CHAPTER I: INTRODUCTION
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The first use of the term ‘adolescence’ appeared in the fifteenth century. The term was a derivative of the Latin word ‘adolescere’, which means to grow up or to grow into maturity (Muuss, 1990).

Social scientists who study adolescence usually differentiate among early adolescence, which covers the period from about age 11 to age 14, middle adolescence, from about age 15 to age 18 and late adolescence (youth) from age 18 to age 21 (Kagan and Coles, 1972; Keniston, 1970; Lipsitz, 1977).

Adolescence is a time of life characterized by enormous growth and development. Adolescents are at an important stage in developing lifelong skills that will enable them to make good decisions about lifestyle, learning, relationships and self-sufficiency. The health and well being of adolescents is significantly influenced by the determinants of health, such as access to health services, personal health and coping skills, social supports, income, physical environment, and biological and genetic endowment.

Youth face two important transitions during the adolescent years. As they enter into the adolescent years, the care and support provided by their family and school changes to accommodate emerging expectations for increased responsibility and self-reliance. Adolescents have a great deal of work to do in the few short years before they reach adulthood when they are expected to be prepared to manage their own health and well-being, develop intimate relationships and participate in the workforce and community life.

Adolescents need supportive environments, families, friends, schools, neighbourhoods, the media and Internet, and their socio-economic status- all influence adolescents personality and behaviour. Adolescence is a time when youth take on more responsibility and become more independent in decision making. One of the important
features of adolescent period is to experiment with new behaviors in the effort to understand choices and define oneself in relation to family, peers, community and future activities. Stable and supportive relationships with family and friends help adolescents to test and refine such life skills as setting goals and expectations, making smart choices, developing social competence, solving problems, dealing with conflict and contributing to community life.

Adolescents are an important element of the society. They have an abundance of positive energy, spirit and fresh ideas, which often challenge the traditional norms of society. It is essential that their strengths, creativity, interests, capacities and abilities are recognized and nurtured.

Adolescents seek out and respond to real opportunities to contribute to the quality of life in their schools, neighborhoods and society. The unique vision and culture of youth has been, and will continue to be, a major contributor to positive social change.

1.1 Adolescence - A Transition Phase from Childhood to Adulthood:

Adolescence as its marks the stage of pubertal changes too, leads the adolescent in attaining an adult size body and acquisition of sexual maturity. While discussing the changes of adolescent from childhood to adulthood, it is wise to refer to it with three sets if changes- biological, cognitive and social.

1.2 Changes During Adolescence:

Change is the keyword of the period termed as adolescence. Beginning with the pubertal changes an adolescent’s physical transition to adulthoods gets initiated. In a nutshell there are changes in primary sex characteristics and also secondary sex characteristics.

1.2.1 Physiological Changes:

In trying to discuss adolescence, most adults tend to confuse the terms adolescence and puberty, and use them synonymously. However, puberty refers to the physiological
changes involved in the sexual maturation of a child, as well as other body changes that may occur during this period of time. Adolescence refers to the stage from puberty to adulthood, and includes the psychological experiences of the child during this period. Adolescence is described as being the teenage years from thirteen to eighteen years of age; however, puberty decides the onset of adolescence. Therefore, adolescence occurs in some children as early as nine years of age. During this period of time the child has a great deal of concern over his/her body image and any discrepancies in the child's eye such as obesity, early or late maturation, etc., may be manifested through a variety of disorders.

During adolescence, there is a large degree of psychological growth as children make adjustments in their personality due to the rapid physical and sexual development, which are characteristic of this period of life. Adolescents face ongoing conflict and difficulty adapting to the sudden upsurge of sexual and aggressive drives. These changes cause unrest and confusion in the adolescents' inner selves and in the way they perceive the world. Most common physiological changes of this period and accompanied consequences are:

- Hormonal secretions cause physical and physiological changes in adolescence.
- Hormones are chemical agents secreted in the bloodstream by the pituitary gland. Hormones stimulate the adrenal, glands, ovaries, and testes.
- As sex hormones enter the bloodstream changes in physical growth and sexual development occurs.
- Increased production of sex hormones: testosterone (male) and estrogen (females). Hormones are present in the body systems since birth.
1.2.2 What is Puberty?

Puberty derived from the Latin Word *pubertas*, which means “adult”. Technically the term refers to the period during which the individual becomes capable of sexual reproduction. Puberty refers to the physiological changes that the adolescent undergoes in order to reach sexual maturity. It is best characterized as the gradual onset of mature reproductive hormonal activity, triggered by the central nervous system, mainly the hypothalamus and pituitary gland. Most people look at puberty in three distinct stages as those of the pre-pubescent, pubescent, and post pubescent. The prepubescent stage includes the first evidence of sexual maturation—primary sexual characteristics—and terminates at the first appearance of pubic hair. During this stage, reproduction is virtually impossible. During the pubescent stage the growth spurt begins to accelerate, males experience their first emission of semen usually in the form of “wet dreams,” and menarche occurs in the females. The post pubescent stage is characterized by the deceleration of growth spurt, completion of both primary and sexual characteristics, and fertility is possible.

The following are the five chief physical manifestations of puberty (Marshall, 1978).

- A rapid acceleration in growth, resulting in dramatic increases in both height and weight.
- The further development of the gonads, or the sex glands, which are testes in males and the ovaries in females.
- The development of secondary sex characteristics, which involves changes in genitals and breasts, and the growth of pubic, facial and axillary (body) hair, and the further development of the sex organs.
- Changes in body composition, specifically, in the quantity and distribution of fat and muscle.
- Changed in the circulatory and respiratory systems, which lead to increased strength and tolerance for exercise (Steinberg, 1987).
Puberty signals the physical maturity of boys and girls, and is a period that signifies reproduction capabilities. Considering the significance of this transition in terms of reproduction it seems strange that most adolescents are expected to delay sexual intercourse. Society often sends messages to young adolescents that are complex and contradictory. When they hit adolescence they are expected to grow up and be responsible for their actions, yet at the same time they are discouraged from behaving in grown up ways and many times responsibility is taken away from them, in terms of the choices they make. Adolescent girls are often told to be virtuous and reserved sexually, however peer cultures often convey the idea that being a little sexy is okay for sake of popularity. Boys are also told to control their sexual desires by society, but most of their peers expect them to be sexually active. Ultimately, the conflicting messages conveyed to adolescents, can interfere with their search for identity and can cause confusion, in terms of what the physical transition into adolescence actually signifies.

1.2.3 The Onset of Puberty in Adolescents:

Pubertal changes once initiated progresses in a rapid manner. Amazing, as it may seem, sexual maturation is programmable for the primary sexual characteristics to begin their development, the pituitary gland must first release stimulating agents called gonadotropins into the bloodstream. Once they reach the testes in the male and the ovaries in the female, a number of changes will occur.

There are two gonadotropins: follicle stimulating hormone (FSH) and luteinizing hormone (LH). These gonadotropins are present in the adolescent during childhood, but at levels too low for sexual maturation to begin. At the beginning of puberty, the pituitary releases increased amounts of gonadotropins while the child is asleep and stops immediately after the child awakens. However, once the child enters the post-pubescent stage, gonadotropins are released both during sleep and during the day. In the ovaries, follicle-stimulating hormone is responsible for the development of the follicle, which contains a developing ovum (egg). Follicle stimulating hormone also helps produce the female hormone estrogen within the follicle when it is stimulated by
luteinizing hormone. In males, FSH incites the growth of seminiferous tubules, which produce sperm in the testes. Luteinizing hormone is responsible for producing androgen male hormone in the Leydig cells. The androgen that the Leydig cells produce, aids in the growth on the seminiferous tubules. As the adolescent grows older, the pituitary releases increased amounts of gonadotropins; ovaries and the testes grow more rapidly, and produce larger amounts of estrogen and/or androgen.

1.2.4 Sexual Maturation In the Male Adolescent:

As individual difference counts for every type of development sexual maturation is also no exception. Even though the male adolescent’s growth rate varies from child to child, a sequential pattern has been identified. The typical sequence of events occurs as follows:

- The testes and scrotum begin to increase in size.
- Pubic hair begins to appear.
- The penis begins to enlarge, and the adolescent growth spurt begins
- The larynx starts to grow and the voice deepens.
- Hair growth begins on the upper lip.
- Nocturnal emissions (ejaculation of semen during sleep) may occur as sperm production increases
- Pubic hair becomes pigmented, and growth spurt reaches its peak
- The prostate gland enlarges.
- Hair growth begins in the axillas (armpits).
- Sperm production becomes sufficient for fertility, and the growth rate decreases.
- Physical strength is at its peak.

1.2.5 Sexual Maturation in the Female Adolescent:

Even though the female adolescent’s growth rate varies from child to child, a sequential pattern has been identified. The typical sequence of events occur as follows:
The adolescent growth spurt begins.

Non-pigmented pubic hair (downy) appears.

The budding stage of development (breast elevation) and the rounding of the hip begins, accompanied by the beginning of downy axillary hair.

The uterus, vagina, labia and clitoris increase in size.

Pubic hair growth becomes rapid and is slightly pigmented.

Breast development advances, nipple pigmentation begins, and the areola increases in size. Axillary hair becomes slightly pigmented.

Growth spurt reaches its peak, and then declines.

Menarche occurs

Public hair development is completed, followed by mature breast development and completion of axillary hair development.

"Adolescent sterility" ends, and the girl become capable of conception.

Difference due to sex is observed in almost all the changes that occur to organisms. Noticeably, for the boys the muscular developments are more rapid than in girls. Men become taller and stronger than women. Rate of heartbeat decrease and remain slower for boys than girls. Proportion of fat to muscle however remains greater for girls than for boys.

Menarche: Taken from the Greek word *arche*, meaning the "beginning" menarche is the scientific term given for first menstruation. First menstrual period occurs in puberty. The timing and tempo of maturation varies widely across culture and geographical location. For example: (New Guinea: average girl menstruates at 18; in US at 12). Duration of puberty also varies from 11/2 years to 6 years. Secular trend: Trend towards earlier puberty. Following menarche, pubic hair and breast development are completed, and underarm hair appears. Most girls take about 3 to 4 years to complete this sequence, although this too, can vary greatly, from 1 1/2 to 5 years (Tanner, 1990: Wheeler, 1991).

Menstruation: The menstrual cycle is controlled by the hypothalamus, which acts as a menstrual clock. The clock operates through the pituitary gland located at the base of
the brain. The pituitary gland cyclically secretes two hormones which directly stimulate the ovary; these hormones are follicle-stimulating and luteinizing hormones.

Menstruation occurs approximately every three to four weeks. If the ovum is not fertilized, most of the lining of the uterus mixed with blood is expelled through the cervix into the vagina. This bloody discharge is referred to as menstruation (menses) or a menstrual period. The entire cycle repeats itself with regularity throughout the reproductive life of the female. However, at its onset after puberty, menstruation may be irregular for up to a year or two.

1.2.6 The Anatomical Development of the Adolescent:

Adolescent growth first centers on the extremities—the legs and arms during the early stages of adolescence. Changes also occur in the facial configurations of both sexes. The lower portion of the head begins to grow because the chin lengthens and the nose grows in width and/or length. Additional changes in proportion of the face are accredited to changes in tissue distribution. Even though both sexes undergo this change, within females a layer of subcutaneous fat develops which causes the rounding and softening of contours of the face and body. Whereas, the male subcutaneous fat development is much less pronounced, but the development of muscles and bones in the face is clearly seen. This gives the males a leaner and more angular face than the females.

Changes also occur on the surface of the body in both sexes. The most observable change is the growth on body hair, both pubic and axillary (armpit). The development of pubic hair is the first sign of a child ending the prepubescent stage and entering the pubescent stage. This process begins about the same time as the growth spurt begins, and is in the form of slightly coarse, straight hairs that grow at the base of the penis and on the labia major. The growth of pubic hair continues throughout adolescence, it spreads horizontally and then vertically until it surrounds the genital areas. Characteristically, pubic hair becomes longer, thicker, darker and kinkier as it spreads over the genital areas. In males, the growth of facial and chest hair may be pronounced,
and tends to represent virility in the eyes of the adolescent. Noticeable chest hair, with a thickness in texture does not usually appear until the post pubescent stage and continues to grow during manhood. Facial hair usually appears in the form of a dark shadow above the lip. Then it appears on the chin, along the jaw line, and then develops along the neck. Females may also find small amounts of facial and chest hair.

Both male and female skin undergoes other changes, such as becoming coarser with the sebaceous glands becoming more active, producing oily secretions, which usually help cause acne or blackheads. Sweat usually causes an odor in adolescents because the oils that the sebaceous glands emit alter the chemistry and composition of sweat. Adolescents also show an increase in their blood pressure, and a decrease in both basal metabolic rate - the rate at which the body in a resting state (basal) consumes oxygen and in pulse rate.

1.3 The Psychological Development Of The Adolescent:

Adolescents face so many physiological changes, as has already been discussed above, it becomes quite inevitable for them to experience the psychological impact. An overall rate of serious psychological disturbances rises only slightly from childhood to adolescence, when it is the same as in adult population-about 20 percent (Costello and Angold, 1995). Although some teenagers encounter serious difficulties, emotional turbulence is not a routine feature of this phase of development. Mead (1928) had found that social environment was entirely responsible for the range of teenage experience, from erratic and agitated to calm and stress free. Later researchers found that adolescence was not as smooth and untroubled as Mead had assumed (Freeman, 1983). Adolescent maturation is a personal phase of development where children have to establish their own beliefs, values, and what they want to accomplish out of life. Because adolescents constantly and realistically appraise themselves, they are often characterized as being extremely self-conscious. However, the self-evaluation process leads to the beginning of long-range goal setting, emotional and social independence, and the making of a mature adult.
Three distinct stages can be identified in the psychological development of the adolescent, even though there is a great deal of overlap in the stages, and they may not occur during the age span indicated.

During early adolescence (ages 11-13), development usually centers on developing a new self-image due to their physiological changes. Adolescents need to make use of their newly acquired skills of logical thinking and ability to make judgments rationally. When they reach the ages of fourteen and fifteen (the period known as mid-adolescence), adolescents strive to loosen their ties to their parents and their emotions and intellectual capacities increase. The adolescent becomes adventuresome, and experiments with different ideas. This plays an important role in finding one's relations to oneself, groups, and opposite sex. During this time, the adolescent battles over his own set of values versus the set established by parents and other adult figures. The adolescent also begins to take on more control of educational and vocational pursuits and advantages. It is during this time that adolescents' self-dependence and a sense of responsibility become apparent, along with their quest to contribute to society and find their place in it.

During late adolescence (ages range from sixteen on), adolescents have a more stable sense of their identity and place in society. At this stage in life they should feel psychologically integrated and should have a fairly consistent view of the outside world. Adolescent should, by this time, have established a balance between their aspirations, fantasies, and reality. In order for them to achieve this balance they should be displaying concern for others through giving and caring, instead of the earlier childhood pattern of self-gratification. At the conclusion of late adolescence they should have had designed or discovered their role in society, have set a realistic goal in life, and have begun in earnest to achieve it.

Researchers and theorists have taken three approaches to the study of identity during adolescence. One emphasizes changes in the way individuals conceive themselves, a
second focuses on changes in the way individuals feel about themselves and the third emphasizes changes in the degree to which individuals feel secure about who they are and where they are headed.

Identity emerges as concern during adolescence because the biological, cognitive and social changes characteristic of development during this period of the life cycle. Together these changes provide changes in the adolescents' self concept, fluctuation in self-image and a struggle to establish coherent sense of identity (Erikson, 1968).

The adolescent years are truly a period of great creativity, empathy, idealism and energy and of new experiences, ideas and skills. The support and understanding from family members during this phase is crucial in enabling them to meet the challenges. Separation accompanies the development of identity during adolescence (Kroger, 1989). Yet, independence evolves in connection to family, peers, and society (Conger, 1991; Steinberg, 1993). Silence, distance, and severing family ties can lead to over identification with the peer group, identity confusion, and excessive rebellion (Steinberg, 1993).

Self-esteem can be important in terms of how one thinks, feels, and responds to stressful life events. Research has also shown a relation between low self-esteem and feelings of depression and hopelessness in adolescence. Females with low self-esteem are twice as likely to develop depression following a stressful life event than those with average or high self-esteem. During adolescence, a person may experience increased stress in relation to school, friends, and family, as well as new responsibilities and interests. One step in the development of emotional autonomy is the de-idealization of parents (Steinberg, 1993). The individuals who achieve emotional autonomy handle criticism, hurdles, and setbacks constructively by developing their own inner strengths and self esteem (Atwater, 1992).

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Physical and sexual maturation profoundly affect the way in which adolescence view themselves and the way in which they are viewed and treated by others. Yet the social environment exerts a tremendous impact on the meaning of puberty and on its psychological and social consequences. In some societies, puberty maturation brings with it a series of complex initiation rites, which mark the passage of the young person into adulthood socially as well physically. The adolescents may revise their self-image during puberty; the nature and magnitude of the revision may be different for those who go through puberty early than for those who mature late. Because boys who mature early are bigger and stronger than their peers, puberty may make them feel more self-assured. But for late matures who are simply catching up with their friend pubertal changes may bring feelings of relief more than anything else.

Researchers have found that puberty’s influence on developmental pathways depend primarily on the perceptions and expectations of the social context (Brooks-Gunn and Reiter, 1990; Clausen, 1975; Lerner, 1992; Magnusson, 1988; McGhee, 1984; Stattin and Magnusson, 1990). When pubertal changes are responded to positively within adolescents’ social contexts, particularly by families and members of the community, the event appears to be experienced without significant adjustment problems, regardless of the age of onset.

It is not unusual for adolescents to feel uncomfortable with their changing bodies, but it is important that they be informed and reassured that this period of transition is normal. With the various messages that the media sends to teenagers, reassurance can be difficult. For example, during puberty girls go through many physical changes; they gain weight, the develop breasts, and their body shape changes. All of these changes are normal, however the media’s portrayal of particular body images (tall, skinny,
narrow hips, large breasts), can make young girls think they are abnormal. The desires to conform and peer pressures are often in conflict with the realities of the body and the mind and it is important to keep these differences in mind (Allen-Meares and Shore, 1986).

1.4 Adolescence: A Phase Of Storm And Stress

Stanley Hall (1904/1916), the first psychologist to formulate a theory of adolescence, proposed that the major physical changes that take place at this time cause major psychological changes. He believed that young people’s efforts to adjust to changing bodies ushered in a period of *storm and stress*. Hall saw adolescence as a period of intense, fluctuating emotions, from which young people may emerge morally stronger.

G. Stanley Hall stresses that A period signaling life beyond childhood but before the adoption of adult social responsibilities. Adolescent behavior is the outcome of biological changes and is characterized by emotional "storm and stress"

Lifespan psychology assumes that development needs to be viewed within its social context. It sees people as active agents in shaping their own lives, exerting a reciprocal influence on their physical and social environments. One of the most influential views of adolescence has been that it is a period of 'storm and stress', producing disruption and emotional upheaval for the adolescent. But more recent research suggests that this applies to only a minority of adolescents. Others have contended this view — storm and stress has roots in cultural and not in biological determinants. Recent studies have found that while for some adolescents this is a period of stress for others is a period of self-assurance. Mead (1920) stressed that simpler societies have a shorter and smoother transition to adulthood. But adolescence is not absent (Weisfield, 1997).

As a link to physiological development, girls psychological reactions were traumatic a generation or two ago. But now, girls react with surprise, due to the sudden nature of the event. Otherwise they typically report a mixture of positive and negative emotions (Brooks and Gunn 1988). For girls who have no advance information about sexuality,
menarche can be shocking and disturbing. In the 1950's, up to 50 percent were given no prior warning (Shainess, 1961). Today few are uninformed.

Spermarche, which is the first ejaculation of the seminal fluid, gives boys such a mixed feeling. Virtually all boys know about ejaculation ahead of time but a few get the information from parents. Usually they obtain it from reading material (Gaddis and Brooks-Gunn, 1985). As with girls, the better prepared boys feel, the more positively they react (Stein and Reiser, 1994).

According to Hall's analogy and expansion of Darwin's concept of biological "evolution." into a psychological theory of recapitulation, adolescence corresponds to a time when the human race was in a turbulent transitional stage (Muuss, 1975). In this theory, Hall stated that the experiential history of the human species had become part of the genetic structure of each individual. The law of recapitulation claimed that the individual organism, during its development passes through states that correspond to those that occurred during the history of mankind. To sum up, the individual relives the development of the human race from early animal like primitivism, through a period of savagery, to the more recent civilized ways of life that characterize maturity (Muuss, 1975). Therefore, Hall described adolescence as a new birth, "for the higher and more completely human traits are now born" (Hall, 1916).

Hall describes this particular aspect of adolescent development (storm and stress) in detail in a chapter of his book on adolescence — "Feelings and Psychic Evolution." He saw the emotional life of the adolescent as an oscillation between contradictory tendencies. Energy, exaltation, and supernatural activity are followed by indifference, lethargy, and loathing. Exuberant gaiety, laughter, and euphoria make place for dysphoria, depressive gloom, and melancholy. Egoism, vanity, and conceit are just as characteristic of this period of life as are abasement, humiliation, and bashfulness. Hall believed that adolescent characteristics contained both the remnants of an uninhibited childish selfishness and an increasing idealistic altruism. The qualities of goodness and virtue are never so pure, but never again does temptation preoccupy the adolescent's thinking. Hall described the adolescence as wanting solitude and seclusion, while he
finds himself entangled in crushes and friendships. Never again does the peer group have such a strong influence over the person. The adolescent also moves between the exhibition of several personality traits including exquisite sensitivity and tenderness at some points in time to callousness and cruelty at other times. The display of apathy and inertia also vacillate with enthusiastic curiosity, along with the urge to discover and explore. According to Hall, during this stage of development, there also is a yearning for idols and authority that does not exclude a revolutionary radicalism directed against any kind of authority.

In late adolescence, according to Hall, the individual recapitulates the state of the beginning of modern civilization. This stage corresponds to the end of the developmental process: maturity. Hall's genetic psychology did not see the human being as the final and finished product of the developmental process; it allowed for indefinite further development (Muuss, 1975).

1.5 Theoretical Foundations of Adolescence:

1.5.1 Sigmund Freud and the Psychoanalytic Theory of Adolescent Development:

Freud paid relatively little attention to adolescent development only to discuss it in terms of psychosexual development. He shared a common idea with that of Hall's evolutionary theory: that the period of adolescence could be seen as phylogenetic. Freud did maintain that the individual goes through the earlier experiences of mankind in his psychosexual development. According to Freud and psychoanalytic theory, the stages of psychosexual development are genetically determined and are relatively independent of environmental factors (Muuss, 1975). Freud believed that adolescence was a universal phenomenon and included behavioral, social and emotional changes; not to mention the relationships between the physiological and psychological changes, and the influences on the self-image. He also stated that the physiological changes are related to emotional changes, especially an increase in negative emotions, such as moodiness, anxiety, loathing, tension and other forms of adolescent behavior.
Anna Freud believes the factors involved in adolescent conflict are:

- The strength of the id impulse, which is determined by physiological and endocrinological processes during pubescence.
- The ego's ability to cope with or to yield to the instinctual forces. This in turn depends on the character training and superego development of the child during the latency period.
- The effectiveness and nature of the defense mechanism at the disposal of the ego.

1.5.2 Otto Rank's Emphasis on the Adolescent's Need for Independence:

Otto Rank (1884-1939), a follower of the psychoanalytic school had been completely under the influence of Freudian realism. He then later developed his own theory and began to challenge Freud's notions.

Rank saw human nature not as repressed and neurotic, but as creative and productive. He criticized Freud's emphasis on the unconscious as a storehouse for past experiences and impulses. Rank pointed out that the past is of importance only to the degree that it acts in the present to influence behavior. He also places less emphasis on instinctual forces and instinctual behavior. He believed that Freud actually neglected the role of the ego and gave value to it only as a repressive force. Rank wanted to restore the balance of power in the psychic realm (Muuss, 1975).

Rank stated that there must be an examination of the place that adolescent development has in this psychoanalytic theory based on consciousness and "will." Sexuality is no longer the strongest determining factor in the developmental process. It has found its counterpart in "will," which can to some degree, control sexuality. It is during the shift from childhood to adolescence that a crucial aspect of personality development occurs - the change from dependence to independence (Muuss, 1975).
During the latency period, the "will" grows stronger, more independent, and expands to the point where it turns against any authority not of its own choosing. The actual origin of the "will" goes further back into the oedipal situation. It is here that the individual will encounters a social will, represented by parents and expressed in a moral code centuries old (Muuss, 1975).

In early adolescence, the individual undergoes a basic change in attitude; he begins to oppose dependency, including both the rule of external environmental factors (parents, teachers, the law, and so on) and the rule of internal cravings, the newly awakening instinctual urges. Establishing volitional independence, which society values and requires, becomes an important but difficult developmental task for the adolescent. This newly developed need for independence and the struggle for the attainment of independence lie at the root of many adolescent personal relationships and their complications. Rank sees no necessity for external sexual restrictions and inhibitions, since the struggle is one in which the individual's will strives for independence against domination by biological needs (Muuss, 1975).

1.5.3 Erik Erikson's Theory of Identity Development:

The core concept of Erikson's theory is the acquisition of an ego-identity, and the identity crisis is the most essential characteristic of adolescence. Although a person's identity is established in ways that differ from culture to culture, the accomplishment of this developmental task has a common element in all cultures. In order to acquire a strong and healthy ego-identity the child must receive consistent and meaningful recognition of his achievements and accomplishments (Muuss, 1975).

Adolescence is described by Erikson as the period during which the individual must establish a sense of personal identity and avoid the dangers of role diffusion and identity confusion (Erikson, 1950). The implication is that the individual has to make an assessment of his or her assets and liabilities and how they want to use them. Adolescents must answer questions for themselves about where they came from, who
they are, and what they will become. Identity, or a sense of sameness and continuity, must be searched for. Identity is not given to the individual by society, nor does it appear as a maturational phenomenon; it must be acquired through sustained individual efforts. Unwillingness to work on one's own identity formation carries with it the danger of role diffusion, which may result in alienation and a lasting sense of isolation and confusion. The virtue to be developed is fidelity. Adhering to one's values contributes to a stable identity.

The search for an identity involves the production of a meaningful self-concept in which past, present, and future are linked together. Consequently, the task is more difficult in a historical period in which the past has lost the anchorage of family and community tradition, the present is characterized by social change, and the future has become less predictable. According to Erikson, in a period of rapid social change, the older generation is no longer able to provide adequate role models for the younger generation. Even if the older generation can provide adequate role models, adolescents may reject them as inappropriate for their situation. Therefore, Erikson believes that the importance of the peer group cannot be overemphasized. Peers help adolescents find answers to the question "Who Am I?" as they depend on social feedback as to what others feel and how they react to the individual. Therefore, adolescents "are sometimes morbidly, often curiously, preoccupied with what they appear to be in the eyes of others as compared with what they feel they are and with the question of how to connect to earlier cultivated roles and skills with the ideal prototypes of the day" (Erikson, 1959).

Pubescence, according to Erikson, is characterized by rapidity of body growth, genital maturity, and sexual awareness. Because the latter two aspects are qualitatively quite different from those experienced in earlier years, an element of discontinuity with previous development occurs during early adolescence. Youth is confronted with a "physiological revolution" within himself that threatens his body image and interferes with the formation of an identity. Erikson maintains that the study of identity has become more important than the study of sexuality was in Freud's time (Muuss, 1975).
Of great concern for many adolescents is the need to settle the question of vocational identity. During the initial attempts to establish a vocational identity some role diffusion frequently exists. Adolescents at this stage hold glamorized and idealized conceptions of their vocational goals, and it is not uncommon that goal aspirations are higher than the individual's ability warrants. Frequently, vocational goal models are chosen that are attainable for only a few: movie heroes, rock musicians, athletic champions, car racers, astronauts, and other glamorized "heroes." In the process the adolescent over identifies with and idolizes his heroes to the extent that he yields his own identity and presumes he has theirs. At this point, according to Erikson, a youth rarely identifies with his own parents; they often rebel against their dominance, their value system, and their intrusion into their private life, since they must separate their identity from that of their family. The adolescent must assert their autonomy in order to reach maturity (Muuss, 1975).

The positive outcome of the identity crisis is dependent on the young person's willingness to accept his past and establish continuity with their previous experiences. The adolescent must find an answer to the question: "Who Am I?" Other questions that must be answered include: "Where am I going?" "Who am I to become?" There must be a commitment to a system of values - religious beliefs, vocational goals, a philosophy of life, and an acceptance of one's sexuality. Only through the achievement of these aspects of ego-identity can it be possible for the adolescent to move into "adult maturity," achieve intimacy of sexual and affectional love, establish deep friendships, and achieve personal self-abandon without fear of loss of ego-identity (Muuss, 1975).

1.6 Risk Behavior and Adolescence:

The troublesome adolescent years have been a documented topic of societal concern for centuries. Plato characterized the adolescents of his era as argumentative and easily excitable, while Aristotle found them impulsive, prone to excess and exaggeration, and
lacking self-restraint. For centuries, the decade of adolescence—from puberty to early adulthood—has been viewed as risky and problematic.

Most common adolescent problems are those of delinquency, drug use, academic failure, and risky sexual behavior. Some experts would add "emotional problems" as a fifth category, including such problems as depression, suicide, anxiety, and eating disorders.

Evidence for the occurrence of all of these problems has been summarized in a number of literature on adolescents. The most recent national statistics are cited below.

**Delinquency, Crime, and Violence:**

- During the 1980s, adolescents accounted for 35.5 percent of non-traffic related arrests while comprising only 14.3 percent of the population.

- The number of youth between 10 and 17 years of age arrested for rape, robbery, homicide, or aggravated assault rose 48 percent between 1986 and 1991, with 130,000 arrests for these offenses occurring in 1991.

- In the mid 1980s, more than 1.7 million youth between the ages of 10 and 17 were arrested, with more than 500,000 of these arrests involving youth 14 years old and younger.

Health risk behaviors are voluntary behaviors that threaten the well being of teens and limit their potential for achieving responsible adulthood. Such behaviors also are commonly referred to as "problem behaviors." Risk-taking is distinguishable from risk outcomes—the consequences of the behavior. For example, unprotected sexual intercourse is a risk behavior, while teenage pregnancy is a risk outcome.

The ten health risk behaviors which researchers have identified are regular alcohol use, regular binge drinking, regular tobacco use, marijuana use, other illegal drug use, physical fighting, carrying a weapon, suicidal thoughts, suicide attempt, and sexual
risk-taking. The consequences associated with these behaviors vary considerably, but each poses a range of potential immediate and long-term health problems.

The definitions of the risk behaviors employed here address regular or established patterns of risk-taking, not just exploratory behavior, by incorporating indicators of recent and frequent participation. For example, "regular tobacco use" refers to the daily use of cigarettes or chewing tobacco during the past 30 days—not infrequent experimentation.

Three recent national surveys—the Youth Risk Behavior Surveys (YRBS), the National Survey of Adolescent Males (NSAM), and the National Longitudinal Survey of Adolescent Health (Add Health)—provide data on the ten risk behaviors.

Other studies have explored additional types of risk-taking, such as dangerous driving, eating disorders, and criminal activity. Conclusions from this study do not necessarily extend to these other types of behaviors.

Finally, both the YRBS and Add Health studies only include students and cannot be used to generalize to all adolescents, including those currently out of school. The surveys likely underestimate the prevalence of risk behaviors among all teenagers, since those who drop out of school are at higher risk of engaging in health risk behaviors. Estimates of risk behaviors among older adolescents will be particularly affected, since they are more likely to drop out or to have completed school.

Besides those above mentioned risk behaviours, adolescents due to their curiosities rooting from rapid physical and physiological changes, become more curious about different things especially about sexuality. The teen years can be tough for both parent and the child. Adolescents are under stress to be liked, do well in school, get along with their family and make important life decisions. Most of these pressures are unavoidable and worrying about them is natural. Owing to cultural barrier among parent-child relationship some children cannot share their personal problems with their parents and become dependent on peer group members. Hence, sometime there is a possibility of
misguidance. At the same time, during this phase a good number of them develop a tendency to take such risks, as premarital and unprotected sex, which sometimes result into early and teenage pregnancy, even sometimes transmission of HIV/AIDS. More than 900,000 American girls-20 percent of those who have had sexual intercourse-become pregnant annually, 30,000 younger than 15. About 40 percent of teenage pregnancies end in abortion, 14 percent in miscarriage (Alan Guttmacher Institute, 1998). Adolescents are far less likely to marry before childbirth. In 1960, only 15 percent of teenage births were to unmarried females, whereas today 75 percent are (Coley and Chase-Landale, 1998). Dependence on substance/alcohol and intake of intravenous injections are other forms of risk behaviours. This apart, over expectation of parents, family violence, gap in parent-child relationship and un-fulfillment of curious mind regarding different issues also cause psychological stress, which in turn affect the career development. Stressed adolescent minds often land up with depression, show aggressive tendencies which could again predispose them more to risk behaviours as those mentioned above.

1.6.1 Adolescents' Premarital Sex and Teenage Pregnancy:

Teenagers who feel incomplete, inadequate and unappreciated are more likely to seek comfort in a sexual relationship. But those with a life rich in relationships, family traditions, activities, interests and — most of all — consistent love and affirmation are less likely to embark on a desperate search for fulfillment that could lead to unwise sexual decisions. Those who have a healthy, productive faith in God are more likely to have deeply rooted reasons to respect and preserve the gift of sex and to respect rather than exploit others. Some factors often act as predisposing ones for adolescent premarital sex are. When there is a steady heterosexual relationship, strong attachments and feelings of exclusivity invite nature to take its course, especially when physical expressions of affection begin early in the relationship. This is a particular risk in a situation where the boy is more than two or three years older than the girl is. When there is a little parental monitoring and parents do leave adolescents alone for hours at a time. Sometimes there are parental beliefs that adolescent sex is appropriate. If
parents think premarital sex is okay, the adolescent will too and will act on that belief. Even parents may believe that adolescent sex is inevitable. Many parents who disapprove of teen sex have also concluded that it is as certain as death and taxes. Their approach to the subject will thus be double-edged: "Don’t do it, but in case you do, use this condom.” Adolescents will get the message loud and clear and are likely to act accordingly.

A low grade-point average/low attachment to school often triggers adolescent to do the same. While school performance is affected by a variety of factors, a basic desire to do well in school reflects a more hopeful outlook on the future and a willingness to put off immediate gratification for long-term goals. Adolescent sex, on the opposite, usually reflects ignorance of or little regard for consequences. This doesn’t mean, of course, that every scholar is a bulwark of morality or that all who are not academically oriented are destined to be promiscuous. What ultimately matters is a person’s commitment to basic values such as responsibility, respect for self and others and concern about the effect of today’s decisions on the future.

A history of physical or sexual abuse is often found to be associated with risks of premarital sex and an early initiation. These acts against children and adolescents violate their bodies, minds and hearts. Sexual abuse creates a grossly distorted view of sexual behavior, destroys boundaries, and drives a deep sense of worthlessness into the emotions. Whether the abuse occurred in the distant or recent past, adolescents with this history need ongoing support, counseling and prayer to help them develop healthy attitudes about sex and about themselves.

Relocation on a frequent interval generally stresses both parents and adolescents (especially if the child resents the decision). This can erode parental authority and distract parents from involvement with their children. Bonds to social supports such as church groups that help prevent sexual activity are severed by multiple moves. Loneliness and loss of friendships may lead some teenagers to use sexual activity to
gain social acceptance. Such relocation leaves the child’s mind disturbed and they lose faith in strong relationships are often prone to sexual involvements.

A single parent family can be a predisposing factor. Parenting is meant to be teamwork, and some risks will naturally increase when one parent is left to do all the protecting and monitoring alone. Some studies do indicate that adolescents living with a single parent are more likely to become sexually active than those living with both parents. Single parents often fail to be as involved and attentive as they need and want to be. And the divorce and desertion that sometimes lead to a one-parent home can make teens uncertain about the value of marriage as the setting for sexual activity and about the role of sexuality in parental relationships. This increased risk does not mean that adolescent sex is inevitable in single-parent families. But it does place an additional responsibility on single parents to send their teenagers clear and consistent messages about sexuality. And it is one more reason for single parents to enlist as much support as they can.

Because of the controversies surrounding premarital intercourse, most of the research conducted on the sexual behaviour of adolescents has focused on the single activity. While this is undoubtedly an important topic of concern, it is also wise to remember that a good deal of the sexual activity of adolescents even sexually experienced adolescents involves other activities than sexual intercourse, such as necking and petting. Moreover most individuals do not begin their sexual careers with intercourse but progress toward it through stages of gradually increasing intimacy.

Given the high rate of sexual activity and poor record of contraceptive use among contemporary adolescents, it becomes as little surprise to learn that many young women become pregnant before the end of adolescence. It is important to keep in mind the not that all adolescent pregnancies result in childbirth. About 40% of all teenage pregnancies are aborted, and slightly more than 10% end in miscarriage. Among women who carry their pregnancy full term, the vast majority, over 90.0% keeps and raises the infant, while one in ten chooses to have the child adopted (Hayes and Hayes, 1992).
Healthy risk-taking is a positive tool in an adolescent's life for discovering, developing, and consolidating his or her identity. Adolescent risk-taking only becomes negative when the risks are dangerous. Healthy risks -- often understood as "challenges" -- can turn unhealthy risks in a more positive direction, or prevent them from ever taking place to begin with. So risks for negative results are to be taken care of.

The percentage of U.S. high school students reporting that they ever had sexual intercourse decreased significantly between 1991 (54 percent) and 2001 (46 percent). The decline was most marked among African American youth (82 to 61 percent) and was also greater among white students (50 to 43 percent) than among Latino youth (53 to 48 percent) (Grunbaum et al., 2002).

Among currently sexually active students in 2001, 58 percent overall reported using a condom at most recent sex, up from 46 percent in 1991. Male students were significantly more likely to report condom use than female students (65 versus 51 percent, respectively). Black students (67 percent) were significantly more likely than white or Latino students (57 and 54 percent, respectively) to report condom use. This significant racial/ethnic difference held for both male and female students (Grunbaum et al., 2002).

1.6.2 Adolescent Substance Use And Abuse:

Adolescent substance use and abuse has become quite a common happening in recent few years. In the United states and other industrialized nations, teenage alcohol and drug use is pervasive (Bauman and Phonsavan, 1999).

- Approximately one of every four young adolescents (12 to 17 years old) report having used illicit drugs, while 50 percent of adolescents over 18 years of age report such use.

- Approximately 10 percent of all sixth graders have initiated alcohol use, and 92 percent of high school seniors report some experience with alcohol. Furthermore, one-third of high school seniors report daily use of alcohol.
• Approximately one of every five high school seniors smokes cigarettes daily.
• By age 14, 56 percent of American young people have tried smoking, 70 percent drinking, and 32 percent at least one illegal drug (usually marijuana). At the end of high school, 22 percent smoke cigarette regularly, 60 percent have engaged in heavy drinking at least once and 50 percent have experimented with illegal drugs. About 30 percent have tried at least one highly addictive and toxic substance, such as amphetamines and cocaine, phencyclidine (PCP), or heroine (US Department of Health and Human Services, 2001b).

Behavioural effects of psychotropic drugs depend on dosing, subject's status (patient or healthy volunteer), acute or chronic administration, and environment. Some psychotropic compounds, particularly sedative drugs, decrease the level of mental alertness and cognitive functioning. But those deleterious effects tend to disappear during the course of a repeated administration. Some psychotropic drugs, especially benzodiazepines, induce a tolerance effect, eventually a psychic or a physiological dependence state evidenced by withdrawal reactions. Such similar dependence processes have been reported with other psychotropic drugs.

Alcohol is the drug of choice among youth. Many young people are experiencing the consequences of drinking too much, at too early an age. As a result, underage drinking is a leading public health problem in this country. Why do so many young people involve themselves into health risk of these substances. However partly it can be influenced by culture. Adolescents live in drug dependent contexts. They see adults using caffeine to wake up in the morning, cigarettes to cope up with daily hassles, a drink to calm down in the evening, and other remedies to relieve stress, depression, and physical illness.

Alcohol is the drug of choice among youth. Many young people are experiencing the consequences of drinking too much, at too early an age. As a result, underage drinking is a leading public health problem in this country.
Each year, approximately 5,000 young people under the age of 21 die as a result of underage drinking; this includes about 1,900 deaths from motor vehicle crashes, 1,600 as a result of homicides, 300 from suicide, as well as hundreds from other injuries such as falls, burns, and drownings.

Yet drinking continues to be widespread among adolescents, as shown by nationwide surveys as well as studies in smaller populations. According to data from the 2005 Monitoring the Future (MTF) study, an annual survey of U.S. youth, three-fourths of 12th graders, more than two-thirds of 10th graders, and about two in every five 8th graders have consumed alcohol. And when youth drink they tend to drink intensively, often consuming four to five drinks at one time. MTF data show that 11 percent of 8th graders, 22 percent of 10th graders, and 29 percent of 12th graders had engaged in heavy episodic (or “binge”) drinking within the past two weeks. The National Institute on Alcohol Abuse and Alcoholism [NIAAA] defines binge drinking as a pattern of drinking alcohol that brings blood alcohol concentration [BAC] to 0.08 grams percent or above. For the typical adult, this pattern corresponds to consuming five or more drinks [men], or four or more drinks [women], in about 2 hours (Smith, 1999; Hingson 2004).

Many adolescents use substance because they want to be like the adults. Research reveals that the majority of teenagers dabble in alcohol as well as tobacco and marijuana. These minimal experimenters are not headed for a life of dependence and addiction. Instead they are psychologically healthy, sociable curious young people (Shedler and Block 1990).

However adolescent drug intake should not be taken lightly. A single heavy dose can permanent injury or death, and most drugs impair perception and thought processes. And a worrisome minority of teenagers move from substance use and abuse-taking drugs regularly, requiring increasing amounts to achieve the same effect, and using enough to impair their ability to meet school, work or other responsibilities.
In contrast to experimenters, drug abusers are seriously troubled young people who are inclined to express their unhappiness through antisocial acts. Longitudinal evidence reveal that their impulsive, disruptive, sensation seeking style is often evident in early childhood. Compared with other young people their drug taking starts earlier (Chassin and Ritter, 2001). Sometimes it can have genetic roots, but a wide range of environmental factors promotes it, for e.g. low SES, family mental health problems, parental and older sibling drug abuse, physical and sexual abuse and lack of parental warmth etc. The risk however remains when teenagers depend on alcohol and hard drug to deal with daily stress, they fail to learn responsible decision making skills and alternative coping techniques.

Peer encouragement – friends who engage in high levels of deviant talk (including law breaking), who use drugs, and who provide access to illegal substance – predicts increased substance abuse and other antisocial behaviours.

James Mc Intosh et al., (2005) examined the experiences of a sample of 43 pre-teenage drug users. The main reasons, which they gave for using drugs, were enjoyment and boredom. These are consistent with the reasons for using drugs reported in studies of older youths. While the children set firm boundaries regarding the drugs, which they would and would not use, several aspects of their experiences give cause for concern. These include the ease with which they were able to obtain illegal drugs, their lack of knowledge of the risks involved with their drug-taking, the tendency of some to combine the consumption of drugs and alcohol, and the secluded or remote nature of the locations in which the drugs were used. The paper concludes by emphasizing the need for interventions, which address the issue of harm reduction for this population and which provide a range of alternative activities as a way of diverting young people from drugs.
1.6.3 Addiction and Adolescents:

At a time when smoking among adults is decreasing in popularity, it is increasing among adolescents and teenagers. Young smokers grow up to be adult smokers, and in many cases, die of smoking-related diseases.

Every day, an estimated 3,000 teenagers begin smoking. According to the Surgeon General, in the lifetimes of those 3,000 teens, 60 will die in traffic accidents, 30 will be murdered, and 750 will die from smoking-related diseases.

Nearly 85 percent of all smokers say they started smoking before age 18. Studies show that the younger a person starts smoking, the more likely they are to become heavy smokers and to develop smoking-related diseases, such as cancer and emphysema.

It is estimated that 3.1 million adolescents smoke. It is most common among high-school seniors, of whom, one in four admits to smoking - even though in most states, Missouri included, it is illegal to sell tobacco products to minors.

Some prevention specialists see Cigarette smoking as a "gateway drug," a substance that leads to the use of other drugs. This is because smoking is seen by many adolescents as an act of defiance of authority and often takes place in groups where other acts of defiance also take place.

Research into the forces affecting cigarette consumption has identified a number of influential factors:

Socio-economic Variables: Several researchers have highlighted income levels and the price of cigarettes as key factors influencing consumption. Bishop et al., (1985) concluded that cigarette costs and excise taxes have a greater impact on consumption than the health scare or the advertising ban. However, Balgati et al., (1991) suggested that taxation may not be as effective as previously thought due to low per capita income elasticity.
Health Care Issues: A number of researchers have examined the effects of anti-smoking messages and the health scare associated with smoking. Hamilton 1972 concluded that anti-smoking messages and the U.S. Surgeon General's Report reduced cigarette consumption much more than advertising had increased it. Warner et al., (1983), however, found that the health scare had little or no effect on cigarette consumption.

Broadcast Advertising Ban: Early studies did not discover any significant impact of the U.S. ban on broadcast advertising for cigarettes on their consumption Boddewyn (1986) reported that cigarette advertising bans in 16 countries have had little, if any, effect on the demand for cigarettes.

Advertising: The effects of advertising on cigarette consumption have been examined by several researchers. Based on annual data covering the years 1925 to 1970, Hamilton concluded that the demand for cigarettes was only minimally related to advertising. In contrast, after analyzing data for the years 1952 to 1968 in the United Kingdom, McGuinnesss and Cowling (1975) found that advertising had a statistically significant effect on aggregate consumption. Similarly, Leefland and Revijl (1985) concluded that advertising appeared to have a significant effect on the primary demand for cigarettes in the German market, although its influence diminished over time. In a recent study, Wilcox (1991) determined that the demand for five cigarette brands exhibited significant positive relationships with their advertising levels. On the other hand, Smith (1990) also studied the impact of advertising on juvenile smoking behavior in 15 countries and found that tobacco-advertising controls did not appear to have the intended impact on the incidence of juvenile smoking.

Interpersonal Variables: Research on adolescent smoking suggests that for beginning smokers, curiosity, social norms, peer influence, and social pressures were the most frequently given reasons for smoking. For current smokers, pleasure and addiction were mentioned most often. Hill and Borland (1991) studied the influences of school,
**Interpersonal Variables:** Research on adolescent smoking suggests that for beginning smokers, curiosity, social norms, peer influence, and social pressures were the most frequently given reasons for smoking. For current smokers, pleasure and addiction were mentioned most often. Hill and Borland (1991) studied the influences of school, work, and other settings on adults' regular smoking behavior. Their results suggested that although school was the dominant setting particularly for younger respondents, the workplace was also an important setting for uptake of regular smoking. Furthermore, about two-thirds of the sample indicated that friends, family, or workmates had influenced them to take up smoking. More recently, Flay et al., (1994) also investigated the differential influence of parental smoking and friends' smoking on adolescents' smoking initiation and escalation of smoking. They found that friends' smoking had both direct and indirect influences on adolescent initiation of smoking, but only indirect effects on escalation. Parental smoking had only indirect effects on initiation and escalation. In general, they concluded that friends' smoking had a stronger effect on adolescents' smoking behavior. This may suggest that when developing interventions, smoking prevention programs need to consider the reasons adolescents give for smoking. Understanding which reasons for tobacco use that are most prevalent at various stages of the smoking onset process might be useful in designing prevention program components to address specific motivations for using tobacco at the various stages.

Cigarette advertising has stronger influence on smoking initiation. These results are counter to Smith's study, which indicated that tobacco advertising has neither direct nor indirect effect on adolescent smoking. It would, therefore, seem a reasonable strategy to suggest further restriction of cigarette advertising by banning the Old Joe Camel cartoon character or all such characters, prohibiting cigarette advertising in magazines with significant youth audiences, permitting only "tombstone" advertising (with just the product packaging), or even banning cigarette advertising entirely. Banning advertising makes it much more difficult for cigarette manufacturers to market their products through warnings on cigarette packs. The federal government ought to embark on an anti-smoking advertising campaign. Although most consumers have been
exposed to the general dangers of smoking, policy makers feel that many are unaware of the specific risks involved. The policy makers particularly note a lack of awareness among potential young adult smokers whose attitudes toward smoking are still evolving. Presenting young adults with specific warning information to assist them over time in their attitude formation about the dangers of smoking can be seen ultimately as one factor influencing smoking behavior. If this information were presented in a way that consumers who acquire it also believe in it, the protective influence intended more likely would result.

1.6.4 Adolescents and HIV/AIDS:

The behaviors of young people, particularly adolescents and risk behaviour taken up by them like those of premarital unprotected sex and use of intra venous injection can make them vulnerable to HIV infection and AIDS. The number of AIDS cases reported annually among U.S. adolescents (13-19 years of age) has increased, from 1 in 1981 to 159 cases in 1992. Through September 1993, a total of 1,412 cases of AIDS among adolescents have been reported. In 1991, HIV infection/AIDS became the sixth leading cause of death among 15- to 24-year olds in the United States.

Although the number of adolescents with AIDS is relatively small, we know many more young people are infected with HIV. Since 1 in 5 reported AIDS cases is diagnosed in the 20-29 year age group, and the median incubation period between HIV infection and AIDS diagnosis is about 10 years, it is clear that many people who were diagnosed with AIDS in their 20s became infected as teenagers.

In the United States, half of all new HIV infections occur in people under age 25; one-fourth in people under the age of 21. Each year U.S. youth under age 20 experience nearly four million sexually transmitted infections (STIs)—including herpes, human papillomavirus (HPV), chlamydia, gonorrhea, and HIV. Although declining rates of vaginal intercourse and increased condom use among sexually experienced youth sound hopeful notes, the increasing HIV epidemic among youth of color—especially young women—and among young men who have sex with men (YMSM) underscores
the need for more focused, gender sensitive, and culturally appropriate prevention programs that will build youth's skills, enhance self-esteem, and promote positive behavior change.

- Because many sexually experienced teens have not been tested for HIV, the actual number of teens living with HIV infection is estimated to be much higher than the reported number (6,587) (Source: CDC, 2002).

- Among youth age 13 to 19, 57 per cent of reported HIV infections occurred among young women and 43 per cent among young men; 66 per cent among non-Hispanic, black youth; 24 per cent among non-Hispanic white teens; and eight per cent among Latino teens. Asian and Native American teens together accounted for less than .009 per cent of reported cases in this age group (Source: CDC, 2002).

- Among youth ages 20 to 24, 64 per cent of reported HIV infections occurred among young men and 36 per cent among young women; 53 per cent among non-Hispanic black youth; 35 per cent among non-Hispanic whites; and 10 per cent among Latino young adults. Asian and Native American youth together accounted for just over one per cent of reported HIV infections in this age group (Source: CDC, 2002).

- Of HIV infection cases reported in 2001 among men ages 13 to 19, 46 per cent occurred in YMSM. Five per cent of infected young men acquired HIV through heterosexual contact. Of HIV infection cases reported among women ages 13 to 19, 37 per cent were acquired heterosexually. Risk factors were not identified for 44 per cent of infected male teens and 57 per cent of infected female teens (Source: CDC, 2002).

- Of HIV infection cases reported in 2001 among men ages 20 to 24, 49 per cent occurred in YMSM. Six per cent of infected young men acquired HIV through heterosexual contract. Among young women the same age, 32 per cent acquired HIV infection through heterosexual contact. Risk factors were not identified for 38 per cent of cases among males and 62 per cent among females this age (Source: CDC, 2002).
• Through 2001, African Americans and Latinas accounted for 84 per cent of cumulative AIDS cases among women ages 13 to 19 and 78 per cent of cases among women ages 20 to 24 (Source: CDC, 2002).

• Through 2001, African Americans and Latinos accounted for 62 per cent of cumulative AIDS cases among men ages 13 to 19 and 60 per cent of cases among men ages 20 to 24 (Source: CDC, 2002).

• In a new study, 93 per cent of HIV-infected black YMSM were unaware of their infection. Seventy-one per cent of those with unrecognized HIV infection said it was very unlikely that they were infected; 42 per cent believed there was little chance they would ever be infected; and 37 per cent had unprotected anal intercourse in the previous six months (Source: CDC, 1994-98).

• In another study, only 18 per cent of HIV-infected YMSM were aware of their HIV status (Valleroy et al., 2000), a finding more common among the black (91 per cent) than among the white (60 per cent) HIV-infected YMSM.

• Research suggests that adolescents rarely use condoms or other barriers during oral sex since many consider it to be either "safer sex" or abstinence. Many Americans, including youth, may not understand that HIV, HPV, herpes simplex, hepatitis B and C, gonorrhea, syphilis, and chlamydia can be transmitted during unprotected oral intercourse (Remez, 2000).

• While racial-ethnic identity and socio-economic status do not determine HIV infection, structural racism within the United States that leads to greater likelihood of poverty and drug use in minority, urban communities creates an environment of high risk for many African American and Latino women (Weeks et al., 1995; Villaruel, 1998).

1.6.5 The Nature Of Adolescent Risk Taking:

The persistence of problem behavior throughout the centuries combined with the magnitude of contemporary problems suggests that there is an inherent risk in being an adolescent. Many social scientists believe that a basic lack of control during adolescence leads to the high-risk profile (Gottfredson, 1994). Several dimensions of adolescent problem behavior and risk taking are noteworthy.
The pattern of problem behavior is the same for both the high risk and low risk groups. Individuals with many problems and those with few problems experience similar developmental changes over the life span. While the frequency and magnitude of these problems differ in general, both high and low risk groups reach the peak in deviant behavior during late adolescence and early adulthood. Because of this pattern of increased risk, prevention efforts should focus on all youth during the adolescent years.

The rate of problem behavior rises dramatically in early adolescence. Because risky and problematic behavior soars at the initiation of puberty and continues to rise into early adulthood, prevention efforts should target pre-adolescents. Sharp inclines among the highly problematic group during the elementary school years indicate a need to start prevention efforts in early childhood.

At the peak of deviancy, the rate for the high-risk group is twice that of the low risk group. Resources allocated to the prevention of deviancy should be increased and address potentially high-risk audiences. Universal prevention efforts targeting all adolescents should be maintained, but significant resources should be allocated to reducing the tremendous gap in deviancy between the low risk group and the high-risk group.

The rate of problem behavior begins to decline after approximately 23 years of age. As dramatically as problem behavior escalates during adolescence, it decreases during early adulthood. Between the ages of 22 and 27, deviancy rates drop by approximately 50 per cent, and continue to decline throughout adulthood. Intense intervention efforts may be justified when problem behavior peaks during late adolescence and early adulthood, but may not be as necessary as problem behavior naturally begins to decline.

During a 10-year period (between the ages of 13 and 23), highly problematic behavior is consistent in both the high and low risk groups. The most optimistic evidence
presented is the relatively short period of time (approximately 1 decade) when problem behavior escalates beyond acceptable limits. Effective prevention and intervention efforts should be strategically targeted to precede this period of time and be maintained primarily throughout the course of the adolescent decade.

The most serious threats to the health and safety of adolescents and young adults are preventable. They result from such risk-taking behaviors as fighting, substance abuse, suicide, and sexual activity rather than from illnesses. These behaviors have harmful, even deadly, consequences.

Changes in teen participation in specific risk behaviors have been well documented. What is less well known, and of growing concern, is how overall teen risk-taking has changed. In addition, information is lacking about the nuances in the behavior of adolescents who engage in more than one of these risks at a time. Teens who participate in multiple risks increase the chance of damaging their health.

- Regular alcohol use
- Regular binge drinking
- Regular tobacco use
- Marijuana use
- Other illegal drug use
- Fighting
- Weapon carrying
- Suicidal thoughts
- Suicide attempts
- Risky sexual activity

The complex picture that emerges alleviates some traditional concerns, while raising new ones. Teens' overall involvement in risk-taking has declined during the past decade (except among Hispanics), with fewer teens engaging in multiple risk behaviors. But multiple-risk teens remain an important group, responsible for most
adolescent risk-taking. However, almost all risk-takers also engage in positive behaviors; they participate in desirable family, school, and community activities. These positive connections offer untapped opportunities to help teens lead healthier lives.

1.7 Violent Behavior: Most Widespread In Adolescence:

Violent behaviours are quite among adolescents. The problem of adolescent violence against parents is not new; its recognition in the public sphere has emerged only recently. Consequently, there has been little research into the causes and effects of adolescent violence against parents, and into the most effective ways of assisting parents who have been challenged in their role as carers.

Some young people develop the idea that they are entitled to get what they want even when this means using violence and/or abuse to intimidate or control members of their families.

Adolescents may use power as a means of control over parents. In some instances, parents who had previously been victims of either child or partner abuse respond to adolescent violence as victims, surrendering the role of adult or a person of authority (Downey, 1997).

Factors that put adolescent children at risk of becoming violent are grouped into five categories: individual; family; peer group; schools; and community, which include neighbourhood and the larger society (US Surgeon General, 2001). As a result of a research focus on parenting styles, risk factors are rarely placed into a mutually dependent framework, which potentially obscures our understanding of adolescent violence against parents. For instance, a sole focus on the role of children as perpetrators at home fails to understand violence in a wider context as these children could concurrently be victims of bullying at school (Cottrell, 2001). However, the most common explanations of adolescent violence emphasize individual and family contexts.
When examining the family context in which adolescent violence occurs, research identifies three types of families. The first one has inadequate parental guidance and supervision, in which adolescents assume an autonomous role that often results in violence (Wilson et al., 1996). Cottrell (2001) warns that equal parent-child relationships can result in a boundaries vacuum, where children are not set any limits. In the second type of family, parents are overprotective of adolescents, and the latter’s struggle for autonomy can result in violence (Heide, 1992; Polk 1998). In the last category parents are often unable to fulfill their role as adults for whatever reason, and adolescents are forced to take on this role (Downey, 1997). This burden can be overwhelming and result in violence.

Many studies provide evidence to suggest that adolescents who are violent towards their parents have often either been abused as children or have witnessed violence between parents. “What seems to be happening is that young men, having seen their fathers beat their mothers, learn that she is an appropriate victim” (Brown, 1997). In other words, in addition to trauma, children may face “behavioural, emotional, physical and cognitive functioning, attitudes and long-term developmental problems” (Mitchell and Finkelhor 2001), due to their having experienced or witnessed violence. This may mean that they are also at risk of accepting violence as a solution to interpersonal conflict (Mitchell and Finkelhor, 2001). This is especially emphasized in relation to boys, who “more than girls identify with their fathers” (Cottrell, 2001).

Whilst exposure to violence at home is one of the risk factors for adolescents to become violent, focusing only on families who are the subject of parental abuse further exacerbates the problem, as it promotes feelings of shame and guilt in parents with violent adolescents, making them even less likely to report it and seek outside assistance. The more permeating level of violence that all adolescents are exposed to is societal. Adolescents are exposed to violence on the Internet, TV, computer games and other ‘pop culture mediums’. Further still, adolescent boys are also subject to social norms that promote physical strength and authority as defining qualities of being a
Peer pressure that encourages “macho” behaviour and involvement in activities such as teen gangs are examples of how such norms are manifested. These wider social influences are crucial in explaining the creation of values and beliefs that underpin violence; however, their acknowledgement in the literature is lacking.

1.8 Parent-Child Relationship:

The family is a system, - a system in which relationships change in response to the changing needs and concerns of family members and in response to changes in the family’s relationships with the larger society (Minuchin, 1974). And like other systems, families attempt to maintain a sense of equilibrium in their relationships. Relationships in families always change most dramatically during those times when individual family members are changing or when the family’s circumstances are changing, since it is during these times that the family’s previously established equilibrium would be upset. During these times, it is healthy for family relationships to change, for through such changes families restore balance to the system. Not surprisingly, one period in which family relationships usually change a great deal is adolescence.

Family has a very major significance in an adolescents’ life. When there is the search for identity and the peers may not be able to show the adolescent the right direction to proceed, the family and its support specially the parents becomes essential for the teenager to be on the proper track. Adolescence is marked by disagreements, bickering, emotional tensions, and minor conflicts with parents over the everyday details of family life, such as doing the chores, feeding the pets, doing schoolwork, and getting along with siblings’ (Shulman, 1991). The family is the first source of socialization for the adolescent. But during adolescence peer groups become the largest source of teen socialization (McFarlane, 1995). Both supportive family and peer relationships are associated with higher levels of social self-efficacy—the extent to which the adolescent feels capable of producing a desired social outcome (McFarlane, 1995).

Adolescence is a time when children strive to become adults, and parents, whose goal it was to raise happy, healthy, independent adults, find it struggling to keep them from
getting there too fast. Actually, the struggle is a bit more complex than that. Parents need to know that their children are ready for each step they take. Adolescents are worried about what they are ready for too, but rather than share the concerns, they need to prove to themselves that they can take the next step. They are always pushing the envelope. They are always ready to try something before parents are ready to let them. And the real paradox of parental anxiety is that adolescents can't prove that they are ready to do something until parents let them do it. Adolescence is a time when children grow into adults and parents grow into parents of adults. This is the most crucial phase when parental gap widens and there are ample possibilities of conflict, revolution, distance and misunderstanding. Parents as they are the matured group among the two should make every possible effort to make things better, act little logically, understand their wards, and accept them with intelligent handling.

At this tender age as adolescents' communication between adolescents and parents, if not taking place in a proper manner may scratch interpersonal relationships. The cornerstones of honest communication are mutual trust, mutual respect, mutual consideration, and listening. The word "mutual" bears the connotation that communication is a two way street. If parents want respect, they must respect their children's honest feelings and opinions even if they don't agree with them. To accept a teen's point of view is not to agree with it or even condone it. However, any teen who demands the right to be heard must be willing to hear his parents' point of view as well with an aim to understand it and respect it even if he doesn't agree with it. The power of real communication is so enormous that it can be a real selling point to get teens' cooperation, but adolescents will not talk about what they really feel unless they believe that their parents are really interested and willing to listen. The teens must feel free to express any idea fully without interruption, and then they must return the favor to their parents. A free discussion of ideas must convey values without being judgmental toward the participants. This will only happen in an environment of mutual trust.

Communication if healthy among parents and adolescents can do a lot to narrow down parental gap. To maintain a healthy parent child relationship, which is a root to any
sweet home and healthy development of child, parental gap should be reduced to minimum. Parents should with their own initiative try to build a platform for open interaction where the two parties behave like friends. The adolescents should always be encouraged to share their problems and open their minds in front of the parents. Adolescents' curiosity can take them to routes awfully unknown and extremely undesirable. In this case the role of the mother is very important. She can play an active role to minimize the gap with her child and assure her that she is a friend to her, so that at any point of time the child can come up with her problems and speak to the mother. Too harsh discipline, restrictions and strict impositions create a firm barrier between the parent and the child. Parents should try to understand the child, explain the strange happenings related to their particular age and clear all their doubts regarding sex related matters and similar other matters.

The standard teen battle cry in the arena for negotiating limits is, "You have to trust me!" And the standard parents' answer is, "Trust has to be earned." Parents must ask themselves, "How will my teen earn my trust if I don't permit him to prove himself in a situation where I must trust him?" One crucial aspect of trust that teens must learn to understand is that trust is not always about them. Most teens never think much about being in a circumstance where things happen that they can't control. The mutual aspect of trust is that teens must trust their parents enough to be honest with them about what's going on in their lives. When parents know what their teens are up to, they worry less, and so trust more. Those teens who try to get around the limits by being dishonest with their parents rather than negotiating honestly for new privileges need to be made aware what a valuable commodity they lose when they lose their parents' trust. It also stands to reason that parents must earn their children's trust. If your response to most problems is predictably awful, don't expect your kids to come to you with their life stories.

One of the biggest pieces of the communication gap between parents and teens is that parents fail to convey their humanity to their children. In their efforts to control their teens, they never admit that they are frightened, or don't have all the answers, and yet a discussion of what a parent is truly concerned about will provide so much more of an opportunity for an adolescent to answer his parents concerns and avoid unnecessary
restrictions. "You can't go to the dance because you're too young" doesn't foster communication about a parent's real concerns about sexuality and drugs. Such a discussion might provide the parents with real reassurances about chaperones and security. In the absence of such reassuring information it might be sufficient for the parents to know what their teen's attitude is toward their concerns. Finally, if a parent is anxious about certain situations, he might educate his child and get the reassurances he needs by trying a little role-playing for certain situations. For example, asking the child what he would do if someone approached him with drugs might not only provide the parent with some reassurance, but if the parents then play the role of someone trying to convince the child to take the drugs, playing through the scenario might help the child figure out how to handle such a situation and give him the confidence necessary to do what's right.

Loneliness is a prevalent and serious problem among adolescents. Changing family structure and characteristics of the parent-child relationship influence attachment sentiments of adolescents predisposing them to the experience of loneliness.

Children and parent seem to have some pre-conceived notion that magical and wonderful things will happen during middle school and high school. It really is only a notion. Reality rears its head, and the wonder and magic of the notion are gone. The adolescent train has arrived and, as yet, the destination is unknown. As the train leaves the pre-teen years behind, neither parent nor child know where they are starting, or where they are going. Academic pressures have increased, social pressures and circles have grown, and parents are restricting the adolescent's movements daily. The adolescent struggles for independence and begins testing limits. Parents need to meet these challenges by giving the adolescent responsibilities and providing them with opportunities to make decisions. Parents will be tested to see if they will provide safety and unconditional love. The family as a system will strive to find a balance between the internal and external pressures they face. This will be a challenge, as both parent and adolescent are attempting to find their own niche in a world that is ever changing.
Parenting is a crucial job. Parenting is a lot like playing a game. The only problem is that this game comes with no instructions and mistakes can have long lasting effects on many people. So, it is essential for the parents to establish how the game of life is going to be played out, by determining rules and consequences. The first step to establishing these rules is to do a self-assessment. This assessment allows each parent involved to identify their expectations and determine a strategy for accomplishing these goals with their adolescent. Each child's response to adolescence is unique. Parents should understand that expectations need to be redefining, as the dynamics of the family and the environment evoke transformations on each individual.

Communication is an interrelated part of the family system. Conversations provide a link between parent and adolescent. A healthy family system permits an even flow of information exhibiting good communication patterns. To assure open expression parents must practice giving congruent messages both verbally and nonverbally.

It has been a matter of controversy whether families with working mothers have negative influence on child development as compared to those with non-working mothers. Mothers are taken to be the best caregivers to the children, children may go astray when they are at home long hours without parental supervision. Even mothers who are working, come back home after hard day's toil and seldom find to give some quality time to their children. So controversial results exists about the issue. It appears that the quality of the time the parents and the children spent together, along with the making of adequate child-care arrangements, outweighs the number of hours (Bralove, 1981; Easterbrooks and Goldberg, 1985). When mothers choose to work and find their work fulfilling, they are happier with their lives. They and their husbands are more egalitarian in the distribution of chores in the homes as well as in the bread-winning role (Gold and Andres, 1978a, 1978b, and 1978c). Perhaps the working mothers' feelings of competence and high self-esteem transfer into more productive relationships with their children in the home.

When seen beyond primary attachment, research with older children suggest that maternal employment, by itself, in unlikely to impede a child's social and emotional
development. In fact, the opposite may be true, for children of working mothers (particularly daughters) tend to be more independent, to enjoy higher self esteem, and to hold higher educational and occupational aspirations and less stereotyped views of men and women than those whose mothers are not employed (Hoffman, 1989; Richards and Duckett, 1994). Moreover, studies of toddlers (Schachter, 1981), grade school children (Gold and Andres, 1978b), and adolescents (Gold and Andres, 1978a) consistently indicate that children of employed mothers are as confident in social settings as children whose mothers remain at home and are somewhat more sociable with peers. Finally, one recent study of a national sample of low-income families links maternal employment to children’s cognitive competence: Second-graders whose mothers had worked a great deal outperformed those whose mothers had worked less (if at all) in mathematics, reading and language achievement (Vandell and Ramanan, 1992). Although there have been reports that young children of working mothers are somewhat more aggressive and less obedient than children cared for at home by mothers who are not employed (Clarke-Stewart, 1989; Hoffman, 1989), these ‘negative returns’ are generally small in magnitude (Bates et al., 1994) are often limited to children receiving low quality daycare where children’s activities are not closely supervised (Howes, 1990; Vandell et al., 1988).

Parents have a role in guiding their adolescent in how to select friends. Open communication about day-to-day events makes parents less threatening when talking about friends. The friends an adolescent chooses will affect the whole family. The importance of peer groups and the need for acceptance by peers increases in the adolescent years (Newman and Newman, 1995). The family system will be impacted by peer group membership, therefore, it is necessary to define friendship and discuss expectations that are mutually agreed upon when considering a person as a friend.

Views on adolescent maturation attribute the destabilization of parent-adolescent relationships to varying features of adolescent maturation. Psychoanalyt theorists (Freud, 1958; Freud, 1949) assumed that hormonal changes at puberty give rise to unwelcome oedipal urges that foster impulse control problems and anxiety, as well as rebelliousness and distance from the
family. More recent psychoanalytic formulations (Blos, 1979; Erikson, 1968) emphasized adolescent autonomy striving and ego identity development rather than impulse control.

No relation can be complete without some type of conflict prevailing. Parent-child relation is also no exception. Theories of adolescent development give a central role to increasing conflict in relationships with parents and to increasing closeness with peers and extra-familial adults (Laursen and Collins, 1994). Surveys of adolescents indicate that disagreements are most common with mothers, followed by siblings, friends, and romantic partners, then fathers; angry disputes arise more frequently with family members than with close peers (Laursen, 1995).

Providing appropriate discipline to children is one of the most essential responsibilities of a parent. And providing consistent and positive discipline helps children grow into responsible adults.

Physical disciplining with the use of corporal punishment is not desirable for healthy development of the child. Physical discipline is not an effective technique for several reasons. Physical punishment doesn't teach the child what to do, only that some behavior is wrong. Children may also behave appropriately out of fear, and then the behavior change may not generalize to other situations. They may also only behave when the parent or another adult is around. One thing that is then learned is how to be sneaky. For discipline techniques to be most effective, they must occur in the context of a relationship in which children feel loved and secure. In this context, parents' responses to children's behavior, whether approving or disapproving, are likely to have the greatest effect because the parents' approval is important to the children.

In sum, healthy parent child relationship, proper discipline, reduced parental gap, proper communication, attachment with parents, can all go a long way in the proper development of the child and reduce the possibilities of risk behaviour and unwanted behaviours from the child.
Violence in the family is as old as history of mankind, but recently the problem has been recognized and researches have been directed towards it. Discussing family violence directed at adolescents poses two problems. The first is that the concept of adolescence as a distinct developmental stage in the life cycle is difficult to apply cross-culturally. In some societies, like our own, adolescence is a long, drawn-out stage with a clear beginning and somewhat less clear end-point. But, in other societies, there is no comparable stage, with children passing directly from the status of child to that of adult, sometimes with and sometimes without the benefit of a formal ceremony marking the transition. Thus, for the purposes of discussion, adolescence is equated with the life stage, regardless of physical maturity, during, which the child is seen by members of his or her society as preparing for or passing into adulthood.

A part of family violence is sibling abuse. Sibling abuse can be defined as physical, emotional or sexual abuse of one sibling. It ranges from relatively mild forms of aggression occurring between siblings, such as pushing and shoving, to extremely violent behavior such as the use of a gun or knife by one sibling against another.

Excluding acts such as slaps, pushes, kicks, bites, and punches, it has been estimated that three children in 100 are dangerously violent toward a brother or sister. When all types of mild aggression and extreme violence toward a sibling are considered, the estimate soars to more than 36 million individual acts of sibling aggression each year. It appears that sibling abuse is the most common and the most overlooked form of family violence.

Over the last three decades, researchers, clinicians, and other health advocates have explored the incidence, prevalence, and consequences of sexual violence occurring within the context of domestically violent relationships, including adult marital and cohabiting relationships. In fact, most research, education, and preventative measures with adolescent populations have largely been related to sexual violence perpetrated by a parent or caregiver.
Though much information exists on sexual violence occurring within adult relationships, extrapolation of these findings to relationships among adolescents, including acquaintance and dating relationships, is problematic (Source: American Academy of Pediatrics, 2001). Despite many similarities, the risk factors for and consequences of sexual violence within adolescent relationships differ from sexual violence within adult marital and cohabiting relationships.

When child sexual abuse by a parent or caregiver is excluded from the analysis, most sexual victimization experienced by young women is perpetrated by dating partners or acquaintances and may occur in the context of other dating violence, including physical and emotional abuse.

1.10 Sexual Abuse: Shows Face In Childhood Walks Through Adolescence

Sexual abuse is any sexual contact between a child and another person from fondling to rape, with or without force. It is a heinous crime for which there is no excuse nor should there be any tolerance. It has a direct and potentially permanent impact on the victim's self-esteem. Few victims enter adulthood without symptoms of the crime perpetrated against them as children.

Sexual abuse is committed against children of both sexes but more often against girls. Most cases are reported in middle childhood, but sexual abuse also occurs at younger and older ages. For some victims, the abuse begins early in life and continues for many years. (Trickett and Putnam, 1998). The adjustment problems of sexual abuse victims are often severe. Depression, low self esteem, mistrust of adults, and anger and hostility can persist for years after abusive episodes.

Child sexual abuse differs from rape although rape is a category of child sexual abuse. Children are more often victimized by family members or friends than are rape victims. Child victimization more often consists of repeated incidents, and less physical force and violence is used than in rape. Importantly, child sexual abuse does not necessarily involve sexual intercourse.
Christine Lawson describes various ways in which women can sexually abuse children (1993).

**Subtle abuse** is defined as behaviors that may not intentionally be sexual in nature but serve to meet the woman’s emotional and/or sexual needs at the expense of the child’s emotional and/or developmental needs (Lawson, 1993).

**Seductive abuse** is defined as sexual stimulation that is inappropriate for the child’s age and/or is motivated by the woman’s needs.... Seductive abuse implies conscious awareness and intention of arousing or stimulating a child sexually (Lawson, 1993).

**Perverse abuse** occurs when the child sexual development is distorted by the behaviors of the abusers.

**Overt sexual abuse** is defined as overt sexual contact between a woman and a child. Overt sexual abuse involves some form of coercion and/or threats to discourage disclosure (Lawson, 1993).

**Sadistic sexual abuse** includes (female) sexual behavior that is intended to hurt the child and may be part of a general pattern of severe physical and emotional abuse. No studies have looked at the actual incidence and/or prevalence of sexual abuse by women, thus it has to be seen in relation to what is already known of the prevalence of child sexual abuse.

Serious sexual abuse in childhood (up to the age of 16 or 17) involving unwanted or coerced sexual contact occurs in at least 15.0 per cent of females in the populations surveyed and in at least 5 per cent of males. Because of various methodological factors, these are likely to be the most conservative or minimum estimates (Bagley and King 1990). The percentage of sexual contact by older female to be about 20.0 per cent.
Children and adolescents who have been sexually abused can suffer a range of psychological and behavioral problems, from mild to severe, in both the short and long term. These problems typically include depression, anxiety, guilt, fear, sexual dysfunction, withdrawal, and acting out. Depending on the severity of the incident, victims of sexual abuse may also develop fear and anxiety regarding the opposite sex or sexual issues and may display inappropriate sexual behavior. However, the strongest indication that a child has been sexually abused is inappropriate sexual knowledge, sexual interest, and sexual acting out by that child.

One of the greatest burdens on children who have been sexually abused is the guilt they carry, often for the rest of their lives. The long-term effects of guilt, the trauma of feeling betrayed and all the secrecy involved is terrible for abused children even when they have reached adulthood and parenthood themselves.

Social, cultural, physiological and psychological factors all contribute to the outbreak of incest taboo. Incestuous behaviour has been associated with alcohol abuse, overcrowding, increased physical proximity, and rural isolation that prevent adequate extra-familial contacts. Some communities may be more tolerant on incestuous behaviour while majority is not. Generally, major mental disorders and intellectual deficiencies have been described in some incestuous perpetrators and sexual abusers. Depending on one's perspective, incest may be considered a form of child abuse, pedophilia, or a variant of rape.

Sexually abused children frequently display sexual knowledge and behavior beyond their years. They have learnt from their abusers that sexual overtures are acceptable ways to get attention and rewards. As they move toward adulthood, many abused girls become promiscuous, believing that their bodies are for others to use. Women are likely to choose partners who abuse them and their children (Faller, 1990).
sexually abused children are prone to become desperate in their lives and chances to be prone to risk behaviours are quite common. Even as mothers they often show poor parenting skills, abusing and neglecting their youngsters (Pianta et al., 1989).

Other than these, a variety of other symptoms, behavioural changes, and diagnosis sometimes occur in sexually abused children/adolescents:

- Anxiety symptoms such as fearfulness, phobias, insomnia, difficulty at bath time and bedtime, nightmares that directly portray the abuse, somatic complaints, and posttraumatic stress disorder.
- Dissociative reactions and hysterical symptoms such as period of amnesia, daydreaming, hysterical seizures, and symptoms of dissociative identity disorder.
- Depression manifested by low self-esteem and self-destructive behaviours and self-manipulative behaviours.
- Disturbance in sexual behaviours as an adult including emotional problems related to intimacy, sex guilt and sex anxiety.
- Somatic complaints, such as enuresis, anorexia, obesity, headache and stomachache.

1.11 Peer Pressure: The Key Influencing Agent In The Life Of Adolescent

As children grow, develop, and move into early adolescence, involvement with one's peers and the attraction of peer identification increases. As pre-adolescents begin rapid physical, emotional and social changes, they begin to question adult standards and the need for parental guidance. They find it reassuring to turn for advice to friends who understand and sympathize — friends who are in the same position as themselves. By "trying on" new values and testing their ideas with their peers, there is less fear of being ridiculed or "shot down". Yet, the word "peer pressure" many adults cringe because the words are laden with negative connotations. The idea that someone, or something, lures children into learning dangerous and destructive behavior by discarding all parental behaviors and values, scares adults.
Sizes of adolescents groups are small. Adolescents' peer groups are usually organized around cliques, small groups between 2 and 12 individuals – the average is about 5 or 6 – generally of the same sex and age. Cliques play a vital role in structuring adolescents' social activities. Usually, teenagers who are in the same clique plan their social and leisure activities together, do things together, and go to places as a group. The clique provides the adolescent with a sense of identity, by serving as a basis of comparison, or reference group. It is partly through comparison with other clique members that adolescents learn about themselves and evaluate their experiences in school, at home, and in the broader peer group. Clique identities are important not only because adolescents use them when talking about one another but also because they become the basis for an adolescent's own identity. Because adolescent's peer group plays such an important role as a reference group and a source of identity, the nature of the crowd with which an adolescent affiliates is likely to have an important influence on his/her behavior, activities, and self-conceptions.

The peer group is critical to an adolescent's healthy emotional development and it doesn't take an Einstein to realize that teenagers prefer each other's company to that of their parents. Although this is a normal and expected part of growing up, parents can still feel a sense of rejection and loss as the child who used to love to help mother in the kitchen or toss around a baseball with father, in the adolescent years prefers to spend every free minute with friends.

Friends provide a sense of security. Feeling part of a group gives teens the confidence to move from childlike dependence upon parents to a more interdependent relationship, an important task of adolescence. Belonging to a group of friends also helps teens as they are developing their, as yet, fragile sense of identity. They can be confused and anxious as they ponder questions like Who am I? And what do I want out of life? Feeling a part of a group, whatever type it is, allows them to feel like they are on their way to answering some of these unsettling questions, at least in part.
Peer relations are extremely important for the teen in that they experience a whole new realm of reality, unique to themselves. Teens are more self-disclosing to peers about things like dating, views on sexuality, personal experiences, common perspectives, interests, and doubts. One can expect that teens tend to spend more time with peers outside of the classroom (approximately 20 hours per week). The frequency of time spent with peers increases as the time spent with parents and family decreases throughout the course of adolescence (Savin-Williams, 1979).

Friends are also important as models of new skills and social behaviors, some good and some not so good. Teenagers learn about what's acceptable in their social group by "reading" their friends' reactions to how they act, what they wear, and what they say. The peer group gives this powerful feedback by their words and actions and so either encourages or discourages certain behaviors and attitudes.

Peer pressure is one of the most potent forces in a child's life, but influence is often subtle. The child may not even realize that he/she's being pressured. And not only from peers: positive and negative pressures also come from parents, teachers and the media.

There are two main ways that the peer group can alter adolescent behavior, either verbally or non-verbally. Direct verbal pressure on the adolescent to perform risky behavior is not common; more often the peer group will use more subtle ways to get compliance from the adolescent (Savin-Williams, 1979). For instance, the group is not likely to force or order the teen to drink beer, but may allude to him being a baby and the teen will drink so he will look better in their eyes. A nonverbal method can be staring at one of the group members until he feels uncomfortable and then performs the behavior.

Adolescent/teenagers submit to peer pressure for many reasons:

- To get a sense of acceptance and belonging
- To get recognition
- To look mature
- To have fun
Negative peer pressure happens when the child's friends ask him, or otherwise try to influence him/her, to do something he knows is wrong. The child doesn't want to say "no" because:

- He doesn't want to be left out
- He doesn't want to seem like a "goody-goody"
- He doesn't want to lose friends
- He's afraid they'll tease him and spread rumors around school

Adolescents experience pressure from all domains. Negative peer pressure has always been a factor in adolescence. Adolescent problem behaviours, particularly those involving drug abuse, delinquency and sexual acting out are the result of negative peer pressure. However, the flip side is that there is also positive peer pressure. Studies of peer pressure indicate that most teenagers feel that their friends are likely to pressure them not to use drugs or not to engage in sexual activities (Steinberg, 1996). There are also positive pressures to participate and excel in athletics, music, and various other types of extracurricular activities (Steinberg, 1996). This can be viewed as a way for adolescents to become better rounded, exploring positive domains other than academics. Adolescents during this period are very aware of social status of different groups and this can affect self-evaluation. If an adolescent perceives himself in an unpopular or low status group, this can harm or decrease their self-worth and self-esteem. The fact is, peer pressure can be positive. It keeps youth participating in religious activities, going to 4-H meetings and playing on sports teams, even when they are not leaders. It keeps adults going to religious services, serving on community committees and supporting worthwhile causes. The peer group is a source of affection, sympathy and understanding; a place for experimentation; and a supportive setting for achieving the two primary developmental tasks of adolescence. These are: (1) identity — finding the answer to the question "Who Am I?" and (2) autonomy — discovering that self as separate and independent from parents. It is no wonder, then, that adolescents like to spend time with their peers.

The adult perception of peers as having one culture or a unified front of dangerous influence is inaccurate. More often than not, peers reinforce family values, but they
have the potential to encourage problem behaviors as well. Although the negative peer influence is overemphasized, more can be done to help teenagers experience the family and the peer group as mutually constructive environments. Here are some facts about parent, adolescent and peer relations:

1. During adolescence, parents and adolescents become more physically and psychologically distant from each other. This normal distancing is seen in decreases in emotional closeness and warmth, increases in parent-adolescent conflict and disagreement, and an increase in time adolescents spend with peers. Unfortunately, this sometimes is caused because parents are emotionally unavailable to their teenaged children.

2. Increases in family strains (economic pressures, divorce, etc.) have prompted teenagers to depend more on peers for emotional support. By the high school years, most teenagers report feeling closer to friends than parents. Stress caused by work, marital dissatisfaction, family break-up caused by divorce, entering a step-family relationship, lower family income or increasing expenses, all produce increased individual and family stress.

3. Parent-adolescent conflict increases between childhood and early adolescence, although in most families, its frequency and intensity remain low. Typically, conflicts are the results of relationship negotiation and continuing attempts by parents to socialize their adolescents, and do not signal the breakdown of parent-adolescent relations. Parents need to include adolescents in decision-making and rule-setting that affects their lives.

4. In 10 to 20 per cent of families, parents and adolescents are in distressed relationships characterized by emotional coldness and frequent outbursts of anger and conflict. Unresolved conflicts produce discouragement and
withdrawal from family life. Adolescents in these families are at high risk for various psychological and behavioral problems.

5. Youth gangs, commonly associated with inner-city neighborhoods, are becoming a recognizable peer group among youth in smaller cities, suburbs, and even rural areas. Gangs are particularly visible in communities with a significant portion of economically disadvantaged families and when the parent is confliction, distant or unavailable.

6. Formal dating patterns of two generations ago have been replaced with informal socializing patterns in mixed-sex groups. This may encourage casual sexual relationships that heighten the risk of exposure to AIDS and other sexually transmitted diseases.

7. As high schools become more culturally diverse environments, ethnicity is replacing individual abilities or interests as the basis for defining peer "crowds." Crowds can be an important source of ethnic identity, but also the center of racial and ethnic tension in schools.

8. There has been an increase in part-time employment among youth, but it has had little impact on peer relations. To find time for work, teenagers drop extracurricular activities, reduce time spent on homework, and withdraw from family interactions, but they "protect" time spent with friends.

Adolescents are better able than younger children to express their thoughts and feelings and share them with friends. Gender affects friendships too. Emotional support and sharing of confidences are particularly vital to female friendships throughout life (Blyth and Foster-Clark, 1987; Bukowski and Kramer, 1986). Boys and men tend to count more people as friends than girls and women do, but male friendships are rarely as close as female friendships. In a survey of 134 sixteen- to eighteen year old girls,
those who had the closest friendships also had affectionate ties with their mothers, saw their mothers as non-authoritarian, and wanted to be like their mothers. Their close relationships with their mothers may well have helped these girls to develop enough trust and autonomy to be ready for intimacy with other people. Adolescents who have close friends are high in self-esteem, consider themselves competent, and do well in school; those whose friendships involve a high degree of conflict score lower in all these measures (Berndt and Perry, 1990). Adolescents tend to choose friends who are already like them; then, friends influence each other to become even more alike (Berndt, 1982; Berndt and Perry, 1990). Friends tend to have similar status within the larger peer group. Similarity is more important to friendship in adolescence than later in life, probably because teenagers are struggling to differentiate themselves from their parents and, as a result needs support from people who are like them (Weiss and Lowenthal, 1975). This need for support also shows in the way adolescents often imitate each other’s behavior and are influenced by peer pressure. As a result, adolescents some time find themselves in a tug-of-war between parents and peers.

Dependence on peers during the adolescent years is thus a inevitable and it depends definitely on the type of interaction that occurs with the peer group that influences whether an adolescent would take up risk behaviour under their pressure or not.

1.12 Depression and Adolescents:

Depression in adolescents has long been conceptualized as a normal or transient phenomenon necessitating no therapeutic intervention. Depression is a disorder occurring during the teenage years marked by persistent sadness, discouragement, loss of self-worth, and loss of interest in usual activities. Depression can be a transient response to many situations and stresses. In adolescents, depressed mood is common because of the normal maturation process; the stress associated with it, the influence of sex hormones, and independence conflicts with parents.

It may also be a reaction to a disturbing event, such as the death of a friend or relative, a breakup with a boyfriend or girlfriend, or failure at school. Adolescents, who have
low self-esteem, are highly self-critical, and who feel little sense of control over negative events are particularly at risk to become depressed when they experience stressful events.

True depression in teens is often difficult to diagnose because both up and down moods mark normal adolescent behavior, with alternating periods of feeling 'the world is a great place' and 'life sucks'. These moods may alternate over a period of hours or days.

Persistent depressed mood, faltering school performance, failing relations with family and friends, substance abuse, and other negative behaviors may indicate a serious depressive episode. These symptoms may be easy to recognize, but depression in adolescents often manifests very differently than these classic symptoms.

Excessive sleeping, change in eating habits, even criminal behavior (like shoplifting) may be signs of depression. Another common symptom of adolescent depression is an obsession with death, which may take the form either of suicidal thoughts or of fears about death and dying.

Adolescent girls are twice as likely as boys to experience depression. Risk factors include stressful life events, particularly loss of a parent to death or divorce; child abuse; unstable care giving, poor social skills; chronic illness; and family history of depression.

The signs of depression in children and adolescents include:

- Lack of interest in friends and activities
- Absences from school; drop in academic performance
- Withdrawal from family or social activities; decreased communication
- Increased crying, irritability, anger, reckless behavior, or mood swings
- Increase in vague, nonspecific physical complaints; fatigue
- Talking about or attempting to run away
- Complaints of being bored; talk of feeling hopeless
- Sadness
• Difficulty concentrating and organizing thoughts
• Significant change in appetite or body weight
• Sleep difficulties: too much or too little
• Feelings of worthlessness
• Overwhelming, inappropriate guilt
• Recurrent thoughts of death or suicide
• Psychomotor agitation (constant movement) or retardation (loss of energy)
• Drug or alcohol abuse

Adolescents who experience depression may be hypersensitive and overreact to minor problems or embarrassments. They may run away, or indulge in self-harming behaviors like reckless driving or abusing alcohol or drugs. They may be easily annoyed, uncommunicative, or anxious and hopeless. Despite the popular myths, all adolescents do not experience intense emotional fluctuations that verge on psychiatric disorder. If an adolescent exhibits extreme behavior or emotional turmoil, then assessment and treat

This has had the effect of limiting research in this domain of childhood and adolescent psychopathology. In the early '80s, the results of clinical reports and epidemiological studies reflecting high rates of depression and suicide in the adolescent population, and the publication of the DSM-III in which it was recognized that adult criteria could be used to diagnose depressive disorders in children and adolescents, markedly influenced the emergence of research on adolescent depression. These changes in the applicability of the adult diagnostic criteria for depression in adolescents have led to greater acknowledgement of the existence of depression in adolescents as a recognizable disorder while recognizing that developmental factors could influence the phenomenology of that disorder at different ages.

In children and adolescents, irrational thinking is conceptualized in cognitive models as being a normal part of the developmental process. In early childhood, irrational thoughts are developmentally appropriate. Gradually, with time, they decrease, giving way to rational thinking processes during adolescence. Therefore, it can be said that i
general, children give up most of their irrational ideas when they grow up, and that psychopathology develops when there is a failure to abandon the immature thinking process. In other words, adaptative problems develop when age-inappropriate thinking is present. More specifically with adolescents, it is possible to expect that cognitive dysfunctional processes would be influenced by the maturational thinking process of formal thinking, which is hypothesized to be consolidated during the middle of adolescence (Piaget, 1972).

Some types of depression run in families, suggesting that a biological vulnerability can be inherited. This seems to be the case with bipolar disorder. Studies of families in which members of each generation develop bipolar disorder found that those with the illness have a somewhat different genetic makeup than those who do not get ill. However, the reverse is not true: Not everybody with the genetic makeup that causes vulnerability to bipolar disorder will have the illness. Apparently additional factors, possibly stresses at home, work, or school, are involved in its onset.

In some families, major depression also seems to occur generation after generation. However, it can also occur in people who have no family history of depression. Whether inherited or not, major depressive disorder is often associated with changes in brain structures or brain function.

Adolescents who have low self-esteem, who consistently view themselves and the world with pessimism or who are readily overwhelmed by stress, are prone to depression. Whether this represents a psychological predisposition or an early form of the illness is not clear.

Only in the past two decades has depression in adolescents been taken very seriously. The depressed adolescent may pretend to be sick, refuse to go to school, cling to a parent, or worry that the parent may die. Older ones may sulk, get into trouble at school, be negative, grouchy, and feel misunderstood. Because normal behaviors vary from one stage to another, it can be difficult to tell whether he is just going through a temporary "phase" or is suffering from depression. Sometimes the parents become
worried about how the child's behavior has changed, or a teacher mentions, "your child doesn't seem to be himself." In such a case, if a visit to the child's pediatrician rules out physical symptoms, the doctor will probably suggest that the child be evaluated, preferably by a psychiatrist who specializes in the treatment of children. If treatment is needed, the doctor may suggest that another therapist, usually a social worker or a psychologist, provide therapy while the psychiatrist will oversee medication if it is needed.

The National Institute of Mental Health (NIMH) has identified the use of medications for depression in children as an important area for research. The NIMH-supported Research Units on Pediatric Psychopharmacology (RUPPs) form a network of seven research sites where clinical studies on the effects of medications for mental disorders can be conducted in children and adolescents. Among the medications being studied are antidepressants, some of which have been found to be effective in treating children with depression, if properly monitored by the child's physician.

Depression can be devastating to family relationships, friendships, and the ability to work or to go to school. It affects the quality of life, productiveness of an individual. The depressed person faces problem to cope everywhere - at home, at school, in friend circle, in social occasions or even at road. At depression's worst, the afflicted person may spend endless hours in bed; often find it difficult to perform even minimal tasks such as bathing or getting dressed.

Depression cause pain and suffering not only to those who are the victims of this deadly disease, but also to those who care about them. Their persistent depressed mood, irritation, agitation, constant lethargy, not caring to others, lack of sense of responsibility, pessimistic thoughts and suicidal ideation make others also irritated and sad. Family members do not get any means to make the suffered person's mind happy, to bring him/ her in to the normal stream of life. Such mental condition of their nearest and dearest one makes them also unhappy, helpless, hopeless and anxious. Initially the family members respond to the depressed person with concern and compassion, but
their reaction eventually turn to dejection and hostility because of the aversiveness of the disease.

Depressed people not only have interpersonal problems, but their own behavior also seems to make these problems worse. A depressed person may induce depressed feeling and negative affect in others (Howes et al., 1985; Joiner et al., 1995) and may make a non-depressed person less willing to interact again with the depressed person.

1.13 Psychological Stress and Adolescents:

No doubt about it, adolescence is a time of high stress for teenagers and parents alike. Stress is the usual result of any rapid change, and rapid change is what adolescence is all about. As a parent, one watches the child cope with the stress and, hope them to grow stronger from the experience. Stress is a part of the adolescent life and is termed that's why period of storm and stress. Stress is thus unavoidable during this period.

Stress is the "wear and tear" bodies go through as one adjusts to the constantly changing environment. Anything that causes change in lives causes stress. Stress can be short-term (acute) or long-term (chronic). Acute stress is the reaction to an immediate threat. This is commonly known as the fight-or-flight response. The threat can be any situation that is perceived, even subconsciously, as a danger. Under stress, the heart rate and breathing increase. The muscles become tense. Multiple sources of stress worsen the stress level. The body needs relief from stress to regain balance.

The adolescent years are among the most stressful times in a person's life. Adolescence is the time of life when children change into adults. They are going through puberty, meeting the changing expectations of others, and coping with feelings that may be new to them. Adolescents are between stages. They have more responsibility and freedom than they did as children. But they have less responsibility and freedom than adults do. Their thoughts, behavior, and social relations are all changing radically. The rate of
change varies from person to person. There are a number of reasons for an adolescent to feel stress.

Because of overall unemployment scenario in our country and over competition, every parent wants their children to perform exceptionally good academic results. On the other hand, a good number of parents wish their unfulfilled desires to be fulfilled by their children. As a result, they always put direct or indirect mental pressure on their children. Some of the parents feel very upset when they find their children's academic results in class test or in the annual examination not up to their expectation. These sorts of expectation motivate some children while de-motivate a large number. Every year after the publication of secondary examination results a good number of students in Kolkata either commits suicide or runaway from their homes to hide themselves from shame, fear, and guilt. Even a fear of not doing well after the public examinations and before the publication of results a good number of children commit suicide every year in Kolkata. After results come out, parents are left only with the report cards while they have lost their children. Thus stress inculcates a somewhat irrational fear among the children. This type of stress thus stems out from over expectation of parents from children and an uncommunicated message that their parents are always by their side, whatever the situation prevails and an absence of a sense of unconditional love and acceptance as they are; and not what they have to be.

1.13.1 Sources of Stress:

Adolescent stresses come from within—that is, they can have a biological cause—as well as from the various social spheres in which adolescents operate: the family, school, peer group, and the society at large.

- **Biological Stress:** In general, the physical changes of adolescence occur most rapidly from age 12 to 14 for girls and between 13 and 15 for boys. In addition to, or perhaps because of rapid changes in their bodies, adolescents tend to be extremely self-conscious and typically assume that everyone is always staring...
at them. Every pimple, every unwanted curve or lack of curves, can be a source of misery and stress, particularly for those who do not fit our culture's narrow ideal of beauty. At the same time, adolescents' busier-than-ever schedules—revolving around school, work, and socializing—compete with an increase in their biological need for sleep. The result is that sleep deprivation is another, often silent, source of stress.

- **Family Stress:** Even the most well adjusted adolescents face a major source of stress in their relationships with their parents. That is because every adolescent must work through the age-old struggle between the need to belong and to be taken care of, and the need for independence and freedom. Psychologist Erik Erikson has pointed out that adolescents are driven by a need to come to grips with their own individual identities, and part of this process involves understanding their origins. Part of this task involves simply knowing their family history: where their parents grew up, how they met, and so on. But the more difficult part of the task involves understanding their parent as human beings, who grew up in a particular place and time and who were shaped by complex emotions and relationships. This sort of understanding is difficult to come by. It is hard enough for an average teenager from a family with both parents living together, but when parents live far apart, or when one or both are unknown (due to abandonment or death), the task becomes even more stressful.

- **School Stress:** It is a known fact that academic pressures mount during high school, particularly the last two years. And although many parents recognize those academic struggles—to avoid failing an important course, for example—can be quite stressful, it may be the *most academically capable* students who feel the greatest pressure, as they find themselves competing for scarce, high-prestige college spots.

- **Peer Stress:** Peer-group stress tends to be highest during the middle-school years, but adolescents who do not find at least a minimal degree of acceptance at that time in their lives are likely to suffer lasting consequences: isolation, low
self-esteem, and stress. The price of admission to cool peer society for many adolescents is involvement with cigarettes, alcohol, and drugs. For some teens, substance use provides temporary relief from stress. However, in the long run the physical and psychological ups and downs end up increasing, not decreasing, the level of stress they feel.

- **Societal Stress:** Adolescents don't yet belong to the wider adult society; for example, they cannot vote or buy alcohol legally, and they are kept out of most well-paying jobs. At the same time, many adolescents recognize that they are about to inherit all of society's largest problems—war, pollution, global warming, an uncertain economy—without any real economic or political power with which to confront them: a recipe for stress.

Adolescents from families marked by hostility and weak support systems have lowered self-esteem (Bishop and Ingersoll, 1984; Rutter 1976). Adolescent stress is also associated with the problems of generation gap. The notable point is that today's adolescents are inalterably opposed to the attitudes and values expressed by their parents generation and conversely, that parents are antagonistic to adolescent’s peers, who are viewed as anti-social or anti-establishment. This so called generation gap leads to inevitable conflicts and hostility between parents and adolescents, because neither side understands the other. The concept of a generation gap has been widely accepted by many social scientists; however, the researchers who have attempted to demonstrate a general discontinuity in values and attitudes between the generations have not found any major rift. In fact rather than discord, there seems to be a good deal of harmony between adolescents and their parents about what are valued (Douvan and Adelson 1996; Fever 1966; Thomas 1974). As concerned with the adolescents stress, the idea of generation gap may be viewed as the outcome of people projecting the behaviour of a minority of adolescents on the whole and it may be reinforced by the emancipation efforts of middle adolescence whether adolescents have positive or negative attitudes about their parents and whether they accept their parents ideals as valid, depend to a large extent on whether they see their parents as caring, responsible
and reliable. Byway of contrast, delinquent youths often describe their parents as inconsistent, unstable and unreliable.

As the adolescents see their parents as less competent, they are more likely to see their peers as an attractive alternative. It has been well noted that at various points of life the individual experiences stressful events which cause distress and serious concern.

The degree to which the individuals are able to cope with stress reflects on their sense of self. If he copes well, he sees a positive light; on the other hand, if he fails to cope well, his self-esteem suffers and further he feels incompetent and worthless. If the individual fails to cope with stress repeatedly, his general sense of worthiness suffers.

The relationship between tobacco smoking and stress has long been an area for controversy. The paradox is, although adult smokers state smoking help them feel relaxed, at the same time they report feeling more stressed than nonsmokers. Research shows that nicotine dependency actually increases stress levels in smokers-adults and adolescence alike. Adolescent smokers report increasing levels of stress as they develop regular patterns of smoking. They gradually become less stressed over a time when they manage to quit smoking. Whatever may be the personal accounts of the smokers, clinical evidence reaffirms that smoking is associated with heightened stress.

Contrary to the belief that smoking is an aid for mood control, it actually heightens tension, irritability and depression, during nicotine depletion in body. This mood swing arises between smokes or during periods of nicotine abstinence. And dependent smokers need nicotine to remain feeling normal. The indirect coping strategy of "lighting up" under stress instead of tackling the problem can leave the real problem unresolved. The frequent failure of smokers to tackle problems may provide a further reason why they suffer from more stress than do nonsmokers. Children of stressed out parents are more likely to be ill equipped to handle stressors positively. They may suffer from emotional disturbances, depression, aggressive behavior or confusion besides chances of weak physical constitutions, which again can be a source of anxiety.
Young people who exhibit maladjustment will frequently describe home settings and school settings that are continuously stressful. However, not all stress is bad; stress can be an important motivation. We operate best under moderate stress. Athletes and executives perform best when competing; they are aroused and motivated. Too much stress however is not good. It may lead to physical and psychological distress. However, it is worthwhile to note that the occurrence of major life transitions is often a source of stress for young people. Their ability to cope with significant life events will reflect on their own sense of personal self-worth and on their ability to cope with subsequent stresses. Contrary to this, however, Mc Cutchson (1980) caution not to automatically presume that all life events are universally stressful is misleading wide individual differences exist using, for example, school changes, some adolescents may look forward to the change and see it in a positive light. Not all significant life events affect all adolescents in the same way. The effect of significant life events depends on how important they are to the individual (Healy and Stewart 1984).

In essence, the review of literature rightly indicates that the subject of adolescent stress has been the interest of several researchers, and many research works have been undertaken with various settings; however, it is evident that certain factors have been neglected in relation to the onset of adolescent stress.

1.14 Mental Health Is Important:

Mental health is how people think, feel, and act as they face life's situations. It affects how people handle stress, relate to one another, and make decisions. Mental health influences the ways individuals look at themselves, their lives, and others in their lives. Like physical health, mental health is important at every stage of life.

Children and Adolescents Can Have Serious Mental Health Problems:

Like adults, children and adolescents can have mental health disorders that interfere with the way they think, feel, and act. When untreated, mental health disorders can lead
to school failure, family conflicts, drug abuse, violence, and even suicide. Untreated mental health disorders can be very costly to families, communities, and the health care system.

**The Causes Are Complicated:**

Mental health disorders in children and adolescents are caused mostly by biology and environment. Examples of biological causes are genetics, chemical imbalances in the body, or damage to the central nervous system, such as a head injury. Many environmental factors also put young people at risk for developing mental health disorders. Examples include:

- Exposure to environmental toxins, such as high levels of lead;
- Exposure to violence, such as witnessing or being the victim of physical or sexual abuse, drive-by shootings, muggings, or other disasters;
- Stress related to chronic poverty, discrimination, or other serious hardships; and
- The loss of important people through death, divorce, or broken relationships.

Children and adolescents with mental health issues need to get help as soon as possible. A variety of signs may point to mental health disorders or serious emotional disturbances in children or adolescents. A child or adolescent is troubled by feeling like:

- Sad and hopeless for no reason, and these feelings do not go away.
- Very angry most of the time and crying a lot or overreacting to things.
- Worthless or guilty often.
- Anxious or worried often.
- Unable to get over a loss or death of someone important.
- Extremely fearful or having unexplained fears.
- Constantly concerned about physical problems or physical appearance.
- Frightened that his or her mind either is controlled or is out of control.
A child or adolescent experiences big changes, such as:

- Showing declining performance in school.
- Losing interest in things once enjoyed.
- Experiencing unexplained changes in sleeping or eating patterns.
- Avoiding friends or family and wanting to be alone all the time.
- Daydreaming too much and not completing tasks.
- Feeling life is too hard to handle.
- Hearing voices that cannot be explained.
- Experiencing suicidal thoughts.

A child or adolescent experiences:

- Poor concentration and is unable to think straight or make up his or her mind.
- An inability to sit still or focus attention.
- Worry about being harmed, hurting others, or doing something "bad".
- A need to wash, clean things, or perform certain routines hundreds of times a day, in order to avoid an unsubstantiated danger.
- Racing thoughts that are almost too fast to follow.
- Persistent nightmares.

A child or adolescent behaves in ways that cause problems, such as:

- Using alcohol or other drugs.
- Eating large amounts of food and then purging, or abusing laxatives, to avoid weight gain.
- Dieting and/or exercising obsessively.
- Violating the rights of others or constantly breaking the law without regard for other people.
- Setting fires.
- Doing things that can be life threatening.
- Killing animals.
1.1 Attachment, Adjustment, Risk Behaviour:

The concept of adjustment has its origin in biology and is derived from Darwin's concept of evolution during mid eighteenth century. Subsequently it was adopted by the psychologists who renewed its definition as "an index of integration between needs and satisfaction and is related to achievement, social acceptance, age, sex, economic security and moral standards" (Chauhan, Tiwari and Khatter, 1972).

Extensive research links attachment and adjustment in childhood. For example, in normative samples, children who are securely attached to their mothers engage in more prosocial behaviour and are perceived as more socially competent than insecure children (Sroufe, 1983). They demonstrate higher positive affect and lower negative affect in social interactions than do insecure children. Their teachers also rate securely attached children as more empathic and more compliant (LaFreniere and Sroufe, 1985).

On the other hand, several sources of research show a link between insecure attachment patterns (avoidant, ambivalent, disorganized) in infancy and noncompliance and aggression in early childhood. Consistent with the theory that insecure attachment is related to poor emotional regulation, longitudinal studies have demonstrated that avoidant attachment in infancy predicts negativity, noncompliance and hyperactivity at 3.5 years of age, and higher ratings of problem behaviour in grades 1 to 3. Compared to secure children, avoidant children are more aggressive and confrontational with their mothers (Main and Weston, 1981), and more aggressive, hostile, and distant with their peers (Erikson et al., 1985; Sroufe, 1983). Similarly, disorganized attachment in infancy has been shown to predict later aggressive behavior. Several researchers have shown, for example, that children with disorganized attachment patterns in infancy develop controlling and coercive behavior as they move into the preschool and early childhood period (Lyons-Ruth et al., 1991; Wanner et al., 1994). Ambivalently attached children, on the other hand, are more adult-oriented and emotionally dependent than securely attached children (Erikson et al., 1985; Renken et al., 1989). With peers, ambivalently attached children have been found to be lower in peer status,
more withdrawn and more apt to be victimized (Finnegan et al., 1996; LaFreniere and Sroufe, 1985; Renken, et al., 1989).

Insecure attachment patterns are not, however, consistently related to later behaviour problems. A number of researchers (Fagot and Kavanagh, 1990; Goldberg et al., 1986) do not report that avoidant or disorganized attachment predicts later aggressive behavior. A review of this literature shows that the relationship between insecure attachment and later problem behavior is found more consistently among children in high-risk contexts (e.g., family poverty, low social support, parental psychopathology) than among children in low-risk contexts. For example, Lyons-Ruth et al., (1991) found that infant security was most predictive of later aggressive problems in families where mothers suffered from psychopathology, particularly chronic depression, and mothers engaged in hostile intrusive parenting practices toward the infant. She reports that 56.0 per cent of low-income children who were classified as disorganized in infancy, and whose mothers suffered from psychopathology at that time, displayed aggressive behavior in kindergarten. In contrast, only 25.0 per cent of low-income children with one risk factor and 5.0 per cent of low-income children with neither risk factor (i.e., maternal psychopathology, maternal use of hostile intrusive parenting) showed aggressive behavior in kindergarten.

In summary, there is consensus that insecure attachment is a risk factor for later problems in life, but neither necessary nor sufficient in itself. However, these are generalizations based on small samples, with attachment measures at only one point in time.

There are three basic and related issues to consider with respect to attachment in adolescence:

1. The nature of changes in the child-parent relationship and their influence on the attachment relationship;
2. The adolescent's development of new close relationships (e.g., with peers and romantic partners) and the impact of these new ties on the child-parent relationship; and,
3. The emergence of a differentiated attachment system versus a generalized attachment stance.

There are complex changes in the child-parent relationship during adolescence. Although some studies have shown that self-reported attachment security to both parents decreases with pubertal maturity (Papini et al., 1991), recent investigations indicate that only certain components of the attachment relationship change while others remain stable. For example, the degree to which children seek proximity and rely on the principal attachment figure in times of stress decreases but that attachment figure’s perceived availability does not (Lieberman et al., 1999). These findings indicate that the maintenance of physical proximity to parents and need for protection in times of threat or stress is less essential for older children due to increased mental and physical capacities (e.g., more sophisticated coping mechanisms), but that the availability of the attachment figure (i.e., the belief that the attachment figure is open to communication and responsive if help is needed) remains important (Bowlby, 1973; Kerns et al., 1996). Moreover, although the frequency and intensity of some attachment behaviour is acknowledged to decline with age, the quality of the attachment bond is viewed as relatively stable (Bowlby, 1980). The ability of adolescents to successfully balance their need to attain autonomy with their desire to maintain a sense of relatedness, particularly in the context of adolescent-parent disagreements, may even is considered a stage-specific manifestation of attachment security (Allen et al., 1997).

With respect to the development of new attachment relationships during adolescence, it is generally accepted that this developmental phase involves a transition from a primary focus on parents as attachment figures to the development of a wider range of attachment relationships (e.g., peers and romantic partners; Fraley and Davis, 1997; Hazan and Zeifman, 1994; Trinke and Bartholomew, 1997). Time with and variety of activities with same-sex friends peaks at Grade 9, and then declines as older adolescents spend more time with a romantic partner (Laursen and Williams, 1997). Children turn to peers more than parents for companionship from age 9 on, and for comfort when upset from age 12-13 (Fraley and Davis, 1997; Hazan and Zeifman, 1994). However, parents, particularly mothers, continue to be sought more than best
friends as a base of security well into late adolescence (Fraley and Davis, 1997; Trinke and Bartholomew, 1997). Some investigators have argued that adolescents generalize from attachment to parents to attachment to best friends and later to romantic partners (Furman and Wehner, 1994), but evidence is lacking.

It is widely accepted that adult long-term romantic relationships are attachment relationships as well as sexual relationships (Hazan and Shaver, 1987; Hazan and Zeifman, 1994). Individuals seek proximity to their romantic partners, desire to rely on them as a safe haven and secure base, feel an emotional tie to them, and mourn their loss (Bowlby, 1979/77 in Trinke and Bartholomew, 1997). However, in early and mid-adolescence, romantic relationships are often quite transitory, and parents, especially mothers, remain the primary providers of security (Hazan and Zeifman, 1994). Though in late adolescence, as in adulthood, romantic relationships become the primary attachment relationship of the individual after two years duration (Fraley and Davis, 1997; Hazan and Zeifman, 1994), parents remain important, albeit secondary, attachment figures (Trinke and Bartholomew, 1997).

The question of whether adolescence ushers in the emergence of a generalized attachment orientation is debatable. On the one hand, some theorists postulate that a generalized attachment orientation emerges which may complement or displace earlier multiple models of attachment that relate to specific attachment relationships (e.g. to mother and to father; Allen and Land, 1999). These researchers point to studies showing that by adulthood this generalized stance is highly predictive of future behaviour in attachment and care giving relationships (Steele et al., 1996). Other researchers disagree, however, arguing that the attachment system during adolescence is characterized by differentiation and relationship-specific patterns of behavior. For example, Furman and Wehner (1994) have noted that although an individual's attachment pattern is relatively stable within specific relationships, their attachment style frequently differs across relationships. This evidence suggests that a generalized attachment style is not well established in adolescence. They and others conclude that a working model of attachment is a composite of representations of different attachment relationships, which are organized hierarchically (Trinke and Bartholomew, 1997).
If a generalized attachment style does emerge in adolescence it does not appear to result in markedly greater stability of attachment pattern for adults versus children. Typical estimates of stability of attachment from infancy to early childhood as assessed by the strange situation are 53-96 per cent (Thompson et al., 1982; Waters, 1978). In young adulthood, typical short-term stability in self-reported attachment is 70 per cent (Baldwin et al., 1996; Scharfe and Bartholomew, 1994). Moreover, concordance of 70 per cent has been found between infant strange situation and late adolescent Adult Attachment Interview classification (Waters et al., 1995, in Allen and Land, 1999). Though changes in self-reported attachment style in young adults have been less clearly linked to changes in environmental circumstances than in infant studies (Scharfe and Bartholomew, 1994, versus Thompson et al., 1982), in at least one study covering the adolescent years (Waters et al., 1995, in Allen and Land, 1999), adolescents who had experienced major life changes evidenced much lower rates of concordance than those who had not (44 per cent versus 78 per cent).

The nature of specific attachments to parents, their relation to a generalized attachment style, and the implications of these attachments for adjustment in adolescence merit closer examination and additional research (Cantor and Sanderson, 1998; Trinke and Bartholomew, 1997). More research is necessary to ascertain whether, and at what developmental stage, attachment status becomes a stable property of the individual rather than primarily a reflection of the qualities of the ongoing relationship (Allen and Land, 1999). Results also indicate considerable potential for change in attachment style in adolescence as well as earlier in childhood. However, the variety of measurement instruments utilized in research on the stability of attachment make it difficult to reach firm conclusions about the essential issues of stability, potential for change, and the relation between attachment to parents and adjustment.

In the past decade, studies have begun to examine the contribution of adolescent-parent attachment to psychological adjustment. The majority of these studies have examined this relationship within late adolescent (junior college, first-year university) samples and relatively few in early and mid-adolescent samples.
With reference to the relation between attachment patterns in adolescence and adjustment, reports to date confirm findings based on studies of young children. That is, secure attachment is typically related to healthier adjustment whereas insecure attachment is linked to various forms of maladjustment.

In normal population studies, late adolescents who are classified as securely attached are rated by their peers as less anxious, less hostile, and more able to successfully regulate their feelings (i.e., more ego resilient) compared to insecurely attached adolescents (Kobak and Sceery, 1988). While problem solving with their mothers, secure adolescents more successfully modulate their anger, and balance assertiveness with their desire to remain connected to their parent, suggesting greater ability to regulate emotion (Kobak et al., 1993). Secure individuals are also able to acknowledge both positive and negative self-attributes, and have been shown to have a coherent, well organized self-structure (Mikulincer, 1995). Adolescents who report a positive relationship with their parents, and who feel comfortable turning to them for support, have been found to have a greater sense of mastery of their worlds (Paterson et al., 1995) and to experience less loneliness (Kerns and Stevens, 1996). Similarly, adolescents secure in a romantic relationship reported significantly fewer symptoms of psychological distress and more positive self-concept (Cooper et al., 1998). Finally, more positive attachment with parents among 15 year olds is also associated with fewer mental health problems such as anxiety, depression, inattention, and conduct problems (Nada-Raja, McGee, and Stanton, 1992).

Secure attachment also appears to play an important role in developing effective coping abilities. Mikulincer and colleagues (Florian et al., 1995; Mikulincer et al., 1993) have found that securely attached young adults seek more emotional and instrumental support from others in times of stress. Adolescents who are more secure with their mothers endorse more constructive coping skills (e.g., problem solving, positive reappraisal, and support seeking; Voss, 1999). Secure attachment also buffers the stressful transition to high school (Papini and Roggman, 1992) and, during their first year of college, securely attached adolescents see themselves as more socially
competent, and report less psychological distress than their peers, even if they are anxious regarding separation (Kenny and Donaldson, 1991).

A good relationship with parents may also protect adolescents from risk. Adolescents who report close, accepting relationships with their mothers report less involvement in delinquent activities (Aseltine, 1995; Smith and Krohn, 1995). Similarly, affect tone, time spent and identification with both parents, and preference for parents over peers, have been negatively associated with teen's subsequent drug use, both directly, and indirectly through adolescent's adoption of conventional attitudes (Brook et al., 1993) and low sensation-seeking (Barnea et al., 1992). These positive relationship qualities are those typical of secure attachment. Indeed, adolescents' secure attachment to mother has been linked to less experimentation with drugs (Voss, 1999) and less frequent substance use (Cooper et al., 1998). Security of attachment is also related to more positive attitudes about safe-sex (Voss, 1999), and for girls, lower rates of risky sexual behaviour, and fewer past pregnancies compared to insecurely attached girls (Cooper et al., 1998).

In terms of specific insecure attachment style, a dismissing style (i.e., poor communication and trust, combined with feelings of alienation and disengagement from the attachment relationship) has been associated with externalizing problem behaviours (e.g., aggression and delinquency, Nada-Raja et al., 1992, Voss, 1999), more experimentation with drugs (Voss, 1999), and riskier attitudes about safe-sex (Voss, 1999). Their peers rate adolescents and young adults with a dismissing style as more hostile than individuals in all other attachment groups (Bartholomew and Horowitz, 1991; Kobak and Sceery, 1988). In problem-solving interactions with their mothers, dismissing teenage boys (but not girls) exhibited more dysfunctional anger than did secure adolescents (Kobak et al., 1993). Dismissing girls, on the other hand, deactivated the attachment relationship, such that their mothers dominated the interaction (Kobak et al., 1993). Finally, dismissing young adults report less family support and more loneliness than their peers (Kobak and Sceery, 1988).
Dismissing individuals appear to protect themselves from feelings of rejection by developing a defensive stance and only acknowledging positive self-attributes (Mikulincer, 1995). This defensive stance is also reflected in the use of distancing strategies to cope with stressful situations (Mikulincer et al., 1993; Mikulincer and Orbach, 1995). Adolescents who are high in dismissing attachment with both mother and father also report using emotion avoidance in response to stress (Voss, 1999).

Like dismissing adolescents, fearful adolescents are avoidant, but they are distressed by their lack of closeness to others, and suffer from feelings of inadequacy and anxiety (Griffin and Bartholomew, 1994). Fearful attachment with mother has been linked to delinquency and greater experimentation with drugs (Voss, 1999). In addition, both forms of avoidant attachment (dismissing and fearful) with father are associated with teen's reports of using drugs in response to negative emotions and conflict with others (Voss, 1999).

Although research regarding fearful attachment is limited, existing findings suggest that adults with a fearful attachment style are socially inhibited, lack appropriate assertiveness skills, and tend to be exploited by others (Bartholomew and Horowitz, 1991). Adolescents who are higher in fearful attachment with their mother or father are also likely to engage in self-criticism when under stress, which may impede effective coping (Voss, 1999). Furthermore, those teens who are more fearful with their fathers are also likely to withdraw behaviourally in response to stress (Voss, 1999).

Adolescents who have a preoccupied attachment style (i.e., have positive views of others, and negative views of themselves) see themselves as socially incompetent and are rated by their peers as more anxious than all other attachment groups (Kobak and Sceery, 1988). Compared to other adolescents, these teens report more physical symptoms (Kobak and Sceery, 1988). In response to distress, preoccupied university students are likely to turn to others for support (Ognibene and Collins, 1998). Adolescents who are more preoccupied with their mothers may also use emotion avoidance when under stress, perhaps as a way of lessening heightened anxiety associated with a "hyperactivated" attachment system (Voss, 1999). In a three-category
system of attachment classification (secure, dismissing, preoccupied), preoccupied adolescents have been found to be the most vulnerable to maladjustment (Cooper et al., 1998). Preoccupied attachment in adults is related to a poorly integrated self-structure, with little differentiation, and difficulty regulating distress (Mikulincer, 1995).

Research in high-risk populations confirms findings based on normative samples: high-risk adolescents with insecure attachment patterns are more likely than securely attached adolescents to experience a range of mental health problems (Allen et al., 1996), including suicidality (Lessard and Moretti, 1998), drug use (Lessard, 1994), and aggressive and antisocial behavior (Fonagy et al., 1997; Moretti et al., 1998; Reimer et al., 1996; Rosenstein and Horowitz, 1996).

In a recent study, Moretti and colleagues employed Bartholomew's family attachment interview to differentiate secure, preoccupied, fearful and dismissing attachment styles in adolescents diagnosed with conduct disorder (Moretti et al., 1999). The majority of adolescents were classified as predominantly fearful or preoccupied, rather than dismissing; consistent with previous research, very few were classified as secure. Fearful and preoccupied attachment predicted higher levels of internalizing problems; in contrast, secure and dismissing attachment predicted lower levels of psychopathology. The study, in addition to others that have examined dismissing and fearful attachment separately (e.g. Bartholomew and Horowitz, 1991; Voss, 1999), points to the importance of differentiating adolescents who desire connection with others but are vigilant of rejection (i.e., fearful) versus adolescents who are uninterested in close relationships with others (i.e., dismissing). Fearful adolescents are more likely to anticipate rejection in social relationships; such beliefs coupled with their desire for closeness is likely associated with over sensitivity to benign social cues and this may lead to aggressive behaviour.

Although similar patterns of results are present in normative and clinical samples (e.g., Allen and Hauser, 1996), research with younger children (Lyons-Ruth et al., 1991) also shows that the relation between attachment and adjustment is stronger among children in high-risk (e.g., poverty, low social support, parental psychopathology) than low-risk
contexts. In other words, the relationship between attachment and adjustment appears to be moderated by exposure to adversity. This suggests that insecure attachment alone does not differentiate well adjusted from poorly adjusted adolescents. Further research is required to confirm the moderating effects of adversity on the relationship between attachment and adjustment in adolescents. Extrapolating from existing research with young children suggests that adolescents who grow up in conditions of adversity and inadequate access to resources may not suffer from psychopathology if they share secure attachment relationships with their parents. Conversely, adolescents who develop in a supportive and resource rich environment, albeit with less secure attachment, may have poor outcomes at least in some domains.

1.16 Adolescents' Aggressive Behaviour:

Aggressive behaviour is a very common problem of adolescent period. There has been much controversy in relation to how aggressive behaviour develops among the adolescents. Researchers have not still been sure whether physical punishment leads to aggressive behaviour or aggressive adolescents leads parents to use physical punishments or some other factors are related with parents' using physical punishment and with adolescent aggression to else some combination of causal and correlational factors is at work.

The term aggression is a mode of Frustration (Chauhan and Tiwari, 1971) Frustrations is a state of affairs against which the effected individuals energies are more of less strongly mobilized which he seeks to eliminate, or if possible entirely to avoid, if happiness may fairly be said to represent the ultimate goal of all human endeavor, frustration as its anti-thesis. (Mowser, 1938), According to Krech and Crutchfield (1962), " Frustration is the most rational and emotional state which results from persistent of blockage of oral-directed behaviour. It may load the individual change in cognition to maladaptive behaviour. Aggression has been considered as a defense mechanism in Abnormal Psychology whereas in general aggression is a normal behaviour and in daily life. We can see the aggression behaviour of all type of individuals. Friend emphasizes the study of aggression to understand human behaviour
disorders. For Freud, aggression is one of the consequences of Frustration. This suggestion of Freud is widely accepted by Dollard, Miller, Doob, Mowrer and Sears (Called as Yale group) who formulated a well-known theory of Aggression, in which they stand that frustration results in aggression (Weller and Suleman, 1986).

Aggression may be defined operationally in terms of made answering to elders, frequent quarrellings, broken engagement, impulses of take revenge reactionary attitudes to traditional and beliefs" (Chauhan and Twari, 1972). By aggression is meant violent attacking" (Hilgard, 1962). Yale group hypotheses of 'Frustration; Aggression' formally advanced by Millar and Dollard (1941) and they defined aggressive behaviour is a logical and expected consequence of frustration. They state that when our efforts related to the goal directed behaviour suffers interference; our first reaction is often one of attacking and attempting to remove the obstacle. So aggression in behaviour follows aggression. The followers of frustration aggression hypotheses do not accept that the behaviour instigated by frustration as different in kind from behaviour elicited by motivation. They believe both types of behaviour are means to an end and punishment is regarded as a method for inhibiting both types of behaviours.

Freud and his associate believe that the aggression is a universal outcome of the frustration and that aggression adhere to destroy was that natural Energy from Thanatos instinct (Death Instinct)" From, Horney, Allport and Maslow have also supported this view of aggression as an inevitable element in the make up of human personality.

In this contest (Frustration-aggression hypotheses) McClelland (1945) has also done significant work. He created situation of frustration in the laboratory. He puts his findings in her own words as far as present data are concerned and aggressive responses, if defined rigidly as responses directed attacking the frustrating object or a substitute directed from only around 13 percent of the total number of responses under condition in which the anticipation of punishment is reduced to a minimum.
Frustration results in aggression (Weller and Suleman, 1985) and aggression results in punishment is inflicted (Sears, 1961), after infancy social tolerance for aggression of children gets diminished (Whitney, 1953). Aggression and phantasy remains positively related (Mussen, Mayer, 1954). Overt motor verbal expression of aggression is inhibited by punishment or retaliation with the result that indirect or covert outlets get started (Anusubel, 1975). Threats of attacks upon the ‘Self’ produce aggressive tendencies.

1.1 Adolescents’ Socioeconomic Status:

Every society is divided into some classes. Income of people can be a classificatory factor. Social class, or socioeconomic status, refers to one’s position within a society that is satisfied according to status or power. Compared with middle and upper class parents, lower and working class parents tend to:

- Stress obedience and respect for authority more and to place somewhat less emphasis on fostering independence, curiosity and creativity.
- Be more restrictive and authoritarian, more frequently using power-assertive discipline.
- Talk to and reason with their children less frequently.
- Show less warmth and affection (Maccoby, 1980; McLoyd, 1990).

Social class has been shown to affect both skills and time spent at parenting work. Co-parenting, in which parenting responsibilities are shared more or less equally by parents, appears to occur predominately in middle and middle-upper class families. Androgynous parents typically are more highly educated. In these families, the parents’ overall circumstances are comparable: Couples who reported that they shared child care were found more likely to have a male first-born, compatible work arrangements, and similar levels of income than were traditional couples. They were also more likely to feel that their relationship was egalitarian and that the division of labor in the household was satisfactory.

Although few social contexts (i.e. maternal education, family income, maternal employment and single-parent family) directly affect child adjustment, some influence the quality of parent-child relationships. Children of mothers with less
education and children in families with lower income tend to perceive their relationships with their parents more negatively. These negative perceptions in turn are associated with poorer adjustment. Maternal employment and single-parent status do not affect child adjustment independent of parenting and the parent-child relationship.

It is also important to assess the generality across different family structures (e.g. both single-earner and dual-earner). Most of the studies of the effects of maternal employment on parenting and attachment have focused on infants and young children. These studies indicate that it is not the mother's employment per se which affects child attachment security, but rather her sensitivity and responsiveness to her child, investment in parenting and participation in shared activities (Hoffman, 1989; Moorehouse, 1991). Early adolescents with employed mothers spend no less time with family, parents, friends, in class or alone, but do spend more time alone with fathers (Richards and Duckett, 1994). Moreover, adolescents with single or employed mothers do not have more contentious or distant relationships with them than their peers in "traditional" families (Laursen, 1995). However, more research is necessary to determine how maternal employment and single parenthood interact with other factors, such as poverty, low social support and life stress, to influence parental availability and adolescent-parent attachment.

Economic stresses on a family can greatly impact all members of that family including adolescents. The more stress a family is under, the more likely the adolescent is to be negatively aggressive behaviour affected.

- Parents under financial strain are less involved, less nurturing, harsher, and less consistent with their discipline (McLoyd, 1990).
- Adolescents under severe economic stress are at a greater risk for psychological difficulties; conduct problems, and poor school performance (Conger et al., 1995).
- Children living in poverty, especially minority children are more likely to be victims of violence, suffer from depression, feel alienated from school, and be exposed to high levels of stress.
It is clear that antisocial children disproportionately come from low-SES families. CD children tended to come from low-income families with unemployed parents who were living in subsidized housing and dependent on welfare benefits (Offord et al., 1986). Low SES, low family income, and parental education predicted CD children (Velez et al., 1989). In general, coming from a low SES family predicts adolescence violence. For e.g., in the U.S. national Youth Survey, the prevalence of self-reported assault and robbery was about twice as high among lower-class youth as among middle class ones (Elliott et al., 1989). A link between low-SES families an adolescent antisocial behavior is mediated by family socialization practices.

Low SES is a less consistent predictor of delinquency. However much depends on whether it is measured by income and housing or by occupational prestige. Low family income and poor housing predicted official and self-reported juvenile and adult delinquency, but low parental occupational prestige predicted only self reported delinquency (Farrington, 1992b, 1992c). Low family income was a strong predictor of self-reported violence (Farrington, 2000), and having an unemployed father was one of the strongest predictors of convictions for violence (Farrington, 1994).

In fine, it is imperative to say that the period of adolescence is perhaps the most important phase in a child's life and if remains uncared for there are ample possibilities of indulgence into risk behaviours, and therefore though the age requires constant supervision, support and guidance from both the parents should come in the form of better understanding, free and frank communication and not a harsh discipline which would create further distance and a communication gap. It is during this time that the child actually starts knowing himself as his personality gradually starts unfolding. High demands should not be placed on him, so that he becomes a prey to higher stress levels and create adjustment problems in him. He therefore needs some time to himself in order to understand
and accept the changes that come to him, better if complemented by knowledge on reproductive health.