ADOLESCENT HEALTH-RISK BEHAVIOURS, EMOTIONAL AUTONOMY AND IDENTITY FORMATION

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ABSTRACT

Adolescent health-risk behaviours are on the rise globally and their prevalence is also alarmingly increasing in Asian countries. The trends of health-risk behaviours present a gory picture of adolescents all over the world. Today’s adolescents indulge in tobacco, alcohol and other drug use, irresponsible sexual behaviours, unhealthy dietary behaviour and physical inactivity. As period of adolescence is becoming longer day by day and opportunities to go astray are many, adolescent health-risk behaviours are rising. The present research is an attempt to conceptualize adolescent health-risk behaviours in the light of adolescent psychosocial developmental task viz. identity formation and the development of emotional autonomy. Classic and recent viewpoints regarding the implications of emotional autonomy for adolescent development are discussed. Also, it becomes evident that identity achievement predicts healthy outcomes for adolescents, while identity diffusion, inability to conceptualize one’s self and exploration of various life patterns is associated with faulty lifestyles in adolescents.

Key Words: Health Risk Behaviours, Identity Formation, Emotional Autonomy

Health can be looked at as a general condition of physical, mental, social, and spiritual well-being. Health professionals, researchers, social workers and psychologists all over the world are devoted to the cause of optimizing health and promotion of wellness. Though recent advancements in knowledge are
creating newer understandings about the issue, ironically a major segment of society is willingly embracing health-risk behaviours. Such dysfunctional patterns and lifestyles are prevalent in all age groups, but markedly these maladaptive behaviours are proving to be a scourge in the younger age group, especially the adolescents.

The adolescents’ risk-taking has its roots in antiquity, since Greeks and Romans have also complained about the reckless behaviour of young people. However, the issue assumes enormous significance today, as in the contemporary society, adolescence is becoming increasingly longer. Sexual maturation, with its changes and reorganizations is more precocious than in the past, while entering adulthood has been postponed for several reasons such as preparing oneself through higher educational degrees and fulfilling job requirements. This extended period of adolescence signifies less precise references, less definite tasks and goals concerning the transition towards sexuality and other adult roles (Peterson, 2000). Today, the choice to experiment with a number of things is possible and social ‘clocks’ which regulate the structured expectations of society pertaining to an age group are milder, softer, offering the individual the freedom to chalk out one’s own developmental path. For some, the unique journey towards adulthood may be fruitful and satisfying, while for others, this may be laden with risks which takes a toll on physical and mental health of the adolescents.

Risk-behaviour has been defined as behaviours that increase the likelihood of adverse physical, social and psychological consequences. Zuckerman (1994) defines risk as ‘the appraised likelihood of a negative outcome for behaviour’. Healthy risk-taking has been viewed as a positive tool in adolescents’ life for discovering, developing and consolidating his or her identity. However, as the frequency and intensity of risk-taking increases, risk-taking no longer serves a positive developmental purpose and becomes problematic (Irwin & Millstein, 1991). It is the extent to which an adolescent engages in health-risk behaviours, and the overall impact of these behaviours on personal health and development that are of increasing public health concern. Centre for Disease Control and Prevention (CDC) has identified six health-risk behaviours as being particularly salient for the development of optimal health, namely (a) behaviours that contribute to unintentional injuries and violence, (b) tobacco use, (c) alcohol and other drug use, (d) irresponsible sexual behaviour, (e) unhealthy dietary behaviours, and (f) physical inactivity.

When adolescents take risks, the consequences can be negative, not only for one’s own well-being but also for the others. Road accidents can occur while driving drunk, smoking can lead to cancer, and unprotected sex can lead to unwanted pregnancies and disease and so on. Health-risk behaviours generally do not occur in isolation. Research indicates that adolescents who engage in one high-risk behaviour are likely to engage in other such behaviours (Irwin & Millstein, 1991). Health-risk behaviours occur in combination with one another,
but it is often unclear which behaviour comes first (Eisen, Pallito, Bradner 2000). Substance use by adolescents will initiate sexual activity, and relatedly, sexually experienced adolescents are more likely to initiate substance use (Mott & Haurin, 1988).

Unhealthy risk-taking behaviours among adolescents are on the rise globally and their prevalence is also alarmingly increasing in the Asian countries (Corraro, Guidon, Sharma and Shokoohi, 2000). The trends of health-risk behaviours present a gory picture of adolescents all over the world. The majority of adolescents aged 15 to 19 years in Canada and the US report having had sexual intercourse at least once. 23.9% and 45.5% of adolescent females from Canada and the US, respectively report having two or more sexual partners in the past one year. CDC Youth Risk Behaviour Surveillance of 2005 in US, published in 2006, reports that 47% of high school students had had sexual intercourse, and 14% of high school students had four or more sex partners during their life. 34% of currently sexually active high school students did not use a condom during last sexual intercourse. In US, each year there are approximately 19 million new STD infections, and almost half of them are among youth aged 15 to 24 (Weinstock, Berman & Cates, 2004). In 2004, an estimated 4833 young people aged 13-24 in the 33 states reporting to CDC were diagnosed with HIV/AIDS, representing about 13% of the persons diagnosed that year (CDC HIV/AIDS Surveillance Report 2005). Jones, Foreest, Goldman (1985) reported the highest teenage pregnancy rate of any developed nation to be the highest in the US, with nearly one million teenage pregnancies each year. In Brazil, Cardoso and Verner (2007) report that 42% had their first sexual relationship, when they were 15 years old or younger (16% when they were 13 or younger). As an Indian evidence, Singh, Schensul and Gupta (2004) suggest that 2.3% of adolescents are sexually active and involved in penetrative sex without knowledge about safe sexual practice. 1993-94 study conducted by Family Planning Association of India among educated urban youth revealed that the average age of first sexual experience among 15-19 year olds was 14.8 years for males and 16.1 years for females; another study reports that just 38% of young men and 63% of young women disapproved of premarital sexual relationship (Jejeebhoy, 1998). Such sexual behaviours and attitudes become all the more risky as the adolescents are ill-informed about sex. In a Goan survey, Andrew, Patel and Ramakrishna (2003) found that for the adolescent students, the most common person from whom information regarding sex was obtained was a friend (72% of boys and 63% of girls).

Another health compromising behaviour which the adolescents indulge in is the tobacco. Tobacco smoking among adolescents is of public concern because of the immediate and long-term health consequences like asthma, chronic coughs, chronic obstructive airways disease and cardiovascular diseases. It is estimated that approximately 55500 adolescents start using tobacco everyday in India,
joining the 7.7 million young people under the age of 15 who already use tobacco (Barai - Jaitly & Sen, 2003). Reddy, Arora and Peery (2002) in a study of Delhi students aged 11 to 14 years, found that 9.3% of students reported having experimented with smoking. A study from Mangalore amongst students showed prevalence of smoking to be 33.1% with a higher proportion of smokers chewed pan and consumed supari (Sajjan, Chacko, & Asha, 2003). The prevalence of cigarette smoking among school adolescents in India using the Global Youth Tobacco Survey data of 2000 and 2001 have reported to be 0.5% in Goa, 22.8% in Mizoram. On the basis of National Family Health Survey (1998-99) of India, Agrawal (2005) concludes that as we move from larger cities to smaller ones, and further to countryside, the propensity of risk-taking behaviours (tobacco chewing, smoking, drinking) increases among adolescents of all age groups.

According to the results of Global Youth Survey Project conducted on school children of age groups 13-15 in 12 countries (Barbados, China, Costa Rica, Fiji, Jordan, Poland, Russian Federation, South Africa, Sri Lanka, Ukraine, Venezuela & Zimbabwe), current cigarette smoking was found to vary from 10% to 33% and ever-smoked from 15% to 70% across different countries. In Russian Federation, Sri Lanka and Ukraine, smoking was found to be more common among boys than in girls, whereas it was more common among girls in China, Fiji, Jordan and Venezuela (Warren, Riley and Asma 2000). Warren et. al. (2000) estimated that if current smoking trends continue, tobacco would kill nearly 250 million of today’s children.

Equally alarming are the trends of alcohol/drug use worldwide. In studies on American youngsters, it has been reported that 45% of older adolescents have tried an illegal drug, nearly 90% have tried alcohol (Harrison & Poettizer, 1996; Weinberg, Redhert, Colliver & Glantz, 1998). Ray (2004) has reported that in India 5-10% of substance users are 14-15 years olds. Kushwaha, Singh, Rathi et. al. (1992) reported prevalence of psychoactive substance abuse to be 25% in slum areas and 18% in college students in Indian Sample. Saluja,Grover, Tripathi et. al. (2007) while studying North Indian adolescents of age less than 18, at Drug De-addiction and Treatment Centre report that the commonest used primary class of substance was opioids (76.2%) and the commonest used opioid was heroin (36.5%). 54.2% were also nicotine dependent. The mean age at first use of the primary substance was 14.8 ± 2.15 years (range 5-17.5 years)

In US, marijuana is the most commonly used illicit drug. In 2001, about 38,000 high school seniors in the US reported that they crashed while driving under the influence of marijuana (O’Malley & Lloyd, 2003).

Adolescents commit various intentional and unintentional injuries, and most of them are carried out under the effect of alcohol/drugs. According to Youth Risk Behaviour Survey in the US, unintentional and intentional injuries constitute 70% of the causes of death among youth aged 10-24 years (Eaton, Kana
Kinchen, et. al., 2006). Intentional injury is defined as a deliberate harm to self or others, such as homicide, and violence. Notably, the CDC indicated that suicide is a behaviour that contributes to violence, placing suicide in the category of intentional injury. Unintentional injury occurs primarily through automobile accidents during the teen years. Toumbourou and Gregg (2002) found that 12% of Australian 8th Grade students had experienced suicidal thoughts or had harmed themselves deliberately. Cases of school shoot-outs, school gangs, school violence are evident in India as well.

Another health-risk behaviour which is spreading its wings among adolescents are the unhealthy dietary patterns, which can potentially prove havoc for an individuals’ health. Hill (2002) states that adolescence is the peak time for body-image dissatisfaction. Adolescents, especially females are very conscious of their weight and are strongly influenced by the appearance of many high-profile celebrities (Mooney, Farley and Strugnell et. al., 2004) and seem to know lifestyles of all leading film figures, ranging from what they eat to how and when they exercise. Dissatisfaction with ones own body image leads to prolonged calorie restriction. Shepherd and Dennison (1996) reported that 30% of female adolescents in UK were dieting- the side effects of which can be irritability, poor concentration, anxiety, depression, mood swings, tiredness etc. Dieters are eight times more likely than non-dieters to fall into a trap of anorexia and bulimia nervosa (Patton, Johnson-Sabine, Wood et. al., 1990). On the flip side it has also come to light that growing number of adolescents are becoming obese and super obese, a lot of which can be attributed to excessive TV viewing (Dietz, 1993), eating junk food, and physical inactivity.

Risk-taking comes naturally with adolescence. Adolescence is a stage associated with substantial change in self. Adolescence disequilibrates an individual with its plethora of changes in the physical, cognitive, emotional and social domains. In studying adolescent risk-taking many explanatory models and points of view have emerged. Some models address the interactions of all these factors (Jessor 1992; Irwin, 1993).

Adolescence becomes a period of elevated vulnerability to risk-taking because of a disjunction between novelty and sensation seeking (both of which increase enormously at puberty) and the development of self-regulatory competence (which does not fully mature until early adulthood). Factors like ‘personal fable’ - a belief in one’s immunity from negative consequences (Elkind, 1967), sensation-seeking (Zuckerman, 1964), also explain the need for risk-taking. Biological, psychological, and social stresses during adolescence often lead to ‘problem’ and health-endangering behaviours as adolescents try to cope with these stresses (Ingersoll & Orr, 1989). According to Jessor and Jessor (1977), adolescents purposely seek out risks. They suggest that such behaviours permit adolescents to (i) take account of their lives, (ii) express opposition to adult authority and conventional society, (iii) deal with anxiety, frustration, inadequacy and failure,
IV) gain admission to peer groups and demonstrate identification with a youth subculture, (v) confirm personal identity, (vi) affirm maturity and mark a developmental transition into young adulthood.

According to developmental perspective, risk-taking is viewed in light of biopsychosocial changes that take place during adolescence. Risk-taking is seen as a way of coping with normal developmental tasks such as identity exploration and achieving autonomy (Lavery, Siegel, Cousins & Rubovits, 1993) and difficulties faced in making decisions (Furby & Brythmarons, 1992). One aspect of the transition from adolescence to adulthood is the development of autonomy (Havighurst, 1948). The developing cognitive processes facilitate evaluation of possibilities and desires, development of personal values and definition of personal goals. Adolescents start moving towards self-governance, regulation of one’s behaviour, acting on personal decisions, independent reasoning without excessive reliance on social validation, and relinquishing dependencies on significant others. The ‘storm and stress’ model of emotional autonomy, embraced by a majority of modern researchers, portrays adolescents as deeply immersed in an emotional struggle with an alliance to either parent or peer. Accordingly, young adolescents become autonomous by learning to distance themselves emotionally from their parents (Freud, 1969). The classic perspective of Anna Freud (1958) that conflict between adolescents and parents is normal and necessary for the developing autonomy of adolescents. Adolescence was described as a time in which striving for autonomy takes the form of detachment or individuation from parents. In particular, these theorists believed that adolescents are rebellious and disagreeable in order to decrease connections with, reliance on, and social influence of primary caregivers. Similarly Steinberg and Silverberg (1986) suggested that the development of emotional autonomy in the form of increasing individuation, independence from parents, deidealization of parents and increasing perception of parents as people who have various roles beyond parenthood. The development of emotional autonomy may represent not only casting off infantile ties but a more general reluctance to rely on the parents, and may relate negatively to parent-child closeness and family cohesion as experienced by the adolescent. Early autonomy from parents destabilizes adolescents and makes them dangerously prone to peer pressure. As children develop emotional autonomy from parents, they become more dependent on peers in various dimensions of decision-making. Adolescents’ peers may begin to compete with and sometimes replace the family as the point of reference (Freiberg, 2000). Another means of declaring this autonomy could be with the experimentation of sex, drugs, and alternative life styles.

Ryan and Lynch (1989) have also viewed the development of emotional autonomy as detachment and noted although detachment could result in some increases in self-reliance, it might also result in the loss of valuable connections to others, leading to other problems such as a lack of a consolidated identity.
lower self-esteem, and problem-behaviour. Consistent with these findings, Lamborn & Steinberg (1993) found that adolescents who display high emotional autonomy may also be more likely to be engaged in delinquent activities. Frank, Pirsch and Wright (1990) found that deidealization was linked to adolescents feelings of insecurity. As adolescents shift away from their identifications with their parents and gradually move towards autonomy, parents no longer fulfill the roles of idealized adult figures, and this creates a space into which media figures can enter. Media figures play an important part in this development, sense they offer a variety of possible selves that a young person might wish to try out, and provide exemplars “of how to think and feel in different circumstances” (Larson, 1995).

Matos Barbosa, Almeida and Costa (1999) have also suggested autonomous qualities to be related to heightened feelings of insecurity. Non-dependency on parents might be stressful too as parents are not used as a resource. Beyers and Goosens (1999) also believe that the process of emotional autonomy could be stressful for adolescents especially for those caught in the middle of the transition.

The detachment perspective of emotional autonomy and its henceforth implications for adolescent well-being have been debated upon enormously and researchers have suggested that consequences of adolescent emotional autonomy differ in the context of different parent-adolescent relationship. Various researchers are of the view point that adolescents need not detach themselves from their parents to develop emotional autonomy. Rather, emotional autonomy can go hand in hand with parental connectedness. Hill and Holmbeck (1986) have proposed that emotional autonomy refers not to freedom from others (e.g. parents) but freedom to carry out actions on the adolescents own behalf while maintaining connections to significant others. Majority of adolescents’ and their parents get along well most of the time, and that conflict/rebellion may not be a necessary feature of development of adolescent autonomy. Though psychic and interpersonal tension may alter the relationship between the parents and the adolescents, but it may not cut -off their emotional bonds. There is a transformation and not a breaking off of family relationships, (Offer, 1969). Contrary to classic viewpoints, autonomous adolescents report being close to their parents, enjoy doing things with their families, have fewer conflicts and feel free to turn to parents for advice (Kandel & Lesser, 1972).

Emotional autonomy in the absence of parental support for autonomy or in conjunction with poor or dysfunctional parent-child relationship may have bad repercussions for adolescent psychological development and adjustment. Noom, Dekovic and Meeus (1999) indicated that higher levels of emotional autonomy in combination with poor relationship with father (and good relationship with peers), fosters behavioural problems in adolescents. Garber and Little (2001) found that emotionally detached adolescents in absence of parental support results in negative outcomes of emotional autonomy. Young people experience
more distress and difficulties in school, become more susceptible to peer pressure and have more problems with deviant behaviour when they report that their parents do not know or understand them. When adolescents report that their parents are high in behavioural and psychological control, they have lower academic grades, and have more problems with alcohol and other substances, or show delinquent behaviour (Eccles, Diana, Kari et al., 1997; Gray & Steinberg, 1999). Similar views have been expressed by Lamborn and Steinberg (1993).

On the contrary, adolescents develop better when caregivers are providing increasing opportunities for discussions, decision-making, and choice. Noller (1995) and Ryan, Deci, and Grolnic (1995) observed that within secure environments, parental encouragement of autonomy facilitates adolescents easier transition into adulthood and healthy development. Fulgini and Eccles (1993) also found that adolescents who had fewer decision-making opportunities in the family were more likely to seek advice from peers (rather than parents) and to be more oriented to peer opinion and advice than adolescents who were given more decision-making opportunities by their families.

Another psychosocial developmental task of adolescence-identity formation can be an important predictor of adolescents’ indulgence in health- risk behaviours. Various changes during adolescence propel an individual to discover his true self, to search for a self-definition, or in short-find his identity. The adolescent in this process, tries on a number of possible selves before committing to a single set of values, beliefs, ideologies. According to Erikson (1950) the sense of identity is the individual’s accrued confidence that his inner sameness and continuity are matched by the inner sameness and continuity of his meaning for others’ Waterman (1984) defines identity as a ‘clearly delineated self-definition comprising the goals, values and beliefs to which a person is unequivocally committed’. Identity, according to Josselson (1987) is a ‘dynamic fitting together of parts of the personality with the realities of the social world so that a person has a sense both of internal coherence and meaningful relatedness to the real world.’ Kroger (1989) has noted that identity must be defined ‘as a balance between that which is taken to be self and that considered to be other’. Erikson (1950, 1968) proposed that it is during adolescence -the fifth stage of human life -that one confronts the challenge of ego identity versus role confusion. His theory of identity development provides a useful theoretical framework within which a variety of data about adolescent problems, behaviours and attitudes can be integrated and interpreted. The construct of identity is discussed by Erikson (1968) in his eight stage theory of psychosocial development, each stage constituting a unique developmental challenge. According to Erikson, stages progress in a definite order that is linked to social expectations and body maturation. The psychosocial crisis rests upon and may modify the outcomes of all preceding stages. At the same time, each crisis incorporates the forerunners
of issues and stages. For adolescents, the crisis is between identity and role confusion. This crisis involves balancing the desire to try out many possible selves and the need to select a single self. Thus, the adolescents struggle to achieve an identity that will allow them to become a part of the adult world. More generally, a sense of identity implies a felt inner cohesiveness from which confident decisions and actions may proceed. In this connection, Erikson (1959) speaks of identity as a ‘feeling of being at home in one’s body’, ‘an assuredness of anticipated recognition from those who count’, ‘a sense of knowing where one is going. Ego identity provides a stable frame of reference, or anchor point from which the young person can confidently proceed to enter society and assume adult responsibilities. It is also suggested that the concept of ego identity implies a way of ‘being in the world’ in that it has to do with how one establishes his or her place in the world and envisages a meaningful world. The ego-virtue gained with a successful mastery of the identity stage is the sense of fidelity or purpose in life. The virtue of fidelity is the capacity to be loyal to a vision of the future, and a need to be true to a variety of pursuits more or less sanctioned by the society.

Identity functions to provide the structure for understanding who one is; provides meaning and direction through commitments, values and goals; provides a sense of personal control and free will; strives for consistency, coherence and harmony between values, beliefs, and commitments; and enables the recognition of potential through a sense of future, possibilities, and alternatives choices (Adams & Marshall, 1996), whereas inability to resolve this crisis results in confusion, isolation and a negative life orientation.

Guided by Erikson’s framework, Marcia (1966) suggested four discrete ordinal levels of ego identity i.e. identity diffusion, foreclosure, moratorium and identity achievement, along the dimensions of exploration and commitment. Generally, the process of identity development begins with identity diffusion. Here, commitment to an internally consistent set of values and goals is absent, and exploration is missing. People in identity diffusion tend to follow the path of least resistance, and may present as having carefree, cosmopolitan lifestyle, and/or as being empty and dissatisfied. Herein, an individual is like an interpersonal chameleon, with no inner core of identity, fitfully reacting in all ways to all people. This kind of a person is highly variable in his behaviour and is plagued by self-doubt and despair for he has no internal reference which can affirm his continuity and self-integrity. Moratorium status refers to the process of forging identity-occupational, interpersonal, and ideological commitments, from the myriad of possibilities available. The person in moratorium status is intensely preoccupied with exploring options and working towards commitment. Identity foreclosure represents a high level of commitment following no exploration. People who follow the foreclosure pattern adopt a single set of values and goals, usually those of their parents.
Identity is achieved when adolescents commit themselves to various ideological and interpersonal spheres of life viz. academics/occupational ideas, religion, politics, life-style philosophy, friendship, recreation and relationships with opposite sex after passing through a period of exploration regarding these issues. This commitment to significant life concerns not only gives a sense of purpose and direction, but also protects one from diffuseness and confusion regarding one’s self. A lack of concern about one’s search for a true self or inability of the individual to negotiate a self definition lays grounds for a host of problems for adolescents.

The search for identity is triggered and propelled by the various changes that dovetail at the beginning of the adolescence. For the first time, a person starts questioning ‘whom am I’, ‘what’s the real me’? The search for identity involves experimentation and exploration of the various options available to oneself. Researchers have no doubt considered exploration, experimentation, and testing one’s boundaries, quite normative. There is also some empirical evidence that abstainers are not the best adjusted adolescents (Shedler & Block, 1990). Pape and Hammer (1996) have also underlined that individuals with a ‘dry’ adolescence tend to experience delayed adoption of adolescent habits (drinking) and conversely individuals with a ‘wet’ adolescence are likely to calm down when they enter adult age. However, there is a fine line of distinction between normative and problematic exploration. The experimentation may become problematic when the adolescent is overwhelmed by the plethora of choices, does not have enough personal and environmental resources to help him/her in sailing through the turbulent times, or when he/she is unable to crystallize commitments keeping in mind the social reality.

Research suggests that the identity status of moratorium, wherein the adolescent is in the process of exploration, but has not yet made firm commitments, is a vulnerable status for problematic behaviour. It is a period of delay before making commitments; different roles and selves are tried out, values and interests change, and relationships with others fluctuate. It is a time of skepticism and change; adolescents in psychological moratoria are somewhat dissatisfied with their perception of self and the attendant uncertainty about life-choices is often accompanied by considerable anxiety. As a result it has been considered as the least stable identity status (Marcia, 1993; Waterman, 1999) and is linked to problem-behaviour during adolescent years (Erikson, 1968; Hernandez & DiClemente, 1992). The exploration and experimentation may in fact be realised through different behaviours- for instance organizing a holiday with friends, having a boyfriend or a girlfriend, or using marijuana or trying alcohol.

Equally problematic is the identity status of diffusion, wherein an individual has not yet made any firm commitments to life goals and is not even bothered by any serious life issues. This status is characterized by confusion regarding
social and occupational roles, and avoidance of commitment. Herein an individual is an interpersonal chameleon, with no inner core of identity, fitfully reacting in all ways to all people and situations. These individuals deploy diffuse/avoidant identity style which is associated with self-handicapping behaviour, other-directedness and maladaptive decisional strategies (Berzonsky, 1994). According to Marcia (1964), members of the identity diffusion status range from the playboy type who shuns responsibility and seeks immediate gratification to the schizoid type with disorganized thought processes. The adolescent in identity diffusion status has been considered as a ‘rudderless ship’ and is often involved in a number of maladaptive behaviour patterns.

It has been reported that identity diffusion is associated with suicidal tendencies in adolescents (Ball & Chandler, 1989; Bar-Joseph and Tzuriel, 1990). The status identity diffusion has been found to be associated with alcohol abuse, drug abuse, cigarette smoking and even the use of psychoactive substances during adolescence (Marcia, 1980; Jones, Ross & Hartmann, 1992). Across a number of studies it has been revealed that individuals in the diffusion status are the most emotionally disturbed (Donovan, 1970; Clancy & Dollinger, 1993). Cramer (2000) reported that in diffused identity status males, instability in their personality along with low self-esteem contributes to their anxiety and depression. In turn this depression occurs in conjunction with an antagonism towards others that may be expressed in rebellious acting-out. Similarly, Bunt (1968), Gruen (1960), Marcia (1967) have also shown low self-esteem to be the consequences of diffusion status—children with low self-esteem are likely to be vulnerable to drug use including the tobacco. As smoking behaviour is associated with maturity and adulthood, tobacco may serve to promote self-esteem (Lynch & Bonnie, 1994).

Marcia (1966, 1976) also found diffused subjects to be most disturbed, however, they were typified more by apathy and a lack of engagement than anxiety. Sandhu and Tung (2004) have also observed, that identity diffusion contributes to adolescents’ alienation. Research also shows that identity diffuseness is also characterized by a tendency to avoid coping directly with problems (Grotevant & Adams, 1984), a reliance on other-directed problem-solving strategies (Berzonsky, 1988) and behavioural reactions determined by hedonic and situational consequences.

Also, youth who are unable to consolidate a sense of identity are vulnerable to fall into a trap of health-compromising behaviours. Butman and Arp (1990) proposed that important dimensions of adolescent depression are linked to unresolved struggle of identity formation process. Cassell (1990) also reports that when the individual fails to achieve identity, a void emerges that often cause persons to turn to cigarettes and drugs. Erikson (1968) also maintained that youth who turn to delinquency do so, in many instances because they are unable to resolve key psychosocial tasks. Schwartz, Thompson, and Johnson (1982)
report that a weak sense of identity is related to subliminal eating disorders in females. Sparks (1993) also found that women with eating disorders were more identity diffused and were less identity achieved than were control subjects. Wheeler, Wintre, and Polivy (2003) have also reported that diffuse-avoidant identity style is associated with greater disordered eating. On the contrary, an integrated identity fortifies the ego and strengthens its defenses to cope with problems. One who has achieved identity has a fundamentally positive view of oneself as a capable and a valuable individual and a positive outlook in life. He/she is capable of assuming independent responsibility for one’s thinking, decision-making, work, life style, values ideologies and sexual component of loving (Banerjee, 1985). Similarly, foreclosure status has been found to be an adaptive status, especially for women. It has been found to be associated with positive mental health, less anxiety, and opposition to drug use (Marcia, 1980). Foreclosed adolescents have made commitments to life tasks according to the parental expectations and desires. They derive security from being under the tutelage and shadow of their parents. Parental approval for every behaviour becomes necessary for them which in a way protects them from maladaptive behaviour patterns.

Seemingly, adolescent health-risk behaviours are to a large extent related to various changes related to self during this developmental period. Adolescents seek greater autonomy, which can deviate them from the mainstream and make them dangerously prone to peer pressure. As is evident from the review, adolescents need not sever ties with their parents in order to be emotionally autonomous. Emotional autonomy attained through parental support predicts healthy outcomes for adolescents. Also it stands out from the review that process of identity formation can be equally stressful for adolescents and not knowing ones direction and place in life determines unhealthy lifestyles in adolescents. The significant others in the child’s life should ensure the former’s hunt for suitable life opportunities and should support their quest for identity.

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