

Thriving Adolescents

Efforts to alleviate rates of violence inflicted by adolescents and efforts to encourage model social development necessarily must include adolescents' emotional (mental health) development. Adolescents' risk-taking, aggressive, delinquent and violent behavior, for example, consistently link to adolescents' lack of emotional health, particularly the most prevalent psychological dysfunction reported during adolescence—depression (Kowaleski-Jones, 2000; Rutter, Giller, & Hagell, 1998). Adolescents' mental health also relates to the extent they will engage in risk behaviors, which in turn influences their responses to challenges placing them at risk for negative emotional health outcomes (Cocozza & Skowrya, 2000; Larson, 2000). Many of the adolescents affected by violence have, or are at risk of developing, a mental health disorder (Porter, Epp, & Bryan, 2000). Likewise, adolescents' positive psychological health, such as their level of happiness, directly links to numerous forms of prosocial behavior, such as community service, altruism, creativity and leadership (Colby & Damon, 1995). Adolescents' healthy emotional development—the extent to which adolescents thrive—simply cannot be extracted from their effective social development.

Given the important role schools can and do play in fostering social development, schools also necessarily play a critical role in students' emotional development. Educational experiences and outcomes reciprocally influence emotional health and thus determine the extent to which adolescents emotionally thrive. The most robust research supporting links actually focuses on adolescents' failure to thrive. School environments that undermine basic psychological needs generate negative emotional responses, negative motivational beliefs and negative behaviors

(Eccles & Midgley, 1989). Schools also can create emotional distress to the extent that schools socialize adolescents in particular ways of making sense of their worlds. Implicit and explicit ways schools emphasize different ways of appraising one's sense of self and signify the purpose of schooling also impact how adolescents view themselves, their abilities, and thus their emotional development. Likewise, early academic problems (such as grade retention, poor motivation, and declining academic performance) predict a wide variety of subsequent emotional or behavioral difficulties that emerge in later adolescence, including drug use and abuse, delinquency, teenage pregnancy, and the failure to complete high school (Eccles et al., 1997). Of course, adolescents also obviously bring emotional difficulties to schools, and that emotional development impacts both adolescents' abilities to learn effectively and to engage competently with their social environment.

Regardless of the initial cause of failing to thrive in and out of educational settings, it does seem that the reciprocal interactions between emotional and educational problems eventuate in widespread comorbidity of academic and emotional difficulties as adolescents move through educational systems (Weist, 1997). Left ignored or addressed ineffectively, emotional difficulties compromise adolescents' ability to learn and become responsible and productive citizens. The effects on educational difficulties should not be underestimated. Approximately 25% of all 10- to 17-year-olds in the U.S. function behind their grade level in school (Roeser, Eccles, & Strobel, 1998) and up to 20% of students are retained at least once in their academic careers (Durlak, 1995). Emotional challenges also influence adolescents' decline in academic motivation and school engagement as they progress through school (Roeser et al., 1998). In addition to the broad impact of emotional development on motivation, adolescents also suffer debilitating emotional disorders that truncate their educational attainments, which affects about 7.2 million Americans (Kessler, Foster, Saunders, & Stang, 1995). Low academic motivation, and lack of support that fosters motivation, also accounts for the failure of students to even finish high school (Rosenthal, 1998).

Fostering adolescents' healthy emotional development undoubtedly constitutes a necessary, but frequently ill-addressed, component of effective socializing institutions. Current systems of care pervasively fail to serve adequately adolescents' mental health needs and do not even consider providing services that would allow adolescents to thrive. The ground-breaking Congressional Office of Technology Assessment's (1991) report on the state of adolescent health found that up to 20% of adolescents present emotional and behavioral disorders severe enough to warrant intervention, but less than one-third of that percentage actually

receive any form of mental health services. Other reports confirm that between 15 to 20% of adolescents are identified as needing, but not receiving, mental health services (Weist, 1997). Thus, despite high prevalence rates of mental health needs by public school students, society currently fails to respond. Reports examining adolescents' mental health do not even mention the nature of positive, thriving mental health, let alone try to index its existence.

The current failure to address adolescents' mental health needs and the necessity to address those needs in order to foster less violent and more model behavior leads to the need to link mental health concerns with broader school reforms aimed at educational outcomes. This chapter addresses the nature, extent, and opportunities to reform that link. The analysis first examines the nature of adolescents' mental health dysfunction and their positive mental health. The discussion then focuses on the peculiarities of adolescent development that challenge efforts to foster positive mental health, a discussion that serves as a springboard to discuss the role of schools in shaping mental health outcomes across adolescent development. As with previous chapters, the social science analyses provide the necessary background for a legal analysis of current and emerging efforts to address adolescents' mental health issues in school settings and the roles schools can play in fostering positive mental health.

ADOLESCENT MENTAL HEALTH: ITS DYSFUNCTIONS AND PROMOTION

Popular perceptions of and academic attention to adolescent development tend to focus on adolescents' negative responses to the significant changes and challenges associated with the adolescent period. The focus on disruptive transitions and negative outcomes, though, centers attention to only part of the adolescent experience. Transitions of this magnitude also bring the opportunity for positive growth. Commentators and researchers recently have begun to attach great significance to sites and opportunities that foster positive growth, a focus which promises to provide an understanding of mechanisms and processes by which adolescents reared in adverse and dysfunctional circumstances develop into competent and productive adults. Understanding adolescent mental health, then, requires an examination of both dysfunctional and optimal responses to developmental challenges. Much significance attaches to this examination. The analysis lays the groundwork to consider the extent to which and manner by which prevention programs and restructured

socializing institutions can provide opportunities to foster adolescents' resilience and optimal development.

MENTAL HEALTH DYSFUNCTIONS

The vast majority of adults view the adolescent period as more difficult in some ways than other periods of life and a period difficult for both adolescents and for the people around them (Arnett, 1999). Adolescents actually do exhibit conflicts, even to the point of serious dysfunctions, as they respond to normative challenges. Available evidence also indicates that conditions that led to the negative view of the adolescent experience actually increase as adolescents face new challenges and present a greater diversity of needs. This section examines trends in the nature of dysfunction adolescents experience and in our understanding of the roots of conditions leading to dysfunction.

Nature of Dysfunction

The most frequently reported symbol of adolescent development is their apparent experience of emotional turmoil. Research confirms the existence of emotional difficulty associated with the adolescent period. Adolescents report more extreme and negative moods than either preadolescents or adults (Larson & Richards, 1994). Adolescents also report higher rates of depressed mood than either children or adults, and their depressed mood peaks in midadolescence (Petersen et al., 1993). The extent of negative emotional experiences is highlighted by the persistent finding that depression constitutes adolescents' most common clinical diagnosis. Studies of prevalence rates of disorders that occur during the adolescent period reveal that the most common diagnosis is for unipolar depression, with a 20% prevalence rate over the adolescent period (Lewinsohn et al., 1993). Other studies reveal even higher rates; a highly cited evaluation of 24 studies of nonclinical samples of adolescents concluded that depressed mood above scores thought to be predictive of clinical depression apply to over one-third of adolescents at any given time (Petersen et al., 1993). Although adolescents may experience swings in moods, their experiences do tend to be marked by negative experiences that reach clinical levels.

Adolescents' familial relationships also provide a common domain of adolescent functioning often perceived as an area wrought with dysfunction. The popular image of adolescence suggests that adolescents' familial relationships are marked by excessive and continued conflict. Conflict with parents does seem to increase during early adolescence and typically

remains high until its decline during late adolescence (Laursen, Coy, & Collins, 1998). Although conflict may be more frequent in early adolescence, intensity peaks in midadolescence. Despite high rates of conflict, however, parents and adolescents do tend to report that their relationships are overall positive, that they share a wide range of core values, and that they retain mutual affection and attachment (Arnett, 1999). The majority of families do not report continued and excessive conflict. The adolescent period does not predict serious conflict with parents; however serious conflict with parents does predict an increase in adolescents' engagement in numerous risk activities that lead to physical and mental health hazards.

By far, the greatest hazards adolescents face emerge from the risks they take. Adolescents engage in risk behavior at greater rates than either children or adults. As a result, adolescents, especially those in their late adolescence, reveal the highest prevalence rates of a variety of behaviors that carries the potential for harm to themselves or others. Rates of crime, substance use, automobile accidents, sexually transmitted diseases all appear higher during adolescence (Moffitt, 1993; Arnett, 1992). These risks and associated hazards account for the primary causes of adolescents' ill health and early death. For example, according to the Centers for Disease Control, only five behavior-based causes account for over three-quarters of all mortality and a great deal of morbidity in American youth: motor vehicle crashes, homicide, suicide, preventable injuries, and sexual activity (Centers for Disease Control, 1998). Research consistently reveals that the main threats to adolescents' health are the risk behaviors they choose (Resnick et al., 1997).

Despite findings emphasizing that adolescents' unhealthy development emerges from the behaviors they engage in, it is important to recognize enormous individual differences and the relatively low percentages of disorders the behaviors actually indicate. For example, problems regularly attributed to adolescents typically include drug use, acting out, and eating disorders. Yet, prevalence rates for several diagnostic disorders among adolescents reveal that only 8% ever meet the criteria for any type of substance use disorder, 7% meet criteria for any form of disruptive behavior disorder, and less than 1% meet criteria for any type of eating disorder (Lewinsohn et al., 1993). Far from a period of excessive rates of chronic and serious dysfunction, the adolescent period does not appear more dysfunctional than other periods.

Although it is important not to diminish or trivialize problems regularly associated with adolescents, such as the seriousness of delinquency, eating disorders, and other problems, the current understanding of adolescent mental health and the image of adolescence suggest important



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