1. INTRODUCTION
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The present research endeavours to intervene in the natural course of rapid and turbulent growth taking place and study the intervention effects of intervention on psychosocial competence of adolescents. This is accomplished by fostering normal development through inputs that augment the adaptation ability and help adolescent to improve their psychosocial competence. In this context it becomes necessary to first understand the multiplicity of the developments taking place simultaneously and also take in to cognizance their proneness for experimentation. Risk taking nature is hallmark of adolescence and if they are not provided with skills to protect them selves, likelihood of deviant or incomplete development becomes very real. Life skills education with its sound theoretical foundation and participatory teaching methods provide the adolescents with opportunity to shape their behavioural attitudes.

Rutter and Rutter (1992) emphasise that the degree to which people are active, rather than passive participants in their own world through their interactions and negotiations with others grow in to well adjusted adulthood. Children and adolescents are thinking and feeling beings with a degree of mental complexity that is only now being recognized. Dawes et al (1997) state that child and adolescent mental health includes a sense of identity and self-worth; sound family and peer relationships; an ability to be productive and to learn; and a capacity to use developmental challenges and cultural resources to maximize development. Good mental health in childhood is a prerequisite for optimal psychological development, productive social relationships, effective learning, and an ability to care for self, good
physical health and effective economic participation as adults. WHO (2005) states that child and adolescent mental health is the capacity to achieve and maintain optimal psychological functioning and well-being. It is directly related to the level reached and competence achieved in psychological and social functioning. Moreover, the good mental health of children and adolescents is crucial for their active social and economic participation. The introductory chapter is presented in such a way that there is logical sequence to concepts presented which will help in progressive understanding of pathways to positive adolescent development and also throw light on adolescent risk taking and why preventive interventions are essential.

1.1. Meaning and Definitions of Adolescence:

It is a period between childhood and adulthood. WHO (1986) define adolescence both in terms of age (10 to 19 years) and in terms of life marked by special attributes.

These attributes include:

- Rapid physical growth and development
- Physical, Social, and Psychological maturity, but not all at the same time.
- Sexual maturity and the onset of sexual activity.
- Experimentation.
- Development of adult mental processes and identity.
- Transition from total socio-economic dependence to relative independence.

According to Government of India, National youth policy (2003) it is some what different and defines youth as those between 10 and 35 years of age,
encompassing the age of adolescence (10 to 19 years) and the age of attainment of maturity (21 to 30 years).

As is true of every important period during the life span, adolescence has certain characteristics that distinguish it from periods preceded or those follow. Adolescence is one of the periods when both the immediate effects and long term effects have ramifications on the remaining life span development. Adolescence is most important for the rapid physical and psychological developments taking place. It is a transition period where the individual's status is ambiguous. However it can be advantageous as it gives them time to try out different life styles, patterns of behaviour, values and attitudes which meet their needs. The studies on changes in behavioural attitude and values throughout adolescence have clearly demarcated the differences of development in early and late phase. Hence adolescence is roughly classified into early and late adolescence. Early adolescence is sometimes called as puberty. The word 'puberty' is derived from the Latin word “Pubertas” meaning age of manhood. Puberty is the period in developmental life span when the child changes from asexual to a sexual being. It is a stage in which maturation of sexual organs occurs and reproductive capacity is attained. It is accompanied by changes in somatic growth and psychological perspective.

Every stage of development is accompanied by set of social expectations. Havighurst (1972) has termed them as ‘Developmental Tasks’. He defined developmental task as “A task which arises at or about a certain period in the life of the individual, successful achievement of which leads to happiness and to success with later tasks, while failure leads to unhappiness and difficulty with later
tasks". This definition purports that physical maturation taking place has significant influence on the individual’s physical well-being and mental health. He delineated the following as the developmental tasks of adolescence.

- Achieving new and more mature relations with age mates of both sexes.
- Achieving a masculine or feminine social role.
- Accepting one’s physique and using one’s body effectively.
- Desiring, accepting and achieving socially responsible behaviour.
- Achieving emotional independence from parents and other adults.
- Preparing for an economic career.
- Preparing for marriage and family life.
- Acquiring a set of values and an ethical system as a guide of behaviour.

Some of the tasks in the above list directly pertain to achievement of psychological competence by the end of adolescence. Therefore adolescence is not only age where the individual has to learn to accept bodily changes and adopt appropriate sex and social role, but also must develop certain skills to be successful in the adopted role and achieve integration.

1.2. Physical Growth During Adolescence:

1.2.1. Pubertal Growth Spurt:

According to Hurlock (1990), Puberty is a very short period lasting from two to four years which overlaps on closing years of childhood and beginning years of adolescence. Children until they are sexually mature are known as “Pubescents” after which they are called “ Adolescents”. The rapid growth and
development that occur at puberty are called "Adolescent growth spurt". These changes often lead to confusion, feelings of inadequacy, insecurity and in many cases unfavorable behaviour. The growth spurt occurs at different ages for boys and girls. It begins in girls between 9 to 11 years and peaks at 12.5 years. For boys it begins at 10.5 to 14.5 years and peaks between 14.5 to 15.5 years. In boys growth spurt lasts longer. During this period important physical changes occur which transform the child into that of an adult. There is change in body size, proportions and development of primary and secondary sexual characteristics.

Height and weight of both the girls and the boys change drastically. Girls prior to menarche exhibit 3.5 inch increase in height annually, but post menarche it decreases to one inch per year and this growth stops by 18 years. For boys greatest increase in height comes in the year following the onset of puberty, after which it decelerates and stops at the age of 20 or 21 years. Because of longer growth spurt boys achieve greater height. Certain areas of the body which in early years of life were proportionally much small, now become proportionally big since they reach maturity sooner than other parts. This is apparent in nose, feet and hands, hips and shoulders broaden and waist line drops. Legs are proportionally too big at this stage.

1.2.1.1. Primary Sex Characteristics:

Growth and development of primary sex characteristics occur during this age. Primary sex characteristics are the sex organs the individual possess. In case of male, the gonads, which are located in the sac outside the body are only 10 %
of natural size at 14 years. They grow to full size by 21 years, following which penile growth accelerates in length and circumference. The result of this maturation is nocturnal emissions. Incase of females, reproductive organs such as uterus, fallopian tubes, ovaries and vagina grow rapidly and result of maturation is menarche.

1.2.1.2. Secondary Sex Characteristics:

These are the physical features which distinguish males from females and which make members of one sex appealing to the other. They are unrelated to reproduction, though they are responsible for making both sexes appealing to each other. In boys facial, body, axillary and pubic hair develop, skin become coarser, sebaceous glands enlarge, muscles increase markedly in size and strength, voice increases in volume, becomes huskier and drops in pitch. In girls hips become wider and rounder, breasts enlarge, axillary and pubic hair appear, skin become coarser, sebaceous glands become active, muscles increase in size and strength and voice becomes fuller and melodious.

1.2.2. Effects of growth spurt:

Due to the above mentioned rapid body changes, child experiences fatigue, restlessness, unfavorable symptoms, and frequent sickness. All this have a bearing on the child's mental health. The common effects seen are incoordination, social antagonism, heightened emotionality, loss of self confidence and excessive modesty. Brooks-Gunn and Reiter (1990) reported that girls with particularly negative expectations, pre menarche also describe the most negative experiences after menarche. Similarly Ge et al (1996) reported that early pubertal onset is associated
with distress as they have less time to prepare for the event, new expectations, and stressors before they are psychologically ready. However, Rutter and Rutter (1992) found that boys who mature early are perceived more positively by peers and develop better self image. According to Eccles (1999) many young people may not be adequately prepared for these biological changes. Adolescent’s concerns about appearance can sometimes lead to unhealthy dieting, and premature initiation of sexual intercourse before achieving a level of cognitive or emotional maturity.

1.2.3. Sexual Behaviour:

Calam (2001) emphasizes that the development of sexual awareness is an important aspect of adolescence. This comes at a time of concurrent developments in self-esteem and self-awareness, leading to increased vulnerability. Recent figures for UK by Brooks Advisory Services (1998) show that 20% of young people have intercourse before their 16th birthday. The figures are consistent across Europe. According to Capaldi et al (1996) the timing of first intercourse in boys is related to early physical maturity, parental transitions (eg. New live-in relationships, remarriage,), anti social behaviour and substance use. It may also be associated with reduced monitoring of the adolescent’s activities. In females low educational attainment, poverty, emotional difficulties and being a child of teenage mother are associated with teen pregnancy. Zani (1991) reported that first intercourse for the males is highly regarded event, while Gordon and Gilgan (1987) found that reports given by females have been described as more anxious. Even at the turn of the millennium, parents remain more concerned over the emerging sexuality of their daughters rather than sons. While the value of female chastity varies markedly across
cultures, the role of male as predator is widespread. Sociobiologists- Baker and Bellis (1995) have plausible explanation for this. In evolutionary terms, the most successful male will be the one who fertilizes the most females; for the female, allowing eggs to be fertilized by a sub-optimal male will reduce her reproductive success.

1.3. Cognitive Development in Adolescence:

Newman and Newman (1988) defined cognition as the “process of organising and making meaning of experience”. According to Piaget (1972), the capacity for abstract thinking begins around the age 11. At the formal operational stage, adolescent reasons much like a scientist searching for solutions in the laboratory. That is to say, at adolescence, young people become capable of hypothetico-deductive reasoning. It is a formal operational problem solving strategy in which adolescents begin with a general theory of all possible factors that could affect an outcome in the problem and deduce specific hypotheses, which they test in orderly fashion.

Abstract reasoning is feature of this stage. It allows the adolescent to entertain and consider a range of possibilities, and to reflect upon these, providing a range of possible solutions to the questions that arise at this time. According to Steinberg (1993) the ability to think in hypothetical terms and consider a range of possibilities helps in the formulation of arguments and counter-arguments. This is an aspect of adolescence the parents universally recognise. This ability also helps in the development of perspective taking skills. It also means that adolescents are able to
use more advanced reasoning and logical processes to think about, for example, morality, friendships, responsibility and ideology.

A further important aspect of this stage is metacognition, the ability to think about thinking. Adolescents are better able to describe the thought processes they are using. As per Piaget (1972), there is also likely to be increased self consciousness and introspection. This is often termed as ‘ego centrism’ which suggests that child has difficulty in seeing the other people may have a perspective of their own.

Elkind (1985) suggested that preoccupation with the self might be associated with ‘imaginary audience’ i.e. a sense of being on show. As a result they become extremely self conscious, often going to great lengths to avoid embarrassment. It helps us understand the long hours adolescents spend inspecting every detail of their appearance. It also accounts for their sensitivity to public criticism. To teenagers, who believe that everyone around them is monitoring their performance, a critical remark from a parent or teacher can be mortifying. Another cognitive distortion characteristic of this age is ‘personal fable’. It is adolescent’s belief that they are special and unique. Berk (2005) says it leads them to conclude others can not possibly understand their thoughts and feelings. Teenagers’ sense of invulnerability coupled with sensation seeking tendency contribute to their risk taking behaviour. Greene et. al (2000) found that young people with both high personal fable and sensation seeking scores took more sexual risks, more often used drugs, and committed more delinquent acts than did their age mates.
Steinberg (1993) also pointed out that adolescents become more skilled in the use of both selective and divided attention, short term and long term memory improve, and organizational strategies for the control of thinking also develop. All these provide the adolescents with powerful set of mental tools.

While Piaget (1972) focuses clearly on an individual’s interaction with the environment, social constructivists believe that knowledge is the result of social interaction and language, and thus is a shared experience. Newman and Newman (1998) point out that Vygotsky (1978), a prominent cognitive theorist, proposed that new levels of understanding begin at an interpersonal level originally between infant and adult, and then through continuous social interaction. He conceptualized that the distance between the actual and potential stage of development of a child is determined by his or her problem solving capacity, when working alone versus collaborating with adults and other, more capable peers. Seen from this perspective, the social environment has a strong influence on the structure of one’s thinking, and cognitive skills can be enhanced by more extensive, structured, high quality interactions with others.

1.4. Understanding of Self in Adolescence:

The process of understanding oneself, others and relationships is an important part of growing into adolescence. According to Slaby et al (1995), social awareness moves from the ego centric perspective of the young child to the ability to understand, predict and respond to others’ feelings and perspectives in early adolescence. Thus, this stage of life is critical for developing empathy and perspective taking. It takes time for children and adolescents to form unified, consistent
representation of themselves. Harter (1986) found that even at age of 14 and 15, adolescents endorse mutually self-contradictory self-descriptions; however with further development these become more consistent. Voluminous research has been conducted on adolescent self-esteem probably due to its importance to overall well-being. In their study Coleman and Hendry (1999) observed that adolescents compare themselves to others in order to ascertain their level of worth, a process which begins around the age of 6 or 7 years and intensifies in adolescence. Therefore, it appears that as Harter (1983) pointed out that self-esteem is closely related to valued domains of skills and activities. It has been shown that an increase is observed in self-esteem from early to late adolescence.

Identity development is central to adolescence. Erikson (1959) discussed the concept of an ‘identity crisis’ as a young person’s struggle to decide who he/she is and what he/she wants to become. Further, Marcia (1966) identified four types of identity status: (1) Identity Diffusion-avoidance of commitment and decision making. (2) Identity Foreclosure- tentative acceptance of the views of others. (3) Moratorium- a state of crisis with active attention to major decisions and exploration of possibilities but no firmly commitments. (4) Identity achievement - crisis is resolved and firm commitments are made to ideals and plans.

Closely tied in with the notion of identity is that of autonomy. Steinberg (1986) suggested that development occurs in three domains. (1) Emotional autonomy (2) Resistance to peer pressure and (3) Subjective sense of self-reliance. Ryan and Lynch (1989) suggested that emotional support and acceptance of the parent allows individuation for securely attached adolescent. Without this sense of
support, adolescents become more reliant on peers. It fosters good adjustment but also may lead to anti social behaviours.

Self-efficacy is another dimension of the developing self-concept. Self-efficacy, defined by Bandura (1999), is “belief about their own abilities and characteristics- that guide responses in particular situations.” This has important implications for adolescent adjustment, i.e. if the adolescent develops distorted sense of self worth and abilities, he/she is likely to develop low self-esteem. Therefore, learning to realistically evaluate oneself and one’s abilities is a very important process during childhood and adolescence. Very young children tend to be overly optimistic about their abilities, but as they grow into late childhood and early adolescence, they begin to reflect on their own successes and to match their achievements with internal goals and external standards. In this context Newman and Newman (1998) stated that the pressures towards conformity, competition and the need for approval complicate the process of self-evaluation as children begin to pay attention to the work of others as a way to assess their own ability.

Certain amount of loneliness is considered normal in adolescence. Larson (1997) suggested that time alone becomes more voluntary through teenage years and that, by late adolescence, intermediate amount of solitary time has positive after-effects like better adjustment.

1.5. Emotionality during Adolescence:

Hurlock (1990) points out though heightened emotionality during adolescence is product of ongoing growth, she says that it slows down after a period of time and factors such as social pressures and changed roles and expectations
contribute to emotional instability. Rutter et al (1976) stated that adolescent boys and girls come under social pressures and face new conditions for which they received little if any preparation during childhood. Emotional instability is logical consequence of necessity of making adjustments to new patterns of behaviour and to new social expectations. Problems related to romance become very real at this age, as a result they become despondent. They also worry about future as schooling is coming to an end.

While adolescent emotions are often intense, uncontrolled, and seemingly irrational, there is generally an improvement in emotional behaviour with each passing year. Gesell et al (1956) have reported that fourteen-year olds are often irritable, and are easily excited, and “explode” emotionally instead of trying to control their feelings. Sixteen-year-olds, by contrast, say they “don’t believe in worrying”. Thus the storm and stress of the period lessens as early adolescence draws to close. Emotional patterns of early adolescence while similar to those of childhood differ in stimuli and the degree of control the individual exercises over expression of emotion. Instead of having temper tantrums, adolescents express anger by sulking, refusing to speak, or loudly criticizing those who angered them. Adolescents also become envious of those with more material possessions. While they may not complain and feel sorry for themselves, they are likely to work hard and earn the desired possessions though good conduct.

By the end of adolescence boys and girls are said to have achieved emotional maturity, if they do not “blow up” when others are present, but wait for convenient time and place to let off emotional steam in socially acceptable manner.
Secondly, they assess the situation critically before responding emotionally and finally they exhibit emotional stability instead of swinging from one emotion to another.

1.6. Social Changes during Adolescence:

One of the most difficult developmental tasks of adolescence relates to social adjustment. According to Greenberger et al (1975), to achieve the goal of adult patterns of socialization, the adolescent must make new adjustments, the most important-and, in many respects, the most-difficult-of which are those to the increased influence of the peer group, changes in social behaviour, new social groupings, new values in friendship selection, new values in social acceptance and rejection, and new values in selection of leaders. Brown (1990) states that peer relationships become increasingly important in adolescence, as the young person pursues a range of activities outside the parental home and they spend twice as much time with peers than anyone else. According to Kirchler et al (1991) peer group membership is associated with the development of autonomy and skills in maintaining relationships, and lack of peer group is far more risky in development. The social status of adolescent is earned through competence and performance with peers. Hansen et al (1998); Csikszentmihalyi and Schneider (2000) observed that during the critical period of early adolescence, they either learn to be competent or productive or to feel inferior, which can lead to long-lasting social, intellectual and emotional consequences. Another important observation by Palmonari et al (1990) is strong identification with peer group is associated with positive views of self and others. In conjunction with above, Steinberg (1993) found that peer group provides a
network of significant others from outside the family. A characteristic of these groups is that they are sex segregated and much larger than the groups of childhood. These groups are of two kinds: Cliques (2-12 individuals) and Crowds (12 and more). Adolescents use these larger structures to locate themselves in a social context. Adolescents learn social skills and to feel secure in wider settings in cliques and crowds provide them with a sense of identity and self-concept.

Acceptance by peer group is of paramount importance to the adolescents. Popular adolescents are friendly, good natured, humorous and intelligent. Social rejection is associated with poor social skills. At this point it is important to note Egan and Perry’s (1998) findings that children neglected by their peers may be withdrawn, shy or unenthusiastic. Where children have a poor view of self and judge themselves to be low in competence, there is increased risk of victimization. Similar study by Parker and Asher (1987) found that rejected adolescents are lonelier and more likely to develop disturbance. Savin-Williams and Berndt (1990) further reported that lack of acceptance is associated with low achievement, school dropout, delinquency, and with emotional and mental health problems in adulthood.

1.7. Relationships in Adolescence:

1.7.1. With Parents:

Brown’s (1990) review of literature disproved the popular notion that adolescence is period of generation gap conflicts. It appears that adolescents and parents generally communicate and get on well. Paikoff and Brooks-Gunn (1991) state that given the many changes and developments that young person is undergoing;
there is an increase in parent-child conflict as adolescence progresses. Laursen and Collins (1994) found that adolescents report on an average seven conflicts per day. These conflicts involve mothers, followed by siblings, friends, romantic partners, fathers, other peers and adults. Adolescents argue with parents over autonomy, authority and responsibility. They see conflicts as a result of cognitive development which enables adolescents of hypothetical reasoning. Whereas, according to Steinberg (1993), sociobiologists see conflict as an adaptive strategy, leading to greater autonomy and peer contact. These conflicts help young adolescents for a life independent from parents. Shantz and Hartup (1992) set adolescent conflict in context, suggesting: ‘Conflicts, defined as oppositional interactions, are natural sequale of shifts in role expectations associated with age-graded transitions and maturational changes.’ Their review further suggests that adolescent sense of identity and social cognition is linked to responsiveness in relationship with parents. Supportive but challenging discussions of issues are associated with more advanced reasoning. Conflicts are better managed as adolescence closure begins due to enhanced conflict resolution ability.

Research has also showed that it is important to look at what other family members are experiencing at adolescence phase of development. The parents of adolescents are typically aged 35-45 and Farell and Rosenberg (1981) has shown that middle adulthood is a time of difficulty for adults. They are likely to face anxieties over changes in physical state, attractiveness and future financial security. They may also have concerns about their own ageing parents and thus be carrying a range of roles and responsibilities which may be burdensome. Small (1998) found
that mothers of girls and fathers of boys show more psychological distress and less satisfaction with marriage as their children mature and emotionally distance themselves. Parental characteristics such as self-esteem are associated with the ability to grant autonomy to the child. In this context Mangrulkar et al (2001) stated that the psychological autonomy-granting, which is defined as the "extent to which parents encourage and permit the adolescent to develop his or her own opinions and beliefs" is crucial to adolescent's development.

Influential set of studies by Baumrind (1987) identified two relatively independent aspects of parenting: Parental responsiveness and parental demandingness. This leads to four-way classification of parenting styles-indulgent (high responsiveness, low demand), Authoritative (high responsiveness, high demand), Authoritarian (low responsiveness, high demand) and Indifferent (low responsiveness, low demand).

It is not difficult to see why authoritative style of parenting is likely to promote good developmental outcomes. Here parents are warm and firm, have realistic expectations of their children which they help them to meet. They value autonomy, but are prepared to take the ultimate responsibility. These families are characterized by rational discussions of issues, including disciplining. Adolescents growing up in this context tend to be more responsible, self-assured, adaptive, creative, curious and socially skilled. They are also more successful at school. Daniels et al (1985) reported that, the best adjusted adolescents are more likely to report a close relationship with their mother, that they are involved in family decision making and that they are given high levels of responsibility around the house.
1.7.2. With Siblings:

Adolescents rate sibling relationship like those with parents for companionship and importance, but more like those peers for power, assistance and satisfaction with the relationship. Adolescents argue a good deal more with siblings than they do with anyone else. Steinberg (1993) states that the closeness of the shared environment provides more opportunity for both positive and negative interactions.

1.7.3. With Grandparents:

For the past two decades, marriage and child bearing is being delayed as more time is spent in educating oneself, settling down in a career and career orientedness of women, however due to increased life expectancy and early marriage many men and women (5-6 decades ago) became grandparents at late forties to early fifties when they are still employed. This is especially true of Indian grandparenting. Hence, they spend 30-40 years in the role of grandparenthood which presents them with an opportunity to see their grand children grow from infancy to parenthood. Today, especially in urban areas, both the parents are employed due to economic necessity or due to desire and willingness to work. So, grandparents often step in as care takers willingly with pleasure. In some instances, they may take up role of parents also when the child lives away from parents for educational purposes or their children have died leaving grandchild in their care. Whatever may be the reason most grandparents enjoy the experience and according to Barber and Tremblay (2007) they express satisfaction even over long distance grandparenting.
In the west limited research has been done to study the grandparenting, similarly, there is a dearth of research in India too on grandparenting especially in relation to adolescents. Studies by Kornhaber (1986) have found that grandparenting is experienced differently by different individuals. The transition to this role, as well as the experience of grandparenting itself, varies according to life circumstances, gender, generation, health, race, ethnic background, social class, and the relationship with adult children. Age and distance too have been found to effect grandparenting style. Barber and Tremblay (2007) report that the relationship between adolescent and grandparents becomes less fun seeking and more formal during adolescence, but they continue to share some leisure time activities.

Thus, grandparents provide maturity, knowledge, stability and unconditional love in their relationship with grandchildren. These provide the child with an anchor, which stabilizes them in times of crisis and help them gain firm footing in the course of life.

1.8. School and Attainment in Adolescence:

Quality of school environment is an important factor in adolescent’s adjustment. They value being treated as intelligent, responsive individuals, and their motivation to work needs careful management and understanding by the teachers and school system. The extent to which goals are meaningful and relevant will influence the extent to which adolescent will engage with the system. Gregory (1995) observed that good schools will work towards making school structures small, adults
accessible, promote healthy peer relations, and allow authentic experiences of success and self-responsibility.

Family and school environments both contribute to academic attainment, Bo (1994) found that stable, affluent, stimulating home with parents who are aware of value of education is associated with better outcomes. Steinberg (1993) found that congruence between family and school values contribute to scholastic attainment. Study conducted by Entwhistle (1990) found that, higher levels of aspirations is associated with higher socio economic status.

Wentzel and Caldwell (1997) study found that extent to which adolescents are able to establish friendships and acceptance by their peer group is related to their academic success. The work of Caspi et al (1987) clearly demonstrates that educational attainments is related to occupational status and success in marriage and parenting at ages 30 and 40.

1.9. Changes in Morality during Adolescence:

According to Hurlock (1990), one of the important developmental tasks adolescent must master is learning what groups expects of them and then being willing to mould their behaviour to conform to these expectations without constant guidance, supervision, proddings and threats of punishment they experienced as children. They are expected to replace the specific moral concepts of childhood with general moral principles and to formulate these into a moral code which will act as guide to their behaviour. Equally important, they must now exercise control over their behaviour, a responsibility that was formerly assumed by parents and teachers.
Westen (1996) defines moral development as "development of values and rules a person uses for balancing or adjudicating the conflicting interests of self and others.

Mitchell (1975) listed five fundamental changes in morality adolescents must make:

1. The individual's moral outlook becomes progressively more abstract and less concrete.
2. Moral convictions become more concerned with what is right and less concerned with what is wrong. Justice emerges as a dominant moral force.
3. Moral judgments become increasingly cognitive. This encourages adolescents to analyse social and personal codes more vigorously than during childhood and to decide on moral issues.
4. Moral judgment becomes less ego centric
5. Moral judgment becomes psychologically expensive in the sense that it takes an emotional toll and creates psychological tension.

According to Kohlberg (1969), the third level of moral development should be reached during adolescence. This is the level of self-accepted principles, and it consists of two stages. In the first stage, the individual believes that there should be flexibility in moral beliefs to make it possible to modify and change moral standards if this will be advantageous to group members as a whole. In the second stage, individuals conform to both social standards and to internalized ideals to avoid self-condemnation rather than to avoid social censure. In this stage morality is based on respect for others rather than on personal desires.
Even with best foundations, the three major tasks in achieving adult morality—replacing specific concepts with general moral concepts, formulating these newly developed concepts into moral code as a guideline for behaviour, and assuming control over one’s own behaviour—are difficult for many adolescents. In this context Lasseinge (1975) stated that two conditions are responsible for the difficulties in transforming specific concepts of right and wrong. First is lack of guidance—parents and teachers believe that adolescents have already learnt the major principles of right and wrong and put little emphasis in helping adolescent replace specific concepts with generalized ones. Second condition is the kind of discipline the adolescent is subjected to at home and in school. Bruggen and Pitt-Aikens (1975) and Kemper et al (1976) made important observation that because parents and teachers assume that adolescents know what is right, their major emphasis in discipline is on punishment for what they regard as intentional misbehaviour. Little emphasis is placed on explaining to the adolescent why certain things are right and others wrong, and even less is placed on rewarding the adolescent for doing the right thing.

In addition Hurlock (1990) states that building a moral code is difficult for adolescent because of inconsistencies in standards of right and wrong they encounter in daily life. These inconsistencies confuse them and impede their progress in building a moral code which is not only satisfactory to them but which will also lead to socially approved behaviour. Sooner or later, most adolescents discover that peers of different socioeconomic, religious, racial backgrounds have different codes of right and wrong, that their parents and teacher’s codes are often stricter than those
their contemporaries and that a "double standard" which is far more lenient for boys than girls.

Hurlock (1990) further states that control becomes central to behaviour regulation in adolescence. Studies in moral development have emphasized that the only effective way people of any age can control their behaviour is through the development of conscience—an inner force that makes external controls unnecessary. Adolescents learn to associate positive emotions with group-approved behaviour, and unpleasant emotions with group disapproved behaviour, they will have necessary motivation to behave in accordance with group standards. Eysenck (1960) and Ausubel, Montemayor and Svajian (1977) noted that behaviour that is controlled by guilt is thus inner-controlled while that controlled by shame is outer-controlled. Langford and George (1975) sums up as, in morally mature adolescents both guilt and shame are present. However, guilt plays an important role when external control is absent.

1.10. Risk-Taking and Dangerous Behaviour in Adolescence:

According to Mullen and Hendren (2005) risk-taking behaviour is ubiquitous to adolescence. A full understanding of how risk-taking and dangerous behaviours among young people is required considering the amount of pressures they face. Zuckerman (1994) defined risk as "the appraised likelihood of a negative outcome of behaviour", further Lightfoot (1997) defined risk taking behaviour as "volitional, purposive, goal-oriented and carry potential of harm." According to report by COMSIS Corporation and John Hopkins University (1995) the incidence and prevalence of risk taking in adolescence indicates that risky behaviour is a
common aspect of adolescent experience. Indeed some risk taking is developmentally appropriate while attempting mastery of developmental tasks. Testing limits, taking risks appears to be a way of adolescence which helps in forming an identity and developing autonomy. Here it is important to note the findings of Furby and Beyth-Marom (1992) who observed that, although adolescents take a disproportionate number of risks compared to any other population, there is no indication that most are willfully attempting to harm themselves or others. What often looks to others like irrational behaviour, risk taking by adolescents can be a rational process. Baumrind (1991) viewed risk taking as normative and adaptive for identity and social competence development. Thus adolescent risk taking behaviour is important not only because it may lead to illness or death but because it can severely compromise a young persons’ mastery of normal developmental tasks and ability to fulfill social roles.

1.10.1. Integrated Theories of Youthful Risk Taking:

Risk taking by adolescents have been variedly viewed by researchers. For some researchers like Irwin and Millstein (1986); Jessor and Jessor (1977); Donovan, Jessor and Costa (1991) and Jessor (1992) risk taking is seen as set of volitional behaviours initiated during the teenage years that have major negative health and social consequences. For others like Hovarth and Zuckerman (1993) and Zuckerman (1979) risk taking is perceived as way individuals meet their biological needs for stimulation and sensation (e.g. mountain climbing, sky diving, racing). Contemporary theories of youthful risk taking take into consideration the interplay between individual characteristics and social contexts.
1.10.2. Various Conceptualisations of Risk:

1.10.2.1. Biomedical Concepts of Risk:

Biomedical researchers define risk as involving both biological as well as psychological factors. Irwin (1993) views puberty as triggering force because it influences individual's perception of social environment, self perceptions, cognitive development and personal values. Effects vary by gender and by the adolescent's pubertal states relative to that of his/her peers. Thus, early maturers are expected to experience strongest effects of biological changes on behaviour since their physical development is in sharp contrast to the development of other young people.

1.10.2.2. Social Developmental Concepts:

For social developmental psychologists, risk incorporates a wide range of personal development and social adaptive behaviours. Risk taking, according to Jessor (1992) transcends physical health outcomes and refers to behaviours that can compromise normal psychosocial development of individual. Psychosocial formulation of risk recognizes the contribution of the social context to adolescent behaviour. Furthermore, it stresses the need to examine the meaning of the outcomes for adolescent. Added to these, there are a set of protective factors, that is, those factors which enable young person to avoid involvement in risk taking and develop a sense of personal adequacy and competence despite exposure to adverse social environment.
1.10.2.3. Cognitive Developmental Concepts of Risks:

Risk as defined by cognitive psychologists and decision making theorists like Furby and Beyth-Marom (1992); von Winterfeldt and Edwards (1996) and Yates (1992) represent acts which may or may not be volitional but involve some probability of loss. Behaviours may be undertaken consciously or unconsciously. According to Furby and Beyth-Marom (1992) risk perception is a construct that is not found in the biomedical or psychosocial theories of risk taking, it refers to an individuals’ conscious assessment of the probability of loss associated with engaging in (not engaging) in a specific behaviour.

According to Gardner (1993) decision making theory assumes that individuals seek to satisfy their own needs and goals by making rational choices regarding which behaviours will minimize loss and maximize gains given by environmental constraints. From this perspective, all behaviours are risky in the sense that they involve some loss. Unlike other conceptualisations of risk taking, decision making theory considers the consequences of either engaging or not engaging in a risk behaviour.

1.10.2.4. Social Learning Theory Concept of Risk:

From social learning theory perspective, adolescents learn behaviour through a process of modeling and reinforcement. Repeated exposure to individuals engaged in risk behaviour in the environment or media may influence adolescents to engage in such behaviours themselves. The view that engaging in risky behaviours is “standard practice” among age mates also helps create norms that are supportive of
risky behaviour. Personal characteristics modulate the degree to which high status role models influence behaviour. However, in contrast, Botvin and Botvin (1992) state that “low self-esteem, low self-satisfaction, low self-confidence, greater need for social approval, low sense of personal control, low assertiveness, greater impulsivity and impatience to assume adult roles” may contribute to adolescent’s vulnerability to engage in risky behaviour. Social learning theory believes that behaviour is determined within a “social situational context”. Muss (1998) states that, behaviour changes are attributed to the interaction between environmental and situational factors. For intervention purposes, a derivative of social learning theory, social influences model, has been used successfully to forestall risky behaviours. It posits that peers play a major role in shaping behaviour.

1.11. What Should Be Done About Risk Taking?

An understanding of the meaning of risk taking in the adolescent culture, from the adolescent perspective, is essential to successful prevention and intervention of health-compromising behaviours, as well as understanding healthy adolescent development. Irwin and Millstein (1991) report that, the frequency and intensity of risk taking during adolescence after a certain stage no longer serves a positive developmental purpose and becomes problematic. Dryfoos (1991) in his study found that early involvement in risk taking has been found to result in worst outcomes. Irwin and Millstein (1991) further contend that risk taking behaviours co-occur, taking place in variety of domains. In her work, while interviewing adolescents, Lightfoot (1997) found that adolescents take risks for many reasons; in defiance of authority, as a commitment to peers, as a transforming experience, and to
define relationships with others. Whereas, Lyng (1993) describes motivation for adolescent risk taking, as an attempt to gain control over an environment perceived by adolescents as mostly within control of adults. Adolescents do not see sufficient important roles for themselves in society. The idea is supported by the work of Benson (1998) for The Search Institute, he states that “Most young perceive that they are devalued by adults and most report their community does not provide useful roles where their energy can be constructively channeled.”

Some studies have attempted to identify factors most likely disinhibit actualisation of possible risks. Werner (1989), as a result of a 32-year old longitudinal study on high-risk children determined three categories of protective factors which can be viewed as disinhibitors of risk: dispositional attributes, family bonds and support, and external support systems. Similarly, The Search Institute (Benson, 1998), in a large scale study of thousands of youth determined 40 developmental assets essential to healthy adolescent development, 20 are internal and 20 are external. Internal assets include commitment to learning, positive values, social competencies and positive identity. External assets include support, empowerment, boundaries and expectations, and constructive use of time made possible by a community’s socialising systems. He found that developmental assets are protective for many forms of risk taking. As assets increase, risk taking behaviours decrease.

A thorough understanding of reasons for risk taking, factors moderating it, and protective factors involved shape the intervention. Weissberg and Elias (1993) found that, at individual level, interventions within the context of particular problem behaviour have been proven most effective. In contrast,
Bogenschneider (1996) states that “successful programs address both risk and protective processes at several levels of human ecology to create a comprehensive multifaceted effort.” placing emphasis on ecology. Similar observation is made by Dryfoos (1991), he identified that programmes with multiple components, multiple settings and multiple goals that focus on the factors putting individuals at risk, as opposed to individual risk behaviours, are more successful.

Lerner (1997) points out that the consequences of risk taking by adolescents put all of society at risk through lessened potential for our collective future. Therefore, Scott (2001) says that it is the time to come together with resources available and knowledge gained thus far toward creating a more hopeful future for all society. A common vision and unified effort is what is needed. In addition, he says that, researchers willing to focus on evaluation of programs to ensure that efforts are more than just well-intentioned are essential to learn what works best at different age, with different issues and with target populations. Besides, it is also important to note the observation by Bogenschneider (1996) who advocates for early and continuous intervention for stemming the risk taking in adolescents.

Werner (1989) found that protective factors at different life stages continue to have positive influence over time, like a chain reaction. Therefore, the interventions must aim towards strengthening the external and internal resources of the individual. If this is the case, early identification of those most “at risk” for negative outcomes in future need to be addressed with interventions specifically tailored to their needs. Thus, it can be concluded that prevention efforts focused on
doing what is possible to reduce risk as well as enhancing protective factors appears warranted.

1.12. Why Mental Health Promotion/Prevention is Important? :

1.12.1. Nature of Adolescence:

The very nature of late childhood to early adolescence is singled out as a critical moment of opportunity for building skills and positive habits by Mangrulkar et al (2001), since at that age there is a developing ability to think abstractly, to understand consequences, and to solve problems. The wider social context of early and middle adolescence provides varied situations in which to practice new skills with peers and other individuals outside of the family. Skills and competencies are recognized as important in a child’s developmental pathway, and in developing a sense of oneself as an autonomous individual.

1.12.2. Prevalence of Mental Health Problems in Adolescents across World and India:

Mental and Behavioural disorders are not exclusive to any special group, they are found in all people of all regions and societies. According to WHO (2001b) one person in four will develop one or more mental or behavioural disorders during their life time. World wide, one fifth (i.e. one in five) under age of 18 years suffer from developmental, emotional or behavioural problems and one in eight has serious mental disorder. Therefore, WHO (2004a, b) suggests that to reduce the health, social and economic burdens of mental disorders it is essential that countries and regions pay greater attention to prevention and promotion of mental health at all
Srinath et al (2005) report the findings from a multicenter epidemiological study, the prevalence rate of various mental disorders for Indian children aged 0-16 years as 12.5%. The various abnormal psychosocial factors involved were also studied; they reported that, 13% were children living with mentally ill parents/relatives, 10% children lived in families with discordant intrafamilial relationships, 20% had family over involvement, 8% had inconsistent or inadequate parental control, 8% has anomalous family situation and 11% had stress or disturbance at school. Kumar (2005) reported on the factors that determined the mental health of Indian children. He found that psychosocial determinants like male gender, low socio economic status, being enrolled in government school, age range 6-8 years, low intelligence levels, physical illness, low sociability, negative emotionality, high energy, low rhythmicity, low distractibility, greater parental control, greater stress and more life events are associated with child and adolescent psychopathology.

1.12.3. Economic and Social Burden on Country’s Limited Resources are Enormous:

Another very important reason why there is need for mental health promotion and preventive interventions is economic costs of treating (not treating) child and adolescent mental health disorders. For children and adolescents with mental health problems, families and societies incur significant costs. Both adolescents and families are affected. The child may miss school chronically, which affects scholastic performance and compromises his chances for a successful career.
The family may incur debts as well as future lost productivity. A study by SANE, Australia (1992) found that family members may also incur costs, as they often change or lose their jobs to stay home with their children with mental health problems. WHO (2005a) notes that even when families do bear the economic burden, governments and societies ultimately pay a price in terms of reduced national income and increased expenditure on social programmes.

Knapp, Scott and Davies (1999) have shown that children with depression or conduct disorder can generate high costs in childhood and adulthood. Similarly Scott et al (2001) found that the costs incurred by individuals from childhood to adulthood were 10 times greater for those who are seriously antisocial in childhood than those who were not. There is mounting scientific evidence like studies by Keating and Hertzman (1999) demonstrates the cost effectiveness of mental health prevention and treatment interventions. Therefore, preventive measures like life skills education that promotes health as a whole is ideal solution for many psychosocial difficulties faced by children and adolescents.

1.12.4. Health Promotion is an Important Strategy of Public Health:

WHO (1998a, 2004a) defined public health as the “science and art of promoting health, preventing disease, and prolonging life through the organised efforts of society.” Health promotion has been recognised as an important public health strategy for a long time, but mental health promotion has been receiving attention only for the past 5 decades. WHO (1998b), in Jakarta Declaration for Health Promotion, placed emphasis on mental health promotion and defined mental health promotion as “that which aims to impact on determinants of mental health so as to
increase positive mental health, to reduce inequalities, to social capital, to create health gain and to narrow health expectancy between countries and groups.” It is important to understand the distinction between mental health by increasing psychological well-being, competence and resilience, and by creating supporting living conditions and environments whereas mental disorder prevention has as its target the reduction of symptoms and ultimately of mental disorders. It uses mental health promotion strategies as one of the means to achieve these goals. Mental health promotion when aiming to enhance positive mental health in community may also have secondary outcome of decreasing the incidence of mental disorders. Positive mental health serves as a powerful protective factor against mental illness. However, Detels et al (2002) clearly state that mental disorders and positive mental health can not be described as the different ends of a linear scale, but rather a two overlapping and interrelated components of a single concept of mental health.

1.12.5. Evidence-based Prevention:

Evidence-based prevention stimulates the use of best available knowledge from systematic research in decision-making for clinical and public health practice. Hosman and Jane-Llopis (2005) paraphrased the definition of Sackett et al (1996) on evidence-based practice. “Evidence-based prevention and health promotion is conscientious, explicit and judicious about interventions for individuals/communities and populations that facilitate the currently best possible outcomes in reducing the incidence of diseases and in enabling people to increase control over and to improve their health.” There is enough evidence which proves the effectiveness of
life skills training in number of settings. It has been discussed in detail in chapter 2-
Review of related literature. Due to this very fact, life skills approach was used in the
current study.

1.12.6. Increased Understanding About Risk and Protective Factors:

WHO (2004b) states that, scientific knowledge has increased about the role of malleable risk and protective factors in the development of mental and behavioural disorders across the life span. Many studies have shown that preventive interventions can be successful in reducing risk factors and strengthening protective factors, and are beginning to show reductions in the onset and recurrence of serious mental health problems and mental health disorders in populations at risk. Rutter (1985) who first discussed risk and protective factors viewed them as being responsible for individuals’ state of mental health. Risk factors are associated with increased probability of onset, greater severity and longer duration of mental health problems. Protective factors refer to conditions that improve peoples’ resistance to risk factors and disorders. He defines them as “those factors that modify, ameliorate or alter a person’s response to some environmental hazards that predisposes to a maladaptive outcome.”

Studies by Coie et al (1993) and Ingram and Price (2000) and many other studies demonstrate the evidence on risk and protective factors and their links to the development of mental disorders. The essence of findings of these studies is that the cumulative effect of the presence of multiple risk factors, the lack of protective situations that predispose individuals to move from a mentally healthy condition to increased vulnerability, then to a mental problem and finally to full-blown disorder.
Both risk and protective factors can be individual, family related, social, economic and environmental in nature.

Preventive interventions aim to counteract risk factors and reinforce protective factors in order to disrupt those processes that contribute to human mental dysfunction. WHO (2004a) has listed many risk and protective factors, the following table presents only those factors which are relevant for child mental health.

Table 1.01: Risk and Protective Factors of Child and Adolescent Mental Health

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Academic failure</td>
<td>• Ability to cope with stress</td>
</tr>
<tr>
<td>• Attention deficits</td>
<td>• Ability to face diversity</td>
</tr>
<tr>
<td>• Child abuse and neglect</td>
<td>• Adaptability</td>
</tr>
<tr>
<td>• Communication deviance</td>
<td>• Autonomy</td>
</tr>
<tr>
<td>• Emotional immaturity and dyscontrol</td>
<td>• Early cognitive stimulation</td>
</tr>
<tr>
<td>• Exposure to aggression, violence and trauma</td>
<td>• Feelings of mastery and control</td>
</tr>
<tr>
<td>• Family conflict and disorganization</td>
<td>• Good parenting</td>
</tr>
<tr>
<td>• Loneliness</td>
<td>• Positive attachment and early bonding</td>
</tr>
<tr>
<td>• Low birth weight</td>
<td>• Positive parent-child relation</td>
</tr>
<tr>
<td>• Low social class</td>
<td>• Problem solving skills</td>
</tr>
<tr>
<td>• Parental mental illness, substance use</td>
<td>• Pro social behaviours</td>
</tr>
<tr>
<td>• Perinatal complications</td>
<td>• Self-esteem</td>
</tr>
<tr>
<td>• Bereavement</td>
<td>• Social and conflict management skills</td>
</tr>
<tr>
<td>• Reading and sensory disabilities</td>
<td>• Socio emotional growth</td>
</tr>
<tr>
<td>• Social incompetence</td>
<td>• Stress management</td>
</tr>
<tr>
<td>• Stressful life events</td>
<td></td>
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<tr>
<td>• Substance use during pregnancy</td>
<td></td>
</tr>
</tbody>
</table>

1.12.7. Priority Area for Research:

The World Health Report (2001b) identified five priority research areas for mental health. These areas, which are also relevant for child and adolescent mental health, are: epidemiological research, treatment, prevention and promotion outcome research, policy and service research, economic research and research in developing countries and cross-cultural comparisons. The present attempt falls under the category of treatment, prevention and promotion outcome research more
specifically focusing on promotion aspect, which tests the efficacy and effectiveness of various models of school-based mental health services.

1.13 What is Life Skills Education?

WHO (2001a) recognises that life skills education effectively addresses the psychological and social needs of young people and helps them, to develop and grow into well adjusted adults. It is relevant to moulding effective responses to behaviour related health problems of children and adolescents. It is a critical part of a comprehensive approach to health education and promotion. Through life skills education a move can be made towards more positive and holistic approaches to educate the new generation, and through them, future generations. Today, children live in a very complex environment. They are exposed to various channels of communication, such as television, the Internet and radio. The electronic media particularly have a strong influence on children and adolescents, outweighing the influence of parents and family in certain situations. Interaction with friends and pressure from peers and media advertisements etc are a strong influence on growing children and adolescents. Parental influence in moulding moral and social values and the traditional school curriculum are seemingly becoming increasingly incapable of equipping young people with the skills needed to face real life.

Lifeskills education is a process of improving a person's abilities to deal effectively with the demands and challenges of everyday life. Young people, both in school and out of school, should have the opportunity to be trained in life skills as it plays an important role in the promotion of health in its broadest sense, in
terms of physical, mental and social well-being. At the individual level, life skills education should be stressed, especially beginning at home and reinforced at school. There is convincing evidence that a person's lifestyle has an important bearing on his or her health. Lack of exercise, a diet high in fat and cholesterol, tobacco use, alcohol and drug abuse cause serious health problems and premature death. Many of these conditions are rooted in habits acquired at a young age, including adolescence. Since 1993, WHO, in close collaboration with UN agencies such as UNICEF, UNESCO and UNFPA, has given technical support to the efforts of member countries in life skills education.

WHO (1993) states that life skills education is a unified and developmental approach to help children and adolescents learn how to deal with difficulties of daily life, growing up and risk situations. Through a long-term curriculum over a number of years of schooling, many diverse needs and problems can be addressed, based on the same underlying pedagogical approach – the learning and application of life skills. Life skills education is an essential component of health promotion. It is not a panacea for all problems, but is an important aspect for addressing young people’s needs in the face of a wide range of problems, including drug abuse, violence, HIV/AIDS and a wide range of needs, including the promotion of safety, peace and human rights. WHO (1993) promotes life skills school based programme as a means to develop skills among young people that lead to healthy life style choices and optimum physical, social and psychological well-being. Life skills approach is built around creating opportunities for youth to acquire skills that enable them to avoid manipulation by out side influences. The idea is for young people to be
able to recognize the coercive pressures, as well as organized campaigns, such as tobacco advertising, that promote behaviours known to jeopardize their health. The life skills approach aims to regain control over their behaviour while taking informed decisions that can lead to positive behaviours and values.

1.14. Definitions of Important Terms:

The following are the definitions of terms 'psychosocial competence', 'life skills' and skills- Problem solving, Decision making, Critical thinking, Creative thinking, Empathy, Self awareness, Coping with emotions, Coping with stress, Interpersonal relations skill, and Effective communication as given by WHO (1993).

**Psychosocial Competence:**

"Person’s ability to deal effectively with the demands and challenges of everyday life. It is person’s ability to maintain mental well-being and to demonstrate this in adaptive and positive behaviour while interacting with others in his/her culture and environment."

**Life Skills:**

"Abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of life."

**Problem Solving:**

"Having made decisions about each of the options, choosing the one, which suits best, following it through even in the face of impediments and going through the process once again till a positive outcome of the problem is achieved"

**Decision Making:**

"The process of assessing an issue by considering all possible/available options and the effects that different decision might have on them."
Critical Thinking:

“Ability to analyse information and experiences in an objective manner.”

Creative Thinking:

“Ability that helps us look beyond our direct experience and address issues in a perspective which is different from the obvious or the norm. It adds novelty, flexibility to the situation of our daily life. It contributes to problem solving and decision making by enabling us to explore available alternatives and various consequences of our actions or non actions.”

Empathy:

“Is an ability to imagine what life is like for another person even in a situation that we may not be familiar with. It helps us to understand and accept others and their behaviour that may be very different from ourselves.”

Self Awareness:

“This includes recognition of our selves, our character, strengths and weaknesses, desires and dislikes. It is a prerequisite for effective communication, interpersonal relationship and developing empathy.”

Coping with Emotions:

“It is an ability, which involves recognising emotions in others and our selves, being aware of how emotions influence behaviour and being able to respond to emotions appropriately”

Coping with Stress:

“It is an ability to recognize the source of stress in our lives, its effects on us and acting in ways that help to control our levels of stress. This may involve taking action to reduce some stress, for e.g. changes in physical environment, life skills, learning to relax etc.”

Interpersonal Relations Skill:

“It is a skill that helps us to understand our relevant others and relate in a positive/reciprocal manner with them. It helps us to maintain relationships
with friends and family members and also be able to end relationships constructively."

**Effective Communication:**

"It is an ability to express ourselves both verbally and non-verbally in an appropriate manner. This means being able to express desires, opinions, fears and seek assistance and advice in times of need."

**Other Definitions:**

1. Hamburg (1990) defines Life-skills training as "the formalized teaching of requisite skills for surviving, living with others, and succeeding in a complex society".

2. Wodarski (1988) reported that life-skills training as "the treatment of choice" when applied to prevention with adolescents.

3. Gilchrist, Schinke, and Maxwell (1987) reported that life skills which assist in the development of an adolescent's self-efficacy "include the ability to solve problems, to communicate honestly and directly, to gain and maintain social support, and to control emotions and personal feelings."

<table>
<thead>
<tr>
<th>Table 1.02: Latest Classification of Life Skills According to WHO (2000)</th>
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<tbody>
<tr>
<td><strong>Communication and Interpersonal Skills</strong></td>
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<tr>
<td><em>Interpersonal Communication Skills</em></td>
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<tr>
<td>• Verbal/non verbal communication</td>
</tr>
<tr>
<td>• Active Listening</td>
</tr>
<tr>
<td>• Expressing feelings: Giving feedback (without blaming) and receiving feedback</td>
</tr>
<tr>
<td><em>Negotiation/Refusal Skills</em></td>
</tr>
<tr>
<td>• Negotiation and Conflict management</td>
</tr>
<tr>
<td>• Assertiveness skills</td>
</tr>
<tr>
<td>• Refusal Skills</td>
</tr>
<tr>
<td><em>Decision-making / Problem-solving Skills</em></td>
</tr>
<tr>
<td>• Information-gathering skills</td>
</tr>
<tr>
<td>• Evaluating future consequences of present actions for self and others-determining alternative solutions to problems</td>
</tr>
<tr>
<td>• Analysis skills regarding the influence of values and of attitudes about self and others on motivation</td>
</tr>
<tr>
<td><em>Critical Thinking Skills</em></td>
</tr>
<tr>
<td>• Analysing peer and media influences</td>
</tr>
<tr>
<td>• Analysing attitudes, values, social norms, beliefs, and factors</td>
</tr>
<tr>
<td><em>Skills for Increasing Personal Confidence and Abilities to Assume Control, Take Responsibility, Make a Difference, or Bring About Change</em></td>
</tr>
<tr>
<td>• Building self-esteem/confidence</td>
</tr>
<tr>
<td>• Creating self-awareness skills, including awareness of rights, influences, values, attitudes, rights, strengths and weaknesses</td>
</tr>
<tr>
<td>• Setting goals</td>
</tr>
<tr>
<td>• Self-evaluation/self-assessment/self-monitoring skills</td>
</tr>
<tr>
<td><em>Skills for Managing Feelings</em></td>
</tr>
<tr>
<td>• Managing anger</td>
</tr>
<tr>
<td>• Dealing with grief and anxiety</td>
</tr>
</tbody>
</table>
### Empathy Building
- Ability to listen, understand another's needs and circumstances, and express that understanding

### Cooperation and Team Work
- Expressing respect for other's contributions and different styles
- Assessing one's own abilities and contributing to the group

### Advocacy Skills
- Influencing skills and persuasion
- Networking and motivating skills

<table>
<thead>
<tr>
<th>Empathy Building</th>
<th>Cooperation and Team Work</th>
<th>Advocacy Skills</th>
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</tr>
<tr>
<td></td>
<td>Assessing one's own abilities and contributing to the group</td>
<td>Networking and motivating skills</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Skills for Managing Stress</th>
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<tbody>
<tr>
<td>Coping with loss, abuse and trauma</td>
</tr>
<tr>
<td>Time management</td>
</tr>
<tr>
<td>Positive thinking</td>
</tr>
<tr>
<td>Relaxation techniques</td>
</tr>
</tbody>
</table>

#### 1.15. Why Use Life Skills Approach?

Mangrulkar et al (2001) provides a brief list of valid reasons why life skills approach can be utilized for intervention purposes.

1. Social, cognitive and emotional coping skills are essential components for healthy development in childhood and adolescence, and are needed for making a successful transition from childhood to adulthood.

2. Life skills programmes can specifically address the needs of children growing up in disadvantaged environments that lack opportunities to develop these skills.
3. Problem-solving skills and social competence are among the characteristics that define a resilient child.

4. Knowing how to manage emotions and interpersonal relations is as important to success in life as intellect.

5. Health promotion and prevention programmes focusing only on transferal of information are less effective than programmes incorporating skills development.

6. The social, cognitive, and emotional coping skills targeted by life skills programmes are shown to be mediators of problem behaviours.

7. Life skills have an impact on multiple adolescent health and development needs.

8. A life skills approach helps school address multiple demands for prevention education curricula by presenting a comprehensive, unified approach to meeting many needs.

9. Communication skills, decision making skills, critical thinking skills, and negotiation skills needed for healthy development are also skills that are valued by employers in the workplace.

10. Life skills programmes promote positive social norms that can impact the greater environment of adolescent health services, schools, staff, administrators and families.

1.16. Theoretical Foundations of Life Skills Education:

Mangrulkar et al (2001) analyses six theories which are not mutually exclusive but contribute to foundation of a life skills approach. These six theories are
social learning, problem behavior, social influence, cognitive problem solving, multiple intelligences, and risk and resilience. They are followed two more theories—theory of reasoned action and health belief model and transtheoretical theory.

1.16.1. Social Learning Theory:

This theory, which is also known as the Cognitive-Social Learning Model, is largely based upon the work of Albert Bandura (1977b). Bandura’s research led him to conclude that children learn to behave through both instruction (i.e., how parents, teachers, and other authorities and role models tell them to behave) as well as observation (i.e., how they see adults and peers behaving). Their behavior is reinforced, or modified, by the consequences of their actions and the responses of others to their behaviors. Children learn to behave, then, through observation and social interaction, rather than just through verbal instruction. Similarly, Ladd and Mize (1983) emphasised that children should be taught skills through a process of instruction, rehearsal, and feedback, rather than just instruction. Bandura also stressed that self-efficacy, defined as “belief in one’s abilities to perform appropriate behaviors”, which is important to learning and maintaining behaviors, especially in the face of social pressure to behave differently. Thus, skills development not only becomes a question of outward behavior, but of internal qualities (such as self-efficacy) that support those behaviors (Bandura, 1977a). Social Learning Theory has two profound influences on the development of life skills and social skills programs. One is the necessity of providing children with methods or skills for coping with internal aspects of their social lives, including stress reduction, self-control, and
decision-making. The second is, to be effective, life and social skills programs need to replicate the natural processes by which children learn behavior. Thus, most life and social skills programs need to include observation, role-play, and peer education components in addition to plain instruction.

1.16.2. Problem-Behavior Theory:

As developed by Jessor (1992), this theory recognizes that adolescent behavior (including risk behaviors) cannot be reduced to a single source, but is the product of complex interactions between people and their environment. Problem-Behavior Theory is concerned with the relationships among three categories of psychosocial variables: (1) the personality system; (2) the perceived environmental system; and (3) the behavioral system. The personality system includes "values, expectations, beliefs, attitudes, and orientations toward self and society." The perceived environmental system concerns perceptions of friends' and parents' attitudes toward behaviors. And, similar to Bandura, the behavioral system is usually described as a certain set of 'socially unacceptable behaviors' (the use of alcohol, tobacco, and other drugs, sexual behavior by persons below a certain age, delinquency, etc.). Each psychosocial system contains variables that act as instigators or controls on problem behavior. As Jessor, Donovan, and Costa (1991) point out, the strength of these variables results in proneness: the likelihood that problem behavior will occur. Weakening instigators or strengthening controls helps decrease a child's "overall proneness for problem behaviors" (that is, the likelihood that the child will engage in problem or unhealthy behaviors). Jessor's early work helped to promote the development of life skills approaches that included strategies in all three systems. In
more recent years, Jessor (1992) and the Problem-behavior theorists have described

two other systems of influence, the social environment (which includes factors such

as poverty and family structure) and biology/genetics (including variables such as

family history of alcoholism and high intelligence). The biological genetic system of

influence (like much genetic research) may be useful to identify children with a

genetic propensity for particular risk behaviors (like alcoholism), but is still limited in

its use in prevention. The social environment domain identifies other variables

(behaviors such as poor school performance) that correlate with risk behaviors (such

as the use of alcohol and other drugs). These variables, if changed, will affect

others—regardless of the workings of the causal links among the variables. Thus,

developing skills such as values clarification (to better understand one’s own values

and beliefs) and critical thinking (to clearly recognize and analyze the values of the

social environment) can have an impact on behavior, and can be even more effective

in coordination with programs that affect other variables, such as poverty reduction

programs, clinical health services or school dropout prevention.

1.16.3. Social Influence Theory:

Social influence approaches are based upon the work of Bandura (1977 a) as well as the psychological inoculation theory developed by researchers,

including McGuire (1964, 1968). Social influence approaches recognize that children

and adolescents will come under pressure to engage in risk behaviors, such as tobacco

use. According to Evans (1998), social pressures include “peer pressure, models of

smoking parents, and smoking-related messages in the mass media that feature

attractive smokers”. Social influence programs anticipate these pressures and teach
children about both the pressures and ways to resist them before they are exposed
(much like vaccination builds resistance to diseases before children are exposed to
those diseases in the environment). This theory was spurred by research
demonstrating that programs that merely provided information on the consequences
of risk behaviors (such as smoking), and/or used fear to try to prevent children from
engaging in these behaviors were unsuccessful. Research by Mangrulkar (2001) into
these programs found that, “Fear induced by knowledge of the long-term dangers of
smoking appeared to be insufficient to prevent its onset among many young
adolescents, when exposed to social pressure to engage in the behavior.” This
approach was first used by Evans and others (1976, 1978) in smoking prevention
programs. The approach is now usually referred to as “peer resistance education,” and
is used in a broad range of curricula to prevent the use of tobacco, alcohol, and other
drugs, as well as high-risk sexual activity. Meta-analysis of prevention programs by
Hansen (1992) revealed that social influence programs were more effective than
programs based solely on information or affective education. Usually, these programs
are targeted at very specific risks, tying peer resistance skills (as well as the
classroom exercises used to teach that skill) to very particular risk behaviors (such as
marijuana use), attitudes (such as the opinion that using marijuana is wrong), and
knowledge (e.g. the consequences of using marijuana on a child’s memory, lungs, and
reproductive health). Social resistance training is usually a central component of
social skills and life skills programs.
1.16.4. Cognitive Problem Solving:

This competence-building model of primary prevention developed by Shure and Spivack (1980) theorizes that teaching interpersonal cognitive problem solving (ICPS) skills to children at a young age can reduce and prevent negative inhibited and impulsive behaviors. Research shows differing levels of interpersonal thinking skills in children displaying positive social behaviors versus children displaying early high-risk behaviors (including antisocial behaviors, inability to cope with frustration, and poor peer relations). The defining skills focus on the ability to generate alternative solutions to an interpersonal problem and secondly, the ability to conceptualize the consequences of different behaviors. Relationships between these problem solving skills and social adjustment were found not only in preschool and kindergarten children, but also in adolescents and adults. An intervention based on this research, the ICPS intervention (also called “I Can Problem Solve”), develops interpersonal cognitive problem-solving skills starting in preschool, with the ultimate goal of preventing later and more serious problems by addressing the behavioral predictors early in life. Solving hypothetical dilemmas, thinking aloud, role playing, and providing performance feedback are some methodologies for teaching these skills. Further research done by proponents with preschool and kindergarten children found that those receiving the ICPS training became better able to cope with typical everyday problems than those who did not. By learning to consider more solutions and consequences, they became better able to cope with frustration, better able to wait, and less overemotional and aggressive when goals could not be satisfied.
immediately. Thus, problem-solving, especially as applied to social or interpersonal situations and starting early in life, is a critical part of life skills programs.

1.16.5. Multiple Intelligences: Including Emotional Intelligence:

Howard Gardner published “Frames of Mind” in 1993, challenging the prevailing view of human intelligence as an uncomplicated set of cognitive and symbol-using capacities, acknowledging primarily only verbal/linguistic and mathematical/logical abilities. Gardner proposed the existence of eight human intelligences that take into account the wide variety of human thinking capacities. These include linguistic, logical/mathematical, musical, spatial, bodily/kinesthetic, naturalist, interpersonal and intrapersonal intelligences. This theory postulates that all human beings are born with the eight intelligences, but they are developed to a different degree in each person and that in developing skills or solving problems, individuals use their intelligences in different ways. The theory of multiple intelligences has important implications for educational systems, and for incorporating a life skills approach to promotion and prevention. Recognizing other intelligences, beyond the traditional verbal and mathematical skills, implies that teachers should teach to this broader range of skills. Secondly, a variety of classroom instruction methods are needed to engage the different learning styles of the students. This implies the use of participatory, active learning methods that stimulate the use of musical, spatial, naturalist and other intelligences, and allows children and young people to engage different intelligences simultaneously. Other researchers have expanded the thinking on the two “personal” intelligences: interpersonal intelligence, the ability to understand and discern the feelings and intentions of others, and
intrapersonal intelligence, the ability to understand one's own feelings and motivations. Daniel Goleman (1997) popularized this idea in his book, Emotional Intelligence, which argues that knowing how to manage one's emotions is at least as important for success in life as intellect. In relation to this Weissberg et al (1998) and Hawkins et al (1992) observed that this idea has served as the basis of some of the work in social and emotional learning.

1.16.6. Resilience and Risk Theory:

Resilience and risk theory attempts to explain why some people respond better to stress and adversity than others. Resilience theory argues that there are internal and external factors that protect against the social stressors or risks of poverty, anxiety, or abuse. If a child has strong protective factors, he or she can resist the unhealthy behaviors that often result from these stressors or risks. Luthar and Zigler (1991) and Rutter (1987) emphasise that internal protective factors include self-esteem and internal locus of control, while external factors are primarily social supports from family and community, such as positive role models or health services. According to Bernard (1991), the characteristics that set resilient young people apart are social competence, problem solving skills, autonomy, and a sense of purpose. Meyer and Farrell (1998) further point out that although the social environments of these young people are marked by risk, they also have “protective qualities, including caring and supportive relationships, high expectations, and opportunities for youth participation, and involvement.” Prevention programs can target a broad array of those etiologic determinants. An understanding of the relationship of the child to the
environment is the foundation of what is often called a comprehensive prevention approach. Such an approach employs strategies that maximize resilience and minimize risk, involving not only the young person, but also the family and the community, as well as health care providers and other service providers (often through case management or a "full-service" approach). Resilience and risk theory provides an important part of a foundation for a life skills approach. Social-cognitive skills, social competence, and problem-solving skills serve as mediators for behaviors, both positive and negative. In other words, life skills programs designed to prevent specific problem behaviors (e.g., high-risk sexual activity, social rejection) or promote specific positive behaviors (e.g., healthy peer relationships, positive school adjustment) do not simply address the behaviors directly. Rather, they build the competencies or skills that are shown to mediate the behaviors.

It is apparent that there is not a one-to-one relationship between risk factors and behavioral outcomes. Greenberg et al (1999) observed that "recent findings in behavioral epidemiology indicate that mental health problems, social problems, and health-risk behaviors often co-occur as an organized pattern of adolescent risk behaviors". It is evidenced in Hawkins et al study (1992) which found that programs that teach social and emotional skills had positive effects in multiple realms, such as decreasing aggression in boys, decreasing suspensions and expulsions, decreasing drug use and delinquency, increasing academic test scores, and increasing positive attachments to school and families. Thus, effective life skills programs address and have an impact on multiple behaviors.
Many of the risk factors that threaten the health and well-being of adolescents (e.g., poverty, mental illness in family members, racial injustice) are out of the range of what most health promotion and prevention programs can do. Life skills programs address the mediating factors that research shows can be influenced to promote health and well-being.

1.16.7. Constructivist Psychology Theory:

The core of constructivist psychology is that individual development, including higher mental function, is rooted in social sources. A child’s cognitive development is thought to be a collaborative process, developed through interactions with other people and with the environment. Thus, the individual is not the center of knowledge-making but rather gets his or her learning and understanding through social interaction. Educators and psychologists Piaget (1972) and Vygotsky (1978) suggest that a key mechanism for child development is the cognitive conflict that is created through social interaction; a contradiction between a child’s existing understanding and a child’s experiences with others, especially peers slightly older or more knowledgeable, causes him or her to question current beliefs and seek new levels of understanding. Vygotsky (1978) in particular argues that “Learning awakens a variety of internal developmental processes that are able to operate only when the child is interacting with people in his environment and with his peers”. Separating the individual from his or her social influences is thought to be impossible, and learning itself is viewed as culturally and contextually specific. A key element in Vygotsky’s theories is the idea of the Zone of Proximal Development (ZPD). He argues that to understand the relationship between development and learning, we need to
distinguish between two different developmental levels: the actual level of
development and the potential level. The actual refers to the problem solving that a
child can do alone, versus the potential development that occurs when the child
problem solves under adult guidance or with more capable peers. Finally, from the
constructivist psychology perspective, the learning environment takes on a prominent
role in guiding a child's development and will be, in turn, influenced by the
collaborative learning and peer interactions taking place. The constructivist
perspective has three important influences on a life skills approach. One is the
significance of peer collaboration as the basis for learning skills, especially problem-
solving skills. Secondly, the constructivist approach highlights the importance of the
cultural context in infusing any life skills curriculum with meaning; the adolescents
themselves co-create the content through the interaction of the factual information
with their particular cultural environment. Finally, this perspective acknowledges that
the development of skills through the interaction of the individual with the social
environment can influence both the learners and the environment (peer group,
classroom, youth group, etc.).

1.16.8. Theory of Reasoned Action and The Health Belief Model:

The Theory of Reasoned Action and the Health Belief Model contain
similar concepts. Based on the research of Fishbein and Ajzen (1975), the Theory of
Reasoned Action views an individual's intention to perform a behaviour as a
combination of his attitude toward performing the behaviour and subjective
normative beliefs about what others think he should do. The Health Belief Model,
first developed by Rosenstock (1966); Rosenstock et al (1988) and Sheehan &
Abraham (1996) recognise that perceptions - rather than actual facts - are important to weighing up benefits and barriers affecting health behaviour, along with the perceived susceptibility and perceived severity of the health threat or consequences. Modifying factors include demographic variables and cues to action which can come from people, policies or conducive environments.

1.16.9. Stages of Change Theory or Transtheoretical Model:

This theory, based on a model developed by Prochaska (1979); Prochaska and Di Clemente (1982), describes stages that identify where a person is regarding her change of behaviour. The six main stages are precontemplation (no desire to change behaviour), contemplation (intent to change behaviour), preparation (intent to make a behaviour change within the next month), action (between 0 and 6 months of making a behaviour change), maintenance (maintaining behaviour change after 6 months for up to several years), and termination (permanently adopted a desirable behaviour).

Table 1.03: Summary of Implications of Theories for Developing Life Skills (Mangrulkar et al, 2001)

<table>
<thead>
<tr>
<th>Theory</th>
<th>Implications</th>
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<tbody>
<tr>
<td>Social Learning Theory</td>
<td>• Teaching life skills needs to replicate the natural processes by which children learn behavior (modeling, observation, social interaction)</td>
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<tr>
<td></td>
<td>• Children need to develop the internal skills (self-control, stress reduction, self management, decision-making) that can support positive outward behaviors</td>
</tr>
<tr>
<td>Problem- Behavior Theory</td>
<td>• Behaviors are influenced by an individual’s values, beliefs and attitudes, and the perception of friends and family about those behaviors. Therefore, skills in value clarification and critical thinking (to evaluate oneself and the values of the social environment) are an important aspect of life skills programs</td>
</tr>
</tbody>
</table>
| Social Influence Theory | • Peer and social pressures to engage in unhealthy behaviors can be defused by addressing them before the child or adolescent is exposed to those pressures, thus pointing towards early prevention, rather than later intervention  
• Teaching children resistance skills is more effective at reducing problem behaviors than just providing information or provoking fear of the results of the behavior |
|-------------------------|---------------------------------------------------------------------------------------------------------|
| Cognitive Problem Solving | • Poor problem-solving skills are related to poor social behaviors, indicating the need to include problem-solving as an aspect of life skills programs  
• Teaching interpersonal problem-solving skills at earlier stages in the developmental process (childhood, early adolescence) is most effective |
| Multiple Intelligences (Including Emotional Intelligence) | • A broader vision of human intelligence points towards using a variety of instructional methods to engage in different learning styles.  
• Managing emotions and understanding one's feelings and the feelings of others are critical to human development and can be learned by children in the same way as reading and arithmetic. |
| Resilience and Risk Theory | • Social-cognitive skills, social competence, and problem-solving skills can serve as mediators for behaviour.  
• The specific skills addressed by life skills programs are part of the internal factors that help young people respond to adversity and are the traits that characterize resilient young people. |
| Constructivist Psychology Theory | • The learning process occurs through social interaction in peer learning, cooperative groups, or open discussion situations.  
• Developing life skills in adolescents, like other processes of teaching and learning, is infused with layers of cultural beliefs and values  
• Developing skills through the interaction of the individual and the social/cultural environment can lead to changes both in the individual and in the environment (peer group, classroom, family, youth group) |
| Theory of Reasoned Action and Health Belief Model | • If a person perceives that the outcome from performing a behaviour is positive, she will have a positive attitude toward performing that behaviour. The opposite can be said if the behaviour is thought to be negative.  
• If relevant others (such as parents, teachers, peers) see performing a behaviour as positive and the individual is motivated to meet the expectations of relevant others, then a positive individual behaviour is expected. The same is true for negative behaviour norms. |
| Trantheoretical model | • It is important to identify and understand the stages where students are in terms of their knowledge, attitudes, motivation, and experiences in the real world, and to match activities and expectations to these.  
• Interventions that address a stage not relevant to students are
unlikely to succeed. For instance, a tobacco-cessation programme for people who mostly do not smoke or who smoke but have no desire to change is not likely to lead to quitting smoking.

1.17. Need for Life Skills Education in India:

Empowerment of the adolescent in India is very essential in today’s context. Bharath (2001) states that almost 40 percent of India’s population falls under the age of 19 years and 10-19 years age group makes up about 21 percent, almost a quarter of the total population. Hackett and Hackett (1993) observed that, Indian families have eastern culture and child rearing practices that are different from west. Here the consensus and collective is more important than the individual freedom and independence. Children are encouraged to be interdependent and under the care of parents even in early adulthood. Indian family with its control systems seems to offer a relative protection to the adolescents from deviance. Despite this, there is need for Life skills promotion in Indian youth for the following reasons:

1. Bharath (2001) states that conventional education (school curricula) lack components which train the child in necessary skills which are requisite for being psychosocially competent. However, efforts are being made to incorporate Life Skills education in the regular curriculum.

2. Rapid industrialization, urbanization, globalization, breaking up of joint families, unhealthy competition in the academic and career fronts on one side with high illiteracy and unemployment on the other side are some of the factors that make adolescents vulnerable.
3. Gender discrimination, suppression of minorities, child marriages, teen pregnancy, abuse, violation of human rights make the situation worse and highlight the need for skills education.

4. According to Weiss, Wheelan and Gupta (1996) though the prevalent culture is sexually less permissive, India is the second leading country in the world for density of HIV/AIDS population and its rapid spread.

5. Poverty, school drop out, child labour, homelessness, lack of infrastructure for effective redressal of these social problems puts the economically disadvantaged adolescents at risk.

6. Lack of comprehensive health services exclusively for adolescents, lack of supportive and guidance services at school, stigma for seeking help from professional in times of distress are also major reasons.

7. WHO (2005a) emphatically states that, there are three compelling reasons for developing effective interventions for children and adolescents: (i) since specific mental disorders occur at certain stages of child and adolescent development, screening programmes and interventions for such disorders can be targeted to the stage at which they are most likely to appear; (ii) since there is a high degree of continuity between child and adolescent disorders and those in adulthood, early intervention could prevent or reduce the likelihood of long-term impairment; and (iii) effective interventions reduce the burden of mental health disorders on the individual and the family, and they reduce the costs to health systems and communities.
1.18. Creating Health Through Schools:

Schools: Ideal Settings for Health Promotion:

WHO (1986) points to The Ottawa Charter (1986) which recognizes that, “Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to make decisions and have control over one’s life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.” WHO (2005b) states that some of the best opportunities for positively influencing the health of young people and preventing the initiation of the health risk behaviours are found in the school setting. The school is an extraordinary setting through which to improve the health of school personnel, families and members of the community, as well as students. It is a means to support the basic human rights of both education and health. It offers opportunities to achieve significant health and education benefits with investments of scarce education and health resources. It also offers highly visible opportunities to demonstrate a commitment to equity and to raising the social status of women and girls.

Primary school enrollments are increasing in nearly every part of the world. The main exception is in Sub-Saharan Africa, where enrollments are stagnating or declining. However, worldwide, schools reach millions of students and, through them, their families and communities. Therefore, as articulated by UNICEF, the formal education system is “the developing world’s broadest and deepest channel
Schooling, alone, has been shown to be a powerful way to influence health, worldwide. Its impact may be clearly seen in benefits to maternal and child health. For example, in developing countries as the literacy rates go up, the fertility rates tend to go down. Literate women tend to marry later and are more likely to use family planning methods. Mothers with even one year of schooling tend to take better care of their babies; they are more likely to seek medical care for their children and to have their children immunized. Furthermore, all schools no matter how scarce their resources can help students and staff to learn to care for themselves and others, make decisions and have control over life’s circumstances, and create conditions that are conducive to health. These are the qualities through which health is created and they are either encouraged or discouraged by a school’s policies, management practices and social conditions. In view of the above reasons, researcher chose to conduct the intervention in a school setting where children spend a lot of time and are influenced by their peers. Finally, it can be summed up in the words of WHO (2007) “It is clear that schools remain a crucial social institution for the education of children in preparation for life. But they need to be more involved in a broader educational role fostering healthy social and emotional development of pupils.”