Data_Products/Data_Highlights/Data_Highlights_link/data_highlights_D1D2D3.pdf. and http://mospi.nic.in/sites/default/files/publication_reports/Youth_in_India-2017.pdf). Administration and legal systems are duty-bound to protect children and adolescence against crimes, and in contemporary times, several strict legislations have been enacted such as the POCSO (Protection of Children against Sexual Offence) Act, 2017 (for more information on POCSO Act, please see https://ncpcr.gov.in/index1.php?lang=1&level=1&&sublinkid=14&lid=607).

Further, cyberbullying and cybercrimes are also coming up more due to the increase in virtual engagement of adolescents.

Variation in the administration and development of different states heightens certain risks for all adolescents in the Indian context. For example, certain states due to several social and political factors encounter challenges in administration and thus, access to schools, hospitals, and other services such as sports and employment and skilling opportunities may not be available. This may be true of rural as well as urban areas. Similarly, there is a state-level variation in terms of access to services and entitlements. An adolescent in backward states such as Bihar faces risks differently than an adolescent growing up in Kerala; this is reflected in higher migrations of adolescents and youth towards states which are more developed and provide better opportunities.

Income Poverty and Deprivation

Income poverty means that the household and the adolescent are not able to have an income that sustains them and their basic necessities. Income poverty and at a larger level, deprivation is a risk that adolescents in India face. Since adolescence is related to physical growth, the role of nutrition and wholesome food is underlined. Deprivation of basic needs of drinking water, shelter, food has a negative impact on physical and psychological development. Food and nutrition are key concerns in India. Deprivation of a healthy and nutritious diet and its impact on their physical and cognitive health is one of the risks that adolescents from poor families and households face. On the other hand, unregulated lifestyle and obesity are also risk factors, among those who do not experience food deprivation in their households. Both result in changes in metabolism and deficiencies that affect growth.

Unregulated lifestyles among adolescents include early exposure to and consumption of tobacco, alcohol, and other substances. A recent study in 2019, commissioned by the Ministry of Social Justice and Empowerment (MSJE), Government of India, shows that tobacco, alcohol, and substance abuse are urgent issues in

India—about 16 crore persons consume alcohol in the country, 3.1 crore individuals use cannabis products, and 2.26 crore use opioids. Lakhs of people are dependent on these substances and it has an impact on their productivity, employment, and quality of life. Even though the public data is not specific to the adolescent population in India, it does indicate that adolescents are at risk to exposure and risks of use (http://socialjustice.nic.in/writereaddata/UploadFile/NAPFDD_EDUCTION_01_04_202063721884770059 5753.pdf).

Lack of access to higher education and vocational opportunities present serious risks. Higher education and vocational skills are the pathways to move out of poverty and deprivation. Access to education and skills is dependent on several factors—the place of residence, the feasibility in terms of money and other resources, the availability of correct information about the opportunities, and the state of economy and industry.

Researches show that formal and informal social and community networks act as a strong protective factor for families who face income poverty and deprivation. Economists have used the term social capital to denote this strength of formal and informal community networks. Leveraging this, the government with several international funding agencies have also created adolescent communities for their interventions in health and education.

Sphoorthi—A community facilitated intervention by Karnataka Health Promotion Trust (KHPT) for adolescent girls in rural North Karnataka

In a facilitated intervention in rural North Karnataka, Karnataka Health Promotion Trust (KHPT), a Bengaluru-based non-governmental organization (NGO), conceptualized a peer learning intervention to arrest sex trafficking of adolescent girls. According to the report published by KHPT, one of the key gaps in vulnerable communities is the lack of peer role models that demonstrate positive behaviours and inspire others. According to KHPT, behaviour change is not sustainable through incentives and penalties. KHPT's theory of change was to create role models from within the community; change through 'emulation'. According to them, parents in marginalized communities also lack peer role models that they can then emulate. Peer role models, on the other hand, become champions and change agents.

This particular intervention project was funded by a philanthropic foundation and activated in Koppal, in Northeast Karnataka, influencing 3600 girls, by directly engaging with 640 adolescent girls and 1280 parents in 42 villages, through 2015–2018.

So, what is interesting about this model? For one, it assumes a 'cascade' effect and an effective use of limited resources. Secondly, it is centred on leveraging the psychological principles of modelling and the evidence that peers

become important during adolescence. The intervention also formulated positive outcomes in terms of secondary school completion, arrest early marriage, and better health outcomes. Can we call it community-led? Maybe not in stricter terms; this model, however, is certainly more insider–outsider in its approach.

Review Questions: Analyze this model, in terms of its engagement with the community and the possible resistance that might be encountered. Do you think, this model is sustainable? Why?

http://www.khpt.org/intervention/adolescent-health-and-education/

Gender, Caste, and Class

Social constructions of gender and diversity, caste, and class create social stigma. All these three are deep structures that affect self-awareness and self-identity. Socialization of girls, transgender people, and people with queer identities create self-stigma and shame. Similarly, a child is socialized into caste and class socialization. This self-stigma deeply affects the self-esteem of adolescents and presents a great risk through social shaming, bullying, and harassment. Gender, caste, and class include deeper processes of self and identity, social roles, etc. This socialization is an ongoing lifelong process and requires deep-rooted social change. Presented in the box is a community-led intervention by an organization called Karnataka Health Promotion Trust (KHPT). The project Sphoorthi was an intervention programme for arresting sex trafficking of rural adolescent girls in North Karnataka in India. This project focused on peer learning and positive role models among adolescent girls and their parents. These girls continued their schooling and their parents did not allow them to drop out of school. The positive role models were those parents who did not allow for the marriage of adolescent girls—just as what we saw in the case of Pratibha at the beginning of the chapter. As a scholarly discussion, the topic of risks and vulnerability due to socialization is vast and can be further read elsewhere in sociology, history, and political science. In the years after the independence of India, there have been some changes at the ground level—more adolescent girls are entering higher education, more Dalit (deprived sections in India) students are entering higher education, yet much more needs to be done. The Constitution of India affirms the values of equality of opportunity and the right to life and liberty.

Indian Cultures and Meditation Traditions as a Protective Factor

Whereas the issues of gender, class, and caste present themselves as risk factors, the complexity of Indian culture and the presence of multiple cultures and subcultures may act as a protective factor as there is a complex mindset that provides a backdrop for human development. Several cultural and sub-cultural assumptions

'co-exist' with their alternatives during the socialization process. This plurality of mental models and values has been discussed by psychologists (Chadda & Deb, 2013; Laungani, 2007; Palmer & Laungani, 1999). Historically multicultural societies such as Indian civilization have always had paradoxical elements, which indeed co-constructed a resilient culture/cultures, that have adapted to the transitioning times (Sinha & Tripathi, 1994). This complexity that is comfortable with contradictions has been called the 'Indian mindset' (Sinha et al., 2009). In terms of day-to-day cultural practices, this has meant the Indian adolescents grow within diversity and heterogeneity of peers, role models, and relational networks. As Tripathi (2019) has written, the relation between the individual and the collective has been framed differently in the Indian culture.

Finally, the Indian philosophical and knowledge traditions have emphasized the cultivation of meditation and contemplation in fostering resilience in face of adversities. Recent research supports the idea of cultivating contemplation and meditation in nurturing resilience (Adhikari, 2012; Goralnik & Marcus, 2020; Priddy et al., 2018; Sharma et al., 2019; Waechter & Wekerle, 2015). Traditionally, resilience was fostered through spiritual transformation (Garg, 2019) and recent interventions have shown efficacy in significant risks such as a family history of mental illness, maltreatment, and substance abuse. There have been two broad approaches to fostering resilience: The first approach has relied on personal strengths and guru–shishya relationship (Raina, 2002). This has been most notably done through yoga praxis, which clearly identifies nurturing personal strengths, increased cognitive capacities, and affective resilience through positive emotions and detachment from negative thoughts and emotions (Herbert, 2018; Pandit & Satish, 2014; Priyadarsini & Rohini, 2017; Sati, 2016). The second approach has been on changing the society, itself. The bhakti movement as well as the Buddhist philosophical thought has focused on social transformation that facilitates the reduction of social risks such as prejudices, othering, and discrimination. Even as social change and transformation is still a work in progress, in the post-independence period, constitutional values provide a cultural protective factor that undergrids education, social relations, and health, both in formal systems as well as informal public discourse.

Risks and Protective Factors at the Meso-ccontexts

Agents in the macro-contexts are largely related to the field of sociology, law, political science, and public administration. Psychology as a discipline has invested itself in understanding individuals and small groups. The large structures in the macro-context affect and shape the individuals and small groups such as families and communities. Similarly, the actions of individuals and small groups relating to the meso-context can also affect and change these structures. If small incremental changes happen at the individual level, then it changes these large structures incrementally and results are seen over a period of time. Another way in which the actions of the individuals can change these large structures is through leadership behaviour. What happens

for example, when one or two individuals file a writ petition in the Supreme Court, saying that their right to life and liberty is at risk, due to a Victorian law? This is precisely what happened when a group of gay people filed a petition in the Supreme Court of India, stating that due to the criminalization of the LGBTQ community through Section 377 of the IPC, their fundamental rights of life and liberty were threatened. In response to the petition, the Supreme Court removed Section 377. In this way, actions by citizens or groups of citizens can change macro-structures such as law, administration, and policy.

At the meso-level, we find that we are talking about risks and protective factors that adolescents are in direct connection with. These are the issues and concerns about schools and colleges and relationships with teachers/mentors and professors, the relationships in the community/residential neighbourhoods, and relationships in the family—the structure and processes of family systems. These are explained below.

Risks and Protective Factors in Educational Institutions and Role of Teachers

In one of the research studies published on employability, which was defined as the ability to successfully secure a job (Pandit et al., 2015), researchers found that students reported the availability of books in the library as one of the most important factors for their success/employability. The second factor reported by students as key to their success or failure in securing jobs was the availability of qualified teachers and professors. This saddening, yet key insight reveals that even if the colleges and universities are accessible, the availability of quality infrastructure and qualified teachers presents a variation that one may not find in the western context. Availability of books, computers, and internet directly affects the student's motivation, access to information, and learning outcomes. Several universities and colleges in India do not have this infrastructure. Even if the infrastructure exists, it is severely rationed. The availability of qualified teachers who can teach updated knowledge is absent in many educational institutions. For science institutions or science work in schools, the availability of lab infrastructure, the freedom to explore and experiment is not found. Thus, at the meso-level, the risks faced by adolescents in education, even if the schools and colleges are accessible are subtle and yet have far-reaching impact on their lives as well as the sector, where they will seek employment.

So, what could be the protective factors in this meso-context? Research shows that the availability of mentors, who can guide with the right information, is one of the key protective factors that students feel. These mentors need not be teachers but can be anyone in the community, who not only provide the right information at the right time but can also connect with other resources such as scholarships, internships, etc.

Risks and Protective Factors in Community and Residential Neighbourhoods

There may be certain neighbourhoods where crime, violence, and other activities may abound. These neighbourhoods can be in urban as well as rural areas. Adolescents in these neighbourhoods face risks of deviance socialization. They may be exposed to alcohol or other substances earlier in their life. They may also be socialized into violence and crime. They may look at it as a part of life—normalizing it. These risks that come from their meso-context, which normalizes crime and violence, put them at a risk, affecting their developmental outcomes through the life span.

Many NGOs in India have worked on bringing about a community-led change. One of the ways is to identify positive role models and recognize and celebrate them in the community. Most of the peer-led interventions for adolescents and youths in India are pivoted on this strategy of identifying positive role models and making them leaders of the peer-led interventions. In this regard, Project Sphoorthy by KHPT was mentioned earlier. There are several such interventions that NGOs have done with adolescents, using sports, theatre, arts, and other interventions. Sports, for example, is an aligned strategy for adolescents as it ties with the physiological changes in their bodies and significantly improves their self-awareness, identity, and self-esteem (Aishath et al., 2019). However, sports, especially competitive sports, increase the risks for violence and injury. Non-competitive sports can indeed benefit the adolescent. In the Indian context, sports in community interventions have been used for non-competitive engagement (Steiner et al., 2000).

Risks and Protective Factors in Family, Friends/Peers, and Social Networks

When we usually talk of family, the middle-class notion of family is seen as the working father in an office-going job/or a small business, the mother who is a homemaker or works in a job or business. We view maybe two/three children in the family and possibly a grandparent. Families in India are diverse. Some families are very large with 7 to 14–20 members, especially in tribes or agricultural families. There may be families with grandparents on both sides, aunts and uncles as well as cousins. Even though a family is formally defined as a unit eating from one kitchen, psychologically, many families may live close by, with separate kitchens. Several families have single parent, either formally or in real term—a mother with her children may have an absentee father or a father who is mostly migrated for work and livelihood. Such families present their own risks and protective factors.

The presence of parents/elders and strong, positive attachment relationships with the family members act as key protective factors to counter the risks inherent in family networks. In single-parent families, the presence of other members in extended families or social networks acts as protective factors.

Domestic violence is one of the serious risks for growing adolescents—both boys and girls. Alcohol and substance abuse also affect a vast proportion of our population. Alcohol and substance abuse are linked to domestic violence, loss of productivity, and an increased health burden. Having an elder in the family who is abusing substances presents a negative role model to the growing adolescent at the minimum and can result in injury or violation/abuse of the adolescent as the worst-case scenario. The research found that mental illness in one of the parents presents a risk to the adolescent's development. What could be the other risks that adolescents face?

Migration and lack of a stable home can be a significant risk for adolescents in the Indian context. In India, it may happen that, half of the family migrates and half stays back in an attempt to continue with school for children, and as Srivastava states in his report published by UNESCO, children and adolescents migrate for work, impacting their education (http://www.unesco.org/new/fileadmin/MULTIMEDIA/FIELD/New_Delhi/pdf/voltwo.pdf#page=7).

Migration by adolescents themselves for work or migration by the families can disrupt education and access to several benefits provided by the government. For example, migrants usually don't have access to public delivery of food rations or other state-specific benefits, because they do not have documentation of residential status. Finding admissions in schools and colleges can also be similarly difficult.

Supportive peers and friends in social networks are also a strong protective factor for adolescents. Karakos (2014) in a qualitative study points out that peers of adolescents in the recovery school (from drugs and alcohol use) act as sources of positive support which provides a sense of community and peers outside the schools act as sources of risky influence. The positive influence of peer leads to positive behaviour in adolescents (Baruah & Boruah, 2016), and negative peer influence leads to risky behaviour (Goel & Malik, 2017), whereas school and family involvement is negatively related to risky behaviour among adolescents 14–17 years. The negative influence of the peer group is more connected to the involvement in risk behaviours, whilst the positive influence is more connected with protective behaviours (Tomé et al., 2012).

Risks and Protective Factors Within a Person

Consistent personality traits can present both risks and protective factors within a person. Given a situation, two individuals perceive and process it differently, even if they are from the same family. Genetic factors, nurture and socialization, and circumstances in the family differ from adolescent to adolescent, even if they are from the same family. Poor attention and processing capacity, poor emotional regulation, lack of self-esteem, and poor coping can be significant risk factors. The silver lining is that adolescent self and identity can be shaped through adolescence, with positive experiences, training and other interventions.

Research shows that several personality factors–consistent traits have a strong impact on resilience. Intelligence and problem-solving capacity, achievement motivation, and emotional regulation are some of the protective factors.

Pravah and Commutiny: An Initiative with Adolescents and Youth in North India

A group of management professionals got together to start Pravah in Delhi, some 25 years back. Pravah and Commutiny are truly at the cutting edge of youth-led interventions, by leveraging the spirit of youth volunteerism. Pravah has a unique concept of a fifth space, which is conceptualized as a space of youth engagement that exists beyond the four legitimate spaces of family, friends, education/career, and recreation. Pravah and Commutiny have thus articulated a social space for youth to engage; a social space which is not self-centred and self-absorbed.

Through their youth-led programmes, Pravah and Commutiny have engaged with thousands of adolescents in India, using innovative adolescent-friendly communication and engagement methods.

Can we say that this is an example of community-led interventions for adolescents? It may come closest to the idea of community-led interventions if we define youth as a community. It has an insider approach in its engagement methods with youth-friendly language and tools such as short videos, photos, youth campaigns, etc.

Review Questions: Study the engagement methods of Pravah and Commutiny and discuss the relevance in a short note.

Reference: https://commutiny.in/about-us/.

Resilience Framework: Understanding Risks and Protective Factors

In general, risk factors are those that increase the probability of a maladaptive outcome while protective factors are variables that reduce the likelihood of maladaptive outcomes under conditions of risk (Ungar, 2013). (Grossman et al., 1992) state that protective factors impact developmental outcomes independent of risk. This is not to assert that the relationship between risk/protective factors with maladaptive outcome or health is linear. Development is complex and the pathways through which risk as well as protective factors impact development outcomes still need to be explored, especially in the Indian context.

Interactions between risks and protective factors pathways at different levels—within an individual—in relational networks and families and large structures also pose a challenge to be understood effectively. It may be noted here that protective factors possibly negate risk factors and augment other protective factors to create a larger positive impact. In this scenario, the role of community in positive adolescent and youth development is significant. There is one community that we are born with, but there are other communities that we join or create for ourselves. For example, adolescents become members of various online communities such as reddit or quora, where people ask questions and interested people view and some answer the questions. This gives a sense of community as the adolescent feels a sense of community by being a member of school or college. One feels a sense of pride about being a member and feels emotionally closer with a member of the same community-ready to help and take care of the person.

A sense of community that makes the adolescent feel good for being a member, ready to affiliate, help, and care for each other, then community becomes a resource—a protective factor. Creating a community of adolescents can then be a possible intervention for adolescents and youth. Several civil organizations have tried this method of creating a community of adolescents and youth—both with on-ground presence and through online media. This sense of community can include mentors and elder peers who can then help with any problems. Knowing that there are elder peers and mentors in the community can make adolescents and youth feel secure as well. So, a co-creation of a trusting community can be a useful intervention for adolescent and youth development.

Community-led interventions can thus be built in the resilience framework, at least tangentially if not in full. One of the organizations—'**Commutiny**' based in Delhi has conceptualized a 'fifth space'—a space of social engagement and is owned by the community of adolescents and youth. Pravah and Commutiny represent one of the ways of creating communities emanating from urban spaces and then moving towards peri-urban and rural adolescents and youth. This is both a weakness and a strength of their model. Models of adolescent development, as they emanate from urban spaces, provide opportunities for the urban youth volunteers to engage deeply with the Indian cultural and social context developing empathic insight and fellowship. On the other hand, some may also carry a set of assumptions that privilege certain learning and pedagogies of learning over other forms of knowing, learning, and being. For example, there may be an assumption that rural areas are underprivileged and backward, thus assuming further that income poverty is equated with cultural deprivation.

Regardless of these issues, community-led interventions having a resilience framework will definitely benefit the adolescents.

Conclusion

The present chapter discussed the development of adolescents beyond the conventional understanding of individual-level changes. The risks and protective factors in the adolescent eco-system were defined and identified. Since the larger context shapes adolescent development, community-led interventions can be identified as a pathway incorporating a resilience framework.

Resilience framework as a way forward in adolescent mental health and well-being highlights the importance of protective factors. Three domains have been identified within protective factors. Firstly, protective factors are viewed as positive internal characteristics of the individual/adolescent like attention, problem-solving ability, illness-free healthy body, or good social skills. The second dimension comprises child–environment relationship, which includes relationship with parents and other adults. The third dimension is essentially about the third-order relationships which indirectly affect the adolescent's health—the macro-contexts of access to schools and colleges, disruptions and role models in the community, etc. (Coie, et al., 1993) suggested that protective factors may work in one or more of the following four ways: directly decrease dysfunction; interact with risk factors to buffer their effects; disrupt the mediational chain by which risk leads to disorder; or prevent the initial occurrence of risk factors. (Coie et al., 1993; Grossman et al., 1992) have suggested that protective factors are the core variable that may help researchers to identify targets for intervention successfully.

The chapter described various community-led or community-embedded interventions oriented on a resilience-based framework. The resilience-based framework is best articulated in meso and micro-contexts. Interventions can be fully state-initiated and state-led, or the community may be involved, or maybe initiated by NGOs but led by the community. These different approaches have benefits for adolescents but differ in terms of the sustainability of the intervention for a longer time. State-led interventions may work well, but as the community is passive, it may not sustain over time. Community-led projects are extremely difficult to work on ground. Several challenges such as local leadership, working while managing group and interpersonal conflict and underlying animosities, etc. play a role, although some interventions such as sports interventions may be more acceptable.

Gergen (2014) called for research to not just be mirroring the society and the world, but also be 'future forming'. Resilience and focus on protective factors help us to work towards a future that we can work towards for the betterment of our adolescents who are the future of the country.

Time to Reflect

Each adolescent is not only the responsibility of the concerned family to which s/he belongs but also the responsibility of the community. It is the right of each child to

get a conducive environment at home and in the community for optimal development and fulfilment of potentials. This needs to be ensured at the micro, meso as well as macro-level. However, given the adverse situations and lack or less availability of resources in which a majority of adolescents live, it is important to approach the development and functioning of adolescents from a rights perspective. A resilience framework is needed to reduce the risk factors and enhance the protective factors to help adolescents thrive in their life and achieve good mental health and well-being. Reflect on the supportive practices in various communities that aid or hinder the psychosocial development of adolescents.

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