CHAPTER -I

INTRODUCTION

Childhood is an important period in human life span as childhood experiences influence an individual’s behaviour during adulthood, especially influencing their self-esteem, coping style, adjustment, moral values etc. Family environment has a major role to play in determining children’s behaviour. A conducive and supportive family environment helps the child learn socially acceptable behaviour. However, several studies have found that the prevalence of behaviour problems among children and adolescents living with their parents varies from 6.9% to 22.5% (Tadesse, Kebede, Tegegne & Alem, 1999; Mullick & Goodman, 2005; Flielich-Bilyk & Goodman, 2004; Goodman, Santos, Nunes, Miranda, Flielich-Bilyk & Filho, 2005; Canino et al., 2004; Offord, 1987; Weyerer, Casell, Biener, Artner & Dilling, 1988; steinhausen, Metzke, Meier & Kannenberg, 1998). Similarly, Indian studies also reported that the behaviour problems of children and adolescents living with their parents varies from 6.3% to 25.2% (Srinath, Girimaji, Gururaj & Seshadri, 2005; Hackett, Hackett & Bhakta, 1999; Malhotra, Kohli & Arun, 2002; Malhotra, Kohli, Kapoor, & Pradhan, 2009; Anees, Najam, Zulfia & Ali, 2007; Ranimohanraj, 2006; Hiremath, Hunshal & Gaonkar, 2008). On the other hand, children who had encountered domestic violence, who came from broken homes or families with alcoholic parents, and who were neglected by their parents, were more vulnerable to emotional and behaviour problems. Some of these children continue to live in such adverse conditions while some of them run away from home. Studies have indicated that an adverse family environment may be the cause for children running away from home. For instance, in one study of 349 runaway youths living in shelters (Thompson & Pillai, 2006)
reported that their parents were negligent and had a significantly higher rate of runaway episodes. Youth who reported little trust and security with parents were 30 percent more likely to run away multiple times. Similarly, two other studies also found that family disruption, poverty, abandonment, and physical or sexual abuse were some reasons for institutionalization (Erol, Simsek & Munir, 2010; Khurana, Sharma, Jena, & Saha, 2004).

Child Line India Foundation (2007) reported that, on an average 44,475 children are “missing” in India every year. Particularly in Tamil Nadu, on an average, 4,618 children are missing every year. The report also revealed that the number of missing children increased every year (between the years 1996 to 2001). These missing children may likely become street children, and thus more vulnerable to child labour, begging, child abuse, trafficking and criminal behaviour. These issues are a major concern for psychologists, social activists, educationalists and policy makers. Keeping this in view, the Government of India enacted a law called the Juvenile Justice (Care and Protection of Children) Act (2000), which was amended in 2006, to protect, educate and rehabilitate these children.

The Juvenile Justice (Care and Protection of Children) Amended Act, 2006, covers boys and girls up to the age of 18 years, and distinguishes between ‘juveniles in conflict with law’ and ‘children in need of care and protection’. A juvenile in conflict with law means a juvenile who is alleged to have committed an offence. Children in need of care and protection means a child who is found begging, or on the street, or a homeless labourer, or an abused or neglected child, or who does not have a parent, or one who is found vulnerable and is likely to get into drug abuse, or where the parent or guardian is unfit or incapacitated to exercise control over the child. In addition, the act also includes the formation of the Child Welfare
Committee (CWC) which deals with matters relating to children in need of care and protection whereas the Juvenile Justice Board (JJB) deals with matters relating to juveniles in conflict with law.

Based on this Act, the Government of Tamil Nadu and Non-Governmental Organizations (NGO) in Tamil Nadu are running children’s homes (referred to as ‘Homes’) for children in need of care and protection. All these Homes, whether State Government or those managed by voluntary organizations, have to be registered under this Act. As per the statistics available as on 31.10.2011, there are 1,527 children’s homes managed by Non-Government Organizations. Out of these, 561 children’s homes furnished the data to the Department of Social Welfare, Government of Tamil Nadu, Chennai about the number of children staying in their Homes. Based on the data provided by the above agencies, it is understood that 49,971 children are staying in 561 children’s homes. The remaining 966 children’s homes did not provide the data to the Government. In addition, there are four children’s homes managed by the Government of Tamil Nadu. Around 400 children are staying in the government children’s homes. In Chennai, there are 41 children’s homes run by NGOs and two homes by Government of Tamil Nadu. However, only 12 homes (including the two Government homes) provided data to the Government of Tamil Nadu. Also it has been reported that there are around 700 children staying in these homes. Considering the reported statistics, it is estimated that the number of children staying in Tamil Nadu homes may likely reach more than a lakh. Thus, this huge proportion of children’s psychosocial issues necessitates immediate attention for the benefit of the society. Considering this, the present study focused on the boys who are in need of care and protection.
Numerous research studies have been done by different psychologists who worked with these children. The first person to document the negative impact of growing up in institutions was Bowlby (1960) who studied the adverse effects of children living in children’s homes. Following his observations, numerous empirical studies conducted in many countries has indicated that children growing up in institutions often reported suffering from higher rates of emotional and learning problems, hostility, depression and insecurity; apart from lower self-esteem. They also exhibited behaviour problems; tended to use the disengagement coping style; experienced more negative life events; had less perceived parental support, and poor academic performances (Deepa, 1993; Priscilla 1998; Maxwell, 1991; Votta & Manion, 2003; Zima, Wells, & Freeman, 1994; Sarbjeet, Sharma, Shivananda, Shah, & Ingle, 2004; Hunshal & Gaonkar, 2008). Moreover, high rates of mental health problems among institutionalized children were well established in many countries such as Finland, US, Norway and Australia (Hukkanen, Sourander, Bergroth, & Piha, 1999; Garland, Hough, McCabe, Yeh, Wood, & Aarons, 2001; Holtan, Ronning, Handegard, & Sourander, 2005; Sawyer, Carbone, Searle, & Robinson, 2007).

Further, a few other studies compared the emotional and behaviour problems of institutionalized and non-institutionalized children. These studies reported that institutionalized children had more emotional difficulties, conduct problems and hyperactivity; lower levels of sympathy and poorer self-confidence. In addition, they were also prone to noncompliance, and were more aggressive than the non-institutionalized children. In addition to these, the institutional children had higher rates of mental health disorders than children living in deprived private households.

The Variables Studied for the Present Study

In this study, self-esteem, emotional intelligence, coping style, perceived social support and behaviour problem variables were selected and studied among boys who were in need of care and protection. The concept of the above variables and its importance in adolescents’ life are described below.

Self-Esteem

“Self-esteem is not everything; it is just that there is nothing without it”

Gloria Steinem

One of the important concepts during adolescence is self-esteem. Interaction with other people is important for an adolescent and plays a vital role in developing self-esteem (Harter, 1993). Self-esteem is an important factor in directing behaviour throughout the various aspects of life (Hamarta, 2004).

Many early theories suggested that self-esteem is a basic human need. Maslow (1954) and Rogers (1961) have theorized that striving to self-actualize is a prime human motive. Maslow described two different forms of esteem: the need for respect from others and the need for self-respect, or inner self-esteem. Respect from others entails recognition, acceptance, status, and appreciation, and was believed to be more fragile than inner self-esteem. According to Maslow, without the fulfillment of the self-esteem need, the individual would be unable to move towards self-actualization.
Definition of Self-Esteem

Self-esteem has been defined in various ways:

Rosenberg (1965) defined self-esteem as, “evaluation which the individual makes and customarily maintains with regard to himself, expressed as an attitude of approval or disapproval”. Coopersmith (1967) defined self-esteem as, “the evaluation, which the individual makes and customarily maintains with regards to him/herself”. Erikson (1968) identified self-esteem as a function of identity development that results from successfully addressing the tasks associated with each of the developmental stages of life. Thus one’s sense of developing, growing, and confronting life’s tasks leads to feelings of worth.

Self-esteem is confidence in one’s capacity to achieve values (Branden, 1970). Harter (1985) has defined self-esteem as, “the level of global regard that one has for the self as a person”. Hales (1989) has defined self-esteem as the evaluative function of the self concept. The California State Task Force on Self-Esteem (1990) has defined self-esteem as, “appreciating my own worth and importance and having the character to be accountable for myself and to act responsibly towards others”.

Osborne (1993) defined self-esteem as, “a relatively permanent positive or negative feeling about self that may become more or less positive and negative as individuals encounter and interpret success and failures in their daily lives”. Campbell and Lavallee (1993) defined self-esteem as, “a self-reflexive attitude that is the product of viewing the self as an object of evaluation”. Self-esteem is a subjective and enduring sense of realistic self-approval. It reflects how the individual views and values the self at the most fundamental levels of psychological experiencing (Bednar & Peterson, 1995). Self-esteem is focused upon feelings of personal worth and the level of satisfaction regarding one’s self (Garry, 1991).
Lynda (1955) in her book on “An interactive approach to changing your life” has described the characteristics of having high and low self-esteem.

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<th><strong>High Self-Esteem</strong></th>
<th><strong>Low Self-Esteem</strong></th>
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<td>Lacking confidence</td>
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<td>Being happy</td>
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<td>Wholeness</td>
<td>A feeling of not belonging</td>
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<td>A feeling of being in control</td>
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<td>Thinking positively</td>
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<td>Being in charge</td>
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<td>Assertive behaviour</td>
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Self-esteem is a developed attitude about one’s personality (Kaya & Sağkes, 2004) and is an important factor in directing behavior throughout the various aspects...

Psychological pathogens such as lack of mastery of skills, rejection by significant others, identification with a maladjusted adult, dishonesty and deception and family stress can affect self-concept and self-esteem, and can continue throughout life. When there is more negative feedback compared to positive feedback from parents and significant others, feelings of inadequacy, inferiority, or despair can arise. When an individual experiences repeated failures, self-worth can be greatly diminished or destroyed. The intensity, duration, and frequencies of these pathogens help to determine how deficient in self-esteem the individual might become and how open to positive change he may be (Frey & Carlock, 1989).

Gray-Little and Hafdahl (2000) has suggested that the approval that matters most to people has the greatest impact on their self-esteem. In this respect, social support is an important factor for the formation of self-esteem during adolescence (Rosenberg, 1981). It is well known that the relationship of parents and peers with the adolescent supports the development of self-esteem (Hoffman, Ushpiz, & Levy-Shiff, 1988; Kulaksizoglu, 2001). According to Coopersmith (1967), the attention an individual receives from other people and the degree of acceptance and respect she/he feels have a role in self-esteem development. High self-esteem makes an individual much more effective, happy, successful, and confident when interacting with the environment.
In a prospective study among young adolescents, Garber and Flynn (2001) found that negative self-worth develops as an outcome of low maternal acceptance, a history of maternal depression, and exposure to negative interpersonal contexts, such as negative parenting practices, early history of child maltreatment, negative feedback from significant others on one’s competence, and family discord and disruption.

Miller (1984) found that when parental absence exists in a home situation the level of self-esteem of children is affected. Kimble and Hilmreich (1972) also believed that a person’s self-esteem is affected by the quality and quantity of approval received from parents and others early in life.

Further, it is also reported that neglected children have low self-esteem and more difficulty in pulling themselves together to deal with various tasks and lack necessary resources to cope with the environment. They also had a deficit in cognitive performance, academic achievement, behaviour problem in the classroom and social interaction (Dubovitz, 1994).

Hence, self-esteem of boys who are in need of care and protection was studied in the present study as the literature suggests that it is an important factor in overall development.

**Emotional Intelligence**

**Origin of the Concept of Emotional Intelligence**

The concept of Emotional Intelligence dates back to Darwin's work on the importance of emotional expression for survival and successful adaptation. In the 1900s, even though traditional definitions of intelligence emphasized cognitive aspects such as memory and problem solving, several influential researchers in the intelligence field of study had begun to recognize the importance of the non-
cognitive aspects. For instance, as early as 1920, Thorndike used the term ‘social intelligence’ to describe the skill of understanding and managing other people (Hein, 2005). Gardner (1983) introduced the idea of ‘multiple intelligence’, which included both interpersonal intelligence (i.e. the capacity to understand intentions, motivations and desires of other people) and intrapersonal intelligence (i.e. the capacity to understand oneself, to appreciate one's feelings, fears and motivations). In this regard, the traditional types of intelligence tests such as Intelligence Quotient (IQ) fail to fully explain cognitive ability. Payne (1985), wrote a doctoral dissertation which included the term emotional intelligence. This seems to be the first academic use of the terms "emotional intelligence". Mayer and Salovey (1990) tried to develop a way of scientifically measuring the difference between people's ability in the area of emotions. As a result of the growing acknowledgment by professionals of the importance and relevance of emotions to work outcomes, the research on the topic continued to gain wide importance. The term ‘emotional intelligence’ was mostly unfamiliar to researchers and the general public until Goleman (1995) wrote the best-selling trade book, ‘Emotional Intelligence: Why it can Matter More than IQ’. The book quickly caught the eye of the media, public, and researchers. Thereafter, articles on Emotional Intelligence began to appear with increasing frequency across a wide range of academic and popular outlets. Also many definitions and claims began to dominate academy.

**Definition of Emotional Intelligence**

There is substantial disagreement and confusion regarding the exact meaning of emotional intelligence such that the constructs are so varied and the researchers are constantly amending their own definitions. (Goleman, 1998; Salovey & Mayer, 2000 & Peterides, Pita, Kakkinaki, 2007). However, the common construct amongst
various researchers in terms of terminology and operationalizations are these three models:

a) Ability Based Emotional Intelligence Model (AKI).

b) Mixed Models of Emotional Intelligence (MEI).

c) Trait Emotional Intelligence Model (TEI)

(a) Ability Based Emotional Intelligence Model

Salovey and Mayer (2000) has defined Emotional Intelligence as "the ability to perceive emotion, integrate emotion to facilitate thought, understand emotions and to promote personal growth". The ability model views emotions as a useful source of information that helps one to make sense of, and navigate the social environment. This ability is seen to manifest itself in certain adaptive behaviours that include four types of abilities namely:

1. **Perceiving Emotions:** Perceiving emotions is the ability to detect and decipher emotions in faces, pictures, voices, and cultural artifacts. It also includes the ability to identify one’s own emotions. Perceiving emotions may represent the most basic aspect of emotional intelligence, as it makes all other processing of emotional information possible.

2. **Using Emotions:** The next step involves using emotions to promote thinking and problem solving. Emotions help prioritize what we pay attention and react to. We respond emotionally to things that garner our attention.

3. **Understanding Emotions:** Understanding emotions is the ability to comprehend emotional language and to appreciate complicated relationships among emotions. For example, understanding emotions encompasses the ability to be sensitive to slight variations between
emotions, such as the difference between happy and ecstatic. Furthermore, it includes the ability to recognize and describe how emotions evolve over time, such as how shock can turn into grief.

4. **Managing Emotions:** The ability to manage emotions effectively is a key part of emotional intelligence. Regulating emotions, responding appropriately and responding to the emotions of others are all important aspects of emotional management.

(b) **Mixed Model of Emotional Intelligence**

Goleman (1998) introduced Mixed Model of Emotional Intelligence and it focuses on a wide array of competencies and skills that drive leadership performance. The model has four main constructs.

(i) **Self-Awareness:** ability to read one's emotion, recognize their impact as well as to use gut feelings to guide decision.

(ii) **Self-Management:** involves controlling one's emotions and impulses and adapting to changing circumstances,

(iii) **Social-Awareness:** the ability to sense, understand and react to others' emotions.

(iv) **Relationship Management:** the ability to inspire, influence and while managing conflict.

The measurement of this mode can be done with two monuments based on Goleman (1998) model namely:

(i) The emotional Competency Inventory (ECI) developed in 1999 and the Emotional and social Competency Inventory (ESCI) Developed in 2007.

(ii) The Emotional Intelligence Appraisal developed in 2001. This is a self-report or 360 degree assessment.
There is also a Bar-On Model of Emotional Social intelligence (ESI) developed by Bar-On (2006) that is used to measure Emotional Social Intelligence on the basis of Emotion Quotient. Bar-On (2006) views emotional intelligence as being concerned with effectively understanding oneself and others, relating well with people and adapting to and coping with the immediate environment. He also notes that a deficiency in emotional intelligence can mean a lack of success and existence of emotional problems. Problems in coping with one's environment are thought by Bar-On to be especially common among those individuals lacking in the subscale of reality testing, problem-solving, stress tolerance and impulse control. This model is considered to contribute essentially to a person's general intelligence that offers an indication of one's potential to succeed in life. The measurement is done with Bar-On developed instrument called "Emotional Quotient Inventory (EQ-i) which is a measure of emotionally and socially competent behavior that provides an estimate of one’s social intelligence. The EQ.i is not meant to measure personality traits or cognitive capacity but rather the mental ability to be successful in dealing with environmental demands and pressures.

(c) The Trait Emotional Intelligence: Peterides, Pita Kokkinaki (2007) proposed a conceptual distinction between the ability based model and a trait based model. Trait emotional model is "a constellation of emotion-related self perceptions located at the lower levels of personality. In lay terms, trait emotional intelligence refers to an individual's self-perceptions of his emotional abilities that encompasses behaviour dispositions and self perceived abilities that can be measured by self-report as opposed to the ability based model. Ability model refers to actual abilities, which have proven highly resistant to scientific measurement.
Benefits of Emotional Intelligence

There are four basic areas where the benefit of emotional intelligence skills can facilitate problem solving capacity in students, namely:

1. Emotional Intelligence and Interpersonal Relationship

One of the most important objectives for any person is to maintain the best possible relations with people around him or her. Strong emotional intelligence offers adequate information about the psychological state of the immediate neighbours. The efficient and effective management of one's own emotional state is a pre-requisite to manage other's emotional state. Emotionally intelligent people also are able to extrapolate these skills to the emotions of others. Emotional intelligence skills are basic factors in establishing, maintaining and having interpersonal relations. Research evidences have established a strong positive relationship between emotional intelligence and interpersonal relationships.

2. Emotional Intelligence and Psychological Well-being

Mayer and Salovey's studies in USA have shown that University students with higher emotional intelligence report fewer physical symptoms, less social anxiety, depression, and greater use of active coping strategies for problem solving. Furthermore, when these students are exposed to stressful laboratory tasks, they perceive stressors as less threatening, and their levels of blood cortisol and blood pressure are lower. Research carried out with Spanish adolescents’ shows that when they were divided into groups according to their level of depressive symptomatology, students in a normal state differed from those classified as depressive, by greater clarity about their feelings and greater ability to regulate their emotions (Fernadez — Berrocal & Extremera, 2006).
3. Emotional Intelligence and Academic Performance

Emotional Intelligence may act as a moderator of the effects of cognitive skills on academic performance. Persons with limited emotional skills are more likely to experience stress and emotional difficulties during their studies.

4. Emotional Intelligence and the Appearance of Disruptive Behaviour

Students with low levels of emotional intelligence show greater levels of impulsiveness and poorer interpersonal and social skills, all of which encourage the development of various antisocial behaviour. Research evidences abound that people with lower emotional intelligence are more involved in self-destructive behaviour such as tobacco consumption. (Trinidad, Unger, Chou, & Johnson, 2005). Adolescents with a greater ability to manage their emotions are able to cope better in their daily life, facilitating psychological adjustment. Hence, they present a less risk for substance abuse.

Emotional intelligence is postulated to promote positive social functioning by helping individuals to detect others’ emotion states, adopt others’ perspectives, enhance communication, and regulate behavior. Indeed, people with higher Mayer–Salovey–Caruso Emotional Intelligence Test (MSCEIT) scores tend to be socially competent, to have better quality relationships, and to be viewed as more interpersonally sensitive than those with lower MSCEIT scores (Brackett, Warner, & Bosco, 2005; Brackett et al., 2006; Lopes, Salovey, Cote, & Beers, 2005; Lopes et al., 2003, 2004).

Rivers, Brackett, Reyes, Mayer, Caruso and Salovey, (2012) conducted an initial validity test of the Mayer–Salovey–Caruso Emotional Intelligence Test – Youth Version (MSCEIT-YV) using student and teacher reports of academic, social, and personal functioning on the Behavior Assessment System for Children (BASC;
Reynolds & Kamphaus, 1992). Students scoring higher on the MSCEIT were less likely to be rated by their teachers as having externalizing problems (e.g., hyperactivity, aggression, conduct problems), internalizing problems (e.g., anxiety, depression), and school problems. According to Liau et al (2003) the lack of a balanced development of emotional intelligence in children could be associated with a variety of internalizing and externalizing problem behaviours. In a study with 54 adolescents recruited from both psychiatric clinics and the community, MSCEIT scores were shown to moderate the association between sexual abuse and both suicidal ideation and attempts (Cha & Nock, 2009). It may be that emotional intelligence is a protective factor for serious psychological problems among adolescents.

Among teenagers, those lower in emotional intelligence were rated in one study as more aggressive than others and tended to engage in more conflictual behavior than their counterparts who scored higher in emotional intelligence (Mayer, Perkins, Caruso, & Salovey, 2001a; Rubin, 1999). Middle school students’ MSCEIT-YV scores were correlated positively with teacher ratings of adaptive skills including social skills and leadership ability. Emotional intelligence scores correlated with student self-reports of the same outcomes. Finally, MSCEIT-YV scores correlated positively with student reports of having healthy social relationships, high self-reliance, and better-quality relationships with their parents (Rivers et al., 2012).

As foreshadowed, assessment of adolescent emotional intelligence may be able to offer a window to predicting, understanding, and attenuating problem behaviours (Petrides et al., 2004). Levels of emotional intelligence have previously been found to be associated with subjective well-being (e.g. Austin, Saklofske, &
Mastoras, 2010; Schutte et al., 2010), and conversely, levels of emotional intelligence have been successfully used to predict psychological maladjustment. For instance, recent research exploring the relationship between emotional intelligence and psychological adjustment found that emotional intelligence uniquely predicted levels of anxiety and depression (Downey et al., 2008), and has been found to be associated with better psychological adjustment independent of the effects of self-esteem or thought suppression (Fernandez-Berrocal, Alcaide, Extremera, & Pizzarro, 2006). Emotional intelligence has been conceptualized as a set of abilities concerned with the regulation, management, control and use of emotions in decision-making (Mayer, Caruso, & Salovey, 2000), particularly in relation to the promotion of healthy and adaptive mental functioning.

Having briefly examined the issue of emotional intelligence and various researches, it seems obvious that emotional intelligence has a large implication especially in ensuring the adolescents’ ability to compete in their life and self development.

**Coping Style**

The transition through adolescence demands the development of a strong repertoire of coping strategies. Compas, Conner-Smith, Saltzman, & Wadsworth (2001) defined coping as, “an important aspect of the more general processes of self-regulation of emotion, cognition, behavior, physiology, and the environment”. Coping strategies are mediators of stress that may aid or inhibit positive adolescent adaptation (Compas et al., 2001).

The coping process is defined as, “cognitive and behavioral efforts to manage specific external and or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus & Folkman, 1984). According to
Lazarus and Folkman (1984), types of coping can be grouped into two categories: emotion focused and problem focused. Emotion-focused coping entails efforts to regulate emotional distress, including avoidance, while problem-focused coping directs attention toward the problem and looks for ways of solving it. The type of coping chosen depends partly on an individual’s appraisal of the situation’s amenability to change.

Coping strategies refer to the specific efforts, both behavioral and psychological, that people employ to master, tolerate, reduce, or minimize stressful events (Aldwin & Revenson, 1987). Research indicates that people use both (emotion-focused & problem-focused) types of strategies to combat most stressful events (Aldwin & Revenson, 1987). The predominance of one type of coping strategy over another is determined by personal style and by the type of the stressful event. Other distinction in coping strategies is between active and avoidant coping strategies. Active coping strategies are either behavioral or psychological responses designed to change the nature of the stressor itself or how one thinks about it, whereas avoidant coping strategies lead people into activities (such as alcohol use) or mental states (such as withdrawal) that keep them from directly addressing stressful events (Carver, Scheier & Weintrauma, 1989). Active coping strategies (behavioral or emotional) are better ways to deal with stressful events than the avoidant coping strategies. Avoidant coping strategies are a psychological risk factor or marker for adverse responses to stressful life events. Tyler (1978) argued that coping behaviour was an important component of psychosocial competence, when an adolescent is able to balance and manage the developmental task of this stage of the life cycle. Valliant (1977) argued that the coping style which emerges from these efforts during adolescence has long-term
consequences in that it shapes the coping style of adulthood. Coping resources during adolescence include those aspects of the self (e.g., the availability of supportive social network) that facilitate or make possible successful adaptation to life stress (Compass, 1987). Adolescence is a critical phase in the development of coping skills because adolescents may encounter more negative events from peers, school, family and individual psychological and physical changes which are associated with increased risk of behaviour/emotional problems (Goodyer, Kolvin, & Gatzanis, 1985; Larson & Ham, 1993; Williamson, Birmaher, Anderson, Al-Shabbout, & Ryan, 1995; & Liu, Kurita, Uchiyama, Okawa, Liu, & Ma, 2000). Adequate coping during adolescence predicts good future outcomes, including higher levels of ego development, fewer behaviour problems, higher self-esteem, lower levels of depressive symptoms, positive adjustment (Mullis & Chapman, 2000; Printz, Shermis & Webb, 1999; Recklitis & Noam, 1999; Seiffge-krenke & Klessinger, 2000). Evidence shows that well-adjusted adolescents use more mature coping strategies than those who are poorly adjusted (Tolor & Fehon, 1987).

One way that adolescents successfully navigate the transition period from childhood to adulthood is by developing positive and effective coping strategies to handle day to day stress.

**Perceived Social Support**

Social support refers to the fulfillment of specific needs that arise as a result of daily life events or changes of events. Social support is defined as, “the existence or availability of people on whom we can relay people who let us know that they care about, value and love us” (Sarason, Levine, Basham & Sarason, 1983).

Perceived support represents the subjective perceptions of the extent to which social network members are available to provide social support (Cohen &
McKay, 1984) and represents the cognitive component of social support. In contrast, received social support can be viewed as the behavioural component of social support, as it requires activation in particular, interpersonal transactions (Dunkel-Schetter & Bennett, 1990). Received social support has been shown to be less reliable in buffering against the adverse effects of life stress on psychological health (Cohen & Wills, 1985) and less predictive of health and well-being (Kessler & McLeod, 1985; Turner, 1992; & Vaux, 1988).

Regardless of the level of stress in the adolescent’s life, social support sources positively affect the individual’s adaptation in a positive way (Cohen & Wills, 1985). Contemporary research on the topic indicates that an individual’s academic success (Yıldırım & Ergene, 2003), problem-solving abilities (Budak, 1999; Unuvar, 2003), social accomplishment level (Altunbas, 2002), decision-making abilities (Gucray, 1998), life satisfaction level (Duru, 2007), and self-esteem (Esenay, 2002; Kahrıman, 2002; Unuvar, 2003) are positively affected by an increased social support system. Research has shown that social support has both direct and indirect (i.e., stress buffering) effects on psychological functioning. There is a positive relationship between perceived social support and psychological wellbeing. Deficits in social support are likely to be related to maladaptive behaviours and poor adjustment (Cauce, Felner & Primavera, 1982; Licitra-Kleckler & Wass, 1993). Adolescents with a history of depression report receiving less support from friends (Mash & Wolfe, 2005).

Social support functions as a buffer or protection when stress arises. Important in this view is the idea that to be helpful, support that is provided must be appropriate to the needs the stress creates. According to this view, individuals experiencing high levels of stress should display relatively low levels of
psychological difficulties and physical symptoms if they have good support (Sarason & Sarason, 2009). An alternative perspective focuses on the availability of support regardless of the particular set of circumstances. From this perspective, social support resembles a component of personality that influences multiple facets of a person's life and how it develops. Bowlby's (1982) attachment theory expresses a similar idea in its concern with the role of social ties in personal development. Bowlby (1982) defined attachment as an interpersonal bond that has important developmental implications. According to this theory, the child seeks proximity to the mother when stress arises, but her contribution goes far beyond providing a stress buffer for the child. Attachment protects the child, but also contributes to a cognitive and behavioral repertoire of skills and outcome expectations. Secure attachment provides an environment for personal growth, including curiosity, learning to take reasonable risks in solving problems and the ability to take initiatives. With secure attachment, the child acquires skills that facilitate coping and avoids stressors that will otherwise be overwhelming. The theory emphasizes the individual differences in the capacity to form and benefit from social attachments. Perceptions of support reduce fear of failure and anticipations of danger because of the availability of caring providers. Consequently, they free the individual to attend to the realities of situations, and explore alternatives.

Hence, considering the previous researches it is imperative to study the social support of boys who are in need of care and protection.

**Behavior Problems**

Behavior problems arise due to the inability to behave appropriately according to the situation. All types of behavior problems can be defined in two terms namely behavioral deficits (too little behavior of a particular type) or
behavioral excesses (too much behavior of a particular type) (Martin & Pear, 1996). Problem behavior is the behavior that is socially defined as a problem, as a source of concern, or as undesirable by the social and/or legal norms of conventional society and its institutions of authority; it is behavior that usually elicits some form of social control response, whether minimal, such as a statement of disapproval, or extreme, such as incarceration (Jessor, Graves, Hanson & Jessor, 1968; Jessor & Jessor, 1977; Jessor, Donovan, Jessor & Costa, 1991).

Achenbach (1966), one of the pioneers in research on behavior problems took the initiative to determine whether children’s problems developed different patterns than those implied by the only two diagnostic categories for childhood disorders provided by the psychiatric nosology of that time (DSM – I; American Psychiatric Association, 1952). These two categories were adjustment reaction of childhood and schizophrenic reaction, childhood type. By factor analyzing problems reported by child psychiatric case records, Achenbach (1966) found many more syndromes than were implied by the two DSM – I categories. The term “syndrome” is used to designate empirically identified patterns without assumptions about the etiologies being biological, environmental or a mixture of both. In addition to numerous syndromes, the factor analysis identified two broad groupings of which Achenbach (1966) coined the terms “Internalizing” and “Externalizing”. Internalizing problems are those that are primarily within the self and externalizing problems are those that primarily involve and connect with people and social moves. Internalizing and externalizing expressions of dysfunction have both behavioral and affective components, as well as cognitive features (Cicchetti & Toth, 1991; Garber, Quiggle, Panak, & Dodge, 1991; Serbin, Schwartzman, Moskowitz, & Ledingham, 1991). Externalizing problems are characterized by behaviors that are harmful and
disruptive to others primarily (externally oriented such as conduct problems), whereas internalizing problems such as withdrawal and anxiety are seen as behaviors that are geared primarily towards the self (internally oriented such as emotional problems). Researchers reported that internalizing behaviors are associated with four kinds of problems: behavioral (they are passive, indecisive, and helpless), emotional (sadness), somatic (food consumption and sleep dysfunctions) and cognitive (thinking life is worthless) (Seligman, Reivich, Jaycox & Gillham, 1995). Developmental theory and research have focused on externalizing behavior problems in terms of four patterns: oppositional behaviors, oppositional/aggressive behaviors, hyperactive/ inattentive behaviors and a combination of hyperactive/inattentive and oppositional/aggressive behaviors (Stormshak, Bierman, & The Conduct Problems Research Group, 1998).

**Internalizing Problems**

Internalizing behavior problems are characterized by feelings of self consciousness, anxiety, worries, unhappiness, withdrawal, shyness, and somatic complaints (Achenbach, 1991; Quay & LaGreca, 1986; Rutter, Tizard, & Whitmore, 1970). Internalizing behavior problems are also defined by core disturbances in self-harming emotions and moods such as sorrow, guilt, fear, and worry (Zahn-Waxler, Klimes-Doughan, & Slattery, 2000). While some amount of anxiety, fear and anger are considered as naturally occurring phenomena, excessively high levels of anxiety can be detrimental (Reed, Carter, & Miller, 1992). Both anxiety and depression are seen as part of a larger, more general category of what is called neuroticism, general psychological distress, or internalizing syndrome. Internalizing problems are often associated with peer relational difficulties and loneliness (Fordham & Stevenson-Hinde, 1999; Rubin, LeMare & Lollis, 1990) and low self-perceived academic
competence (Weiss, Susser, & Catron, 1998). Children with anxiety disorder have reported more negative social expectations and lower self-competence than controls, to have a poorer social functioning, to receive less support from classmates, and to remain less accepted (Chansky & Kendall, 1997; LaGreca & Lopez, 1998).

**Externalizing Problems**

Externalizing behavior problems are of major concern to both education and mental health professionals. Such problems comprise most common referrals for children and adolescents to mental health services (Kazdin, 1987). Externalizing behavior problems are characterized as feelings of outbursts of anger, hitting and kicking, impulsive behaviors, hostile defiance, anti-social, destructive behavior, and over-activity, or arguing and teasing, social exclusion or harming peer’s reputation by spreading rumors which are also described as confrontative and non-confrontative types (Cairns & Cairns, 1994; Willoughby, Kupersmidt, & Bryant, 2001). The prevalence rates of externalizing behavior difficulties (defined as disruptive and behaviorally troublesome) range between 12-16% (Broidy, et al., 2003; Shaw, Gilliom, Ingoldsby, & Nagin, 2003; Petras et al., 2004). In some of the above studies 4-12% of the boys were identified as having chronic aggressive behaviors.

These disruptive behaviors influence relationships with parents, teachers, peers, and others in the children’s environment. These behaviors are also known to be associated with low school achievement and poor self-esteem. Even more alarming is the real possibility that children with one kind of externalizing problem are at high risk for developing other kinds of externalizing problems as well (Bird, Gould, & Staghezza, 1993). Childhood aggressive behavior is widely recognized as a precursor for antisocial behaviors, delinquent, and drug use in adolescence and
adulthood. Externalizing problems have been associated with school failure, adult unemployment and criminality, especially in boys with high levels of early aggressiveness (Campbell, Pierce, March, Ewing, & Szumowski, 1994; Krohn, Thornberry, Rivera, & LeBlanc, 2001; Kokko & Pulkkinen, 2000; Kupersmidt & Coie, 1990; Hymel, Rubin, Rowden, & LeMare, 1990; Overbeek, Vollebergh, Meeus, Engels, & Luijpers, 2001; Stattin & Magnusson, 1989).

After understanding the vital role of self-esteem, emotional intelligence, coping style and perceived social support to deal with everyday life demands, it was felt these variables need to be enhanced among boys who are in need of care and protection. Also behaviour problems were the major hindrance for the adolescents’ smooth transition to successful adulthood. Hence, behaviour problems of these boys have to be reduced with the help of appropriate intervention.

Life Skills

Origin and Development of the Concept of Life Skills

Life skills is in existence from the period when man started living on the earth, but Life Skills Education as a concept started emerging only during recent years. Life skills education became imperative due to the paradigm shift on the focus of education from the ancient work-related learning approach to the more theoretical oriented overall development approach. Educational initiatives over the last three decades have also contributed significant insight to the educationalist about the applicability of the curriculum experience in real life situations and the employability part of it. The adolescent group in general had many physical and psychological queries that were normally not answered by the curriculum content. United Nations agencies then started focusing on the health aspects of the adolescents through life skills approach. It worked well to expose and settle the
problems of many health related issues of the target group. The limitation of this approach was that they could reach only to a very small group of the population and the activities were restricted to health related issues only. During the period there was a general feeling that the kind of education that is being imparted in schools worldwide has failed to meet the expectations of the people. It did not equip girls and boys to meet real life challenges. This feeling promoted the concept of a generalized approach to life skill to improve the overall development of children and adolescents. The life skills training was first developed in the late 1970s by Dr. Gilbert J. Botvin to prevent alcohol, tobacco, drug abuse and violence.

Definitions of Life Skills

There are many different interpretations of life skills but no definition is universally accepted. Different organizations attach different meanings to the term based on their applicability. Some of the definitions given by different organizations and persons are presented below.

- The World Health Organization (1997) has defined life skills as, “the abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life”.
- United Nations Children’s Fund (UNICEF) (1997) defined life skills as, “a behaviour change or behaviour development approach designed to address a balance of three areas: Knowledge, attitude and skills”.
- “Living skills refers to the personal competence that enables a person to deal effectively with the demands and challenges confronted in everyday life” (Yarham, Kak , et al.,1999).
- The international Bureau of Education (IBE) derived its understanding from the Delors’ ‘Four Pillars of Learning’ (learning to know, learning to do,
learning to be and learning to live together) and defined life skills as “personal management and social skills that are necessary for adequate functioning on an independent basis”.

- Rychen and Salganik (2001) defined life skills on three general criteria, a) they are the key competencies that contribute to an overall successful life and a well-functioning society, b) they are instrumental to meet important challenges in a wide spectrum of relevant context, and finally, c) they are relevant to all individuals.

The term life skills and life skills training has been defined and developed by different organizations with different objectives. For example, to prevent substance abuse (alcohol, tobacco and other psychoactive substances) (Perry & Kelder, 1992), bullying, to prevent adolescent pregnancy, HIV/AIDS, violence, child abuse, suicide etc., (UNICEF, 1997 & WHO, 1997). Based on its purpose various life skills have been identified by different organizations. Hence, WHO organized an Inter-Agency Meeting at Geneva during the year 1998. The purpose of the meeting was to bring together the United Nations Agencies that are working to support the advancement of life skills education. It was an opportunity for different organizations to clarify and agree upon a common conceptual basis for support from the United Nations systems to facilitate the development of life skills education in schools. The meeting aimed to generate consensus as to the broad definition and objectives of life skills education and strategies for its implementation and improve collaboration between the various agencies working to support life skills education in schools.

In the meeting, the term “Life Skills” was open to wide interpretation. However, there was a consensus that all participants were using the term to refer to psychosocial skills. Keywords used to describe psychosocial skills were personal,
social, interpersonal, cognitive and affective. The following list of descriptive words and phrases was generated during a brainstorming session to identify life skills such as dealing with conflict that cannot be resolved, dealing with authority, solving problems, making and keeping friends/relationships, cooperation, self-awareness, creative thinking, decision-making, critical thinking, dealing with stress, negotiation, clarification of values, resisting pressure, coping with disappointment, planning ahead, empathy, dealing with emotions, assertiveness, active listening, respect, tolerance, trust, sharing, sympathy, compassion, sociability, self-esteem. Several items in this list occasioned debate as to what were and what were not life skills. The promotion of self-esteem, for example, is clearly an important goal for life skills education, but is it a skill? Not all the items listed during the brainstorming were life skills: for example, self-esteem, sociability, sharing, compassion, respect and tolerance were all desirable qualities, but, it could be argued, were not skills. Skills are abilities. Hence it should be possible to practice life skills as abilities. Self-esteem, sociability and tolerance are not taught as abilities: rather, learning such qualities is facilitated by learning and practicing life skills, such as self-awareness, problem-solving, critical thinking, and interpersonal skills.

Life skills training was defined by WHO (1997) as “an education that is designed to facilitate the practice and reinforcement of psychosocial skills in a culturally and developmentally appropriate way; it contributes to the promotion of personal and social development, the protection of human rights, and the prevention of health and social problems”. The core set of skills that follow the above description are: Self-awareness, Empathy, Decision-making, Problem solving, Creative thinking, Critical thinking, Effective communication, Interpersonal
relationship, Coping with emotions and Coping with stress. These ten life skills are described below.

**Self-awareness**

Self-awareness is a probe into one’s own self, in relation to the surrounding in which he lives. It is an unbiased assessment about ones character, capacity, capability, competency, desires and dislikes. Developing self-awareness can help us to recognize when we are stressed or feel under pressure. It is also often a prerequisite for effective communication and interpersonal relations, as well as for developing empathy for others.

**Empathy**

Empathy is the ability to imagine what life is like for another person, even in a situation that we may not be familiar with. Empathy can help us to understand and accept others who may be very different from ourselves, which can improve interpersonal relationships. Empathy is defined by Campbell and Schalekamp (2001) as the ability to understand another’s feeling. It means to put oneself in another person’s shoes, so to speak – to feel what the person feels, to understand with ones heart. Empathy requires abilities like understanding another person’s point of view, accurately identifying another’s emotions, expressing an appropriate emotion in response and to act and communicate on this internal experience. A prerequisite for empathy is self-awareness, recognizing and dealing with one’s own emotions. One cannot understand the feelings of others, if one does not understand one’s own

**Decision Making**

Decision making is our ability to choose the best alternative solution to a problem from the alternative options, with due consideration of the consequences of different decisions. While decision making, we may be trying to maximize our
expected gain by minimizing the possible loss. It helps us to deal constructively with decisions about our lives. This can have consequences on health if young people actively make decisions about their actions in relation to health by assessing the different options, and what effects different decisions may have.

**Problem Solving**

A problem arises when there is a controversy between two needs. Problem solving is a way to get one's need accomplished without using anger, intimidation, insubordination, aggressive behaviour or force. This skill enables us to deal constructively with problems in our lives.

**Creative Thinking**

Creativity is the ability to produce work that is both novel (original and unexpected) and appropriate (useful or meets task constraints). Creativity is a unique way of thinking, which bases on the insight we have in a particular area. Creativity is the ability to generate new ideas by combining, changing, or reapplying existing ideas. It contributes to both decision making and problem solving by enabling us to explore the available alternatives and various consequences of our actions or non-action. It helps us to look beyond our direct experience, and even if no problem is identified, or no decision is to be made, creative thinking can help us to respond adaptively and with flexibility to the situations of our daily lives.

**Critical Thinking**

Critical thinking is an evaluative thinking. Critical thinking is making objective judgments about choices and risks. It is the ability to analyse facts, issues and experiences rationally based on the positive and negative aspects in an independent way. Critical thinking goes beyond subject matter and analyses clarity, credibility, accuracy, precision, relevance, depth, breadth, logic, significance and
fairness. Critical thinking can contribute to health by helping us to recognize and assess the factors that influence attitudes and behaviour, such as values, peer pressure, and the media.

Effective Communication

Communication is the process by which information and understanding transfer from one person to another. Communication becomes effective only when we give some message and the other party receives and understands it. Communication is a dynamic and ongoing process, which interacts and leads to changes in behaviour and attitudes of individuals.

Interpersonal Relationship Skills

Interpersonal relation starts with interactions and interdependence that are the two pertinent and persistent features of social life. For interdependence, interaction is necessary. These interactions influence perception, motivation and self-concept and thereby accelerate the development of personality and leadership. Interpersonal skill is the skill to initiate and maintain a positive relationship with other individuals. It helps us to relate in positive ways with the people we interact with. This may mean being able to make and keep friendly relationships, which can be of great importance to our mental and social well-being. It may mean keeping good relations with family members, which are an important source of social support.

Coping with Emotions

An emotion is a state of feeling that has physiological, situational and cognitive components and it energizes and directs behaviour. Emotions reflect through language, facial expressions, body movements and gestures. Coping with emotions involves recognizing emotions in ourselves and others, being aware of
how emotions influence behaviour, and being able to respond to emotions appropriately. Intense emotions, like anger or sorrow can have negative effects on our health if we do not react appropriately.

**Coping with Stress**

Stress is a dynamic condition of physical or mental strain or disturbances that produce changes in the body and behaviour of the person. When an individual confronts an opportunity, constraint or demand of which the perceived outcome is both uncertain and important, it produces a mental strain and changes in the body and behaviour. The source that disturbs and causes the mental strain is a stressor. Coping with stress is about recognizing the sources of stress in our lives, recognizing how this affects us, and acting in ways that help to control our levels of stress. This may mean that we take action to reduce the sources of stress, for example, by making changes to our physical environment or lifestyle. Or it may mean learning how to relax, so that tensions created by unavoidable stress do not give rise to health problems.

Orley (1997) advocates learning life skills as it is a desirable activity on its own, helps individuals to deal effectively with everyday demands and does not have to be justified as preventing anything. Nor is it necessary to introduce a life skills education programme only when and where there are mental and behaviour disorders (WHO, 1999). Effective acquisition and application of life skills can influence the way we feel about ourselves and others, and will equally influence the way we are perceived by others. Life skills contribute to our perceptions of self-efficacy, self-confidence and self-esteem. Life skills therefore play an important role in the promotion of mental well-being of adolescents. The promotion of mental
well-being contributes to our motivation to look after ourselves and others, prevents mental disorders, and also health and behaviour problems (WHO, 1997).

Applying these core skills is crucial for the overall development of any adolescent. In particular, acquiring life skills are imperative for the boys who are staying at children’s home as they have more demanding situations and emotional problems compared to boys who are living with their parents, which necessitates more coping skills.

**Need for the Study**

Studies conducted in various countries among the boys who are in need of care and protection consistently reported that, these children were having emotional and behaviour problems. Particularly in India, very few studies have been conducted among these children. These studies indicated that children living in children’s homes had emotional and behaviour problems ((Deepa, 1993; Ross, 1996; Priscilla 1998 & Hiremath. Hunshal & Gaonkar, 2008). These published and unpublished studies have not included any survey to understand the nature and extent of behaviour problems of children staying in children’s homes. A true diagnosis is the half cure. Hence, knowing the nature and severity of the emotional and behaviour problems of these children could help the people to work with these children to reduce their emotional and behaviour problems. Further, the present study concentrated only on boys due to the following reasons: First, problems faced by boys and girls are found to be different. Due to this, boys need to be studied separately. Studies have also reported that boys found to have more externalizing behaviour problems such as aggression, rule breaking behaviour, delinquency and bulling compared to girls (Campbell, 1991; Maccoby, 1998; Keller, Wetherbee, Le Prohn, Payne, Sim, & Lamont, 2001; Rosenthal & Curiel, 2006; Tarren-Sweeney,
Further, boys’ externalizing behaviour problems not only affect their own development (e.g. interpersonal relationship problems, unable to get into job etc.,) but also affect girls (e.g. sexual abuse, domestic violence etc.,) as well as the whole society (e.g. violence, crime etc.,), directly or indirectly. Second, the delinquency cases filed under Indian Penal Code (IPC) during the year 2001 to 2010 indicates that the delinquency rate has been increasing every year in India. In particular, the highest number of juvenile delinquents were reported in Tamil Nadu under Special and Local Laws (SLL) which accounted for 21.5% of juvenile crimes under SLL in India. In addition, it was reported that the ratio of girls versus boys was 1:11. This indicates that more number of boys were arrested for juvenile crime (National Crime Records Bureau, 2011). Thirdly and most importantly, there is a dearth of research among boys, while more research has been conducted among girls (Deepa, 1993; Ross, 1996 & Priscilla, 1998). Hence, it was felt that the need of the hour in the current scenario was to understand the nature of the boys’ problems and cater to their needs.

Considering the dearth of research studies in India, the present study made an attempt to understand the extent of behaviour problems by conducting a survey among boys from various children’s homes in Chennai city.

Knowing the nature and severity of the behaviour problems of these boys is imperative to choose an appropriate intervention for them. In order to reduce the behaviour problems of these children a few intervention studies have been conducted. A study was conducted to find out the effect of self-concept training on self-concept among orthopedically handicapped, institutionalized destitute and normal adolescents. The study also seen the difference in self-concept between the groups and found out that institutionalized destitute adolescents had poor self-
concept compared to orthopedically handicapped and normal adolescents. Further, the study also reported that self-concept training had improved the self-concept of these adolescents (Deepa, 1993). Similarly, Ross (1996) conducted a study to identify the factors contributing to various dimensions of anger and also to determine the efficacy of the psychological intervention on the management of anger of institutionalized female juveniles. The study found out that onset of puberty, academic performance, negative feelings, physical illness of the juveniles, and tensions in the family contribute to various dimensions of anger. The study also found that anger management intervention was effective in the management of anger of institutionalized female juveniles. Likewise, Priscilla (1998) also found that self-esteem training was effective in enhancing self-esteem, academic performance and reducing adjustment and behaviour problems among neglected institutionalized adolescent girls. The above Indian studies stated different terminologies such as, institutionalized destitute adolescents, institutionalized female juveniles and neglected institutionalized adolescent girls to denote the populations studied. However, at present all of them are covered under the Juvenile Justice (Care and Protection of Children) amended Act, 2006.

All the above three studies made an attempt to reduce the emotional and psychological problems of these children by giving intervention, focusing on any one aspect of the life skill intervention such as self-concept, anger management and self-esteem. According to WHO (1997), the life skill intervention includes ten components such as self-awareness, empathy, interpersonal relationship, effective communication, decision-making, problem solving, creative thinking, critical thinking, coping with emotions and coping with stress, which need to be addressed comprehensively for the overall development of an adolescent. Keeping this in
mind, the present study has chosen eight life skills such as self-awareness, empathy, interpersonal relationship, effective communication, decision-making, problem solving, coping with emotions and coping with stress which are felt relevant to the boys who are in need of care and protection to reduce their behaviour problems. Hence, the present study also aimed at providing life skills intervention and finding out the impact on self-esteem, emotional intelligence, coping style, perceived social support, and behaviour problems of boys in need of care and protection.

Previous studies related to the present study are reviewed and presented in the next chapter.