CHAPTER I

Introduction
Introduction

Adolescence, a vital stage of growth and development, marks the period of transition from childhood to adulthood. It is characterized by more physical, psychological, social and cognitive changes than any other stage of life, except infancy (Holmbeck & Updegrove, 1995). The development of adolescence involves connections among the biological, psychological and socio-cultural factors, and no single influence either acts alone or as the prime mover of change (Brooks-Gunn et al., 1985; Peterson 1988; Lerner, 1993).

One of the most fascinating and complex transitions in the life span is adolescence. It is a time of accelerated growth and change; a time of expanding horizons, self-discovery, and emerging independence. The events of this formative phase can shape an individual’s life course and, by extension, an entire society.

Adolescence can be a specifically turbulent as well as a dynamic period of one’s life. It is a phase in the life cycle that has its difficulties, delights and opportunities. The need to establish a sense of identity and self-concept involves alterations of his or her body image, adaptations for more behavioural maturity, internalization of a personal value system and preparations for adult roles. During this period the mind becomes more questioning and independent. As adolescents mature cognitively, their mental process becomes more analytical. They are now capable of abstract thinking, better articulation and of developing an independent ideology. These are truly the years of creativity, idealism, buoyancy and a spirit of adventure.

It may be said that the years of adolescence, have been romanticized and maligned. Various researchers, scholars and therapists have marked adolescence as a critical period, if not the most critical period in human development. Adolescents have always been perplexing to the adults who often find them frustrating, confusing and even threatening, yet are enchanted by their verve and virility, their passionate sincerity, their idealism and their quest for truth and meaning. Holmes (1964) said that the intensity of
an adult's interest in adolescence varies directly with his distance from adolescents. Adolescent stage has also been recognized for its potential for the development of individual and for humanity.

Adolescents are notably at risk for developing behavioural and emotional problems. The changes in adolescence profoundly influence, and in some instances disrupt, the psychosocial functioning of adolescents. Adolescence is thus a turning point in one's life, a period of increased potential but also one of greater vulnerability (Draft Final Report of the Working Group on Youth Affairs and Adolescents' Development, 2007). The adolescents require special understanding and help at this stage. Because of the vulnerability of this period there is great possibility for injury and rejection. Many of them, during this period of life, experience deep periods of frustration, separation and loneliness. The forward movement of life usually carries along into greater maturity, but the scars that may be left on life during this period can be deep and may have a long effect on their psychosocial functioning and on their personality in general.

The vulnerabilities and risks of adolescence are heightened when the adolescents are deprived of a normal family condition and staying in an institutional set up. Early studies documented the adverse effects that long-term institutional care had on young children's emotional, social, and cognitive development (Goldfarb, 1945; Bowlby, 1951; Provence & Lipton, 1962; Spitz, 1965). Today, studies continue to affirm that institutional/orphanage care is an unsatisfactory option for young children.

Children's and adolescents' experience in orphanages or institutions clearly constitutes a risk factor for their optimal development. However, given an optimal post-orphanage environment with few stressors, orphanage children appear to do well and overcome early adversity. This is consistent with the suggestion that one risk factor in isolation does not lead to an increased probability for psychopathology. It is the combination of several risk factors working together that substantially increases the likelihood of future difficulty (Rutter, 1985).

Compounded with the stress of the adolescent life stage and adverse effects of institutionalization, boys and girls in institutional care face unique psychosocial challenges that adolescents in parental care do not.
Meaning of Adolescence

The term adolescence did not have its current meaning before the middle of the 19th century. However, young people have always had to make the transition of being considered dependent children to being regarded as independent adults. Great importance has been attached to the developmental changes that happen during this phase since the dawn of human civilization. Special rituals were held when a child was initialized into adolescence in the Vedic period in India.

It appears that different societies have different timeframes for the adolescent transition, and even the same society is likely to modify the steps and ages over time. Even today traditionalists and tribes hold special socio-religious functions on the occasion of the entry of a child into adolescence.

Adolescence is that period of life which lies between childhood and adulthood. It is a phase in the development of a person which lasts from puberty to adulthood. It is the period of “the teens,” covering about seven years. It is to be understood clearly that there are no sudden changes in the growing person, which definitely mark the beginning or the end of adolescence. The child grows by imperceptible degrees into the adolescent and the adolescent turns by gradual degrees into the adult (Sharma, 2005).

“Adolescence” is derived from the Latin word, “adolescere,” which means to grow to maturity (Rogers, 1969). It begins with the rapid physiological and psychological changes of pubescence when an individual is capable of begetting an offspring and ends when one assumes the responsibilities of adulthood.

It is customary to regard adolescence as beginning when children become sexually mature and ending when they reach the age of legal maturity. Sociologically, adolescence is a transitional phase between childhood and adulthood when a child moves from dependency to independency in his or her behaviours. Psychologically, an adolescent may be viewed as a young person in transition between a period of rapid development as an individual and a period when the individual learns to make adjustment to the needs of self, others and the community. The interplay of biological
changes and social attitude will determine the psychological meaning of puberty for its members.

**Universalistic vs. Cross-cultural notion of adolescence**

Adolescence is often described as a phase of life that begins in biology and ends in society (Sharma, 1996). It means that physical and biological changes are universal and take place due to maturation but the psychosocial and behavioural manifestations are determined by the meaning given to these changes within a cultural system. The experience of adolescents during teen years would vary considerably according to the cultural and social values of the network of social identities they grow in.

There are markedly different notions of adolescence in different parts of the world. These stand apart from western account of what does or should happen during this transitional period between childhood and adulthood (Brown et al. 2002). The evidence in literature from cross-cultural studies both supports and challenges the hypothesis that adolescence is a difficult period in development. There are cultures where adult status is granted to both boys and girls through initiation rites at puberty, amounting to an abrupt transition from childhood to adolescence and adulthood. But it clearly confers the adult identity on the individual. However, it may be an extended period of transition in other cultures.

Documented work related to experience of young people, across the globe, indicates that the forms adolescence take within culture, let alone across cultures, are diverse and distinctive. Still, one can certainly identify common features related to biological, cognitive and psychological imperatives of human development. Further, with the world becoming a global village through increased communication has led to the emergence of world youth community, resulting in to commonalities in interest of adolescents across cultures such as style of dressing up, eating habits, music preferences and sexual explorations. However, these commonalities get coloured, adapted and transformed to give different meaning within a cultural system (UNFPA, 2003).

Adolescence needs to be understood in historical and cultural context and its variegated and tentative nature is to be acknowledged and appreciated. It is particularly
significant when policies are formulated and interventions are planned for adolescents to ensure their wellbeing with reference to a particular culture/country.

**Age of adolescence**

Lack of uniformity in the age parameter for defining the group of adolescents is a major constraint. Adolescents are most often subsumed with youth or with children or with young adults. Different policies and programmes of the Government of India define the adolescents’ age group differently. Adolescents in the Draft Youth Policy have been defined as the age group between 13-19 years; under the ICDS programme adolescent girls are considered to be between 11-18 years; the Constitution of India and labour laws of the country consider people up to the age of 14 as children; NCERT speaks of adolescence as 13-19 years, whereas the Reproductive and Child Health Programme mentions adolescents as between 10-19 years.

Internationally, the age group of 10-19 years is considered to be the age of adolescence. UN defines youth as 10-24 years of age while for WHO the age of adolescence is 10 to 19 years. It is evident that in India, age limits of adolescents have been fixed differently under different programmes keeping in view the objectives of that policy or programme. Considering the characteristics of this age group, it is widely felt and recommended that it would be most appropriate to consider adolescents as between 10-19 years of age (UNIAWG-P&D, 2003).

**Stages of Adolescence**

Although adolescence is often discussed as one phase, teens actually pass through three distinct stages on their path to adulthood - early, middle, and late adolescence. Specific physical, cognitive, and social and emotional developments mark each of these stages. The changes that occur and the timing of those changes differ for boys and girls and vary greatly among individuals.

Many researchers now consider that while the most rapid growth in particular area may occur during a specific stage, many issues in development require continuous integration of new events and experiences and may be considered to be issues for the lifespan. Human development in any stage of the life course can be conceptualized as
involving progressive, continual change within a given context rather than involving transformation from one stage to the context (Peterson, 1988; Stern, 1985).

Though there are significant variations among the individuals with regard to the age, onset and duration of each phase, adolescence is usually divided into phases of early (12-14 years), middle (14-17 years) and the late adolescence (17-19 years) described in terms of physical, cognitive, psychological, and social changes; developmental tasks; typical pathological behaviours and feelings; and healthy outcome measures for each task (Schowalter and Towbin, 1997). In India the NCERT divides adolescence into three stages: Early Adolescence: 13-14 years, Middle Adolescence: 15-17 years and Late Adolescence: 16-19 years.

During early adolescence the rapid physical changes associated with puberty occur and the adolescent has to accept the changes in his or her body (Offer and Boxer, 1990). It is characterized by the growth spurt, beginning development of secondary sexual characteristics, greater social separation from parents and family, and greater affinity with peers. These changes are often manifested by the changes in attitude, clothing and hairstyle.

**Ramifications of the concept of Adolescence**

Puberty is often used to define the onset of early adolescence. Triggered by preprogrammed events in the brain, the pituitary gland produces hormones that in turn stimulate the secretion of sex hormones. These hormones have powerful effects on many tissues of the body, including the brain, and lead to significant changes in social, emotional, and sexual behaviour.

Although the biology of puberty has remained essentially the same for many generations, the social context in which these biological events occur has changed dramatically. Institutionalization, urbanization, technological advances, geographic mobility, and cultural diversity have radically transformed the world, and the interaction between biology and this new environment has fundamentally altered the circumstances of growing up as an adolescent (Kipke, 1999).
While the physical change of pubescence and puberty is considered to mark the end of childhood, the phase of ‘adolescence’ has been recognized for centuries as that which extends from the completion of puberty up to young adulthood in the early 20s (Parry -Jones, 1994). Demarcation of its end-point differs widely, and has been strongly influenced by social, cultural and economic factors, as well as behavioural markers such as legal age of maturity, defined simply by chronological age.

In technologically advanced societies, ‘adolescence’ emerged in its present form in the second half of the 19th century, when it became associated with new stage-related problems, generated by prolongation of compulsory schooling and extended economic dependence on parents. This lengthy transition phase does not occur, however, in many parts of the developing world, and instead there may be briefer, and often ritualized, passage to adult responsibility. As cultures become more complex, achievement of adult roles is increasingly delayed.

Adolescents are no longer children, but not yet adults, and this period is full of paradox. Adolescents can seem old beyond their years, but need adult support. They can put themselves at risk without thinking through the consequences, and display optimism and curiosity, quickly followed by dismay and depression. Biologically, they can become mothers and fathers, without being ready for the responsibility. They feel a growing sense of independence, but depend on adults for their material needs. And as they change, so their needs change with them.

Recapping we could highlight certain key concepts that are useful in describing the period of adolescence:

1. Adolescence is simultaneously a biological, social and a psychological phenomenon.
2. It is a period of transition, where on one side he/she shows child like characteristics and other times show highly matured behaviour.
3. It is a period of role experimentation where in he/she has to develop a personal conception of how they fit in to the society.
4. It has its own unique psychological, social and personal challenges. The event of adolescence is important both for the experience of the period itself and for the pattern they set for the future life choice.
Adolescence - a Period of Change

Adolescence is typically a time of great stress and strain on the body, mind, and emotions. G. Stanley Hall referred to the period of adolescence as a time of “sturm und drang” or storm and stress (Le François, 1996). This is explained by the fact that adolescents experience more life-changing external and internal factors and situations than pre-adolescents (Mullis et al., 1993).

Development and maturation in adolescence may be disturbed by variables related to one’s life; one’s self, experiences and the environment. The young person must deal with these changes as well as the conditions of modern society, which is characterized by a weakened family structure, rapid urbanization, competition for education and employment and exposure to drugs and alcohol.

There are five almost universal concomitants of changes that occur during adolescence:

i. **Heightened emotionality**
   The intensity of heightened emotionality depends on the rate at which the physical and psychological changes are taking place. Because these changes normally occur more rapidly during early adolescence, heightened emotionality is generally more pronounced in early than in late adolescence.

ii. **Uncertainty about oneself**
   The rapid changes that accompany sexual maturing make young adolescents unsure of themselves, of their capacities, and of their interests. They have strong feelings in instability, which are often intensified by the ambiguous treatment they receive from parents, teachers and care-givers.

iii. **New problems created by changes**
   The changes in their bodies, their interests, and in the roles the social group expects them to play, create new problems. To young adolescents, these may seem more numerous and easily solved than any they had to face before. Until they have solved their problems to their satisfaction, they will be preoccupied with them and with themselves.
iv. **Change in values**

As interests and behaviour patterns change, so do values. What was important to them as children seem less important to them now that they are near-adults. For example, most adolescents no longer think that having a large number of friends is a more important indication of popularity than friends of the type that are admired and respected by their peers. They now recognize quality as more important than quantity.

v. **Ambivalence about changes**

Most adolescents are ambivalent about changes. While they want and demand independence, they often dread the responsibilities that go with independence and question their ability to cope with these responsibilities.

**Physical changes during adolescence**

Puberty marks the beginning of sexual awareness and is a maturational and growth period. Puberty is defined as a period of transformation from a stage of reproductive immaturity to a stage of full reproductive competence. On an average girls reach puberty at the age of 13 and boys in approximately one year later that is 14 years of age. During adolescence considerable rates of increase in height, weight and brain size are experienced, with girls reaching maturity about one or two years before boys. Other factors observed include increase in the metabolic rate and blood pressure, a deepening of voice in boys, the growth of hair in the pubic area and under the arms for both boys and girls and on the chest and face for boys, breast development in girls and increased sweat gland activity. Sexual urges and feelings become intense and are accompanied by fantasy and masturbation. Heterosexual relationships become prominent and there is a natural attraction to the opposite sex.

**Emotional Changes during adolescence**

The physical changes with the onset of puberty are often accompanied by emotional tensions. The adolescent is exposed to new social situations, patterns of behaviour and societal expectations which bring a sense of insecurity. It has been found that there is increase in the incidence of depression. The adolescents show the tendency of impulsive urge to take immediate action which often leads to risk taking behaviour. The peer group support emphasizes the decision of risk taking behaviour.
Social changes during adolescence

Socialization and social adjustment are difficult developmental tasks of adolescence. These adjustments have to be made to members of the opposite sex in a relationship that never existed before and to adults outside the family and school environment. Early socialization takes place within the family unit. Social learning theory suggests that learning takes place as a result of the child imitating those close to him and receiving reinforcement and approval for desired behaviour. Adolescence is a time when the young person becomes involved in greater activity and interaction outside the home.

To achieve the goal of adult patterns of socialization, the adolescent must make several new adjustments. The most important and in many respects, the most difficult adjustments to be made are those to the increased influence of the peer group, changes in social behaviour, new social groupings, new values in friendship selection, new values in social acceptance and rejection, and new values in the selection of leaders.

Changes in Morality during Adolescence

It is an important developmental task of the adolescents to learn what the group expects of them and then being willing to shape their behaviour to conform to these expectations without the constant guidance, supervision, prodding and threats of punishment they experienced as children. They are expected to replace the specific moral concepts of childhood with general moral principles and to formulate these into a moral code, which will act as a guide to their behaviour. According to Kohlberg (1963), the third level of moral development, post-conventional morality should be reached during adolescence.

Personality Changes during Adolescence

The adolescence brings a change in the habitual pattern of behaviour, attitude and personality. By early adolescence boys and girls are well aware of their good and bad traits, and they appraise these in terms of similar traits in their friends. They are also well aware of the role, personality plays in social relationships and thus strongly motivated to improve their personalities. Older adolescents are also aware of what constitutes a pleasing personality. They know what traits are admired by peers of their own sex as well as by peers of the opposite sex.
Adolescents use new set of values in selection of friends and social grouping. The choice of friends depends more on similar interests and values. The peer group influences the attitudes, values and behaviour more than the child’s own family. Interest in world affairs, politics and government often develops during this period. There is genuine desire to help others and engaging in benevolent activities like collecting funds for a cause, arranging charity show etc. This also helps the adolescent to learn to adjust in variety of situations. It must be noted that along with these changes adolescence also brings in negative syndromes like being self-centered, showing off, emotional immaturity, stubbornness, unsatisfactory relationship with the family and other unattractive personality traits.

Cognitive changes during adolescence

Very noticeable changes in intellectual development take place during adolescence. The adolescent gains the ability to think in more abstract and logical terms. The quality of thinking in terms of great ideals also emerges during the period. The three main characteristics of adolescent thought are as follows:

a. Capacity to combine several factors and find solution to a problem.
b. Ability to see what effects one factor will have on other factors.
c. Ability to combine and separate factors in a probabilistic manner.

Cognitive development in adolescence builds the foundation for a more differentiated, multi-leveled, abstract, subtle and complex view of self, others and society. Emerging adolescent thinking tends to involve abstract rather than concrete descriptions; to entertain future or ideal possibilities; to become self-reflective and self-aware; to become relative rather than absolute in the conception of knowledge. These developing abilities have enormous practical impact. Teenagers can integrate concrete experiences, inferences, possible scenarios, historical facts and remembered experiences into an abstract generalization (e.g. a new perception of self, parents, or a peer as reliable or trustworthy). Self-reflection can create new dimensions of the self-involving higher-order personal or moral categorizations.
Chapter I

Developmental tasks of Adolescence

From examining the changes in our own lifespan we can see that critical tasks arise at certain times in our lives. Mastery of these tasks is satisfying and encourages us to go on to new challenges. Difficulty with them slows progress toward future accomplishments and goals. As a mechanism for understanding the changes that occur during the lifespan, Robert Havighurst (1952, 1972, and 1982) has identified critical developmental tasks that occur throughout the lifespan.

Havighurst (1972) defines a developmental task as one that arises at a certain period in our lives, the successful achievement of which leads to happiness and success with later tasks while failure leads to unhappiness, social disapproval, and difficulty with later tasks. The mastery of the developmental tasks listed below is critical to adaptive adolescent development:

1. Accepting one's physical makeup and acquiring a masculine or feminine sex role.
2. Developing appropriate relations with age-mates of both sexes.
3. Becoming emotionally independent of parents and other adults.
4. Achieving the assurance that one will become economically independent.
5. Determining and preparing for a career and entering the job market.
6. Developing the cognitive skills and concepts necessary for social competence.
7. Understanding and achieving socially responsible behaviour.
8. Preparing for marriage and family.
9. Acquiring values that are harmonious with an appropriate scientific world picture.

At any given time, adolescents may be dealing with several of these tasks. The importance of specific developmental tasks varies with early, middle and late periods of the transition (Ingersoll, 2007).

Theories of Adolescence

Various theories have been proposed for adolescent development like the psychoanalytic, psychosocial, behavioural, cognitive and humanistic theories. Hall (1904), father of the scientific study of adolescence described adolescence as a period, full of contradictions and wide swings in mood and emotion. Early theorists like Anna Freud (1958) said that to be normal during adolescent period is by itself abnormal. This
statement exemplifies her influential views of adolescence as the period of turmoil. The accompanying assumption was that the symptoms of emotional disturbance were temporary and would dissipate with time (Powers et al., 1989). These views were based on the theoretical work of prominent clinicians in the 1950’s and 1960’s (Freud, 1958; Erickson, 1959; Blos, 1962). These beliefs have led mental health professionals and researchers to minimize the importance of psychiatric problems that some adolescents do manifest (Offer et al., 1981; Offer & Schonert-Reichl, 1992).

Recent research suggests that the view of adolescence as a period of storm and stress is inaccurate (Buchanan et al., 1992; Offer & Schonert-Reichl, 1992). The current consensus is that adolescence is not normally a time of great psychological turmoil. Some adolescents may be able to pass through this stage without showing significant emotional or behavioural difficulties, which may be due to a combination of positive coping skills and availability of support.

**Stanley Hall’s Theory of Adolescence (1844-1924)**

Stanley Hall systematically conducted useful research on the changes and behavioural characteristics of American adolescence in the first decade of the last century. His theory is influenced by Darwin’s and Haeckal and Rousseau’s theories of evolution of species. For him adolescence is a period between 12 and 25 years of age. Hall characterized this as a period of ‘storm and stress’. According to him, during this phase of development, contradictory tendencies develop.

**Sigmund Freud’s Theory of Adolescence (1856-1939)**

Sigmund Freud emphasized on the importance of early childhood experiences in the development of adolescent personality. He too, like Hall was impressed by the writings of Darwin and his theory of evolution. According to Freud human beings experience an active and varied array of sexual wishes and feelings from the time of infancy. He believed that puberty was the time when the genital zone attained primacy. Anna Freud in the mid-1930’s focusing on the adolescent years describes the defence mechanisms and highlights their use for adaptation during adolescence. She theorized that at this time a relatively strong id, enhanced by the biological changes of puberty, confronts a relatively weak ego, which can become disorganized by quickly shifting parental and social expectations.
Erickson’s Psychosocial Theory of Adolescence (1902-1994)

Erickson (1968) adopted a lifespan approach. This theory proposes that an individual passes through the stages propelled by biological maturation and social expectation. Each stage can be negotiated to different degrees of success and problems may affect the outcome of subsequent changes. The psychosocial theory of Erickson propounds that adolescence is in the “identity versus confusion” stage i.e., a period for establishing a new sense of identity, which is unique and individual.

Sullivan’s Theory of Adolescence (1892-1949)

According to Sullivan, adolescence is tempestuous neither because it recapitulates a translation slap in human history nor because it recalls the conflicts of an earlier period but because it represents a number of new and planned challenges. During adolescence an interpersonal need for rightful satisfaction develops due to physiological changes in the body of the adolescent. This need must be integrated with the outer interpersonal needs, the need for security or need to be free of anxiety.

Jean Piaget’s Theory of Adolescence (1896-1980)

According to Piaget during adolescence, there is rapid development of a person from formal operations, developing gradually rather than abruptly. The turning point often occurs about the age of twelve, after which rapid progress in the direction of free reflections is no longer directly allocated to external reality.

Bandura’s Theory of Adolescence (1925-)

Bandura suggests that the prototypical adolescence, subject to the turmoil, anxieties, sexual tension, compulsive conformity and acute identity so commonly described in movies, literature and mass media, represents only 10 percent of the adolescence population. McCandless (1979) who developed the learning theory agrees that these arbitresses are gender different and hence differential patterns of behavioural characteristics among them.

Stress and Coping perspective

The research on stress and adjustment in adolescence is in its nascent stage. Most current work has been derived from a stress and coping perspective of adult psychopathology. The fact that stressful life events place individuals at greater risk for
Psychopathology and antisocial behaviour (psychosocial problems or lack of psychosocial wellbeing) is well known (Lazarus & Folkman, 1984). The hassles of everyday living have been shown to have a greater impact on mediating the effects of stressful life events on developmental outcomes (Rowlison & Felner, 1988).

Due to the changes experienced in the various domains of development like biological, cognitive and social development, the adolescents experience increased expectation and demands. The work of Compas (1987) and Garmezy & Masten (1994) and many other investigators suggest that coping behaviours may provide a crucial link between the experience of distressing events and adjustment. Prior studies of adolescent coping have shown that cognitive and behavioural efforts to alter stress as well as attempts to regulate the negative emotions associated with stressful circumstances are important in reducing the negative effects of a range of stressful events, including interpersonal problems and achievement related stressors (Compas, 1987).

**Problem Behaviour Theory**

Jessar & Jessar (1977) offers a theory of problem behaviour, which suggests that a variety of behaviours considered problematic during adolescence, such as delinquency, drug use and precocious sexuality, are associated with one another and constitute a ‘syndrome’ of problem behaviour. According to these authors, overall psychosocial proneness toward different forms of problem behaviour is caused by psychosocial risk factors, for e.g., low value set and motivation for academic achievement, aggressiveness, poor peer relations (personality level), low parent and friend support, poverty and family disorganization (perceived environment systems), and high level involvement in various problem behaviours (behaviour level).

Adolescent problem behaviour can set processes in motion that eventuate in compromised physical and social wellbeing in the adult years. In early to middle adolescence, antisocial, sexual and drug using behaviours tend to correlate, as in problem behaviour syndromes (Jessar & Jessar, 1977; Hawkins et al., 1992). Unlike a syndrome, however, there is a developmental sequence to how these behaviours unfold (Loeber, et al., 1984). Therefore, interventions should target the behaviour and its correlates early in adolescence. These may reduce escalations in problem behaviour later.
Problems in Adolescence

In a prospective study, Offer and Offer (1975) categorized that one-fourth of the adolescents were continuous (no periods of difficulty), one-third as surgent (with progressions and regressions), the rest as tumultuous. Mental health problems range from relatively minor to transient disturbances to serious and long-term disorders (Hendren et al., 1994).

The problems faced by adolescent can be broadly classified as either internalizing problems characterized by feelings of loneliness, social withdrawal, sadness and anxiety. The other is externalizing problems characterized by behaviours such as disruptive behaviour, aggression, hyperactivity, lying, stealing, fighting, bullying, etc. They exhibit their impairments in a variety of ways, like failure in academics, social rejection, poor self-esteem/image and difficulty in relating to peers or adults. This can have lasting consequences.

If an adolescent is showing persistent and unsuccessful coping in some areas of his life, this behaviour must not be dismissed as “normal” adolescent turmoil. Inner turmoil as represented by feeling of misery, self-depreciation, anxiety, ideas of being laughed at are quite common in adolescents. Adolescents who persist with problems that seem to be of transitory or of simple neurotic nature may turn out to be much more disturbed if not intervened or dealt with properly (Laufer, 1975).

Prevalence of Psychological Disturbance in Adolescence

Studies have found that nearly one in five children and adolescents will have an emotional or behavioural disorder at some time during their youth regardless of where they live (Offord et al., 1987; Costella, 1989). According to a W.H.O. publication in 1994, 20 to 30 percent of students have psychosocial problems; and 3 to 10 percent of students in schools have mental disorders (Hendren et al., 1994).

WELLBEING

Even as a vast body of research has been dedicated to understanding social problems and psychological disorders, remarkably little is known about the positive aspects of life, the things that make life worth living (Huppert, 2005). However, recent
years have witnessed a shift in the literature from an emphasis on disorder and
dysfunction to a focus on wellbeing and positive mental health. Within psychology, the
heralds of this revolution have included researchers such as Ryff (1995), Ryff and Singer
(1996) and Diener (1984, 2000), and Diener et al., (1999), building on the earlier work of
investigators such as Bradburn (1969) and Argyle (1987). This perspective is also
enshrined in the constitution of the World Health Organization (WHO 1948) where
health is defined as a state of complete physical, mental and social wellbeing and not
merely the absence of disease or infirmity. Health not only provides freedom from all
illness but also ensures that all physical, mental and social wellbeing pervade in that state
(Hasnain & Kumar, 2006).

Concept of wellbeing

The term wellbeing usually refers to the degree to which an individual is well. In
this sense it is synonymous with ‘quality of life’. Sometimes, however, the word is also
used to indicate the quality of supra-individual phenomena, such as the family, or society
as a whole. Wellbeing means then that the social system is functioning well.

In using the term wellbeing for individuals, three things can be distinguished: 1) living conditions, 2) living skills and 3) life’s outcomes.

Living conditions

In the first meaning the term wellbeing denotes the quality of the living environment. Sociologists often employ this definition of wellbeing.

Living skills

In the second meaning word wellbeing is used to indicate the capacity to deal with the environment. This comprises such things as ‘coping’, adequate ‘awareness’ and ‘actualizing’ capacities. Wellbeing is the degree to which a person is master of his own fate. This is the favorite definition used by psychologists.

Outcomes of life

In the third meaning the word wellbeing denotes the outcome of the foregoing, the final quality of life that result from the configuration of living conditions and living
Wellbeing has been also defined as a dynamic state characterized by a reasonable amount of harmony between an individual's abilities, needs, expectations, environmental demands and opportunities (Levi, 1987). It is connotative as a harmonious satisfaction of one's desire and goals (Chekola, 1975). Wellbeing involves subjective satisfaction and individual pleasure depending upon psychological status of the individual and his environmental conditions.

**Psychosocial Wellbeing**

North American and European psychologists at the end of the twentieth century, coined the term ‘psychosocial’ in an effort to recognize both the limitations of ‘mental health’ and the impact of social influences on child development. In this definition, ‘psychosocial’ encompasses both the psychological and social aspects of an individual (Psychosocial Working Group, 2005). Psychosocial specifically addresses the variety of gradual psychological, emotional and social changes that children go through as they mature (Duncan and Amtson, 2003).

The term “psychosocial wellbeing” has come to be preferred to narrower concepts such as mental health by humanitarian agencies to the extent that it points explicitly to psychological, social and cultural influences on wellbeing. The term is widely used, but defined in a myriad of ways. In academic literature and youth programming, this term encompasses a wide range of issues including, but not limited to, mental, emotional, social, physical, economic, cultural, and spiritual health. A definition of psychosocial wellbeing found in academic literature or used in programme proposals may be very different from the understanding of the term at a community level (Shah et al., 2005).

The psychological dimensions refer to the cognitive capacity, stabilizing of emotional experiences and improving the understanding of self. The social aspects encourage the young in their ability to form attachments and meaningful relationships, to maintain satisfying reciprocal social relationships, and to learn and follow the social code
of behaviour of their culture. Consequently, the individual achieves the expected developmental, cognitive, social and emotional milestones and develops secure attachments, satisfying social relationships and effective coping skills and resiliency (Satcher, 1999).

Existing Frameworks for Psychosocial Wellbeing of Children and Adolescents

Among the frameworks for describing psychosocial wellbeing, two models from which the researcher arrived at an adapted model include the Psychosocial Working Group (Psychosocial Working Group, October 2005, see Figure 1) and John Williamson and Malia Robinson's models of wellbeing (Williamson and Robinson, see Figure 2). Both models illustrate that overall wellbeing is dependent upon a number of closely interrelated factors including an individual’s ability to improve in physical, mental, cognitive, emotional, spiritual, social and economic areas of his or her life. A person who does well in many of these domains increases his or her chances of overall wellbeing and can then be considered healthy. Unfortunately, due to the various stressors in their lives, most vulnerable children are not able to completely fulfill all of these aspects.

Psychosocial Working Group’s Model of Wellbeing

Figure 1: Psychosocial Working Group’s Model of Individual Wellbeing

According to this model a person’s wellbeing is to be viewed in the context of a community’s diminished economic, environmental and physical resources. Three domains of wellbeing that impact the individual are:
• Human Capacity (physical and mental health, knowledge and skills)
• Social Ecology (social connections and support structures)
• Culture and Values (cultural constructions of experience, wider rights issues)

John Williamson and Malia Robinson’s Model of Child Wellbeing

Figure 2: Williamson – Robinson Model of Child Wellbeing

Figure 2 illustrates John Williamson and Malia Robinson’s unpublished model of child wellbeing. This model has proved useful in conceptualizing the specific aspects of child wellbeing. They argue that child wellbeing depends upon a number of different factors which to an extent are inter-related, but which can also be understood and addressed as distinct (Williamson and Robinson). The resulting wellbeing milestones, and the interventions that lead to change, are all inter-related and integrated. Furthermore, Williamson and Robinson argue that child wellbeing depends in part on some minimum level of satisfaction in all these domains.
This model identifies eight key areas of positive overall health. The first and all encompassing aspect of wellbeing is the Developmental, meaning that changes over time in a child due to his or her own human development may buttress or undermine individual wellbeing. Within the developmental realm exists the following seven additional factors:

- **Biological** (physical health and nutrition),
- **Mental** (Cognitive abilities, knowledge, skills),
- **Material** (non-biological aspects of the physical environment and all that is in it; includes economic resources),
- **Emotional** (a child’s feelings and emotions),
- **Social** (social interactions and relationships with peers and adults),
- **Spiritual** (belief in and a relationship with some higher power), and
- **Cultural** (thoughts, behaviours, values at the country, community and family levels).

While all of these domains affect an individual’s overall psychosocial wellbeing, John Williamson suggests that the Emotional, Mental, Social, Spiritual and Cultural domains are the most obviously relevant to psychosocial wellbeing.

The six areas of a child’s psychosocial wellbeing as defined in this model can be conceived as the factors influencing the child’s internal self-perception. The family, community and cultural ecology spheres impact these domains in varying degrees and conversely, deficiencies in these domains within the child can negatively impact the surrounding spheres.

**Adapted Model of Psychosocial Wellbeing of Adolescents**

The researcher has arrived at an adapted model of psychosocial wellbeing which serves as the conceptual model for the present study on the psychosocial wellbeing of adolescents. This model is created taking elements from the Psychosocial Working Group’s Model of Individual Wellbeing and Williamson – Robinson Model of Child Wellbeing.
The general principles underlying the model of wellbeing proposed by the present study are:

1. Wellbeing is considered in the context of the study on adolescents in institutional and parental care.
2. Wellbeing is to be viewed in the socio-economic, cultural, and environmental context and the age and developmental stage of the individual.
3. Adolescent psychosocial wellbeing can be measured according to its manifestations in various dimensions. The dimensions selected by the researcher for the present study are security/insecurity, self-esteem, adjustment, academic interest and general wellbeing.
4. The dimensions of psychosocial wellbeing studied here are interrelated as contributing and concomitant factors but sufficiently discrete to be described separately; and
5. There are different levels of adolescent psychosocial wellbeing that can be described according to their manifestation in the dimensions.
Security/Insecurity feelings of Adolescents

One of the basic psychological needs that contribute to the wellbeing of the individual is security. Parents in the home atmosphere foster it by proper upbringing. A child or adolescent who is deprived of love and affection at home or deprived of home and parental care would feel highly insecure and he or she is likely to carry over this feeling to the world outside. Case studies of delinquent children and children with behaviour problems reveal that, by and large, they emerge from broken homes and unhappy families (Dandapani, S., 2006).

Insecurity is a feeling of general unease or nervousness that may be caused by perceiving oneself to be unloved, inadequate or worthless. A person who is insecure lacks confidence in their own value and capability, trust in themselves or others, or has fears that a present positive state is temporary and will let them down and cause them loss or distress by going wrong in future. Insecurity is not an objective evaluation of one’s ability but an emotional interpretation, as two people with the same capabilities may have entirely different levels of insecurity.

The main determinants of the emotional security are immediate social environment, parents and siblings. The relationship between the parents and the interaction with parents and siblings lays the foundation stone for the child’s emotional state. Parental conflicts are the main cause of the emotional insecurity of children. Quarrelling in the presence of children, abusing a child, nagging, sarcasm, belittling the child, comparing with other children, all create emotional conflicts within the child.

The emotionally insecure child lacks confidence and unable to trust his/her immediate environment. They cannot trust anybody, and will be in a state of perpetual anxiety. They always forgo all opportunities in life, rather than venturing into new territories. Insecurity may cause shyness, and social withdrawal, or alternatively it may encourage compensatory behaviours such as arrogance, aggression, or bullying. Many people suffer a period of insecurity during puberty, which gives rise to a lot of the stereotypical behaviours of adolescents.
Insecurity has many effects in a person's life. It nearly always causes some degree of isolation as a typically insecure person withdraws themselves to some extent. The greater the insecurity, the higher may be the degree of isolation. Insecurity is often rooted in a person during their childhood years. It often grows becoming an immobilizing force that sets a limiting factor in the person's life. As insecurity can be distressing and feel threatening to the psyche, insecurity can often be accompanied by a controlling personality type or avoidance, as psychological defence mechanisms.

Insecurity can be overcome. It takes time and patience and a willingness to believe each person (and specifically oneself) is in fact of innate value. The first of Erikson's stages of psychosocial development details the challenge of finding security and learning to trust one's self and environment.

**Self-esteem**

The development of a sense of self is a major developmental task of adolescence. The self-concept is an amalgamation of an individual's physical, emotional, social, intellectual and educational traits. Self-esteem is the value an adolescent applies to the self-concept. Researchers like Bee (1992), Santrock (1994), Zigler and Stevenson (1987) and Sprinthall and Collins (1995) agree that self-esteem is the evaluative and affective dimension of self-concept. Rosenberg (1965) defines self-esteem as "totality of the individual's thoughts and feelings with reference to himself as an object." Self-esteem is also referred to as self-worth or self-image. Every teen needs to pass through psychosocial development during adolescence in order to have a realistic view of self. A task of this developmental process is to achieve a realistic and positive self-image.

Global self-esteem, which refers to a person's general sense of worth or acceptance (Wylie, 1979), is recognized for the critical role it plays in mental health and psychopathology (Bednar et al., 1989; NAMHC, 1996), yet not enough is known about how youth evaluate themselves as they move across adolescence.

Self-esteem has been ranked as among the most important aspects of self-development since evaluation of our own competencies affect emotional experiences, future behaviour and long term psychological adjustment. Self-esteem is a positive or
negative orientation toward oneself; an overall evaluation of one’s worth or value. People are motivated to have high self-esteem, and having it indicates positive self-regard, not egotism.

Researchers have established direct connections between self-esteem and several correlates. Physical appearance consistently correlates positively with adolescent self-esteem (Abell & Richards, 1996; Harter, 1983; Petersen et al., 1984). Peer and family relationships have been associated with adolescent self-evaluations. Peer influences such as social acceptance, peer relationships (Moran and Eckenrode, 1991), and peer popularity (Miller, 1990) contribute to the adolescent’s evaluation of the self, though the effects differ by gender.

Rosenberg (1965) has stated that high self-esteem expresses the feeling that one is ‘good enough’ and the individual feels that he is a person of worth. Low self-esteem on the other hand implies self-rejection, self-dissatisfaction and self-contempt.

**Adolescent Adjustment**

It has been established that the period of adolescence is significant in many aspects, exposing the adolescent to situations that require adjustment and generate adjustment problems. Thus important psychological determinants influence the adolescent and bring about consequent changes in the behaviour of the adolescent.

The term adjustment refers generally to the relationships that any organism establishes with respect to its environment. It is a state of complete equilibrium between an organism and its environment. The term usually refers to social or psychological adjustment. The social transition of adolescence focuses on such diverse areas of personality as identity, independence, sex roles, morals, values and achievement.

Adolescents have ideas and attitudes about what they really are like. They do have an image of themselves. Adolescents, who realistically accept themselves, while still exploring their potentialities, are considered to be better self-accepting individuals, have a realistic appraisal of the self, recognize their assets and are free to explore them. They also recognize their short-comings. They accept the qualities of humanity without
condemning themselves. They feel that they have a right to have ideas, aspirations and wishes of their own. Adolescents are self-rejecting if they see all others are against them, view them unfairly and belittle them and disapprove of them. They can reject themselves if shown gross disapproval.

Adjustment is the behaviour that helps one to meet the demands of the environment. In an attempt to meet the demands of the environment, individuals either try to change the environment or change their own attitudes. This is achieved by having a wealth of models to imitate so that they learn many ways of influencing the environment. These models could be such as interpreting experiences in such a way that they perceive solutions to problems which do not arouse negative emotions such as fear and anger; believing in their own abilities to achieve desired reinforcement; being able to regulate their own behaviour so that they bring about the desired effects by changing the environment; or by creating a new environment so that reinforces become available (Spencer & Jeffrey, 1992)

Academic interest

It is widely recognized that one of the most important channels of upward social mobility in modern societies is academic success and access to first-rate education (e.g., Duncan & Hodge, 1963). Social dominance theory suggests that one of the several types of factors responsible for the production and maintenance of group-based social hierarchy is the simple fact that children from low status and subordinate groups are less likely to enjoy academic success to the same degree as children from high status and dominant groups (Sidanius & Pratto, 1999). One of the categories of processes that translate subordinate social status into lower academic achievement consists of the effects of lower economic, cultural, and social capital (Bourdieu, 1986). Obviously, because of the more limited economic resources of parents from subordinate social groups in comparison to parents from dominant social groups, lower status parents are less able to purchase goods and services which would enhance their children’s educational success (Kozol, 1991; Biddle, 2001). Limited wealth also limits the quality and variety of enriching experiences to which lower status children are exposed.
If schools are to meet the challenge of preparing students for knowledge-based tasks associated with the world of the 21st century, they must dramatically increase the intellectual opportunities that they offer to all students (Darling-Hammond, 1996). This implies that schools must increasingly cater to diverse needs. For the enhancement of academic interest the school environment need to have a commitment to the success of all students, the creation of new roles for teachers and the development of schools as caring communities. It is suggested within the literature, that schools transform into caring communities when collaborative relations of power exist between and among students, teachers and administrators (Cummins, 1994; Weimer, 2002). The learner-centered perspective embodies such an approach and identifies the educational reform agenda as being consistent with the need to facilitate learning and achievement for all students while improving the quality of education. Proponents of this perspective assert that, to maximize motivation, learning and achievement for all students, schools need to provide supportive learning contexts for diverse students (Darling-Hammond, 1996; Nieto, 1996; Osterman, 2001). This is especially true for at-risk students whose maladjusted behaviour and poor scholastic achievements make them likely candidates for dropping out of school.

Learning interest and motivation are enhanced when educational programmes are tailored to the unique individual needs of each learner while meeting basic needs such as choice, competency and connectedness (Ryan & Deci, 2000). The main innovation of learner-centered education is its explicit emphasis on personalized attention to the needs of the learner (Alexander & Murphy, 1998; Weinstein, 1998).

**General wellbeing**

General wellbeing is the subjective feeling of contentment, happiness, satisfaction with life’s experiences, sense of achievement, utility, belongingness, and no distress, dissatisfaction or worry, etc. It may be maintained in adverse circumstances and conversely may be lost in favourable situation. It is related to but not dependent upon the physical or psychological conditions. The psychological wellbeing has only one prominent sign and that is that it speaks of a mind that is peaceful and quiet (Krishnamurti, 1986). The two-factor theory of mental health advocates that absence of psychological ill-health does not necessarily mean presence of psychological wellbeing.
Hence, a person can have both conditions poor, both conditions good, and any one of them good, with all its accompanying results (Verma, 1988).

There are several empirically informed models, with a large degree of conceptual overlap, on the structure of subjective wellbeing. In his seminal work, Bradburn (1969) found subjective wellbeing to be a function of the independent dimensions of general positive and negative affectivity. Building on this work, Argyle and Crossland (1987) and Diener (2000) have defined subjective wellbeing as an individual’s affective and cognitive evaluation of their life.

Similarly, Veenhoven (1997) defined subjective wellbeing as a set of affective and cognitive appraisals concerning one’s life including ‘how good it feels, how well it meets expectations, how desirable it is deemed to be, etc.’ Overall, high subjective wellbeing is comprised of the combination of three specific factors: (1) frequent and intense positive affective states, (2) the relative absence of anxiety and depression, and (3) global life satisfaction. It is argued that individuals high in social wellbeing are not by definition higher in social interest and perceived physical attractiveness, rather they have a high frequency of positive affect, a low frequency of negative affect, and have a greater overall positive evaluation of their life situation.

Conventional conceptions of wellbeing have come from the clinical perspectives of health or the psychological perspectives of mood or affect (Hattie et al., 2004). The clinical tradition has generally operationalised wellbeing as the absence of negative conditions such as depression, distress, anxiety or substance abuse, whereas the psychological tradition has tended to operationalise wellbeing as the prevalence of positive self-attributes (Keyes, 1998; Ryff & Singer, 1996). In the psychological tradition, the term wellbeing is mostly used as a generic qualifier of the degree to which a person exhibits an attribute that is valued. For example, psychological wellbeing has been described as positive affect, academic wellbeing as academic achievement and mental and physical wellbeing as mental and physical health (Carr-Gregg, 2000b; Marks & Fleming, 1999; Whatman, 2000).
Adolescence: Indian Context

Adolescence is a comparatively new term in contemporary India and the word youth is better known and has been used at the levels of policy formulation and programming (Singh, 1997). However, even the ancient text of Dharamashastra recognized the crucial nature of adolescence and prescribed specific codes of conduct for the phase. These codes are deeply rooted in the Indian psyche and continue to influence cultural practices towards adolescents in a powerful manner (Verma and Saraswathi 2002).

The family universally is acknowledged as an institution of socialisation, however, it plays a major role in the life of an Indian. Despite the fast pace of social change, it continues to have a direct bearing on adolescents’ development, since most young people stay in family until adulthood or even later in the case of joint family set-up. Most Indian families observe sacred ritualistic ceremonies at various stages of life cycle (Kakar, 1979; Saraswathi & Pai 1997). These are markers of progressive attainment of competencies both in social and behavioural aspects of life. The onset of puberty is acknowledged by the family and new code of conduct is prescribed both for boys and girls (Abraham, 2000).

Profile of Adolescents in India:

There are an estimated 1.2 billion young people aged 10-19 in the world – the largest generation of adolescents in history. More than four fifths of them live in developing countries, particularly in urban areas (UNICEF, 2002). The population of persons between the age of 10 - 19 years in India is over 225 million, comprising nearly 22% of the total population, the largest ever cohort of young people to make a transition to adulthood. It is this population of young people, which constitutes, for India, a potential demographic dividend, and/or a challenge of mega proportions if not properly addressed and harnessed (Draft Final Report of the Working Group on Youth Affairs and Adolescents’ Development, 2007).
Figure 4: Proportion of Adolescents in Total of Population of India

![Proportion of Adolescents in Total of Population of India](image)


Of the total adolescent population, 54% (121.5 million) belong to 10-14 age group and nearly 46% (103.5 million) are in the 15-19 age group. Female adolescents comprise almost 47% (105.75 million) and male adolescents 53% (119.25 million) of the total population. The sex ratio among 10-19 years is 882 females per 1000 males, lower than the overall sex ratio of 933. It is 902 for younger adolescents aged 10-14 years and 858 for older adolescents aged 15-19 years (Central Statistical Organization, Government of India, 1998; Department of Education, Annual Report 2002-2003).

Care and Development of Children and Adolescents in India


Moving towards its commitments, the Government of India introduced the National Charter for Children 2003, which stipulates the duties for the State and community, followed by a National Plan of Action for Children in 2005, which ensures collective commitment and action towards the survival, development, protection and participation of children by all sectors and levels of government and civil society. India
has also signed the SAARC Convention on Regional Arrangements for the Promotion of Child Welfare in South Asia, 2002 and is signatory to the SAARC Decade on the Rights of the Child 2001-2010, decided in Rawalpindi Resolution on Children in South Asia in 1996.

In order to reach out to all children, in particular to those in difficult circumstances, the Ministry of Women and Child Development has proposed to combine its existing child protection schemes under one centrally sponsored scheme titled “Integrated Child Protection Scheme (ICPS).” According to the Draft Scheme brought out in August, 2006, the proposed ICPS brings together multiple vertical schemes under one comprehensive child protection programme and integrates interventions for protecting children and preventing harm (ICPS Draft Scheme, 2006).

Despite the commitment to child protection enshrined in the Constitution of India and the UN Convention on the Rights of the Child ratified by India in 1992, and the two Optional Protocols ratified in 2005, and the various national and international commitments made, children continue to remain vulnerable with the number of those needing care and protection ever increasing (Sub Group Report on Child Protection in the 11th Five Year Plan, 2007-2012). Adolescents are the greatest national resources of any country. Hence if they become wasteful and destructive they can damage and weaken the nation (Pandey, 1988).

Policies relating to Adolescents in India:

Adolescents in India, until recently, were not considered as a special target group within social policies. However, they are now being accepted as a distinct group with specific needs, and a number of policy initiatives have already been taken. There has also been paradigm shift in the approach and objectives of social policy from welfare to development, empowerment and rights. The major policies that directly or indirectly impact adolescents are:

- National Policy on Child Labour (1987),
- National Education Policy, 1986 as modified in 1992,
- National Nutrition Policy (1993),
- National Population Policy (2000),
An analysis of the policies reveals the following:

1. Adolescents in most of the policies are not identified separately but grouped with children and in the case of girls, with women.
2. Most of the policies primarily address themselves to specific sectors like education, health, HIV/AIDS, sports etc., even though, in the last ten years the need for an integrated and holistic approach has been recognized in some policies, such as the Youth and Population policies.
3. The rights of adolescents in a wider perspective have not been articulated.
4. Most of the policies acknowledge the low social and economic status of girls and gender discrimination.

Some of the needs and concerns of adolescents in India:

While analyzing the needs and concerns of adolescents in India we can note the following areas that call for attention:

1. **Developing an identity:** Many of the adolescents are not able to effectively explore their potential and establish a positive image. Girls are groomed for stereotyped gender roles.
2. **Managing emotions and coping with stress:** Sex hormones secreted during puberty lead to sexual and emotional changes reflecting feelings of anger, sadness, happiness, fear, shame, guilt, and love. Very often adolescents are unable to understand these changes and feel stressed.
3. **Redefining relationship:** Adults do not understand the feelings of adolescents and have high expectations of them. Hence relationship has to be redefined with parents, peers and members of the opposite sex.
4. **Resisting peer group pressure**: The influence of friends sometimes leads them to experiment with risky sexual behaviour resulting in lifelong consequences. The pressure to conform introduces many adolescents to drugs.

5. **Inability to pursue education**: Many adolescents drop out of school because of poverty. There is inadequate opportunity to continue education and upgrade vocational skills.

6. **Girls are forced into early marriage**: This has negative consequences in terms of their development and the discontinuation of education. Teenage pregnancy results in risks of haemorrhage, anaemia, and low birth weight for the baby, miscarriage and even the death of the mother.

7. **Lack of skills to face the challenges of life**: The education system does not equip them with life skills to cope with difficulties.

8. **Lack of information on sexual and reproductive health**: This leads to unwanted/early pregnancy, STDs/RTIs/HIV. Adolescents want sexuality education but there is resistance from adults in the family and community. Teachers feel inhibited to discuss issues related to sexuality and reproductive health.

9. **Limited access to reproductive health services**: Attitude of health service providers towards unmarried adolescents is not positive regarding contraceptives and services.

10. **Vulnerability to sexual exploitation and gender based violence**: Crimes are rarely registered and conviction rates are low. There are hardly any support services to deal with the mental trauma of victims of sexual violence. Counselling facilities barely exist.

11. **Influenced to a large extend by a media-driven global youth culture and lifestyle**: The young people in the Indian Society are being influenced to a large extent by a media-driven global youth culture and lifestyle fuelled by liberalization and a rapid growth and expansion of information and communication technologies.

12. **Urgent need to strengthen power of volunteerism**: There is also an urgent need to strengthen power of volunteerism to engage young people in community development and nation building activities in order to balance career pursuits with community concerns.

13. **Opportunities for creative use of free time**: Young peoples’ need for leisure and recreation should be considered with priority by providing them with a range of
constructive outlets both in urban and rural areas (Draft Final Report of the Working Group on Youth Affairs and Adolescents’ Development, 2007).

**Paradigm shift in the approach regarding adolescence in the Indian scenario**

For the first time the importance of adolescents as a distinct subgroup was highlighted by the Planning Commission’s Working Group on the Development of Adolescents for the 10th Plan in 2001. It emphasized the need to view adolescents as a valuable human resource for nation building and as a representative of the nation’s unique economic opportunity for the future. By constructively harnessing their creative energies the country can mobilize their potential to launch a socio-economic transformation.

The National Youth Policy 2003, accords priority to following categories of young people namely, adolescents, youth, in-school/out-of-school, rural/urban, tribal and the disabled and those in difficult circumstances. The Policy highlights repeatedly the challenges faced by both male and female adolescents and the need for appropriate programmes for them. Moving a step forward, the National Commission for Youth (NCY) in its Report in July 2004, has strongly advocated for evolving a National Policy on Adolescents to take cognizance of the issues and challenges affecting them.

**Rights of the Child – Role of United Nations Organizations**

In the resolution 1386(XIV) of 20 November 1959, the General Assembly of UN proclaimed the Declaration of the Rights of the Child. The declaration presents a code for the wellbeing of every child without any exception whatsoever and without distinction or discrimination on account of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, whether of himself or his family.

The United Nations, in the Declaration of the Rights of the child again states that the child by reason of physical and mental immaturity needs special treatment, education and care required by his particular condition. It further says that the child shall be protected against all forms of neglect, cruelty and exploitation.
The UN adopted the comprehensive Convention on the Rights of the Child in 1989. The preamble of the convention recognizes that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding and consider that the child should be fully prepared to live an individual life in society brought up in the spirit of the ideas proclaimed in the Charter of the UN, and in particular in the spirit of peace, dignity, tolerance, freedom, equality and solidarity.

Article 19 of the Convention on Rights of the Child says that the state parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation including sexual abuse while in the care of parent(s), legal guardian(s) or any other persons who has to take care of the child.

Article 20 says that a child temporarily or permanently deprived of his or her family environment, or in whose best interest cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the state.

Article 27 points out that the state parties recognize the right of every child to a standard of living adequate for the child’s physical, mental, spiritual, moral and social development.

Article 39 directs the state parties to take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of any form of neglect, exploitation or abuse, torture or any other form of cruel, inhuman, degrading treatment or punishment (National Policy for Children, 1974; United Nations, 1992; United Nations, 1996).

**Alternative Care for Children without Parental Care**

The United Nations Convention of the Right of the Child affirms that it is in the overriding interest of children that they be brought up in their own families. But there are growing numbers of children who do not enjoy this most basic right and suffer from neglect and extreme vulnerability. In a recent publication UNICEF estimated that in
2003 more than 143 million children under the age of eighteen in 93 developing countries had lost one or both parents (UNICEF, 2005). There are also children all over the world, who are separated from their parents due to lack of basic economic and/or social security within their families. Abandoned and destitute children have for long been a welfare concern. While their magnitude is not known, their numbers are not too few to be ignored either (Bose, 2006).

The emotional, educational, spiritual and physical needs of children who live without parental care are often neglected. Separation of the child from his/her family should be as temporary as possible, unless the child experiences any form of exploitation, abuse or neglect in the family. In that case it is still preferential for a child to grow up in a family or family-like environment - though not its own family - because of the support and affection, necessary for the healthy development of a child, it can offer. However, orphanages or children’s home as they are often called, have been the oldest form of taking care of destitute children or children without parental care and they continue to be the major form of alternative care for such children.

The 1989 UN Convention on the Rights of the Child guarantees every child the right to family. The family is the natural environment for the optimum development and wellbeing of all its members, especially the child. If the family is unable, unwilling or not present to provide a loving and nurturing environment to the child or if the child cannot be allowed to continue in the family in the best interest of the child, the child has the right to grow up in an alternative setting (Indiramma et al., 2007). Alternative care is provided by adoption, foster care, family sponsorship or institutionalization. These four are recognized as priority order in the interest of the child (Victor, 1997).

Adoption

Adoption of abandoned or orphan children provides the best possible solution to the child’s future. However, there is no uniform law in the country applicable to all communities wanting to adopt a child. Adoption among the Hindus is governed by the Hindu Adoption and Maintenance Act, 1956. Foreigners who wish to adopt a child take recourse to the Guardians and Wards Act of 1890 for taking the child outside the country as a guardian, and then adopting the child as per their own laws. Detailed guidelines have been prepared by the Central Adoption Resource Agency of the Ministry of social Justice.
and Empowerment, and agencies in the country and outside engaged in adoption have been recognized. The Ministry of Social Justice and Empowerment gives grants to foundling homes where the infant is kept till adoption takes place. The official policy is to encourage in-country adoption. Between 1989 and 2000, the average number of children adopted annually has been about 3000 only, which is too small a number for a country and population of the size of India (Bose, 2006).

A large number of Indian parents are now coming forward to adopt children. The adoption agencies are often disappointed with the choices of the prospective parents. The background, colour, choice for a male child and age preferences are some of the factors which make a large number of children remain outside the scope of adoptions in India. For this large number of children, non-institutional services like foster care, sponsorship are proposed as solutions. However, both have their inherent limitations in implementing them successfully in the prevailing socio-cultural situation. This leaves institutionalization as the other option available.

Foster Care

Among the non-institutional forms of alternative child care is foster care, under which a child is provided a substitute home for a period till the child has grown up, or can be restored to his family, or till some other arrangements can be made. Foster care was conceived as providing a family environment to the child. Payments are made to the family to cover the child’s expenses. However, foster care has hardly made progress in India because of the absence of good casework services which can match the family and the child. Often families also do not come forward to undertake foster care.

Sponsorship

Sponsorship programmes for children in their own families or institutions has expanded in India. A large number of sponsors are individuals as well as national and international NGOs. The sponsor pays for the upkeep, education, and other needs of the child. In some cases, care of more than one child in very poor families is also sponsored. Sponsorship can be effective when there are field level organizations which have contact with the community, can identify the beneficiaries, and closely monitor the implementation. Many states and districts, particularly in the rural areas, have not been covered by sponsorship because of the absence of good NGOs.
INSTITUTIONAL CARE

Historically India has the tradition of the joint family system. Therefore, orphans, widows, destitute and the aged were given shelter, care, love and protection within the family itself. However, due to the changes in the economic scenario and rapid industrialization, migration became a necessity. The socio-cultural pattern also began to then change. This led to more individual family units and the breakdown of the traditional joint family system. Urbanization and rural poverty, as well as dilution of social controls have affected the children most. Majority of the poor families seek institutional care for their children as a solution to their poverty than as a solution to other problems faced by their children.

It is alarming to see the increasing numbers of such children and the numbers entering the institutional system. These children are not necessarily orphans but destitute and they do have a family somewhere, however, once these children enter the institutional system there are very limited opportunities for them to get out and go back to their families.

According to the India Country Report on Violence against Children (June 2005), India has a child population of 427 million (2001 census). The number of destitute children stands at 44 million while there are 12.44 million orphans in the country, many of them in institutional care. The institutions for children in conflict with the law host about 40,000 children.

Research has shown that being taken away from one’s biological parents after incidences of neglect and abuse, and placed in substitute care can itself be associated with harmful effects (Frankel, 1998). Priority should be given to family-based care that builds on existing social structures. However, there are situations when family-based care is not possible and temporary institutional care and protection is necessary (Dunn et al., 2003). Institutional care refers to children’s centres or orphanages, where children are cared for in groups by one or more adults. Institutional care should be used as a last resort since it can rarely offer the individual care that a child needs to develop
holistically. It should be considered only as a short-term arrangement, until reunification
or community-based care is found.

In fact, in India the traditional response to child destitution is the
institutionalization of children. Institutions thus have been playing an important role in
providing services to children who are deprived of a natural family and are run by the
government as well as private bodies.

According to the JJA, 2000 “Children’s home” means an institution established
by a State Government or by voluntary organization and certified by that Government
under section 34. In section 34 the Act states as follows:

1. The State Government may establish and maintain either by itself or in
association with voluntary organizations, children’s homes, in every district or
group of districts, as the case may be, for the reception of child in need of care
and protection during the pendency of any inquiry and subsequently for their
care, treatment, education, training, development and rehabilitation.

2. The State Government may, by rules made under this Act, provide for the
management of children’s homes including the standards and the nature of
services to be provided by them, and the circumstances under which, and the
manner in which, the certification of a children’s home or recognition to a
voluntary organization may be granted or withdrawn.

In compliance with the stipulations of the JJA, 2000 the State Government of
Kerala made the Kerala Juvenile Justice (Care and Protection of Children) Rules, 2003.
In section 29, the KJJ Rules states the following: The Government may establish and
maintain by itself or in association with Voluntary Organizations Children’s Home for

A statement by the Health and Social Welfare Minister of Kerala on 9th 2008 in
the Legislative Assembly, reiterated that the orphanages should be run only with the
permission from the State Orphanage Control Board and should be run according to the
strict guidelines of the government. In the Assembly there was also a fervent plea to
rename orphanages to remove the negative connotation of the title (The Hindu, 2008).
Categories of Institutions for Children and Adolescents

The institutions for children in India fall into four categories: (1) the statutory institutions formed as part of the juvenile justice system under JJA, 2000 to house children in conflict with law pending enquiry; (2) Institutions to look after the children in need of care and protection (children’s homes and shelter homes) as directed by the Child Welfare Committees set up under the JJA, 2000; (3) Institutions run by civil society organizations and religious groups to look after children in need of care and protection; (4) Government-run institutions for vulnerable children belonging to the scheduled castes and tribes.

In addition to government-run institutions, there are institutions run by private organizations, some of them generate funds by themselves, while others receive aid from private funding agencies. Child care institutions are varied not only in numbers, but also in the nature of services provided to the children. They are called by different names as adoption centres, shelter homes, orphanages, hostel for poor students, ashrama schools, etc., and in case of government institutions they are known as Observation Homes, Juvenile Homes, Fit Persons Institutions, Backward Class and Minorities Hostels, etc.

Large number of children and adolescents are accessing the services from these institutions and for many of the children, institutions are the only source of support. However, many studies and reports suggest that child care institutions have detrimental effects over child’s growth and development instead of promotive/rehabilitative effects. The quality of care provided in institutions is poor and impersonal, and children have been reported to escape from these institutions. Most of the care of destitute or abandoned children is carried out by children’s homes run by voluntary organizations, which are unevenly distributed between and within states. There is no doubt that there is a huge gap between the need for care and the services that are provided.

Majority of children and adolescents in institutions experience some sort of emotional and behavioural disturbances as it is difficult to provide personalized care in the institutions and the opportunities for children to experience familial warmth and emotional experiences are limited. Most of the studies on child care institutions and lives
of children in institutions indicate that the longer the children stay in institutions, the greater is the likelihood of emotional or behavioural disturbances and cognitive impairment.

**Factors Responsible for dominance of institutional care in India**

Across India, children continue to be separated, temporarily or permanently, from their families as a result of conflict and displacement, the HIV/AIDS pandemic, endemic poverty, death of parents, disasters, alcoholism of parents and abuse. Many such separated children frequently end up in institutions for residential care that rarely provide the environment that children need for healthy development.

Many children are also removed from their families against the family's wishes in the belief that this is the best or only option because of the family's poverty, the mother's unwed status, a child's disability, chronic illness of parents, a parent's positive HIV status, or the lack of educational opportunities for the child. Poverty is often the driving force behind the vulnerability of single orphans (those who have lost one parent).

Private donors, faith-based organizations, NGOs, and governments channel significant resources into more orphanages or residential care institutions for children, rather than supporting programmes to assist single parents, relatives, and foster carers. This promotes a situation where those same parents and families, together with communities and government officials, turn to those institutional facilities as a first response. As a consequence, resources for family-based and community-based alternatives for vulnerable children decreases even further as key donors construct new institutions and direct funding into existing ones.

**Factors of Concern**

While institutional care is very much prevalent in our country as a major form of alternative child and adolescent care there are number of factors which cause concern and require urgent attention and solutions. These concerns include:

1. Lack of a uniform registration mechanism for institutions caring for children.
2. Lack of gate keeping policy to check the entry of children into institutions.
3. Lack of a data gathering mechanism to know the number of children in institutions at a given point in time.

4. Resistance from traditional structures: Reducing numbers of children in institutions or closing them down in the extreme cases can meet resistance from the staff as well as local officials. Also institutions are funded by NGOs and the State and often this becomes an obstacle.

5. Lack of resources: Where the resources are limited or not available, appropriate implementation of community based programs becomes impossible. This is despite the fact that community based alternatives are more cost-effective than institutional care. Appropriate reallocation is therefore important or the raising of additional funds.

6. Schemes from the government are formulated in such a way that there need to be a minimum number of children within the institution to get the support from the government. This forces many of the institutions to make sure they keep so many children to receive the assistance from the government.

7. Overcrowding and lack of basic amenities are very common in many of the institutions. Even in institutions set up for care and protection of children, "prison" like atmosphere exists and children are not free even to meet family members regularly.

8. Most institutions do not have trained caregivers/staff equipped with knowledge in child/adolescent psychology and skills in effectively dealing with the challenges for adolescent wellbeing.

**Factors Responsible for the Need of Institutionalization**

The adolescents are institutionalized because of circumstances that are complex. Institutionalized adolescents often come from broken homes created by a variety of factors, some more detrimental than others. They could have been voluntarily removed, or physically abused and may have experienced parental poverty or alcoholism (Ketterlinus and Lamb, 1994). Factors responsible for institutionalization of children and adolescents could be classified under following:
1. **Individual Factors**

Physiological and psychological deprivations make an individual destitute or orphan. By being born as physically or mentally handicapped, one is liable to become a destitute. Divorce, death of one or both parents, alcoholism, poverty, implications of accidents or disease, etc. are certain important individual factors responsible for institutionalization of children.

2. **Social Factors**

The downfall of joint family system, the emergence of nuclear family, industrialization, urbanization, etc. narrowed down the social, cultural, moral and philanthropic outlook of human beings. As a result the weaker member is often left to his fate.

The broken family conditions, the premature death of parent or parents, marital disharmony, divorces, separations, family tensions, ill-treatment by step-parents, sexual or physical abuse in the family, selling of children as bonded labourers, extreme poverty conditions, large families to support with low income, low income and unemployment, lack of proper housing facilities in the urban areas, break-up of traditional social structure of joint family and close neighbourhood, discord among parents, alcoholism, drug addiction, gambling, crime, parents involved in antisocial activities, etc. are some of the conditions that have caused the need for institutionalization of children (Indiramma et al., 2007).

3. **Economic Factors**

The livelihood of a child is determined by socio-economic conditions of the family. The child in a rich family enjoys all privileges, whereas a child born in poor family suffers, indeed, even to enjoy childhood (Damodaran, 2009). Economically backward family is often large and parents find it hard to meet all the expenses with just a tiny income. The children are forced to do manual labour or beg in the street to supplement the family income and sustain themselves. The unemployment, disease or deaths of the bread-winner are certain other factors that lead to institutionalization.
4. **Gender Factors**

   The problems of food, dress, safe and comfortable accommodation, huge amount for dowry and marriage and other expenses for girl children burden the families when there are more female members. Girls are trained to depend on men, first on father, then on brother and next on husband and finally on son. When one of these men fails, the woman is not capable of facing the new challenges and she surrenders and resort to institutionalization.

5. **Natural Factors**

   Natural calamities like drought, flood, landslides, earthquakes, fire, etc. are also causes of institutionalization.

6. **Other Factors**

   Child abuse has been found to be more associated with low income status, negative marital quality, unmanageable stress, social isolation, cultural attitudes and so on. The child abuse occurs more often among families of low socio-economic status. The anger and withdrawal generated by marital conflict may make parents actively hostile or physically aggressive with their children. These factors too force children to take refuge in institutions.

**Constitutional and Legal Provisions**

   Indian Constitution also highlights the need and significance of providing protection and assistance to deprived children. The Indian Constitution provides all citizens equality before law. Article 10 of the Indian Constitution states that a child permanently or temporarily deprived of his family environment for any reason shall be entitled to special protection and assistance provided by the State.

   According to Article 39(e) and (f) of the Indian constitution the State must direct its policy towards securing ‘interalia’ that children are not forced to economic necessity to enter vocation unsuited to their age and strength and that childhood and youth are protected against exploitation and against moral and material abandonment.
As per the 46th article of the Indian Constitution, the State shall promote with special care, the educational and economic interests of the weaker sections of the people, and shall protect them from social injustice and all forms of exploitations.

In 1960, the Union Government enacted the Central Children’s Act, and it had the care, custody, protection, welfare, training, etc. as its objectives. Various states in India passed their own Children’s Act for the protection of the delinquent and neglected children, which were in tune with the Central Children’s Act 1960. The preamble of the Central Children’s Act (1960) speaks of providing care, protection, maintenance, welfare, training, education and rehabilitation of neglected or delinquent children.

National Policy for Children (1974) points out that the nation’s children are its supreme asset. The 8th section of the National Policy for Children says about providing the facilities for education, training and rehabilitation for children who have become delinquents or are being forced to resort to begging or are otherwise in distress. The 9th section envisages for the protection of children against neglect, cruelty and exploitation.

Several laws have been enacted and some still in the process to ensure the welfare of the child and adolescent, which indicate the conscious effort of our law makers to give protection to the children in the field of education, health, labour, employment and protection from exploitation both physically and mentally. A landmark in this regard is the JJA, 2000, which distinguishes between the child in conflict with law and the child in need of care and protection. Several provisions are there in the Act to ensure the welfare, safety and protection of the child.

Central Juvenile Justice Act of 2000 was enacted to rehabilitate children below 18 years who are in conflict with law and who need care and protection under JJA. Central Juvenile Justice Act 2000 has come into force with effect from 1-4-2001. As part of implementing the Central Juvenile Justice Law in the State, Juvenile Justice Rules of Kerala was published in the year 2003. For providing rehabilitation, care and protection to these children specialized bodies such as Juvenile Justice Board, Child Welfare Committee and Special Juvenile Police Units are constituted under the provisions of the JJA, 2000.
Chapter I

Introduction

The child rights advocates, NGOs, the UN and other organizations for children at national and international level working for the welfare of children have played a vital role to put pressure on the government to enact child-friendly policies and laws.

Though high expectations are stated in the Directive Principles in the Constitution, National Policy of the Government of India, Declaration of the Rights of the Child and in the various Children’s Acts enacted, still the problem of the disadvantaged children is a great cause of concern.

Problems related to Institutionalization

Children who have been brought up in various State homes routinely describe these as “children’s jails.” Even though the confined children are physically provided for—food, clothes, schooling and medicines—they rebel against the loveless environments intrinsic to all institutions (Mander, 2009).

Placement in institutions during early critical developmental periods and for lengthy periods of time is often associated with developmental delays due to environmental deprivation, poor staff to child ratios, or lack of early childhood stimulation. The experience of physical or psychological abuse to which the children in institutions are more exposed to can have a long term and deleterious effect up on their social development and emotional wellbeing. Maltreatment of children places them at an increased risk of developing a variety of problems including anxiety, low self-esteem, behaviour disorders, educational backwardness and distorted relationship with peers and adults.

Institutionalized children have deep psychological disturbances. They show severe personality disturbances centering on an inability to give or receive affection. Their troubles included hopelessness, inferiority, aggressiveness, abstinence, selfishness, excessive crying, food difficulties, speech defects, over-activity, fears, financial and educational problems. The other psychological health problems include mood disorders, depression, suicidal tendencies, anxiety and phobias, post-traumatic disorders, cognitive disorders and learning difficulties. Hence these children are also referred to as “children at risk.”
These children express high levels of dissatisfaction in the areas of creative expression, social maturity and protection, recognition, praise and social acceptance. A sense of inferiority complex is fairly apparent. They are often socially isolated group. They have lost their self-respect and experience strong inhibitions, preventing their coming to the forefront of the social life. In the 16th century, a Spanish Bishop noticed that many infants left in an orphanage died from apparent sadness - death resulting from insufficient love (Spitz, 1945).

Goldfarb (1947) concludes that institution child does not have identification and a developed capacity for relationship; his behaviour is passive and undirected and has very little insight. He needs stimulation growth of a normal ego structure than the amelioration of conflict and anxiety. Most of the studies show, perhaps unsurprisingly, that children who have spent an extended period of time in orphanages display deficits in all areas of development when compared to any other group (i.e., adopted or home-reared children). This is the same pessimistic picture that both Goldfarb (1945) and Spitz (1945) painted.

In an institutional set up even though inmates’ physical needs are met, there is no opportunity for natural family environment, care and affection. There is absence of warm, day-to-day contact with an adult in the role of parent person and deprived from the practical experiences of family when institutionalized adolescents go back to the original family, they might be in a difficult position to carry over their role in a meaningful way (Ganasaraswathy, 1994).

Children regard incarceration in such homes as a punishment. Cut off from the larger community, behind their opaque walls, corruption and institutionalized systems of bullying and sexual and physical abuse are known to pervade these homes. The children raised in these homes are typically withdrawn or violent, and find it hard to integrate with the larger world into which they are ejected as soon as the State is not bound by the law to protect them (Mander, 2009).
Psychosocial Wellbeing of Adolescents – The Social Work Perspective

Adolescence which marks an important time in the process of human development is a time of tremendous opportunity and promise. It is a time when young people begin to explore their burgeoning individuality and independence and begin to think critically about themselves and the world around them. They begin to adjust and adapt to the profound biological, psychological, and social changes and challenges that are by-products of adolescence.

The manner in which an adolescent navigate these changes and challenges depends on his or her psychosocial resources and interactions both positive and negative - with families, communities, and the larger social environment. The health and wellbeing of our young people are critically affected by their experiences during this developmental milestone.

Healthy adolescent development depends on safe and supportive environments that are free from the risks of physical, mental, and emotional harmful environments and that provide opportunities for youths to build strong and meaningful connections with their families, their schools, and their communities and development of their potentialities. Adolescents also greatly benefit from engagement in activities in which their value is demonstrated and affirmed and their inherent talents, capabilities, and strengths are enhanced.

Social environments that are inclusive and accepting of diversity encourage all youths to feel good about and value themselves and others around them. Equitable access to the bio-psycho-social needs (health care, mental and emotional development, quality education, employment opportunities, and social supports) also is essential for ensuring positive outcomes for youths.

Most young people are able to steer the adolescent years successfully with the support of caring families and communities. Far too many youths, however, experience significant challenges during this time that impede their ability to move successfully into adulthood. Their healthy development is thwarted by many problems and deprivations they suffer due to death of one or both parents; break-up of homes through separation or
divorce of parents and parental conflicts; neglect and abandonment by parents and
relatives; abuse, bullying, harassment, drugs, violence and neglect in their homes,
schools and communities; extreme poverty of the family, and other problems. These
barriers prevent access to adequate health care, emotional and social connectedness and
support, social services, education, employment opportunities, housing, and nutrition
which adversely affect their psychosocial wellbeing. The adolescents in institutional care
face these challenges that hamper their ability to make a successful passage to adulthood,
as they belong to the categories of the disadvantaged and deprived children.

Social work, a helping profession with unique methods and techniques, has a
distinctive role to intervene to help all adolescents who are in a critical stage of their
development and especially the disadvantaged adolescents who face risks and challenges
caused by their deprivation. The unique perspectives and breadth of social work practice
can provide systemic linkages between the social work profession and the psychosocial
entities that affect adolescent development. Adequately meeting the needs of youth
means engaging all systems - individual, family, and the broader community - in efforts
to prevent problems and promote health and well being.

The comparative appropriateness of different alternative forms of care for
children and adolescents deprived of parental care or in need of care and protection have
been in debate for long among childcare policy makers, service providers and child
rights proponents. Different forms of care such as institutional care, foster care, kinship
care and adoption are in practice in all countries. While the debate continues, it is evident
that no one form of care is the ideal one though adoption is considered as a more
appropriate one.

Since different forms of care are prevalent social workers have a significant role
to assess and monitor the kind of care provided and ensure that they serve the best
interest and wellbeing of children and adolescents. Social work practitioners have an
important and unique role to perform as they possess the fundamental knowledge and
skills to work effectively with adolescents who are not in parental care. The theory,
principles, and methods of social work, including casework, group work, community
organization, administration, and research can standardize the services and practices of
various care-giving entities.
Social workers understand that everyone - individuals, communities, and society as a whole - reaps the benefits from investments in helping young people achieve optimal physical and mental health. They provide essential services in the environments, communities, and social systems that affect the lives of youths. Considering the fact that institutional care is the major alternative form of care for children and adolescents in our country it is necessary that their psychosocial wellbeing is assessed and necessary interventions made based on the results. Social work seeks socio-economic wellbeing and the deeper source of happiness that is self-actualization for all people (Young, 1949). Hence institutionalization in the Indian context though seems inevitable, should be only a temporary arrangement until the child could be rehabilitated in the home environment.

The researcher in the present study assesses some important domains of psychosocial wellbeing of adolescents in institutional and parental care such as insecurity feelings, self-esteem, adjustment, academic interest and general wellbeing. The socio-demographic characteristics of the adolescents and their association and relationship with the psychosocial variables are also investigated. The outcomes of the study will help to understand the implications of institutional care and to frame suitable social work interventions to enhance the psychosocial wellbeing of adolescents in institutional care and reintegrate them into society.