A Reference for Professionals

# Developing Adolescents

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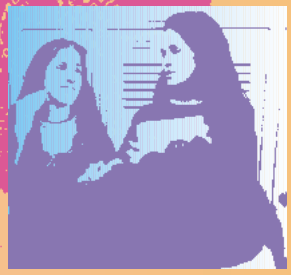

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# *Developing Adolescents:*

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AMERICAN PSYCHOLOGICAL ASSOCIATION

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## Contents

# Acknowledgments

Many kinds of expertise are needed to fully address health issues of adolescents in American society, and many kinds of expertise went into the development of this document.

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American Academy of Pediatric Dentistry
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We offer *Developing Adolescents* as an information resource for many professionals, including psychologists, as they deal with adolescents in varied roles—as health professionals, school teachers and administrators, social service staff, juvenile justice officials, and more.

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*Views expressed in this document have not been approved by the governing or policy-setting bodies of any of the PIPPAH partners and should not be construed as representing policy of any specific organization.*



# Preface

The American Psychological Association (APA) is pleased to offer *Developing Adolescents: A Reference for Professionals* for the many professionals who, because they work with adolescents, need substantive knowledge about the trajectory of youngsters' lives from late elementary school ages through high school years.

*Developing Adolescents* is a response to requests by numerous professionals in various fields for help in understanding and working with adolescents. In particular, the organizations involved in the Partnership in Program Planning for Adolescent Health (PIPPAH), who work together to promote adolescent health activities nationally, expressed interest in having a document to help professionals—physicians, attorneys, nurses, school-based health providers, social workers, dentists, and dieticians, to name a few—understand crucial aspects of normal adolescent development and relate more effectively to the adolescents with whom they work.[1]

Although an impressive array of literature on adolescent development exists, much of this information is published in specialized journals not easily accessible to professionals in other fields. *Developing Adolescents* presents, in an accessible way, research findings on the cognitive, physical, social, emotional, and behavioral aspects of "normal" adolescent development to help guide professionals working with adolescents in many different contexts.

There is currently no standard definition of "adolescent." Although often captured as an age range, chronological age is just one way of defining adolescence. Adolescence can also be defined in numerous other ways, considering such factors as physical, social, and cognitive development as well as age. For example, another definition of adolescence might be the period of time from the onset of puberty until an individual achieves economic independence. What is most important is to consider carefully the needs and capabilities of each adolescent. For the purposes of this document, adolescents are generally defined as youth ages 10 to 18.[2] Using this definition, there were an estimated 36.6 million adolescents in the United States in 2000 (U.S. Census Bureau, 2001a).

### *Professional Contexts and Boundaries*

A first step in working with youth—and often by extension their families and the social systems with which they engage, such as schools—is to understand one's role and professional boundaries. School social workers, for example, are often called on to provide guidance to families or to conduct parenting groups and so may be particularly interested in learning what psychological research has discovered about effective parenting strategies with adolescents.

Attorneys, on the other hand, may have little need for such information and may be stepping outside of the boundaries of their professional role if they make suggestions to parents about such things as parenting styles,[3] even if they are asked to provide advice on parenting. Physicians, who play an important role in interpreting normal physical development to teens and parents, are also often the first contact for consultation about behavioral issues such as substance abuse.

Thus, sections of this publication that refer to parenting will be more or less relevant depending on one's professional role. The same is true with regard to other topics—they will be more or less relevant depending on the reader's professional context and roles.

Legal statutes govern some behavior of professionals. Medical and mental health professionals and teachers, for example, have specific legal obligations to act upon if they suspect that a young person has been abused. Matters of confidentiality are pertinent to all professionals and are generally addressed in law as well



[1] *PIPPAH is funded by the Office of Adolescent Health, a unit of the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services. The PIPPAH partners include the American Academy of Pediatric Dentistry, American Bar Association, American Dietetic Association, American Medical Association, American Nurses Association, American Psychological Association, American School Health Association, and National Association of Social Workers.*

[2] *There is no standard age range for defining adolescence. Individuals can begin adolescence earlier than age 10, just as some aspects of adolescent development often continue past the age of 18. Although the upper age boundary is sometimes defined as older than 18 (e.g., age 21 or 25), there is widespread agreement that those in the age range of 10 to 18 should be considered adolescents. That being said, professionals who work with young adults over age 18 may still find the information contained in this report to be relevant for understanding their clients.*

[3] *Although the term "parents" is used throughout this report for purposes of readability and flow, it is recognized that the information presented here is also often relevant to guardians or other caring adults in the lives of adolescents.*

as in professional ethical codes regarding such practices. Each professional must keep abreast of changes in codes and laws pertaining to his or her professional conduct with adolescents and their families. These codes and laws, which sometimes vary from state to state and can apply differently in different settings, always supersede guidance provided in this or similar publications.

Although this publication presents a substantial amount of research on topics related to behavioral and mental health, its aim is not to train professionals to do psychological counseling. Rather, it is intended to describe the characteristics of adolescents and aspects of the contexts in which they live that make a difference in promoting healthy adolescent development. Psychotherapy or counseling, whether provided by a licensed psychologist, psychiatrist, social worker, nurse, or other trained mental health professional, requires many years of specialized graduate education and supervised experience. Professionals who are knowledgeable about normal adolescent development are in a good position to know when an adolescent needs this kind of professional psychological help.



# Introduction

Media portrayals of adolescents often seem to emphasize the problems that can be a part of adolescence. Gang violence, school shootings, alcohol-related accidents, drug abuse, and suicides involving teens are all too frequently reflected in newspaper headlines and movie plots. In the professional literature, too, adolescence is frequently portrayed as a negative stage of life—a period of storm and stress to be survived or endured (Arnett, 1999). So, it may not be surprising that a 1999 survey of the general public by Public Agenda reported that for 71% of those polled, negative terms, such as "rude," "wild," and "irresponsible," first came to mind when they were asked what they thought about American teenagers (Public Agenda, 1999). Many other negative attitudes were also expressed by those surveyed. At the same time, however, the survey found that 89% of the respondents believed that "almost all teenagers can get back on track" with the right kind of guidance and attention. In fact, most adults agree about the kinds of things that are important for adults to do with young people—encourage success in school, set boundaries, teach shared values, teach respect for cultural differences, guide decision making, give financial guidance, and so on (Scales, Benson, & Roehlkepartain, 2001). However, fewer actually act on these beliefs to give young people the kind of support they need.

Despite the negative portrayals that sometimes seem so prevalent—and the negative attitudes about adolescents that they support—the picture of adolescents today is largely a very positive one. Most adolescents in fact succeed in school, are attached to their families and their communities, and emerge from their teen years without experiencing serious problems such as substance abuse or involvement with violence. With all of the attention given to negative images of adolescents, however, the positive aspects of adolescents can be overlooked. Professionals can play an important role in shifting perceptions of adolescents to the positive. The truth is that adolescents, despite occasional or numerous protests, need adults and want them to be part of their lives, recognizing that they can nurture, teach, guide, and protect them on the journey to adulthood. Directing the courage and creativity of normal adolescents into healthy pursuits is part of what successfully counseling, teaching, or mentoring an adolescent is all about.

Much has been written, both in the lay press and the scientific literature, about adolescents' mental health problems—such as depression, suicide, and drug abuse—and about the serious problems that some adolescents experience.[4] The purpose of *Developing Adolescents*, however, is not to describe these problems or the therapeutic strategies to address them, but to address them in the context of adolescent development, with a focus on preventing these problems and enhancing positive outcomes even under adverse circumstances. Efforts are made to move to a new way of understanding and working with adolescents in the context of larger systems (Lerner & Galambos, 1998); although working with adolescents and families is critical, systemic change is sometimes needed to safeguard adolescent health.

Also at the heart of *Developing Adolescents* is the theme that today's adolescent needs one thing that adults seem to have the least surplus of—time. It takes time to listen and relate to an adolescent. In a report by the U.S. Council of Economic Advisers, teens rated "not having enough time together" with their parents as one of their top problems. This report also indicates that adolescents whose parents are more involved in their lives (as measured by the frequency of eating meals together regularly, a simple measure of parental involvement) have significantly lower rates of "problem behaviors" such as smoking, alcohol or marijuana use, lying to parents, fighting, initiation of sexual activity, and suicidal thoughts and attempts (U.S. Council of Economic Advisors, 2000).

A crosscutting theme, regardless of one's professional role, is the need to communicate effectively with youth. Adolescents will not simply "open up" to adults on demand. Effective communication requires that an emotional bond form, however briefly, between the professional and the adolescent. Professionals must find a way to relate comfortably to adolescents, and be flexible enough to accommodate the wide range of adolescents they are likely to encounter. And, professionals must recognize that developing effective communication with the adolescents with whom they work requires effort on their part. It may take a number of sessions of nonjudgmental listening to establish the trust needed for a particular adolescent to share with an adult what he or she is thinking and feeling. It may take even longer before an adolescent feels comfortable asking an adult for help with an important decision. Discussing options for using birth control with a physician or telling a school psychologist or social worker that one is feeling depressed or sad generally requires both time and trust.

[4] *By age 17, it is estimated that about 25% of all adolescents have taken part in activities that can be considered to be harmful either to themselves or others (e.g., getting pregnant, taking drugs, failing school; Hamburg, 1997).*

Professionals may find that the strategies they use to provide information and offer services to adults just don't work as well with adolescents. Young people need adults who will listen to them—understand and appreciate their perspective—and then coach or motivate them to use information or services offered in the interest of their own health (Hamburg, 1997). Simply presenting information on the negative consequences of high-risk behaviors is not enough. Having an understanding of normal adolescent development can help professionals be effective communicators with young people.

### *Recognizing Diversity*

It is critical that professionals educate themselves about the different cultural and ethnic groups with whom they work in order to provide competent services and to relate effectively one-on-one with adolescents. The population of adolescents in the United States is becoming increasingly racially and ethnically diverse, with 37% of adolescents ages 10 to 19 today being Hispanic or members of non-White racial groups (see table on page 5). This population diversity is projected to increase in the decades ahead.



A growing number of households in the United States include individuals who were born in other countries. Immigrants enter the United States for diverse reasons; some may be escaping a war-torn country, just as others are in the country to pursue an advanced education. They vary in their English proficiency and educational levels and in their cultural practices and beliefs. The number of foreign-born in the United States grew 44% between 1990 and the 2000. People born in other countries now constitute 10% of the U.S. population, the highest rate since the 1930 census (U.S. Census Bureau, 2002).[5] Half of those from other countries are from Latin American countries—overall, about 15% of adolescents ages 10 to 19 are of Hispanic or Latino origin (U.S. Census Bureau, 2001a). [6]

Unfortunately, many of the studies of adolescents reported in the scientific literature have looked only at White middle-class adolescents (Lerner & Galambos, 1998; Ohye and Daniel, 1999). Thus, research on most areas of normal adolescent development for minority youth is still lacking; so caution should be used in generalizing the more global findings reported here to all adolescents.[7]

[5] *To put this in a larger historical context, at the beginning of the 20th century, approximately 15% of the U.S. population was foreign-born, a result of the large-scale migration from Europe during that period. This percentage declined steadily until it began to climb again after 1970 (U.S. Census Bureau, 2002).*

[6] *Those with Hispanic or Latino identity may be of any race.*

[7] *One important exception is the* National Longitudinal Study on Adolescent Health *(also known as the Add Health study), a large-scale cross-sectional sample of 12,000 "normal" adolescents from 80 junior high and high schools, their parents, and their schools. Data are continually being analyzed, and new findings are emerging regularly about various aspects of adolescent health and mental health. The study is particularly important in that it is based on a large nonclinical sample of normal adolescents and includes an ethnically diverse large sample.*

## Population of Adolescents Ages 10-19 by Race: 2000[8]

| Race | Percent of total |
|---|---|
| White only | 70* |
| Black only | 15 |
| Asian/ Pacific Islander only | 4 |
| American Indian/ Alaska Native only | 1 |
| Some other race only | 7 |
| Two or more races | 3 |

**White race, not Hispanic or Latino, represents 63% of the population of adolescents.*

### *Organization of* Developing Adolescents: A Reference for Professionals

The physical changes that herald adolescence—the development of breasts and first menstrual periods for girls, the deepened voices and broadened shoulders for boys—are the most visible and striking markers of this stage. However, these physical changes represent just a fraction of the developmental processes that adolescents experience. Their developing brains bring new cognitive skills that enhance their ability to reason and to think abstractly. They develop emotionally, establishing a new sense of who they are and who they want to become. Their social development involves relating in new ways both to peers and adults. And, they begin to experiment with new behaviors as they transition from childhood to adulthood. In *Developing Adolescents*, we thus discuss adolescent development with reference to physical, cognitive, emotional, social, and behavioral development. Each section presents basic information about what is known about that aspect of adolescent development and suggests roles professionals can play to help support adolescents.

Of course, no adolescent can truly be understood in separate parts—an adolescent is a "package deal." Change in one area of development typically leads to, or occurs in conjunction with, changes in other areas. Furthermore, no adolescent can be fully understood outside the context of his or her family, neighborhood, school, workplace, or community or without considering such factors as gender, race, sexual orientation, disability or chronic illness, and religious beliefs. Thus, these issues are also touched on throughout.

*Developing Adolescents: A Reference for Professionals* is not intended to solve all of the mysteries of relating to adolescents, but it will provide scientifically sound, up-to-date information on what is known about today's youth. Hopefully, this will make it just a bit easier and more comfortable for professionals to relate to adolescents in the context of their particular professions.



[8] *Derived from data in U.S. Census Bureau (2001b).*

# Adolescent Physical Development

Entering puberty heralds the physical changes of adolescence: a growth spurt and sexual maturation. Professionals who work with adolescents need to know what is normative and what represents early or late physical development in order to help prepare the adolescent for the myriad changes that take place during this time of life. Even in schools where sex education is taught, many girls and boys still feel unprepared for the changes of puberty, suggesting that these important topics are not being dealt with in ways that are most useful to adolescents (Coleman & Hendry, 1999).

### *Puberty and Sexual Development*

Although it sometimes seems that adolescents' bodies change overnight, the process of sexual maturation actually occurs over a period of several years. The sequence of physical changes is largely predictable, but there is great variability in the age of onset of puberty and the pace at which changes occur (Kipke, 1999). There are numerous factors that affect the onset and progression of puberty, including genetic and biological influences, stressful life events, socioeconomic status, nutrition and diet, amount of body fat, and the presence of a chronic illness. The growth spurt, which involves rapid skeletal growth, usually begins at about ages 10 to 12 in girls and 12 to 14 in boys and is complete at around age 17 to 19 in girls and 20 in boys (Hofmann & Greydanus, 1997). For most adolescents, sexual maturation involves achieving fertility and the physical changes that support fertility. For girls, these changes involve breast budding, which may begin around age 10 or earlier, and menstruation, which typically begins at age 12 or 13.[9] For boys, the onset of puberty involves enlargement of the testes at around age 11 or 12 and first ejaculation, which typically occurs between the ages of 12 and 14. The development of secondary sexual characteristics, such as body hair and (for boys) voice changes, occurs later in puberty.[10]

Many adults may still believe that the magic age of 13 is the time to talk about puberty, but for many boys and girls, this is years too late. A recent study of 17,000 healthy girls ages 3 through 12 visiting pediatricians' offices found that 6.7% of White girls and 27.2% of African American girls were showing some signs of puberty by age 7 (i.e., breast and/or pubic hair development) (Herman-Giddens et al., 1997; Kaplowitz and Oberfield, 1999). The findings of this study suggest that onset of puberty may be occurring about 1 year earlier in White girls and 2 years earlier in African American girls than had previously been thought.[11] However, studies have not yet been completed on nonclinical samples to confirm that this is the case for girls in general. Relatively little research has examined differences in the course of puberty among different ethnic groups; this is clearly an area that deserves additional attention (Lerner & Galambos, 1998). Professionals who work with children and their families can alert parents to the need to prepare their children early for the changes of adolescence. Professionals can also offer helpful advice to parents and other adults about how to discuss puberty with younger adolescents.

Research findings suggest that adolescent girls who are unprepared for the physical and emotional changes of puberty may have the most difficulty with menstruation (Koff & Rierdan, 1995; Stubbs, Rierdan, & Koff, 1989). When 157 ninth grade girls were asked to suggest how younger girls should be prepared for menstruation, they recommended that mothers provide emotional support and assurance, emphasize the pragmatics of menstrual hygiene, and provide information about how it will actually feel, emphasizing positively their own first experiences with menstruation (Koff & Rierdan, 1995). The girls also recommended that fathers not comment on their daughters' physical changes, and that mothers not discuss these changes with fathers in front of the adolescent, even when they become evident.

Although research on boys' first experiences of sexual maturation is limited, some evidence suggests that boys, too, are more comfortable with the physical changes of adolescence when adults prepare them. For example, young adolescent boys who were not prepared for these changes have reported feeling "somewhat perplexed" upon experiencing their first ejaculations of semen during dreaming or masturbation (Stein & Reiser, 1994). The implication of these findings is that adolescents should be prepared for the upcoming changes early, at about 9 or 10 years of age, so they will not be caught off guard when the changes occur.



[9] *African American girls begin menstruating an average 6 months earlier than White girls, possibly due to genetic or dietary differences (Archibald, Graber, & Brooks-Gunn, 1999; Dounchis, Hayden, & Wilfley, 2001; Herman-Giddens, Slora, & Wasserman, 1999).*

[10] *Health care professionals and researchers refer to the 5-point Tanner scale, which describes the external physical changes that take place during adolescence (e.g., the stages of development of breasts and pubic hair in girls and of genitalia and pubic hair in boys), to assess progression through puberty. Others, including parents and non-medical professionals, can also learn to use this scale (Archibald, Graber, & Brooks-Gunn, 1999; Marshall & Tanner, 1969, 1970).*

[11] *Several reasons have been proposed for this early onset of puberty in girls, including increased body weight, genetics, exposure to hormones in meat or milk, and increased exposure to sexual images in the media. For a recent discussion in the popular press of why some girls are reaching puberty at earlier ages, see the* Time *magazine cover story, October 30, 2000.*

*Early or Late Sexual Development*

It is important for adults to be especially alert for signs of early and late physically maturing adolescents—particularly early maturing girls and late maturing boys—because these adolescents appear to be at increased risk for a number of problems, including depression (Graber, Lewinsohn, Seeley, & Brooks-Gunn, 1997; Perry, 2000). For example, early maturing girls have been found to be at higher risk for depression, substance abuse, disruptive behaviors, and eating disorders (Ge, Conger, & Elder, 2001; Graber et al., 1997; Striegel-Moore & Cachelin, 1999).[12] Likewise, there is growing evidence that boys whose physical development is out of synch with their peers are at increased risk for problems. Early maturing boys have been found to be more likely to be involved in high-risk behaviors such as sexual activity, smoking, or delinquency (Flannery et al., 1993; Harrell, Bangdiwala, Deng, Webb, & Bradley, 1998). Although early physical maturation does not appear to pose as many problems for boys as it does for girls, late maturation seems to place boys at greater risk for depression, conflict with parents, and school problems (Graber et al., 1997). Because of their smaller stature, late maturing boys may also be at higher risk for being bullied (Pollack & Shuster, 2000).

Adults, including parents, may not be aware of the risks of early maturation for girls and be unprepared to help these adolescents deal with the emotional and social demands that may be placed on them (Graber et al., 1997). For example, older boys—and even adult men—may be attracted to early maturing girls at a time when the girls do not yet have the social maturity to handle these advances, placing them at risk for unwanted pregnancies and sexually transmitted diseases (Flannery, Rowe, & Gulley, 1993).

Professionals can talk openly with early maturing youth and their parents about the likelihood that they will confront peer pressure to engage in activities that they are not yet emotionally ready to handle, such as dating and sexual activity. For most teens, telling them to "just say no" does not help them to deal with sexually stressful interpersonal situations in which they are anxious to be liked. Instead, professionals can help the adolescent identify and practice strategies in advance for dealing with or avoiding these situations.

Parents may need guidance to understand that adolescent autonomy should be linked to the teen's chronological age and social and emotional development, and not to the level of physical development, whether early, on time, or late. For example, 13-year-olds should be given earlier curfews and be more closely supervised than older teens, even if they physically appear to be much older. Likewise, an adolescent whose physical maturity is behind his or her peers may still be ready for increased independence.

## *Physical Appearance and Body Image*

Regardless of the timing of the physical changes that take place during adolescence, this is a period in which physical appearance commonly assumes paramount importance. Both girls and boys are known to spend hours concerned about their appearance, particularly in order to "fit in" with the norms of the group with whom they most identify. At the same time, they wish to have their own unique style, and they may spend hours in the bathroom or in front of the mirror trying to achieve this goal.

Adults should take adolescents seriously when they express concerns about aspects of their appearance, such as acne, eyeglasses, weight, or facial features. If an adolescent is concerned, for example, that he is overweight, it is important to spend the time to listen, rather than dismissing the comment with the reassurance that "you look fine." Perhaps a peer made a comment about his appearance at a time when he had been wondering about the same thing. Adults need to understand the meaning and context of the adolescent's concern and to keep the lines of communication open. Otherwise, the adolescent may have a difficult time keeping the problem (and potential solutions) in perspective or be less likely to express concerns in the future.

*Physical Activity and Weight*

Approximately 14% of adolescents aged 12 to 19 years are overweight—nearly 3 times as many as in 1980 (USDHHS, 2001). Overweight adolescents are at greater risk for type II diabetes, high blood lipids, and hypertension and have a 70% chance of becoming overweight or obese adults. In addition, they may suffer from social discrimination, particularly from their peers, which can contribute to feelings of depression or low self-esteem. Diseases directly related to lack of exercise, such as obesity and diabetes, have been reported to be more prevalent among ethnic minority teens (Ross, 2000). For example, type II diabetes is particularly preva-

[12] *Early maturation may increase the risk for eating disorders in part because the weight gain associated with the physical changes of adolescence can lead to negative body image (Striegel-Moore and Cachelin, 1999).*

lent among Native American and Alaska Native adolescents, and obesity is more frequent among African American teenage girls than among White teenage girls (Ross, 2000).

Several factors contribute to the increased prevalence of overweight among teens. One factor is that levels of physical activity tend to decline as adolescents get older. For example, a 1999 national survey found that over a third of 9th through 12th graders do not participate regularly in vigorous physical activity (USDHHS, 2000). Furthermore, enrollment in physical education drops from 79% in 9th grade to 37% in 12th grade; in fact some of the decline in activity is due to fewer opportunities to participate in physical education classes and to reduced activity time in physical education classes. Lastly, many teens do not have nutritionally sound diets: Three-quarters of adolescents eat fewer than the recommended servings of fruits and vegetables per day (MMWR, 2000).

Participation in sports, which has important direct health benefits, is one socially sanctioned arena in which adolescents' physical energies can be positively channeled. Other activities in which physical energy can be channeled include dance, theatre, carpentry, cheerleading, hiking, skiing, skateboarding, and part-time jobs that involve physical demands. These activities provide adolescents with opportunities for getting exercise, making friends, gaining competence and confidence, learning about teamwork, taking risks, and building character and self-discipline (Boyd & Yin, 1996).

Despite the considerable rewards of sports and other extracurricular activities, many adolescents do not participate in them. Barriers to participation in organized sports activities include costs, lack of transportation, competing time commitments, competitive pressures in the sport, and lack of parental permission to participate (Hultsman, 1992). Other barriers can include lack of access to safe facilities, such as recreation centers or parks, particularly in inner city or rural areas. Some youth may also have other important obligations, such as working or caring for younger siblings, that prevent their participation. Youth with disabilities or special health needs may especially experience difficulty identifying recreational opportunities that accommodate their particular needs (Hergenroeder, 2002). Professionals should examine each of these impediments to determine how to overcome them to reduce barriers to participation.

Professionals can help adolescents and their parents understand the importance of physical activity and good nutrition for maintaining health and suggest healthy options. In doing so, it is important to keep in mind the family's resources, such as the family's ability to pay for organized athletic activities, and its cultural background, which may, for example, influence its diet.[13]

### *Disordered Eating*

Puberty, by its very nature, is associated with weight gain, and many adolescents experience dissatisfaction with their changing bodies. In a culture that glorifies being thin, some adolescents—mostly girls—become overly preoccupied with their physical appearance and, in an effort to achieve or maintain a thin body, begin to diet obsessively. A minority of these adolescents eventually develops an eating disorder such as anorexia nervosa or bulimia (Archibald, Graber, & Brooks-Gunn, 1999; Striegel-Moore & Cachelin, 1999).[14] The consequences of eating disorders are potentially very serious, resulting in death in the most extreme cases.

Between 0.5% and 1% of all females ages 12 to 18 in the United States are anorexic, and 1% to 3% are bulimic, with perhaps 20% engaging in less extreme but still unhealthy dieting behaviors (Dounchis, Hayden, Wilfley, 2001). Although boys can also have these eating disorders, the large majority are female (over 90%). Symptoms of eating disorders usually first become evident early in adolescence. Factors that appear to place girls at increased risk for anorexia or bulimia include low self-esteem, poor coping skills, childhood physical or sexual abuse, early sexual maturation, and perfectionism. Daughters of women with eating disorders are at particular risk for developing an eating disorder themselves (Striegel-Moore & Cachelin, 1999).



[13] *The March 2002 Supplement to the* Journal of the American Dietetic Association *(Volume 102, Number 3), Adolescent Nutrition: A Springboard for Health, focuses on nutritional issues for adolescents, strategies for nutrition professionals who work with adolescents, and programs designed to improve the nutritional status of adolescents.*

[14] *Anorexia nervosa is characterized by body image disturbance (e.g., seeing oneself as fat even though emaciated) and refusal to maintain a minimal body weight; bulimia is characterized by binge eating, drastic weight control measures (such as vomiting) to compensate for binge eating episodes, and body image disturbance (Striegel-Moore & Cachelin, 1999).*

Information is limited about the prevalence of eating disorders among different ethnic groups, although there is some evidence to suggest that patterns of disordered eating differ. For example, dieting appears to occur most frequently in Hispanic females and least frequently in Black females, and binge eating may be more frequent in Black females (Dounchis et al., 2001). Although anorexia and bulimia appear to occur much more frequently in White girls as compared to ethnic minority girls, there is also evidence that the prevalence of eating disorders is more common than has been reported among ethnic minorities. Thus, it is important that professionals not assume that only White girls are at risk. Although much more research is needed (particularly with regard to ethnic minority adolescents), some strategies hypothesized to protect adolescents in general from developing an eating disorder or an obsession with weight include:

- Promoting the acceptance of a broad range of appearances;
- Protecting adolescents from abusive experiences;
- Promoting positive self-image and body image;
- Educating adolescents and their families about the detrimental consequences of a negative focus on weight; and
- Promoting a positive focus on sources of self-esteem other than physical appearance, such as academic, artistic, or athletic accomplishments (Striegel-Moore & Cachelin, 1999).

## Adolescent Cognitive Development

The changes in how adolescents think, reason, and understand can be even more dramatic than their obvious physical changes. From the concrete, black-and-white thinkers they appear to be one day, rather suddenly it seems, adolescents become able to think abstractly and in shades of gray. They are now able to analyze situations logically in terms of cause and effect and to entertain hypothetical situations and use symbols, such as in metaphors, imaginatively (Piaget, 1950). This higher-level thinking allows them to think about the future, evaluate alternatives, and set personal goals (Keating, 1990). Although there are marked individual differences in cognitive development among youth, these new capacities allow adolescents to engage in the kind of introspection and mature decision making that was previously beyond their cognitive capacity. Cognitive competence includes such things as the ability to reason effectively, problem solve, think abstractly and reflect, and plan for the future.

Although few significant differences have been identified in the cognitive development of adolescent boys and girls, it appears that adolescent boys and girls do differ in their confidence in certain cognitive abilities and skills. Adolescent girls tend to feel more confident about their reading and social skills than boys, and adolescent boys tend to feel more confident about their athletic and math skills (Eccles, Barber, Jozefowicz et al., 1999). This is true even though their abilities in these areas, as a group, are roughly the same (there are, of course, many individual differences within these groups). Conforming to gender stereotypes, rather than differences in ability per se, appears to be what accounts for these difference in confidence levels (Eccles et al., 1999). Adults can help to dispel these myths, which can lead adolescents to limit their choices or opportunities. For example, an adolescent girl might be encouraged to take advanced math or technology courses, and an adolescent boy to consider relationship-based volunteer opportunities such as mentoring—options that they might not otherwise consider.

Despite their rapidly developing capacity for higher-level thinking, most adolescents still need guidance from adults to develop their potential for rational decision making. Stereotypes to the contrary, adolescents prefer to confer with their parents or other trusted adults in making important decisions about such things as attending college, finding a job, or handling finances (Eccles, Midgley, Wigfield et al., 1993). Adults can use this openness as an opportunity to model effective decision making or to guide adolescents as they grapple with difficult decisions.

Box 1

*Yes...*
*It's Normal for Adolescents To...*

- ***Argue for the sake of arguing.*** *Adolescents often go off on tangents, seeming to argue side issues for no apparent reason; this can be highly frustrating to many adults (Walker & Taylor, 1991). Keep in mind that, for adolescents, exercising their new reasoning capabilities can be exhilarating, and they need the opportunity to experiment with these new skills.*
- ***Jump to conclusions.*** *Adolescents, even with their newfound capacities for logical thinking, sometimes jump to startling conclusions (Jaffe, 1998). However, an adolescent may be taking a risk in staking out a position verbally, and what may seem brash may actually be bravado to cover his or her anxiety. Instead of correcting their reasoning, give adolescents the floor and simply listen. You build trust by being a good listener. Allow an adolescent to save face by not correcting or arguing with faulty logic at every turn. Try to find what is realistically positive in what is being said and reinforce that; you may someday find yourself enjoying the intellectual stimulation of the debates.*
- ***Be self-centered (Jaffe, 1998).*** *Adolescents can be very "me-centered." It takes time to learn to take others' perspectives into account; in fact, this is a skill that can be learned.*
- ***Constantly find fault in the adult's position (Bjorklund & Green, 1992).*** *Adolescents' newfound ability to think critically encourages. them to look for discrepancies, contradictions, or exceptions in what adults (in particular) say. Sometimes they will be most openly questioning or critical of adults with whom they feel especially safe. This can be quite a change to adjust to, particularly if you take it personally or the youth idealized you in the past.*
- ***Be overly dramatic (Jaffe, 1998).*** *Everything seems to be a "big deal" to teens. For some adolescents, being overly dramatic or exaggerating their opinions and behaviors simply comes with the territory. Dramatic talk is usually best seen as a style of oration rather than an indicator of possible extreme action, unless an adolescent's history indicates otherwise.*

As adolescents develop their cognitive skills, however, some of their behaviors may be confusing to the adults who interact with them. These characteristics are normal, though, and should not be taken personally (see Box 1). In a later section on emotional development, practical strategies for communicating with adolescents will be discussed; these strategies will be helpful for fostering adolescents' budding cognitive competencies.

Just as adults sometimes make poor decisions, so do adolescents. This can especially be a problem when poor decisions lead adolescents to engage in risky behaviors, such as use of alcohol or violence. Immature adolescents are especially likely to choose less responsible options. This level of maturity of judgement has been found to be more important than age in predicting whether an adolescent will make more responsible decisions (Fischoff, Crowell, & Kipke, 1999). It is important to understand that level of maturity of judgement may actually drop during the mid-teen years before increasing again into young adulthood.

There are a number of ways that adults can help adolescents to make better decisions. One is to help them expand their range of options so they can consider multiple choices (Fischoff et al., 1999). Because adolescents who make snap decisions are more likely to be involved in risky behaviors, adults can help adolescents to carefully weigh their options and consider consequences. Because adolescents can be more influenced by what they believe their peers are doing, thus increasing the social pressure they feel to engage in these activities, it can be helpful to provide them with more accurate objective information if it is available.[15] Adults can help adolescents to understand how emotions—both positive and negative—can affect their thinking and behavior. Finally, it is important to understand that adolescents may fear potential negative social consequences of their choices more than they do possible health risks. For example, a teen may fear being ostracized from a social group or being made fun of if he or she refuses to drink alcohol at a party more than the potential negative consequences of consuming alcohol. Thus, it is important for adults to consider and understand the context in which adolescents make decisions about risk behaviors.

Even adolescents who are very skilled or talented in some areas may have weaknesses in others. For example, an adolescent who has trouble with learning mathematical concepts may excel on the basketball court or at learning a foreign language. Harvard University psychologist Howard Gardner has developed a theory of multiple intelligences, or ways of approaching problems and analyzing information that expands the traditional view of ability (Gardner, 1993). According to Gardner, these different pathways for learning—which everyone possesses and has developed to varying degrees—include verbal/linguistic, logical-mathematical, spatial, musical, bodily kinesthetic, intrapersonal, naturalist, and possibly existential intelligence (i.e., the capacity to tackle fundamental questions about human existence). Traditional approaches to learning have focused primarily on logical—mathematical and verbal/linguistic intelligence. Gardner suggests that the other forms of intelligence are just as important and that teaching and learning will be most successful when multiple intelligences are engaged. Consequently, adults can help adolescents develop their multiple intelligences and not just focus on problems or deficits.

Another theory of intelligence that focuses on multiple strengths has been proposed by Yale University psychologist Robert Sternberg, who posits that creativity and practical abilities (i.e., common sense), and not just the analytical abilities and memory skills measured by traditional intelligence tests, are important components of intelligence (Sternberg, 1996). In order to be successfully intelligent, it is not necessary to be equally high in each of these spheres. Rather, one must find ways to exploit effectively whatever pattern of abilities one has. For example, Sternberg found in one of his studies that when high school students taking a psychology course were placed in sections of the course that better matched their particular pattern of analytical, creative, and practical abilities, they outperformed students who were more poorly matched (Sternberg, Ferrari, Clinkenbeard, & Grigorenko, 1996). In other words, giving young people the opportunity to learn in ways that emphasize different types of abilities increases their chances of success.

Adults can foster the development of adolescents' sense of competence. Although parents often feel that they have little influence during the teen years, research has found that feelings of competence in both adolescent boys and girls are directly linked to feeling emotionally close and accepted by parents (Ohannessian, Lerner, Lerner, & Eye, 1998). Professionals can educate parents about their role in fostering these competencies and in engendering feelings of competence in their children. Parents need to know just how influential they are in

[15] *For example, there are a number of national surveys that regularly gather and publish information on such things as teen drug use and sexual activity. These include the National Survey of Family Growth (www.cdc.gov/nchs/nsfg.htm), the National Survey on Drug Use and Health (nhsdaweb.rti.org), and the National Health Interview Survey (www.cdc.gov/nchs/nhis.htm). Compiled data on teen sexual activity can also be found on sites such as Child Trends (www.childtrends.org), the Alan Guttmacher Institute (www.agi-usa.org/), and the National Campaign to Prevent Teen Pregnancy (www.teenpregnancy.org).*

their adolescent's life. Professionals can directly reinforce adolescents' growing competencies by simply noticing and commenting on them during routine contacts. Even passing comments can mean a great deal to a young person, especially one who may be getting little in the way of positive feedback.

### *Moral Development*

Moral development refers to the development of a sense of values and ethical behavior. Adolescents' cognitive development, in part, lays the groundwork for moral reasoning, honesty, and prosocial behaviors such as helping, volunteerism, or caring for others (Eisenberg, Carlo, Murphy, & Van Court, 1995). Adults can help facilitate moral development in adolescents by modeling altruistic and caring behavior toward others and by helping youth take the perspective of others in conversations. For example, an adult might ask the adolescent, "How would you feel if you were _____?" Educators and other adults can ensure that issues involving fairness and morality are identified and discussed sensitively and in a positive atmosphere where adolescents are encouraged to express themselves, ask questions, clarify their values, and evaluate their reasoning (Eisenberg, Carlo, Murphy, & Van Court, 1995; Santilli & Hudson, 1992). This atmosphere should reinforce the concept that racism, sexism, homophobia, ageism, and biases against persons with disabilities are inherently destructive to both the individual and society.

Volunteering in the community is an important positive avenue for youth that can help promote their moral development. In addition to helping foster a sense of purpose and meaning and enhancing moral development, volunteering is associated with a number of positive long-term outcomes. For example, one national study of girls from 25 schools found that those who volunteered in their communities were significantly less likely to become pregnant or to fail academically than girls who did not volunteer (Allen, Philliber, Herrling, & Kuperminc, 1997). Professionals can help adolescents understand the value of volunteering and direct them toward valuable volunteer experiences.

### *Learning Disabilities*

Learning disabilities refer to disorders that affect the ability to interpret what one sees and hears or to link information from different parts of the brain (Neuwirth, 1993). Individuals with learning disabilities may have problems with reading, spoken language, writing, memorizing, arithmetic, or reasoning. Without careful assessment, some adolescents with learning disabilities may be seen as having behavior problems, and the cognitive problems underlying their behavioral problems may be overlooked and left untreated. Hormonal changes of adolescence and the increased demands of school can exacerbate learning disabilities that adolescents were able to manage or mask when they were younger. Once they reach middle and high school, adolescents with learning disabilities are at increased risk of school failure if their problems are not understood and addressed. In addition, problems with processing verbal information or poor reasoning skills can make it difficult for some adolescents with learning disabilities to form positive relationships with their peers.

Adolescents with learning disabilities reportedly experience severe emotional distress at rates 2 to 3 times higher than other adolescents, with girls being more likely to experience these problems than boys (Svetaz, Ireland, & Blum, 2000). Furthermore, youth with learning disabilities are significantly more likely than adolescents in the general population to report having attempted suicide in the past year or to have been involved in violence. They are at especially high risk for these negative outcomes if they are experiencing emotional distress. For adolescents with learning disabilities, feeling connected to family and school and having a religious identity are all factors found to be associated with lower risk for negative outcomes such as emotional distress, suicide attempts, and involvement in violence. Thus, families, schools, and other institutions have important roles to play in protecting these youth from negative outcomes (Svetaz et al., 2000).

Because of the higher risk that adolescents with learning disabilities have for serious problems, professionals should monitor adolescents' social and emotional functioning, paying particular attention to signs of anxiety and depression. Conversely, youth experiencing anxiety or depression who have not been identified as having a learning disability or emotional disorder should also be evaluated to rule out the presence of these problems.

# Adolescent Emotional Development

Emotional development during adolescence involves establishing a realistic and coherent sense of identity in the context of relating to others and learning to cope with stress and manage emotions (Santrock, 2001), processes that are life-long issues for most people. Identity refers to more than just how adolescents see themselves right now; it also includes what has been termed the "possible self"—what individuals might become and who they would like to become (Markus & Nurius, 1986). Establishing a sense of identity has traditionally been thought of as the central task of adolescence (Erikson, 1968), although it is now commonly accepted that identity formation neither begins nor ends during adolescence. Adolescence is the first time, however, when individuals have the cognitive capacity to consciously sort through who they are and what makes them unique.

### *Developing a Sense of Identity*

Identity includes two concepts. First is self-concept: the set of beliefs one has about oneself. This includes beliefs about one's attributes (e.g., tall, intelligent), roles and goals (e.g., occupation one wants to have when grown), and interests, values, and beliefs (e.g., religious, political). Second is self-esteem, which involves evaluating how one feels about one's self-concept. "Global" self-esteem refers to how much we like or approve of our perceived selves as a whole. "Specific" self-esteem refers to how much we feel about certain parts of ourselves (e.g., as an athlete or student, how one looks, etc.). Self-esteem develops uniquely for each adolescent, and there are many different trajectories of self-esteem possible over the course of adolescence. (Zimmerman, Copeland, Shope, & Dielman, 1997). Thus, self-esteem, whether high or low, may remain relatively stable during adolescence or may steadily improve or worsen.

Many of the factors already described in *Developing Adolescents* influence identity development and self-esteem during adolescence. For example, adolescents' developing cognitive skills enable them to make abstract generalizations about the self (Keating, 1990). The physical changes they are experiencing can strongly influence, either positively or negatively, global self-esteem. This is particularly true in early adolescence when physical appearance tops the list of factors that determine global self-esteem, especially for girls (Harter, 1990a). Comments by others, particularly parents and peers, reflect appraisals of the individual that some adolescents may incorporate as part of their identity and feelings about themselves (Robinson, 1995).

The process by which an adolescent begins to achieve a realistic sense of identity also involves experimenting with different ways of appearing, sounding, and behaving. Each adolescent approaches these tasks in his or her own unique way. So, just as one adolescent will explore more in one domain (e.g., music), another will explore more in another (e.g., adopting a certain style or appearance). Professionals whose role involves advising parents or adolescents can assure them that most experimentation is a positive sign that adolescents feel secure enough to explore the unknown. Adolescents who fail to experiment in any realm are sometimes seen to be more stable but may, in fact, be experiencing more difficulty than youth who seem to flit from one interest to another. Adolescence is a time when experimenting with alternatives is developmentally appropriate, except when it seriously threatens the youth's health or life. Although it may seem a simple strategy, professionals can help adolescents begin to define their identity through the simple process of taking time to ask questions and listen without judgment to the answers. Box 2 contains some suggestions that may be helpful for having conversations with youth that not only help to bolster their sense of identity but also help to promote their cognitive and moral development. [16] It is amazing how many youth are hungry to discuss these issues with a trusted adult, and how few are offered the opportunity. Discussing these issues can also help adolescents to develop their new abstract reasoning skills and moral reasoning abilities.



[16] *A helpful guide for parents about communicating with teens is* Helping Your Children Navigate Their Teenage Years: A Guide for Parents, *which can be found at www.mentalhealth.org/publications (White House Council on Youth Violence, 2000).*

Box 2

## *Tips for Talking With Adolescents*

- *Engage adolescents with nonthreatening questions. Choosing only one or two questions at a given time, ask adolescents questions that help them to define their identities. For example, whom do you admire? What is it about that person that makes them admirable? What do you like to do in your free time? What do you consider to be your strengths? What are your hopes for the future? What have you done in your life that you feel proud of (even if just a little)?*
- *Listen nonjudgmentally (and listen more than you speak). This enables the adolescent to realize that you value his or her opinions, and thus to trust you more (Forgatch & Patterson, 1989).*
- *Ask open-ended questions. Ask questions that require more than a yes or no response; this helps the adolescent think through ideas and options (Hill & O'Brien, 1999).*
- *Avoid "why" questions. "Why?" questions tend to put people on the defensive (Plutchik, 2000). Try to rephrase your questions to get at what the adolescent was thinking rather than the reason for something the adolescent has said or done. For example, instead of asking, "Why did you say that?" say instead: "You seemed to be really trying to get across a point when you did that. Can you tell me more about what you meant?"*
- *Match the adolescent's emotional state, unless it is hostile. If the adolescent seems enthusiastic or sad, let your responses reflect his or her mood. Reflecting someone's mood helps the individual feel understood (Forgatch & Patterson, 1989).*
- *Casually model rational decision-making strategies. Discuss how you once arrived at a decision. Explain, for example, how you (or someone you know well) defined the problem, generated options, anticipated positive and negative consequences, made the decision, and evaluated the outcome. Keep in mind that the adolescent has a relatively short attention span, so be brief. Choose a topic that is relevant to adolescents (e.g., deciding how to deal with an interpersonal conflict, identifying strategies for earning money for college) (Keating, 1990).*
- *Discuss ethical and moral problems that are in the news. Encourage the adolescent to think through the issues out loud. Without challenging his or her point of view, wonder aloud about how others might differ in their perspective on the issue and what might influence these differences (Santilli & Hudson, 1992).*



*Raising Self-Esteem*

Low self-esteem develops if there is a gap between one's self-concept and what one believes one "should" be like (Harter, 1990b). How can a professional know whether an adolescent has low self-esteem? The following characteristics have been identified by different researchers as being associated with low self-esteem in adolescents (Jaffe, 1998):

- Feeling depressed
- Lacking energy
- Disliking one's appearance and rejecting compliments
- Feeling insecure or inadequate most of the time
- Having unrealistic expectations of oneself
- Having serious doubts about the future
- Being excessively shy and rarely expressing one's own point of view
- Conforming to what others want and assuming a submissive stance in most situations

Because consistently low self-esteem has been found to be associated with negative outcomes, such as depression, eating disorders, delinquency, and other adjustment problems (Harter & Marold, 1992, Striegel-Moore & Cachelin, 1999), it is important that professionals identify youth who exhibit these characteristics and help them get the extra help they need.

How can a professional help an adolescent raise his or her self-esteem? The most important task is to identify the specific areas that are important to the adolescent. Trying to improve global self-esteem is difficult, but helping adolescents to improve their self-concepts in specific valued areas is both doable and contributes to global self-esteem in the long run (Harter, 1990b). For example, a professional may find that an adolescent with low self-esteem is interested in learning to play the guitar. Encouraging the adolescent to explore that specific interest and helping to find resources that might lead to guitar lessons may lead to important gains in self-esteem.

Professionals can help to enhance adolescents' self-esteem by helping them face a problem instead of avoiding it. This can involve such activities as teaching the youth interpersonal or problem-solving skills, role-playing a difficult conversation, or providing information and resources. Or, it may simply entail providing ongoing encouragement and support in facing feared situations, such as taking an exam, breaking up with a boyfriend, or telling a parent that one has decided to stop participating in a sport. The professional must use his or her skills and knowledge to determine

whether the youth is in over his or her head and needs more than coaching and support to handle a particular situation. For example, if a youth is expressing thoughts of suicide, this is clearly a situation where professional psychological help is needed.

### *Emotional Intelligence*

Identity development as well as moral development occurs in the context of relating to others (Jordan, 1994). All adolescents must begin to master the emotional skills necessary to manage stress and be sensitive and effective in relating to other people. These skills have been called "emotional intelligence" (Goleman, 1994). Emotional intelligence involves self-awareness, but above all, relationship skills—the ability to get along well with other people and to make friends. Professionals who can help adolescents develop emotional intelligence provide them with resources that will help them succeed as adults in both their personal and professional lives. However, one does not have to look to the future for the benefits; youth without relationship skills are at greater risk than their peers who have these skills for a number of problems, including dropping out of school (Olweus, 1996).

What follows is a brief description of the most important skills for adolescents to begin to master as part of their emotional development.

- *Recognizing and managing emotions.* In order to label their feelings accurately, adolescents must learn to pay conscious attention to them. Without this self-awareness, they may simply say that they feel "good" or "bad," "okay"or "uptight." When adolescents are able to specify that they feel "anxious" about an upcoming test or "sad" about being rejected by a possible love interest, then they have identified the source of their feelings, which can lead to discovering options to resolve their problem. For example, they can set aside time to study or ask for help in preparing for the test, or they can talk over their feelings about being rejected by a love interest with a friend or think about a new person in whom to become interested. The important point is that being aware of and being able to label their feelings helps adolescents identify options and to do something constructive about them. Without this awareness, if the feelings become uncomfortable enough and the source is undefined, they may seek to numb their emotions with alcohol or other drugs, to overeat, or to withdraw and become depressed. Adolescents who feel angry may take out their anger on others, hurting them or themselves instead of dealing with their anger in constructive ways, if they are not aware of its source Goleman, 1994).

- *Developing empathy.* Recognizing their own emotions lays the groundwork but does not ensure that youth will recognize that others have feelings and that they need to take these feelings into account. Some youth have particular difficulty "reading" the emotions of others accurately, for example, mistaking neutral comments for hostility. Empathy can be taught in various contexts, such as helping students to empathize with different groups of immigrants and understand emotionally the negative consequences of prejudice (Aronson, 2000).

- *Learning to resolve conflict constructively.* Given the unique and differing needs and desires that people have, conflict is inevitable. Tools for managing conflict can be modeled informally by professionals or, as in some schools, actively taught to adolescents. Conflict resolution programs teach students to define their objectives in conflicts, their feelings, and the reasons for what they want and feel, and then ask them to take the perspective of others involved when coming up with options that might resolve conflicts (Johnson & Johnson, 1991). Although many of these skills are taught within programs targeting adolescents, they can also be taught informally with good results.

- *Developing a cooperative spirit.* It is hardly surprising that schools mirror the competitive attitudes present in our larger society. Yet, in the contemporary work world, the importance of teams and the ability to work cooperatively with others is increasingly emphasized.



Even some Nintendo and video games require cooperation among the players (Santrock, 2001). The "jigsaw classroom" is a teaching technique pioneered to facilitate the development of cooperation skills (Aronson & Patnoe, 1997). It requires students to rely upon one another to learn a subject, using strategies that reduce competition and that elevate the standing of students who are sometimes ignored or ridiculed. The name derives from the fact that each student becomes part of a small expert group that is an informational puzzle piece that must be assembled with others in order to fully understand a subject. This approach has been successful not only in helping adolescents learn how to work cooperatively toward a group goal, but also in improving their academic performance.

Professionals can bring an awareness of the importance of these skills to their work with youth and can develop strategies for helping youth to build these skills in their everyday contacts with them.

### *Group Differences in Emotional Development*

Emotional development occurs uniquely for each adolescent, with different patterns emerging for different groups of adolescents. Boys and girls can differ in the challenges they face in their emotional development. For adolescents from minority cultures in the United States, feeling positive about their ethnic identity, sometimes in the wake of negative stereotypes about their culture, is an important challenge for healthy emotional development. Youth whose sexual orientation is gay, lesbian, or bisexual and youth who have a physical disability or are chronically ill, experience additional challenges in building a positive self-esteem in a culture where the predominant media image of an adolescent is a White, heterosexual, thin, and able-bodied middle-class teen. Adolescents need adults who can model positive self-esteem, teach them to be proud of their identity, and help them cope positively with any prejudice they encounter in their lives.



#### *Gender Differences*

Longitudinal research has shown that feelings of self-esteem tend to decrease somewhat as girls become adolescents, with different patterns emerging for different ethnic groups (Brown et al., 1998). Particularly in early adolescence, some studies have shown that boys tend to have higher global self-esteem than girls (e.g., Bolognini, Plancherel, Bettschart, & Halfon, 1996; Chubb, Fertman, & Ross, 1997).

Because of differences in how boys and girls are socialized in our society, male and female adolescents may also differ in their specific needs for help from professionals in promoting identity formation. For example, some adolescent girls may need help learning to become more assertive or in expressing anger. Adolescent boys, on the other hand, may need to be encouraged to have cooperative rather than competitive relationships with other males and helped to understand that it's okay to feel and express emotions other than anger (Pollack & Shuster, 2000).

#### *Ethnic Diversity*

Developing a sense of ethnic identity is an important task for many adolescents, and numerous studies have found that having a strong ethnic identity contributes to high self-esteem among ethnic minority adolescents (e.g., Carlson, Uppal, & Prosser, 2000). Ethnic identity includes the shared values, traditions, and practices of a cultural group. Identifying with the holidays, music, rituals, clothing, history, and heroic figures associated with one's culture helps build a sense of belonging and positive identity. For many of these youth, adolescence may be the first time that they consciously confront and reflect upon their ethnicity (Spencer & Dornbusch, 1990). This awareness can involve both positive and negative experiences.

Adolescents with a strong ethnic identity tend to have higher self-esteem than do those who do not identify as strongly with their ethnic group. Professionals can advise parents of this fact, encouraging them to discuss and practice aspects of their own ethnic identity (e.g., history, culture, traditions) at home to help their child develop a strong ethnic identity (Phinney, Cantu, & Kurtz, 1997; Thornton, Chatters, Taylor, & Allen, 1990).

Quite naturally, the values that parents consider to be most important to impart to youth vary among ethnic cultures. For example, Asian American parents consider valuing the needs and desires of the group over those of the individual and the avoidance of shame to be important values to convey to youth (Yeh & Huang, 1996). African American families tend to value spirituality, family, and respect. Values stressed by Latino parents include cooperation, respect for elders and others in authority, and the importance of relations with the extended family (Vasquez & de las Fuentes, 1999). Parents from many Native American Indian cultures highly value harmony with nature and ties with family (Attneave, 1982). And, parents from the mainstream White culture may stress independence and individualism.

Great diversity exists within each of these ethnic groups. Well-meaning individuals can still fail to recognize that within the Latino community, for example, there are wide cultural differences among those who come from Mexico, Cuba, El Salvador, or Puerto Rico. Black adolescents may have cultural roots in such varied parts of the world as Africa, the West Indies, Europe, or Latin American countries. Asian Americans from Vietnam, China, and Japan also differ significantly in their cultural heritage.

Similarly, it can be important to consider whether an adolescent is from a family that has recently immigrated to the United States or from a family whose roots have been in America for many generations. Different levels of acculturation, that is, the adoption of behaviors and beliefs of the dominant culture, are important to consider in working with adolescents and their families. For example, parents who are not proficient in English may rely on their children to interpret important information for them.

For many in the United States, becoming aware of racism and gaining an understanding of the manifestations of social injustice is an inevitable and important part of building a sense of ethnic identity. Professionals who work with ethnic minority youth can help them to make sense of the discrimination they may face and to build the confidence and skills necessary to overcome these obstacles (Boyd-Franklin & Franklin, 2000; Oyserman, Gant, & Ager, 1995).[17] Professionals can also help White youth to understand and be aware of racism and discrimination and their impact on people of color.

*Gay, Lesbian, and Bisexual Youth*

Lesbian, gay, and bisexual (LGB) youth constitute another minority group for whom identity concerns may be particularly salient during adolescence. In addition to the typical identity tasks of any adolescent, these youths may also be negotiating the development task of incorporating a sexual identity in a society that discriminates against homosexuals and a youth culture that is largely homophobic. Ethnic minority youth, who must also deal with the stress of racial discrimination, face the additional challenge of developing an identity that reflects both their racial or ethnic status and their sexual identity. The development of a gay, lesbian, or bisexual identity often begins with an awareness of being "different," of feeling attracted to members of one's own sex, and of not sharing peers' attraction to the opposite sex. An adolescent may find this awareness frightening and try to deny feelings of attraction to the same sex and to intensify feelings toward the opposite sex. A supportive environment can help adolescents negotiate this process and realize their sexual orientation (Fontaine & Hammond, 1996; Ryan & Futterman, 1998; Savin-Williams, 1998). As with heterosexual youth, sexual exploration proceeds with variability, depending on the individual. Most youth will disclose their sexual orientation to trusted friends first, but may prefer that their status remain a secret because of the stigma associated with differing sexual orientation. When family members are told, mothers tend to be told before fathers (Savin-Williams, 1998).

It is important to understand that there are numerous reasons that some adolescents (particularly males) will engage in same-sex sexual behavior—they may self-identify as gay, lesbian, or bisexual; they may be questioning their sexual identity; or they may simply be experimenting. Professionals who are privy to disclosures from youth about such experiences should not necessarily assume that those youth are in the process of discovering or developing a gay, lesbian, or bisexual identity—they may or may not be. At the same time, professionals should be aware that being gay, lesbian, or bisexual could present unique challenges for teens.

Lesbian, gay, and bisexual youth are at higher risk than their heterosexual peers for a number of health-related concerns. These include, for example, substance use, earlier onset of heterosexual intercourse, unintended pregnancy, HIV infection (especially males), and other sexually transmitted diseases (Blake, Ledsky, Lehman, & Goodenow, 2001; Faulkner & Cranston, 1998; Saewyc, Bearinger, Blum, & Resnick, 1999; Saewyc, Skay, Bearinger, & Blum, 1998). Lesbian, gay, and bisexual youth have also been reported to be at greater risk for experiencing verbal and physical violence directed toward them in a variety of settings (Faulkner & Cranston, 1998; Russell, Franz, and Driscoll, 2001). In addition to the danger associated with violence from others, there is some evidence that homosexual or bisexual boys are at higher risk for suicide attempts than heterosexual youth (Remafedi, French, Story, Resnick, & Blum, 1998). This risk of suicide is not related to sexual orientation per se, but to the intolerable stress created by the stigma, sexual prejudice, and the pressure to conceal one's identity and feelings without adequate interpersonal support (Rotheram-Borus, Rosario, Van Rossem, Reid, & Gillis, 1995).



[17] *Boyd-Franklin and Franklin (2000) and Ward (2000) have outlined some concrete ways parents and professionals can help adolescents to deal with issues related to racism.*

A challenge for professionals is not just to endeavor to reduce risks for these youth, but to promote resilience so youth can deal effectively with the challenges that may come their way. Youth who are connected to their family, school, and community are more likely to have the resources necessary to help them cope with the stresses and challenges they face. Professionals who work with adolescents who are in the process of discovering and accepting their lesbian, gay, or bisexual identity can do the following:

- Provide accurate information about sexual orientation to dispel stereotypes about gay, lesbian, or bisexual sexuality;
- Avoid communicating disapproval of gay, lesbian, or bisexual sexuality;
- Help the adolescent identify sexual prejudice and reject its messages;
- Refrain from pressuring the adolescent to reach a decision about his or her sexual orientation;
- Provide developmentally appropriate information about sexual behaviors, including both same-sex and opposite sex behaviors, that can lead to HIV infection, STDs, and unintended pregnancy in a manner that is inclusive of a lesbian, gay, or bisexual sexual orientation;
- Be aware of the heightened risk of suicide for some youth and make appropriate referrals for psychotherapeutic help for distressed youth; and
- Acknowledge and address any biases they may have about gay, lesbian, or bisexual youth.

# Adolescent Social Development

The social development of adolescents is best considered in the contexts in which it occurs; that is, relating to peers, family, school, work, and community. It is important to keep in mind when interpreting the findings of research on the social development of adolescents that most of the research to date is based on samples of White, middle-class adolescents. Research done with more diverse groups of adolescents has revealed differences among youth of different ethnic backgrounds, so generalizations to specific ethnic groups should be made with care when the research is based solely on samples of White adolescents.

### *Peer Relationships*

One of the most obvious changes in adolescence is that the hub around which the adolescent's world revolves shifts from the family to the peer group. It is important to note that this decreased frequency of contact with family does not mean that family closeness has assumed less importance for the adolescent (O'Koon, 1997). In fact, family closeness and attachment has recently been confirmed as the most important factor associated with not smoking, less use of alcohol and other drugs, later initiation of sexual intercourse, and fewer suicide attempts among adolescents (Resnick, Bearman, & Blum et al., 1997).

In order to establish greater independence from their parents, adolescents must orient themselves toward their peers to a greater extent than they did in earlier stages of development. Those professionals whose role is to advise parents can help reassure them that increased peer contact among adolescents does not mean that parents are less important to them, but that the new focus on peers is an important and healthy new stage in their child's development. Professionals can also educate parents about the importance of positive peer relationships during adolescence.

Peer groups serve a number of important functions throughout adolescence, providing a temporary reference point for a developing sense of identity. Through identification with peers, adolescents begin to develop moral judgment and values (Bishop & Inderbitzen, 1995) and to define how they differ from their parents (Micucci, 1998). At the same time, however, it is important to note that teens also strive, often covertly, for ways to identify with their parents. Another important function of peer groups is to provide adolescents with a source of information about the world outside of the family and about themselves (Santrock, 2001). Peer groups also serve as powerful reinforcers during adolescence as sources of popularity, status, prestige, and acceptance.

Being accepted by peers has important implications for adjustment both during adolescence and into adulthood. One study found, for example, that fifth graders who were able to make at least one good friend were found to have higher feelings of self-worth at age 30 when compared to those who had been friendless (Bagwell, Newcomb, & Bukowski, 1998). Positive peer relations during adolescence have been linked to positive psychosocial adjustment. For example, those who are accepted by their peers and have mutual friendships have been found to have better self-images during adolescence and to perform better in school (Hansen, Giacoletti, & Nangle, 1995; Savin-Williams & Berndt, 1990). On the other hand, social isolation among peer-rejected teens has been linked to a variety of negative behaviors, such as delinquency (Kupersmidt & Coie, 1990). In addition, adults who had interpersonal problems during adolescence appear to be at much greater risk for psychosocial difficulties during adulthood (Hansen et al., 1995).

The nature of adolescents' involvement with peer groups changes over the course of adolescence. Younger adolescents typically have at least one primary peer group with whom they identify whose members are usually similar in many respects, including sex (Savin-Williams & Berndt, 1990). During this time, involvement with the peer group tends to be most intense, and conformity and concerns about acceptance are at their peak. Preoccupation with how their peers see them can become all consuming to adolescents. The intense desire to belong to a particular group can influence young adolescents to go along with activities in which they would otherwise not engage (Mucucci, 1998; Santrock, 2001). Adolescents need adults who can help them withstand peer pressure and find alternative "cool enough" groups that will accept them if the group with which the adolescent seeks to belong is undesirable (or even dangerous). The need to belong to groups at this age is too strong to simply ignore.

During middle adolescence (ages 14-16 years), peer groups tend to be more gender mixed. Less conformity and more tolerance of individual differences in appearance, beliefs, and feelings are typical. By late adolescence, peer groups have often been replaced by more intimate dyadic relationships, such as one-on-one friendships and romances, that have grown in importance as the adolescent has matured (Micucci, 1998). For some adolescents from ethnic minority

groups, higher emphasis may be placed on peer groups throughout adolescence, particularly when they are in the minority in a school or community, as the group may provide a much needed sense of belonging within the majority culture (Spencer & Dornbusch, 1990).

Adolescents vary in the number of friends that they have and in how they spend time with their friends. Introverted youth tend to have fewer but closer friendships, and boys and girls differ with regard to the kinds of activities they engage in most frequently with their friends. In general, boys tend to engage in more action-oriented pursuits, and girls spend more time talking together (Smith, 1997). Individuals of both sexes, however, appear to value the same qualities in a friend: loyalty, frankness, and trustworthiness (Claes, 1992). Some studies have also shown that adolescent girls value intimacy, the feeling that one can freely share one's private thoughts and feelings, as a primary quality in friendship (Bakken & Romig, 1992; Claes, 1992; Clark & Ayers, 1993). Boys also speak of the high importance of intimacy in friendship (Pollack & Shuster, 2000). One review of studies showed that White adolescent girls tend to reveal their innermost thoughts and feelings to friends more so than do boys, and that they receive more social support from friends. However, this gender difference does not appear to hold for African American adolescents (Brown, Way, & Duff, 1999).



To have a friend presupposes that one has the social skills to make and keep that friend. For most adolescents, the rudiments of those skills are in place, and peer groups and friendships allow them to further hone those skills. For a small subset of adolescents, however, this is not the case. These adolescents may be rejected by their peers, and this rejection can have serious negative effects, such as delinquency, drug abuse, dropping out of school, and aggression (Asher & Coie, 1990). For adolescents who lack social skills, adults who informally coach them in the appropriate skill areas can be lifesavers. Discussions about how to initiate conversations with peers, give genuine compliments, be a good listener, share private information appropriately, and keep confidences can go a long way toward enhancing social skills.

Professionals who come in contact with youth with more significant deficits in social skills should take the time to find ongoing professional help for these adolescents. Youth who lack social skills who also develop aggressive behaviors are likely to need professional help to eliminate their aggressive and disruptive behavior (Coie & Dodge, 1998). However, youths who lack social skills but who do not exhibit behavior problems need help as much as the youths who are acting out in antisocial ways, such as by getting into fights or having problems in school. They may not be making as much "noise" in the community as these youth, but they are still at risk for long-term difficulties if their problems do not receive attention during adolescence.

*Dating and Sexual Behavior*

Dating typically begins in middle adolescence, usually between the ages of 14 and 16 years. Even very young adolescents are now "cyberdating" over the Internet, chatting about mutual interests without having to risk face-to-face or even telephone encounters (Santrock, 2001). Early romantic relationships tend to be of short duration, usually just a few months, with most of the dating occurring in a group context, at least for White adolescents. As the amount of time invested in a particular relationship increases, the expectation that sexual involvement will occur tends to increase for many adolescents. The latest data from the National Longitudinal Study on Adolescent Health indicate that nearly half of White and Hispanic adolescents and 65% of Black adolescents have had intercourse by 12th grade. For reasons not yet understood, Black adolescents tend to begin having intercourse at younger ages than other ethnic groups, with 37% reporting having had intercourse by eighth grade (Resnick et al., 1997).

Reliable data on sexual experiences other than vaginal intercourse, such as oral sex or anal sex, are not currently available for adolescents. There is some anecdotal evidence, however, that adolescents sometimes engage in these "outercourse" activities as an alternative to vaginal intercourse as a way to protect against pregnancy or maintain virginity (Remez, 2000). Certain sexual behaviors (e.g., anal sex) can put young people at especially higher risk for sexually transmitted diseases. It is important that sexually active adolescents who engage in these behaviors understand the heightened risk for contracting sexually transmitted diseases, including HIV, herpes simplex, human papillomavirus, gonorrhea, syphilis, and chlamydia. Because adolescents may have different ideas about what constitutes "having sex," professionals must take care that both they and the adolescent understand exactly what behaviors they are talking about when discussing issues of sexuality. For example, although both will view vaginal sexual intercourse as having sex, they may differ in their perceptions about whether such activities as oral sex, mutual masturbation, or even kissing constitute "having sex."

Negotiating sexuality in relationships can be challenging for adolescents. For some, there are significant costs in terms of unwanted pregnancies and sexually transmitted diseases. Professionals can help adolescents by being

open and willing to discuss frankly the interpersonal and health aspects of teens' developing sexuality. Many sexually active adolescents, even if unwilling to stop being sexually active, may be open to guidance about making decisions about their sexual partners and about changing sexual behaviors that increase risk for pregnancy and sexually transmitted diseases (e.g., multiple sexual partners, failure to use contraceptives and barriers that protect against sexually transmitted diseases) (Rosenthal, Burklow, & Lewis et al., 1997).

Issues related to adolescent sexuality can come up for professionals who work with adolescents in many different settings. Nurses and physicians, as well as various other professionals, must be well informed about state and local laws governing the provision of contraceptive information and services to minors, as well as any relevant guidelines that may be present in the professionals' particular work settings. Evidence suggests that at least some adolescents are open to discussing sexuality with adults. In a study of 148 adolescent girls who had not yet had intercourse, 33% stated that they would discuss sexuality with a health care professional. In addition to information about contraception and prevention of sexually transmitted diseases, these girls mentioned the following topics as appropriate: "decisions about having sex," "whether ready for sex," "alternatives to sex," "how to refuse sex," and "help you talk to parents." The predominant concern about talking to a health care professional was confidentiality, but these adolescents also feared being lectured to or were concerned that the professional would use "big, confusing words" (Ford, Millstein, Eyre, & Irwin, 1996).

In addition to sensitivity about issues of sexuality in relationships, it is important that professionals be aware of the grief and sense of loss associated with the ending of romantic relationships during adolescence. Adolescents need emotional support to work through their grief, and feelings of sadness and distress should be taken seriously and validated. Although clearly not the sole cause of suicide, loss of a boyfriend or girlfriend has been reported to trigger suicide attempts for adolescents with a prior history of difficulty or loss (Santrock, 2001).

Professionals should also be alert for signs of emotional or physical (including sexual) abuse in adolescent relationships, including same-sex relationships. If an adolescent is in a relationship that exhibits patterns of uncontrolled anger, jealousy, or possessiveness or if there is shoving, slapping, forced sex, or other physical violence—even once—it's time to find help. The American Psychological Association has published a helpful pamphlet, *Love Doesn't Have to Hurt Teens*, to help adolescents understand abuse and take action if they are in an abusive situation (see www.apa.org/pi/pii/teen/contents.html).

### *Family Relationships*

Families today can take many forms—single parent, shared custody, adoptive, blended, foster, traditional dual parent, to name a few. Regardless of family form, a strong sense of bonding, closeness, and attachment to family have been found to be associated with better emotional development, better school performance, and engagement in fewer high-risk activities, such as drug use (Resnick et al., 1997; Klein, 1997; Perry, 2000).

For more than half of families in the United States, divorce is a fact of life. Whether divorce will have negative effects on adolescents appears to depend on a number of factors, not simply the fact of the divorce itself. Although it is true that adolescents from divorced families exhibit more adjustment problems than do adolescents from intact families (Conger & Chao, 1996), evidence suggests that most adolescents are able to cope well with their parents' divorce (Emery, 1999). The factors that appear to have the greatest impact on coping include whether parents can harmoniously parent after the divorce (Hetherington, 2000) and whether the economic problems that often occur after a divorce and lead to other stresses, such as having to move, can be kept to a minimum (Emery, 1999).

Parents often ask professionals how they should modify their parenting practices as their children become older. It appears that parents who are warm and involved, provide firm guidelines and limits, have appropriate developmental expectations, and encourage the adolescent to develop his or her own beliefs tend to be most effective. These parents tend to use reasoning and persuasion, explain rules, discuss issues, and listen respectfully. Adolescents who come from homes with this style of parenting tend to achieve more in school, report less depression and anxiety, score higher in measures of self-reliance and self-esteem, and be less likely to engage in delinquent behaviors and drug abuse (Carlson et al., 2000; Dornbusch, Ritter, Liderman, & Fraleigh, 1987; Sessa & Steinberg, 1991; Steinberg, 2001). It should be noted, however, that the level of parental supervision and monitoring necessary to promote healthy adolescent development can differ depending on the characteristics of the adolescent's peer and neighborhood environments. For example, setting stricter limits may in fact be desirable for adolescents who live in communities where there is a low level of adult monitoring, a high level of danger, and higher levels of problem behavior among peers, such as in some inner-city, high crime neighborhoods (Roth & Brooks-Gunn, 2000).

During adolescence, parent–adolescent conflict tends to increase, particularly between adolescent girls and their mothers. This conflict appears to be a necessary part of gaining independence from parents while learning new ways of staying connected to them (Steinberg, 2001). Daughters, in particular, appear to strive for new ways of relating to their mothers (Debold, Weseen, & Brookins, 1999). In their search for new ways of relating, daughters may be awkward and seem rejecting. Understandably, mothers may withdraw, and a cycle of mutual distancing can begin that is sometimes difficult to disrupt. If parents can be reassured that the awkwardness their teen is displaying is not rejection and can be encouraged to stay involved, a new way of relating may eventually evolve that is satisfying for all.

Parent–teen conflict tends to peak with younger adolescents (Lauren, Coy, & Collins, 1998). Two kinds of conflict typically occur: spontaneous conflict over day-to-day matters, such as what clothes the adolescent is allowed to purchase or wear and whether homework has been completed, and conflict over important issues, such as academic performance. Interestingly, the spontaneous conflict that occurs on a day-to-day basis seems to be more distressing to parents than to the adolescents (Steinberg, 2001). This is important for parents to keep in mind. Parents often give greater meaning to conflict-laden interactions, construing them to be rejections of their values or as indicators of their failures as parents. Adolescents, on the other hand, may see the interaction as far less significant—just another way of showing Mom or Dad that they are individuals or just as a way to blow off steam. Professionals can help parents understand that minor conflict or bickering is normal and that these exchanges do not mean that they are not skilled or effective parents (Steinberg, 2001).



### *School*

For most adolescents, school is a prominent part of their life. It is here that they relate to and develop relationships with their peers and where they have the opportunity to develop key cognitive skills. For some youth, it is also a source of safety and stability. Some of the same qualities that characterize families of adolescents who do well—a strong sense of attachment, bonding, and belonging, and a feeling of being cared about—also characterize adolescents' positive relationships with their teachers and their schools. One additional factor, adolescent perception of teacher fairness, has also been found to be associated with positive adolescent development. These factors, more than the size of the school, the type of school (e.g., public, private), or teacher–pupil ratio, have been found to be strongly associated with whether adolescents are successful or are involved with drugs or delinquency or drop out of school (Resnick et al., 1997; Klein, 1997). Because schools are such a critical setting for adolescents, it can be important even for professionals who work in other settings to connect with the school psychologist, counselor, or social worker of an at-risk adolescent to help create a supportive system of care.

During adolescence, young people typically move from elementary school to middle or junior high school and then to senior high school. Each of these transitions can present challenges both to academic performance and psychological well-being (Seidman, Aber, & French, in press). Declines in academic performance are common following the move to middle or junior high school, a transition that can be quite disruptive for some adolescents. For some, this signals the beginning of a process of disengaging from school. Declines in

self-esteem are also common. Although most will "bounce back" later, for some this decline will continue, increasing their risk for lower grades and even failure in high school. Although the transition to senior high school is not as dramatic, some students will continue to disengage at this stage. Professionals should be alert to the difficulty that adolescents can have with school transitions and be ready to provide additional support and guidance during these periods.

More than ever before, having a high school diploma is required for economic success in this country. Fortunately, the trend over the past 20 years has been for adolescents, including those from most ethnic minority groups, to complete high school. Furthermore, the gap in scholastic achievement between ethnic minority and majority groups has narrowed considerably in the past two decades. Despite these gains, however, significant disparities continue among ethnic groups. Although 92% of non-Hispanic White and 84% of Black non-Hispanic 18- to 24-year-olds in 2000 had completed high school with either a diploma or equivalency certificate, only 64% of Hispanics in this age group had completed high school (Kaufman, Alt, & Chapman, 2001). It is also important to keep in mind that adolescents have variable access to quality education. In particular, school systems in poor areas, where students are more likely to be ethnic or racial minorities, are typically less well-funded, may have teachers who are less qualified, and have fewer resources than schools in more affluent areas.

Having a college degree has become increasingly important for economic success. Distressingly, some groups are being left behind, particularly African American adolescents and adolescents who come from families with lower incomes (U.S. Council of Economic Advisors, 2000). Professionals can help to make these teens aware of the financial and other assistance available to them to obtain a college degree and provide them with access to resources to overcome the economic and social barriers that can make it more difficult for them to succeed academically. They also need adults in their lives who believe in their potential as college-bound students, particularly if they come from homes where they will be the first to attend college. Without at least one adult reaching out to them early in their junior high school career, these young people may not see college as being within their range of possibilities. College is, however, only one option for youth after high school. Vocational training is another important choice to consider. Increased emphasis is now being placed on linking students to community job training while they are in high school and in preparing them for vocational training beyond high school. According to the American Vocational Association, 9,400 postsecondary institutions currently offer technical programs that provide training ranging from the culinary arts to computer technology. Students who are not drawn to college should be directed to explore these options. If not, they are likely to drift into easily accessible jobs that initially seem to offer high pay given the youth's limited experience. Although the ease with which these jobs are obtained can make them very attractive, in the long run, they are unlikely to provide the resources necessary to allow a young adult to live independently, much less to support a family (Jaffe, 1998). The large number of students and the small number of guidance counselors in many schools virtually guarantee that many students will fall through the cracks in terms of career planning. Therefore, regardless of one's professional role, it is helpful to inquire about and encourage adolescents to pursue postsecondary education and career training.

### *Work*

Many adolescents hold part-time jobs during high school. These jobs can help youth learn many important lessons, such as how the business world works, how to get and keep a job, how to manage time and money, and how to set goals and take pride in one's accomplishments (Committee on the Health and Safety Implications of Child Labor, 1998; Perry, 2000). What appears to be clear from the most extensive research conducted to date, however, is that the number of hours an adolescent works is critical for determining whether these positive benefits are offset by negative ones. Adolescents who work 20 or more hours per week during the school year are at higher risk for a variety of negative outcomes, including work-related injuries, lower educational attainment, substance abuse, and insufficient sleep (Committee on the Health and Safety Implications of Child Labor, 1998). Findings from the National Longitudinal Study on Adolescent Health suggest that these young people are more emotionally distressed, have poorer grades, are more likely to smoke cigarettes, and are more likely to become involved in other high-risk behaviors, such as alcohol and drug use (Resnick et al., 1997). Adults who work with youth should caution them that, whenever possible, they should keep their work hours to fewer than 20 hours a week during the school year, recognizing that for some youth working is an economic necessity.

For youth who are not going on to college, the transition to work after high school can be difficult. Young people can feel they are drifting and feel a lack of connection to either school or the world of work. Mentoring and school-to-work programs can be helpful for some of these youth, particularly when planned as a prevention rather than crisis-intervention strategy (Besharov, 1999).

### *Community*

The characteristics of the community in which an adolescent lives can have a profound impact on the adolescent's development. Community includes such factors as the socioeconomic characteristics of one's neighborhood, the types of resources available, the service systems within the community (including schools), religious organizations, the media, and the people who live in the community. Some communities are rich in resources that provide support and opportunity for adolescents. Unfortunately, many communities, particularly in inner cities or poor rural areas, do not.





#### *The Influence of Neighborhood Characteristics*

Neighborhood socioeconomic status (SES) and stability (i.e., the degree to which people of all SES classes tend to remain in the neighborhood over a period of time) can significantly affect adolescent development. For example, living in a high SES neighborhood is positively associated with academic achievement and negatively associated with dropping out of school, especially for adolescent males. On the other hand, adolescents who reside in low SES neighborhoods—particularly younger adolescents—are more likely to be involved in delinquent and criminal behavior and to experience behavioral problems, such as acting out or aggression and substance use. If youth have the opportunity to move out of poor neighborhoods, however, their prospects improve. For minority youth, those who move from public housing to more affluent neighborhoods have been found to be more likely to stay in school and to go to college than their peers who remain in public housing. And, adolescent boys involved in the criminal justice system who move to higher SES neighborhoods are less likely to be arrested again for violent crimes than their peers who remain in the same low-SES environments. The links between low SES and adolescent delinquent and problem behavior may be due in part to the lack of community institutions in poorer neighborhoods to monitor the activities of youth (e.g., recreation, employment) (Leventhal & Brooks-Gunn, 2000).

Neighborhood stability is another important factor. For example, neighborhood instability has been linked to higher rates of substance abuse in young adolescents (Leventhal & Brooks-Gunn, 2000). On the other hand, the presence of professional and managerial workers in a neighborhood, as well as lower unemployment rates, are associated with more positive outcomes for adolescents. As the number of professional and managerial workers in a neighborhood decreases and the unemployment rate increases, rates of adolescent sexual activity and childbearing increase. Lack of institutional resources (e.g., education, child care, medical, and employment opportunities) and lack of support for positive parenting relationships and practices are also implicated in these outcomes, although further research is needed to clarify their influence (Leventhal & Brooks-Gunn, 2000).

Grassroots efforts are important to strengthen support networks for parents and children in unstable and low SES neighborhoods. However, without other changes, they are unlikely to make much difference. Employment opportunities for youth, affordable and accessible health care, community policing, rehabilitation of housing, and other resources that provide stability and safety are also needed (Greene & Smith, 1995; Leventhal and Brooks-Gunn, 2000).

Many professionals choose to become involved in their communities as members of boards of directors of community organizations or on school boards and other public policymaking agencies. In this way, they are in a position to help decide which programs are developed and funded in their community. These professionals

need to know which programs have been evaluated and found to be effective for promoting healthy adolescent development. The characteristics of the most successful programs, for example, tend to engage youth as early in adolescence as possible, involve at least one adult who is personally attached to each adolescent in a meaningful way, involve parents and peers, be located in schools, and address the varied needs of youth (Lerner & Galambos, 1998).

To succeed, community intervention efforts must consider the values of the cultural groups in that neighborhood (Greene & Smith, 1995). Because lower SES neighborhoods in many regions of the country are predominately populated by ethnic minority groups, it is particularly important that efforts to help youth in these neighborhoods keep the cultural context in mind. For example, the "I Have a Future" program, which takes a community-based approach to (among other things) improve knowledge and attitudes related to personal health and to reduce risk of behaviors that endanger health (e.g., substance abuse, unprotected sex), is purposefully structured around values of African American culture (Greene & Smith, 1995).

*Faith Institutions*

Adolescents from many ethnic groups, including European Americans, are positively influenced by spiritual and cultural values. Adolescents, hungry for meaning, benefit from positive role models, explicit discussions of moral values, and a community in which there are activities structured around prosocial values, including religious values. That religious issues are important to many adolescents is illustrated by a recent study of youth aged 11 to 25, in which more than 85% said that they believed in God, and more than 90% that religion was at least somewhat important in their lives (Holder et al., 2000). Religious values are prominent among many ethnic minority cultures. African American groups have been particularly articulate about the strengths that they derive from religion and from faith communities (Franklin & Franklin, 2000). For many American youth, their church serves both as a spiritual resource and a source of social support (Santrock, 2001). Religiosity is associated with less involvement in alcohol and marijuana use. Specifically, the National Longitudinal Study on Adolescent Health found that youth whose families place importance on church attendance and prayer are less likely to become involved with these substances than those whose families do not place importance on church attendance and prayer (Resnick et al., 1997). Adolescents who attach greater importance to religion also reported less involvement in sexual activity (Holder et al., 2000).

*The Media*

The media—including music, television, and most recently, the Internet—are an important part of the adolescent's "community." Adolescents spend an estimated 6 to 8 hours per day exposed to some form of media (Roberts, 2000), and youth are increasingly attending to more than one form of media at a time (e.g., conversing on a cell phone with one friend while "instant messaging" several others on the computer). Although media will continue to be a growing influence on the development of adolescents, the ultimate effects will depend upon the extent to which positive possibilities can be harnessed and negative influences minimized. On the one hand, for example, television and movies can be negative influences because of their portrayals of violence and unhealthy sexuality and their lack of positive role models (e.g., for adolescents of color; Berry, 2000). On the other hand, they can also be venues for education, providing young people with valuable information about such issues as how to handle sexual situations (e.g., information about how to say "no" or about the importance of contraception), substance abuse, nutrition, violence prevention, and mental health concerns (e.g., Kaiser Family Foundation, 2002).

The Internet is now a ubiquitous presence in the lives of adolescents. Although all youth do not have equal access to computers, either at home or at school, the vast majority of youth today do have access to computers and to the Internet. A recent survey found that 95% of 15- to 17-year-olds have been online, with most in this age group (83%) having access to the Internet from home. Nearly a third (29%) have access to the Internet from a computer in their bedroom, where parents are much less able to monitor its use (Rideout, 2001). Much of adolescents' online activity consists of talking with people via e-mail, instant messaging, and chat rooms (Girl Scout Research Institute, 2002; Rideout, 2001). Typically, this activity is simply a form of interacting with peers. However, it is also important to be aware of the potential risks of going online. For example, youth who enter chat rooms can be targets of sexual harassment or worse, and pornography is easily accessible on the World Wide Web, even by accident (Girl Scout Research Institute, 2002; Rideout, 2001).

In a recent study of Internet use among girls ages 13 to 18, most reported that they receive very little advice from adults in their lives about the Internet, with most of the advice they do receive consisting of general precautions about online safety issues (Girl Scout Research Institute, 2002). On the other hand, respondents indicated that they wished that adults would provide them with help to avoid emotionally charged situations, such as sexual harassment or online porn, and to process them when they occur. Although almost a third reported that they had been sexually harassed while online (e.g., asked to have cyber sex or about their bra size) and had found the experience disturbing, most were hesitant to tell their parents about the experience. Professionals and other adults can help youth to understand the potential risks of being online in a nonjudgmental way and help them to identify and implement specific strategies for dealing with unwelcome or scary situations.

Finally, professionals can also act as advocates for adolescents, first learning about media influences on youth (for example, see the August 2000 Supplemental issue of the *Journal of Adolescent Health* on youth and media at www.elsevier.com/locate/jahonline) and then providing input to and supporting policies that protect youth from harmful media influences (Hogan, 2000). In this way, they both help to change unhealthy conditions and serve as important role models for youth, showing that it is important to act on one's beliefs, not simply to talk about them.

# Adolescent Behavioral Development

All of the ways adolescents develop—cognitively, physically, socially, emotionally—prepare them to experiment with new behaviors as they transition from childhood to adulthood. This experimentation in turn helps them to fine-tune their development in these other realms. Risk taking in adolescence is an important way that adolescents shape their identities, try out their new decision-making skills, and develop realistic assessments of themselves, other people, and the world (Ponton, 1997). Such exploratory behaviors are natural in adolescence (Hamburg, 1997), and teens need room to experiment and to experience the results of their own decision making in many different situations (Dryfoos, 1998). However, young people sometimes overestimate their capacities to handle new situations, and these behaviors can pose real threats to their health. To win the approval of peers or to avoid peer rejection, adolescents will sometimes take risks even they themselves judge to be "too risky" (Jaffe, 1998).

Adults have legitimate reasons to be concerned about adolescents' risk-taking behaviors. In the United States in 1999, 72% of all deaths among youth and young adults aged 10 to 24 years resulted from only four causes, all linked to behavior: motor-vehicle crashes (31%), homicide (18%), suicide (12%), and other unintentional injuries (11%) (Kann et al., 2000). And, in 2000, nearly one-half million teenaged girls gave birth (Moore et al., 2001). Many adolescents today have much more free unsupervised time on their hands compared with previous generations, particularly in the afternoon, and parents worry that their teenagers will get into trouble during these hours. For many youth of course, these hours are spent in constructive pursuits, such as hobbies, extracurricular activities associated with school, and studying. For others, however, this unsupervised time becomes an opportunity to experiment with sexual behavior, crime and delinquency, or substance abuse (Sickmund, Snyder, & Poe-Yamagata, 1997; U.S. Department of Education & U.S. Department of Justice, 1998). This time at the end of the day is also when an adolescent is at highest risk of being a victim of a violent crime, such as robbery or assault (Snyder & Sickmund, 1999). Although it is important to focus on the positive aspects of youth, awareness of the health-endangering behaviors of adolescents is also of vital concern to those who wish to help prevent and modify those behaviors (see Box 3).

Box 3

## *Adolescent Risk-Taking Behaviors*[18]

***Cigarette Smoking***

- *70% of high school students have tried cigarette smoking, 25% before the age of 13.*
- *About one-quarter of high school students smoke at least one cigarette per day, with male students smoking more than female students.*
- *Smoking has been on the rise for girls; in 1991, one in eight girls in eighth grade reported smoking (13%), but by 1996 more than one in five reported smoking (21%) (Lee, 2000).*

***Alcohol Use***

- *81% of high school students have tried alcohol; 32% had their first drink before the age of 13.*
- *Half of all high school students report having had more than one alcoholic beverage in the past 30 days, and approximately 30% report having had more than five alcoholic beverages at one time during this period. Girls ages 12–18 are now as likely as boys to drink alcohol (Lee, 2000).*
- *Male students are more likely than female students to report heavy episodic drinking, as are those in the upper grades (11 and 12) compared to those in the lower grades (9 and 10).*
- *13% of students drove a vehicle more than once after drinking during the past month, with males significantly more likely to do so than females. A third (33%) report having ridden more than once during the past month with a driver who had been drinking alcohol.*

***Other Drug Use***

- *47% of high school students have tried marijuana, with males more likely than females to report such use; 11% tried marijuana beforethe age of 13.*
- *9% of high school students have used some formof cocaine, and 4% have used cocaine more thanone time in the past 30 days.*
- *14% of students have used inhalants to get high; 4% more than once in the past 30 days.*
- *9% of high school students have used methamphetamines, and approximately 4% have used steroids.*

*(continiued on pg. 30)*

[18] *Unless otherwise noted, data on all risk behaviors that follow are from the* CDC Youth Risk Behavior Surveillance report for 1999 *(Kann et al., 2000), a large-scale nationally representative school-based survey of students in grades 9 through 12. For purposes of this publication, only national averages are reported; state and local data may differ.*

***Weapon Carrying, Fighting, and Sexual Violence***

- *17% of students have carried a weapon (e.g., a gun, knife, or club) to school on one or more days during the past month, with boys significantly more likely than girls to carry weapons.*
- *Approximately 36% of high school students have been in a physical fight one or more times during the 12 months, with male students (44%) more likely than female students (27%) to have been in a fight.*
- *During the past 12 months, approximately 9% of students were hit or slapped on purpose by their boyfriend or girlfriend.*
- *Approximately 9% of students had ever been forced to have sexual intercourse when they did not want to.*[19]
- *Homicide rates for Black youth ages 10 to 14 are 3 to 4 times greater than those for White youth (Ross, 2000).*

***Sexual Intercourse***

- *Half of all high school students have had sexual intercourse, with 8% having had intercourse before the age of 13, and 36% having had sexual intercourse during the past 3 months.*[20]
- *19% of male high school students report having had more than four sexual partners, as do 13% of female students.*
- *Approximately 25% of sexually active students used alcohol or drugs at last sexual intercourse.*
- *Among currently sexually active high school students, 58% used a condom during last sexual intercourse, with males more likely to report using a condom than females. Among sexually active female students, 20% report using birth control pills.*

***Pregnancy***

- *Approximately 6% of students report that they have been pregnant or responsible for getting someone pregnant.*
- *Between 1991 and 2000, the pregnancy rate for girls ages 15-19 years declined from 56.8 per 1,000 teens to 48.7 (Moore et al., 2001).*

***Failure To Use Motorcycle or Bicycle Helmets***

- *Of the 24% of students who report having ridden a motorcycle in the past year, 38% rarely or never wore a helmet. Of the 71% of students who rode a bicycle in the past year, 85% rarely or never wore a helmet.*



### *Reasons for Adolescent Risk Taking*

Several theories have been proposed as to why adolescents engage in risky behaviors (e.g., Arnett & Balle-Hjensen, 1993; Gibbons & Gerrard, 1995; Jessor, 1991). One theory stresses the need for excitement, fun, and novel, intense sensations that override the potential dangers involved in a particular activity (Arnett & Balle-Jensen, 1993). Another theory stresses that many of these risk behaviors occur in a group context and involve peer acceptance and status in the group (Jessor, 1991). A third theory emphasizes that adolescent risk taking is a form of modeling and romanticizing adult behavior (Gibbons & Gerrard, 1995). In other words, adolescents engage in some behaviors, such as cigarette smoking and sex, to identify with their parents and other adults. In considering these theories, it should be kept in mind that teenagers are not all alike and that they may have different reasons for engaging in the same risk behavior (Jaffe, 1998).

Adolescents may also have multiple reasons for engaging in a particular risk behavior. For example, given the use of sexuality to market just about every product imaginable, it is no wonder that adolescents are so curious and tempted to experiment. At the same time, research shows that many youths experience significant peer pressure to engage in sexual behavior. In a national survey of 12–18 year olds, 61% of the girls and 23% of the boys said that they thought that pressure from a partner was "often" a reason that teenagers have sex, and 43% of boys and 38% of girls said they thought that fear of being teased by others about being a virgin was often a reason (Kaiser Family Foundation, 1996).

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[19] *It is important to note that a disproportionate percentage of rape victims are adolescent girls, and the majority of these rapes are perpetrated by someone the victim knows. In 1992, 62% of all reported forcible rape cases involved victims younger than 17 (Lee, 2000).*

[20] *Recent data from the National Longitudinal Study on Adolescent Health show similar percentages of sexually active adolescents. From a subset of that study that included 12,105 7th-12th-grade students who completed 90-minute interviews in addition to data collected by questionnaire, 10.8% of White students, 16.1% of Hispanic students, and 36.9% of Black students had experienced sexual intercourse by eighth grade. By 12th grade, 45.9% of White students, 46.6% of Hispanic students, and 66.9% of Black students had experienced sexual intercourse (Blum et al., 2000).*

Overall, many experts conclude that risk taking in adolescence is "normal" (Dryfoos, 1998; Hamburg, 1997; Roth & Brooks-Gunn, 2000) and that the key is to provide guidance in decision making and encourage the adolescent to channel the positive developmental aspects of this energy into less dangerous and more constructive "risky" pursuits. Adults also need to consider where current programs and policies may be going wrong. For example, despite the fact that American adolescents are no more sexually active than adolescents from other cultures, our teen pregnancy rates are still much higher than those of most other industrialized nations (Santrock, 2001), even though they have declined over the past decade (Kann et al., 2000). These differences may be due to a number of factors, including differential access to birth control and abortion, differences in sex education, and cultural differences in attitudes toward sexual behavior, especially among young people.

How can adults provide guidance, and what other outlets are there for healthy risk taking for adolescents? First, adults must become comfortable talking with adolescents about decision making in these somewhat sensitive areas—sex, drugs and alcohol, and other safety concerns. The goal is to help the adolescent weigh the dangers and benefits of a particular situation, consider his or her own strengths and weaknesses that may affect decision making, and then make the best decisions possible (Ponton, 1997). This requires being knowledgeable both about the risks of a particular behavior and about that adolescent and being able to listen and respond to the adolescent without being dogmatic. The mere fact that an adolescent is having a conversation with an adult about these topics is a positive sign. Keep in mind that there are many positive aspects of adolescent risk taking and that most adolescents will take some risks. With time, most youths gradually learn to assess risks realistically and modify their behavior accordingly.

Second, adults must be tuned into positive pathways that youth might take—volunteering at a local youth center, taking up a sport, becoming involved in the school play, learning to play a musical instrument, and so forth. Keep in mind that risk taking does not have to be dramatic. Simply stretching beyond one's former capacities constitutes taking a risk and can satisfy many adolescents' needs for risk taking if they are encouraged to do so (a youth who is talented in art may need to be encouraged to try a new medium; a shy youth who has a facility for languages may need prompting to use his skills in the community). Finding out what talents or interests a youth might have and then challenging that youth to channel his or her energies to take risks in positive ways takes time. But it is incredibly rewarding to see a potential problem behavior become an asset for the youth and the community.

### *When Risk-Taking Behavior Becomes Problem Behavior*

For some youths, risk-taking behavior may signal a problem that can threaten their well being in both the short and long term. It is very important that professionals understand the difference between normal experimentation and signs of troubled or high-risk youth so they can make appropriate referrals to mental health professionals when warranted. What are some signs that youth have crossed the line between normal experimentation and problem behavior? Concern is warranted when high-risk behaviors begin early, such as at ages 8 or 9, are ongoing rather than occasional, and usually occur in a social context of peers who engage in the same activities. In this case, consideration should be given to referring the adolescent and his or her family to a mental health professional. In addition, it may be a sign that an adolescent is in serious trouble and needs professional help if he or she is engaged in multiple risk behaviors (Lerner & Galambos, 1998). Indeed, research has found that serious problems tend to cluster in the same adolescents (Hamburg, 1997). Youths who are at greater risk for serious negative outcomes tend to engage in multiple problem behaviors, such as drug use and unprotected sexual intercourse, at an early age and usually have several antecedent risk factors in common, such as poor school performance and low self-esteem (Jessor, 1991; Lerner & Galambos, 1998).



The major problem areas of most concern for high-risk adolescents are alcohol and drug abuse; pregnancy and sexually transmitted diseases; school failure and dropping out; and crime, delinquency, and violence. Information about what is known regarding the risk factors for each of these problems is briefly summarized in the following sections. Because protective factors, on the whole, tend to be the same for all of the problem behaviors, these will be discussed as a group after the problem behaviors.

#### *Alcohol and Drug Abuse*

It is difficult to draw the line between teens who are simply experimenting with alcohol and drugs and teens who have developed an alcohol or drug problem. Often, only a trained substance abuse professional can make this judgment. Teens who begin using drugs early, who rely on alcohol and drugs to alleviate feelings of anxiety or depression ("self-medicate"), especially when such use is shared by their friends, may be at higher risk than other teens for developing a substance abuse problem (Simons, Whitbeck, Conger, & Melby, 1991).

Parental substance abuse, including alcohol abuse, is a risk factor for the development of substance abuse problems for adolescents (Obot & Wagner, 2001), as are

certain parenting and family management characteristics. These include lack of monitoring or supervision of youth, unclear expectations of youth behavior, and no (or only rare) rewarding of positive behavior (Barnes, Farrell, & Banerjee, 1995; Peterson, Hawkins, Abbott, & Catalano, 1994). Exposure to peer use of substances and susceptibility to peer pressure can also increase risk of substance abuse, although there is some evidence that this may be less of a factor for African American youth (Barnes, Farrell, & Banerjee, 1994).

*Pregnancy and Sexually Transmitted Diseases*

Despite the recent decline in teen pregnancy rates in the United States, pregnancy and birth rates for youth in this country continue to be among the highest of all developed countries, largely because of differences in contraceptive use (Boonstra, 2002; Moore et al., 2001). Pregnancy results when sexually active adolescents fail to use or effectively use contraceptives. Despite dramatic increases over the past two decades in the reported use of contraceptives (especially condoms) by teens at first intercourse, contraceptive use at most recent sexual intercourse has declined (Terry & Manlove, 2000). While an estimated 24% of teen girls ages 15 to 19 report that they did not use contraceptives the first time they had intercourse, 31% report that they did not use contraceptives the last time they had intercourse. These figures are higher for Hispanic females, only 47% of whom report that they used contraceptives at their last intercourse. Thus a substantial number of sexually active teen girls remain at risk for unintended pregnancy.



Factors associated with delaying first intercourse include being in a two-parent family, having a higher socioeconomic status, greater feelings of religiosity, belief that parents or other adults care and have high expectations of adolescents, and better high school performance (Lammers, Ireland, Resnick, & Blum, 2000). Other factors are associated with increased risk of teen pregnancy. Teens who live in low-income, socially disorganized communities in which family planning services are not readily available are at higher risk (Lerner & Galambos, 1998). Several studies have also found that girls are more likely to use contraception when they believe that their parents support this behavior (Balassone, 1991; Lerner & Galambos, 1998). Finally, having sexual partners unwilling to use contraception increases risk, highlighting the need to discuss contraception in the context of communication within relationships.

Roughly 4 million teens contract a sexually transmitted disease (STD) each year (Lee, 2000), with older Hispanic and African American adolescents tending to have higher rates of HIV/AIDS compared to other groups of teens (Ross, 2000). Although adolescents have become their feelings or intuition about whether a person is "safe." If an adolescent likes and trusts a person and has known that person for a period of time, the adolescent may have a false sense of security about his or her risk for sexually transmitted diseases, thus feeling that there is no need to use condoms to protect against STDs (Jaffe, 1998; Thompson, Anderson, Freedman, & Swan, 1996).

*School Failure and Dropping Out*

Dropping out of school can be one of the most detrimental actions youths can take, with potentially disastrous effects on their economic futures. Each year, about 15% of students drop out of school, with higher rates among low-income students, particularly those in large cities. Although the dropout rate for African Americans has decreased in recent years, that for Hispanics has remained quite high—approximately 36% of those ages 18 to 24 have failed to graduate from high school or receive an equivalency certificate.

Some studies have found that members of different ethnic groups cite different reasons for dropping out of school. In one national study, White teenagers who dropped out spoke mainly of feelings of estrangement and alienation from school, not getting along with teachers, and failing academically. Black and Hispanic teenagers, on the other hand, cited the need to provide income for their families and to help with younger children, with Black teenagers also citing getting suspended or expelled as reasons for dropping out (Jordan, Lara, & McPartland, 1996).

*Delinquency, Crime, and Violence*

Qualitatively different patterns of delinquency and antisocial behavior (e.g., shoplifting, using drugs, or otherwise breaking the rules of society) have been noted (Moffitt, 1993). For the majority of adolescents who act out, their behavior reflects a gap between their biological and social maturity. Young people commit these acts impulsively and, if handled in a way that discourages them from this type of behavior and puts them back on the right track, most cease all forms of this type of behavior by adulthood (Moffitt, 1993).

This is not to say that the youths who commit these acts are not at risk for further trouble. For example, youths whose one-time antics put them in contact with more seriously offending youths may be influenced by these youths, who reinforce their antisocial behaviors (Dishion, McCord, & Paulin, 1999). But single acts, particularly those that occur in adolescence without any antecedents in childhood, are of less serious concern than multiple acts or acts that follow aggressive behaviors in childhood.

Box 4

*Factors Associated With Resilience and Positive Outcomes*

***Stable, Positive Relationship With at Least One Caring Adult***

*Numerous studies have found that the presence of an adult—a parent or someone other than a parent—with a strong positive, emotional attachment to the child is associated with resilience (Garbarino, 1999). This might be a teacher or coach, an extended family member, or a mentor, such as those found in the Big Brothers/Big Sisters Program (Roth & Brooks-Gunn, 2000).*

***Religious and Spiritual Anchors***

*A sense of meaning is one of the major pathways through which violent youth find their way to a constructive future, with religious and spiritual institutions and practices being important vehicles for developing a sense of meaning for these youth (Garbarino, 1999).*

***High, Realistic Academic Expectations and Adequate Support***

*Schools that provide students with a sense of shared cooperative responsibility and belonging, convey high expectations for participation, and provide high levels of individual support for students tend to enhance resilience (Siedman et al., in press).*

***Positive Family Environment***

*A warm, nurturing parenting style, with both clear limit setting and respect for the growing autonomy of adolescents, appears to be associated with resilience in adolescents (Jessor, 1991; Lerner & Galambos, 1998). Strong, positive mother-adolescent relations have also been found to be associated with resilience among youth when fathers are absent from the home (Mason, Cauce, Gonzales, & Hiraga, 1994).*

***Emotional Intelligence and Ability To Cope With Stress***

*Although intelligence per se has been reported to be associated with resilience (Fergusson & Lynskey, 1996), the factors that may be more important, because they are more amenable to change and are also involved in resilience, are emotional intelligence and the ability to cope with stress (Garbarino, 1999).*

Another much more serious pattern, which is referred to as "life course persistent antisocial behavior," extends beyond adolescence. Typically, this pattern of behavior expresses itself in childhood through cruelty toward animals and vulnerable children and through antisocial acts at younger ages and more serious acts at older ages (e.g., shoplifting and truancy at ages 8 or 10, selling drugs and stealing cars at 13 or 14, robbery at 16 or 17) (Moffitt, 1993).

Many factors, including violence in the media, the availability of handguns, exposure to violence in the home and in the community, and the economically and socially impoverished communities in which many youths and their families live can contribute to antisocial or violent behavior among youth. Living in poverty is a particularly powerful risk factor for increasing the chances that a youth will engage in high-risk problem behaviors (Lerner & Galambos, 1998; Perry, 2000).

### *Protective Factors and Resilience*

Just as there are a number of factors that can place adolescents at higher risk, there are also factors that can help protect young people from developing problems, even under such adverse circumstances as poverty. The term "resilience" is used to refer to having good outcomes despite serious threats to healthy development (Masten, 2001). Resilience can be facilitated not just by reducing the level of risk, but also by promoting competence and strengthening assets (Maton, Schellenbach, Leadbeater, and Solarz, in press). Several factors associated with resilience are summarized in Box 4. Although it is not necessary for all of these factors to be in place in order for an adolescent to be resilient in the face of adversities, greater resilience tends to be associated with having more of these kinds of protective factors present.

Many psychologists caution against viewing resilience from an individual framework. Instead, resilience should be seen as a function of developmental experiences that are grounded in a community context (Debold et al., 1999; Perry, 2000). Whether a community is able to offer the relationships, resources, and commitment needed to provide the kinds of supports and developmental experiences that produce resilient youth depends on many factors, but primary is whether the needs of youth are given priority.



## Conclusion

*We end* Developing Adolecents: A Reference for Profesionals *with a discussion of resilience because we believe that all youth can be resilient if they have adults to nurture and support them as they navigate the sometimes-risky passage from adolescence to adulthood. Each professional who works with adolecents can make a positive difference in their lives. All youths can be given the message that they are worthwhile, that there are people who care about them, and that there are resources available to meet their needs.*

*Adolescents are creative, energetic, and challenging. We hope that this publication has made their normal developmental course more understandable and that this understanding will help professionals in their day-to-day work with them.*

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