

Socioemotional Development in Adolescence

OBJECTIVE

- 12.1.** Identify ways in which self-conceptions and self-esteem change in adolescence.
- 12.2** Outline the process of identity development during adolescence, including influences and outcomes associated with identity status.
- 12.3** Explore changes in adolescents' relationships with parents and the contributions of parenting style and monitoring to adolescent adjustment.
- 12.4** Compare and contrast the nature of friendship and dating during adolescence.
- 12.5** Differentiate the developmental progression of cliques and crowds.
- 12.6** Analyze how susceptibility to peer influence changes from early adolescence to late adolescence.
- 12.7** Compare the factors that contribute to sexual activity, contraceptive use, and the transmission of sexually transmitted infections (STIs) during adolescence.
- 12.8** Discuss risk factors for adolescent pregnancy and influences on the adjustment of adolescent mothers and their children.
- 12.9** Compare and contrast the risk factors for and treatments for adolescent problems such as depression and suicide, eating disorders, and substance use and abuse.
- 12.10** Characterize normative delinquent activities during adolescence as compared with serious lifelong criminal activity.

CHAPTER CONTENTS

Psychosocial Development: The Changing Self

- Self-Concept
- Self-Esteem
- Identity

Adolescents and Their Families

- Parent-Adolescent Conflict
- Parenting Style and Monitoring

Adolescents and Their Peers

- Friendships
- Cliques and Crowds
- Peer Conformity
- Dating

Adolescent Sexuality

- Sexual Activity
- Influences on Sexual Activity
- Lesbian, Gay, Bisexual, and Transgender Adolescents
- Contraceptive Use
- Sexually Transmitted Infections
- Adolescent Pregnancy

Problems in Adolescence

- Depression and Suicide
- Eating Disorders
- Alcohol and Substance Use
- Delinquency

m a walking contradiction,” declares 15-year-old Casey. “I’m shy but also outgoing, kind but sometimes I want to be mean. I don’t know what I want to do with my life. I’d like to go away to college, but I don’t want to leave my friends. I think protecting the environment is important, and I want to make a difference in the world. But what does that mean for me? I guess I’m still figuring myself out,” Casey concludes. She has summed up much of the socioemotional task of adolescence: figuring yourself out. Specifically, adolescents construct a sense of self and **identity**, an understanding of who they are and who they hope to be. Adolescents’ attempts at self-definition and discovery are influenced by their relationships with parents and peers, relationships that become more complex during the adolescent years.



PSYCHOSOCIAL DEVELOPMENT: THE CHANGING SELF

Adolescents spend a great deal of time reflecting on themselves and engaging in introspective activities, such as writing in journals; composing poetry; and posting messages, photos, and videos about their lives on social media. Adults often view these activities as self-indulgent and egotistical, but they help adolescents work through an important developmental task: forming a sense of self. During adolescence, we undergo advances in self-concept and identity.

SELF-CONCEPT

A major developmental task of adolescence is to construct a more complex, differentiated, and organized self-concept. As discussed in Chapter 9, older children can use broad characteristics to describe their personalities (e.g., funny, smart). With cognitive advances, young adolescents use more labels to describe themselves, and the labels they choose become more abstract and complex (e.g., witty, intelligent). Adolescents learn that they can describe themselves in multiple ways that often are contradictory, such as being both silly and serious, and that they show different aspects of themselves to different people (e.g., parents, teachers, friends; Harter, 2006b; Harter, 2012). Adolescents' views of themselves influence their behavior. For example, adolescents' views of their academic competencies in early adolescence predict their academic achievement in middle adolescence (Preckel, Niepel, Schneider, & Brunner, 2013).

In middle adolescence, young people recognize that their feelings, attitudes, and behaviors may change with the situation, and they begin to use qualifiers in their self-descriptions (e.g., "I'm sort of shy"). Adolescents' awareness of the situational variability in their psychological and behavioral qualities is evident in statements such as, "I'm assertive in class, speaking out and debating my classmates, but I'm quieter with my friends. I don't want to stir up problems." Many young adolescents find these inconsistencies confusing and wonder who they really are, contributing to their challenge of forming a balanced and consistent sense of self. Adolescents identify a self that they aspire to be, the **ideal self**, which is characterized by traits that they value. Adjustment is influenced by the match between the **actual self**—the adolescents' personal characteristics—and their aspirational, ideal self. Mismatches between ideal and actual selves are associated with **depression** symptoms, low self-esteem, and poor school grades (Ferguson, Hafen, & Laursen, 2010; Stevens, Lovejoy, & Pittman, 2014). Adolescents who show poor self-concept clarity, or poor stability or consistency in their self-descriptions, tend to experience higher rates of depressive and anxiety symptoms throughout adolescence (Van Dijk et al., 2014). As adolescents become increasingly concerned with how others view them, positive social characteristics such as being helpful, friendly, and kind become more important (Damon & Hart, 1988).

Self-concept is influenced by experiences in the home, school, and community. At home, the authoritative parenting style can provide support, acceptance, and give-and-take to promote the development of adolescent self-concept (Lee, Daniels, & Kissinger, 2006; Van Dijk et al., 2014). Interactions at school also influence how adolescents view themselves. African American middle school students' experiences with racial discrimination at school are associated with poor academic self-concepts, but a strong connection to their ethnic group and a feeling of affinity with African American culture can buffer the negative impact of discrimination (Eccles, Wong, & Peck, 2006). Participation in youth organizations, such as the Boys' and Girls' Clubs of America, has positive effects on the self-concept of young people reared in impoverished neighborhoods because such organizations foster competence, positive socialization, and connections with the community (Quane & Rankin, 2006). Adolescents' evaluations of their self-conceptions are the basis for self-esteem (Harter, 2006b; Marsh, Trautwein, Lüdtke, Köller, & Baumert, 2006).

SELF-ESTEEM

As self-conceptions become more differentiated, so do self-evaluations. **Global self-esteem**, an overall evaluation of self-worth, tends to decline at about 11 years of age, reaching its lowest point at about 12 or 13, and then rises (Harter, 2006a; Orth & Robins, 2014). Declines in global self-esteem are likely due to the multiple transitions that young adolescents undergo, such as body changes and the emotions that accompany those changes, as well as adolescents' self-comparisons to their peers. Although school transitions (as discussed in Chapter 11) are often associated with temporary declines in self-esteem, most adolescents view themselves more positively as they progress from early adolescence and through the high school years (Moneta, Schneider, & Csikszentmihalyi, 2001; Orth & Robins, 2014; Zeiders, Umaña-Taylor, & Derlan, 2013). For example, comparisons of adolescents in Grades 8, 10, and 12 reveal higher ratings of self-esteem with age for European American, African American, Asian American, and Latino youth (Bachman, O'Malley, Freedman-Doan, Trzesniewski, & Donnellan, 2011).

Global evaluations of self-worth give way to more complex views. Adolescents evaluate themselves with respect to multiple dimensions and relationships, such as within the context of friendships, academics, and athletic abilities (Harter, 2012). Adolescents describe and evaluate their capacities in many areas and view their abilities more positively in some and more negatively in others.

Adolescents develop a positive sense of self-esteem when they evaluate themselves favorably in the areas that they view as important. For example, sports accomplishments are more closely associated with physical self-esteem in adolescent athletes, who tend to highly value physical athleticism, than nonathletes, who tend to place less importance on athleticism (Findlay & Bowker, 2009; Wagnsson, Lindwall, & Gustafsson, 2014). Similarly, adolescents with high academic self-esteem tend to spend more time and effort on schoolwork, view academics as more important, and demonstrate high academic achievement (Preckel et al., 2013; Valentine, DuBois, & Cooper, 2004). There is also spillover as exemplary performance and self-esteem in one area, such as athletics, often is associated with positive self-evaluations in other areas, such as social, physical, and appearance (Marsh, Trautwein, Lüdtke, Gerlach, & Brettschneider, 2007; Stein, Fisher, Berkey, & Colditz, 2007).

Whereas favorable self-evaluations are associated with positive adjustment and sociability in adolescents of all socioeconomic status and ethnic groups, low self-esteem is associated with adjustment difficulties and depression (Burwell & Shirk, 2006; McCarty, Stoep, Vander, & McCauley, 2007). Low self-esteem is associated with depression during adolescence, and it also predicts depression in adulthood (Orth & Robins, 2014). For example, in one longitudinal study, researchers assessed self-esteem annually in over 1,500 12- to 16-year-old adolescents and found that both level and change in self-esteem predicted depression at ages 16 and 35 (Steiger, Allemand, Robins, & Fend, 2014). Those who entered adolescence with low self-esteem and whose self-esteem declined further during the adolescent years were more likely to show depression two decades later as adults; this pattern held for global and domain-specific self-esteem (physical appearance and academic competence).

High-quality relationships with parents, peers, and other adults (relationships characterized by many positive and few negative features) are associated with higher estimates of self-worth





and better adjustment. Relationships with parents play an important role in influencing adolescents' self-evaluations. For example, a study of Dutch, Moroccan, Turkish, and Surinamese adolescents living in the Netherlands, as well as adolescents from China, Australia, Germany, and the United States, confirmed that the overall quality of the parent-adolescent relationship predicted self-esteem (Harris et al., 2015; Wang & Sheikh-Khalil, 2014; Wissink, Dekovic, & Meijer, 2006). Parents who adopt a warm, encouraging, but firm style of parenting are more likely to raise adolescents who display high self-esteem (Milevsky, Schlechter, Netter, & Keehn, 2007; Steinberg, 2001; Wouters, Doumen, Germeijs, Colpin, & Verschueren, 2013). Among Latino adolescents in the United States,

high self-esteem is predicted by authoritative parenting coupled with **biculturalism**, adopting values and practices of two cultures, and **familism**, valuing the family over the individual and community (Bámaca, Umaña-Taylor, Shin, & Alfaro, 2005; Smokowski, Rose, & Bacallao, 2010; Telzer, Tsai, Gonzales, & Fuligni, 2015). In contrast, if parental feedback is critical, insulting, inconsistent, and not contingent on behavior, and parent-adolescent conflict is high, adolescents tend to develop poor self-esteem, are at risk to turn to peers for self-affirmation, and show adjustment difficulties (Milevsky et al., 2007; Wang et al., 2014).

Relationships with parents have a powerful impact on adolescents' views of themselves; however, peers also matter. Adolescents who feel supported and well-liked by peers tend to show high self-esteem (Litwack, Aikins, & Cillessen, 2010). In addition, peer acceptance has protective effects on self-esteem and can buffer the negative effects of a distant relationship with parents (Birkeland, Breivik, & Wold, 2014). Unfortunately, however, adolescents with low self-esteem are more likely to report poor relationships with peers (Laursen & Mooney, 2008; Vanhalst, Luyckx, Scholte, Engels, & Goossens, 2013).

IDENTITY

As adolescents' self-concept and self-esteem become more descriptive, comprehensive, and organized, they begin to form an identity, a coherent sense of self. In devising an identity, young people integrate all that they know about themselves, their self-conceptions, along with their evaluations of themselves, to construct a self that is coherent and consistent over time (Erikson, 1950). **Identity achievement** represents the successful resolution of this process, establishing a coherent sense of self after exploring a range of possibilities. In establishing a sense of identity, individuals must consider their past and future and come to a sense of their values, beliefs, and goals with regard to vocation, politics, religion, and **sexuality**.

Identity Status

"Black again?" Rose sighs, "You wear too much black." Her daughter, Stephanie, retorts, "How can anyone wear too much black?" Rose wonders where last year's preppy girl went and hopes that Stephanie will lose interest in wearing goth attire. "Maybe next year she'll try a new style and stop wearing so much black." Stephanie's changing styles of dress reflect her struggle with figuring out who she is, her identity. Researchers classify individuals' progress in identity development into four categories known as **identity status**, the degree to which individuals have explored possible selves and whether they have committed to specific beliefs and goals (Marcia, 1966).

Identity status is most commonly assessed by administering interview and survey measures (Årseth, Kroger, Martinussen, & Marcia, 2009; Jones, Akers, & White, 1994; Schwartz, 2004). Young people typically shift among identity statuses over the adolescent years, but the specific pattern of identity development varies among adolescents (Meeus, 2011). Some adolescents remain in one identity status, such as **identity moratorium**—a state of exploration—for the bulk of adolescence, while others experience multiple transitions in identity status. The most common shifts in identity status are from **identity diffusion** (not having explored or committed to a sense of self) and **identity foreclosure** (prematurely choosing an identity) in early adolescence, to moratorium and achievement in middle and late adolescence (Al-Owidha, Green, & Kroger, 2009; Meeus, 1996; Yip, 2014). Table 12.1 depicts four identity statuses, or categories, describing a person’s identity development.

Identity statuses reflect different ways of viewing and responding to the world. Having not engaged in any exploration, individuals who are in the identity-foreclosed status tend to be inflexible and view the world in black-and-white, right-and-wrong terms. Pervasive uncertainty that feels like it will never be resolved is linked with identity diffusion (Berzonsky & Kuk, 2000; Boyes & Chandler, 1992). Patterns of development vary across identity domains, such as vocation, political ideology, religious values, and **sexual identity** (Kroger, 2007a). For example, having chosen a career, an adolescent may demonstrate identity achievement with regard to vocation yet remain diffused with regard to political ideology, never having considered political affiliations. The overall proportion of young people in the moratorium status tends to increase during adolescence, peaking at about age 19 and declining thereafter (Kroger, Martinussen, & Marcia, 2010). Identity diffusion and foreclosure become less common in late adolescence. The identity-achieved status in each domain requires that individuals construct a sense of self through exploring or trying out new ideas and belief systems, critical examination, and reflection as well as that they have formed a commitment to a particular set of ideas, values, and beliefs. Even in early adulthood, a great many young people have not reached identity achievement (Kroger, 2007b; Kroger et al., 2010; Meeus, 2011).

Influences on Identity Development

Just as authoritative parenting fosters the development of positive self-concept and self-esteem, it also is associated with identity achievement. When parents provide

TABLE 12.1 Identity Status

		COMMITMENT	
		PRESENT	ABSENT
Exploration	Present	<p>Identity Achievement</p> <p>Description: Has committed to an identity after exploring multiple possibilities</p> <p>Characteristics: Active problem-solving style, high self-esteem, feelings of control, high moral reasoning, and positive views of work and school</p>	<p>Identity Moratorium</p> <p>Description: Has not committed to an identity but is exploring alternatives</p> <p>Characteristics: Information-seeking, active problem-solving style, open to experience, anxiety, experimentation with alcohol or substance use</p>
	Absent	<p>Identity Foreclosure</p> <p>Description: Has committed to an identity without having explored multiple possibilities</p> <p>Characteristics: Avoid reflecting on their identity choice, not open to new information, especially if contracts their position, rigid and inflexible</p>	<p>Identity Diffusion</p> <p>Description: Has neither committed to an identity nor explored alternatives</p> <p>Characteristics: Avoidance; tend to not solve personal problems in favor of letting issues decide themselves, academic difficulties, apathy, and alcohol and substance use</p>

a sense of stability along with **autonomy**, adolescents tend to explore, much as toddlers do, by using their parents as a secure base (Årseth et al., 2009; Beyers & Goossens, 2008; Meeus & de Wied, 2007). Adolescents who feel connected to their parents, supported, and accepted by them but who also feel that they are free and encouraged to develop and voice their own views, are more likely to engage in the exploration necessary to advance to the moratorium and achieved status. As adolescents become individuated from parents, they begin to make identity commitments and move toward identity achievement (Meeus, Iedema, Maassen, & Engels, 2005). Adolescents who are not encouraged or permitted to explore, who are raised in authoritarian homes, are more likely to show the foreclosed status. A lack of parental support and encouragement to develop and express ideas predicts the failure to seek out and make commitments to possible selves characteristic of identity diffusion (Hall & Brassard, 2008; Reis & Youniss, 2004; Zimmermann & Becker-Stoll, 2002)

Attachment to peers is also associated with identity exploration (Harter, 2006b; Meeus, Oosterwegel, & Vollerbergh, 2002). Peers serve as a mirror in which adolescents view their emerging identities, an audience to which they relay their self-narratives (McLean, 2005). When adolescents feel close, supported, and respected by peers, they feel more comfortable exploring identity alternatives. As with parents, conflict with peers harms identity development as adolescents often feel less free to explore identity alternatives and lack a supportive peer group to offer input on identity alternatives, which holds negative implications for identity development, such as identity foreclosure or diffusion (Hall & Brassard, 2008).

Outcomes Associated With Identity Development

Identity development is an important influence on well-being. Specifically, identity achievement and identity moratorium are both associated with positive functioning, an adaptive, mature sense of self, prosocial behavior, and the capacity for romantic attachments among high school students (Berman, Weems, Rodriguez, & Zamora, 2006). Identity achievement is also associated with high self-esteem, feelings of control, high moral reasoning, and positive views of work and school (Adams & Marshall, 1996; Kroger, 2000). In contrast, the moratorium status is associated with anxiety (Lillevoll, Kroger, & Martinussen, 2013). Young people in the moratorium status often feel puzzled by the multiple choices before them and are driven to make decisions and solve problems by using an active information-gathering style characterized by seeking, evaluating, and reflecting on information to determine their views and make decisions (Luyckx et al., 2008). Some adolescents, however, become extremely overwhelmed and anxious, which may be paralyzing and prevent identity exploration (Crocetti, Klimstra, Keijsers, Hale, & Meeus, 2009).

As noted, foreclosed and diffused identity status become less common with age, especially after 19. Foreclosure and diffusion are associated with passivity and, in late adolescence, maladaptive long-term outcomes (Archer & Waterman, 1990; Berzonsky & Kuk, 2000). Young people who show identity foreclosure have adopted an identity, often prescribed by others, without evaluation. Young people classified as identity foreclosed choose an identity without considering its implications or evaluating other options. They tend to take a rigid and inflexible stance, avoid reflecting on their identity choice, and reject information that may contradict their position (Kroger, 2007b). Individuals who display the identity-foreclosed status are not open to new experiences or considering new ways of thinking. For example, a 14-year-old adolescent in a family of doctors who has not considered any careers and comes to the decision, after prodding by her parents and grandparents, that she wants to be a doctor may be in the identity-foreclosed status. Foreclosure is common in early adolescence.

The identity-diffused status is the least mature form of identity. While it is developmentally appropriate for early adolescents to have neither explored nor

committed to a sense of identity, by late adolescence identity diffusion is uncommon and has been considered indicative of maladjustment (Kroger et al., 2010). Young people who show identity diffusion tend to use a cognitive style that is characterized by avoidance; rather than dealing with personal problems and making decisions, their choices are dictated by situational pressures, not reflection. Identity-diffused individuals tend to not make independent decisions; they call upon fate, follow others, or let issues decide themselves. Academic difficulties, organization and time management problems, general apathy, and alcohol and substance abuse are associated with identity diffusion. “Bryan’s again on academic probation, and it looks like he’ll be expelled from the dormitory after the resident assistant found drugs in his room. And he doesn’t seem to care. I just don’t get it,” exclaims Bryan’s academic advisor. Behavior problems both precede and accompany identity diffusion. Longitudinal research suggests that behavior problems in early adolescence predict identity diffusion in late adolescence (Crocetti, Klimstra, Hale, Koot, & Meeus, 2013).

Although the task of forming an identity is first encountered during adolescence, identity development is an important task among college-age youth and remains a lifelong process for all individuals (Côté, 2006; Kroger, 2007a). Changes within the person and his or her context, such as graduating from college, changing careers, getting married, and having children, provide opportunities to reflect upon, organize, and reorganize identity.

Ethnic Identity

An important aspect of identity, especially for ethnic minority adolescents, is **ethnic identity**, or a sense of membership to an ethnic group including the attitudes, values, and culture associated with that group (Phinney, 2000; Phinney & Ong, 2007). Like other components of a sense of self, ethnic identity develops and changes over time as individuals explore, gain experience, and make choices in various contexts. Adolescents explore their ethnic identity by learning about the cultural practices associated with their ethnicity by reading, attending cultural events, and talking to members of their culture (Quintana, 2007; Romero, Edwards, Fryberg, & Orduña, 2014; Wakefield & Hudley, 2007). After developing a sense of belonging, young people may become committed to an ethnic identity. A strong sense of ethnic identity helps young people to reject negative views of their culture that are based on stereotypes (Rivas-Drake et al., 2014). For example, one study found that feelings of affirmation and belonging to ethnic heritage predicted positive psychological adjustment in Navajo youth (Jones & Galliher, 2007).

Ethnic minority adolescents often face challenges to the development of identity. With cognitive advances, adolescents can consider themselves and their worlds in more complicated ways—and become better at taking other people’s perspectives. Many ethnic minority adolescents also become sensitive to negative feedback, discrimination, and inequality from the majority group. Many adolescents find it difficult to develop a feeling of cultural belonging and personal goals, especially when the standards of the larger society are different from those of the culture of origin, such as the differing emphases of collectivism and individualism. Collectivist cultures stress commitment to family, although the emphasis on family obligations often lessens the longer the family has been living in an emigrant country that emphasizes individualism (Phinney, 2000). Sometimes adolescents are restricted from participating in the larger culture out of parental



fear that assimilation will undermine cultural values. One study of Vietnamese adolescent living in an ethnic enclave in southern California found that most felt that their parents encouraged them to embrace their heritage, make friends, and engage in activities within the community rather than the larger school and neighborhood community (Vo-Jutabha, Dinh, McHale, & Valsiner, 2009). As one boy explained, “My parents expect me to speak Vietnamese consistently. Every now and then they just say that I forgot it and that I don’t know how to speak it anymore.... Of course, I understand it and my parents expect me to be in a Viet Club or something. But I mean c’mon, really c’mon” (Vo-Jutabha et al., 2009, pp. 683–684). Another girl adds, “I think living in the Asian community kinda stops me from branching out. I live in this area and all of my friends are mostly Asian and I want to have other friends” (Vo-Jutabha et al., 2009, p. 680). Adolescents who perceive excessive parental pressure and restrictions might respond with rebellion and rejection of ethnic heritage.

Discrimination against particular ethnic groups can make it difficult for youth to form a positive sense of identity. Adolescents from a variety of racial and ethnic groups, both native born and immigrant, report experiences of discrimination which are associated with lower self-esteem, depression, lower social competence behavior problems, and distress (Mrick & Mrtorell, 2011; Rivas-Drake et al., 2014; Wakefield & Hudley, 2007). For example, a study of Mexican American youth demonstrated that those who perceived and experienced more discrimination were less likely to explore their ethnicity, feel good about it, and incorporate a sense of ethnic identity (Romero & Roberts, 2003). Some ethnic minority adolescents perceive discrimination in the classroom, such as feeling like their teachers called on them less, graded them more harshly, or disciplined them more punitively, African American adolescents who face racial discrimination from teachers and peers at school show declines in grades, academic self-concept, mental health (anger, depression, self-esteem, and psychological resilience), school engagement, and ethnic identity (Dotterer, McHale, & Crouter, 2009; Wong, Eccles, & Sameroff, 2003). Likewise, in a study of Navajo 9th- and 10th-grade adolescents, those who perceived discrimination showed poorer psychosocial adjustment and higher levels of substance use over a one-year period (Galliher, Jones, & Dahl, 2011). Adolescents often must manage confusing messages to embrace their heritage while confronting discrimination, making the path to exploring and achieving ethnic identity challenging and painful for many adolescents, leading many to remain diffused or foreclosed (Markstrom-Adams & Adams, 1995).

What fosters ethnic identity development? The exploration and commitment process key to identity achievement also underlies establishing a sense of ethnic identity (Yip, 2014). Parents can help adolescents withstand discrimination and contradictory messages and develop a positive ethnic identity by encouraging them to act prosocially and disprove stereotypes of low academic achievement or problem behavior (Phinney & Chavira, 1995; Rivas-Drake et al., 2014; Umaña-Taylor, Alfaro, Bámaca, & Guimond, 2009). Adolescents who learn about their culture, such as values, attitudes, language, and traditions, and regularly interact with parents and peers within their culture, are more likely to construct a favorable ethnic identity (Phinney, Romero, Nava, & Huang, 2001; Romero et al., 2014; Umaña-Taylor, Bhanot, & Shin, 2006). For example, ethnic identity is positively associated with an adolescent’s proficiency in speaking his or her heritage language (Oh & Fuligni, 2010).

Similar to other aspects of development, perception matters. It is adolescents’ perception of their ethnic socialization—their view of the degree to which they adopt the customs and values of their culture—that predicts ethnic identity rather than simply their parents’ views (Hughes, Hagelskamp, Way, & Foust, 2009). Likewise, among African American adolescents, high levels of peer acceptance and popularity among African American peers is associated with a strong sense of ethnic identity (Rivas-Drake et al., 2014; Rock, Cole, Houshyar, Lythcott, & Prinstein, 2011). Adolescents’ perceptions of their ethnicity and ethnic groups are influenced

by multiple layers of a dynamic ecological system, including families, schools and peers, as well as the political social and economic climate (Way, Santos, Niwa, & Kim-Gervey, 2008).

Adolescents who have achieved a positive sense of ethnic identity tend to have higher self-esteem, optimism, and a more positive view of their ethnicity (Carlson, Uppal, & Prosser, 2000; Galliher et al., 2011). A strong positive sense of ethnic identity reduces the magnitude of the negative effects of racial discrimination on academic self-concept, academic achievement, and problem behaviors among African American adolescents, as well as acts as a buffer to stress, including discrimination stress (Kiang, Gonzales-Backen, Yip, Witkow, & Fuligni, 2006; Romero et al., 2014; Seaton, 2009). Adolescents with a strong sense of ethnic identity tend to show better adjustment and coping skills and fewer emotional and behavior problems than do those who do not or only weakly identify with ethnicity (Chavous et al., 2003; Kerpelman, Eryigit, & Stephens, 2008; Mrick & Mrtorell, 2011). Ethnic identity is an important contributor to well-being and is associated with school achievement in adolescents from diverse ethnicities, such as Mexican, Chinese, Latino, African American, and European backgrounds (Adelabu, 2008; Fuligni, Witkow, & Garcia, 2005).

Thinking in Context 12.1

1. An important theme of development is that domains or types of development interact and influence each other. How might this hold true for the development of a sense of self and identity development? How might other areas of development influence how adolescents view themselves? For example, consider aspects of physical development, such as puberty, and cognitive development, such as reasoning.
 2. Identify contextual influences on the development of a sense of self and identity. In what ways do interactions with contextual influences, such as parents, peers, school, community, and societal forces, shape adolescents' emerging sense of self?
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ADOLESCENTS AND THEIR FAMILIES

Adolescence marks a change in parent-child relationships. As they advance cognitively and develop a more complicated sense of self, adolescents strive for autonomy, the ability to make and carry out their own decisions, and they rely on parents less (Steinberg & Silverberg, 1986). Physically, adolescents appear more mature. They also can demonstrate better self-understanding and more rational decision making and problem solving, creating a foundation for parents to treat adolescents less like children and grant them more decision-making responsibility. The parenting challenge of adolescence is to offer opportunities for adolescents to develop and practice autonomy while providing protection from danger and the consequences of poor decisions. Parents may doubt their own importance to their adolescent children, but a large body of research shows that parents play a critical role in adolescent development alongside that of peers (Steinberg, 2001; Wang, Peterson, Morphey, & Aimin, 2007).

PARENT-ADOLESCENT CONFLICT

Julio's mother orders, "Clean your room." "It's my room. I can have it my way!" Julio snaps back. This exchange between Julio and his mother reflects the type of conflict that is common during adolescence. Conflict between parents and adolescents rises in early adolescence and peaks in middle adolescence (Steinberg & Morris, 2001). Changing views of parents coupled with new capacities to reason and debate contribute to the rise in parent-child conflict in early adolescence. Adolescents begin

to see their parents as people, fallible and subject to good and bad decisions, and adolescents thereby feel justified in arguing for their own autonomy (Steinberg & Silverberg, 1986).

Conflict is a normal part of adolescent–parent relationships, but the majority of adolescents and parents continue to have warm, close, communicative relationships. Most adolescents report feeling close to, and loved by, their parents, and respecting their parents (Steinberg, 2001). Parent–adolescent conflict generally takes the form of bickering over mundane matters—small arguments over the details of life, such as household responsibilities, privileges and relationships, including curfew, cleaning a room, choices of media, or music volume (Smetana, 2002; Van Doorn, Branje, & Meeus, 2011). Conflicts over religious, political, or social issues occur less frequently, as do conflicts concerning other potentially sensitive topics (e.g., substance use, dating, sexual relationships; Renk, Liljequist, Simpson, & Phares, 2005; Riesch et al., 2000).

Over the course of a typical day, adolescents report three or four conflicts or disagreements with parents, but they also report one or two conflicts with friends (Adams & Laursen, 2007). Conflict tends to be higher in homes with early-maturing girls and tends to be focused on mothers more than fathers (Caspi, Lynam, Moffitt, & Silva, 1993). Conflicts are common in early and middle adolescence and indicate adolescents’ desire for increased autonomy and independence from their parents (Renk et al., 2005). Conflicts tend to decline in late adolescence, as adolescents establish autonomy from parents. One study examined adolescents and their parents over a four-year period from ages 13 to 17 and found that both parents and adolescents used conflict resolution and other positive ways of interacting and solving conflicts over time

Although parent–adolescent conflict is a natural part of development, relationships that are very high in conflict and low in acceptance are harmful to adolescent development (Demo & Acock, 1996). Moreover, in most cases of severe conflict the parent–child relationship difficulties began in childhood. One longitudinal study of parent–child conflict found that mothers’ anger in conflict reactions with their 13-year-old sons predicted boys’ internalizing problems two years later (Hofer et al., 2013). Severe parent–adolescent conflict is associated with internalizing problems, such as depression, externalizing problems such as aggression and delinquency, social problems, such as social withdrawal and poor conflict resolution with peers, poor school achievement, and among girls, early sexual activity (Adams & Laursen, 2007; Castellani et al., 2014; Eichelsheim et al., 2010). Fortunately, intense conflict is not the norm. One study found that conflict-filled relationships and chronic escalating conflict occurred in less than 10% of families surveyed (Collins & Laursen, 2004). Healthy parent–adolescent relationships are characterized by warmth and emotional attachments with parents in which adolescents seek and receive guidance from parents and parents provide developmentally appropriate freedom and decision-making ability (Steinberg, 2001). Conflict exists in these relationships, but conflict is coupled with acceptance, respect, and autonomy support.

PARENTING STYLE AND MONITORING

Parenting plays a large role in the development of autonomy during adolescence. As Romana explains, “My parents have rules. I hate some of those rules. But I know that my parents will always be there for me. If I needed to, I could tell them anything. They might be mad, but they’ll always help me.” Romana describes the most positive form of parenting, authoritative parenting. Recall from Chapter 8 that authoritative parenting is characterized by warmth, support, and limits. Across ethnic and socio-economic groups, and in countries around the world, multiple studies have found that authoritative parenting fosters autonomy, self-reliance, self-esteem, a positive view of the value of work, and academic competence in adolescents (Mayseless, Scharf, & Sholt, 2003; McKinney & Renk, 2011; Uji, Sakamoto, Adachi, & Kitamura,

2013; Vazsonyi, Hibbert, & Blake Snider, 2003). Parental support and acceptance, as characterized by authoritative parenting, are associated with reduced levels of depression, psychological disorders, and behavior problems (Hair, Moore, Garrett, Ling, & Cleveland, 2008). Authoritative parents' use of open discussion, joint decision-making, and firm but fair limit-setting helps adolescents feel valued, respected, and encouraged to think for themselves (Dornbusch, Ritter, Mont-Reynaud, & Chen, 1990; Spera, 2005). Parents in a given household often share a common parenting style, but when they do not, the presence of authoritative parenting in at least one parent buffers the negative outcomes associated with the other style and predicts positive adjustment (Hoeve, Dubas, Gerris, van der Laan, & Smeenk, 2011; McKinney & Renk, 2011; Simons & Conger, 2007).

In contrast, authoritarian parenting, which emphasizes control and punishment (e.g., “my way or the highway”) is much less successful in promoting healthy adjustment. The authoritarian parenting style, particularly the use of psychological control, inhibits the development of autonomy and has been found to be linked with low self-esteem, depression, low academic competence, and antisocial behavior in adolescence through early adulthood in young people from Africa, Asia, Europe, the Middle East, and the Americas (Ang, 2006; Barber, Stolz, & Olsen, 2005; Griffith & Grolnick, 2013; Lansford, Laird, Pettit, Bates, & Dodge, 2014; Uji et al., 2013). Similar to findings with young children, as discussed in Chapter 8, a permissive or lax parenting style has been found to interfere with the development of self-regulatory skills that are needed to develop academic and behavioral competence (Fletcher, Darling, Steinberg, & Dornbusch, 1995; Maccoby, 2000). In other words, adolescents reared in permissive homes are more likely to show immaturity, have difficulty with self-control, and are more likely to conform to peers (Hoeve et al., 2011; Milevsky et al., 2007).

Parenting is also influenced by culture. Although many studies have shown that authoritarian parenting is associated with negative outcomes in teens reared in Western cultures, studies with adolescents reared in non-Western and collectivist cultures have shown few negative outcomes of authoritarian parenting (Dwairy & Menchar, 2006; Peterson & Bush, 2013). Non-Western cultures tend to be more collectivist, placing less emphasis on autonomy and identity and more on dependence and connection to family—characteristics that are consistent with authoritarian parenting. For example, research with Chinese, Turkish, and Arab adolescents reared in collectivist cultures has found that authoritarian parenting does not predict negative outcomes, likely because authoritarian parenting is well matched to collectivist cultures'



valuing of interconnections over independence (Dwairy & Menshar, 2006). Research with Indonesian adolescents revealed that, as expected, authoritative parenting was associated with the most positive outcomes, but authoritarian parenting was not associated with either negative or positive outcomes (Abubakar, Van de Vijver, Suryani, Handayani, & Pandia, 2014). Indeed, some argue that it is inconsistency between the authoritarian parenting style and the culture that produces negative outcomes in Western cultures (Dwairy & Menshar, 2006).

Parent–child relationships develop within the context of routine family activities (Hair et al., 2008). The presence of family rituals promotes adolescents’ sense of identity, self-esteem, and family cohesion as well as helps family members weather difficult times (Steinberg & Morris, 2001). Parents who encourage more regular family activities and know more about their children’s friends and teachers tend to have children who are less prone to substance use through middle adolescence (Coley, Votruba-Drzal, & Schindler, 2008).

Parental monitoring, in which parents aware of their teens’ whereabouts and companions, is associated with academic achievement, overall well-being, and reduced sexual activity; it has also been found to deter delinquent activity and substance use in youth of all ethnicities (Huang, Murphy, & Hser, 2011; Kiesner, Poulin, & Dishion, 2010; Racz & McMahon, 2011; Wang et al., 2014). Effective parental monitoring is accompanied by warmth and is balanced with respecting autonomy and privacy (Stattin & Kerr, 2000). On the other hand, when adolescents feel that their parents are intrusive, they are more likely to conceal their activities concurrently and over time (Rote & Smetana, 2015). Adolescents’ views of the warmth and control provided by their parents is linked with their psychological adjustment, including conduct, emotional symptoms, and peer relations (Maynard & Harding, 2010). What is considered to be effective parental monitoring changes as adolescents grow older. From middle to late adolescence, parental knowledge declines as adolescents establish a private sphere and disclose less as parents exert less control (Masche, 2010; Wang, Dishion, Stormshak, & Willett, 2011).

Overall, parenting entails a delicate balance of warmth and support, monitoring, and limit-setting and enforcement—no easy task indeed.

Thinking in Context 12.2

1. In what ways might physical and cognitive development influence adolescents’ interactions with their parents and, especially, parent–adolescent conflict?
 2. Compare and contrast popular views of how parents should interact with their adolescent children with the research on parenting style and parental monitoring.
-

ADOLESCENTS AND THEIR PEERS

The most easily recognizable influence on adolescents—and that which gets the most attention from adults and the media—is the peer group. Beginning in early adolescence, the amount of time young people spend with parents declines as time spent with friends—often unsupervised—increases (Larson, 2001). Each week, adolescents spend up to one third of their waking, nonschool hours with friends (Hartup & Stevens, 1997).

After spending the school day with same-age peers, adolescents also spend most of their time out of school with friends. When relations with family are poor, adolescents often turn to friends for emotional support. Close relationships with friends can ease some of the negative effects of poor relationships with parents (Way & Greene, 2006).

FRIENDSHIPS

The typical adolescent has four to six close friends (Hartup & Stevens, 1999). The quality of friendships tends to improve with age (Poulin & Chan, 2010). With advances in cognition, adolescents view their social world in more sophisticated ways and develop more complex understandings of friendship (Buhrmester, 1996). Adolescent friendships are characterized by intimacy, self-disclosure, and trust (Bauminger, Finzi-Dottan, Chason, & Har-Even, 2008). Adolescents also expect loyalty from their friends. They expect their friends to be there for them, stand up for them, and not share their secrets or harm them. Adolescent friendships tend to include cooperation, sharing, and affirmation, which reflect their emerging capacities for perspective taking, social sensitivity, empathy, and social skills. Intimacy also increases over the course of adolescence as teens become better able to find mutually supportive and validating friendships and as they explore and achieve their own identities (Way et al., 2008).

Although both boys' and girls' friendships become more complex, girls' friendships tend to include a greater level of emotional closeness than do boys' (Markovits, Benenson, & Dolenszky, 2001). Boys get together for activities, usually sports and competitive games, and tend to be more social and vocal in groups as compared with one-on-one situations. In contrast, most girls tend to prefer one-on-one interactions over group situations and often spend their time together talking, sharing thoughts and feelings, and supporting each other (Benenson & Heath, 2006). The challenge for many adolescents is that close friendships entail a great deal of sharing, which, in the presence of conflict, can fuel relational aggression. Relational aggression, such as when a friend tells another's secrets or teases about sensitive topics, is especially common among girls and associated with more extreme negative moods in girls and increases in aggression in both girls and boys (Low, Polanin, & Espelage, 2013; Monahan & Booth-LaForce, 2015; Rusby, Westling, Crowley, & Light, 2013). However, relational aggression between best friends, such as aggressive discussions, is not always associated with maladaptive outcomes. In one longitudinal study, relational aggression among some best friend dyads was associated with higher ratings of perceived friendship quality six months later (Banny, Heilbron, Ames, & Prinstein, 2011). Adolescent friendships are complex. The intimacy that makes close friendships possible can also make adolescents feel more comfortable asserting themselves in aggressive ways.

Among early adolescents it is estimated that one third to one half of friendships are unstable, with young people regularly losing friends and making new friendships (Poulin & Chan, 2010). Early adolescent friendship instability is influenced by the many biological, cognitive, and social transitions that young people make, as well as by school transitions, which are associated with social and emotional changes, as was discussed in Chapter 11. After early adolescence, young people may retain up to 75% of their friendships over a school year (Poulin & Chan, 2010). Overall, girls' friendships tend to be shorter in duration but characterized by more closeness than are boys' (Benenson & Christakos, 2003). High-quality friendships characterized by sharing, intimacy, and open communication tend to endure over time (Hiatt, Laursen, Mooney, & Rubin, 2015). Other-sex friendships become more common in adolescence than they were in middle childhood, increasing gradually in early adolescence and continuing through high school (Poulin & Pedersen, 2007).

Similarity characterizes adolescent friendships. Friends tend to be similar in demographics, such as age, ethnicity, and socioeconomic status; they also tend to share psychological and developmental characteristics (Berndt & Murphy, 2002). Close friends tend to be similar in orientation toward risky activity, such as willingness to try drugs and engage in dangerous behaviors such as unprotected sex (Henry, Schoeny, Deptula, & Slavick, 2007; Osgood et al., 2013; Scalco, Trucco, Coffman, & Colder, 2015). For example, best friends are highly similar with one another in the onset and level of delinquent activity (Selfhout, Branje,

& Meeus, 2008) and relational aggression (Dijkstra, Berger, & Lindenberg, 2011). Best friends also show similar rates of depression (Giletta et al., 2011) and body dissatisfaction (Rayner, Schniering, Rapee, Taylor, & Hutchinson, 2013). Adolescent friends tend to share interests, such as tastes in music; they are also similar in academic achievement, educational aspirations, and political beliefs; and they show similar trends in psychosocial development, such as identity status (Selfhout, Branje, ter Bogt, & Meeus, 2009; Shin & Ryan, 2014). Friends tend to select friends who are similar to themselves, but over time and through interaction, friends tend to become more similar to each other (Berndt & Murphy, 2002; Nurmi, 2004; Scalco et al., 2015).

Sometimes, however, middle and older adolescents choose friends who have different attitudes and values, which encourages them to consider new perspectives. Cross-ethnic friendships, for example, are less common than same-ethnic friendships, but are associated with unique benefits. Adolescent members of cross-ethnic friendships show decreases in racial prejudice over time (Titzmann, Brenick, & Silbereisen, 2015). Ethnic minority adolescents with cross-ethnic friends perceive less discrimination, vulnerability, and relational victimization and show higher rates of self-esteem and well-being over time (Bagci, Rutland, Kumashiro, Smith, & Blumberg, 2014; Graham, Munniksma, & Juvonen, 2014; Kawabata & Crick, 2011).

Close and stable friendships aid adolescent adjustment (Bukowski, 2001; Kingery, Erdley, & Marshall, 2011). Close friendships help adolescents explore and learn about themselves. By communicating with others and forming mutually self-disclosing supportive relationships, adolescents develop perspective taking, empathy, self-concept, and a sense of identity. Friends who are supportive and empathetic encourage prosocial behavior, promote psychological health, reduce the risk of delinquency, and help adolescents manage stress, such as the challenges of school transitions (Hiatt et al., 2015; Waldrup, Malcolm, & Jensen-Campbell, 2008; Wentzel, 2014).

CLIQUEs AND CROWDS

Each day after school, Paul, Manny, and Jose go with Pete to Pete's house where they apply what they learn in their automotive class to work on each other's cars and, together, restore a classic car. During adolescence, one-on-one friendships tend to expand into tightly knit peer groups of anywhere from three to about eight but most commonly around five members who are close friends. These close-knit friendship-based groups



are known as **cliques**. Paul, Manny, Jose, and Pete have formed a clique. Like most close friends, members of cliques tend to share similarities such as demographics and attitudes (Lansford et al., 2009). The norms of expected behavior and values that govern cliques derive from interactions among the group members. For example, a norm of spending time exercising together and snacking afterward as well as valuing health and avoiding smoking, alcohol, and drugs may emerge in a clique whose members are athletes. Belonging to a peer group provides adolescents with a sense of inclusion, worth, support, and companionship (Lansford et al., 2009).

Both boys and girls form cliques (Gest, Davidson, Rulison, Moody, & Welsh, 2007). In early adolescence, cliques tend to be sex segregated, with some composed of boys and others composed of girls. Girls' groups tend to be smaller than boys' groups, but both are similarly tight knit (Gest et al., 2007). By mid-adolescence, cliques become mixed and form the basis for dating. A mixed-sex group of friends provides opportunities for adolescents to learn how to interact with others of the opposite sex in a safe, nonromantic context (Connolly, Craig, Goldberg, & Pepler, 2004). By late adolescence, especially with high school graduation, mixed-sex cliques tend to split up as adolescents enter college, the workforce, and other post-high school activities (Connolly & Craig, 1999).

In contrast with cliques, which are based on intimate friendships, **crowds** are larger and looser groups based on shared characteristics, interests, and reputation. Rather than voluntarily "joining," adolescents are sorted into crowds by their peers. Common categories of peer groups found in Western nations include populars/elites (who are high in social status), athletes/jocks (who are athletically oriented), academics/brains (who are academically oriented), and partiers (who are highly social and care little about academics); other types of crowds include nonconformists (who like unconventional dress and music), deviants (who are defiant and engage in delinquent activity), and normals (who are not clearly distinct on any particular trait; Delsing, ter Bogt, Engels, & Meeus, 2007; Kinney, 1999; Stone & Brown, 1999; Sussman, Pokhrel, Ashmore, & Brown, 2007; Verkooijen, de Vries, & Nielsen, 2007).

Crowd membership is based on an adolescents' image or reputation among peers (Brown, Bank, & Steinberg, 2008; Cross & Fletcher, 2009). Members of a crowd may or may not interact with one another; however, because of similarities in appearance, activities, and perceived attitudes, they are perceived by their peers as members of the same group (Verkooijen et al., 2007). Crowds and group affiliations are crucial components of identity development because they demarcate values and lifestyles that can form the core of an individual's identity. Crowds differentiate young people on behaviors such as alcohol substance, sexual activity, academic achievement, psychiatric symptoms, and health risks. Crowds also differ on social characteristics such as social acceptance or popularity among peers, exposure to peer pressure, and the qualities or features of friendships (Brown et al., 2008; Cross & Fletcher, 2009). Crowd membership often predicts later adolescent behavior. Across a broad range of research studies, for example, adolescents within the peer classification category of deviants tend to report greater participation in drug use and other problem behaviors, longitudinally, whereas members of the academic and athlete crowds exhibit the least participation in these problem behaviors (Sussman et al., 2007). In middle adolescence, as cognitive and classification capacities increase, adolescents begin to classify their peers in more complex ways and hybrid crowds emerge, such as *popular-jocks* and *partier-jocks*. In late adolescence, and with high school graduation, crowds decline.

Some adolescents may use a particular crowd as a reference group and model their behavior and appearance accordingly, but adolescents do not always accurately perceive their own crowd status (Verkooijen et al., 2007). In one study, about one half of students placed themselves in a crowd different than that assigned by peers—generally most tended to label themselves as *normals* or as not having a crowd. Only about 20% of adolescents classified in the low-status crowds, such as *brains*, agreed



Popularity

Popular children, those who receive many peer nominations of likability and therefore experience high levels of peer acceptance, have a variety of positive characteristics, such as cooperativeness and social competence. In adolescence, popularity becomes more complicated and can be defined in more than one way. In addition to peer acceptance, in adolescence, **perceived popularity** becomes important. Perceived popularity refers to peer ratings of an adolescent's social status—that is, social dominance, influence, and prestige in the peer group (Parkhurst & Hopmeyer, 1998). Whereas adolescents who score high in peer acceptance are prosocial and low in aggression, perceived popular teens demonstrate both positive and negative qualities. Perceived popular adolescents are often viewed as powerful, arrogant, exclusionary, elitist, manipulative, controlling and aggressive. They show behaviors of social dominance and prestige and are judged by their peers as more attractive than other peers. They are trendsetters, show high self-esteem, dress well, know how to use their social skills, and are socially visible (De Bruyn & Van den Boom, 2005). Perceived popular adolescents tend to engage in highly visible and prestigious activities like athletics and cheerleading (de Bruyn & Cillessen, 2006, 2008). Perceived popular adolescents can be some of the most aggressive members of the peer group—engaging in overt and relational bullying and aggression—and these aggressive acts actually positively predict perceived popularity (Robertson et al., 2010; Rose & Swenson, 2009). Perceived popularity is linked with risk behaviors in high school including alcohol use and sexual activity (Choukas-Bradley, Giletta, Neblett, & Prinstein, 2015; Mathys, Burk, & Cillessen, 2013).

Perceived popularity overlaps with peer nominations of likability in elementary school, but the two become less related over time, especially among girls. Relational aggression is positively related to perceived popularity but negatively related with peer nominations of likability (Cillessen & Borch, 2006; De

Bruyn, Cillessen, & Wissink, 2009). For example, girls' perceived popularity in Grade 10 predicted lower ratings of peer likability at Grade 12, as peers saw them as mean and aggressive—yet the perceived popular girls continued to engage in more aggression (Mayeux & Cillessen, 2008). It seems that for perceived popular teens, relational aggression has few repercussions (Rose & Swenson, 2009).

Teens' perceptions of their own social status predict long-term functioning so that even teens who are not broadly popular may demonstrate positive adjustment over time if they maintain a positive internal sense of their social acceptance (McElhaney, Antonishak, & Allen, 2008). Perceptions of popularity and peer acceptance are at least as critical in determining future social outcomes as is actually being liked by other teens. For example, 13- and 14-year-olds who saw themselves as socially accepted showed positive adjustment regardless of their level of popularity, and even unpopular teens became less hostile and more desirable companions when they believed that they were accepted by peers (McElhaney et al., 2008). Adolescents who feel successful will seek out social experiences and those who think they have difficulty with peers are likely to withdraw.

What Do You Think?

1. **Can you identify popular peers from middle school and high school?**
2. **Describe the popular students.**
3. **What were their characteristics?**
4. **Can you distinguish between popular students and perceived popular students?**
5. **How do your experiences compare with these findings?**

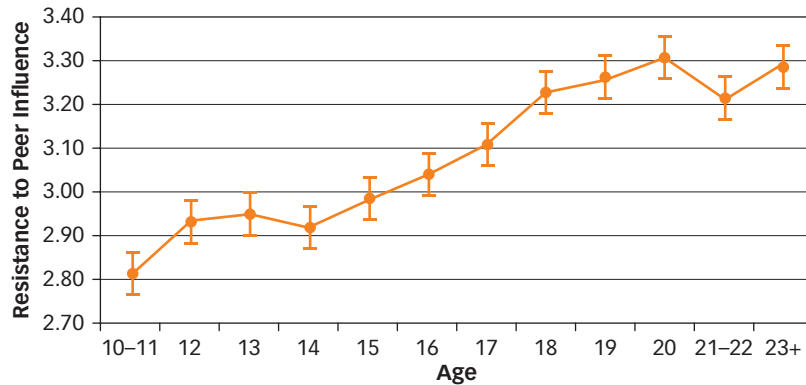
with their peers on their crowd status (Brown et al., 2008). Adolescents who did not perceive themselves as part of a low-status crowd showed higher self-esteem than did adolescents who agreed with their crowd placement.

Similar to cliques, crowds tend to be apparent in high school settings. The importance of crowd affiliation declines with age, after leaving high school, and especially as young people adopt stable identities (Delsing et al., 2007). For more on affiliation and popularity, see Box 12.1.

PEER CONFORMITY

“Look at these shoes. They're red. Cool, huh?” asks Jamaica's mother. “No—I want the black ones,” Jamaica replies. “But honey, these are so different from what everyone else has, you'll really stand out.” Jamaica shakes her head. “I don't want to stand out. The shoes need to be black. That's what everyone wears.” Jamaica's insistence on wearing the black shoes that all of her friends own illustrates her desire to conform to peer norms about dressing. The pressure to conform to peers rises in early adolescence, peaks at about age 14 and declines through age 18 and after (see Figure 12.1; Berndt & Murphy, 2002; Steinberg & Monahan, 2007).

FIGURE 12.1: Age Differences in Resistance to Peer Influence



SOURCE: Obtained with permission from Steinberg and Monahan (2007, p. 1536).

Most adults view peer pressure as a negative influence on adolescents, as pressure to behave in socially undesirable and even harmful ways. In fact, though, American youths tend to feel the greatest pressure from peers to conform to day-to-day activities and personal choices such as appearance (clothing, hairstyle, makeup) and music (Brown, Lohr, & McClenahan, 1986; Steinberg, 2001). In laboratory experiments, adolescents were more likely to show prosocial behavior after believing that anonymous peers approve of their prosocial actions, such as sharing coins with others (van Hoorn, van Dijk, Meuwese, Rieffe, & Crone, 2014). Youths also report pressure from their friends to engage in prosocial and positive behaviors such as getting good grades, performing well athletically, getting along with parents, and avoiding smoking (Berndt & Murphy, 2002; Brown et al., 1986; Brown et al., 2008; Wentzel, 2014). For example, research with youths from Singapore demonstrates that peers exerted more pressure on one another to conform to family and academic responsibilities, values that are particularly prized in Singapore culture (Sim & Koh, 2003).

Nevertheless, peers do pressure one another to engage in risky activities and adopt an antisocial stance. Peer smoking predicts the initiation and escalation of smoking in adolescents (Bricker et al., 2006; Hoffman, Monge, Chou, & Valente, 2007). Similarly, adolescents' reports of unsafe sex are associated with their peers' sexual behavior (Choukas-Bradley, Giletta, Widman, Cohen, & Prinstein, 2014; Henry et al., 2007; van de Bongardt, Reitz, Sandfort, & Deković, 2014). Adolescents often show more deviant behavior as a group than as individuals, as teens may socialize and encourage one another to engage in activities that they would not consider alone, such as vandalizing property (Dishion, Andrews, & Crosby, 1995). It is not simply peer behavior that influences adolescent behavior, but it is adolescents' perceptions of peer behavior, beliefs about peers' activity, that predicts engaging in risky activities such as smoking, alcohol use, and marijuana use (Choukas-Bradley et al., 2014; Duan, Chou, Andreeva, & Pentz, 2009).

Young people vary in how they perceive and respond to peer pressure based on a variety of factors such as age, personal characteristics, and context. Adolescents are more vulnerable to the negative effects of peer pressure during transitions, such as entering a new school and undergoing puberty, which are common in early adolescence (Brechwald & Prinstein, 2011; Bukowski, Sippola, Hoza, & Newcomb, 2000). A particular type of negative peer pressure, **cyberbullying**, is discussed in Box 12.2.





Cyberbullying



Over the past decade, technology such as text messaging and the Internet has spawned a new form of bullying. Adolescents who engage in cyberbullying carry out aggressive acts against a victim by using electronic means such as text messaging, posting in chat rooms and discussion boards, and creating websites and blogs (Smith et al., 2008). Similar to traditional forms of bullying, the aggressive acts are intended to hurt the victim, are perceived as hurtful by the victim, and are conducted repeatedly against a victim who cannot easily defend himself or herself.

Several features of cyberbullying distinguish it from regular bullying. One is the difficulty of escape. Unlike school bullying, which generally ends at the end of the school day, cyberbullying is carried on 24/7. Cyberbullying can reach a reach large audience, increasing the potential for humiliation. In addition, cyberbullying is invisible. It does not occur face-to-face, making it difficult for victims to identify their attackers and easy for bullies to lack empathy for victims (Slonje & Smith, 2008). However, there is a large overlap between traditional and electronic bullying, with 85% of victims of cyberbullying also experiencing bullying at school and over 90% of cyberbullies engaging in bullying at school (Raskauskas & Stoltz, 2007). About two thirds of cyberbullying victims reported knowing their perpetrators, and most know the bully from school (Juvonen & Gross, 2008).

As Internet use has become a part of adolescents' everyday life, cyberbullying has become increasingly prevalent. Ninety-five percent of adolescents are online (Pew Research Center, 2015). Up to one quarter of adolescents engage in cyberbullying (Raskauskas & Stoltz, 2007; Slonje & Smith, 2008). Researchers estimate that between 5% and 20% of adolescents in the United States, United Kingdom, Canada, and Australia experience cyberbullying during a school year (Jones, Mitchell, & Finkelhor,

2013; Livingstone, Haddon, Görzig, & Ólafsson, 2011; Livingstone & Smith, 2014). For most adolescents, a cyberbullying episode lasts a couple of weeks, but about one third report cyberbullying that lasts over a month and in some cases a year or more (Smith et al., 2008).

Youngsters mostly react to cyberbullying by ignoring it; pretending to ignore it; and, often, bullying the bully (Dehue, Bolman, & Völlink, 2008). The majority of adolescents who experience cyberbullying do not tell adults, and only about one third report telling friends (Juvonen & Gross, 2008; Slonje & Smith, 2008). Cyberbullying has similar effects as traditional bullying, including distress, anxiety, depression, poor self-esteem, social withdrawal, and poor academic achievement (Juvonen & Graham, 2014; Mason, 2008; Wade & Beran, 2011). However, cyberbullying poses a unique threat to psychological health because it can occur 24 hours a day, not just at school. Because of this many adolescents feel hopeless and pessimistic about stopping cyberbullying, placing them at risk for suicide (Bauman, Toomey, & Walker, 2013). Cyberbullying has been linked with many cases of suicide, such as 13 year-old Megan Meier, who committed suicide after months of harassment on the social network Myspace.

School policies on bullying should include statements regarding cyberbullying. Anti-bullying strategies are also effective in reducing cyberbullying. Class-wide lessons in assertiveness, Internet safety, social skills, and strategies for standing up to bullies and cyberbullies as well as encouraging students to support each other, aids in improving class climate and reducing all forms of bullying (Mason, 2008). Education directed at parents and school personnel can increase their awareness of cyberbullying and help them learn how to assist adolescents who are victimized. Parental monitoring and restriction of Internet use serves as a protective factor against online harassment (Khurana, Bleakley, Jordan, & Romer, 2014). Monitoring can be challenging, however, given that about three quarters of adolescents access the Internet at least occasionally through a mobile device such as a cell phone or tablet, and 25% access the Internet nearly exclusively by cell phone, modes that may be challenging for parents to monitor (Madden, Lenhart, Duggan, Cortesi, & Gasser, 2013).

Cyberbullying often is hidden. By illuminating it, schools and parents can intervene effectively to reduce it and create a safe and supportive school climate.

What Do You Think?

1. What role do parents and schools have in cyberbullying?
2. From your perspective, how can they effect change?

As in other areas of adolescent development, the authoritative style of parenting, which provides support while setting limits, has been found to have positive outcomes. Adolescents with authoritative parents tend to respect them, adhere to rules, and seek advice from them, reducing teens' reliance on peers for advice (Sim, 2000).

Adolescents tend to turn to peers when confronted with decisions about short-term choices such as lifestyle preferences, including hairstyles, clothing, musical tastes, and social activities (Wang et al., 2007). Parents, however, remain important influences on adolescents. Adolescents tend to turn to parents when making decisions with long-term future consequences, such as those regarding education and religion (Brechwald & Prinstein, 2011). Furthermore, parents tend to have more influence than peers on adolescents' long-term plans, values, and educational aspirations (Berndt & Murphy, 2002; Brown et al., 1986). Although peers' increase in importance and conformity to peers is strong in adolescence, most adolescents report feeling close to, loved by, and respected by their parents (Steinberg, 2001).

DATING

"Daryl and I are seeing each other," proclaimed 13-year-old Sharese. "Hmm. You only go out with groups of friends and are way too young to date," her mother thought to herself, but instead sighed, gave a quizzical look, and then asked, "Who's Daryl?" Establishing romantic relationships, *dating*, is part of the adolescent experience. Most young people have been involved in at least one romantic relationship by middle adolescence and by age 18 over 80% of young people have some dating experience (Carver, Joyner, & Udry, 2003). By late adolescence, the majority of adolescents are in an ongoing romantic relationship with one person (Collins & Steinberg, 2006; O'Sullivan, Cheng, Harris, & Brooks-Gunn, 2007).

Dating typically begins through the intermingling of mixed-sex peer groups, similar to that described by Sharese's mother, progresses to group dating, and then one-on-one dating and romantic relationships (Connolly et al., 2004; Connolly, Nguyen, Pepler, Craig, & Jiang, 2013; Furman, 2002). Adolescents with larger social networks and greater access to opposite-sex peers date more (Connolly & Furman, 2000). However, some research suggests that adolescents date outside of their friendship networks and that preexisting friendships are less likely to transform into romantic relationships (Kreager, Molloy, Moody, & Feinberg, 2015). Early relationships, from ages 12 to 14, tend to be brief, but by age 16 the average relationship continues for nearly two years (Carver et al., 2003).

Dating varies by culture. Youths in Western societies date earlier than those in Asian cultures. Similarly, Asian American adolescents begin dating later than African American, European American, and Latino adolescents in the United States (Regan, Durvasula, Howell, Ureño, & Rea, 2004).

Early adolescents date for fun and for popularity with peers. Often the purpose of dating is simply to have a relationship (Furman, 2002). As teens grow older, the reasons reported for dating change. In late adolescence, dating fulfills needs for intimacy, support, and affection in both boys and girls (Furman, 2002; Giordano, Longmore, & Manning, 2006). However, adolescents' capacity for romantic intimacy develops slowly and is influenced by the quality of their experiences with intimacy in friendships and their attachments to parents (Connolly & Furman, 2000; Furman, 2002; Scharf & Maysel, 2008). Adolescents interact with their romantic partners in ways that are similar to their interactions with parents and peers (Collins, Welsh, & Furman, 2009; Furman & Shomaker, 2008). Through close friendships, adolescents learn to share of themselves, be sensitive to others' needs, and develop the capacity for intimacy. Adolescents also learn about relationships by observing their parents. For example, they may employ ineffective interactional strategies that they have observed, such as withdrawal, verbal aggression, negativity, and poor problem solving (Darling, Cohan, Burns, & Thompson, 2008).

In middle and late adolescence, dating is associated with positive self-concept, expectations for success in relationships, fewer feelings of alienation, and good health (Ciairano, Bonino, Kliewer, Miceli, & Jackson, 2006). Close romantic relationships provide opportunities to develop and practice sensitivity, cooperation, empathy, and

social support as well as aid in identity development (Ciairano et al., 2006; Furman & Shaffer, 2003). Adolescents' behaviors, such as academic achievement, tends to be very similar to that of their romantic partners (Giordano, Phelps, Manning, & Longmore, 2008). Early dating, relative to peers, is associated with increases in alcohol and substance use, smoking delinquency, and low academic competence over the adolescent years as well as long-term depression, especially in early maturing girls (Connolly et al., 2013; Fidler, West, Jarvis, & Wardle, 2006; Furman & Collibee, 2014; Martin et al., 2007). Overall, romantic experiences in adolescence are continuous with romantic experiences in adulthood, suggesting that the construction of romantic relationships is an important developmental task for adolescents (Collins et al., 2009). Adolescents who date fewer partners and experience better quality dating relationships in middle adolescence tend to demonstrate smoother partner interactions and relationship processes in young adulthood (e.g., negotiating conflict, appropriate caregiving; Madsen & Collins, 2011).

Dating violence, the actual or threatened physical or sexual violence or psychological abuse directed toward a current or former boyfriend girlfriend or dating partner, is surprisingly prevalent during adolescence. Like adult domestic violence, adolescent dating violence occurs in youth of all socioeconomic, ethnic, and religious groups (Herrman, 2009). This behavior is discussed in Box 12.3.

Thinking in Context 12.2

1. Researchers who study peer relationships in adolescence might argue that cliques get a bad rap because common lay views explain cliques as negative and harmful to adolescents. Compare the research on cliques with common views about cliques.
 2. How might relationships with peers such as friends or dates vary by context? Consider an adolescent from an inner city neighborhood and another from an affluent suburban community. In what ways might their peer interactions and relationships be similar? Different? How might contextual factors influence adolescents' peer relationships?
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ADOLESCENT SEXUALITY

An important dimension of socioemotional development during adolescence is sexual development, a task that entails integrating physical, cognitive, and social domains of functioning. Sexuality encompasses feelings about oneself, appraisals of the self, attitudes, and behaviors (McClelland & Tolman, 2014). With the hormonal changes of puberty, both boys and girls experience an increase in sex drive and sexual interest (Fortenberry, 2013). Social context influences how biological urges are channeled into behavior and adolescents' conceptions of sexuality.

SEXUAL ACTIVITY

Although researchers believe that sexual behaviors tend to progress from hand-holding to kissing, to touching through clothes and under clothes, to oral sex and intercourse, research on adolescent sexuality tends to focus on intercourse, leaving gaps in our knowledge about the range of sexual activity milestones young people experience (Diamond & Savin-Williams, 2009). Adolescents are about as likely to engage in oral sex as vaginal intercourse (Casey Copen, Chandra, & Martinez, 2012). The majority of one sample of over 12,000 adolescents initiated oral sex after experiencing first vaginal intercourse, with about one half initiating oral sex a year or more after the onset of vaginal sex (Haydon, Herring, Prinstein, & Halpern, 2012). Interestingly, oral sex did not appear to precede vaginal intercourse, suggesting that adolescents are not engaging in oral sex as a substitute for vaginal intercourse, contrary to popular beliefs.



Adolescent Dating Violence



Between 10% and 60% of high school students have been victimized by dating violence. Although the majority of cases are limited to psychological aggression, between 20% and 40% of adolescents report experiencing physical aggression in a dating relationship (Herrman, 2009; Raiford, Wingood, & DiClemente, 2007). The most serious dating violence—physical assault that results in serious wounds or violent sexual assault—is less frequent, with less than 2% of adolescents reporting these forms of dating violence (Wolitzky-Taylor et al., 2008).

Dating violence emerges in early adolescence, with the majority of victims experiencing their first victimization before age 15 (Leadbeater, Banister, Ellis, & Yeung, 2008). Both males and females perpetrate dating violence at roughly equal rates and within the context of relationships of mutual partner aggression in which both partners perpetrate and sustain the aggression (Sears, Sandra Byers, & Lisa Price, 2007; Williams, Connolly, Pepler, Laporte, & Craig, 2008). Girls are more likely to inflict psychological abuse and minor physical abuse (slapping, throwing objects, pinching), and boys are more likely to inflict physical abuse, including more severe types of physical abuse, such as punching, as well as sexual abuse, making girls more likely to suffer physical wounds than boys. Physical violence tends to occur alongside other problematic relationship dynamics and behaviors such as verbal conflict,

jealousy, and accusations of “cheating” (Giordano, Soto, Manning, & Longmore, 2010).

Risk factors for engaging in dating violence include difficulty with anger management, poor interpersonal skills, early involvement with antisocial peers, a history of problematic relationships with parents and peers, exposure to family violence and community violence, and child maltreatment (Foshee et al., 2014, 2015; Vagi et al., 2013). Many of the risk factors for experiencing dating victimization are also outcomes of dating violence, such as depression, anxiety, negative interactions with family and friends, unhealthy weight-control behaviors, sexually transmitted infections (STIs), poor life satisfaction, low self-esteem, substance use, and adolescent pregnancy (Exner-Cortens, Eckenrode, & Rothman, 2013; Nilon et al., 2015).

Adolescent dating violence is less likely to be reported than adult domestic violence. Only about 1 in 11 cases is reported to adults or authorities (Herrman, 2009). Common reasons for not reporting dating violence include fear of retaliation, ongoing emotional ties, denial, self-blame, hope that it will get better, and helplessness. In addition, about only one third of adolescents report that they would intervene if they became aware of a peer’s involvement in dating violence, predominately believing that dating violence is the couple’s own private business (Weisz & Black, 2008). Encouraging close relationships with parents is an important way of preventing dating violence because adolescents learn about romantic relationships by observing and reflecting on the behaviors of others. Adolescent girls who are close with their parents are more likely to recognize unhealthy relationships, are less likely to be victimized by dating violence, and are more likely to seek help (Leadbeater et al., 2008).

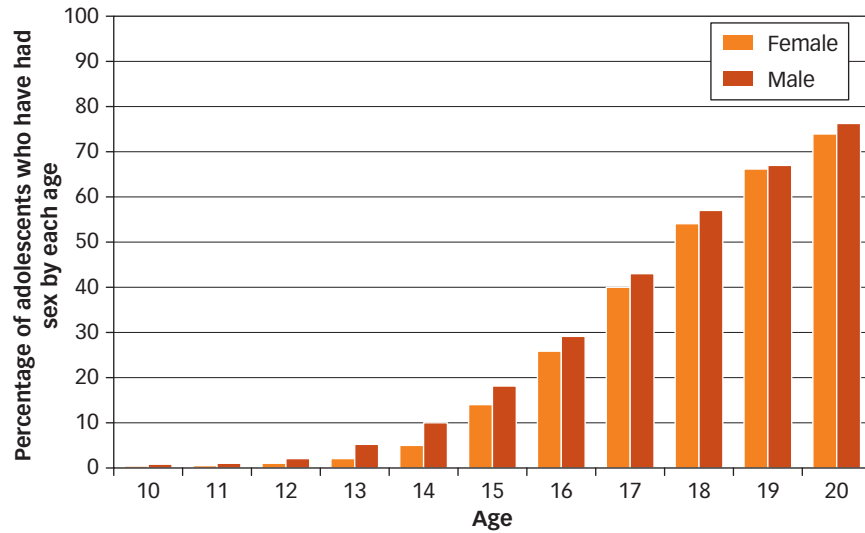
What Do You Think?

1. From your perspective, how prevalent is dating violence in adolescence?
2. Why do you think it occurs?
3. What is underreported?
4. What can be done?

Overall, males and females are about as likely to indicate that they have received oral sex (47% and 42%, of 15- to 19-year-old males and females, respectively; Child Trends Data Bank, 2013).

Many adults are surprised to learn that the overall rate of sexual intercourse among U.S. high school students has declined from 54% in 1991 to 47% in 2013 (Kaiser Family Foundation, 2014). Overall, rates of sexual activity are similar internationally, with similar declines in recent years (Guttmacher Institute, 2014). About 30% of 16-year-olds have had sexual intercourse, and most young people have sexual intercourse for the first time at about age 17 (Finer & Philbin, 2013; Guttmacher Institute, 2014). Figure 12.2 depicts rates of sexual activity by age. About 34% of high school students reported being sexually active within the last three months and, as

FIGURE 12.2: Sexual Initiation During Adolescence



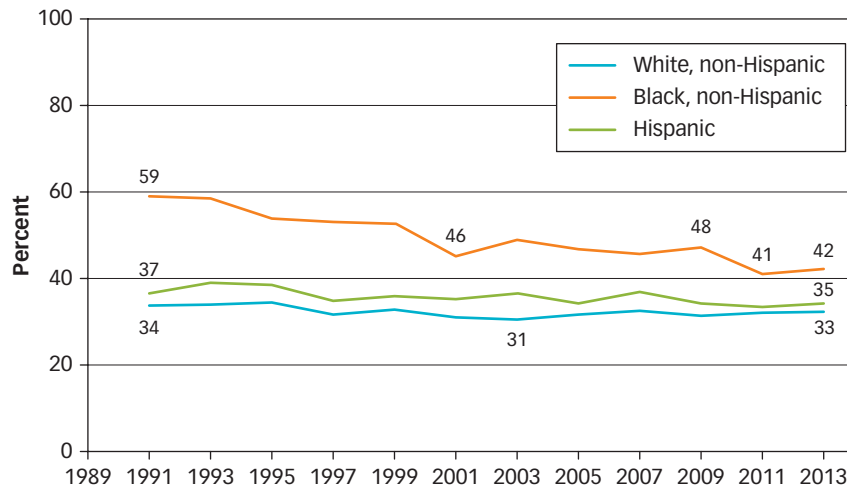
SOURCE: Guttmacher Institute (2014).

shown in Figure 12.3, African American high school students are more likely to have had intercourse (60%) compared to white (44%) and Hispanic students (49%; Kaiser Family Foundation, 2014).

Ethnic differences in sexual activity are thought to be influenced by socioeconomic and contextual factors that are associated with ethnicity, such as an increased likelihood of growing up in a single parent home, potentially with less parental monitoring, and in poor neighborhoods with fewer community resources, all of which are associated with early sexual activity (Browning, Leventhal, & Brooks-Gunn, 2004; Carlson, McNulty, Bellair, & Watts, 2014; Santelli, Lowry, Brener, & Robin, 2000). In addition, ethnic differences in rates of pubertal maturation, with African American girls experiencing puberty earlier than other girls, influence sexual activity as early maturation is a risk factor for early sexual activity (Carlson et al., 2014; Moore, Harden, & Mendle, 2014).

While sexual activity is normative in late adolescence, early sexual activity, prior to age 15, is associated with problem behaviors, including alcohol and substance use,

FIGURE 12.3: Percentage of High School Students Who Report They Are Sexually Active, 1991–2013



SOURCE: Kaiser Family Foundation (2014).

poor academic achievement, and delinquent activity, as well as having a larger number of sex partners relative to peers (Armour & Haynie, 2007; McLeod & Knight, 2010; Sandfort, Orr, Hirsch, & Santelli, 2008). Risk factors for early sexual activity in U.S. teens are those that place adolescents at risk for engaging in a variety of problem behaviors, such as early pubertal maturation, poor parental monitoring, poor parent–adolescent communication, poor school performance, perceived parental attitudes as permissive toward sexual activity, and peers who are sexually active (Anaya, Cantwell, & Rotheram-Borus, 2003; Biro & Dorn, 2006; McClelland & Tolman, 2014; Negri, Susman, & Trickett, 2011). Risks for early sexual activity begin well before adolescence. For example, early aggression and disruptive behavior during the transition to first grade is associated with school problems, antisocial behavior, and substance use in middle school, which in turn are linked with early sexual activity (Schofield, Bierman, Heinrichs, & Nix, 2008).

INFLUENCES ON SEXUAL ACTIVITY

It may not be a surprise that adolescents who report many positive motivations for sexual activity show higher levels of sexual activity; these positive motivations include physical (feelings of excitement or pleasure), relationship-oriented (intimacy), social (peer approval, respect) and individual factors (gain a sense of competence, learn about the self; Manlove, Franzetta, & Ryan, 2006; Michels, Kropp, Eyre, & Halpern-Felsher, 2005; Ott, Millstein, Ofner, & Halpern-Felsher, 2006). Adolescents' beliefs about sexuality are influenced by their peers. Having sexually active peers and perceiving positive attitudes about sex among schoolmates predicts initiation and greater levels of sexual activity and a greater number of sexual partners (Coley, Kull, & Carrano, 2014; Moore et al., 2014; White & Warner, 2015). Specifically, adolescents who report having had oral sex are more likely to report that their best friend has also engaged in oral sex, believe that a greater number of friends are sexually active, and that close friends would approve of their sexual activity (Bersamin, Walker, Fisher, & Grube, 2006; Prinstein, Meade, & Cohen, 2003). In addition, adolescents' perceptions of the sexual norms in their neighborhood, as well as siblings' sexual activity, are associated with age of initiation, casual sex, and the number of sexual partners, even after controlling for neighborhood demographic risk factors (Almy et al., 2015; Warner, Giordano, Manning, & Longmore, 2011).

Adolescents' views of normative sexual behavior are also influenced by exposure to the media. High school students who report frequent television viewing, including “sexy” prime-time programs, viewing TV for companionship, and identifying strongly with popular TV characters, tend to report greater levels of sexual experience than their peers (Cox, Shreffler, Merten, Schwerdtfeger Gallus, & Dowdy, 2014; Ward & Friedman, 2006). One study of Belgian 12- and 15-year-old boys and girls found that television viewing was associated with higher expectations for peers' sexual activity, and this relationship held regardless of the adolescents' pubertal status or own sexual experience (Eggermont, 2005). Sexually active adolescents are more likely to expose themselves to sex in the media and those exposed to sex in the media are more likely to progress in their sexual activity. These findings are consistent with others in the literature that demonstrate cross-sectional and longitudinal reciprocal links between exposure to sexual content and sexual behavior, including heightened risk for pregnancy during adolescence (Bleakley, Hennessy, Fishbein, & Jordan, 2009; Chandra et al., 2008). Recent research suggests that exposure to sexy media influences adolescents' perceptions of normative behavior. That is, those who view more sexual content tend to rate sexual behavior as more common among adolescents (Bleakley, Hennessy, Fishbein, & Jordan, 2011). However, other studies show no link between media exposure, including viewing Internet pornography and sexual behavior (Escobar-Chaves & Anderson, 2008; Luder et al., 2011; Steinberg & Monahan, 2011), suggesting that sexual behavior has multiple complex influences.

Sexting, the exchange of explicit sexual messages or images via mobile phone, is increasingly common among adolescents. An estimated 7% to 15% of adolescents with mobile phones have reported sharing a naked photo or video of himself or herself via digital communication such as the Internet or text messaging (Kaiser Family Foundation, 2014; Rice et al., 2012). Females and older youth are more likely to share sexual photos than males and younger youth.

Adolescents who themselves sexted were more likely to report being sexually active and to engage in risky sexual activity (Rice et al., 2012; Ybarra & Mitchell, 2014). Adolescents who shared sexual photos also were more likely to use substances, experience higher rates of depression, and report low self-esteem as compared with peers (Van Ouytsel, Van Gool, Ponnet, & Walrave, 2014).

What role do parents play in adolescent sexual activity? The majority of adolescents (84%) and parents (90%) report having talked with each other about sex, including topics such as intercourse and the prevention of pregnancy and STIs (Planned Parenthood Federation of America, 2012). Parent-child communication about sexuality—specifically, open conversations characterized by warmth, support, and humor—is associated with later onset of sexual activity and reductions in sexual risk taking (Lefkowitz & Stoppa, 2006; Lohman & Billings, 2008; Trejos-Castillo & Vazsonyi, 2009). However, about one half of adolescents and as many as two thirds of parents report that communicating about some aspects of sexuality is embarrassing, which may influence the quality of conversations (Jerma & Constantine, 2010; Planned Parenthood Federation of America, 2012). In addition, many parents underestimate their adolescent's sexual activity. For example, in one study, 56% of mothers of sexually active 14- to 16-year-olds, and 78% of mothers of sexually active 11- to 13-year-olds, believed that their child was not sexually active (Liddon, Michael, Dittus, & Markowitz, 2013). Authoritative parenting, regularly shared family activities (such as outings, game nights, or shared dinners), parental monitoring, and parental knowledge are associated with lower rates of sexual activity (Huang et al., 2011; McElwain & Booth-LaForce, 2006). In one study of nearly 15,000 adolescents, those who perceived that their parents made more warnings about the negative consequences of sex tended to accumulate more sexual partners (Coley et al., 2014).

Early sexual activity and greater sexual experience is more common in adolescents reared in stressful contexts, such as low socioeconomic status homes and poverty stricken and dangerous neighborhoods where community ties are weak (Carlson et al., 2014; Dupéré, Lacourse, Willms, Tremblay, & Leventhal, 2008). Positive relationships with adults can mitigate the effects of disenfranchised communities. For example, African American adolescents who reported high levels of communication and monitoring by their parents showed lower rates of sexual initiation. Similarly, religiosity acts as a protective factor—youth who perceive religion as important and are active in their religious community are less likely to engage in sexual activity than their peers (Rink, Tricker, & Harvey, 2007; Sinha, Cnaan, & Gelles, 2007).

LESBIAN, GAY, BISEXUAL, AND TRANSGENDER ADOLESCENTS

Sexual identity, one's sense of self regarding sexuality, including one's awareness and comfort regarding one's sexual attitudes, interests, and behaviors, develops in a process similar to other aspects of identity development: it entails a period of exploration and commitment. During adolescence, the identity search drives young people to consider their sexuality and determine their **sexual orientation**. Many youth enter a period of questioning in which they are uncertain of their sexuality and attempt to determine their true orientation (Saewyc, 2011). Similar to other aspects of identity, they explore and consider alternatives. For example, many preadolescents and young adolescents engage in sex play with members of the same sex yet develop a heterosexual

orientation. After a period of questioning and exploration, adolescents commit to a sexual orientation and, over time, integrate their sexuality into their overall sense of identity. Eventually most lesbian, gay, and bisexual youth disclose their sexual orientation to others (Bos, Sanford, de Bruyn, & Hakvoort, 2008; Cates, 2007). The final stage of sexual identity development, acceptance and disclosure, may occur in adolescence, but often occurs in young adulthood and afterward (Savin-Williams & Ream, 2007).

Many youth who identify as lesbian, gay, bisexual, or transgender (LGBT) report having felt “different” as children. Lesbian, gay, and bisexual youth report feeling attracted to members of the same sex whereas transgender youth report experiencing a different gender orientation that does not match their genitalia. Constructing an identity as an LGBT young person is complicated by the prejudice and discrimination that many LGBT youth experience in their schools and communities. Many middle and high school students—especially boys and younger adolescents—report that they are less willing to remain friends or want to attend schools with nonheterosexual peers (Poteat, Espelage, & Koenig, 2009). LGBT adolescents experience more harassment and victimization by peers and report a more hostile peer environment than their heterosexual peers (Robinson & Espelage, 2013). Perceived discrimination and victimization by peers contributes to LGBT adolescents’ increased risk for psychological and behavioral problems, such as depression, **self-harm**, suicide, running away, poor academic performance, substance use, and risky sexual practices, (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Collier, van Beusekom, Bos, & Sandfort, 2013; Haas et al., 2011; Plöderl et al., 2013). As sexual minority youth transition out of the school setting and experience less victimization, they tend to experience declines in distress (Birkett, Newcomb, & Mustanski, 2015).

LGBT youth tend to feel less accepted and perceive less social support and greater conflict with peers and parents, especially fathers, than do other adolescents (Bos et al., 2008; Busseri, Willoughby, Chalmers, & Bogaert, 2006). Social isolation might reflect rejection by other students or intentional withdrawal from family and other close relationships by adolescents who choose not to disclose their sexual identity from family and close relationships. Adolescents who anticipate negative responses from parents are less likely to disclose their sexual orientation; to avoid disclosure, LGBT youth may become emotionally distant from their parents and friends (Ueno, 2005). Support from parents and peers can buffer the negative effects of stigmatization and victimization (Birkett et al., 2015).

Schools can play a role in aiding LGBT students by cultivating a safe environment and climate where adolescents are able to develop a healthy sexual identity and offering protection from undue social emotional and physical harm. Certain characteristics of schools, such as a large student body, may offer a safer climate for LGBT youth. For example, students in more racially diverse schools reported greater willingness to remain friends and attend school with sexual minority peers, and adolescents with lesbian or gay friends report positive attitudes toward same-sex romantic and sexual relationships and less tolerance toward the unfair treatment of their LGBT peers (Heinze & Horn, 2009; Poteat et al., 2009). Similar to bullying, schools should develop and implement policies and procedures to promote a positive school climate and environment of acceptance and safety for all students (Fisher et al., 2008). Schools can promote acceptance for LGBT students by educating students and staff about gender identity and sexual orientation and integrating accurate information about social minority issues into the curriculum; staff development should instruct teachers and administrators on how to deal with discrimination, harassment, and bullying on the basis of sexual orientation. In addition, school-based support groups and group counseling can aid LGBT students who experience serious social, psychological, and behavioral problems (Fisher et al., 2008).

The presence of gay–straight alliances (GSAs) is an important source of support and education for students and helps sexual minority students connect with peers, reduces hopelessness, and is associated with lower suicide attempts (Davis, Royne



Stafford, & Pullig, 2014). Schools that have GSAs show lower rates of student truancy, smoking, drinking, suicide attempts, and casual sex than do those in schools without GSAs, with this difference being more sizable for LGBT than heterosexual youth (Poteat, Sinclair, DiGiovanni, Koenig, & Russell, 2013). Perceived GSA support predicts greater well-being in racial and ethnic minority students, regardless of sexual orientation (Poteat et al., 2015). In addition to GSAs, LGBT adolescents often turn to the Internet as a source of information and exploration of their sexual orientation by learning about sexual orientation, communicating with other LGBT people, and finding support from others (Harper, Serrano, Bruce, & Bauermeister, 2015).

CONTRACEPTIVE USE

One of the greatest concerns to parents, teachers, health care professionals, and policy makers regarding adolescent sexuality is their sporadic use of contraceptives. About three quarters of sexually active 15- to 19-year-olds report using contraception during first intercourse (Kaiser Family Foundation, 2014; Martinez, Copen, & Abma, 2011). Two thirds of sexually active adolescents report the condom as the method used during the most recent sexual intercourse method used at first intercourse (Guttmacher Institute, 2014). However, many adolescents use contraceptives only sporadically and not consistently (Pazol et al., 2015). Common reasons

given for not using contraceptives include not planning to have sex, the belief that pregnancy is unlikely, and difficulty communicating and negotiating the use of condoms (East, Jackson, O'Brien, & Peters, 2007; Johnson, Sieving, Pettingell, & McRee, 2015).

What predicts condom use, often referred to as “safe sex”? Some research indicates that authoritative parenting and open discussions about sex and contraception are key (Bersamin et al., 2008; Malcolm et al., 2013). However, parents do not always discuss sensitive topics like sexuality and sexual activity with their teens. One study of mother–adolescent communication in Latino families found that Latina mothers were more likely to discuss certain sex-related topics, such as the importance of waiting and the consequences of sexual activity, such as pregnancy, but were much less likely to discuss others, such as factual details about sexual intercourse and birth control (Guilamo-Ramos et al., 2006). At the same time, many of the adolescents expressed the desire to discuss sexual topics with their mothers, yet most did not, citing fears that their mothers would assume they were sexually active and would punish them. The influence of parental communication is complicated as other research with Scottish adolescents suggests that teens’ perceptions of comfort talking about sex with their parents is not associated with sexual behavior (Wight, Williamson, & Henderson, 2006). Instead, it is adolescents’ knowledge that is important. Girls with more reproductive knowledge report greater use of contraceptives and more consistent use of contraceptives (Ryan, Franzetta, & Manlove, 2007).

As with other behaviors, peers play a role in adolescents’ contraceptive use. Friends’ attitudes about the consequences of sexual activity and use of condoms during intercourse predicts adolescents’ attitudes about the potential risks of sex and condom use a year later (Henry et al., 2007). Cognitive development aids adolescents’ capacities to reason about various alternatives, but recall from Chapter 11 that adolescents often pay more attention to the rewards than consequences, are swayed by emotional cognitions and situations, and often fail to apply reasoning to everyday contexts (Figner, Mackinlay, Wilkening, & Weber, 2009; Shad et al., 2011; Strang, Chein, & Steinberg, 2013).

SEXUALLY TRANSMITTED INFECTIONS

Given adolescents' overall lack of communication about sexuality and sporadic use of condoms, it may not be surprising that adolescents have higher rates of STIs than all other age groups. Teens and young adults represent only 25% of the sexually active population, but 15- to 24-year-olds account for one half of all STI diagnoses each year (Centers for Disease Control and Prevention [CDC], 2014). About one of six U.S. adolescents experiences a STI each year, three times more than do teens in Canada, which also is higher than most Western nations. Untreated STIs can result in sterility and serious, even life threatening, illness. Despite the higher risk for acquiring STIs among youth, only one third of adolescent girls and almost half (45%) of young women aged 19 to 25 report that they have discussed STIs with their health care providers (Kaiser Family Foundation, 2014).

The most serious STI is HIV, which causes AIDS. Young people aged 13 to 24 represent 21% of all new HIV/AIDS diagnoses in 2011 (Guttmacher Institute, 2014). Symptoms of AIDS, specifically a weakening of the immune system, occur about 8 to 10 years after infection with HIV. Although it was once believed that adolescents who abuse drugs and share needles were most at risk for HIV infection, we now know that HIV is more often spread through heterosexual contact, especially from male to female (European Study Group on Heterosexual Transmission of HIV, 1992; Kelley, Borawski, Flocke, & Keen, 2003; Padian, Shiboski, & Jewell, 1991).

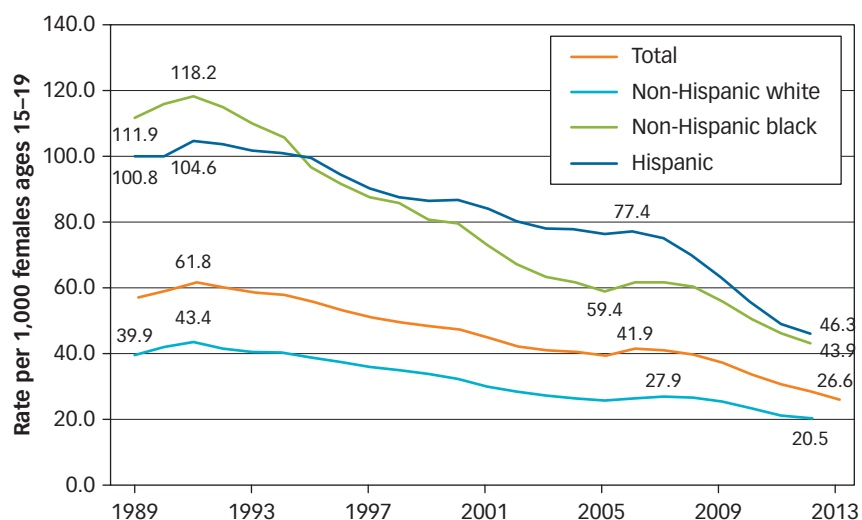
Although most adolescents (about 85% of high school students) receive education and demonstrate basic knowledge about HIV/AIDS (Kann et al., 2014), most underestimate their own risks, know little about other STIs, and are not knowledgeable about how to protect themselves from STIs (Boyce, Doherty, Fortin, & MacKinnon, 2003). In 2013, only 13% of high school students reported that they had ever been tested for HIV (Kann et al., 2014). Even in the Netherlands, a country with low STI rates among adolescents, most middle to late adolescents underestimate their risk of infection (Wolfers, de Zwart, & Kok, 2011). STIs are most likely among young people aged 15 to 24, and youth are especially vulnerable within the first year of initiating sexual activity (CDC, 2014; Forhan et al., 2009). The three ways to avoid STIs are to abstain from sex; to be in a long-term, mutually monogamous relationship with a partner who has been tested and does not have an STI; and to use condoms consistently and correctly. Making and carrying out decisions to abstain from sex or to engage in safe sex is challenging. With advances in cognition and executive functioning, specifically, perspective taking, decision making, and self-regulation, as well as experience, adolescents are better able to carry out their decisions in the real world, and show increase in safe sex.

ADOLESCENT PREGNANCY

In 2010, about 6% of 15- to 19-year-old girls in the United States became pregnant (Kost & Henshaw, 2014). The rate of adolescent pregnancy has dropped from its high of 117 of every 1,000 adolescent girls in 1990 to 57 of every 1,000 adolescent girls in 2010. Pregnancies are least common among girls younger than 15. In 2010, 5.4 pregnancies occurred per 1,000 teens aged 14 or younger, representing fewer than 1% of teens younger than 15 each year (Guttmacher Institute, 2014). As shown in Figure 12.4, the birth rate for U.S. adolescents has also declined substantially since 1990. The decline in adolescent birth rates can be attributed to a trend beginning in the 1990s for adolescents to initiate sexual activity later than in prior decades, as well as an increase in contraceptive use (Santelli, Lindberg, Finer, & Singh, 2007).

Despite overall declines over the past two decades, the United States continues to have one of the highest teen birth rates in the developed world (see Table 12.2; Sedgh, Finer, Bankole, Eilers, & Singh, 2015). Rates of sexual activity are similar across Western nations, but U.S. adolescents are less likely to use contraceptives than are those in other countries (Santelli, et al., 2007).

FIGURE 12.4: Birth Rates for Adolescents Aged 15 to 19, 1960–2013



SOURCE: Child Trends Data Bank (2014).

One half of adolescent pregnancies in the United States occur within the first six months of the time a girl begins having sexual intercourse (Klein, 2006). More than 90% of 15- to 19-year-olds describe their pregnancies as unintended (Finer & Henshaw, 2006). The acceptability and consequences of adolescent pregnancy are influenced by social context. In places where advanced education is necessary for vocational and economic advancement, adolescent pregnancy is viewed as a handicap to success. Adolescent parenthood is a greater problem today

in Western cultures, largely because adolescent girls are less likely to marry before giving birth and are less likely to receive financial or emotional support from the father than are those of prior generations. The risks for adolescent parenthood also contribute to the outcomes for adolescent parents and their children.

Because their bodies are not yet mature, girls who become pregnant shortly after menarche are at higher risk for many complications, such as spontaneous miscarriage, high blood pressure, low birth weight infants, and still birth (Phipps, Sowers, & Demonner, 2002). Pregnancy in early adolescence interferes with girls' physical development because the hormones of pregnancy conflict with those of puberty. By age 16, in most girls the reproductive system and body growth are complete, and the complications of pregnancy and birth are no more likely than they are at age 20 (Phipps et al., 2002).

The risks for adolescent pregnancy are much the same as for early sexual activity. Low socioeconomic status homes, poor neighborhoods, and low levels of parental warmth and monitoring influence early sexual activity and the risk for adolescent pregnancy. Similarly, poor academic achievement, delinquency, substance use, depression, and affiliation with deviant peers are risk factors for early sexual activity and adolescent pregnancy (Carlson et al., 2014; Fortenberry, 2013). Girls who experience menarche early relative to peers are at risk as this early maturation predicts early sexual behavior and, in turn, pregnancy (De Genna, Larkby, & Cornelius, 2011; Dunbar, Sheeder, Lezotte, Dabelea, & Stevens-Simon, 2008). In addition, the presence of family members, especially parents and siblings, who are adolescent parents is associated with a high risk of adolescent pregnancy (East, Reyes, & Horn, 2007). Involved and firm parenting during early adolescence can

TABLE 12.2 International Adolescent Birth Rates in 2012 (per 1,000 women)

COUNTRY	RATE
Austria	4
Australia	12
Brazil	71
China	9
Canada	14
Dominican Republic	100
France	6
Germany	4
Ireland	8
Japan	5
Netherlands	6
Russian Federation	26
Switzerland	2
United Kingdom	26
United States	31

SOURCE: Adapted from World Bank (2014).

buffer the effects of multiple home and community risk factors on the likelihood of early sexual activity and adolescent pregnancy (East, Khoo, Reyes, & Coughlin, 2006).

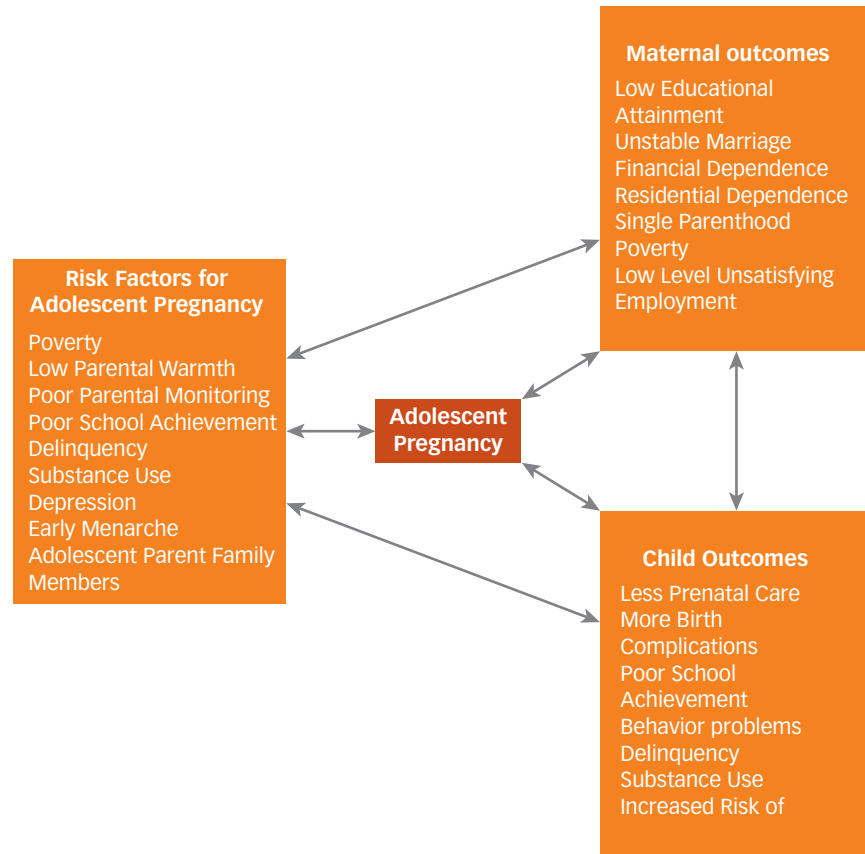
Adolescent mothers are less likely to achieve many of the typical markers of adulthood, such as completing high school, entering a stable marriage, and becoming financially and residentially independent (Casares, Lahiff, Eskenazi, & Halpern-Felsher, 2010; Taylor, 2009). Low educational attainment means that adolescent mothers often work low-paid and often unsatisfying jobs. Those who experience high levels of stress accompanied by little support are at risk for maternal depression and their infants are at risk for developmental delays (Huang, Costeines, Ayala, & Kaufman, 2014). Adolescent mothers tend to spend more parenting years as single parents than do mothers who have children later in life. When they marry, adolescent mothers are more likely to divorce (Moore et al., 1993). Lack of resources, such as child care, housing, and financial support, influence poor educational outcomes; adolescents with child care and financial resources tend to show higher educational attainment (Casares et al., 2010; Mollborn, 2007). Although adolescent pregnancy is associated with negative outcomes, the risk factors for adolescent pregnancy are also those that place youth at risk for negative adult outcomes in general, such as extreme poverty, few educational and community supports, and family instability (Oxford et al., 2005). It is therefore difficult to determine the degree to which outcomes are caused by adolescent pregnancy itself or the contextual conditions that are associated with it.

It must be noted, however, that there is a great deal of variability in short- and long-term outcomes of teen pregnancy (Furstenberg, 2003; Miller, Forehand, & Kotchick, 1999). Adolescent parenthood is associated with long-term economic disadvantage. Adolescent mothers are more likely to be unemployed, have lower personal income, live in poverty, and have lower levels of education than their peers in their 30s (Assini-Meytin & Green, 2015; Gibb, Fergusson, Horwood, & Boden, 2015). For example, a longitudinal study of adolescent mothers showed that 17 years after giving birth as adolescents, more than 70% graduated from high school, 30% received a postsecondary degree, and one half achieved income security, more positive outcomes than often reported (Furstenberg, 2003; Miller et al., 1999). In another longitudinal study of adolescent mothers, only about 15% of adolescent mothers experienced the most negative outcomes over the transition to early adulthood, such as financial dependence, low education, unemployment, unstable housing, casual sexual activity, victimization by crime, criminal activity, and illicit drug use (Oxford, et al., 2005). These dire outcomes are predicted by drug and alcohol use, criminal activity, clinical depression, anxiety, and experience with violence during adolescence. The remaining 85% of adolescent mothers showed more positive outcomes including achieving markers of adulthood such as financial independence, though about one half of these young women experienced mental health issues such as anxiety or depression (Oxford, et al., 2005). Figure 12.5 summarizes risk factors and outcomes for adolescent pregnancy.

Children born to adolescent mothers are at a disadvantage relative to their peers. Adolescent mothers are less likely than older mothers to seek prenatal care and are more likely to smoke and use alcohol or other drugs (Dell, 2001; Meade, Kershaw, & Ickovics, 2008). Infants born to adolescent mothers are more likely to be born preterm and low birth weight (Xi-Kuan et al., 2007). Children of adolescent mothers tend to perform poorly in school, score lower on intelligence



FIGURE 12.5: Influences on Adolescent Pregnancy



Risk factors for adolescent pregnancy also influence how adolescents adjust to parenthood, their long term outcomes, and their children's outcomes. Protective factors promote positive adjustment in the face of risk factors for adolescent pregnancy as well as the outcomes of adolescent pregnancy for mothers and children. Examples of protective factors include warm relationships with parents and other caring adults, parental monitoring, authoritative parenting, coping skills, and access to health care.

tests, and be disruptive. They are at risk for a variety of negative developmental outcomes such as conduct and emotional problems, lower cognitive functioning, developmental delays, and poor academic achievement (Rafferty, Griffin, & Lodise, 2011; Tang, Davis-Kean, Chen, & Sexton, 2014). Children of adolescent mothers show lower educational attainment in young adulthood (Lipman, Georgiades, & Boyle, 2011). These outcomes are influenced by the characteristics of adolescents who are likely to become mothers as well as the consequences of having a child at a young age (e.g., lower maternal education, low socioeconomic status, frequent caretaker and residence changes, poor parenting; Carothers, Borkowski, & Whitman, 2006; De Genna et al., 2011; Rafferty et al., 2011). Adolescent mothers know less about child development than do adult mothers and therefore are more likely to have unrealistically high expectations of infants, perceive their infants as difficult, and show less effective interaction skills (Moore & Florsheim, 2001; Pomerleau, Scuccimarri, & Malcuit, 2003). In one longitudinal study of infants from 14 to 36 months of age, older mothers were more supportive during play than were adolescent mothers and differences in parenting behaviors predicted cognitive and language abilities at age 3 (Rafferty et al., 2011).

Children of adolescent mothers are at risk to demonstrate increasingly deviant behavior into adolescence including delinquency, substance abuse, incarceration,

school dropout, and early childbearing (Furstenberg, 2003; Jaffee, Caspi, Moffitt, Belsky, & Silva, 2001). Girls are at increased risk to themselves become adolescent parents, but after taking into account other contextual factors, the risk attributable to adolescent parenting declines (Meade et al., 2008). However, there is variability in outcomes. Many children of adolescent mothers often demonstrate resilience, adjustment, in face of these risks (Levine, Emery, & Pollack, 2007; Rhule, McMahon, Spieker, & Munson, 2006). Positive adjustment is predicted by secure attachment; low maternal depressive symptoms; and positive parenting on the part of the mother, characterized by warmth, discussion, and stimulation.

Adolescent fathers are similar to adolescent mothers in that they are more likely than their peers to have poor academic performance, higher school dropout rates, finite financial resources, and lowered income potential (Kiselica & Kiselica, 2014; Klein, 2006). Some adolescent fathers disappear from their children's lives. Many stay involved, often while struggling. In one study, about 60% of adolescent fathers maintained consistent contact over the first eight years of the child's life (Howard, Lefever, Borkowski, & Whitman, 2006). Father contact was associated with the child's having better socioemotional and academic functioning at 8 and 10 years of age, particularly in school-related areas. Children with greater levels of father contact have fewer behavioral problems and higher scores on reading achievement (Howard, et al., 2006).

Adolescent parents can be effective if provided with supports—economic, educational, and social. Effective supports for adolescent parents include health care, encouragement to stay in school, vocational training, parenting skills, coping skills, and access to affordable child care (Easterbrooks, Chaudhuri, Bartlett, & Copeman, 2011; Mollborn, 2007). Social support predicts increased parenting self-efficacy and parental satisfaction (Angle, Divney, Magriples, & Kershaw, 2015; Umaña-Taylor, Guimond, Updegraff, & Jahromi, 2013). Relationships with adults who are close, supportive, and provide guidance predict completing high school (Klaw, Rhodes, & Fitzgerald, 2003). Adolescents who share caregiving with their mothers or other adults learn as apprentices and become more competent over time (Oberlander, Black, & Starr, 2007). Adolescent parents benefit from relationships with adults who are sensitive to their needs as parents but also to their own developmental needs for autonomy and support.

Thinking in Context 12.3

1. Identify influences on adolescent sexual activity (e.g., intercourse, oral sex, contraceptive use) at each of Bronfenbrenner's ecological levels. How might interventions apply this information to reduce sexual activity and increase safe sex practices among adolescents?
 2. It is a common belief that today's adolescents are more sexually active at younger ages than ever before. How would you respond to that statement, based on what you know about adolescent sexuality?
 3. Given what is known about child development, specifically infant and young children's developmental needs, as well as what is known about parenting and its influence on developmental outcomes, what supports do adolescent parents need in order to become effective parents?
-

PROBLEMS IN ADOLESCENCE

As much as adolescence is a time of excitement, firsts, and learning about the world and the self, it can also be an emotionally challenging time. Most young people traverse the adolescent years without adversity, but about one in five teenagers

experience serious problems that pose risks to their health and development (Lerner & Israeloff, 2007). Common problems during adolescence include eating disorders, substance abuse, depression, and delinquency.

DEPRESSION AND SUICIDE

When adolescents experience problems in development, they are most likely to suffer from depression. Depression is characterized by feelings of sadness, hopelessness, and frustration; changes in sleep and eating habits; problems with concentration; loss of interest in activities; and loss of energy and motivation. About 9% of adolescents experience a depressive episode, and about 2% to 8% experience chronic depression that persists over months and even years (Substance Abuse and Mental Health Services Administration, 2013). Rates of depression rise in early adolescence, and lifelong sex differences emerge, with girls reporting depression twice as often as boys (Galambos, Leadbeater, & Barker, 2004; Paxton, Valois, Watkins, Huebner, & Drane, 2007; Thapar, Collishaw, Pine, & Thapar, 2012). About one third of adolescents report feeling hopeless (Kann et al., 2014). The stereotype of the typical adolescent presents a danger when it comes to identifying depression. Parents and teachers who buy into the storm and stress myth of adolescence may assume that depressive symptoms are a normal part of adolescence and thereby ignore real problems.

There are multiple pathways to depression. Genes play a role in depression by influencing development of the brain regions responsible for emotional regulation and stress responses as well as the overall balance and production of neurotransmitters (Franić, Middeldorp, Dolan, Ligthart, & Boomsma, 2010; Maughan, Collishaw, & Stringaris, 2013). Longitudinal research suggests the role of epigenetics in depression during adolescence. For example, in one study, boys with a specific neurotransmitter allele showed severe symptoms of depression in the presence of poor family support but in the presence of high family support showed positive outcomes (Li, Berk, & Lee, 2013). The allele may increase reactivity to both negative and positive family influences, serving as a risk factor in an unsupportive family context but protective factor when coupled with family support. Genetics plays a complex role in determining depression; some alleles may serve as both risk and protective factors depending on contextual circumstances.

Many environmental factors are thought to serve as risk factors for depression (Dunn et al., 2011). Adolescents who are depressed are more likely to live in homes with depressed parents (Natsuaki et al., 2014). Depression often limits the capacity to parent effectively and with sensitivity. Feelings of alienation from parents contribute to depression (Smith, Rachel, & Catherine, 2009). Similar to adults, depression during adolescence often occurs after specific events like parental divorce, failure, or the loss of a friend (Oldehinkel, Ormel, Veenstra, De Winter, & Verholst, 2008). The longitudinal effects of stressful life events on depression is buffered by parent–child closeness and worsened by parental depression (Bouma, Ormel, Verhulst, & Oldehinkel, 2008; Ge, Natsuaki, Neiderhiser, & Reiss, 2009).

Cultural factors also play a role in influencing adolescents' susceptibility to depression. Unlike Western cultures, males and females display similar rates of depression in non-Western cultures (Culbertson, 1997). Within the United States, culturally influenced coping styles and responses to stressful life events influence sex and ethnic differences in depression. Many adolescents find the common discrepancy between their level of acculturation and that of their first-generation immigrant parents stressful. For example, Chinese immigrant parents whose level of acculturation differed from their adolescent children showed more unsupportive parenting practices and the adolescents reported greater feelings of alienation (Kim, Chen, Wang, Shen, & Orozco-Lapray, 2013). Poor parental acculturation is linked with adolescent depression when adolescent–parent relationships are poor (Kim, Qi, Jing, Xuan, & Ui Jeong, 2009). Likewise, Vietnamese fathers who are

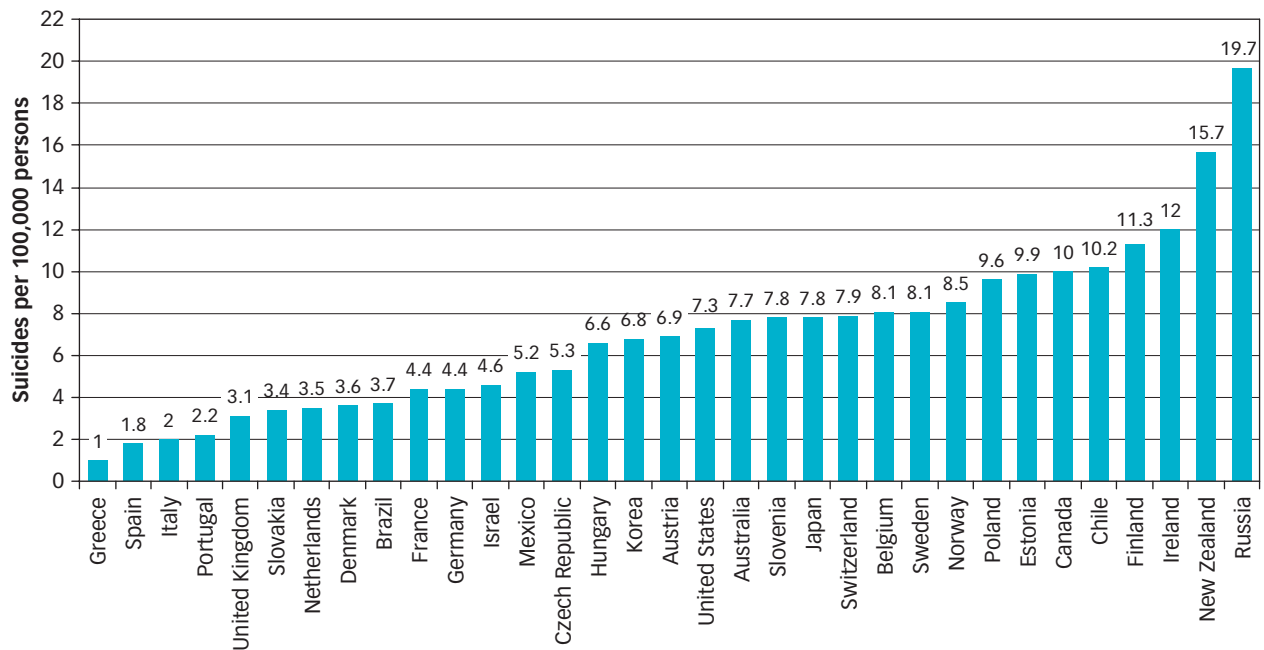
less acculturated to the United States use more authoritarian methods that fit their society, but their adolescents experience more depression (Nguyen, 2008). Latino adolescents who experience a discrepancy in acculturation as compared with their parents also are at risk for depression (Céspedes & Huey, 2008). As young people acculturate, they may challenge traditional attitudes and beliefs of their immigrant parents, leading to greater family conflict and emotional distress (Gonzales, Dearth-Dorff, Formoso, Barr, & Barrera, 2006).

Intense and long-lasting depression can lead to thoughts of suicide. Increases in depression during adolescence are accompanied by increases in the suicide rate. Suicide remains among the top three leading causes of death in the United States and Canada (Heron, 2013; Ornstein, Bowes, Shouldice, & Yanchar, 2013). For unknown reasons, rates of adolescent suicide vary widely across industrialized countries, from low in Denmark, Greece, Italy, and Spain, intermediate in Australia, Canada, Japan, and the United States, to high in Finland, New Zealand, and Singapore (Lester, 2003; McLoughlin, Gould, & Malone, 2015). Figure 12.6 illustrates the suicide rate across several Western countries.

Consistent ethnic differences occur in rates of suicide. Native American and Canadian Aboriginal adolescents commit suicide at very high rates relative to their peers—2 to 7 times the national averages (Joe & Marcus, 2003; Kutcher, 2008). Challenges with acculturation as well as contextual risk factors that are associated with ethnicity, like an increased likelihood of living in poverty, influence suicide rates among minority youth (Goldston et al., 2008). Gay and lesbian youth, especially males, are also at high risk with 3 to 4 times as many attempts than other youths; typically, these teens report family conflict, peer rejection, and inner conflict about their sexuality as influences on their attempts (Liu & Mustanski, 2012; Mustanski & Liu, 2013).

Although females display higher rates of depression and make more suicide attempts, males are four times more likely to succeed in committing suicide (Xu, Kochanek, Murphy, & Arias, 2014). Girls tend to choose suicide methods that are more slow and passive and that they are more likely to be revived from, such as overdoses of pills. Boys tend to choose methods that are quick and irreversible, such

FIGURE 12.6: Suicide Rates in the United States, Ages 15–19, 2008



SOURCE: McLoughlin et al. (2015).

as firearms. The methods correspond to gender roles that expect males to be active, decisive, aggressive, and less open to discussing emotions (Canetto & Sakinofsky, 1998; Hepper, Dornan, & Lynch, 2012).

Adolescents who commit suicide are more likely to have experienced multiple recent stressful events such as parental divorce; abuse and neglect; conflict with parents; family members with emotional, psychological, or antisocial problems; and economic disadvantage as well as final triggering events such as failure, loss of a friendship, or intense family arguments (Beautrais, 2003; Miranda & Shaffer, 2013). Adolescents' suicide attempts are influenced by those of their friends. Adolescents are more likely to attempt suicide following a friend's attempt (Nanayakkara, Misch, Chang, & Henry, 2013). Some adolescents who commit suicide are perfectionists who may find that they and the people around them are unable to meet their own rigidly high standards (Flett, Hewitt, & Heisel, 2014). Other adolescents who commit suicide first express their depression and frustration through antisocial activity such as bullying, fighting, stealing, abusing drugs or alcohol, and risk-taking (Fergusson, Woodward, & Horwood, 2000). Peer victimization is a risk factor for suicide attempts (Bauman et al., 2013) as is high levels of anxiety (Hill, Castellanos, & Pettit, 2011). Although 20/20 hindsight is quite clear, determining if a teen needs help is challenging. Frequently, however, adolescents who attempt suicide show warning signs beforehand, as listed in Table 12.3. The availability and advertisement of telephone hotlines, such as the National Suicide Prevention Lifeline at (800) 273-8255 (and available at <http://www.suicidepreventionlifeline.org>) can help adolescents in immediate danger of suicide.

Adolescents are also at risk for self-harm: deliberate and voluntary physical self-injury that is not life-threatening and is without any conscious suicidal intent (Laye-Gindhu & Schonert-Reichl, 2005). This behavior is discussed in Box 12.1.

Preventing and treating depression and suicide requires looking beyond myths and stereotypes about adolescent behavior to be aware of the signs of adolescents in pain. Parent and teacher education about the signs of depression is an essential first step.

TABLE 12.3 Suicide Warning Signs

Any of the following behaviors can serve as a warning sign of increased suicide risk.

- Change in eating and sleeping habits
- Withdrawal from friends, family, and regular activities
- Violent actions, rebellious behavior, or running away
- Drug and alcohol use, especially changes in use
- Unusual neglect of personal appearance
- Marked personality change
- Persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork
- Frequent complaints about physical symptoms, such as stomachaches, headaches, and fatigue
- Loss of interest in pleasurable activities
- Complaints of being a bad person or feeling rotten inside
- Verbal hints with statements such as the following: "I won't be a problem for you much longer." "Nothing matters." "It's no use." "I won't see you again."
- Affairs are in order—for example, giving away favorite possessions, cleaning his or her room, and throwing away important belongings
- Suddenly cheerful after a period of depression
- Signs of psychosis (hallucinations or bizarre thoughts)

Most important: Stating "I want to kill myself," or "I'm going to commit suicide."

SOURCE: Adapted from American Academy of Child and Adolescent Psychiatry (2008).



Self-Harm

Brianna closed the door to her room, rolled up her shirtsleeve, and looked down at the scarred and healing gashes in her arm before reaching for a new razor blade. Brianna engages in self-harm, a behavior that often becomes habitual among adolescent girls. Although self-harm may indicate serious psychological disorders, it is also common among adolescents in Western countries, with lifetime prevalence rates of 13% to 23% of adolescents in the United States, Canada, Australia, Belgium, England, Hungary, Ireland, the Netherlands, and Norway (Muehlenkamp, Claes, Havertape, & Plener, 2012; Plener, Libal, Keller, Fegert, & Muehlenkamp, 2009). One sample of over 1,000 7th- and 8th-grade students in Sweden found that over 40% reported engaging in self-injury in the last six months (Bjärehed, Wångby-Lundh, & Lundh, 2012). Rates may be even higher because most self-harming adolescents never seek help or medical attention for their injuries (Hall & Place, 2010). Most adolescents who engage in self-harm behaviors do so occasionally, and most do not show recurring self-harm (Brunner et al., 2007).

Self-harm behaviors, particularly cutting, tend to emerge at around age 13, but the age of initiation ranges from 12 to 15 years (Bjärehed et al., 2012). Girls are more likely than boys to report harming themselves, most commonly by cutting behaviors, but also hitting, biting, or burning behaviors, but there are no differences on the basis of ethnicity or socioeconomic status (Laye-Gindhu & Schonert-Reichl, 2005; Nock, Prinstein, & Sterba, 2009).

Social problems and a difficulty forming close relationships are common among adolescents who self-harm (Ross, Heath, & Toste, 2009). They may view their relationships as tense, disappointing, and of poor quality and may be more likely to experience bullying (Fisher et al., 2012; Laukkanen et al., 2009). Psychological and behavioral difficulties such as anxiety, depression, antisocial behavior, poor problem-solving skills, and impulsivity are associated with self-harm (Bjärehed et al., 2012; Marshall, Tilton-Weaver, & Stattin, 2013). Adolescents who self-harm tend to report being more confused about their emotions, experiencing difficulty recognizing and responding to them and more reluctance

to express their feelings and thoughts to others (Bjärehed et al., 2012; Nock et al., 2009). Common reasons that adolescents endorse for self-harm include depression, feeling alone, anger, self-dislike, and inadequacy.

Adolescents who repeatedly engage in cutting and engaging in other acts of self-harm tend to report that the act relieves emotional pain, reducing negative emotions (Scoliers et al., 2009; Selby, Nock, & Kranzler, 2014). Interestingly, self-harming adolescents tend to show little or no pain during the harm episode (Nock, et al., 2009). Instead, the act of cutting or other self-harming behavior produces a sense of relief and satisfaction for adolescents who repeatedly self-harm. Soon, they tend to value self-harm as an effective way of relieving anxiety and negative emotions, making it a difficult habit to break (Madge et al., 2008; Selby et al., 2014). The *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition, or *DSM-V* (American Psychiatric Association, 2013), includes a diagnosis for severe self-harm: nonsuicidal self-injury—self-injurious behavior that occurs with the expectation of relief from a negative feeling—to solve an interpersonal problem, or to feel better, and interpersonal difficulty and negative feelings of thoughts, premeditation, or rumination on nonsuicidal self injury. Many adolescents who self-harm receive treatment similar to other internalizing disorders, including a combination of medication, therapy, and behavioral treatment. However, repeated self-harming behaviors are difficult to treat because the relief they produce is very reinforcing to adolescents, making psychologists and other treatment providers' work very challenging (Bentley, Nock, & Barlow, 2014; Nock, 2009).

What Do You Think?

1. **Why might some adolescents find that “feeling bad” makes them “feel good”?**
2. **What role might brain development or contextual factors such as parents and peers contribute to the increase in cutting and other self-harm behaviors that many experience in adolescence?**

Although school-based suicide prevention programs tend to increase awareness and knowledge about suicide, they are not associated with lower rates of suicide (Cusimano & Sameem, 2011). Depression is treated in a variety of ways that include therapy and the provision of antidepressant medication (Brent, 2009). Therapy that is designed to help the adolescent be more self-aware, identify harmful patterns of thinking, and change them is especially effective and can be administered in school or community settings (Shirk, Gudmundsen, Kaplinski, & McMakin, 2008). Counseling and peer support groups can be provided by schools and community centers (Corrieri et al., 2014).

After a suicide, family, friends, and schoolmates of the adolescent require immediate support and assistance in working through their grief and anger. The availability of support and counseling to all adolescents within the school and community after a suicide is important because adolescent suicides tend to occur in clusters, increasing the risk of suicide among adolescents in the community (Gould, Jamieson, & Romer, 2003; Haw, Hawton, Niedzwiedz, & Platt, 2013). Depression and suicide are challenging problems that illustrate the complex interactions between the individual and his or her context.

EATING DISORDERS

Adolescents' rapidly changing physique, coupled with media portrayals of the ideal woman as thin with few curves, leads many to become dissatisfied with their **body image** (Benowitz-Fredericks, Garcia, Massey, Vasagar, & Borzekowski, 2012). Girls who have a negative body image are at risk of developing a strong drive for thinness and unhealthy weight loss behaviors, such as excessive exercise and use of food supplements in place of meals (McCabe & Ricciardelli, 2006). Severe dieting can be an indicator of an eating disorder, which is defined as unhealthy and uncontrolled attitudes and patterns of weight control. Core features of eating disorders are unhealthy negative body image (overvaluing thinness, weight, or shape), obsession with weight control, extreme over or under control of eating, and extreme behavior patterns designed to control weight, such as compulsive exercise, dieting, or purging (American Psychiatric Association, 2013). Two eating disorders, **anorexia nervosa** and **bulimia nervosa**, pose serious challenges to health. About 4% of adolescents are diagnosed with anorexia nervosa and bulimia nervosa (Smink, van Hoeken, & Hoek, 2013) Table 12.4 lists symptoms of anorexia and bulimia.

Although both anorexia nervosa and bulimia nervosa entail excessive concern about body weight and attempts to lose weight, they differ by means. Young people who suffer from anorexia nervosa starve themselves in an attempt to

TABLE 12.4 Criteria for the Diagnosis of Anorexia Nervosa or Bulimia Nervosa

ANOREXIA NERVOSA	BULIMIA NERVOSA
<ol style="list-style-type: none"> 1. Persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory, and physical health) 2. Either an intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain (even though significantly low weight) 3. Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight 	<ol style="list-style-type: none"> 1. Recurrent episodes of binge eating characterized by the following: <ol style="list-style-type: none"> a. Eating, in a discrete period of time (e.g., within any two-hour period) an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances; b. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating) 2. Recurrent inappropriate behavior to prevent weight gain such as the following: <ol style="list-style-type: none"> a. Self-induced vomiting b. Misuse of laxatives, diuretics, or other medications c. Fasting d. Excessive exercise 3. The binge eating and inappropriate compensatory behavior both occur, on average, at least once a week for three months. 4. Self-evaluation unduly influenced by body shape and weight 5. Disturbance does not occur exclusively during episodes of anorexia nervosa

SOURCE: American Psychiatric Association (2013).

achieve thinness, maintaining a weight that is substantially lower than expected for height and age (American Psychiatric Association, 2013). A distorted body image leads youth with anorexia to perceive themselves as “fat” despite their emaciated appearance, and they continue to lose weight (Gila, Castro, Cesena, & Toro, 2005; Skrzypek, Wehmeier, & Remschmidt, 2001). Girls with anorexia avoid eating even when hungry. For example, 16-year-old Jessica often consumed a lunch of five baby carrots and one half of an apple. In addition to avoiding eating despite hunger, many girls with anorexia exercise vigorously to increase their weight loss. Anorexia affects about 2% of girls 19 and under; however, many more girls show poor eating behaviors characteristic of anorexia (Smink et al., 2013; Smink, van Hoeken, Oldehinkel, & Hoek, 2014).

Bulimia nervosa is characterized by recurrent episodes of binge eating—consuming an abnormally large amount of food (thousands of calories) in a single sitting coupled with a feeling of being out of control—followed by purging, inappropriate behavior designed to compensate for the binge, such as vomiting, excessive exercise, or use of laxatives (American Psychiatric Association, 2013). Girls with bulimia nervosa experience extreme dissatisfaction with body image and attempt to lose weight, but they tend to have a body weight that is normal or high-normal (Golden et al., 2015). Bulimia is more common than anorexia, affecting between 1% and 5% of females across Western Europe and the United States (Kessler et al., 2013; Smink et al., 2014). One study estimated that many more young people in North America and Europe show symptoms of bulimia but remain undiagnosed (Keel, 2014).

Both anorexia and bulimia are dangerous to young people’s health. Girls with anorexia may lose 25% to 50% of their body weight (Berkman, Lohr, & Bulik, 2007). They may not experience menarche or may stop menstruating because menstruation is dependent on maintaining at least 15% to 18% body fat (Golden et al., 2015). Starvation and malnutrition contributes to extreme sensitivity to cold, pale skin, and growth of fine hairs all over the body. The starvation characteristic of anorexia nervosa has serious health consequences, such as loss of bone mass causing brittle and easily broken bones, kidney failure, shrinkage of the heart, brain damage, and even death in as many as 16% of cases of anorexia (Golden et al., 2015; Reel, 2012). Side effects of bulimia nervosa include nutritional deficiencies, sores, ulcers, and even holes in the mouth and esophagus caused by repeated exposure to stomach acids, as well as bad breath, tooth damage and an increased likelihood of cancers of the throat and esophagus (Katzman, 2005).

What causes eating disorders? Both anorexia and bulimia occur more often in both members of identical twins than fraternal twins, indicating a genetic basis (Strober, Freeman, Lampert, Diamond, & Kaye, 2014). Eating disorders are much more prevalent in females than males, with about 1% of males diagnosed with an eating disorder as compared with about 6% of females (Raevuori, Keski-Rahkonen, & Hoek, 2014). Adolescents who develop eating disorders tend to have problems with impulse control and anxiety, as well as symptoms of depression; and these are all influenced by abnormal levels of neurotransmitters in the brain (Haleem, 2012; Kaye, Bailer, Frank, Wagner, & Henry, 2005). Girls who develop eating disorders also tend to experience body dissatisfaction and rate themselves negatively in comparison with other girls (e.g., “I am less good-looking, likable, and popular”; McCabe & Ricciardelli, 2006). Interactions with parents and especially peers influence girls’ body image, dieting behaviors, and eating disorder symptoms (Blodgett Salafia & Gondoli, 2011). Girls with eating disorders often find that strictly regulating their eating is a way to exert control in their lives. Girls with anorexia, in particular, tend to set high, often unrealistic, standards for themselves. They tend to be academic achievers, perfectionists, and focused on achieving success (Halmi et al., 2000). Their perfectionist tendencies extend to their bodies, which they perceive as not meeting the societal ideal of beauty. Controlling their bodies and

restricting their intake of food provides a sense of control and reduces their anxiety and negative mood states (Kaye, Wierenga, Bailer, Simmons, & Bischoff-Grethe, 2013; Tyrka, Graber, & Brooks-Gunn, 2000).

Eating disorders occur in all ethnic and socioeconomic groups in Western countries and are becoming increasingly common in Asian and Arab cultures (Isomaa, Isomaa, Marttunen, Kaltiala-Heino, & Björkqvist, 2009; Latzer, Witztum, & Stein, 2008; Pike, Hoek, & Dunne, 2014; Reel, 2012). Girls who compete in sports and activities that idealize lean figures, such as ballet, figure skating, gymnastics, and long distance running, are at higher risk for developing eating disorders than are other girls (Nordin, Harris, & Cumming, 2003; Voelker, Gould, & Reel, 2014). In the United States, white and Latina girls, especially those of higher socioeconomic status, are at higher risk for low body image and eating disorders than are black girls, who may be protected by cultural and media portrayals of African American women that value voluptuous figures (Nishina, Ammon, Bellmore, & Graham, 2006; Smink et al., 2013; Striegel-Moore & Bulik, 2007). Some researchers suggest, however, that ethnic differences in eating disorders are not as large as they appear. Instead, eating disorders may exist in Latina and black girls but remain undetected and undiagnosed because of barriers to diagnosis and treatment (Wilson, Grilo, & Vitousek, 2007).

Eating disorders are difficult to treat. In one study of over 2,500 adolescents, 82% of those diagnosed with an eating disorder showed symptoms five years later (Ackard, Fulkerson, & Neumark-Sztainer, 2011). Anorexia nervosa and bulimia nervosa are treated in similar ways but show different success rates. Standard treatment for anorexia includes hospitalization to remedy malnutrition and ensure weight gain, antianxiety or antidepressant medications, and individual and family therapy (Lock, 2011; Wilson et al., 2007). Medications are commonly prescribed, with mixed outcomes (Bulik et al., 2007). The success of therapy also varies. Therapy is designed to enhance girls' motivation to change and engage them as collaborators in treatment, providing them with a sense of control. However, the success of therapy depends on the patients' attitudes about their symptoms and illness (Bulik et al., 2007; Lock, Le Grange, & Forsberg, 2007; Lock, 2011). Unfortunately, girls with anorexia tend to deny that there is a problem as they are unable to objectively perceive their bodies. Many hold the conviction that thinness and restraint are more important and healthy than recovery, making anorexia very resistant to treatment (Berkman et al., 2007). As a result, only about 50% of girls with anorexia make a full recovery and anorexia nervosa has the highest mortality rate of all mental disorders (Smink et al., 2013).

Bulimia tends to be more amenable to treatment because girls with bulimia tend to acknowledge that their behavior is not healthy. Girls with bulimia tend to feel guilty about bingeing and purging and are more likely than those with anorexia to seek help. Individual therapy, support groups, nutritional education, and antianxiety or antidepressant medications are the treatments of choice for bulimia nervosa (Hay & Bacaltchuk, 2007; Le Grange & Schmidt, 2005). Medication tends to improve symptoms but, without therapy, rarely leads to the cease of purging (Shapiro et al., 2007). Individual and family-based therapy helps girls become aware of the thoughts and behaviors that cause and maintain their bingeing and purging behaviors, which decreases binge eating and vomiting and reduces the risk of relapse (Lock, 2011; Smink et al., 2013).

ALCOHOL AND SUBSTANCE USE

Nearly one half of U.S. teens have tried an illicit drug, and nearly three quarters have tried alcohol by the time they leave high school, as shown in Table 12.5. Experimentation with alcohol, tobacco, and marijuana use—that is, “trying out” these substances—is so

TABLE 12.5 Substance Use in U.S. Adolescents—2014

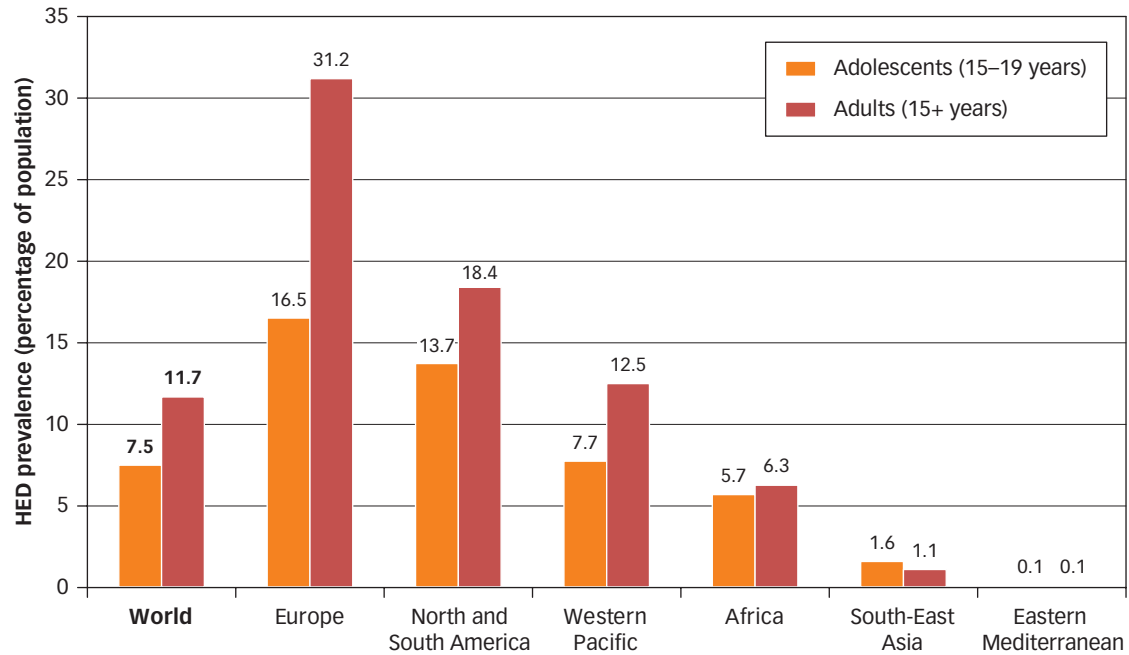
		LIFETIME PREVALENCE	30-DAY PREVALENCE
Cigarettes			
	8th grade	13.5	4
	10th grade	22.6	7.3
	12th grade	34.4	13.6
Alcohol			
	8th grade	26.8	9
	10th grade	49.3	23.5
	12th grade	66	37.4
Been drunk			
	8th grade	10.8	2.7
	10th grade	30.2	11.2
	12th grade	49.8	23.5
Marijuana			
	8th grade	15.6	6.5
	10th grade	33.7	16.6
	12th grade	44.4	21.2
Illicit drugs			
	8th grade	10	3.3
	10th grade	15.9	5.6
	12th grade	22.6	7.7

SOURCE: Johnston et al. (2015).

common that it may be considered somewhat normative for North American adolescents, especially as rates of experimentation rise during the adolescent years into young adulthood (Johnston, O'Malley, Miech, Bachman, & Schulenberg, 2007; Palmer et al., 2009; World Health Organization, 2004). Alcohol, in particular, is commonly used by adolescents around the globe; however, there are cultural differences in drinking patterns, as shown by Figure 12.7.

Most adolescents begin to use alcohol in early adolescence; show steady increases in use throughout the high school years, with a peak in the mid-20s; and then decline (Windle & Zucker, 2010). Perhaps surprising to some adults is that North American adolescents who experiment in a limited way with drugs and alcohol tend to be psychosocially healthy (Shelder & Block, 1990; Windle et al., 2008). For example, adolescents who score high on measures of subjective well-being at age 16 tend to report using alcohol at age 18, suggesting that some alcohol use in late adolescence is common in well-adjusted middle and older adolescents (Mason & Spoth, 2011). Why? Alcohol and substance use may serve a developmental function in middle and late adolescence, such as a way of asserting independence and autonomy from parents, taking risks, forming social relationships, and learning about oneself (Englund et al., 2013). Although most adolescents experiment with

FIGURE 12.7: Prevalence of Heavy Episodic Drinking, 2010



The highest rates of heavy drinking among adolescents are found in the WHO European Region, WHO Region of the Americas, and WHO Western Pacific Region, and heavy episodic drinking (HED) is more prevalent among adolescents than among the total population aged 15 years or older in all these WHO regions. In the WHO South-East Asia Region, HED is more prevalent in older age groups and in the WHO African Region, a similar proportion of HED is found among adolescents and among the total population aged 15 years or older.

SOURCE: World Health Organization (2014).

alcohol, tobacco, and marijuana, without incident, there are short-term dangers of alcohol and substance use, such as overdose, accidents, and motor impairment pose serious risks as well as long-term dangers of dependence and abuse. In addition, regular intermittent use—using alcohol and substances in spurts on a regular basis (common among adolescents)—can have harmful, even catastrophic, effects on neurological and cognitive development.

Adolescents are more sensitive to neurological damage and show more cognitive impairment in response to alcohol use as compared with adults. Alcohol use, especially the regular intermittent drinking common in adolescence, is associated with damage to the brain, particularly the prefrontal cortex and hippocampus (Bava & Tapert, 2010; Feldstein Ewing, Sakhardande, & Blakemore, 2014). The resulting neurocognitive deficits reduce young people’s capacities for executive function, memory, and learning. Adolescents who use alcohol heavily show smaller hippocampal and prefrontal white matter volume than other adolescents (Bava & Tapert, 2010; Jacobus et al., 2013). Adolescent heavy drinking is associated with reduced frontal cortex response during spatial working memory tasks; slower information processing; and reductions in attention, visiospatial functioning, and problem solving (Feldstein Ewing et al., 2014). Poor executive functioning, a common neurological outcome of alcohol use during adolescence, is associated with a decrease in the ability to use social information to regulate their behavior, decreased awareness of the consequences of alcohol abuse, and higher rates of drinking (Schepis, Adinoff, & Rao, 2008).

Adolescents are more vulnerable to alcohol abuse because they show reduced sensitivity to the effects of alcohol that serve as cues in adults to limit their intake, such as motor impairment, sedation, social impairment, and quietness or distress (Spear, 2011). Regular intermittent exposure to alcohol, the typical pattern

of adolescent drinking, is associated with increased tolerance to the impairing effects of alcohol and reduced sensitivity to the aversive effects, such as nausea or hangover. Adolescents develop a tolerance for alcohol more quickly than do adults (Schepis et al., 2008; Spear, 2013).

Alcohol and substance use and abuse are associated with negative consequences that can interfere with adolescents' development, such as unwanted sexual encounters and risky sexual activity. Although alcohol and substance use may help adolescents feel that they are achieving social goals such as being comfortable in social situations and making friends, it may threaten their short- and long-term health and well-being. Risks and negative consequences of alcohol and substance use include academic problems, social problems, aggression and victimization, unintentional injuries, anxiety, depression, car crashes, and suicide (Maggs & Schulenberg, 2005; Marshall, 2014). Relying on alcohol and substances to manage day-to-day stressors and hassles prevents the development of coping, self-regulatory, and decision-making skills, which in turn promotes continued drug use.

Adolescents at risk to abuse alcohol and substances tend to begin drinking earlier than their peers (Chen, Storr, & Anthony, 2009; Palmer et al., 2009). The tendency to abuse alcohol and substances has genetic roots: A family history of alcohol and substance use is a risk factor. However, contextual factors also promote use (Chassin, Ritter, Trim, & King, 2003; Silberg, Rutter, D'Onofrio, & Eaves, 2003). Adolescents are at reduced risk of developing alcohol and substance abuse problems if their parents are involved, warm, supportive, and aware of their children's whereabouts and friends. Low socioeconomic status, family members with poor mental health, drug abuse within the family and community, and disadvantaged neighborhoods increase the risk of alcohol abuse in adolescence (Chaplin et al., 2012; Trucco, Colder, Wiczorek, Lengua, & Hawk, 2014). In turn, adolescents who have mental health problems, difficulty with self-regulation, or are victims of physical or sexual abuse are at higher risk of alcohol and drug abuse than their peers. However, perhaps the most direct influences on adolescents are their peers' drinking or substance abuse behavior, their perceptions of peer support for such use, and their access to alcohol and substances (Brooks-Russell, Simons-Morton, Haynie, Farhat, & Wang, 2014).

Because adolescent alcohol and substance use is a complex problem with multiple influences, prevention and treatment programs must be multipronged. Effective prevention and intervention programs target parents by encouraging that they be warm and supportive, set rules, and be aware of their children's activities. Education is also important. Effective alcohol and substance abuse prevention and treatment programs educate adolescents about the health risks of substance use and that, contrary to depictions in the media and society, substance use is not socially acceptable. Such programs teach adolescents how to resist pressure from peers, how to refuse offers, and how to build their coping and self-regulatory skills (Poth, Greenberg, & Turrisi, 2008; Wagner, 2008; Windle & Zucker, 2010).

DELINQUENCY

"Have you got it?" asked Corey. "Here it is: Mrs. Scarcela's mailbox!" Adam announced as he dropped the stolen item on the floor in front of his friends. During adolescence, young people experiment with new ideas, activities, and limits. For many adolescents, like Adam, experimentation takes the form of delinquent activity. Nearly all young people engage in at least one delinquent, or illegal, act, such as stealing, during the adolescent years without coming into police contact (Flannery, Hussey, & Jefferis, 2005). For example, in one study boys admitted to engaging in, on average, three serious delinquent acts, and girls reported one serious delinquent act between ages 10 and 20, yet nearly none of the adolescents had been arrested (Fergusson & Horwood, 2002). Adolescents account for 9% of police arrests in the

United States (Federal Bureau of Investigation, 2014). Males are about four times as likely to be arrested as females. African American youth are disproportionately likely to be arrested as compared with white and Latino youth, who are similar in their likelihood of arrest, and Asian American youth are least likely to be arrested (Andersen, 2015; Federal Bureau of Investigation, 2014).

Adolescents' own reports, however, tend to suggest few to no gender or ethnic differences in delinquent activity (Rutter, Giller, & Hagell, 1998). Differences in arrest rates may be influenced by the tendency for police to arrest and charge ethnic minority youths in low socioeconomic communities more often than European American and Asian American youths in higher socioeconomic status communities (Rutter et al., 1998).

Most adolescents tend to show an increase in delinquent activity in early adolescence that continues into middle adolescence and then declines in late adolescence into early adulthood (Farrington, 2004). Although mild delinquency is common and not necessarily cause for concern, about one quarter of violent offenses in the United States, including murder, rape, robbery, and aggravated assault, are conducted by adolescents (Office of Juvenile Justice and Delinquency Prevention, 2014). Adolescents who engage in serious crime are at risk to become repeat offenders who continue criminal activity into adulthood. Yet most young people whose delinquent activity persists and evolves into a life of crime show multiple problem behaviors that begin not in adolescence but instead in childhood (Farrington & Loeber, 2000). Chronic offenders and those who commit more serious crimes are more likely to have their first contacts with the criminal justice system by age 12 or earlier (Baglivio, Jackowski, Greenwald, & Howell, 2014).

When biological and individual risk factors are coupled with challenging home and community environments, the risk for the childhood onset of serious antisocial behavior that persists into adulthood increases. Parenting that is inconsistent, either highly controlling or negligent, accompanied by harsh punishment, and/or low in monitoring can worsen impulsive, defiant, and aggressive tendencies in children and adolescents (Bowman, Prelow, & Weaver, 2007; Chen, Voisin, & Jacobson, 2013; Harris-McKoy & Cui, 2012; Lahey, Hulle, D'Onofrio, Rodgers, & Waldman, 2008).

Communities of pervasive poverty offer limited educational, recreational, and employment activities, coupled with access to drugs and firearms, opportunities to witness and be victimized by violence, and offers of protection and companionship by gangs that engage in criminal acts, all of which contribute to the onset of antisocial behavior (Chen et al., 2013; Chung & Steinberg, 2006; Hay, Fortson, Hollist, Altheimer, & Schaible, 2007). Exposure to high levels of community violence predicts delinquent activity (Jain & Cohen, 2013; Mrug, Loosier, & Windle, 2008). Low-income communities tend to have schools that struggle to meet students' educational and developmental needs, with crowding, limited resources, and overtaxed teachers (Flannery et al., 2005). Young people who experience individual, home, community, and school risk factors for antisocial behavior tend to associate with similarly deviant peers, which tends to increase delinquent activity as well as chronic delinquency (Evans, Simons, & Simons, 2014; Lacourse, Nagin, & Tremblay, 2003).

Fortunately, for most adolescents, delinquent acts are limited to the adolescent years and do not continue into adulthood (Piquero & Moffitt, 2013). Antisocial behavior tends to increase during puberty and is sustained by affiliation with similar peers. With advances in cognition, moral reasoning, emotional regulation, social skills, and empathy, antisocial activity declines (Monahan, Steinberg, Cauffman, & Mulvey, 2013). Preventing and intervening in delinquency requires examining individual, family, and community factors. Promoting authoritative parenting and close relationships with parents by providing training in discipline, communication, and monitoring fosters healthy parent-child relationships, which buffers young people who are at risk for delinquency (Bowman et al., 2007). High-quality

teachers, teacher support, resources, and economic aid foster an educational environment that protects young people from risks for antisocial behavior. A three-year longitudinal study following adolescents of low-income single mothers transitioning off welfare showed that involvement in school activities protects adolescents from some of the negative effects of low-income contexts and is associated with lower levels of delinquency over time (Mahatmya & Lohman, 2011). Economic, social, and employment resources empower communities to create environments that reduce criminal activity by all age groups and promotes the development of children and adolescents.

The psychosocial developments of adolescence leave a lifelong imprint on young people. Beginning the identity search, developing more complex and autonomous relationships with parents and friends, and exploring sexuality are important tasks for adolescence that serve as a foundation for development in the next period of life: early adulthood.

Thinking in Context 12.4

1. Using Bronfenbrenner's bioecological systems theory, how do adolescents' physical, cognitive, and social characteristics interact with their context to influence their likelihood of developing an eating disorder such as anorexia nervosa or bulimia nervosa? How might context influence treatment options?
 2. How might adults distinguish normative from atypical delinquent activity? For example, increases in some delinquent activities is somewhat normative during adolescence and will decline in late adolescence, and sometimes the activity continues and increases.
 3. Are there dangers in taking the perspective that some alcohol and substance use is common and simply a part of growing up? How should parents, teachers, and professionals respond to adolescent alcohol and substance use?
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Apply Your Knowledge 12.1

At 16, John recently had his very first alcoholic drink while at a party hosted by his best friend. Since then, John has begun drinking at parties every few weeks, though he usually stops after a couple of beers. Afterward, he always catches a ride with a friend or a taxi. Big for his age, John is popular in school and has many opportunities to socialize. Even so, he only goes out once a week or so because his football schedule keeps him busy, and he works hard to maintain at least a B+ average.

Tim, also 16, has at least one beer nearly every day—often more than one. He explains that parents, school, work, and simply meeting expectations are overwhelming and frustrating. Drinking is calming, a refuge from the stress of everyday life. Last year, Tim's best friend brought marijuana to a party, and Tim found that it was even better than alcohol; marijuana made him feel free. Tim smokes marijuana whenever he can, which is not often given that it is much more expensive than alcohol. Lately, Tim has found

that alcohol doesn't seem to make him feel as relaxed as it once did, so he's begun trying to obtain marijuana as often as possible. Sometimes Tim steals money—from his mother, job, even teachers—to fund a fun night out.

1. What experience does the average adolescent have with substances such as alcohol and marijuana? What is normative, statistically?
2. Describe correlates of substance use in adolescence. How do John's and Tim's experience compare with that of the typical adolescent?
3. Many aspects of development offer insights into adolescent risk behavior, such as substance use, delinquency, and sexual activity. How might changing relationships with parents, including monitoring, parenting styles, and conflict, contribute to adolescent risk behavior? What role might relationships and interactions with peers take?

Chapter Summary

12.1 Identify ways in which self-conceptions and self-esteem change during adolescence.

With cognitive advances, adolescents begin to use more abstract and complex labels to describe themselves. They evaluate themselves with respect to multiple dimensions and recognize that their qualities can vary with the situation. Global self-esteem dips in early adolescence. Favorable self-evaluations are associated with positive adjustment and sociability in adolescents of all socioeconomic status and ethnic groups, while low self-esteem is associated with adjustment difficulties.

12.2 Outline the process of identity development during adolescence, including influences and outcomes associated with identity status.

Adolescents are faced with the task of constructing an identity that is coherent and consistent over time. Authoritative parenting and close relationships with peers encourage adolescents to explore identity alternatives. Identity achievement is associated with high self-esteem, feelings of control, high moral reasoning, prosocial behavior, and positive views of work and school. Foreclosed and diffused identity statuses are associated with passivity and maladaptive long-term outcomes.

12.3 Explore changes in adolescents' relationships with parents and the contribution of parenting style and monitoring to adolescent adjustment.

Conflict between parents and adolescents rises in early adolescence and peaks in middle adolescence but takes the form of small arguments over minor details. Authoritative parenting fosters autonomy, self-esteem, and academic competence in adolescents. Authoritarian parenting inhibits the development of autonomy and is linked with poor adjustment. Parental monitoring promotes well-being and is a protective factor against risky behavior.

12.4 Compare and contrast the nature of friendship and dating during adolescence.

Adolescent friendships are characterized by intimacy, loyalty, self-disclosure, and trust. Friends tend to be similar in demographics and share psychological and developmental characteristics. Over time, friends tend to become more similar. Close friendships promote positive adjustment. Dating typically begins through the intermingling of mixed-sex peer groups, progresses to group dating, and then goes to one-on-one dating and romantic relationships. Early adolescents date for fun, but

in late adolescence, dating fulfills needs for intimacy and support and aids in identity development.

12.5 Differentiate the developmental progression of cliques and crowds.

During adolescence, one-on-one friendships tend to be cliques of about five to seven members who are close friends and share demographic and attitudinal similarities. In early adolescence, cliques tend to be sex segregated, but by mid-adolescence, cliques become mixed and create opportunities for dating. By late adolescence, the mixed sex clique tends to disappear. Crowds emerge in early adolescence. Crowds are reputation-based groups of adolescents who are classified by peers into groups based on perceived characteristics, interests, and reputation. Crowds decline in late adolescence.

12.6 Analyze how susceptibility to peer influence changes from early adolescence to late adolescence.

Peer conformity rises in early adolescence, peaks in middle adolescence, and declines thereafter. American youths tend to feel the greatest pressure from peers to conform to day-to-day activities and personal choices such as choice of clothes and music, appearance but also to engage in prosocial and positive behaviors and sometimes to engage in risky activities and adopt an antisocial stance.

12.7 Compare the factors that contribute to sexual activity, contraceptive use, and the transmission of sexually transmitted infections (STIs) during adolescence.

Sexual activity among U.S. adolescents has declined since 1990, and adolescents are waiting longer to have sex, yet sexual activity begins earlier in the United States than in Canada and Western Europe. Risk factors for early sexual activity include early pubertal maturation, poor parental communication and monitoring, sexually active peers, risky behaviors, and stressful homes and neighborhoods. Adolescents have higher rates of STIs than all other age groups and U.S. adolescents have higher rates of STIs than do those in nearly all Western nations. Although most adolescents receive education, most underestimate their own risks and know little about most STIs or how to protect themselves.

12.8 Discuss risk factors for adolescent pregnancy and influences on the adjustment of adolescent mothers and their children.

Despite a decline since 1990, the United States has one of the highest teen pregnancy rates in the developed world.

Adolescent mothers are less likely to achieve many of the typical markers of adulthood and are more likely to work low-paid jobs, spend more years as single parents, and are more likely to divorce. However, there is variability in outcomes. Infants born to adolescent mothers are more likely to be born preterm and low birth weight and show academic and behavioral problems. Positive adjustment in children is predicted by secure attachment, low maternal depressive symptoms, and positive parenting on the part of the mother.

12.9 Compare and contrast the risk factors for and treatments for adolescent problems such as depression and suicide, eating disorders, and substance use and abuse.

Rates of depression rise in early adolescence, and lifelong sex differences emerge, with girls reporting depression twice as often as boys. Hereditary factors are coupled with environmental factors to influence susceptibility to depression. Adolescents who are depressed are more likely to live in homes with depressed parents; to have experienced significant life events such as parental divorce, failure, or the loss of a friend; and, in girls, to have matured early relative to peers.

Anorexia nervosa and bulimia nervosa become more common in adolescence. Both have a genetic basis and are influenced by problems with impulse control, anxiety, and body dissatisfaction. Treatment includes hospitalization, individual and family therapy, nutritional education, and antianxiety or antidepressant medications.

Alcohol and substance use rises during the adolescent years into young adulthood. They may serve developmental functions but are associated with short- and long-term effects, such as accidents, academic problems, risks for dependence and abuse, and impaired neurological development. Alcohol and substance abuse is influenced by genetics but also contextual factors. Effective prevention and intervention programs provide adolescents with education; teach adolescents the skills to resist pressure, refuse offers, and cope; and educate parents as well.

12.10 Characterize normative delinquent activities during adolescence as compared with serious lifelong criminal activity.

Nearly all young people engage in at least one delinquent act during adolescence without coming into police contact. Rates of delinquency rise in early adolescence and decline in late adolescence. A minority of adolescents engage in serious crime and become repeat offenders who continue criminal activity into adulthood. Most adolescents whose delinquent activity persists and evolves into a life of crime displayed antisocial behavior in childhood, engaging in delinquent acts early, relative to their peers. Preventing and intervening in delinquency entails targeting individual, family, and community factors, such as promoting authoritative parenting, parental monitoring, high quality educational environments, and close-knit communities.

Key Terms

Actual self 000	Crowds 000	Ideal self 000	Perceived popularity 000
Anorexia nervosa 000	Cyberbullying 000	Identity 000	Parental monitoring 000
Autonomy 000	Dating violence 000	Identity achievement 000	Popular 000
Biculturalism 000	Depression 000	Identity diffusion 000	Self-harm 000
Body image 000	Ethnic identity 000	Identity foreclosure 000	Sexual identity 000
Bulimia nervosa 000	Familism 000	Identity moratorium 000	Sexual orientation 000
Cliques 000	Global self-esteem 000	Identity status 000	Sexuality 000

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