CHAPTER I
INTRODUCTION

“If you think about disaster, you will get it.
If you brood about death, you hasten your demise.
Think positively with confidence and faith;
Life becomes more secure and
Richer in achievement and experience”
- Swami Vivekananda

Adolescence itself is a cultural construct that varies across settings and contexts. In terms of the future health status of countries and regions, however, the period of adolescence can generally be considered the “gateway” and the period of youth the “pathway” to adult health. Attention must be paid to the health of adolescent and youth populations irrespective of their size, yet adolescents (10 to 19 year old) remain largely invisible and youth (15 to 24 year old) often disappear from the data screens because of inappropriate or convenience clustering. Even in the referential Global Burden of Disease Survey, data on key conditions are aggregated in a cohort comprising 15 to 29 year old. National demographic and health surveys, however, are now (more often than previously) structured to pinpoint young people. In many countries, including India and Senegal, up to a third of the population are between the ages of 10 and 24. In other countries, such as France, the demographic pyramid long ago evolved into a cylinder, with fewer young people supporting an ageing population; this phenomenon is becoming more prevalent in emerging economies such as the Republic of Korea. Some transitional economies, in particular the Russian Federation, are experiencing rapid drops in fertility even to below replacement levels but still have a sizeable youth population. National demographic patterns notwithstanding, youth represent a large global client base with evolving needs in the areas of health services, information and counselling, which has implications not only for the present but also in terms of future requirements for a reformed health sector. Within this context, youth constitute an important resource base for improving their own health and that of society, contributing to global development and intergenerational solidarity (United Nations, 2002).

Data on secondary school enrolment patterns are generally available and offer clear indications of variability within and between countries and regions. This is of some interest from a health perspective. Statistics showing either a slightly or much higher percentage of
Boys enrolled than girls often coincide with poorer indicators for the health status of young women. Where a higher percentage of girls are enrolled in secondary and tertiary education, there may be a concomitant increase in levels of substance use, violence and depression among young men.

Adolescence is the stage in a person’s life between childhood and adulthood. It is the period of human development during which a young person must move from dependency to independence and maturity. The young person moves from being part of a family group to being part of a peer group and to stand alone as an adult. It is multidimensional, involving a gradual transformation or metamorphosis of the person as a child into a new person as an adult. Adolescence involves a process, which extends over a significant period of a person’s life. However, there are individual differences, with some young people moving through adolescence much more quickly than others (Hurlock, 2005).

World Health Organization defines Adolescence as the period of life between 10-19 years, youth as between 15-24 years and young people as those between 10-24 years (Organização Mundial da Saúde, 2001). Adolescence poses many challenges as physiological, biological, psychological and social changes are confronted. Important processes of change need to occur within the young person if these challenges are to be confronted adaptively and with success. An adolescent’s inability to confront and deal with a developmental challenge successfully may result in unhelpful psychological, emotional and behavioural consequences. Adolescent development can be considered in terms of the following challenges, which inevitably occur namely, biological, cognitive, psychological, social, moral and spiritual.

**BIOLOGICAL CHALLENGES IN ADOLESCENCE**

Adolescence begins with the well-defined maturation event called puberty. Puberty refers to the biological event - the first menstruation in girls and the first ejaculation in boys. These events signal the beginning of a process of profound physical change. Although this is a normal maturation process, it can cause difficulties for an individual. This may particularly be the case where a young person is precocious in puberty or if puberty is significantly delayed. In these situations, the adolescent may experience an uncomfortable level of stress. Consequences may be lowering of self-esteem and self-concept, with the person feeling awkward and lacking self-confidence. The biological changes of adolescence result in physiological changes, sexual changes and emotional changes (Susman and Rogol, 2004).
PHYSIOLOGICAL CHANGES IN ADOLESCENCE

The significant physical change in adolescence is puberty, a period of rapid skeletal and sexual maturation that occurs in early adolescence. The young person grows in height, weight and strength, develops sexually and changes in appearance. Girls develop breasts, boys’ voices break, body hair grows and changes occur in sexual organs. They happen at different ages and at different rates for different young people.

In addition to menarche, a spurt in height and weight characterize pubertal change. This growth spurt occurs about 2 years earlier for girls than for boys. Today, the mean growth spurt is 9 years of age for girls and 11 years of age for boys. The peak of pubertal change occurs at an average age of 11½ for girls and 13½ for boys (Ge and Brody, 2002).

Hormonal changes lie at the core of pubertal development (Sarigiani and Petersen, 2000). The concentrations of certain hormones increase dramatically during puberty. Testosterone, an androgen, is associated in boys with the development of genitals, increase in height and voice change. Estradiol, an estrogen, is associated with girls in breasts, uterine and skeletal development. Developmental psychologists believe that hormonal changes occur for at least some of the emotional ups and downs of adolescence (Van, Matthys, Cohen, Thijssen and Engleland, 2000).

However, hormones alone are not responsible for adolescent’s behaviour. Social factors such as stress, getting bad grades and relationship problems also account for two to four times as much variance as hormonal factors for depression and anger in young girls. Stress, eating patterns, sexual activity and depression can either activate or suppress hormones (Guttmacher, 2000).

COGNITIVE CHANGES IN ADOLESCENCE

Adolescents undergo some significant cognitive changes. Adolescents enter a fourth, most advanced stage of cognitive development, which Piaget called the ‘Formal Operational Stage’, at about 11 to 15 years of age. It is characterized by thought that is abstract, idealistic and logical. The abstract quality of thought at the formal operational level is evident in the adolescent’s new problem solving ability. Another indication of the abstract quality of adolescent’s thought is their increased tendency to think about thought itself (Kuhn and Franklin, 2006).
Formal operational thought is also full of idealism and possibilities. Adolescents begin to engage in extended speculation about the qualities they desire in themselves and in others. In search of the ideal, adolescents’ thoughts may take fantasy flights into future possibilities. It is not unusual for adolescents to become impatient with these newfound ideals and become perplexed over, which of many ideal standards to adapt. At the same time, adolescents begin to think more abstractly and idealistically and they begin to think more logically about problems and possible solutions (Wertsch, 2000).

The thought is egocentric especially in early adolescence. Adolescent egocentrism involves certain beliefs that others are as preoccupied with the adolescent, as he or she is, unique and invincible. The aspect of adolescent egocentrism that can produce the greatest harm is a sense of invincibility, which may lead to race down a city street, to drug use, to suicide attempts or to sexually transmitted diseases or adolescent pregnancy. On a positive note, the adolescent’s sense of invincibility may also lead to courageous effort to save people’s life in hazardous circumstances, as when someone is drowning or is trapped in a burning car (Kuhn, 2000).

**SOCIOEMOTIONAL CHALLENGES IN ADOLESCENCE**

Many aspects of socioemotional development such as relationships with parents, interaction and friendships and cultural and ethnic values contribute to an adolescent’s identity development. Erickson’s theory categorizes the main concern of the fifth stage of socioemotional development as identity versus identity confusion. In seeking an identity, adolescents face the challenges of finding out who they are, what they are all about and where they are heading towards life. Adolescents are confronted with many new roles and adult statuses from the vocational to the romantic. Erickson argues that parents should allow adolescents to explore many different roles and parts within a particular role and not push an identity on them.

Erickson described adolescence as a moratorium, a temporal and psychological gap between the security of childhood and autonomy of adulthood. Adolescents who use the moratorium to explore alternatives can reach some resolution of their identity crisis and emerge with a new sense of self that is both refreshing and acceptable; those who do not successfully resolve the crisis become confused, suffering what Erickson called as ‘Identity Confusion’. This confusion is expressed in one of the two ways: either the individuals
withdraw, isolating themselves with peers or family or they may lose themselves in the crowd. One’s strength that equips them to effectively pursue their identities is that their thoughts have become more abstract and logical, as they are able to reason in increasingly sophisticated ways (Sinnott, 2003).

**MORAL AND SPIRITUAL CHALLENGES IN ADOLESCENCE**

Important to the processes of social development and the formation of a personal identity are issues relating to moral and spiritual development. No longer does the individual act merely out of fear or the need for approval. Instead, moral principles are integrated within and owned by the individual.

As adolescents seek to establish their personal identity, they attempt to find meaning in their lives. They look within themselves to examine their thoughts and feelings and to analyze them. This leads many young people to seek answers to questions of a spiritual nature. Conventional religious beliefs and participation in organized religious practices demonstrate aspects of spirituality. However, adolescent spirituality is often demonstrated in a more fundamental way through the adolescent’s search for meaning in life’s daily experiences (Brainerd, 2002).

**STRESS**

Stress is a biological term which refers to the consequences of the failure of a human or animal body to respond appropriately to emotional or physical threats to the organism, whether actual or imagined. It is "the autonomic response to environmental stimulus”. It includes a state of alarm and adrenaline production, short-term resistance as a coping mechanism and exhaustion. It refers to the inability of a human or animal body to respond (Voelker, 2004).

Sameroff, Seifer, Barocas, Zax and Greenspan (2001) have discussed the effects of different kinds of stress accumulated in adolescents. An adolescent may be able to handle one or two, but as the stresses and risks pile up, the probability that he/she will thrive intellectually, emotionally or socially declines steadily. Some children have problems like irritability, truancy, high anxiety, crying spells, sad mood, phobia, poor scholastic performance and other such academic problems.

According to the UNESCO Report 2008 by (U.N.D.P. REPORT, 2008) India stands at
- 102\textsuperscript{nd} position in the "Education for all developmental index out of 129 countries
- 132\textsuperscript{nd} place in the list of 172 Nations on Human Development Index (H.D.I)

Ten percent of 5-15 year olds have a diagnosable mental health disorder. This suggests that around 50 million children under eighteen would benefit from specialist services. There are upto 20 million adolescents with a severe mental health disorder. Around 90% of children with a mental health disorder are not currently receiving any specialist service. All the elements that play key role in a child development and mental health are in unattended state in India. This includes basic amenities, poor infrastructure and Human Resource Development along with essential Health and Hygiene Measures (Shastri, 2009).

Almost 20\% of all children and adolescents are affected by mental health problems and at least half of these show impaired schooling and social development (Sawyer, 2000).

Zubrick et al. (2007) found that among children and adolescents, problems such as Child Abuse and Neglect, Conduct Disorders, Alcohol and Drug Abuse, Depression, Attention Deficit Disorders and Suicide are all becoming more common. Furthermore, mental disorders (notably depression) are appearing at a younger age and they also seem to be increasing in severity. Children and adolescents with mental health problems are:

- Twice as likely to report feeling 'very stressed'
- Three times more likely to have poor or fair physical health
- Three times more likely to perform below grade level at school
- Three times more likely to use alcohol and other drugs
- Six times more likely to think about killing themselves

**PHYSICAL SYMPTOMS OF STRESS**

- Rapid Heart Rate
- Elevated Blood Pressure
- Nausea and/or Vomiting
- Chest Pain
- Difficulty Breathing
• Fainting
• Dizziness
• Tremor
• Increased Perspiration
• Headaches
• Muscle Twitching
• Thirst
• Weakness
• Fatigue
• Grinding Teeth
• Visual Difficulties
• Hearing Difficulties
• Nonspecific Body Complaints

COGNITIVE SYMPTOMS
• Poor Concentration
• Loss of Self-confidence
• Memory Impairment
• Increased or Decreased Awareness of One’s Surroundings
• Difficulty Making Decisions
• Poor Abstract Thinking
• Blaming Other Persons
• Difficulty Identifying Familiar Objects or People
• Loss of Time, Place or Person Orientation
• Racing Thoughts
• Disturbed Thinking
• Intrusive Images

EMOTIONAL SYMPTOMS
• Apprehension
• Uncertainty
• Fear
• Agitation
• Anxiety
• Severe Panic
• Anger
• Feeling Overwhelmed
• Irritability
• Hopelessness
• Emotional Shock
• Guilt
• Grief
• Depression
• Denial
• Inappropriate Emotional Response

**BEHAVIOURAL SYMPTOMS**

• Change in Activity Levels
• Sleep Disturbances
• Erratic Movements
• Change in Usual Style of Communication
• Loss of Interest in Previously Pleasurable Activities
• Change in Eating Habits
• Emotional Outbursts
• Antisocial Behaviour
• Inappropriate Use of Humour
• Suspiciousness
• Hyperarousal
• Substance Use (e.g., Caffeine, Nicotine or Alcohol Use)
• Deterioration in Performance Effectiveness
• Accident Proneness
• Nervous Mannerisms (e.g., Foot Tapping, Nail Biting, Teeth Grinding, Hair Pulling, Handwringing)
SOURCES OF STRESS

Both negative and positive stressors can lead to stress. Some common categories and examples of stressors include: sensory input such as pain, bright light or environmental issues such as a lack of control over environmental circumstances, such as food, housing, health, freedom or mobility. Social issues can also cause stress, such as struggles with non-specific or difficult individuals and social defeat or relationship conflict in deception or break ups and major events such as births and deaths, marriage and divorce. Life experiences such as poverty, unemployment, depression, obsessive/compulsive disorder, heavy drinking or insufficient sleep can also cause stress. Students may face stress from exams and group projects (Glavas and Weinberg, 2006).

Adverse experiences during development such as prenatal exposure to maternal stress, poor attachment histories and sexual abuse are thought to contribute to deficits in the maturity of an individual’s stress response systems (Davis, 2007).

RELATIONSHIP OF STRESS WITH PROBLEMS OF ADOLESCENCE

Children between 11 and 14 years of age are particularly sensitive to feedback from peers. They need to feel accepted by their peers and to believe that their feelings and fears are normal. They may experience “survival guilt” and their anxieties are frequently manifested as aggression, rebellion, withdrawal or attention-seeking behaviour, or as a decline in academic and social performance. Like younger children, they also exhibit regressive behaviours, develop irrational fears, experience sleep disturbances or have various somatic complaints which have no medical basis.

Adolescents 14 years of age and over tend to develop stress reactions that are similar to those manifested by adults. However, behaviours specific to younger children can resurface in adolescents due to their tendency, not unlike younger children, to use regression as a coping mechanism. Academic and social performance may decline and psychosomatic reactions are common. When adolescents are experiencing high levels of stress, males are more likely to externalize as evidenced by delinquent behaviour, while females are more likely to internalize as evidenced by features of depression. Some adolescents respond to stress by “growing up” too quickly and they may adopt lifestyles several years in advance of their age. Perhaps because of a combination of peer pressure and a need not to have to rely on parental support, adolescents often act out their distress in ways that are ultimately misguided and self-destructive. Typical patterns include isolation, substance use, sexual indiscretion,
violence, delinquency, running away and suicidal behaviour. Adolescents may also displace their rage onto unsuspecting and undeserving victims, such as teachers, other school personnel, peers and/or the wider community. In addition, adolescents tend to be very self-centered and exposure to stressful situations may intensify such self-reoccupation as well as destroy their self concept of omnipotence. This coupled with their readiness to blame themselves for the course of events may result in very poor self-esteem (Zubrick, Silburn, Barton and Blair 2000).

HEALTH RISK FACTORS

Both negative and positive stressors can lead to stress. The intensity and duration of stress changes depending on the circumstances and emotional condition of the person suffering from it. Some common categories and examples of stressors include:

- Sensory input such as pain, bright light, noise, temperatures or environmental issues such as a lack of control over environmental circumstances, such as food, air and/or water quality, housing, health, freedom, or mobility.

- Social issues can also cause stress, such as struggles with non-specific or difficult individuals and social defeat, or relationship conflict, deception, or break ups, and major events such as birth and deaths, marriage, and divorce.

- Life experiences such as poverty, unemployment, clinical depression, obsessive compulsive disorder, heavy drinking or insufficient sleep can also cause stress. Adolescents and workers may face performance pressure stress from exams and project deadlines.

- Adverse experiences during development (e.g. prenatal exposure to maternal stress, poor attachment histories, sexual abuse) are thought to contribute to deficits in the maturity of an individual’s stress response systems.

TECHNIQUES OF STRESS MANAGEMENT

There are several ways of coping with stress. Some techniques of time management may help a person to control stress. In the face of high demands, effective stress management involves learning to set limits and to say ‘No’ to some demands that others make. A destressitizer is any process by which an individual can get relief from stress. The following techniques have been recently called ‘Destressitizers’ by The Journal of the Canadian Medical Association (Spence, Barnett, Linden, Ramsden and Taenzer, 2000).
AUTOCOMMENIC TRAINING

Autogenic Training is a relaxation technique developed by the German Psychiatrist, Johannes Schultz and first published in 1932. This technique involves the daily practice of sessions that last around 15 minutes, usually in the morning, at lunch time and in the evening. During each session, the practitioner will repeat a set of visualizations that induce a state of relaxation. Each session can be practiced in a position chosen amongst a set of recommended postures (e.g. lying down or sitting). This technique can be used to alleviate many stress-induced psychosomatic disorders.

Autogenic Training restores the balance between the activity of the sympathetic (flight or fight) and the parasympathetic (rest and digest) branches of the autonomic nervous system. This has important health benefits, as the parasympathetic activity promotes digestion and bowel movements, lowers the blood pressure, slows the heart rate and promotes the functions of the immune system (Bird and Christine, 2002).

RELAXATION TRAINING

A relaxation technique is any method, process, procedure or activity that helps a person to relax; to attain a state of increased calmness or otherwise reduce levels of anxiety, stress or tension. Relaxation techniques are often employed as one element of a wider stress management programme and can decrease muscle tension, lower the blood pressure and heart rate, among other health benefits.

Movement-based relaxation methods incorporate exercises such as Walking, Gardening, Yoga, Tai Chi, Qigong and more. Some forms of bodywork are helpful in promoting a state of increased relaxation. Examples include Massage, Acupuncture, Reflexology and Self-regulation. Some relaxation methods can also be used during other activities such as, Autosuggestion and Prayer (Lehrer, Woolfolk, Sime and Barlow, 2007).

COGNITIVE THERAPY

Cognitive Therapy seeks to help the client to overcome difficulties by identifying and changing dysfunctional thinking, behaviour and emotional responses. This involves helping clients develop skills for modifying beliefs, identifying distorted thinking, relating to others in different ways and changing behaviours. Treatment is based on collaboration between client and therapist and on testing beliefs. Therapy may consist of testing the assumptions one
makes and identifying how one's thoughts are distorted, unrealistic and unhelpful. Once those thoughts have been challenged, one's feelings about the subject matter of those thoughts are more easily subjected to change. Beck developed a list of ‘errors’ in thinking that he proposed could maintain depression, including arbitrary inference, selective abstraction, overgeneralization and magnification of negatives and minimization of positives. These cognitive biases are quick to make negative, generalized and personal inferences of the self, thus fuelling the negative schema (Judith, 2008).

**PHYSICAL EXERCISE**

Physical exercise is any bodily activity that enhances or maintains physical fitness and overall health. It is performed for many different reasons. These include strengthening muscles and the cardiovascular system, honing athletic skills, weight loss or maintenance. Frequent and regular physical exercise boosts the immune system and helps to prevent the ‘diseases of affluence’ such as heart disease, cardiovascular disease, Type II diabetes and obesity. It also improves mental health and helps to prevent depression. Exercise also reduces levels of cortisol, thereby benefitting health. Cortisol is a stress hormone that builds fat in the abdominal region, making weight loss difficult. Cortisol causes many health problems, both physical and mental (Stampfer, Hu, Manson, Rimm and Willett, 2000).

**MEDITATION**

Meditation has been defined as, ‘self-regulation of attention, in the service of self-inquiry and in the here and now’. The various techniques of meditation can be classified according to their focus. Some focus on the field or background perception and experience, referred to by some as ‘Mindfulness’; others focus on a pre-selected specific object and are called ‘Concentrative’ meditation. There are also techniques that shift their focus between the field and the object.

In Mindfulness Meditation, the meditator sits comfortably and silently, centering attention by focusing awareness on an object or process (such as the breath; a sound like a mantra, visualization or an exercise). The meditator is usually encouraged to maintain an open focus.

Concentration Meditation is used in many religions and spiritual practices. In Mindfulness Meditation, there is an open focus and in Concentration Meditation, the
meditator holds attention on a particular object (e.g. a repetitive prayer), while minimizing distractions and bringing the mind back to concentrate on the chosen object (Craven, 2000).

DIAPHRAGMATIC BREATHING

Diaphragmatic breathing is the act of breathing deep into the lungs by flexing the diaphragm rather than breathing shallowly by flexing the rib cage. This deep breathing is marked by expansion of the stomach (abdomen) rather than the chest when breathing. It is generally considered a healthier and fuller way to ingest oxygen and is often used as a therapy for hyperventilation and anxiety disorders. Performing it can be therapeutic and with enough practice, can become one’s standard way of breathing (Williams, Smith and McGavin, 2001).

PROGRESSIVE MUSCLE RELAXATION

Progressive Muscle Relaxation (PMR) is a technique of stress management developed by American Physician, Edmund Jacobson in the early 1920’s. Jacobson argued that since muscular tension accompanies anxiety, one can reduce anxiety by learning how to relax the muscular tension. He trained his patients to voluntarily relax certain muscles in their body in order to reduce anxiety symptoms. He also found that the relaxation procedure is effective against ulcers, insomnia and hypertension.

Progressive Relaxation involves alternately tensing and relaxing the muscles. A person practising it may start by sitting or lying down in a comfortable position taking some deep breaths and then he or she will proceed to tense, then relax, groups of muscles in a prescribed sequence (one such sequence is starting with the hands and moving up to the arms, shoulders, neck and head and then down the torso and legs to the feet). The outcome of the tension-relaxation sequence is to cause deeper relaxation (Huang, Sousa, Tu and Hwang, 2005).

COGNITIVE RESTRUCTURING AND RATIONAL EMOTIVE THERAPY

Cognitive Restructuring was developed by Lazarus (1971) explains where faulty and irrational thoughts are replaced by more constructive or realistic ones. A widely known approach that focuses on Cognitive Restructuring is Rational Emotive Therapy (RET), which was developed by Ellis (1962), is based on the view that stress often arises from faulty or irrational ways of thinking. The procedures used in RET focus on several aspects or stages of the person’s thought processes, using Ellis A-B-C-D-E paradigm.
activating experience that creates the stress; B refers to the beliefs and thoughts that are the responses to the stress; C symbolizes the emotional and behavioural consequences of positive or negative coping behaviours; D refers to the disputing of irrational beliefs that go on in therapy and E stands for the effect of the therapy (Tolan, Gorman-Smith, Henry, Chung and Hunt, 2004).

**TIME MANAGEMENT**

An important approach for organizing one’s time is called ‘Time Management’. Time management refers to a range of skills, tools and techniques used to manage time when accomplishing specific tasks, projects and goals. This set encompasses a wide scope of activities like planning, allocating, setting goals, delegation, analysis of time spent, monitoring, organizing, scheduling and prioritizing. Initially, time management referred to just business or work activities, but eventually the term broadened to include personal activities also. A time management system is a designed combination of processes, tools and techniques.

Time management consists of three elements. The first element is to set goals which should be reasonable and obtainable. The second element involves making of lists indicating priorities, keeping the goals in mind. The third element is to set up a schedule for the day, allocating estimated time periods to each item in the list. If an urgent new task arises during the day, the list should be adjusted to include it (Sandberg, 2004).

**STRESS INOCULATION**

The goal of this treatment is to teach the patient a set of skills that will help them cope with stress. Examples include relaxation training, training in slow abdominal breathing, thought stopping of unwanted thoughts, assertiveness training, and training in positive thinking. Stress management is more effective than supportive psychotherapy, but given on its own less effective than trauma-focused treatments (Bisson, Ehlers, Matthews, 2007).

On the whole, it is important to bring about changes in diet, exercise, sleep, leisure and pacing the entire lifestyle in order to lead a stress-free life.

**BEHAVIOUR PROBLEMS OF ADOLESCENTS**

Behaviour problems of adolescents can be as serious a handicap to their development and learning as the mentally retarded children’s slowness to learn. The World Health
Organization estimates the prevalence of behaviour and emotional disorders among children and adolescents at 20%. Behaviour problems arise from external influences whose effects are not often noticed or understood by others. Often, emotional and psychological factors in apparently normal children are not readily seen or understood but are often labelled as depression, hostility, withdrawal or day dreaming to combat the stress. They may be battered and abused sexually, emotionally or physically (Halpern, 2004).

Teachers and parents are faced with the difficulty of dealing with the behaviour problems of their children. Behaviour problems often interfere with the learning process and are incompatible with their educational programme. The behaviours reflecting behaviour problems range from extreme withdrawal to intense hostile aggression. These adolescents, if not identified and helped during their school days would continue to have difficulties dealing with society and their problems may become progressively more serious later in life (Greenberger and Steinberg, 2000).

The period of adolescence is often marked by intense striving for independence and by rebellion directed at adult authority. Problems with parental and school supervision, drugs and alcohol misuse, truancy, theft and sexual misconduct are common at this age. Therefore, it is not surprising that adolescents with such problems are generally reported to be suspicious of adults (including the therapist), rebellious, defiant and resistant to treatment attempts (Costello, Compton, Keeler and Angold, 2003).

TYPES OF BEHAVIOUR PROBLEMS OF ADOLESCENTS

The widespread prevalence of problem behaviours during adolescence is troubling because these behaviours can have concurrent and long-term consequences for youth development, including Failure to Complete High School, Underemployment, Incarceration, Long-term Substance Abuse, Sexually Transmitted Infections (STI) and Unplanned Parenthood. While many youths navigate adolescence without negative consequences of problem behaviours, problem behaviours become chronic for others, increasing the likelihood of adversity in multiple domains including physical health, life expectancy, psychosocial adjustment and successful transition to adulthood. Indeed, adolescence is marked by greater involvement in problem behaviours than either earlier or later developmental periods and problem behaviours tend to co-occur in adolescence compared to earlier and later developmental periods. The developmental pattern of problem behaviours during adolescence
across multiple problem behaviours has led some to suggest that these various behaviours represent a syndrome of “problem behaviours” (Lindberg, Boggess and Williams, 2000).

The problems of the adolescents can be categorized as internalizing problems and externalizing problems. Internalizing problems occur when individuals turn their problems inward; for example, anxiety and depression. Externalizing problems occur when problems are turned outward such as delinquency (Sroufe, Egeland, Carlson and Collins, 2005).

CAUSES OF BEHAVIOUR PROBLEMS

There are several factors, which cause behaviour problems in adolescents. The important factors are explained below:

PERSONAL AND SOCIAL NEEDS

An adolescent’s need for attention, recognition, approval and belonging are just as real and compelling as its need for food and drink. An adolescent deprived of attention might resort to any activity, which may bring it to the limelight. Adolescent often does not know how to get social satisfaction properly. Besides social needs, the need for self-respect, the need for independence and importance as an individual might be expressed by an individual in several ways such as, in the form of disobedient talks, disorderly uncooperative talks, when he/she should be listening or pushes when he/she should be waiting for his/her turn. Adolescents who are notably above or below average in mental ability are apt to misbehave in order to help satisfy their social and personal needs because their desires are not otherwise being met (Benson, Scales, Hamilton and Sesma, 2006).

EFFECTS OF MATURATION

Regardless of what an individual's chronological or even mental age may be, he/she may be no more mature in self-control or human relations than an average individual who is some years his/her junior. Behaviour problems such as temper tantrums, negativism and attention-seeking are indicative of immaturity.

THE TEACHER AND CLASSROOM CONDITIONS

Some behaviour problems may be attributed to the teacher. It is improbable that any teacher consciously invites misconduct but many do so inadvertently. Teachers who are sarcastic or who humiliate their adolescents and those who are downright unfair to them, earn the animosity of the adolescents. The teacher's methodology as well as personality can
contribute to the incidence of behaviour problems. If the work of the class is boring, if the interest and attention of the adolescents cannot be held, if the lessons are not well planned, if every student is not given some worthwhile task to perform, if the teacher allows discussions to get out of hand and degenerate into a number of private conversations, the teacher is helping to set up the kind of environment in which disciplinary problems are likely to breed and flourish (Loukas and Prelow, 2004).

Another aspect to be considered is the physical dimension of the classroom itself, particularly the size of the room, the number of adolescents and the seating arrangements. The greater the number of adolescents in the class, lesser the opportunity to obtain the attention he/she needs. The more crowded the room, the greater is the opportunity and temptation for a student to misbehave. The crowdedness of a classroom might also, of course, have a bearing on the student's physical discomfort by necessitating restrictions on bodily movement, which are not conducive to normal classroom behaviour. Sub-groups within a classroom exert a considerable effect on individual’s behaviour (Compas, 2004).

SOCIAL AND CULTURAL CONDITIONS

Among the socio-cultural factors which have been found to contribute to the misbehaviour of children and youth are certain television shows, movies, comics and magazines in which they encounter violence, horror, sadism, disregard of principles of decency and morality. The behaviour problem of adolescents is often explained in terms of the unfavourable world conditions in which they live. Discrimination, persecution and inequality of opportunity on the basis of race, religion or nationality, may also contribute to the misbehaviour in young people (Masten and Reed, 2002).

HOME CONDITIONS

Inadequate maternal reactions and family trauma were strongly associated with behaviour problems. A good relationship between mother and adolescent plays an important role in preventing these problems, whereas inadequate maternal reactions and maternal psychiatric morbidity, such as depression, were identified as risk factors for behaviour problems in adolescents. Family traumas, problematic families, stressful events such as death of relatives have also been shown to be positively associated with behaviour problems by Nix, Pinderhughes, Dodge, Bates, Pettit and McFadyen (2000).
Various kinds of unsatisfactory home conditions are also the factors contributing to student's misbehaviour. For example, adolescents whose home have been broken by the death of a parent, divorce or separation or by the prolonged absence of both parents for business or social reasons probably lack the firm but loving parental guidance they need for satisfactory adjustment. Feeling rejected or dejected, they might attempt to compensate by resorting to different forms of behaviour. When parents and other adults in the home environment are rude to one another; when they fail to respect each other’s rights and dignity; when they speak ill of others, adolescents learn to disregard social or moral conventions (Kalff, Kroes and Vles, 2001).

Some adolescents have never had their share of attention and recognition, some have had too much in that, all their wishes have been catered to. Such adolescents become accustomed to the belief that the rest of the world exists to serve them. When such adolescents find themselves in a situation where they are not expected to perform tasks, which are not immediately enjoyable or to conform to needed regulations for the good of the group, they do not know how to act. Aggressive adolescents and adolescents with behaviour problems often come from homes in which their parents are inconsistent disciplinarians who use harsh and excessive punishment and who show little love or affection for their good behaviour (Olsson, Band, Burns, Brodrick and Sawyer, 2003).

**OCCASIONAL LAPSES**

In some instances, none of the factors that have been mentioned above might be applicable. The explanation of the misbehaviour might be the simple fact that adolescents were unaware of certain regulation or that they had forgotten it or that they did not think it would be enforced or that they were carried away in the excitement of a moment and did something that they know they should not have done (Ann, 2001).

**TRUANCY**

Truancy from school can mean one of the two things: either the student is escaping from an intolerable situation in which the school programme brings nothing but failure, shame, disgrace and ridicule from peers or the student is suffering from serious emotional conflicts. In either case, truancy is a symptom demanding immediate attention from a psychologist or a responsible adult.

**MANAGEMENT OF BEHAVIOUR PROBLEMS**
To deal effectively with behaviour problems, a teacher must understand the reasons for behaviour problems. These reasons are the attempts to satisfy personal or social needs, the teacher and classroom conditions and home, social and cultural conditions. Number of suggestion has been given for dealing with behaviour problems of adolescents. Teachers and parents should use positive rather than punitive methods for behaviour modification. Under certain conditions only punishment can be effective. In deciding which type of corrective measures to employ, the teacher and parent should take into account its problem effects on adolescent’s mental health and character formation, the effects on the morale and attitudes of other students. Corrective measures should also be suited to the individual student (Chang and Gjerde, 2000).

**BEHAVIOUR MODIFICATION TECHNIQUES**

Behaviour Modification Techniques are helpful for parents and teachers who wish to relate more effectively to adolescents and to assist them to grow in the healthiest way, both physically and mentally. Behaviour Modification involves Reinforcement, Punishment, Extinction, Shaping, Consistency and Observation (Barry, Dunlap, Cotton, Lochman and Wells, 2005).

**ACADEMIC PROBLEMS OF ADOLESCENTS**

Education is one of the most important aspects of Human Resource Development. Poor school performance not only results in the adolescent having a low self-esteem but also causes significant stress to the parents. There are many reasons for adolescents to underperform at school, such as, Medical Problems, Below Average Intelligence, Specific Learning Disability, Attention Deficit Hyperactivity Disorder, Emotional Problems, Poor Socio-cultural Home Environment, Psychiatric Disorders and even environmental causes (Karande and Kulkarni, 2005).

Schools play a crucial and formative role in the spheres of cognitive, language, emotional, social and moral development of a child. Academic skills such as reading, writing and mathematics form the foundations upon which a student’s performance at school is assessed. A learning problem may engender feelings of anxiety, inadequacy and shame, leading to behaviour disturbances in adolescents.

Any negative feedback from school is likely to have an impact on the emotional, social and family functioning of adolescent. Academic difficulties in children and adolescents
can accompany a wide range of psychosocial conditions related to the family, the environment, mood and behaviour problems and peer groups. The DSM-IV-TR refers to an academic problem as a problem that is not caused by a mental disorder or if caused by a mental disorder, is sufficiently severe to warrant clinical attention. Intervention is necessary because the adolescent’s achievement in school is significantly impaired (Parke and Buriel, 2006).

Success at school enhances adolescents’ self-esteem. Any difficulty will have consequential effects on the psychological health of the adolescents. The conditions now prevailing in the educational institutions force the teenager to submit to the methods of teaching and to the school system. School can reveal the student’s personal problems like anxiety, phobia or depression but may equally create pathology by not recognizing the heterogeneity of individual development and differences in cognitive functioning (Catheline, 2005).

CAUSES OF ACADEMIC PROBLEMS

Many psychological factors contribute to a adolescent’s confidence, competence and academic success. Subclinical states of anxiety or depression, family stressors such as divorce, marital discord, abuse or mental illness in a family member, may interrupt academic performance. School is the main social and educational venue for children and adolescents. Success and acceptance in the school setting depend on children’s physical, cognitive, social and emotional adjustment. Adolescents’ general coping mechanisms in many developmental tasks usually are reflected in their academic and social successes in school. Adolescents’ who are troubled by social isolation, identity issues and preoccupation with sexuality or extreme shyness may withdraw from full participation in academic activities. Students lose interest in studies due to the fear of failure, which is usually reinforced by parents and teachers (Pianta, 2005).

ANXIETY

Anxiety can play a major role in interfering with adolescent’s academic performances. It can hamper their abilities to perform well in tests, to speak in public and to ask questions when they do not understand something. Some children are so concerned about the way others view them that they cannot attend to their academic tasks. For some adolescents, conflicts about success and fears of the consequences imagined to accompany the attainment
of success can hamper academic success. Freud described persons with such conflicts as ‘those wrecked by success’ (Gould, Greenberg, Velting and Shaffer, 2003).

**DEPRESSION**

Depressed adolescents also may withdraw from academic pursuits; they require specific interventions to improve their academic performances and to treat their depression. Adolescents who do not have major depressive disorder but who are consumed by family problems, such as financial troubles, marital discord in their parents and mental illness in family members, may be distracted and unable to attend to academic tasks.

Adolescents who receive mixed messages from their parents about accepting criticism and redirection from their teachers can become confused and unable to perform well in school. The loss of the parents as the primary and predominant teachers in a adolescent’s life can result in identity conflicts for some adolescents. Some students lack a stable sense of self and cannot identify goals for themselves, a situation that leads to a sense of boredom or futility (Beckham, 2003).

**2ACADEMIC PRESSURE**

Academic pressure caused due to unfavourable negative attitude, prejudice and partiality of the teachers will adversely affect the academic achievement of the adolescents and lead to academic problems.

**PERSONAL FACTORS**

Lack of interest, low intelligence, low socio-economic status and family problems may also lead to academic poor performance of the adolescents.

**PEER INFLUENCE**

Influence of peers who has academic or behaviour problems may also affect adolescents resulting in poor academic achievement and academic problems.

**CULTURAL AND ECONOMIC BACKGROUND**

Cultural and economic background can play a role in the adolescent’s academic achievement. Familial socio-economic level, parental education, race, religion and family functioning can influence adolescent’s sense of fitting in and can affect the adolescent’s preparations to meet school demands.
Students may possess adequate study habits and high self-efficacy but may not use these skills if they have little motivation to master the learning materials. It is expected that even if the students are distressed, if they are highly motivated, they will have high academic performance. Thus, motivation will be a good moderator of the psychopathology - academic performance nexus (Lock, Walker, Rickert and Katzman, 2005).

Anxiety, depression, stress and behaviour problems can negatively affect academic performance by interfering with the effective use of study methods and by reducing the students’ motivation to succeed by lowering their self-efficacy and expectations of academic success. A reasonable way of getting over the poor academic performance of distressed students is to increase their study skills, self-efficacy and motivation in addition to alleviating their underlying stress (Santelli, Rogin, Brener and Lowry, 2001).

MANAGEMENT OF ACADEMIC PROBLEMS OF ADOLESCENTS

The initial step in determining a useful intervention for an academic problem is a comprehensive diagnostic evaluation. Identifying and addressing family, school and peer-related stressors are critical. An individualized educational plan evaluation and meeting may be requested by writing to the school so that specific educational testing can be integrated into the assessment of the overall academic problems and then, the educational accommodations can be considered (Weissberg, Kumpfer and Seligman, 2003).

Psychosocial intervention may be applied successfully for scholastic difficulties related to poor motivation, poor self-concept and underachievement. Early efforts to relieve the problems are critical, sustained problems in learning and school performance are compounded and precipitate severe difficulties. The emotions that most often accompany school failures such as feelings of anger, frustration, shame, loss of self-respect and helplessness, damage self-esteem emotionally and cognitively, disabling future performance and clouding expectations for success.

Generally, children with academic problems require either school-based intervention or individual attention. Tutoring is an effective technique for dealing with academic problems and should be considered in most cases. Taking examinations repetitively and using relaxation skills are two behavioural techniques of great value in diminishing anxiety (Sadock and Sadock, 2003).

POSITIVE THERAPY
Positive Therapy evolved by Hemalatha (2004), is a package, combining the Eastern techniques based on Yoga and Western techniques based on Cognitive Behaviour Therapy. Positive Therapy had its inception in 1978. After 20 years of successful implementation, it has been made a full-fledged one in 1998.

ASSUMPTION

Any behaviour problem is owing to the way an individual perceives himself/herself, the situation, the people around and his/her future. Any problem becomes a problem, only when it is perceived as a problem. Hence, the perception of a situation or a person as a problem is owing to one’s own perception, rather than the actual situation or the person. A person with negative perception will also have negative thoughts. Negative thoughts lead to negative beliefs, which are more often irrational. These negative beliefs pave the way for negative emotions and in the long run, affect the person’s mental as well as physical health.

Positive Therapy aims at modifying negative thoughts, beliefs, emotions and behaviour by using four major strategies namely, Relaxation Therapy, Counselling, Exercises and Behavioural Assignments. The assumption of Positive Therapy is that when negative thoughts are replaced by positive thoughts, the individual becomes more realistic and reasonable in his perception.

FOCUS

The focus of Positive Therapy is on the present. It has been found that many individuals waste their time and energy brooding over the past or worrying about the future. To be happy or sad is one’s own choice. Some people choose to be dull, depressed and they brood over most of the time. Some have a tendency to think about their aches, pains and bodily disorders and worry about them continuously. Some tend to worry a lot about the negative events that occurred in the past, such as failures, harassment, financial problems, death of a close relative, etc. Some keep on worrying about problems, which they think will occur in the future.

In Positive Therapy, the individual is made to understand that worrying about the past or the future is unnecessary and unwanted. He/she is trained to live in the present and enjoy the present. Positive Therapy helps to replace debilitating negative thoughts with positive, self-enhancing thoughts. It is presumed that change in thoughts will automatically lead to change in behaviour. Positive Therapy helps in the development of positive personality traits
such as courage, confidence, cheerfulness, optimism, etc. and trains people to face their problems boldly. Thus, Positive Therapy facilitates sound mental health.

**PROBLEMS TREATED BY POSITIVE THERAPY**

Stress, depression, anxiety, fear, anger, inferiority, insomnia, pain, academic problems, adjustment problems, menstrual problems, pre-marital/marital problems and suicidal ideation are treated successfully by Positive Therapy.

**RESEARCH ON POSITIVE THERAPY**

The author and other researchers have carried out a number of researches in different states of India namely Tamil Nadu, Kerala, Karnataka, Rajasthan and in Cambodia (Sok and Hemalatha, 2004), proving the efficacy of Positive Therapy in the management of stress (Rajakumari and Hemalatha, 2006), depression, anxiety (Hemalatha and Jeyabharathi, 2007), anger (Ramya and Hemalatha, 2003), insomnia, pain (Preetha and Hemalatha, 2004) and in the enhancement of general well-being, self-concept (Susan and Hemalatha, 2004), self-esteem, emotional intelligence (Bhuvaneswari and Hemalatha, 2003) and adjustment (Sathya and Hemalatha, 2003).

**NEED FOR THE STUDY**

Stress is an inevitable part of life and adolescence is not an exception to it. Today, nearly half of all adolescents report difficulty in coping with stressful situations either at home or at school. These stressors include major life changes such as changing schools, constant family conflicts and day to day hassles such as school tests, arguments with siblings, peers and parents. These may lead to behaviour problems, poor academic achievement, truancy and dropping out from school. Some may even go to the extent of attempting suicide.

Earlier researches have proved the efficacy of Positive Therapy in the management of stress, anxiety and other problems in various sample. Hence, in this study, an attempt is made to help the selected adolescents manage their stress, behaviour problems and academic problems through Positive Therapy.