

# EFFECTIVENESS OF SOCIAL CHANGE ON ADOLESCENT BOYS AND GIRLS

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## ABSTRACT

The process of socialisation as it takes place in the lives of children and adolescents, including its development and functioning, with a specific focus on the socialisation processes and their effects. The following theoretical perspectives are taken into consideration: (a) how children and adolescents learn social roles; (b) the role that agency plays in social development; (c) the social contexts in which socialisation takes place; (d) socialisation over the course of one's life; and (e) how socio-historical change influences the socialisation process. In this article, a wide variety of research methods that are applicable to the study of young people, including, but not limited to, experiments, survey techniques, observational and ethnographic research, interviews, and mixed method research, are dissected and analysed. It is essential to investigate the social contexts in which the process of socialisation takes place. Families, groups of friends and other social networks, places of employment and educational institutions, cities and neighbourhoods, and social and cultural variables are all included in these settings. This research places a significant amount of emphasis on the impact that early socialisation has on future experiences, such as an individual's identity as well as their behavioural and educational outcomes, and it does so by examining the relationship between the two. This section discusses both developing areas of inquiry and potential future lines of inquiry that may be pursued.

**Keywords:** *Socialization, adolescence.*

## INTRODUCTION

Societies are collective societies that may be identified by the complex rules and hierarchical structures that they employ. People go through a process known as socialisation, in which they acquire used to and take on the rules, values, practises, and behaviours of a shared social group. This process takes place throughout the course of their lives (see Lutfey& Mortimer, 2006; Parsons, 1951). The degree to which children are taught how to participate in society and still maintain their place within it has major repercussions not just on their personal development but also on the kinds of lives they will go on to lead in the years to come.

Not only are the social norms that are taught to children and young adults specific to the countries and regions of the world in which they are acquired, but they are also specific to the historical eras in which those norms emerged and the social groupings that exist within larger civilizations. This is an important point to keep in mind. The socio-historical environment is an essential component in the process of socialising children and adolescents, both in terms of their standing in society (in comparison to that of adults) and the responsibilities they play in their communities. This is true for both the standing that children and adolescents occupy in society as well as the roles that they play in their communities. During the course of the past fifty years, formerly limiting social categories like gender and ethnicity have become less

restrictive. Nevertheless, each of these social categories is associated with its own distinct set of social norms and expectations, in particular with relation to the educational endeavours and career pathways that one may pursue. It is also extremely essential to keep in mind that individuals of the same "society" might not necessarily feel as though they belong to the same dominant culture as the rest of the members of the group that they are a part of. This is something that has to be kept in mind. Studies on socialisation theory have a tendency to place a greater emphasis on the role that "broader society" plays in the process; however, people frequently encounter concurrent socialisation pressures from both the dominant culture and marginalised subcultures. Notably, studies have demonstrated the socialising impact of teenage peer cultures, as well as the influence of their parent cultures, in the replication of socioeconomic class and other types of social division (S. Hall & Jefferson, 1976; Willis, 1977).

The formative years of childhood and adolescence are the focus of this chapter's investigation of the processes and results of socialisation throughout those years. The first section of this chapter is dedicated to an analysis of how socialisation theory may be used across the lifetime. In this article's second section, we take a high-level look at the research inquiry approaches that are relevant to the study of socialisation. The third section is devoted to an in-depth discussion of the conditions in which the child was socialised, beginning with those that are immediately next to the youngster and progressing farther and further away. After this, an examination of socialisation is carried out in terms of the influence it has on subsequent experiences. These latter experiences include the creation of an individual's identity, their behaviour, and their education. In conclusion, we are going to discuss about possible future avenues of investigation.

### **Childhood and Adolescence**

Throughout the course of the development of socialisation, children have been represented either as passive recipients of socialisation messages or as active participants in the process of adjusting to various aspects of society in a variety of different ways (Corsaro, 2011). Theories of passive socialisation centre their attention on the malleable child who can be moulded in the image of society and serve as their primary research subject. Individuals reach maturity through the process of adjusting to the numerous environmental situations in which they find themselves, as postulated by Bronfenbrenner's ecological model (1977), which was developed in 1977. These environmental settings take the shape of concentric rings of influence, starting with the family and expanding outward to include neighbourhoods, schools, and the cultural forces of society. The concentric rings of influence begin with the family and begin with the family. In a manner that is analogous, Pierre Bourdieu (1984) describes individual socialisation as a process through which people are shaped by the class-specific cultural environment in which he or she is being reared. This includes the preferences as well as ways of speaking and behaving that define a person's habitus. According to Bourdieu's premise, class-specific tastes and acts serve as a method for perpetuating rigidly stratified social status categories in specific civilizations. This is the case since these preferences and activities are class-specific. The term "social reproduction" refers to this particular process (Bourdieu, 2000; see also Chin & Phillips, 2004). In the same vein, Michel Foucault (1979) frequently portrayed socialisation as a disciplining process that originated from an apparently unseen power structure conveying norm-enforcing forces that appeared to permeate society and constrain the agency of people. He did this by referring to the power structure as a "machine for the production of conformity." Even Foucault acknowledges that people are not only inert objects that are shaped by society, but rather that people have the potential to enact their own subjectivities in the world (Foucault, Martin, Gutman, & Hutton, 1988).

The process through which individuals become socialised in society. According to research that are both theoretical and empirical in character, the process of socialisation is brought about by the interactions that take place between young people and the circumstances in which they find themselves (e.g., Handel, Cahill, & Elkin, 2007; LeVine, 2003; Strayer & Santos, 1996). According to Bronfenbrenner's ecological systems theory of human development (1979), a child is placed within a series of concentric rings that represent diverse socialisation circumstances. These rings surround the child like a cocoon. Figure 1 presents an outline of the most important aspects of his paradigm. The child is influenced by society in the following ways: the most immediate contexts in which the child is present (microsystem) – the family, siblings, peer groups, and classrooms; the contexts in which the microsystems meet (mesosystem) – for example, parent-teacher relationships, parents' work environments, and extended family networks; the community context (exosystem) – for example, schools, neighbourhoods, local media, and local government; and the broader sociocultural context (sociosystem) (macrosystem).

## **MATERIALS AND METHODS**

The participants were a subsample of 523 young people (54.9% of whom were female) who were taken from the LIFECOURSE (Longitudinal Investigation For Epidemiologic Causes and OUtcomesRiSing in Early Childhood and Adolescence) project, which had a total participant population of 2378 persons. The LIFECOURSE study could not have been carried out without the support of the Project Grants (206580 and 217612) awarded by the Icelandic Research Fund and the Research Consolidator Grant awarded by the European Research Council (ERC-CoG-2014-647860). To be eligible for participation in the LIFECOURSE project, a child must have been born in Iceland in 2004 and be a resident of Iceland in 2017. Candidates for participation were considered any and all children who fit these criteria. In order to carry out the recruiting procedure for the current study, families who had previously taken part in the LIFECOURSE study were contacted over the phone and mailed letters inviting them to take part in the study. In addition, secondary schools were informed about the research through advertisements. At the time that the data for this research was being gathered, 1930 of the families that had participated in the first LIFECOURSE study were currently residing in Iceland and had a postal address that was still operational. This was the case at the time that the research was being carried out. As soon as the study project received clearance from both the National Bioethics Committee of Iceland (11-078) and the Personal Protection Authority in Iceland, it was registered by both organisations.

### **Measures**

#### **Background variables**

#### **Mental health outcomes**

The Icelandic Centre for Social Research and Analysis (ICSRA) has been conducting population-based surveys on a biannual basis among Icelandic adolescents between the ages of 10 and 20 throughout the country ever since the year 1998. More than 80 percent of the nation's overall population is asked to participate in these surveys in order to collect statistics. Because the ICSRA studies and this study used the same mental health measures, the prevalence rates of mental health problems among same-aged peers from the ICSRA administration in 2018 (1554 girls and 1445 boys) were used as expected scores of the prevalence of mental health problems. This was done because the ICSRA studies and this study both used the same mental health measures.

## **Depressive symptoms and anger**

The sad mood and anger subscales of the Symptom Checklist-Revised (SCL-90) (Derogatis et al., 1975) were used for the goal of evaluating depressive symptoms and levels of anger in the week before to the study. The participants were given a four-point Likert scale and asked to rate how frequently 10 items relating to a depressed mood and 5 items pertaining to anger applied to them throughout the course of the preceding week. Responses varied from "almost never" to "frequently" in frequency of use. On the basis of these items, a composite score was established, with larger scores indicating higher degrees of both angry symptoms (ranging from 0 to 30) and depression symptoms (ranging from 0 to 30). (ranging from 0 to 30). (range, 0–15). The grading scales demonstrated exceptional psychometric properties (the depression scale had a reliability coefficient of .91, and the rage scale had a reliability coefficient of .83). In clinical settings as well as in research that is focused on the general health of a community, the SCL-90 is a well-established and regularly used measure of severity of chronic lung disease. Despite the fact that it has typically been used to study psychopathological aspects, the SCL-90 has been shown to be useful in detecting psychopathology in adolescents. This is despite the fact that its primary use has been to explore psychopathological features. Previous research that our group has carried out has shown, among other things, that the frequency of visits to paediatric psychiatrists and clinical child psychologists corresponds to the subscales of the depressive component of the SCL-90 when it is administered at a nationwide level. This was one of the findings that emerged from this line of inquiry.

In order to investigate how adolescents reacted to the COVID-19 epidemic, survey questions that were formulated expressly for this research project were developed. The poll was developed in the wake of the start of the COVID-19 epidemic in Iceland, and it was constructed with reference to previous research from across the world that examined the impact of the pandemic on young people at the time it was occurring. You may find the specifics of each measurement lower down on this page, and the full survey questions are included in the supplemental information that is available online (Tables S1 and S2).

## **Broad-scale effect of COVID-19**

Respondents were asked to rate the potential effects that COVID-19 had on their overall day-to-day life, academic performance, relationship with family and peers, and physical and mental health using a five-point Likert scale, with one representing a significant deterioration and five representing a significant improvement. The scale was designed so that five represented a significant improvement. These responses were examined utilising two distinct approaches, the first being as a continuous variable, and the second being as a binary variable. Because of this, we were able to achieve a deeper and more nuanced comprehension of the impact that COVID-19 was thought to have had on adolescents. For the latter, the replies for each were dichotomized according on whether or not they were considered as being favourably impacted by COVID-19 (zero = worse or no change, one = better or much better) or adversely impacted by COVID-19 (zero = better or no change, one = worse or much worse).

## **Behavioral change during COVID-19**

Items in the survey were able to pick up on COVID-19 specific shifts in the teens' daily routines. On a Likert scale from one point (much less time) to five points (much more time), respondents were asked to rate how much time they spend on a list of 16 activities now compared to before the pandemic. These activities

include sleeping, engaging in physical activity, using social media, and getting together with friends or family.

**Negative and positive effect on mental health due to COVID-19**

The survey had items that were able to pick up on COVID-19 specific alterations in the daily routines of the adolescents. When compared to the time they spent on a list of 16 activities before the pandemic, respondents were asked to rate how much time they spend on those activities today using a Likert scale that ranged from one point (much less time) to five points (much more time). These include getting enough sleep, being physically active, partaking in social media, and getting together with friends or family.

**Procedure**

Every individual who participated in the LIFECOURSE study was sent an invitation to take part in this one as well. Before the adolescent participant completed the survey into RedCap, one of the participant's carers gave their informed consent using an electronic or bank ID, and the adolescent participant gave their approval to the research being conducted on them. Participants in COVID-19 had the chance to reply to a survey that questioned about their level of wellbeing between the dates of October 14, 2018 and April 16, 2017. The survey was administered between those two days. The RedCap platform was utilised by the participants in the current study in order for them to fill out the self-report survey battery. During this period of seven months, Iceland was hit by two waves of the COVID-19 virus. Each wave lasted around one month. For this time period, the average incidence rate of infections during a period of 14 days was 49.5 per 100,000 individuals in the population. This figure was calculated during the course of this time period. During this time period in history, there were needed social restrictions in place that capped the number of individuals who may be in the same location at the same time at a maximum of twenty. These restrictions prevented larger gatherings from occurring. These restrictions were in place for a total of one year and one month. As a direct consequence of these constraints, secondary schools have made the shift to online education, organised group and sports activities have been placed on hold, and restaurants and bars have been compelled to temporarily close their doors for a considerable portion of this time period.

**RESULTS**

The disparities between the genders are broken down in Table 1, which also includes information on the whole sample. 0.5% of the participants described themselves as non-binary (n = 2), 54.9% of the participants identified themselves as female (n = 287), and 41.5% identified themselves as male (n = 217). This survey item was skipped by 0.6% of the participants, which amounts to n = 17 people. Because of the small size of the study's sample, non-binary young people who took part in the research were not included for the gender breakdowns. There was not a discernible difference between the sexes in terms of the job that the parents did, the state their families were in, or the utilisation of mental medicine (p > 0.199).

**TABLE 1.** Demographic and clinical characteristics of the sample

Characteristic	Total, n (%)	Girls, n (%)	Boys, n (%)	p
Sample size	523	287 (54.9)	217 (41.5)	

Maternal employment				.199
Full-time employment	366 (70.0)	164 (75.6)	199 (69.3)	
Part-time employment	77 (14.7)	21 (9.7)	42 (14.6)	
Other	80 (15.3)	32 (14.7)	46 (16.0)	
Paternal employment				.900
Full-time employment	434 (83.0)	186 (85.7)	244 (85.0)	
Part-time employment	67 (12.8)	21 (9.7)	31 (10.8)	
Other	22 (4.2)	10 (4.6)	12 (4.2)	
Two-parent household	399 (76.3)	168 (77.4)	227 (79.1)	.732
Psychotropic medication	80 (17.4)	29 (15.2)	51 (19.2)	.317

*Note:* Participants who identified as non-binary gender ( $n = 2$ ) or chose not to answer the gender question ( $n = 17$ ) were not included in the girls or boys categories. In terms of psychomedication, there were participants who did not complete the survey item during the administration ( $n = 62$ ).

When comparing the youth who took part in the current study to the general population of 16- to 17-year-olds in Iceland, significant differences were found in terms of gender. For example, the percentage of girls who took part in this study was 54.9%, whereas the percentage of girls who took part in the general population was 49.3% ( $2(1) = 11.264, p = .001$ ). However, the percentage of participants in this sample who lived in a household with two carers (76.3%;  $2(1) = 0.755, p = 0.385$ ) and who were enrolled in secondary school (95.4%) were comparable to the percentages found in the general population of Iceland (74.6%;  $2(1) = 0.755, p = 0.385$  and 93.6%;  $2(1) = 1.195, p = 0.274$ ). (prevalence rates for the general population were derived from Thorisdottir et al., 2017 and the Icelandic Statistics Bureau).

### A widespread and far-reaching consequence of the epidemic

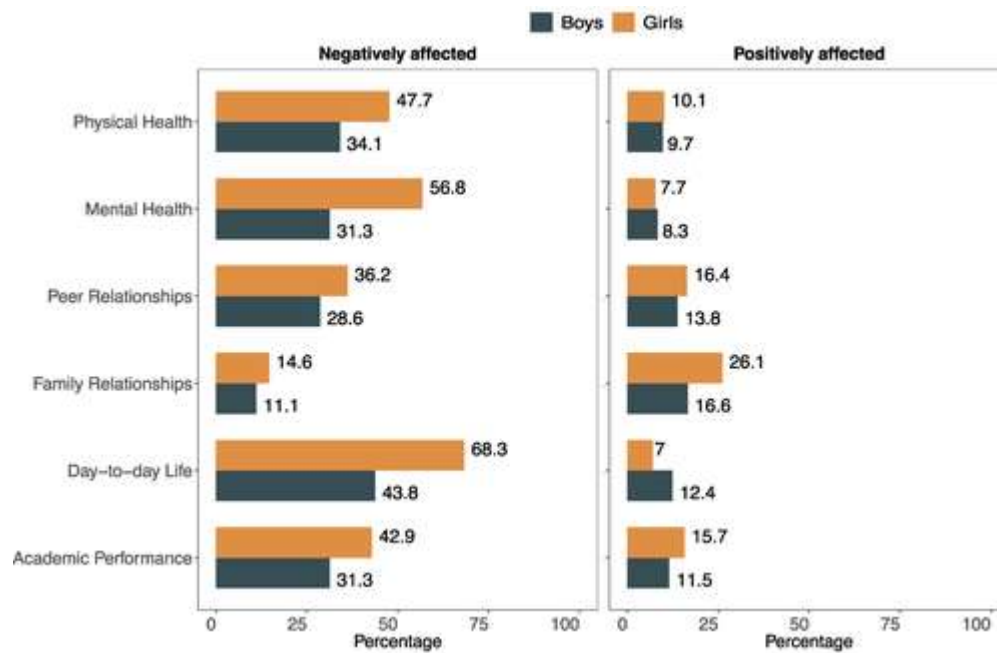
In particular, academic performance, day-to-day life, family relationships, peer relationships, mental health, and physical health were the broad-scale indicators of well-being that were studied using regression models in order to determine whether or not there were differences in the perceived effects of COVID-19. Other broad-scale indicators of well-being included family relationships, peer relationships, and mental health. During the course of the pandemic, a sizeable percentage of young people stated that there was no change in how well they were functioning in any of these areas (see Figure S1 in the supporting information material for the distribution of responses by gender). Girls were significantly more likely than boys to believe that the pandemic had a negative influence on their day-to-day lives ( $b = 0.503, SE = 0.090, p = .001, Cohen's d = 0.246$ ), physical ( $b = 0.192, SE = 0.088, p = .029, Cohen's d = 0.096$ ), and mental health ( $b = 0.470, SE = 0.092, and Cohen's d = 0.096$ ). It was demonstrated that there were no statistically significant differences between the sexes in terms of academic achievement, connections with family or friends, or the monetary position of the home (Table 2).

**TABLE 2.** Analysis of gender differences in broad-scale indicators of well-being during the COVID-19 pandemic, as well as a comparison of the percentage of young people who rated these broad-scale indicators of well-being as being negatively or positively affected by the pandemic. During the COVID-19 pandemic.

					Negative				Positive			
	B	SE	p	Cohen's d	OR	Lower CI	Higher CI	Cohen's d	OR	Lower CI	Higher CI	Cohen's d
Day-to-day life	-0.503	0.090	.000	-0.246	2.843	1.967	4.135	0.576	0.498	0.266	0.916	-0.385
Academic performance	-0.129	0.095	.178	-0.059	1.651	1.141	2.402	0.276	1.400	0.832	2.400	0.185
Family relationships	0.087	0.081	.286	0.047	1.425	0.836	2.479	0.195	1.769	1.138	2.788	0.314
Peer relationship	-0.051	0.091	.575	-0.025	1.480	1.009	2.183	0.216	1.168	0.710	1.945	0.086
Physical health	-0.192	0.088	.029	-0.096	1.798	1.249	2.601	0.324	0.991	0.545	1.826	-0.005
Mental health	-0.470	0.092	.000	-0.224	2.998	2.062	4.395	0.605	0.943	0.488	1.847	-0.032

Note: The analyses were adjusted for parental employment status and household status.

Comparison of the percentage of teenagers who regarded these broad-scale measures of well-being as being adversely or favourably influenced by the COVID-19 pandemic and gender disparities in these broad-scale well-being indicators during the pandemic).



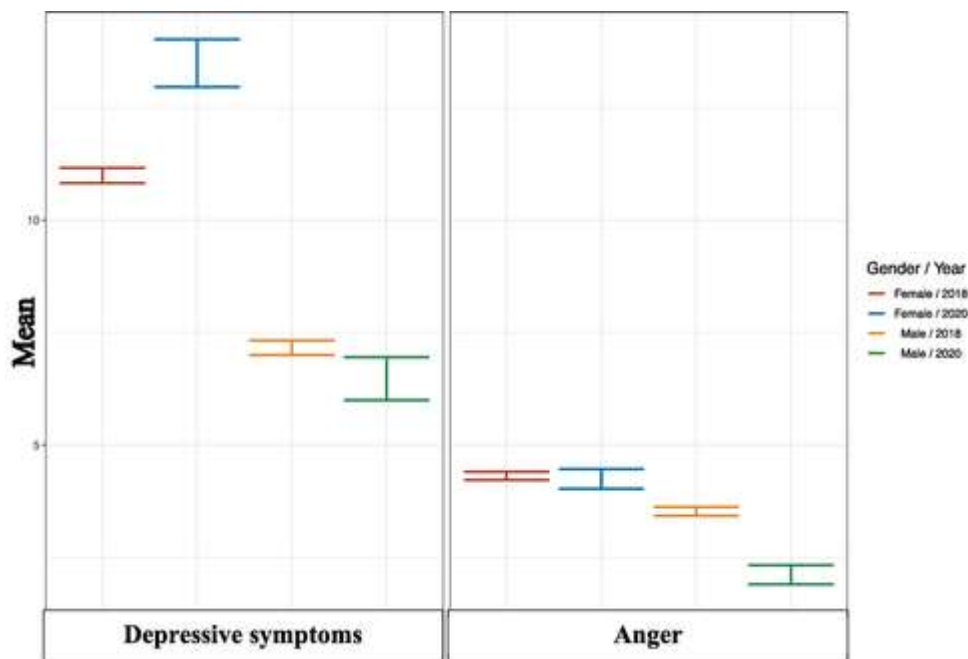
**FIGURE 1**

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The percentage of adolescents (both girls and boys) who felt that COVID-19 had a positive or negative impact on their physical and mental health, family and peer relationships, day-to-day life, and academic performance is displayed in the table below when compared to the period prior to the pandemic.

**Mental health problems**

There was a substantial rise in depressed symptoms among girls during the pandemic (M = 13.49, SD = 8.91 vs. M = 10.99, SD = 7.70;  $t(1514) = 4.80, p .001, \text{Cohen's } d = 0.315$ ), which is consistent with the low mental health ratings among girls reported above. Contrary to expectations, there were no differences in depressive symptoms between 16-year-old males who took the COVID-19 (M = 6.46, SD = 7.03,  $t(1272) = 0.905, p = 0.450, \text{Cohen's } d = 0.101$ ; Figure 2).



**FIGURE 2**

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Mean sad and angry symptoms were greater among 16-year-old boys (shown in green) and girls (shown in blue) during the COVID-19 pandemic than they were among their peers of the same age before the epidemic (girls depicted in red and boys in yellow). The expected outcomes were derived from data gathered from school surveys that were distributed nationally in Iceland in 2018. The error bars are standard errors.

In contrast to the prevalence rates among 16-year-old girls (4.5%) and boys (4.4%) in 2018 ( $2(1) = 0.323, p = 0.570$  and  $2(1) = 0.018, p = 0.894$ ), there was no statistically significant difference between the prevalence rates of girls (5.3%) and boys (4.7%) who had attempted suicide within the previous 12 months during the pandemic. Following are the percentages of females who had tried suicide within the previous 12 months throughout the pandemic: girls In a similar vein, the levels of rage assessed in teenage girls (M



= 4.24, SD = 3.16) and boys (M = 2.89, SD = 3.67) during the pandemic did not differ from those predicted (girls: M = 4.31, SD = 3.66, and boys: M = 3.52, SD = 3.52; Figure 2).

## CONCLUSION

One of the first studies to examine gender variations in teenage responses to COVID-19 broadly and possible causes of such differences. In particular, the answers of teenagers between the ages of 13 and 19 were examined in this study. Boys and girls differed in their likelihood of believing that the pandemic will have a big and lasting impact on their lives. Girls were thus more prone to suffer unfavorable effects from the epidemic. Overall, the results suggest that keeping a regular schedule and being socially connected through phone and internet connections may help young people, and especially young females, cope with the uncertainties and social constraints that are related to a pandemic. Additionally, during and after the COVID-19 epidemic, healthcare providers, educators, and other professionals should pay close attention to the emergence of depressive symptoms, especially in females.

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