CHAPTER- I

INTRODUCTION
Introduction

The focus of this chapter is on introducing the various concepts that are part of the present study in terms of its operational definitions and the other required details for conceptual clarity. This chapter is structured in the following manner with an introduction to the following concepts along with operational definitions:

1.1 Adolescence
1.2 Rational Emotive Behaviour Therapy
1.3 Group Counseling
1.4 Self-esteem
1.5 Aggression
1.6 Depression

1.1 Adolescence

The word “Adolescent” has its origin in the Latin word, “Adolescere” which means ‘to grow up’. Adolescence is the developmental period of transition from childhood to adulthood which includes biological, cognitive and social changes (Santrock, 2006). Although the age range of adolescence diverges by cultural and historical circumstance, the beginning is typically obvious by the onset of puberty and the conclusion is related with the full assumption of adult roles (Cotton Bronk, 2011).

The World Health Organization defines adolescence “as the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19 years” (WHO, 2015). According to Wade and Tavris (2008, p. 548), “adolescence refers to the period of development between puberty, the age at which a person becomes capable of sexual reproduction”. Many people become confuse between adolescence with puberty (Coon & Mitterer, 2014). “Puberty is the stage during which sexual functions reach maturity which makes the beginning of
adolescence” (Weiten, 2007, p. 442). The timing of puberty is not the same in all individuals. In fact, “the timing of puberty varies from one adolescent to the next over a range of about 5 years (10-15 for girls, 11-16 for boys)” (Weiten, 2007, p. 443). Although adolescence age boundaries are not precise, in the United States, adolescence initiates at around age 13 and finishes at about age 22. “Even though most contemporary societies have at least a brief period of adolescence, it has not been universal historically or across culture. In some societies, young people used to move directly from childhood to adulthood” (Weiten, 2007, p. 442).

In adolescence, body image becomes especially important. Also, the influence of peers increases at this age (Zimbardo, Johnson, Mccann, & Carter, 2006). Moreover, “from a developmental psychology point of view, adolescence is a stressful period of growth. This period poses many challenges to the adolescent such as finding identity and values and respect for self and others, taking increasing responsibility for him-or herself, and an increase in problem-solving skills” (Emami, Ghazinour, Rezaeishiraz, & Richter, 2007, p. 574). Adolescents can critically consider their beliefs, attitudes, values, and goals because they achieve the ability to think and discuss about abstract concepts (Plotnik & Kouyoumdjian, 2013). However, adolescents may have psychological distress because they have irrational beliefs also (Flett, Hewitt, & Cheng, 2008).

Adolescence is not automatically the time of psychological turmoil (Plotnik & Kouyoumdjian, 2013). “For some adolescents, it is a time of adaptation and improved mental health, but for others it is a period of maladaptation and enhancing levels of psychopathology” (Holmbeck, O’mahar, Abad, Colder, & Updegrove, 2006, p. 421). In other words, “many adolescents experience new levels of emotional intensity, including positive feelings such as romantic sentiments, sexual desires, tenderness and spirituality, as well as the negative emotions of jealousy, hatred, and rage” (Neuman & Neuman, 2006, p. 319).

According to Weiten (2007), adolescents do experience more unstable and more negative emotions than their parents, or younger children do. Also, they may involve in risky behaviors such as substance abuse, careless sexual practices, and dangerous driving. On the other hand, adolescence does bring an enhancement in parent-child conflicts. There is an interesting question about adolescents’ thinking and reasoning. That is: “why do some seem so slow to develop thinking and reasoning skills that prepare them to deal with typical problems and stressful situations that occur during adolescence”? Researchers have only recently discovered that the answer involves the developing adolescents’ brain.
The adolescent’s brain has an underdeveloped prefrontal cortex which is involved in clear thinking and reasoning; but a well-developed limbic system or emotional center (Plotnik & Kouyoumdjian, 2013). “The relationship of the brain and behaviors is bidirectional” (Newman & Newman, 2014, p. 327). Overall, adolescence is slightly more traumatic than other developmental periods. Therefore, it is important to pay attention to the psychological needs of this age group. Interventions can be developed to prevent psychological problems such as depression, as well as promoting mental health among adolescents (Charoensuk, 2007).

One important issue in meeting the psychological needs of adolescents is providing counseling programs in schools. “Such programs could help to enhance adolescents’ coping strategies with their mental health problems, to improve their general coping and problem solving skills, and even to prevent onset of mental health problems in this vulnerable population” (Emami et al., 2007, p. 575).

By using different methods, counselors may provide help for adolescents in order to cope with their problems. For example, by using techniques of behavioral therapy such as assertiveness training, counselors may help adolescents to improve their social skills and emotional health and prevent psychological problems. Group therapy is beneficial for adolescents, because it provides a positive atmosphere in which approval and support help them to study new behaviors. Furthermore, since adolescents are influenced by their peers, they will acquire new behaviors which are demonstrated by peers (Eroğul, Rezan, & Zengel, 2009).

1.1.1 Developmental Challenges of Adolescence

1.1.1.1 Biological Development

The beginning of adolescence is noticeable by the physical changes associated with puberty. Marshall (1978) as cited by Cotton Bronk (2011) concluded that puberty is categorized by significant height and weight gain, the growth of primary and secondary sex characteristics, changes in body composition, and changes in the circulatory and respiratory systems. The endocrine system, which is answerable for producing, circulating, and regulating hormonal levels, plays an eminent role in triggering and regulating puberty.
1.1.1.2 Cognitive Development

Along with the rest of the body, the adolescent’s brain experiences prominent physical changes. It is not just that adolescents become more operative at processing information; they also start to think and reason in qualitatively different ways. Whereas children desire to think in a concrete and absolute manner, adolescents become progressively able to involve in thinking and reasoning that is abstract and relative. Deductive reasoning (in which one draws logically necessary conclusions from a general set of premises), and inductive reasoning (in which one draws a general conclusion from a set of specific facts) appear and adolescents mature the skill to engage in metacognition, or thinking about thinking (Cotton Bronk, 2011).

1.1.1.3 Psychosocial Development

The physical changes that signal the start of adolescence happen alongside psychological and social changes that mark this stage as a critical period in becoming an adult (Viner, 2005). Psychosocial development in adolescents is characterized by significant comprising growth in the areas of identity, gender, sexuality, morality and intimacy. According to Erikson (1959) as cited by Cotton Bronk (2011) the founding of a coherent sense of self or identity, is the main task of adolescence. Prior to adolescence, children have a scattered, incompatible conception of who they are, but during adolescence they raise a more unified and enduring picture of who they are and of who they expect to become. For some, adolescents, particularly the minority youth, integrating a sense of ethnic identity into their overall sense of self is an important part of their identity development.

1.1.2 Development and Adjustment

At the most overall level, the outline presented in Figure 1.1 shows that the primary developmental alterations of adolescence have an influence on the developmental consequences of adolescence through the interpersonal settings in which adolescents mature. In other words, the growing changes of youth have an effect on the behaviors of important others, which, in turn,
effect ways in which adolescents detoxify the main matters of adolescence, namely, self-rule, sexuality, identity, and so on.

For instance, presume that a young preadolescent girl starts to physically mature much earlier than her age-mates. Such initial maturity will probably disturb her peer relationships, insofar as early maturing girls are more likely to date and start sexual behaviors at an earlier age than are girls who mature on time (APA, 2000). Such dating and sexual experiences may influence her self-perceptions in the areas of identity and sexuality. In this mode, the behaviors of peers in reply to the girl’s initial maturity could be thought to mediate relations between pubertal alteration and sexual consequences (and consequently account, at least in part, for these important relations). The term mediation is used because of the proposed $A \rightarrow B \rightarrow C$ relationship inherent in this example, whereby $B$ is imagined to mediate relations between $A$ and $C$. Such causal and mediational influences may vary depending on the demographic and intrapersonal context in which they occur (see figure 1.1, “Demographic and Intrapersonal Moderating Variables”). Specifically, associations between the primary developmental changes and the developmental outcomes may be moderated by demographic variables such as ethnicity, gender, socio economic status. The term “moderated” is used because it is expected that associations between the primary changes and developmental outcomes may differ, depending on the demographic status of the individual. For instance, if relations between pubertal alteration and certain sexual consequences were only evident in girls, we could conclude that gender moderates such associations. Moreover serving a mediational role, as defined above, the interpersonal contexts (i.e., family, peer, school, and work settings) can similarly help a moderational part in the continuity between the primary alterations and the developmental outcomes. For example, early maturity may lead to poor adjustment outcomes only when families respond to initial pubertal growth in certain ways (e.g., with improved restrictiveness and supervision); in this sample, familial responses to puberty moderate relations between pubertal growth and adjustment (Kendall, 2011).
Figure 1.1:


1.1.3 Sub-Divisions of Adolescence

According to Bhuvaneswari (2011), the period of adolescence can be generally divided into five sub-divisions:

- **Pre-adolescence (10-12 years)** characterized by interest in small groups of same sex, close peers and dependence on the family.
- **Early adolescence (12-14 years)** is made up of same sex groups, interested in opposite sex from a distance, beginning of conflict with parents especially same sex parents.
• **Middle adolescence (14-16 years)** is obviously governed by strong peer ties with groups or individuals and with which is identified the peak of turmoil and questioning of authority.

• **Late adolescence (16-18 years)** is characterized by heterosexual contact at an individual level and lessening conflict with parents and interest in the family.

• **Post-adolescence (18-21 years)** is obvious by the establishment of close friendships, more adult relationships and increased attachment to parents and family members.

Neuman & Neuman (2011) according to their research on youth, and also their assessment of the research literature, have concluded that two distinct periods of psychosocial growth happen during these years, early adolescence i.e., between 12 and 18 years and later adolescence between 18 and 24 years. Early adolescence starts with the beginning of puberty, and ends at about age 18. Some rapid physical changes happen in early adolescence (Neuman & Neuman, 2006). At nearly age 10 for girl adolescents and age 12 for boy adolescents, growing hormones stream into the bloodstream (Gerrig, Zimbardo, Campbell, Cumming, & Wilkes, 2011). This period is also characterized by newly energized sexual interests and sensitivity to peer relations as well as significant cognitive and emotional maturation. Later adolescence, which starts at about age 18 and ends at about age 24, is categorized by new improvements in the formation of autonomy from the family and the improvement of a personal identity (Neuman & Neuman, 2006).

### 1.1.4 Historical Perspective of Adolescence

There are different theoretical perspectives and points of view that help scientists to understand adolescence period. There are many theories of adolescence; however, each of them has particular and different assumptions to explain adolescence period. As a result, none of the theories covers all aspects of adolescence period. (Atwater, 1992).

#### 1.1.4.1. G. Stanley Hall's Biogenetic Psychology of Adolescence

Hall (1844-1924) was the leading psychologist to progress to a psychological science of adolescence in its own right and to employ scientific approaches to study them. Hall’s adolescence contains research, commentary, and hypothesis on nearly every imaginable topic relating to adolescent growth (ages 14 – 24, in Hall’s theory) (Arnett, 2006).
In Hall’s initial theory as cited by Ausubel (2002) stressed the importance of physiological changes at pubescence and their relationship to psychological events throughout adolescence. Second, the history of recapitulation was biological in kind. It expected that the experiential history of the race is written into the genetic constitution of the individual, whose progress, therefore, is prearranged to reveal in parallel sequence. The distinctive characteristics of psychological development in adolescence, then, rely upon the very fact that the adolescence recapitulate a disturbed transition and physiological period in human analysis.

1.1.4.2 Sigmund Freud and the Psychoanalytic Theory of Adolescent Development

Freud as cited by Muuss (1975) focused relatively lightly on adolescent’s development, just to speak of it in terms of psychosexual development. Freud’s idea has similarity with Hall's evolutionary theory that the adolescence period could be understood as phylogenetic. Freud stressed that by psychosexual development of mankind the individual can go through his earlier experiences. According to Freud and psychoanalytic theory, the phases of psychosexual development are genetically specified and are comparatively independent of environmental aspects. Consequently, Freud and his followers, in early 20th century expressed that the reason of adolescents’ turbulent behaviours are due to physiological changes and to handling with the transition to full adult sexuality (Baroowa, 2014).

1.1.4.3 Anna Freud's Theory of Adolescent Defense Mechanism

According to Freud (1948) as cited by Muuss (1975), puberty has a greater and more serious impact on character foundation. She emphasizes on the relationship between the id, the ego and the superego also. She considers that the physiological procedure of sexual maturation start with the operation of the sexual glands, playing an earnest part in influencing the psychological area. This interface results in the instinctual reawakening of the libidinal forces, which, in turn, can bring about psychological disequilibrium. The painfully established balance between ego and id during the latency period is damaged by puberty. Therefore, one aspect of puberty, the puberty conflict, is the effort to retrieve balance.

Anna Freud dealt mostly with deviant or pathological growth and paid very little attention to normal sexual modification. She explained difficulties to normal growth: 1) the id overriding
the ego - in which she states no effect will be left of the prior character of the individual and entering into adult life will be noticeable by an insurgency of uninhibited pleasure of instincts and 2) the ego may be successful over the id and limit it to a confined area, continually checked by many defense mechanisms (Freud, 1948 as cited by Muuss, 1975).

1.1.4.4 Erik Erikson's Theory of Identity Development

The main concept of Erikson's theory as cited by Muuss (1975) is the attainment of an ego-identity, and the identity tension is the greatest vital characteristic of adolescence. Although a person's identity is recognized in methods that vary from culture to culture, the performance of this growing role has a joint part in all cultures. In order to obtain a powerful and healthy ego-identity the child should receive steady and significant recognition of his successes and activities.

Adolescence is defined by Erikson as the period during which the individual should assign a sense of own identity and elude the threats of role propagation and identity distraction (Erikson, 1993). Ego-Identity though in progresses during the period of adolescence, though its stability in the next development stages is very important for the expression of suitable behavior of mankind. Number of research brings several facts to the limelight. The exploration tendency thought-out as one of the attributes of Ego-Identity facilitate the development and growth of identity of the individuals (Kunnen, Sappa, van Geert, and Bonica, 2008) and also aids in processing self-referential information (Dunkel & Lavoie, 2005). Commitment is also another significant attribute of Ego-Identity which permits the individual to form dedication and loyalty (Samuolis, Layburn, & Schiaffino, 2001).

1.1.4.5 Kurt Lewin: Field Theory and Adolescence

Central to Lewin’s (1890-1947) theory of development is the view that adolescence is a period of transition in which the adolescent should shift his group membership. While both the kid and the adult have a reasonably clear thought of how they appropriate into the group, the adolescent belongs partially to the child group, partially to the adult group, without belonging totally to either group. Parents, teachers, and society reflect this absence of obviously defined group position; and their vague feelings about the adolescent become noticeable when they treat him at one time like a child and at another time like an adult. Problems happen because certain
childish methods of behavior are no longer passable. At the equal time some of the adult methods of behavior are not yet allowable either, or if they are allowable, they are new and odd to the adolescent (Lewin's, 1890 as cited by Muuss, 1975).

1.1.4.6 Jean Piaget's Cognitive Theory of Adolescent Development

The adolescent in the concrete operational phase deals with the present, the here and now; the adolescent who obtains the ability to use formal operational thought can think about the future, the abstract, the hypothetical. Piaget’s last phase intersections with the start of adolescence, and signs the beginning of abstract thought and deductive reasoning. Thought is more pliable, rational, and systematic. The adolescent can now imagine all the possible ways they can resolve a problem (Piaget, 1970).

1.1.4.7 Social Learning Perspectives on Adolescent Development

Modeling, Imitation and Identification: As children grows older they have a tendency to copy dissimilar models from their social setting. The adolescent typically identifies with his parents and makes efforts to imitate their behavior, such as language, motion, and characteristics, as well as more basic attitudes and ethics. Identification with his teacher is not uncommon for the child starting school or for the preadolescent speech patterns and mannerisms imitates by child from their teacher (Muuss, 1975).

1.2 Rational Emotive Behaviour Therapy

1.2.1 Meanings and Definitions

Rational Emotive Behaviour Therapy (REBT) is constructed on the concept that emotions and behaviours originated from cognitive processes; and that it is probable for human beings to adjust such procedures to attain different ways of feeling and behaving (Froggatt, 2005). Rational Emotive Behaviour Therapy (REBT) stressed that our beliefs about events cause our suffering but not the activating event we experience. Two persons can experience the same activating event, and yet reply totally inversely according to the type of beliefs they have. This elementary principle
explains the use of Rational Emotive Behaviour Therapy (REBT) theory to understand health results, where the activating event (e.g., being identified with an illness) may be infeasible to control, but one’s response to it is not. For instance, consider two persons that have been diagnosed with cancer, and have planned to have external beam radiation treatment. Person A might irrationally think in response to this event, “This is AWFUL! This treatment will destruct my life! I can’t stand it,” whereas person B might rationally think, “I wish I didn’t have to deal with this treatment, but it is only a portion of my life. It will not dominate 100% of my life. And even though I don’t like having to go through this, I will be able to stand it.” Based on their different beliefs, these two persons (Person A and B) might experience very distinct emotional, behavioral, and physical replies to cancer and its treatment. Person A, who holds irrational beliefs, may well experience dysfunctional negative emotions (e.g., rage, depression), engage in unhelpful health-related behaviors (e.g., refuse or delay treatment), and hurt from various stress-related physical complaints (e.g., nausea, fatigue, headaches). On the other hand, as a consequence of having more rational beliefs, person B might fare significantly better than person A emotionally (e.g., annoyance, mild sadness), behaviorally (e.g., maintain treatment compliance), and physically (e.g., reduced physical complaints) (David, Lynn, & Ellis, 2010).

The theory of Rational Emotive Behaviour Therapy (REBT) is based on the following sequence of psychological premises (Patterson, 1966):

1. Folks are both rational and irrational. When persons performance rationally they are more effective and gladder than when they act irrationally.

2. Human psychological/emotional disturbance is because of human irrationality. Thoughts and emotions are indissolubly linked; thoughts comprise emotions, so that irrational thinking is to go along with irrational (i.e. maladaptive, unsuitable, unrealistic) emotions.

3. Irrational thinking has its origins in childhood, principally in our initial experiences with our oldsters and with our society’s culture.

4. Human thinking is symbolic, typically verbal, in nature. Our thoughts are our self-talk, the items we are saying to ourselves. For the reason that thinking and emotion are connected, what we have a tendency to tell ourselves in our internal self-talk provokes emotions. When we interact in irrational thinking, what we are express to ourselves will cause irrational (i.e. maladaptive,
unsuitable, unrealistic) emotions. When we involve in rational thinking, our self-talk will produce rational (i.e. adaptive, acceptable, realistic) emotions. Human psychological/emotional disturbance is the result of human irrational thinking. Continues psychological/emotional disturbance, i.e. neurosis or other mental disorders result from continuous irrational thinking. To dominate emotional disorders, it is not sufficient to comprehend the origins of our irrational thoughts; the irrational thoughts should be destroyed and substituted by rational thoughts.

5. Human psychological/emotional disturbance is not because of outer events and conditions, it is because of the irrational thinking that go along with those events and conditions. Our irrational thinking falsifies our perception and commentary of external actions. It is what we express ourselves about external incident (not the incident themselves) that reason our psychological/ emotional disturbance. Our irrational thoughts evoke our irrational emotions.

6. One can assault, defy, and reject our irrational thinking (perceptions and interpretations) of external incidents. By replacing our irrational thoughts about external incidents with rational thoughts, we can substitute our irrational (i.e. maladaptive, unsuitable, unrealistic) feelings with new rational (i.e. adaptive, suitable, realistic) feelings. By using Rational Emotive Behaviour Therapy (REBT), a therapist can help a client to comprehend that the client’s irrational thinking (perceptions and interpretations) of external incidents is the basis of the client’s psychological/ emotional disturbance. By using Rational Emotive Behaviour Therapy (REBT), a client can learn how to assault, test, reject his irrational thinking (perceptions and interpretations) of external incidents and substitute them with different rational thinking. Through the on-going repetition and use of Rational Emotive Behaviour Therapy (REBT), a client can decrease his irrationality and advance his efficiency and pleasure.

Rational Emotive Behaviour Therapy (REBT) overlaps with the cognitive-behavioral therapies (CBTs) of Beck (1976), Meichenbaum (1994), Barlow (1996), and other therapists. But, as Ellis (2004) stressed, Rational Emotive Behaviour Therapy (REBT) not only displays to clients how they think, feel, and behave irrationally, and how to become more preferential and less absolutistic, but it also actively and continually keeps teaching them three main ‘‘rational’’ philosophies:
1. Individuals can select to have unconditional self-acceptance (USA) despite their failings at significant tasks and their being despicable to significant people. Why? Because they simply and powerfully can reject to barricade themselves for their behavior.

2. People can choose to have unconditional other-acceptance (UOA) despite the frequent “bad” behavior of others. Just as they refuse to rate their selves for their effective and ineffective thoughts, feelings and acts, they can do the same for others. If they do so, they have mercy for others by accepting them, but not their fault. They are often disgusted by what people do, but not the people who do what is hateful.

3. According to Takefman, Brender, Boivin, and Tulandi (1990) People can select to have unconditional life-acceptance in spite of the common unfortunate life circumstances. They can accept their life when it is full of difficulties and still choose to be as glad as they can be in spite of these difficulties. They can select to emphasize on whatever is joyous and fortunate in the many things accessible in life, to change the changeable things, and observe and dislike the unchangeable things they cannot change, and have knowledge to know the difference. Life may never be as happy as they would like it to be, but they can still lead a reasonably good existence (David et al., 2010).

1.2.2. The Origins of Rational Emotive Behaviour Therapy (REBT)

Rational Emotive Behaviour Therapy (REBT) was established by Albert Ellis (1950) after he became displeased with the lack of utility and potency of psychoanalysis, the psychotherapeutic approach in which he was primarily trained. Since its development, Rational Emotive Therapy (RET) has had a deep impact on the professional practice of psychotherapy, with Ellis being rated by clinicians as among the 10 most influential of all psychotherapists (Kendall et al., 1995). Ellis derived the basic principles of Rational Emotive Behaviour Therapy (REBT) from the writings of a variety of ancient and modern philosophers. His philosophical influences were Greek and Roman stoics, such as Zeno of Citium, Epicurus, Epictetus, and Marc Aurelius. Additionally, Ellis adapted the ideas and philosophies of Asian thinkers, such as Confucius, Buddha, and Lao Tsu. Modern philosophers, Immanuel Kant, John Dewery, and Bertrand Russell were influential in Ellis’s development of Rational Emotive Behaviour Therapy (REBT) also. The philosophic notion that the way in which person
perceives and interprets a condition directly affects his or her psychological welfare is the foundation for Rational Emotive Behaviour Therapy (REBT) (Ellis, 1994).

Through adapting these ancient ideas, Ellis derived a psychological theory and therapeutic technique that has changed into Rational Emotive Behaviour Therapy (REBT) (Ellis & Dryden, 1997). Writers have stated that the essence of Rational Emotive Behaviour Therapy (REBT) lies in the words of Epictetus, a Stoic philosopher from the first century A.D. Epictetus wrote, “Men are not disturbed by things, but by the views which they take of them.” Rational Emotive Behaviour Therapy (REBT), in part, is a philosophical theory according to the statement that dysfunction is mostly a result of an individual’s perceptions, belief system, values, and interpretations of the world around him or her (Walen, Digiuseppe, & Dryden, 1992).

The first of the modern cognitive behavior therapies and a pioneering philosophy was developed in 1955 by Albert Ellis in Eastern USA, in New York. His work strongly influenced by the viewpoint of a Freudian Sexual-Therapist. Rational Emotive Behaviour Therapy (REBT) is based on the opinion that whenever we become unhappy, it is not the events taking place in our lives that sadden us; it is the beliefs that we hold, make us to become depressed, anxious, enraged, etc. (Dryden, 2003).

1.2.3 Rational Emotive Behaviour Therapy (REBT) as Theory of Causation

Rational Emotive Behaviour Therapy (REBT) isn’t simply a collection of techniques– it is also a comprehensive theory of human behaviour. Rational Emotive Behaviour Therapy (REBT) suggests a ‘biopsychosocial’ explanation of causation – i.e. that a mixture of biological, psychological, and social factors are concerned with the way humans feel and behave. The most basic premise of Rational Emotive Behaviour Therapy (REBT), which it shares with other cognitive-behavioural theories, is that nearly all human emotions and behaviours are the results of what people think, assume or believe (about themselves, people, and also the world in general). It is what folks believe regarding things they face – not the situations themselves – that determines how they feel and behave. Rational Emotive Behaviour Therapy (REBT), however, additionally argues that a person’s biology also affects their feelings and behaviours – a significant point, as it is a reminder to the therapist that there are limitations to how far a person can change.
A person’s belief system is seen to be a result of both biological inheritance and learning throughout life (Froggatt, 2005).

A beneficial way to illustrate the role of cognition is by using Ellis’ ‘ABC’ model. A represents an activating event. B represents beliefs about the event (which is critical for Ellis’ theory); and C represents the emotional and behavioural consequences following the beliefs. For Ellis, we are what we think and we disturb ourselves when we tell ourselves repeatedly irrational sentences that we have learned from our backgrounds or devised ourselves.

Figure 1.2:

Ellis model of ABC (Ellis, 1994 as cited by Ridgway, 2007)

The A

Event: This person is passed in the road by her friend who doesn’t recognize her.

Inferences about the event: ‘She’s ignoring me; she doesn’t like me.’
The B

Beliefs about A:

1. I could end up without any friends and that would be awful!

2. For me to be glad and feel valuable, people must like me.

3. I’m intolerable as a friend so I must be valueless as a person.

The C

Feelings: lonely, depressed.

Behaviours: evading people generally.

Additionally, the main model included “D” and “E” whereby the primary aim of Rational Emotive Behaviour Therapy (REBT) was to educate clients on how to recognize and dispute (D) irrational and dysfunctional ideas that result in unhealthy negative consequences. Finally, the client and the therapist dispute irrational beliefs until they arrive at point (E), healthy effects, both cognitive and behavioral (Ellis, Bernard, & Digiuseppe, 1989). Another significant aspect of the original model was the letter “G” which represents “Goals” and revealed the values, and desires that people bring to their ABC’s of personality and emotional disturbance. Ellis (1994) stated that from a biological viewpoint, as well as the principal of social learning theory, mankind are goal-seeking and their “Fundamental Goals” or “FGs” are to survive, avoid pain and be content humans. Furthermore, Ellis defined the sub goals or “Primary Goals” of human beings as including various levels of happiness and contentment.
Table 1.1:

Outline of Ellis’s original A-B-C model

<table>
<thead>
<tr>
<th>Moral</th>
<th>Definition</th>
<th>Elaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Activation Event</td>
<td>Adversary (real or imagined)</td>
</tr>
<tr>
<td>B</td>
<td>Belief Irrational / Rational</td>
<td>Belief Irrational / Rational</td>
</tr>
<tr>
<td>C</td>
<td>Consequences</td>
<td>Emotional/Behavioral, Unhealthy/Healthy</td>
</tr>
<tr>
<td>D</td>
<td>Disputation</td>
<td>Identifying, questioning, and challenging</td>
</tr>
<tr>
<td>E</td>
<td>New Effect</td>
<td>Cognitive/Behavioral</td>
</tr>
<tr>
<td>G</td>
<td>Goals</td>
<td>Existing values and desires</td>
</tr>
</tbody>
</table>

Table 1.2:

Unhealthy and Healthy Negative Emotions

<table>
<thead>
<tr>
<th>Unhealthy</th>
<th>Healthy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>Concern</td>
</tr>
<tr>
<td>Depression</td>
<td>Sadness</td>
</tr>
<tr>
<td>Anger/Rage</td>
<td>Annoyance</td>
</tr>
<tr>
<td>Hurt</td>
<td>Disappointment</td>
</tr>
<tr>
<td>Shame</td>
<td>Regret</td>
</tr>
<tr>
<td>Guilt</td>
<td>Remorse</td>
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</tbody>
</table>

Although, our joint hypothesis is that A causes C, Ellis suggests that A causes B which in turn causes C. Furthermore, these ABC sequences do not stand alone but may engender more such connections. The C above may cover the inference, ‘Oh, no, I’m getting depressed again!’ and ‘I couldn’t bear that’ which could lead to anxiety feelings. What makes the above orders powerful is that many of the beliefs may be beyond conscious awareness, being habitual or unconscious. Fundamentally the beliefs are rules about how the world and life ought to be. However, with practice, people can learn to discover such out-of-awareness beliefs (Ridgway, 2007).
1.2.4. Rational Emotive Behaviour Therapy (REBT) as Theory of Change

According to Rational Emotive Behaviour Therapy (REBT), alteration can happen at different levels. For example, someone is anxious because he thinks someone is in judgment of him. At a low level he can feel better by changing his body chemistry (e.g. via exercise, dietary change or medication); by altering the condition (e.g. by avoiding contact with the other person); or by altering his inferences about the condition (for instance, he makes himself feel less nervous by persuading himself that the rejection isn’t going to occur). For an individual to go beyond feeling healthier to actually get better – that is, to attain fundamental and lasting alteration - he has to modify the underlying central beliefs that create problems for him in a range of circumstances. Using the example above, rather than persuade himself that rejection isn’t going to occur, he must admit that it might, but deal with his underlying essential belief that he needs approval and should not ever obtain disapproval (Froggatt, 2005).

1.3 Group Counseling

Group counseling is a therapeutic intervention which is widely used in a variety of settings (Corey, 2005). Group counseling enable a secure environment in which members can experiment with new behaviors, advance communication skills, and obtain feedback from other members with similar concerns and interests. These interpersonal interactions can provide group members an opportunity to deepen their level of self-awareness, and learn how to relate to others. Group counseling is especially beneficial for adolescents because it provides a positive atmosphere in which admire and support aid them to learn new behaviors. Furthermore, adolescents learn new behaviours from their peers since they influenced by them (Eroğul & Zengel, 2009). Group therapies have been effective in short-term psychiatric settings, long-term psychiatric settings, counseling for special population, and with the chronically physically ill (Posthuma, 2001). According to Jacobs, Masson, Harvill, and Schimmel (2011), many people get benefit more from group counseling rather than individual counseling. For instance, group counseling can be valuable for teenagers and those stuck in the grief process. Also, abused women, adult children of alcoholics, and men who need to learn anger control can benefit from group counseling (Nugent, 2000).
Group counseling is inappropriate for those experiencing conflicts too private to share in a group; or those who have strong fears about social interactions. Also, group counseling is inadvisable for those who might constantly disrupt group interactions (Nugent, 2000). A competent group counselor is skilled in screening appropriate members for a group. The size of a group depends on the age of the members, experience of the leader, type of group, and type of presenting problem (Posthuma, 2001). According to Nugent (2000), the recommended number of group members varies with the group’s age range. Adolescent groups function best with 6-8 members. According to Jacobs et al. (2011), there are several contemporary theories that have particular relevance for group work. They are as follows: Reality Therapy, Adlerian Therapy, Transactional Analysis, Gestalt Therapy, and Rational Emotive Behavior Therapy (REBT).

In group counseling, some issues such as ethical and professional considerations, leadership, and stages of the group are of immense importance. There are different ethical considerations with groups than with individuals. Some of them are screening of group members, allowing freedom to leave the group, confidentiality, and guarding against group members abusing each other (Nugent, 2000). Group counseling requires skilled and competent leaders. There are several leadership skills which facilitate the process of group counseling. They are as follows: active listening; reflection; clarification and questioning; summarizing; linking; mini lecturing and information giving; encouraging and supporting; tone setting; modeling and self-disclosure; use of eyes; use of voice; use of the leader’s energy; identifying allies; and multicultural understanding (Jacobs et al., 2011). Other than special skills, some attributes are considered important for group leaders.

Posthuma (2001) has cited fourteen attributes which are thought to be representative of basic qualities displayed by effective group leaders. These are as follows: self-confidence; responsibility; attending and listening; objectivity; genuineness; empathy; warmth and caring; respect; flexibility; creativity and spontaneity; enthusiasm; humor; clinical reasoning; and therapeutic use of self.

1.3.1 Stages of Group Counseling

According to Jacobs et al. (2011), all groups go through three stages: the beginning stage, the middle stage and the ending stage. The beginning stage is the time for introduction and
discussion of topics such as the purpose of the group, the process of group counseling, and group rules. In the middle stage which is the core of the group process, members interact in several ways. Eventually, in the ending stage members deal with sharing what they have learnt, and how they are going to use their learning in their everyday life. Terminating of the group happens in this stage.

1.4 Self-esteem

1.4.1 Meaning and Definitions

The term self-esteem originates from a Greek word meaning “reverence for self.” The “self” part of self-esteem relates to the values, beliefs and attitudes that we grip about ourselves. The “esteem” part of self-esteem defines the value and worth that one gives oneself. Simply self-esteem is the approval of ourselves for whom and what we are at any given time in our lives (Moses, 2013). In the dictionary of psychology, self-esteem or self-worth includes a person’s subjective evaluation of himself or herself as fundamentally positive or negative to some degree. In other words, self-esteem reflects a person’s general assessment or appraisal of his or her own worth. Self-esteem is a widely used concept both in popular language and in psychology (Jasmine, 2010). Self-esteem, in very general terms, means the value ascribed by the individual to himself, the way he views or evaluates himself. Like the other aspects of the self, it is learnt and builds up by interacting with the others. Self-esteem means a favorable opinion of oneself. Developing good self-esteem involves encouraging a positive (of course realistic) attitude towards ourselves and the world around us and appreciating our worth. Self-esteem is the way one feels about one-self including the degree to which one possesses self-respect and self-acceptance (Kaur, 2012).

According to Bradley (2011) self-esteem is defined as an individual’s evaluation of his own self-worth. The most broad and frequently cited definition of global self-esteem in psychology is by Rosenberg (1965), who defined it as a favourable or unfavourable attitude towards the self. High global self-esteem shows a feeling that one is “good enough “and has high positive sense of one’s value as a person. Global self-esteem has positive relationship with life satisfaction and well-being and may be observed as a result of achievement and having positive social relations (Birkeland, Melkevik, Holsen, & Wold, 2012). Self-esteem has become a household word. Teachers, parents, therapists, and others have concentrated their efforts on increasing self-esteem,
on the hypothesis that high self-esteem will cause many positive results and welfare (Baumeister, Campbell, Krueger, & Vohs, 2003). It is an eminent component of psychological health. Many previous studies indicated that lowered self-esteem often accompanies psychiatric disorders. It has been recommended that low self-esteem is an etiological factor in numerous psychiatric conditions (Salsali & Silverstone, 2003).

1.4.2 Characteristics of High and Low Self-esteem

High global self-esteem

- A feeling that one is “good enough“
- Accepting one’s weaknesses and strengths
- Respecting and liking oneself and others
- Trusting oneself
- Making one’s decisions based on what one feels is right for oneself.

Low global self-esteem

- Lacking self-confidence
- Being unable to accept oneself
- Not respecting or liking oneself and others
- Distrusting oneself

1.4.3 What Happens if Self-Esteem is Low?

People with low self-esteem will invariably have problems in forming close attachments, partly because it is often so difficult for them to believe themselves worthy of a fulfilling relationship with another person. Low self-esteem can also lead to anxiety and confusion where misunderstandings can easily occur and where there is a tendency to do a lot more biased filtering, leading to distorted view of self and others. They may act in a very passive way or may be aggressive, quick to get in first before they themselves are attacked, rejecting others before they are rejected. To defend themselves, they hide behind a wall of distrust and sink into the terrible human state of loneliness and isolation. They tend to place little value on their abilities and often deny their successes (Plummer, 2014).
1.4.4 Self-Esteem and Related Ideas

The term “self-esteem” sometimes is used interchangeably with terms such as “self-confidence”, “self-efficacy”, “self-concept”, “self-knowledge”, “self-acceptance”, “self-reliance”, “self-expression” and “self-awareness” but such usage is inaccurate and should be discouraged.

1.4.4.1 Self-Confidence

According to Moses (2013) self-confidence refers to belief in one’s personal worth and probability of succeeding. Self-confidence is a mixture of self-esteem and general self-efficacy. Knowing that my opinions, thoughts and actions have value and I have the right to express them. Developing a creative approach to solve problems and being confident enough in my own abilities to be able to experiment with different methods of problem-solving and to be flexible enough to alter strategies if needed. Be able to accept challenges and to make choices. Being secure enough in myself to be able to develop strategies for coping successfully with the unexpected events (Plummer, 2014).

1.4.4.2 Self-Efficacy

Self-efficacy is a judgment of specific capabilities rather than a general feeling of self-worth (Keshi, 2013). According to Moses (2013) belief in one’s overall capacity to handle responsibilities is the definition of general self-efficacy. Specific self-efficacy refers to beliefs about one’s capacity to carry out specific tasks that produce desired results in a specific domain (Moses, 2013) (e.g., riding, public speaking, reading, etc.).

1.4.4.3 Self-Concept

Self-concept is defined as nature and organization of beliefs about one’s self. According to Bradley (2011), “self-concept is defined as our information of who we are and may contain our physical characteristics, our psychological states and our considerations of how other people may judge us. Self-concept is theorized to be multi-dimensional. For instance, people have distinct beliefs about physical, emotional, social, etc. parts of themselves. Initially in development, children have a tendency to have an ambiguous, general concept of them, which slowly expands
into ideas concerning themselves as students in class, in reference to peers, in reference to family, showing emotion, physically, and so on. It is uncharted whether self-concepts are formed top-down (specific beliefs flow from general beliefs) or bottom-up (general beliefs flow from specific beliefs) (Moses, 2013).

1.4.4 Self-Knowledge

Developing a sense of security in terms of a strong sense of self: an understanding of who ‘I’ am and where I fit into the social world around me. Developing and maintaining my personal values - my guiding principles in life. Understanding differences and commonalities - how I am different from others in looks and character and how I can also have things in common with others. How I can act in different ways according to the situation that I’m in (Plummer, 2014).

1.4.5 Self-Acceptance

Knowing my own strengths and recognizing areas that I find difficult and may want to work on. Accepting that it is natural to make mistakes and that is often how we learn best. Knowing that I am doing the best that I can with the knowledge and skills currently available to me. Feeling ok about my physical body (Plummer, 2014).

1.4.6 Self-Reliance

Knowing how to take care of myself. Understanding that life is often difficult but there are lots of things that I can do for myself to help smooth the path. Building a measure of independence and self-motivation. Being able to self-monitor and adjust my actions, feelings and thoughts according to realistic assessments of my progress. Believing that I have mastery over my life and can meet challenges as and when they arise (Plummer, 2014).

1.4.7 Self-Expression

Understanding how we communicate with each other, not just with words but also through facial expression, body posture, intonation, the clothes we wear, etc. learning to ‘read the signals’ beyond the words so that I can understand others more successfully and also express myself more
fully and congruently. Developing creativity in self-expression. Recognizing and celebrating the unique ways in which we each express who we are (Plummer, 2014).

1.4.4.8 Self-Awareness

Developing the ability to be focused in the here and now, rather than absorbed in negative thoughts about the past or future. This includes an awareness of my feelings as they arise. Knowing that I am capable of, and learning to set realistic yet challenging goals. Understanding that emotional, mental and physical change is a natural part of my life. Understanding that I have some control in how I change and develop (Plummer, 2014).

1.4.5 Concept of Self-Esteem

The term “self-esteem” is one of the oldest concepts in psychology. The Oxford English Dictionary traces the use of the word “self-esteem” in English as far back as 1657. After a career in the proto-psychological lore of phrenology in the 19th century the term entered more mainstream psychological use in the work of the American psychologists and philosophers Lorne and William James in 1890 (Jasmine, 2010). James (1890) gave the first clear definition of self-esteem when he said that self-esteem equals success divided by pretensions. Horney (1937) views self-esteem as essential for adequate personal functioning. Coopersmith (1959) suggested four types of self-esteem namely: what a person purports to have, what he really has, what he displays, and what others believe he has. Stotland (1961) described self-esteem as an individual’s evaluation of his own worth and attributes, and an individual’s self-esteem affects the evaluation he places on his performance in a particular situation and proposed that individuals with high self-esteem may react with expectations of success while those with low self-esteem may have expectations of failure. Gordon and Gergen (1971) defined self-esteem as a person’s characteristic evaluation of himself and what he thinks of himself as an individual. Harter (1982) opined that self-esteem is global evaluation one makes of his worth and competence. Simpson, Weiner, and Press (1989) defined self-esteem as confidence in one’s own worth or abilities. Thus self-esteem is a specific way of experiencing the self.

Greenberg et al. (1992) reported that self-esteem had been found to function as a buffer, which protects against the negative impact of stress and reduces anxiety. Bee and Boyd (2000)
believed that during the process of self-description, the evaluative (positive or negative) statement about himself is referred to as self-esteem. Enfield (2010) stated that self-esteem is the rating a person gives himself on a set of items and descriptive of personal attributes. Self-esteem also entails certain action dispositions; to move toward life rather than away from it; to move toward awareness rather than away from it; to treat facts with admiration rather than denial and to activate self-responsibly rather than the opposite (Kaur, 2012).

1.4.6 Subtypes of Self-esteem

1.4.6.1 Implicit Self-Esteem

Implicit self-esteem is the automatic, unconscious aspect of self-esteem. It is conceptualized as a self-evaluation that occurs unintentionally and often outside of awareness (Baccus, Baldwin, & Packer, 2004). Therefore Implicit self-esteem is assessed with indirect measures that infer self-evaluations from reactions to self-relevant stimuli (Vater et al., 2013).

1.4.6.2 Explicit Self-Esteem

Explicit self-esteem is typically viewed as the sum of his or her conscious self-evaluative thoughts and feelings (Baccus et al., 2004). It would result from reflective self-evaluation, from deliberative analysis of information related to the self. It can be viewed as the judgment about themselves that people consider as valid (Richetin, Xaiz, Maravita, & Perugini, 2012). Therefore, the explicit self-esteem is assessed with direct self-report measures containing items such as “At times I think I am no good at all”.

1.4.7 Theories of Self-Esteem

1.4.7.1 Self-Actualization Theory

The term self-actualization was first introduced into the psychology field by Kurt Goldstein, an organismic theorist, but was popularized and expanded on by Abraham Maslow who included the concept in his well-known developmental theory: Maslow’s Hierarchy of Needs. Maslow’s Hierarchy of Needs consists of five tiers often depicted in pyramid form with the most
basic needs at the bottom. The hierarchy begins with the Physiological needs, which include food, water, breathing, sex, and sleep. The second tier includes needs related to safety and security such as physical health, resources such as money, nurturance, and shelter. The third tier represents the need for love from a range of belonging to family, friends, and intimate partners. Esteem makes up the fourth tier and includes self-esteem, confidence, need for achievement and recognition, and respect for self and others. The fifth and final tier is the need for self-actualization, the realization of one’s full potential and the desire to reach that potential (Barney, 2011).

Figure 1.3:

Abraham Maslow Hierarchy of Needs (Maslow, Frager, Fadiman, Mccreynolds, & Cox, 1970)

1.4.7.2 Sociometer Theory of Self-Esteem

Sociometer theory was initially theorized by Leary & Downs (1995) who stated that self-esteem is a mechanism by which an individual can assess his or her behaviour and current standing in his or her social group (Usha, 2012). According to this theory, self-esteem serves as a gauge or “sociometer” which monitors people’s level of belongingness or social inclusion. In line with this reasoning, it has been shown that the quality and quantity of social interaction
predicts self-esteem on an intra-individual, inter-individual, and international level (Back et al., 2009).

1.4.7.3 Terror Management Theory

This existential theory intends to explain two basic tendencies that are thought to characterize human behavior: a desire to maintain a favorable self-image (i.e., the need for high self-esteem) and, at the same time, a desire to promote the beliefs and values of one’s culture. According to terror management theory, self-esteem and cultural worldviews function as anxiety buffers to protect the individual from the existential terror or anxiety that is engendered by awareness of the inevitability of death and the extinction of one’s culture (Greenberg, Soloman, & Pyszczynski, 1997). Self-esteem is maintained by displaying culturally valued attributes, behaviors, and achievement; fulfilling culturally valued roles; and by engaging in a variety of defensive responses when self-esteem is threatened. In essence, self-esteem consists of the perception that one is a valuable member of a meaningful universe. Terror management theory posits both the universal and the cultural specific aspects of self-esteem. On the one hand, the need for self-esteem in the service of anxiety reduction is universal. On the other hand, the specific manner by which self-esteem is acquired and maintained depends on the demands of a particular social milieu at any given point in time. For instance, the standards by which people evaluate themselves are clearly culturally determined (Wang & Ollendick, 2001).

1.4.7.4 Social Identity Theory

Social identity theory (SIT) was first proposed by Tajfel (1978, 1979) and later by Tajfel and Turner (1979). It is a social-psychological theory that attempts to explain cognitions and behavior with the help of group-processes. SIT assumes that we show all kinds of “group” behavior, such as solidarity, within our groups and discrimination against out-groups as a part of social identity processes with the aim to achieve positive self-esteem and self-enhancement (Trepte, 2006).
1.4.7.5 Self-Evaluation or Self-Esteem Maintenance Theory

The self-evaluation maintenance (SEM) model assumes that (a) persons behave in a manner that will maintain or increase self-evaluation; and (b) one's relationships with others have a substantial impact on self-evaluation. The SEM model is composed of two dynamic processes. Both the reflection process and the comparison process have as component variables the closeness of another and the quality of that other's performance. These two variables interact in affecting self-evaluation but do so in quite opposite ways in each of the process (Tesser, 1988).

1.4.8 Self-Esteem in Adolescence

The adolescence period is obvious by rapid maturational changes, shifting societal expectations, conflicting role demands and self-esteem playing a critical role in this process. Self-esteem may act as an indicator of how adolescents face and manage their challenges. An adolescent lacking self-esteem appropriate to normal personality experiences insecurity because he fails to perceive in himself those qualities which are necessary to cope with the exigencies of the world; such an individual will be afraid to seek new experiences, and be afraid of being rejected as inferior. He will even depreciate his own achievements because they surpass his self-image. Adolescence is therefore a particularly important period for exploring the stability and changes in self-esteem (Birkeland et al., 2012).

1.5 Aggression

1.5.1 Concept of Aggression

The word “aggression” is usually used in an emotional, motivational or behavioral sense. It is one of man’s most important and most controversial fields of study. In spite of the enormous literature available on the topic and the continuous efforts by many scholars dedicated to the scientific study of aggression, there is still considerable disagreement about its precise meaning and causes, with no singular or even preferred definition (Ramirez, Rodríguez, & Manuel, 2009).
Lewin (1935) stated that aggression occurs when the person attempts to overcome barriers. Dollard, Doob, Miller, Mowrer, and Sears (1939) defined aggression as “an act whose goal-response is injury to an organism”. Lecky (1945) considered that it is a natural consequence of the struggle to achieve and maintain consistency of the personality. Buss (1963) defined aggression as “a response that delivers noxious stimuli to another organism”.

Dollard, Doob, Miller, Mowrer, and Sears (1939) defined aggression as “an act whose goal-response is injury to an organism”. Lecky (1945) considered that it is a natural consequence of the struggle to achieve and maintain consistency of the personality. Buss (1963) defined aggression as “a response that delivers noxious stimuli to another organism”.

Geen (1976) as cited by Alyson, Bond, Lader, & Silveira (1997) gives working definition which can be summarised in three points. 1) “aggression consists of the delivery of noxious stimuli by one organism to another”; 2) the stimuli are delivered by the former with the intent to harm the latter”; 3) “the one delivering the stimuli expects that the probability of the stimuli reaching the source is greater than zero”. Zillmann (1988) defined aggression as a response to any condition that poses a threat to the well-being of a person. Human aggression is any behavior directed toward another individual that is carried out with the proximate (immediate) intent to cause harm. In addition, the perpetrator must believe that the behavior will harm the target, and that the target is motivated to avoid the behavior (Bushman and Anderson 2001; Baron and Richardson 1994; Berkowitz 1993a). According to Moeller (2001) aggressive behavior is defined as any “intentional act to hurt others, physically or psychologically”. Miczek and Almeida (2010) defined aggression as a behaviour by an individual directed at another person or object in which either verbal force or physical force is used to injure, coerce, or express anger.

1.5.2 Theoretical Perspectives

According to Anderson, Deuser, and Deneve (1995) five main theories of aggression guide most current research:

1.5.2.1 Cognitive Neoassociation Theory

The theory of Cognitive Neoassociation developed by Berkowitz (1993b) has proposed that aversive events such as frustrations, provocations, loud noises, uncomfortable temperatures, and unpleasant odors produce negative effect. Negative effect produced by unpleasant experiences automatically stimulates various thoughts, memories, expressive motor reactions, and physiological responses associated with both fight and flight tendencies. The fight associations give rise to rudimentary feelings of anger, whereas the flight associations give rise to rudimentary
feelings of fear. Furthermore, cognitive neoassociation theory assumes that cues present during an aversive event become associated with the event and with the cognitive and emotional responses triggered by the event. In cognitive neoassociation theory, aggressive thoughts, emotions, and behavioral tendencies are linked together in memory (Collins & Loftus, 1975). Cognitive neoassociation theory not only subsumes the earlier frustration aggression hypothesis (Dollard et al., 1939), but it also provides a causal mechanism for explaining why aversive events increase aggressive inclinations, i.e., via negative effect (Berkowitz, 1989). This model is particularly suited to explain hostile aggression, but the same priming and spreading activation processes are also relevant to other types of aggression.

1.5.2.2 Social Learning Theory

Bandura (1973) suggested that aggressive behavior is educated and preserved via situational experiences either straight or vicariously, and that learning of aggression is controlled by reinforcement contingencies and penalty in a fashion akin to the learning of any new behaviors. Social learning theory clarifies the attainment of aggressive behaviors, through observational learning procedures, and supplies a useful set of concepts for comprehension and explaining the opinions and expectations that act as leader for social behavior (Anderson & Bushman, 2002).

1.5.2.3 Script Theory

Huesmann (1988) is the person who established the information processing script theory. This theory proposes the stability of aggressive tendencies over time and the predictability of even “nonviolent” crime from early aggression. Huesmann’s theory adopts the presupposition that social behavior is controlled to a great extent by programs for behavior that are appointed throughout a person’s early development. These programs can be defined as cognitive scripts (Abelson, 1981) that are cumulative in a person’s memory and are utilised as leaders for behavior and social problem resolving (Huesmann & Eron, 1992). When things are so powerfully linked that they form a script, they become a theist concept in semantic memory. Additionally, even a few script practices can change a person’s expectations and purposes including important social behaviors. A regularly rehearsed script gains availability strength in two ways. Multiple rehearsals produce additional connect to other concepts in memory, thus enhancing the number of ways by
which it can be started. Multiple practices also enhance the stability of the links themselves. Consequently, for a child who has witnessed numerous examples of using a gun to settle a conflict on television, it is possible to have a very reachable script that has generalized across numerous circumstances. In another way, the script becomes chronically available. (Anderson & Bushman, 2002).

1.5.2.4 Excitation Transfer Theory

Zillmann (1983) noted that physiological arousals disintegrate slowly. If two arousing events are detached by a little amount of time, stimulation from the first incident may be misattributed to the second incident. If the second event is associated to anger, then the extra arousal must make the person even furious. The view of excitation transfer as well proposes that anger may be extensible over long phases of time if a person has deliberately attributed his or her heightened arousal to anger. (Anderson & Bushman, 2002).

1.5.2.5 Social Interaction Theory

Tedeschi & Felson (1994) interpreted aggressive behaviour (or coercive actions) as social influence behaviour, i.e., as actor uses coercive actions to produce some change in the targets behaviour. Coercive actions can be used by an actor to obtain something of value (e.g., information, money, goods, sex, services, safety) to bring about desired social and self-identities (e.g., toughness, competence). Social interaction theory prepares a clarification of aggressive performances driven by advanced level aims. Even hostile aggression might have several rational aims behind it, for instance punishing the provocateur in order to decrease the probability of future motivations. This theory prepares a brilliant way to understand current findings that aggression is often the consequence of threats to high self-esteem, particularly to pointless high self-esteem (i.e., narcissism) (Bushman, 1998).

1.5.3 Adaptive and Maladaptive Aggression

Aggression may be adaptive and serve important social and biologic goals, such as when a child or adolescent is rough-housing with a sibling or aggressively defends himself or herself from an attacker. Adaptive aggression is normal, has a place in society, and does not require treatment.
Maladaptive aggression, on the other hand, is a dysfunctional behaviour, which is ultimately harmful to the individual. Compared to adaptive aggression, maladaptive aggression is often inappropriate to the social context; is more intense, frequent, or long-lasting than its apparent cause warrants; and often, but not always, appears to be impulsive and unregulated (Cheng & Myers, 2010).

1.5.4 Types of Aggression

Aggressive behaviour can be expressed in eight forms: physical, verbal, relational, direct, indirect, social, hostile and instrumental. All these forms can be manifested in different types of aggression, such as bullying, reactive aggression, and proactive aggression. Physical aggression includes activities in which actual physical harm is intentionally done to a person, animal, or object. Examples are hitting, kicking, stabbing, shooting, pushing and shoving, throwing objects, breaking windows, and setting fires (Shechtman, 2009, P. 3). Verbal aggression involves the use of words to harm another, and it includes behaviors such as making threats or writing threatening notes, calling names, cursing, and teasing. Recently, a third type called “relational aggression” has been suggested, defined as behaviors that harm others through damage to social relationships or feelings of acceptance, friendship, or group inclusion (Crick, Grotzter, & Bigbee, 2002).

Instrumental aggression is aggressive behaviour intended to attain a goal. It is not essentially intended to offend another person.

Hostile aggression, on the other hand, is aggressive behaviour which only purpose is to offend someone. It contains physical or verbal assault and other antisocial behaviours. Most studies of aggression are geared towards hostile aggression. There have been several attempts to distinguish between types of aggression based upon antecedent conditions i.e. conditions that precede or lead up to the aggressive behaviour.
Table 1.3:
Different Types of Aggression (Baron & Richardson, 2004)

<table>
<thead>
<tr>
<th>Types of Aggression</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical-active-direct</td>
<td>Stabbing, punching, or shooting another person</td>
</tr>
<tr>
<td>Physical-active-indirect</td>
<td>Setting a booby trap for another person; hiring an assassin to kill an enemy</td>
</tr>
<tr>
<td>Physical-passive-direct</td>
<td>Physically preventing another person from obtaining a desired goal or performing a desired act (as in a sit-in demonstration)</td>
</tr>
<tr>
<td>Physical-passive indirect</td>
<td>Refusing to perform necessary tasks (e.g., refusing to move during a sit-in)</td>
</tr>
<tr>
<td>Verbal-active-direct</td>
<td>Insulting or derogating another person</td>
</tr>
<tr>
<td>Verbal-active-indirect</td>
<td>Spreading malicious rumors or gossip about</td>
</tr>
<tr>
<td>Verbal-passive-direct</td>
<td>Refusing to spread to another person, to answer questions, and so on</td>
</tr>
<tr>
<td>Verbal-passive-indirect</td>
<td>Failing to make specific verbal comments (e.g., failing to speak up in another person’s defense when he or she is unfairly criticized)</td>
</tr>
</tbody>
</table>

Moyer (1976) recognized eight distinct types of aggression that can be found in some form in virtually all species, including human behaviour. These are:

- Predatory aggression: It is directed to natural hunt and is extremely rooted in our ancestors hunting behaviour.
- Intermale aggression: Physical violence or submissive behaviour displayed by males towards each other.
- Fear-induced aggression: Responses believed to be biologically programmed into us so that we act in an aggressive manner towards any form of forced confinement.
- Territorial aggression: Threat or attack behaviour displayed towards an invasion of one territory or the submissive-retreat behaviour displayed when confronted while intruding.
- Maternal aggression: Aggression behaviour put forward by females (and most likely males as well) when an intruder is a presence of one’s children.
- Irritable aggression: Aggression and rage directed towards an object when the aggressor is frustrated, hurt, deprived or stressed.
Sex related aggression: Aggressive behaviour that is elicited by the same stimuli that elicits sexual behaviour. Any person who can evoke sexual desire can equally evoke aggression via jealousy etc.

Instrumental aggression: Aggressive behaviour is displayed because it previously resulted in a reward. Much of human aggression seems to be related to this.

1.5.4.1 Bullying

Bullying among school-aged youth is additionally being documented as a significant problem influencing well-being and social functioning. While a specified amount of conflict and persecution is characteristic of youth peer relations, bullying shows a potentially more earnest danger to healthy youth development. Bullying is a specific form of aggression in which (1) the person’s behavior is intended to damage or disturb, (2) the behavior happens frequently over time, and (3) there is an disbalance of power, with a more influential person or group attacking a less influential one. This irregularity of power may be physical or psychological, and the aggressive behavior may be verbal (e.g., name-calling, threats), physical (e.g., hitting), or psychological (e.g., rumors, shunning/exclusion) (Nansel et al., 2001).

1.5.4.2 Reactive and Proactive Aggression

Researchers had made this distinction before, but they had used different labels for reactive (i.e. hostile, affective) and proactive (i.e. instrumental, predatory) aggression. Proactive aggression is goal-oriented requiring neither provocation nor anger. It can be directed toward possessing objects (object oriented) or dominating people (person oriented or bullying). Reactive aggression, on the other hand, involves angry outbursts in response to provocation (Dodge, 1991). Although proactive and reactive aggressions often co-occur, not all aggressive individuals display both forms of aggressive behavior. Specifically, although around 53% of children who engage in some form of aggressive behavior have been found to be both proactively and reactively aggressive, around 32% are only reactively but not proactively aggressive. Comparatively few children, around 15%, seem to engage only in proactive but not in reactive aggression, however (Brendgen, Vitaro, Tremblay, & Lavoie, 2001).
Aggressive styles are subject to developmental change during the life course. Among animals and young children lacking verbal skills, aggression is predominantly physical. When verbal skills develop, aggression is expressed through communication rather than physical force. With the development of social skills even more sophisticated strategies of aggression are facilitated i.e. the aggressor is able to harm a target person without even being identified. This may be referred to as indirect aggression (Lagerspetz, Björkqvist, & Peltonen, 1988).

1.5.5 Causes of Aggression

There are similar characteristics among bullies, proactive aggressors, and reactive aggressors. Furthermore, physical, verbal, and relational aggressions also have much in common, and aggressive behaviours are similar among boys and girls as well.

For treating aggression among adolescence, we need to focus on all of these types. But at first step we need to comprehend the origins of aggressive behavior, as aggression is a complex behavior with several causes. Understanding these reasons can aid us offer more effective treatments (Shechtman, 2009).

1.5.5.1 Genetic, Biological, and Temperamental Factors

Enormous evidence recommends that a substantial part of children’s aggressiveness is due to internal biological and physiological processes, which, if not innate, appear within the first few years of life. In particular, studies indicated a positive relationship between uninhibited temperament in infancy and subsequent aggression, delinquency, and violence in childhood and adulthood. Additionally, minor physical anomalies, unique brain waves, and early neurological impairment have been found to be linked (Shechtman, 2009). The possibility that some human aggression may be attributable to hereditary factors is supported by a growing number of studies. At one time, especially in the United States when behaviourism dominated psychology, few psychologists believed that human behaviour had hereditary origins. It was practically a truism that all behaviour is learned. Nowadays this premise is not as widely accepted. Hereditary aggression in lower animals has never been seriously questioned, and in recent years the idea that
at least some part of human aggressiveness is inherited has been gaining increasingly in acceptance (Geen, 1988).

1.5.5.2 Family Factors

Physically aggressive children tend to have had physically punitive parents, who disciplined them by modeling aggression with screaming, slapping, and beating (Patterson, Chamberlain, & Reid, 1982). These parents often had parents who were themselves physically punitive (Straus, 1980). Violent parents tend more to have aggressive children. Therefore, it is obvious that violence is transmitted intergenerational. However, the interpretation of how the family influences the child’s behavior differs from one psychological tendency to another. An obvious and direct description, broadly supported by research, is presented by cognitive-behavioral theory. Therefore, children who observe aggressive behaviors in their family climate, learn aggressive behaviors (Shechtman, 2009).

1.5.5.3 Social Learning

The social learning theory of aggression emerged in the 1960s, largely as a result of the theorizing of Albert Bandura and his associates. The approach has undergone several elaborations since it was first presented and it continues to exert a strong influence. It emphasizes the acquisition and maintenance of aggressive response tendencies. Although it does not rule out provocations as important contributors to aggression, the social learning approach treats such events as conditions under which learned aggressive behaviors may be enacted. Likewise, the theory includes recognition of biological factors in aggression without regarding such factors as direct causes of aggressive behaviour. Instead, the theory assumes that a person’s genetic and biological endowment creates a potential for aggression, while the specifics of aggressive behaviour– its forms and frequency, the situations that evoke it and the targets towards which it is directed– are acquired through experience (Geen, 1988).

1.5.5.4 Learning Disabilities
As learning disabilities obtain significant attention currently in schools, and because ADHD is closely related to reactive aggression (Dodge, & Schwartz, 1997), this sub-group habilitates unique attention in the discussion of childhood aggression.

1.5.6 Aggression Versus Violence

Although “aggression” is frequently used interchangeably with “violence,” violence is physical aggression at the tremendously high end of the aggression dynasty (General, 2001).

1.5.7 Aggression Versus Anger

Anger refers to feelings and represents the emotional or affective component of at least some kinds of aggressive behaviour. State anger is defined as a psychobiological, subjective experience that, over time and across situations, “usually refers to an emotional state that involves displeasure and consists of subjective feelings that vary in intensity, from mild irritation or annoyance to intense fury and rage”. Anger refers to an emotion but can also be considered a personality trait. Trait anger may be considered to be a general temperament of low threshold reactivity in which angry feelings are experienced in response to a very wide variety of relatively innocuous triggers – e.g., a short delay on a cashier’s line, a slightly late mail delivery by the postal service, or noticing that a student has made unexpected spelling errors – or a more narrow pattern of reactivity to specific classes of stimuli for the person such as competition, rejection, or perceived unfairness (Ramirez et al., 2009).

1.5.8 Aggression Versus Hostility

Hostility is a multidimensional concept that can be categorised into attitudinal, emotional, and behavioural components. It is a negative evaluation of persons and things, often accompanied by a clear desire to do harm or to aggrieve others. Plutchik considered it as a negative attitude that mixes anger as well as disgust, and it is accompanied by feelings of indignation, disgust, contempt and resentment towards others (Buss, 1961).
1.5.9 Adolescents with Aggression

Adolescent’s aggression has been defined as “a harmful behavior which violates social conventions and which may include deliberate intent to harm or injure another person or object” (Berkowitz, 1993a). Aggression and related behaviours in adolescence are central issues in our time. From public school shooting and similar instances of children killing other children to concern about rising rates of youth crime and delinquency in the community to the relationship between unrecognized and entreated mental illness and violence in youngsters, there are many worries and much debate about excessive, inappropriate aggression in young people in our society (Connor, 2012). According to Shechtman (2009, P. 3) “aggression among children and adolescents is a extremely disturbing behaviour, whether it happens at home, in the school, on the playground or in the community”. Over the past 50 years, a rate of maladaptive aggression has increased in frequency and severity among children and adolescents. Records on aggressive behaviour among school children in India, although rare, indicates aggressive behaviour is common among both boys and girls, starting as direct physical aggression (more among boys) and gradually changing to more of verbal and then to indirect and passive aggression (starting earlier in girls) (Dutt, Pandey, Pal, Hazra, & Dey, 2013).

There are many factors working together; making a situation in which aggressive behaviour is over determined and over-learned, turning children into aggressors. Reducing dysfunctional aggression has been the attention of all psychologists regardless of their different specializations. Researches have been focused to understand factors associated with aggression, information about which would enable the practitioner to plan interventional programmes to reduce aggression (Mohan, Singh, & Singh, 2009).

1.5.10 Gender and Aggression

Gender is an issue that plays a role in both human and animal aggression. Males are historically supposed to be usually more physically aggressive than females (Coie, Dodge, & 1998), and men commit the massive majority of murders (Buss, 1966). This is one of the significant behavioural gender differences that consistence among many different age groups and cultures.
Some scientists discuss that indirect forms of non-violent aggression, such as relational aggression and social rejection, among females are more, although aggression among females is hardly expressed physically (Card, Stucky, Sawalani, & Little, 2008).

1.5.11 Prevalence of Aggression

Over the past 50 years, a rate of maladaptive aggression has increased in frequency and severity among children and adolescents in the United States. Although most youth are not extremely aggressive or antisocial, the rates of these behaviors are yet alarming. Reported prevalence of mild and low-level school aggression are tremendously high. Some researchers indicated that every second boy and every fourth girl in school is preoccupied in physical conflict (Horne, Stoddard, & Bell, 2007), while others reported even higher rates. For example, Benbenishty & Astor (2005) indicated that 20% of students tolerated severe physical aggression, 60% suffered from mild physical aggression, and the prevalence of verbal aggression were even more (about 80%) (Shechtman, 2009). These findings recommend that, nowadays being safe in the different environment such as school, bus, and playground is a daily concern of children and adolescents (Connor, 2012).

Records on aggressive behavior among school children in India, although rare, indicate males to be more aggressive, with the proportion of physical aggression being 45% in boys (Dutt et al., 2013).

1.6. Depression

1.6.1 Meaning and Definition

“Depression” comes from the Latin word “deprimere”, meaning to press down. Many researchers assume that the term "depression" refers not simply to a state of depressed mood, but to a syndrome comprising mood disorder, psychomotor changes and a variety of somatic disturbances. Depression is typically characterized by low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities. A DSM-TV-TR criterion for depression is given below:
A. “Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

1- Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.

2- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).

3- Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.

4- Insomnia or hyper insomnia nearly every day.

5- Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feeling of restlessness or being slowed down).

6- Fatigue or loss of energy nearly every day.

7- Feeling of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8- Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observe by other).

9- Recurrent thoughts of death (not just fear of dying), recurrent suicide ideation without specific plan, or a suicide attempt or a specific plan for committing suicide” (DSM-TV-TR as cited by First, Frances, & Pincus, 2004).

The diagnosis of depressive disorder is based on the patient's self-reported experiences, behavior reported by relatives or friends, and a mental status examination. Physicians generally request tests for physical conditions that may cause similar symptoms. If depressive disorder is not detected in the early stages it may result in a slow recovery and affect or worsen the person's physical health. Standardized screening tools such as Major Depression Inventory can be used to detect major depressive disorder (Bech, Rasmussen, Olsen, Noerholm, & Abildgaard, 2001).

A person having a depressive episode usually exhibits a very low mood, which pervades all aspects of life, and an inability to experience pleasure in activities that were
formerly enjoyed. Depressed people may be preoccupied with, or ruminate over, thoughts and feelings of worthlessness, inappropriate guilt or regret, hopelessness, and self-hatred. In severe cases, depressed people may have symptoms of psychosis. These symptoms include delusions, less commonly, hallucinations, usually unpleasant (APA, 2000). Other symptoms of depression include poor concentration and memory (especially in those with melancholic or psychotic features), withdrawal from social situations and activities, reduced sex drive, and thoughts of death or suicide (Delgado & Schillerstrom, 2009).

Insomnia is common among the depressed. In the typical pattern, a person wakes very early and cannot get back to sleep, but insomnia can also include difficulty falling asleep. Insomnia affects at least 80% of depressed people. Hypersomnia, or oversleeping, can also happen, affecting 15% of depressed people (APA, 2000).

A depressed person may report multiple physical symptoms such as fatigue, headaches, or digestive problems; physical complaints are the most common according to the World Health Organization's criteria for depression (Patel, Abas, Broadhead, Todd, & Reeler, 2001). Appetite often decreases, with resulting weight loss, although increased appetite and weight gain occasionally occur (APA, 2000).

1.6.2 Prevalence of Depression

In India, depression is a major public health problem resulting in increased suffering, diminished social and occupational functioning as well as high levels of suicide. A number of Indian studies (Amin, Shah, & Vankar, 1998; Nambi et al., 2002; Pothen, Kuruvilla, Philip, Joseph, & Jacob, 2003) have reported a wide range of prevalence of depression in India. A World Health Organization study examining 15 primary care centers, in 14 countries worldwide, including Bangalore in Southern India, was conducted to assess psychological problems in general healthcare on the basis of which it was determined that 9.1% of the general population in Bangalore, India suffers from depression (Goldberg & Lecrubier, 1995).

Nandi, Banerjee, Mukherjee, Nandi, and Nandi (2000) suggested that the rate of depression has increased significantly over the years in India as well. Madhavs (2001) found that prevalence rates for depression in India is 31.2 per 1000 population. Sengupta (2005) stated that depression is a major health problem in countries like India. Poongothai, Pradeepa, Ganesan, and Mohan (2009), in the largest population based study from India, reported that prevalence
of depression among south Indians is 15.1%. This is consistent with the figures reported for developing countries (10-44%) by World Health Organization (2001). Reddy (2010) stated that Indian union health ministry estimates that 120,000 people commit suicide every year in India and that the majority of those committing suicide suffer from depression. A review of eight epidemiological studies on depression in South Asia shows that the prevalence in primary care was 26.3%. The occurrence of depression among adolescents between primary-care and pediatric care situations in India is 11.2%. The lifetime prevalence for major depression in adolescence across the world is 15% to 20% with a recurrence degree of 60–70%. (Mona, Prabhakar, Sushila, & Paul, 2007).

1.6.3 Adolescent Depression

Adolescent depression is a disorder that happens during the adolescence years and includes persistent sadness, discouragement, loss of self-worth, and loss of interest in common activities (such as hobbies and games). Depression in Adolescents is a mood disorder, lasting at least 2 weeks or longer. The major symptoms of depression are irritability, difficulty at school, changes in sleep habits, feelings of persistent sadness and worthlessness, decreased interest in daily activities and responsibilities (APA, 2000). When adolescents face disappointment or loss it is natural to have feelings of sadness and despondency. All adolescents infrequently experience distress and sadness but in those who have major depressive disorder (MDD), their feelings continue for weeks, months, or longer and limit the individual’s ability to function; then this disorder may have negative influence on the adolescent’s academic performance, social life, and family relationship (Mona, Prabhakar, Sushila, & Paul, 2007).

Adolescents are at the greatest risk for depression, with community prevalence ranging from 2.9% to 8%, and as many as 25% of youth meeting criteria for a diagnosis of major depression by late adolescence (Lewinsohn, Hops, Roberts, Seeley, & Andrews, 1993). Depressive disorders are recognized by the World Health Organization as a priority among mental health disorders of adolescents because of its high spread, recurrence, ability to cause significant complications and impairments (Basker, Moses, Russell, Swamidhas, & Russell, 2007). Rates of depressive disorders rise during early to middle adolescence, particularly in females, with the peak age of onset happening at about 13–15 years old (Street & Garber, 2009). Most of the time, major
Depression in adolescence results in suicide, school dropout, pregnancy, substance abuse, continuing in to adult depression, functional disability and significant impairment (Mona, Prabhakar, Sushila, & Paul, 2007).

1.6.4 Depression as a Developmental Reaction

Adolescence has been characterized as a hallmark period of transition with numerous biological, social, and psychological challenges. Such difficulties frequently persist into adulthood and may have important long-term implications that forecast continued problems with physical and mental health and development (Hankin, Mermelstein, & Roesch, 2007). Adolescence is a phase of life characterized by change in every aspect of individual development as well as in every major social context (Powers, Hauser, & Kilner, 1989). The biological changes of puberty as well as the social changes related to the move from elementary to secondary school may be considered primary, without her/his changes derived from one or both of these. For example, puberty affects body and self-image as well as how the adolescent is seen by others. Similarly, the move to a larger secondary school affects the peer group and friendships. Like other phases of the life course, Adolescence also includes experience of stressful life events, with some likely to be more frequent or stressful at this age (Camarena, Sarigiani, & Petersen, 1990). For example, school changes are more frequent in adolescence, and parental divorce may have a stronger impact on some aspects of adolescent development (e.g., romantic relationships). Thus, the extent of potentially difficult changes in adolescence predicts increased psychological difficulty.

With the child’s passage into adolescence, the potential for experiencing depressive feelings and true depressive illness greatly increases. In an epidemiological study of psychiatric disorders among 2000 children on the Isle of Wight, Rutter (1989) found only 3 cases of depression at age 10 but 35 cases at ages 14-15. Similarly, Kashani, Rosenberg, and Reid (1989) found the prevalence of depression in a community sample to be 4 times greater at age 17 than at ages 8 and 12. The reasons for this marked increase in affective disturbance following puberty derive partially from external social expectations at this time of life and partially from internal maturation changes that transform the manner in which the self and the environment are phenomenological apprehended. The image of adolescence as a time of storm and stress, intense moodiness, and preoccupation with the self has permeated both professional and lay perspectives on this developmental period. The belief that significant difficulties, including depression, during
adolescence represent normal development has had two major effects on research and practice: (a) Difficulties during adolescence were not considered as an important developmental variation, and (b) adolescent problems were often not treated because of the belief that the adolescent would grow out of them. Although this view of adolescence is the one commonly reflected in the media and in many professional descriptions of adolescence, it is not supported by research on this period (Petersen, 1988). It is now known that the majority of adolescents of both genders successfully negotiate this developmental period without any major psychological or emotional disorder, develop a positive sense of personal identity, and manage to forge adaptive peer relationships and at the same time they maintain close relationships with their families (Powers et al., 1989).

### 1.6.5 Vulnerability Factors for Depression

#### 1.6.5.1 Age

The risk for depression increases as a child gets older. According to the World Health Organization, major depressive disorder is the leading cause of disability among Americans age 15 to 44. One risk factor for developing depression is age. The risk for a first episode of any degree of depression is highest in women between the ages of 20 to 29. For men, the similar risk period is between the ages of 40 and 49 (Rorsman, Grasbeck, Hagnell, Lanke, & Otterbeck, 1990). Explanations given about why younger people are more likely to be at risk for depression include changes in the stability of marriages and the structure of families, fewer employment and promotion opportunities, urbanization, and the effect of increasing population (Sarason & Sarason, 2007).

#### 1.6.5.2 Gender

A considerable amount of theory and research points to enhanced difficulties for girls as they enter adolescence. Indeed, girls begin to exhibit internalizing emotional problems, especially symptoms of depression, more than boys starting in early adolescence and lasting throughout most of adulthood (Hankin et al., 2007). Although the most reproducible finding in the epidemiology of major depressive disorders has shown a higher prevalence in females, there are no clear differences between genders in symptoms, course, treatment response, or functional consequences. In women, the risk for suicide attempts is
higher, and the risk for suicide completion is lower. The disparity in suicide rate by gender is not as great among those with depressive disorders as it is in the population as a whole (APA, 2013).

1.6.5.3 Genetic Factors

Depression appears, at least in part, to be a heritable condition. As a number of authors have noted, family studies tend to confound genetic contributions with the effects of a shared environment. Children raised in the same environment are often exposed to similar stressors, parenting, and social support. The specific “micro-environments” of children in the same family can differ, however, as can the ways in which these experiences are perceived or interpreted by each child. Genes do not function in isolation from the environment. Rather, environmental stressors activate gene expression at specific times (Caspi et al., 2003).

A recent genetic epidemiological study of female adolescent twins reported that 40% of the variance in depression was accounted for by genetic factors and the remaining variance was accounted for by non-shared environmental factors (Glowinski, Madden, Bucholz, Lynskey, & Heath, 2003).

1.6.5.4 Changes in Family and Social Network

Adolescence is a time of social change. One of the developmental challenges of this period centers on shifts in family and social networks, a transition that can be stressful for some teens. With the increasing importance of peer relationships comes the need to cope with negative events such as an inability to join desired peer groups or consequences of affiliating with a negative peer group. Conflicts can occur as adolescents and their parents negotiate increased responsibility, independence, and privileges (Mark, Reinecke & Simons, 2005). Rueter, Scaramella, Wallace, and Conger (1999) have suggested that conflicts with parents stemming from increased independence may be implicated in the development of depression among adolescents. Negotiating this transition involves distanitation from parents, which may create conflict and anxiety in both parents and adolescents.
1.6.5.5 Neurotransmitter Dysregulation

One of the ways in which genetic factors may affect mood is through Neurotransmitter regulation. For example the serotonin transported gene is important for the regulation of serotonin, which has many functions in the brain including mood regulation, while the BDNF gene is important for regulating BDNF in the brain which also functions to regulate mood and has important cognitive functions. Additionally, there are multiple, complex relationships between gonadal hormones and the neurotransmitter that regulate mood. In genetically vulnerable girls, normal hormonal cycling which begins in puberty may trigger dysregulation of neurotransmitter systems, leading to increases in the depressive symptoms (Hoeksema & Hilt, 2013).

1.6.5.6 Psychosocial Factors

There are also several psychosocial risk factors that may be present before puberty which interact with stresses caused by the pubertal transition to cause increases in depressive symptoms, especially for adolescent girls (Hoeksema & Hilt, 2013).

1.6.5.7 Negative Cognitive Style

The basic idea is that depression occurs in people who attribute the causes of negative events to negative qualities of themselves that are unchanging and pervasive (Abramson, Seligman, & Teasdale, 1978). For example, an adolescent who fails an exam but believes that the teacher made this test too difficult will not be depressed, whereas a student who attributes the cause of his failure to low ability (e.g., “I lack intelligence”, i.e., an internal-global-stable attribution) will be depressed. There is abundant evidence that high levels of depression in adolescents are related to internal-global-stable attributions for negative events and that the reverse (i.e., making external-specific-unstable attributions) is true for positive events (Joiner & Wagner, 1995).

1.6.5.8 Negative Life Events

The presence of negative life events is a life reliable risk factor for depression in adolescents. Experiences such as parental divorce, death, loss, abuse, and unresponsive or neglectful parenting can occur and may play a role in precipitating the onset of depressive
episodes (Compas, Grant, & Ey, 1994). Research by Cyranowski, Frank, Young, and Shear (2000) revealed that over 70% of depressed females reported they had experienced one or more severe negative life events prior to the onset of their depressive episode. Interestingly, the corresponding number for males was only 14%. Life events with interpersonal consequences have been found to be especially potent approximately; 95% of stressful events associated with the onset of a depressive episode were social in nature. Minor life events or “hassles” have also been associated with severity of depression among adolescents (Reinecke & Dubois, 2001).

It is worth acknowledging that losses and stressful life events may not occur randomly across families. Divorce, for example, is associated with a range of stressors, including parental psychopathology, parental conflict, and marital violence. Moreover, the occurrence of a specific loss or traumatic event may foreshadow the occurrence of additional losses and stressors. A divorce or parental separation is frequently accompanied by a reduction in family income, a move to a new home or school, and disruptions in relationships with peers and the extended family. It may not, as a consequence, be the occurrence of a specific loss or trauma that is associated with vulnerability for depression so much as its association with an ongoing series of losses and stressors (Reinecke & Simons, 2005).

**1.6.5.9 Personality Traits**

Hoeksema and Girtus (1994) suggested that girls have certain traits that interact with the stresses of being a teenage girl that produce depression and lower self-esteem. The traits are thought to be emotional dependence on relationships, less assertiveness and passivity (or an inclination to worry about a problem situation rather than do something about it quickly and decisively, as a boy might do). Thus maturing young girls may get distresses when interacting with desirable but sexually aggressive, scary young males; when they dislike or don’t know how to handle their own bodily changes; when sexually teased, used, or abused; when their social activities are restricted more than boys, when peers, culture; and parents start to emphasize attractiveness, sexiness, and friendships more than intelligence, genuine caring, and preparing for one’s life work.
1.6.5.10 Coping Ways in Boys and Girls

Coping styles are generally considered as a protective factor for mental health. The basic idea is that some coping styles screen the individual from stressful life events, whereas other coping styles enhance the individual’s vulnerability to mental health problems. Direct support for this notion in adolescent populations was provided by two subsequent studies of Herman-Stahl and colleagues (Stabl, Stemmler, & Petersen, 1995; Stahl & Petersen, 1996). Results indicated that depressive symptomatology is accompanied by higher levels of passive and avoidant coping but lower levels of active and approach coping. Furthermore, evidence coming from the adult literature suggested that depression is negatively associated with problem-focused coping but positively with emotion-focused coping.

1.6.5.11 Academic Factors

Understanding academic correlates of depression is essential to implementing treatment programs within the school setting. Academic factors such as school violence, class well-being and lack of teacher’s support, grades and peer pressure may play roles as predisposing factors to depression. Students who do not achieve as readily as their peers are at risk for developing a poor academic self-concept, negative self-perceptions, and cognitions related to school and to their ability to succeed more globally.

Elbaum and Vaughn (2001) proposed that because of the significant role that schools play in shaping students’ self-perceptions, those students who experience severe difficulties in school setting are considered at-risk for developing poor self-concept, such as a diminished self-image. School plays a prominent role in a student’s life experience, and negative feelings about academic identity would therefore significantly reduce one’s sense of self-competence and alter his or her self-perceptions (Mennuti, Freeman, & Christner, 2006).

1.6.6 Theories of Depression

1.6.6.1 Psychoanalytic Theories of Depression
Psychoanalysis regards mourning and depression as types of bio-psychological reactions to loss. Any significant loss stimulates fear, anxiety and anger. The activity of the emotional system connected with fight or flight is triggered and emotional systems to do with nurturance are enormously disturbed. These powerful emotional reactions have to be managed by the organism (Richards & Freud, 1979).

Psychoanalytic theory and its most recent manifestation, object relations theory, have led to psychotherapeutic interventions for depression and other psychiatric problems. Traditional psychoanalytic theory was fairly long-term initially, striving to uncover unconscious emotional material through free association. Refinements have focused more upon emotional catharsis, the venting and expressing of emotions, something a psychoanalytic therapist would think best done in the context of stable, continuing, and well-boundaried relationship. The spotlight is trained upon emotional expressiveness, since emotional traumas and patterns of repressed emotional expressiveness are seen by the psychoanalyst as the heart of depression (Mays & Croake, 1997).

1.6.6.2 Aggression in Depression

Psychoanalysts since Abraham Maslow have ascribed a central role to aggression in the development of depression but writers have challenged the universality of this association. Balint considered the depressive’s feelings of bitterness and resentment as reaction to, rather than essential elements of, depression. Bibring also regarded aggression as a secondary phenomenon due to the breakdown of self-esteem. Cohen and her group posited that the hostility exhibited by the patient is due to his or her “annoying impact upon others, rather than the primary motivation to do injury to them” (Bibring as cited by Beck & Alford, 2009). Gero also challenged the view that self-devaluation can be considered self-directed aggression (Gero as cited by Beck & Alford, 2009).

1.6.6.3 Cognitive Theories of Depression

Cognitive-behavioral theories have their origins in the work of Adler and Kelly and have received attention more recently from Albert Ellis, David Meichenbaum, and Aaron Beck. The theories generally suggest that it is the thoughts intervening between a stimulus and an emotional reaction that moderate and determine the reaction (Mays & Croake, 1997). These theories propose
that it is not so much what happens to people that causes depression as it is how they think about what happens.

The cognitive theory Beck (1967) stated that there are idiosyncratic patterns of thought in depressed patients which not only correlate with, but might be seen as causing, depression. The three major types of thinking “errors” are (1) negative automatic thoughts- those which occur so quickly that they may not even be perceived by the individual and which contribute to depression in depressed patients. Those with depression usually believe that they, personally, are inadequate to deal with the challenges they face. They view the external world as impossibly hard, demanding, exacting, and unforgiving. These “automatic thoughts,” or assumptions about the world, are seen as one aspect of the cognitive cause of depression. (2) Systematic logical errors in thinking. There are several types of systematic logical errors in thinking:

A) *Arbitrary inference* - takes place when an individual makes conclusions from insufficient data. An extreme example of this is found in severe depression, including psychotic depression where patients may even believe that they are responsible for wars or natural disasters.

B) *Selective abstraction* - refers to focusing on one detail out of many, ignoring aspects of the context of the situation and understanding the whole situation or experience on the basis of this one detail.

C) *Overgeneralization* - refers to a pattern of drawing a general role or conclusion merely because one incident, or rare incidents, has occurred.

D) *Magnification and minimization* - refer to errors in evaluating the magnitude or significance of an occurrence.

E) *Personalization* - refers to the tendency to assume that external events are related to the person even when there is no evidence for this.

F) *Absoluteness or dichotomous thinking* - is the tendency to think in black and white categories, an “all-or-none” cognitive approach.

(3) Depressogenic schemas-“are a structure for screening, coding and evaluating impinging stimuli”. These schemas can be seen as dimensions that the person considered relevant or meaningful.
1.6.6.4 Psychosocial and Interpersonal Theories of Depression

Psychosocial and interpersonal theories of depression explore psychosocial and interpersonal explanation for depression. The research on life events, particularly negative events and association between loss and depression, seems significant for an understanding of depression. The research suggested that social and interpersonal factors, rather than merely biological factors or individual behavioral or cognitive factors, play a role in the onset and persistence of depression (Mays & Croake, 1997). According to Thomas and Hersen (2010) the **Interpersonal theory** holds that the basic reason for the individual to become depressed is that he does not know how to get along with his intimate partners. As a result he becomes increasingly disappointed and frustrated. The interpersonal therapist therefore focuses on the patient’s key relationships.

1.6.6.5 The Humanistic-Existential Theories of Depression

Existential theories considered the depressed state to be an arrest or insufficiency of all the vital activities. For existential theories, instead of emphasising on the loss of a loved object or an important person as central to depression, they emphasize that the loss can be symbolic power, for example money (Beck & Alford, 2009). A humanistic theorist such as Carl Rogers (1951, 1980) emphasized that the source for depression and anxiety is the discrepancy between a person’s ideal self and his/her perceptions of the actual state of things. They believed that depression is likely to result when the discrepancy between the ideal and the real self becomes too great for the individual to tolerate. This discrepancy occurs frequently, especially among people who have high aspirations for achievement and are trying to fill several roles simultaneously (Sarason & Sarason, 2007).

1.6.6.6 Lewinsohn’s Behavioral Model (1974)

The theory accounts for behavioral aspects of depressed individual. Here, depressive behaviors are related to a reduction in response contingent to positive reinforcement. Essentially, an individual over time does not get reinforcement for adaptive behaviors (extinction) and reinforcement is then received for the lack of production of adaptive behaviors. This low instance of response-contingent positive reinforcement leads to dysphoric mood, fatigue, and somatic complaints that are primary signs of depressive disorders (Mennuti et al., 2006).