Volume 1

Mental Health Problems in Adolescents: The Impact on Self and Identity

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Overview

Volume 1 is divided into three parts. The *Literature Review* is the first part of this volume and explores the extent to which mental health problems during adolescence have been considered in relation to identity development. It describes the period of adolescence and associated developmental tasks. 'Identity', the development of a sense of 'who am I?' is explored in more detail with specific reference to Eriksonian theory. Due to the lack of research on mental health problems and identity development, chronic physical health problems are considered. In conclusion the general absence of research on adolescents with mental health problems and identity development indicates a need for further research in this area.

Part 2, the *Empirical Paper*, is a study of the affect of having a mental health problem on identity development during adolescence. Ten young people aged between 14 and 18 participated in this study. Participants' personal accounts of having a mental health problem were explored through in-depth semi-structured interviews, specifically focusing on sense of self, future plans, values and relationships. In addition, participants completed a standardised self report questionnaire. The present findings indicate that mental health problems during the adolescent years can have a negative impact on identity development in the young person concerned.

Lastly, part 3, the *Critical Appraisal*, takes a more detailed look at the present study and considers the methodological issues that arose in more depth. In addition, reflections on my position as the researcher, in terms of how I approached the research and how the research experience in turn has influenced me, will be covered.

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I would like to take this opportunity to say 'thank all' to all of the young people who participated in this study, your time, trust, and honesty was warmly felt and much appreciated. My research supervisor, Katrina Scior, for without whom I do not think I would have had such a great experience. You helped bring me this far by facilitating a smooth passage, by having true belief in me and elevation when needed. To Vicki Connop a big 'thank you' for your all-round assistance and abundant availability. To my family and my man, Chris, your faith, support and love assisted me on my journey – I have now arrived.

Part 1

Literature Review

Mental Health Problems in Adolescents: The Impact on Self and Identity

Abstract

This review explores the extent to which mental health problems have been considered in relation to theories of identity development during adolescence. Erikson's theory of identity development and the work of others (e.g. Adams and Marcia) who have embraced his ideas have been very influential in this field. Erikson's original ideas have been extended and more recent research has considered the relationship between contextual factors and identity development (Yoder, 2000). However, despite an increase in the prevalence of adolescents experiencing mental health problems, the impact on identity development has not yet been investigated. Adolescence and the associated developmental tasks are outlined below. Theories of identity development are described and what is known about mental health problems which occur during this period. Due to a dearth of research on mental health problems, identity development is explored in relation to chronic physical illnesses. The paper concludes with a summary of key findings and highlights neglected areas which require further investigation.

Introduction

This review will investigate the extent to which having a mental health problem impacts on identity development during adolescence. Gaining a sense of 'who am I?' during this developmental period is seen by many (e.g. Erikson, 1968) as a focal concern. Many mental health problems have their onset during adolescence (e.g. Department of Health, 2004; Kramer & Garralda, 2000; Meltzer, Gatward, Goodman & Ford, 2000). Yet there has been virtually no attempt to examine how the

experience of having a mental health problem affects the young person's developing sense of self. This review will firstly provide a context to the concept of 'adolescence' and then go on to consider the major developmental tasks associated with this period. The paper will then proceed by examining theories of identity development, the most influential of which is undoubtedly the prolific and often cited work of Erikson (1968). Therefore the theoretical framework underpinning this review is that of Eriksonian ideas. There is much literature on identity as conceptualised by Erikson and many others have built on his original ideas, for example, Marcia, Adams and Phinney who have considered ways in which identity can be measured and the relationship between contextual factors and identity development. Mental health problems during adolescence will also be reviewed, as this will provide a background of the prevalence and potential risk and protective factors associated with this age group. However, to date there is a dearth of empirical research reporting on the possible influential nature of having a mental health problem on identity development. Yet within the literature on chronic illness, identity development has been studied and will be considered here in order to glean potential indicators that may prove fruitful in considering the impact of mental health problems of identity.

The Nature of Adolescence

Traditionally adolescence has been portrayed as a 'troubled' period. Writing in this area was largely put forth by psychoanalytic theorists who purported that normative adolescent development was turbulent (Blos, 1962). Young people were depicted as troublesome and largely out of control; they were seen as unstable due to their fluctuating moods and hormones and perceived to be in constant conflict with their

parents. However, more recently 'adolescence' has been re-visited and it has been suggested that much of what has been previously written about this period is in fact part of 'the myth of adolescence' (Offer & Schnert-Reichl, 1992). Offer and Schnert-Reichl (1992) challenge such myths with empirical research findings and argue that 80% of this population do not experience a period of turmoil.

The Transition

Adolescence is defined as the 'transition' between childhood and adulthood. The transition spans several years of a young person's life, approximately from the age of 10 to 20 and has been divided into three sub-stages; early adolescence (10-14), middle adolescence (15-17) and late adolescence (18-20) (Petersen & Leffert, 1995). Coleman and Hendry (1999) though argue that each sub-stage and at what age it occurs is still not clearly defined. Secondly, the depiction of a ten year period as a 'singular' stage in adolescence has also raised much debate. In response to this, different approaches to studying adolescence have emerged within a European context. Some researchers have focused on the 'exit out' of adolescence and into adulthood as a key feature to understanding and explaining this period (Jones, 1995) and others have considered the numerous events that occur during this stage as types of transitions in their own right (Graber & Brooks-Gunn, 1996). Jones (1995) highlights three markers that indicate transition out of adolescence and into adulthood, firstly leaving education and starting work, secondly, obtaining relative independence from the family and, lastly, moving out of the parental home.

Graber and Brooks-Gunn (1996) are in support of the notion of transition but in addition they have utilised the concept of 'turning points' which can occur during

transitions and coined the term 'transition-linked turning points'. Graber and Brooks-Gunn (1996) argue that developmental transitions, for example puberty, are relatively universal across adolescents. In contrast, turning points are particularly salient events, such as negative life events which occur within a transitional period. These are argued to be more likely to alter behaviour, affect, cognition or context, than if they occurred outside of such a transition period. Importantly this framework enabled the authors to consider individual differences in negotiating developmental transitions and consequently point out four possible problematic circumstances for individuals;

(1) When the timing of turning points within transitional periods creates additional stress;

(2) When too many events occur at the same time;

(3) Lack of 'goodness of fit' between context and behaviour during transitional periods;

(4) When mental health issues arise at the same time as turning points are required to be negotiated.

Point number four is of particular relevance to this review and will be considered further under the section of 'mental health problems in adolescence'.

Influential Nature of Changing Social Circumstances on 'Adolescence'

In addition, changing social and political structures may directly impact on the experiences of "adolescence" (Côté & Allahar, 1994). There is now a greater emphasis placed by researchers on the key part played by contextual factors such as the environment, family and wider society, on influencing adolescence (e.g. Adams & Marshall, 1996; Phinney & Goossens, 1996). Social and political changes have

greatly influenced and shaped the experiences of adolescence. Coleman and Hendry (1999) pointed out that changes in the family and the labour market have probably been the most influential. With regard to employment, in Britain, the labour force has witnessed a shift over the past 30 years, partly as a response to high levels of unemployment. Young people are being encouraged to remain longer in higher education. The proportion of 16 to 18 year olds in education and/or training at the end of 2004 was 75.4%. In addition at the end of the same year, 73.3% of 16 year olds were in full-time education, which is the highest number recorded (Heyworth, 2005). The implication of this for young people today is a delay in economic independence from their parents and a delay in taking on adult responsibilities. Overall this has meant an extension of the adolescent period and for most young people a much less clearly defined transition from childhood to adulthood.

In addition, the structure of the family unit over the past few decades has seen many changes. There has been a decline in the number of families headed by a married or cohabiting couple and a corresponding increase in lone-parenting. The proportion of children living in lone-parent families in Great Britain has more than tripled between 1971 and 2002, increasing from 8% to over a ¼ (27%) of families (Census, 2001). In line with these figures the divorce rates in the United Kingdom have increased by 3.7% between 2002 and 2003 to 69%, witnessing a third successive annual increase (Census, 2001). In addition, according to the Census (2001), 1 in 10 dependent children live in a step-family. Possible implications of these changes for young people include a less close family unit and increased importance of peer relationships as well as changes in their values and beliefs about the role of men and women, marriage and family. Also parenting styles may be affected as the roles of lone-

parents and reconstituted families have to be negotiated and are often difficult to define. Such uncertainty at home can be unsettling for an adolescent at a time when many other external changes and new demands need to be negotiated.

Overview of the Development during Adolescence

The successful transition from childhood to adulthood has been associated with several developmental tasks (e.g. Coleman & Hendry, 1999). These tasks involve change on a physical, intellectual, psychological and social level, which are reviewed below.

Physical Development

The biological changes that occur during this period are dramatic and relatively rapid, transforming a child into a biologically mature adult capable of sexual reproduction. During this period of time the young person experiences maturation of the reproductive system and develops secondary sexual characteristics such as growth of pubic hair, facial hair, breasts (in girls) deepening of the voice (in boys) and skin changes. These changes, which are referred to as 'puberty', occur over a period of about one and a half to six years (four years on average) with great individual variation in the age at which they begin and the rate at which they progress (Petersen & Leffert, 1995). However there are differences between girls and boys; girls can begin puberty as early as eight years old and as late as 14 years old whereas boys enter puberty about one and a half to two years later than girls. The average age of onset of puberty is around 10 years old for girls and 12 years old for boys (Coleman & Hendry, 1999). Coleman and Hendry (1999) add that such differences in timing can provoke anxieties due to comparisons with peers.

On the whole research has demonstrated that for boys early maturation is perceived as being beneficial; early developing boys tend to view their appearance and selves more positively than less mature boys (Simmons & Blyth, 1987). Simmons and Blyth (1987) argued that, in part, this appears to be due to the social benefits gained from having strength and being physically fit, such as the ability to play sports well. In contrast, Petersen and Crockett (1985) found that late maturing boys struggled in that they were less popular and successful and were found to be less attractive by peers and adults. For girls it appears that almost the opposite holds true, early maturing girls tend to be less satisfied with their weight and appearance (Blyth, Simmons & Zakin, 1985). Research findings have also demonstrated that early maturing girls are more likely to engage in excessive dieting or other eating problems (Brooks-Gunn, Attie, Burrow, Rosso & Warren, 1989), have lower self-esteem (Simmons & Blyth, 1987) and experience higher rates of depression (Alsaker, 1992) than less mature girls.

Offer et al. (1992) highlight however, that the media and other sources mediate what young people think they should aspire to and consequently this has a significant impact on their psychological experience of puberty. With regards to physical attractiveness, for girls, the popular culture emphasises a thin slender shape, arguably similar to the shape of a prepubertal body but for boys the idealised norms are to be tall and muscular. Hence an increase, for girls, and a delay, for boys, in weight can lead to discontentment and anxiety, as one's idealised image is not realised. However Offer et al. (1992) add that for most adolescents their experience of puberty is fairly ambivalent, characterised by both negative and positive feelings.

Thinking and Reasoning

Piaget (1952) developed a theory of how children's abilities to think and to reason progress through a series of four stages which are age related. The fourth stage 'formal operational' thinking, according to this theory, should occur from around the age of 11 or 12 years old. Piaget stressed that intellectual development following puberty is more than an increase in cognitive skills; instead a qualitative change occurs in the nature of mental abilities (Inhelder & Piaget, 1958). Primarily abstract reasoning and the ability to develop and test out hypotheses systematically become possible. The ability to conceive of possibilities beyond what is present in reality and anticipate possible consequences is fundamentally the essence of formal operational thinking.

The acquisition of an increase in intellectual functioning has far reaching consequences for the young person's behaviours and attitudes. To start with, it enables a move toward independent thought and action, for example, becoming concerned with philosophical and ideological problems. The young person also becomes aware of the notion of a future, which includes taking on adult roles in society and, hopefully, smoothes the progress of a developing interest in sexual relationships (Coleman & Hendry, 1999).

A range of criticisms have emerged of Piagetian theory overtime. An obvious criticism is the validity of such distinct stages of cognitive development at the expense of other variables such as personal experiences and intelligence (Sutherland, 1992). With reference to the concept of formal operational thought, probably the

most important criticism to note is that it is actually unlikely that all adolescents acquire this level of thinking during this period of time. Coleman and Hendry (1999) point out that only a minority of 16 year olds actually have the ability to think at the sophisticated level described by Piaget.

With formal operational thought, the young person reaches a point whereby they are not only able to think about their own thoughts but also acquire the capacity to think about the thoughts of others. Kohlberg (1981) provided an extended view on the work of Piaget to include the notion of moral development; essentially, the ability to take account of the perspective of others. Additionally advances in intellectual abilities enable the young person to be able to consider moral issues. In his work on the moral judgement of children, Kohlberg (1981) described six stages associated with moral development. More sophisticated modes of reasoning accordingly occur from the age of 10 or 11 to young adulthood. The young person moves out of the 'conventional' (seeking to do what is 'right' to gain the approval of others) and into the 'post conventional' mode (developing a genuine interest in the welfare of others and society at large). Various criticisms have been raised of Kohlberg's theory; one of his most vocal critics, Gilligan (1982), noted that Kohlberg's theory raised many contentious issues regarding gender. Fundamentally, Gilligan argued that concepts of morality are different for males and females and that Kohlberg's theory is biased as it is androcentric.

Development of Sexuality

Sexual development encompasses the biological changes discussed above, and the growth and maturation in the social and emotional worlds of young people. As with

all developmental tasks, there are a number of influential factors shaping adolescent sexuality including internal factors such as the speed of pubertal maturation and external factors such as environment, family, political climate etc. Over the years it would appear that people are having sexual intercourse for the first time at a younger age. In Wellings, Field, Johnson and Wadsworth's (1994) study, for example, 27.6% of males aged 16 to 19 reported that they had had sexual intercourse before they were 16 compared with only 5.8% of men aged 55 to 59.

Parental attitudes about sexuality inevitably bear weight on factors related to the functions of the body, the nature of intimate relationships and beliefs about gender appropriate roles. Additionally, parents act as role-models for young people and can influence the sexual behaviour of young people in both positive and negative ways. Taris and Semin (1997) pointed out that if parents are open with their children without being intrusive and are able to be sensitive to the young person's concerns they can be the most effective sex educators. Interestingly, Treboux and Busch-Rossnagel (1995) discovered that the strength of parents' influence over young people is age related. Between the ages of 15 to 17 discussions with a parent, usually the mother, have a strong influence but at 19 years of age approval from peers was rated as more important. Sex education often occurs between peers; 69% of sexually active young people said that they were happy to discuss sexual problems with their peers compared with 33% who felt able to discuss similar issues with their mother, only 15% reported feeling able to talk to their fathers (Moore & Rosenthal, 1991).

Research has compared romantic relationships with same-sex friendships of 15 year olds (Feiring, 1996). The findings showed that the length of dating relationships was

much shorter than same sex friendships (four months compared to over a year) but that romantic relationships were described as much more intense, in terms of amount of contact. Also girls and boys tended to highlight different factors as being important in romantic relationships, namely support and disclosure for girls and shared activities and physical attractiveness for boys. Drawing on Erikson's (1968) concept of identity, Moore and Rosenthal (1998) have suggested that falling in love is integral to identity development, which will be discussed more thoroughly later. They argue that intimacy facilitates self-exploration which plays an important role in Eriksonian ideas on the development of identity.

Development of Autonomy

Important changes also occur in the adolescent's relationships with their parents and peers (Coleman & Hendry, 1999; Janus, McCormack, Burgess & Hartman, 1987; Petersen & Leffert, 1995). The aim for most young people is to liberate themselves from the restrictions and rules placed on them by parents and to be in command of their own life. It is recognised that this is largely a Western viewpoint and that the process will be influenced by a number of factors including cultural background, family circumstances (e.g. number of siblings, parents' attitudes etc.), gender, social and economic opportunities available in the environment, in addition to the young person's personality. Views of the ways in which parents and young people negotiate this interaction have changed. The original psychoanalytic viewpoint held that a young person must emotionally disentangle themselves from their parents in order to become a mature independent adult (Blos, 1970). Inherent in this perspective is a sense of 'turmoil' and a belief that the adolescent period is 'stormy', almost inevitably bringing with it much conflict between parents and adolescents.

However, more recently research findings have emerged that throw a more positive light on this, emphasising that a complete breakdown of relationships is not necessary and more generally questioning the notion of the inevitability of the turmoil. The idea of 'connectedness' was proposed by Grotevart and Cooper (1986), to describe their notion that close family ties do not necessarily hinder adolescents' moves toward independence. Their view that adolescents can remain connected with their parents during this time is supported by findings which demonstrate that time spent with parents on a one-to-one basis remains consistent between the ages of 10 to 18 (Larson, Richards, Moneta, Holmbeck, & Duckett, 1996). However, it is important to emphasise that such concepts are based in Western thinking, for example, the notion of autonomy and independence as desired outcomes of adolescence are very different to the emphasis in most Asian cultures on interdependence and family responsibility (e.g. Markus & Kitayam, 1991).

In addition to the four developmental tasks outlined above, the development of identity or 'sense of self' is considered to be of particular importance during the period of adolescence. Coleman and Hendry (1999) argue that developing a clear sense of self, including an understanding of 'who am I?', is the consolidation of all the above outlined tasks of adolescence. Specifically adolescents are required to adjust to major physical changes altering their sense of their body image; secondly due to an increase in intellectual abilities they are now able to hold a more multifaceted and sophisticated view of themselves; and finally, increased independence from family and the ensuing decisions they are making regarding future career plans, values, friendships and sexual relationships undoubtedly adds to the way in which they view themselves. Identity development as the key focus of

this review will be looked at in more detail below. At this point it should be noted that the above major developmental tasks of adolescence have been primarily considered separately, for the purpose of this review. However, the influence of one task on another or the overlap between all tasks cannot be ignored. The importance of the adolescent making a successful transition from childhood to adulthood has been emphasised and the most salient components of adolescent development have been noted. This begs the question what happens if the adolescent is unsuccessful in this transition or only succeeds in negotiating some but not all of the developmental tasks outlined. Once identity development theory has been outlined such difficulties navigating this period will be considered with specific reference to mental health problems. Due to the virtual absence of research reporting on this, evidence reported on chronic illness will be reviewed in order to shed light on the impact of having an 'illness' during adolescence on identity development.

Identity Development Theory

A number of terms, for example, 'identity', 'I', 'self', 'me' and 'ego' have been used by various social scientists interested in a similar concept. However, the term 'identity' is mostly used when discussing the work of Erikson and those who have been inspired and built on his original writings such as Marcia, Adams and Phinney. Identity is defined as a balance between that which is taken to be 'self' and that considered to be 'other' (Kroger, 2004). Kroger (2004) adds that the very essence of our experience of identity is defined by the way in which we distinguish ourselves from other people as well as from our own organic functions. The five most commonly documented functions of identity, according to Adams and Marshall (1996), are:

a. Providing the structure for understanding who one is;
b. Providing meaning and direction through commitments, values, and goals;
c. Providing a sense of personal control and free will;
d. Striving for consistency, coherence, and harmony between values, beliefs and commitments;
e. Enabling the recognition of potential through a sense of future, possibilities, and alternatives choices.

A variety of perspectives have attempted to understand the process of identity development. None have been more influential than Erikson's conceptualisation of identity formation. The theoretical framework at the heart of the present research project is based on Erikson's (1968) psychosocial theory of identity, which forms part of a lifespan model. However, in order to provide a broader overview, I will briefly summarise some other key theories.

Socio-Cultural Approaches to Adolescent Identity

There are a variety of theoretical orientations encompassed in this approach. The core theme shared by all is an acknowledgement of the importance played by socio-cultural and historical factors on the process of identity development (e.g. Goossens & Phinney, 1996). These theories consider the ways in which the interaction of the individual and context take place in the process of identity development. To begin with, Yoder (2000) highlighted contextual factors that are likely to affect and possibly hinder the process of identity development. She coined the term 'barriers' to describe the external limitations imposed upon this process, including; (a) ethnicity; (b) age; (c) gender; (d) geographical isolation; (e) childhood socio-

economic status; (f) parental domination; (g) educational opportunity; and (f) religion. Yoder (2000) highlights that the common denominator of barriers is that whilst the young person has very little, if any, control over them, they profoundly affect his or her identity development.

Baumeister and Muraven (1996) suggest that identity is a reflection of the relationship between one's own individual identity and the socio-cultural context. They conceptualise the complex relationship between identity and social context as an 'adaptation', i.e. individual identity is an adaptation to a social context. Therefore the individual develops and continually changes their ideas about themselves according to the social context. Hence this approach recognises, firstly, the underlying influence played by society in producing and shaping identity and, secondly, that people are not completely passive in this process and at least to some extent, have choices and are able to alter and modify their identities in ways that will provide a perceived best fit within their social and cultural situations. In order to ascertain how a Western cultural context has influenced the nature of identity over time, Baumeister and Muraven (1996) explored social and historical changes through the centuries, emphasising the ways in which people adapt to new social conditions. Of particular relevance they considered the influential nature of the loosening of societal restrictions and the subsequent plethora of choices available on the process of identity development. Specifically they suggest that centuries ago limitations were placed on individuals that were determined by their gender, family background and ancestry. With the materialisation of universal education, Baumeister and Muraven (1996) argue that one is now freed from such limitations in relation to career choices. However their argument appears to ignore culturally specific factors,

for example, within some families there is an expectation that children will continue the family business. Interestingly though they propose that a loosening of restrictions may also be experienced by the adolescent as burdensome, as there is additional pressure to 'create' an identity rather than to simply adopt one.

In summary, there is recognition that changing events and socio-cultural factors have impacted on the fabric upon which one weaves one's identity. Socio-cultural factors, depending on individual circumstances, may accelerate, delay or even arrest the developmental process of identity development. Such factors have been largely neglected in empirical research. Goossens and Phinney (1996) suggest this is largely due to difficulties in studying such variables.

Developmental Approaches to Adolescent Identity

Within technologically advanced Western cultures, changing social and historical circumstances may have possibly added to the difficulties a young person encounters when dealing with their evolving sense of who they are. However others have focused on 'internal' factors, which are likely to be common to all adolescents. Whilst acknowledging the influential nature of social and cultural contextual factors, developmental models examine the biological and psychological factors involved in the process of identity development. Developmental approaches depict the phenomenon of identity within a lifespan approach that comprises of age related stages. Each stage contains a unique feature and exists within a sequential hierarchy. The assumption is that each stage builds upon the stages that went before, incorporating yet transcending the last stage to provide the underpinning for subsequent stages (Loevinger, 1987).

Several theorists have offered a developmental perspective on identity development, but none have been as plentiful as Erikson (LaVoie, 1994). Originally from a psychoanalytic perspective, Erikson was the first to enquire into the phenomenon of identity formation in adolescence. He appeared to be rather dissatisfied with traditional psychoanalysis though, arguing that biology is important but without considering the individual's cultural and historical context one would not be able to truly conceptualise the development of identity. Hence he moved beyond classic psychoanalysis with its focus on the 'id' and libidinal drives of development to emphasise the 'ego' and its adaptive capacities in the environment. Based on his observations of returning World War II veterans, Erikson noticed a central disturbance to their sense of identity. Even though they had a clear sense of who they were, for these veterans the lives they were returning to lacked sameness and continuity which Erikson referred to as 'ego identity' (Erikson, 1963). From these observations Erikson highlighted that such loss of ego identity provides an opportunity to understand normative modes of identity formation. Hence identity is more easily defined through its disruption or loss. Furthermore, the veteran's stories brought to light the nature of the relationship between biology, social and historical context and individual life history and their potential impact on identity.

Erikson (1968) defined identity as a psychosocial phenomenon rooted within the individual as well as within the communal culture. He proposed that biology operates in conjunction with personal organisation of experience and cultural setting to give meaning, form and continuity to one's unique being. Erikson further stressed that identity formation primarily occurs during the developmental period of

adolescence. The first sense of 'I', he suggests, occurs during infancy through the trustful and safe interaction with parental figures. At this point the foremost way by which the self is structured is by processes of introjection and identification. Introjection (the incorporation of another's image) prepares the way and is gradually replaced by more mature forms of identity resolution. Being liked and assuming the roles and values of admired others reflects the mechanism of identification. It is only when the adolescent is able to select some of these childhood identifications and discard others in accordance with his or her interests, talents and values that identity formation occurs. Thus in Erikson's (1968) theory, identity formation involves a synthesis of these earlier identifications into a new configuration which is based on, but different from, the sum of its individual parts. It is also a dependent process which relies upon the way society 'identifies the young individual, recognising him as somebody who has to become the way he is and who, being the way he is, is taken for granted' (Erikson 1968; 159).

In order to fully appreciate Erikson's conceptualisation of identity, it is important to review his life-cycle model. For Erikson identity is depicted as the fifth of eight sequential stages (from birth to death in old age), each having a particular developmental task associated with it. Such tasks involve a bipolar conflict that must be addressed and resolved before one can proceed unhindered to the next stage. The polarity of each stage presents a 'crisis', which refers to a crucial turning point whereby the individual is faced with a period of active questioning and decision making. However it is important to note that each stage does not demand an 'either/or' resolution but rather requires a balance of 'more or less' between the poles (hopefully favouring the positive end). The fifth stage which comes to the fore

during adolescence is described by Erikson as that of a *coherent identity versus role confusion.* Drawing upon resolutions of earlier stages the individual must now approach the task of identity formation. Erikson suggests that 'fidelity' is the essence of identity; fidelity can be acquired when one has encountered a crisis that provides the young person with the opportunity to become faithful and committed to a chosen pathway that incorporates a cause worthy of one's vigour, values and talents. Subjectively an optimal sense of identity should result in a sense of well-being: 'its most obvious concomitants are a feeling of being at home in one's body, a sense of "knowing where one is going" and an inner assuredness of anticipated recognition from those that count' (Erikson, 1968; 165). Kroger (2004) pointed out that psychosocial indicators of an optimal identity formation are demonstrated through commitment to work roles, values and sexual orientations that best fit one's own unique combination of talents and needs. Identity formation takes place across the lifespan and the expectation is that the transition to adulthood involves a progressive strengthening in the sense of identity (Waterman, 1982).

Criticism of Erikson's Identity Concept

One of the most commonly cited criticism is the unclear nature of the definition ascribed to identity by Erikson. Kroger (2004) points out that Erikson uses the term 'identity' for different purposes; he uses it to refer to both a structure and a process. At times it is referred to as a conscious subjective experience and at others as an unconscious entity. However she adds that Erikson is seemingly aware of this and makes no apology as he suggests that the concept can be used from different positions. The stages described within Erikson's psychosocial life-span model have also come under attack for a variety of reasons. Firstly, the timing of the stages has

been questioned, particularly the fact that each stage is bracketed with an age band, with a specific crisis occurring within this period. It has been pointed out that although research does support movement toward a more achieved sense of identity as the young person proceeds through adolescence (Meeus, Iedema, Helsen & Vollebergh, 1999), it is not always the case that identity is resolved within the confines of adolescence. Instead it is an issue that permeates the life cycle and gains increased importance at certain points, for example, around the birth of a first child or at retirement (Fisher, 1991). Secondly, the notion of a singular 'crisis' has also been questioned as it would appear that during this period the young person is dealing with a number of potentially difficult issues (Coleman & Hendry, 1999), as outlined under the section on development during adolescence. In addition, Erikson's model is likely to reflect cultural bias as it inherently assumes that an individual is in a position to explore, make choices and commitments depending on their own desires, talents and needs, for their identity to be successfully resolved (Kroger, 2004). In addition this may reflect white Western ideas of what is important and to be valued. Despite the outlined criticisms, Erikson's conceptualisation of identity development continues to inspire many empirical inquiries into the phenomenon.

Marcia's Identity Status Model

In an attempt to operationalise identity formation in accordance with Erikson's ideas, Marcia (1966) conceptualised a model which defines four modes of dealing with identity defining issues in adolescence, known as 'identity statuses'. The identity statuses are derived from a typology based on the dimensions of 'exploration' (originally referred to as 'crisis' by Erikson) and 'commitment'. Exploration

pertains to information seeking behaviour for the purpose of making decisions and choices whilst commitment refers to the consolidation of the explorations by making a firm, unwavering decision. Domains deemed indicative of a more or less successful identity resolution during adolescence include vocational plans, religious and political views, sexual expression and sex role beliefs. The presence or absence of exploration and commitment toward these domains serve as the criteria for distinguishing the four identity statuses: *(1) Diffusion, (2) Foreclosure, (3) Moratorium* and *(4) Achievement.* The identity statuses are arranged in a hierarchical continuum namely from lowest *diffusion* to highest *achievement* with *foreclosure* and *moratorium* in the middle. Advocates of this model point out that the individual progresses through the above outlined continuum in a developmental sequence (Berzonsky and Adams, 1999). With reference to table 1 below, identity *diffusion* refers to an individual who has not yet made any commitments and is not currently in a period of exploration of their identity options. A person who is categorised as in the *foreclosure* status holds firm commitments but these were made without a period of exploration and merely constitute the adoption of the roles and values of significant others. A young person classified as in the *moratorium* status is undergoing an evaluative process actively exploring possible suitable social roles but as yet has made no firm commitments. Finally, *achievement* defines the process whereby a young person has embraced a decision-making period on his or her own terms by entering into an active period of reflection and exploration and as a result has formulated firm commitments. This model has sustained over 500 empirical investigations in the last three decades (Waterman, 1999).

Table 1: Marcia's Identity Statuses

		Commitment	
		Present	Absent
Exploration	Present	*Achievement*	*Moratorium*
	Absent	*Foreclosure*	*Diffusion*

Adopted from Freitas (1995)

Criticism of Marcia's Identity Status Model

One criticism which has been noted by many authors (e.g. Côté & Levine, 1988; Van Hoof, 1999) is that Marcia's identity status model is not grounded in Erikson's theory and seriously under-represents his conceptualisation of identity. Waterman (1999) however strongly challenges such claims and highlights that Marcia's model specifically focuses on the two central aspects of Erikson's theory, namely exploration and commitment. He adds that Erikson's writing on identity was abundant and that Marcia's status model was not supposed to represent everything covered in Erikson's work. It would appear that Marcia initially assumed that the sequential order of the identity statuses was indicative of a developmental continuum. However Meeus et al. (1999) make the point that Marcia's model does not qualify as a developmental theory as (1) an individual's status can remain stable

over a period of time; (2) status can move in both directions, from left to right; and (3) achievement status is not necessarily the end point. Waterman (1999) adds to this by noting his discontentment with the positioning of foreclosure and moratorium statuses along the continuum. He points out that the intermediate positions do not make sense along a continuum as they are equal to one another in reverse. Therefore he advocated that the continuum offers a means by which to describe the transitions between the identity statuses.

Yoder (2000) points out that Erikson states identity is interrelated with the social context yet Marcia does not consider contextual factors within his model. Marcia's model implies that adolescent identity exploration and commitment occur in a static environment composed of (a) a defined social structure; (b) an absence of physical and/or socio-economic limitations; and (c) an identifiable set of work and life options or choices which the adolescent understands. By disregarding the impact of external socio-cultural influences, she argues, Marcia wrongly places much if not all of the responsibility for successful identity resolution upon the individual. Interestingly this may go part way to explaining why a so-called normative process which is common to all adolescents, as described by Marcia (1966) can result in individual variations (Yoder, 2000). Additionally, others (including Côté & Schwartz, 2002; Kroger & Green, 1996; Phinney & Goossens, 1996) have noted that much of the research often exclusively focuses on the internal psychological processes and neglects the relationship between contextual factors and identity development processes.

Measurement and Assessment of Identity Development

The notion of identity is so broad and all encompassing that its conceptualisation has prompted many questions and discussions concerning measurement (e.g. Adams, Shea & Fitch, 1979; Jones, Akers and White, 1994; Schwartz, 2004). In the main, identity status measures have taken the form of either semi-structured clinical interviews (e.g. ISI; Marcia, 1966), which are taped, transcribed and coded or objective self-report paper and pencil questionnaires (e.g. Objective Measure of Ego Identity Status; OM-EIS Adams et al., 1979).

In an attempt to operationalise identity formation, as discussed in the previous section, Marcia (1966) devised a semi-structured interview, the Identity Status Interview (ISI). Over the past 30 years this interview has been used widely and revised several times. The interview covers the following topics considered to be the most relevant to adolescents: vocational plans, religious and political values, sexual expression and sex role beliefs. For Marcia, within a Western context, commitment to a vocation, a set of meaningful values and a sexual identity were indicative of a successful identity resolution. Drawing on the concepts of exploration and commitment as described by Erikson, Marcia (1966) devised semi-structured questions to assess any commitments held by the young person and the level of crisis involved at arriving at such commitments. The interview takes approximately 30 to 45 minutes to administer and is audio recorded to allow for analysis. Interrater reliability between two raters has generally been reported to be around 80% (Kroger, 2004). Kroger and Green (1996) selected 25% of participants' transcripts which were rated by three judges, percentage of agreement ranged from 93% to 98%,

suggesting that the measure has very high face validity. This interview is widely accepted as a valid measure of identity development (Adams, 1998).

Self report measures were devised, in contrast, for ease of administration and scoring. One of the most popular measures is the Objective Measure of Ego Identity Status (OM-EIS; Adams et al., 1979). Adams et al., (1979) based their development of test items on previous types of responses to interview questions (e.g. Marcia, 1966), which reflected the theoretical level of 'exploration' and 'commitment' that would be typical for each identity status. The OM-EIS contains 24 items with six questions reflecting each of the four identity statuses *(diffusion, foreclosure, moratorium and achievement)* for the domain areas of occupation, religion and politics. Participants rate the extent to which statements are self-descriptive on a 6-point Likert scale (from 1 = strongly disagree to 6 = strongly agree). A quality of this measure is that it acknowledges individuals do not necessarily neatly 'fit' into one identity status and may indeed straddle more than one identity status at a time. Hence it was argued that an instrument needed to be able to measure the 'transition' between identity statuses, for example, movement from one status to another, for instance from *diffusion* to *moratorium*. The problem however is that most research findings do not report on 'transitional' statuses, but instead make specific reference to a singular identity status following on Adams (1998), who provided instructions on how to collapse transitional statuses into a singular status.

In an attempt to improve on this measure, revisions were made and an extended 64 item version was developed (Bennion & Adams, 1986). The Extended Objective Measure of Ego Identity Status-II (EOM-EIS-II) was primarily designed in order to

add 'interpersonal identity' which incorporates friendship, dating, sex roles and recreational choices to the existing 'ideological identity' already outlined. The psychometric properties of the EOM-EIS-II have been evaluated by several studies, as reported by Adams (1998). Internal consistency estimates across 20 studies, as measured by Cronbach's alpha were reported from .30 to .91, the median alpha was 0.66 and median test-retest reliabilities 0.76. Efforts to establish construct, predictive and concurrent validity have generally produced moderate to high relationships between the EOM-EIS-II and associated measures (Adams, 1998).

Across the measures different approaches have been used in deriving identity statuses. A 'global' identity is derived from the entire interview or self report measure across all domains e.g. occupation, religious and political values etc. hence a person is categorised within a single identity status i.e. *'moratorium'*. Whereas a 'domain-specific' identity is arrived at by considering the information related to a specific domain. Therefore a person can obtain more than one identity status, for example be categorised as *'moratorium'* in relation to occupation but for religious beliefs may fit the *'foreclosure'* status (Goossens, 2001).

In summary, a number of measures have been developed and the two outlined are amongst the most frequently used. Depending on the nature of the research both approaches, the interview and self-report measures have their strengths and weaknesses. Obviously the former lends itself to a more qualitative methodology whereby detailed information is gathered from a relatively small number of participants. In contrast the latter is more appropriately used when data is gathered from a much larger population. It has also been suggested that an interview format

and self-report measures of identity status may measure different components of the identity construct (Berzonsky & Adams, 1999), a claim that has been untested to date.

However it is important to note that the above mentioned measures would benefit from being updated as some items appear to be out of date as they are based on conservative views and or a Christian ethos. Additionally, seemingly more contemporary issues pertaining to adolescents in 21st century, such as the use of drugs and homosexuality need to be included in order to modernise the measures. Hence the limitations in the measures available mean that possible relevant domains in identity development are not being assessed.

Mental Health Problems in Adolescence

As already alluded to, the impact of having a mental health problem during adolescence may affect the young person's ability to successfully negotiate the transition from childhood to adulthood. The relationship between mental health problems and the successful navigation of this period is however likely to be 'reciprocal' in nature. In that, the presence of a mental health problem is likely to hinder the successful negotiation of adolescent development and equally, difficulties encountered dealing with the tasks of adolescence may place the young person at risk of mental health problems.

Morbidity

Mental health refers to primarily; a) the ability to develop psychologically, emotionally, intellectually and socially; and b) to be able to function at an optimal

level, for example, the ability to cope with stress and adversity (Kazdin, 1993; Young Minds, 2003). There are recognised difficulties defining the various kinds of problems encountered by young people, not least due to the fact that some terms, such as 'mental disorder' can be stigmatising and locate the problem within the young person (Health Advisory Service, 1995). However the Department of Health (2004) endorsed the definition of 'mental health problems', used by the Health Advisory Service (1995) which is as follows: 'Mental health problems may be reflected in difficulties and/or disabilities in the realm of personal relationships, psychological development, the capacity for play and learning and in distress and maladaptive behaviour'. However, when the problem is persistent, severe and affects functioning on a day-to-day basis, for example, school performance and interpersonal relationships, such difficulties are referred to as 'mental health disorders' (DOH, 2004). Classification frameworks have been developed, for example the ICD-10 (WHO, 1993) and DSM-IV (APA, 1994), which specify sets of symptoms and/or behaviours associated with specific disorders. Common types of disorders in childhood and adolescence include emotional disorders such as anxiety, depression and obsessions; hyperactivity disorders involving inattention and overactivity; and conduct disorders characterised by awkward, troublesome, aggressive and antisocial behaviours (Meltzer, Gatward, Goodman & Ford, 2000).

Rutter & Smith (1995) reported that there has been a growth in such disorders among young people over the past 50 years in Western Europe, including depression, eating disorders, self harm and suicide. Meltzer et al. (2000) conducted a survey of over 10,000 British 5 to 15 year olds. They collected data from parents, young people and teachers to look at the three main categories of mental health disorders as highlighted

above. They found significant mental health disorders in over 10% of 5 to15 years old and an increased prevalence rate among boys. The prevalence rate of mental disorders increased with age, so that among 11 to 15 years old 11.2% presented with mental health problems compared to 8.2% of 5 to 10 year olds. Amongst 5 to 10 year olds, 10% of boys compared with 6% of girls were found to meet the criteria of a 'mental disorder' in line with ICD-10 and DSM-IV, as were 13% of boys and 10% of girls in the 11-15 year age group. When the disorders were divided by categories girls slightly outnumbered boys under emotional disorders while boys were more likely to present with conduct disorders. It has also been noted that mental health problems tend to get more complex and serious as young people get older (Petersen & Leffert, 1995). This may be associated with the additional demands and stresses experienced by adolescents as they negotiate the developmental tasks outlined above e.g. puberty. Additionally, the Department of Health (1995) reported that 2-8% of adolescents experience major depression; 1.9% have OCD; 0.5-1% of 12 to 19 year olds (mainly girls) have anorexia nervosa and 1% bulimia nervosa.

Meltzer et al. (2000) also examined the impact of children's mental health problems on education and social functioning of the family and child. 19% of children with a mental health problem were more than twice as likely to have been absent from school for 11 days of more in the past term compared to children without a mental health problem (8%). Those with a mental health problem (33%) were four times more likely than other children (9%) to admit to playing truant. Family relationships were reported by 1 in 3 parents to be strained as a result of their children's problems. 9% of young people aged 11 to 15 reported a severe lack of friendships as compared with 5% of young people with no disorder. Young people with a mental disorder

were nearly twice as likely to have felt so unhappy or worried that they had sought help and advice from others (41% compared to 23%). Alcohol and cannabis use were markedly higher amongst young people experiencing mental health problems. However, it is important to note that the relationship between factors is unclear; one cannot be sure whether the above outlined difficulties are a cause or result of the problems.

Risk and Protective Factors

The development of mental health problems in adolescents is influenced by many factors. Risk factors are considered to be any variable that increases the likelihood of the onset, exacerbation, or maintenance of a mental health problem (Smokowski, Mann, Reynolds & Fraser, 2004). Three major risks factors that place young people in a vulnerable position have been highlighted by many; (1) personal predisposing factors; (2) the family; and (3) the community (e.g. Young Minds, 2003). Risk factors associated with the young person include low intelligence and difficult temperament which incorporates problems establishing regular patterns for feeding and sleeping during the earlier years and increased conflict with parents, peers and teachers. Family factors that predispose the young person to mental health problems include; family breakdown; overt parental conflict; physical, sexual or emotional abuse; harsh, inconsistent or unclear discipline; and parental drug, alcohol or mental health problems. Community factors include poor housing; poverty; lack of economic of social support; or experiencing discrimination. Bearing in mind the adolescent 'tasks' outlined earlier and the fact that there are numerous external pressures exerting potential stress, not least academic stresses of exams, it would seem reasonable to suggest that these combined with risk factors make some young

people particularly vulnerable to developing mental health problems during this period.

Kazdin (1993) further points out that some adolescents participate in 'at-risk' behaviours which increase the risk to their mental health. At-risk behaviours are defined as activities engaged in by young people that place them at higher risk of adverse consequences, such as substance misuse; unprotected sexual activity; antisocial and violent behaviour; running away from home and leaving school early. Kazdin (1993) argues that such behaviours are linked with mental health problems during adolescence and that the two are often interrelated. Kazdin (1993) adds that at-risk behaviours need to be considered on an individual basis and their influence on mental health is mediated by a variety of factors, including severity and chronicity of the behaviour as well as contextual factors such as available support systems.

It seems that the potential impact of risk is determined by, the number of risk factors present, context, timing of onset and the duration of the risk (Elder, 1999). It appears that risk factors are cumulative: while a single risk factor, such as a family stressor, appears to be largely unrelated to mental health problems (Rutter, 1979), increased numbers of risk factors exert a stronger influence on young people (Fergusson & Lynskey, 1996; Rutter, 2001). Smokowski et al. (2004) found that the reverse seems to hold true, namely that children exposed to the least number of risk factors appear to do best.

Protective factors are internal and external resources that increase the young person's resilience to risk factors and consequently reduce the chances of experiencing a

mental health problem (Luthar, Cicchetti & Becker, 2000). Garmezy (1985) highlighted three areas that appear to enhance resilience; (1) the individual's predisposing characteristics, for example, cognitive abilities, temperament, responsiveness to change and coping skills; (2) family factors, particularly at least one good parent-child relationship, warmth, consistency and protection; (3) extrafamilial social environment, which incorporates the availability of wider social support networks and the use of these.

While scant literature to date has focused on the impact of having a mental health problem on identity development during adolescence, several studies have examined the impact that chronic or life-threatening physical illnesses can have on identity development in young people. These shall be reviewed below and subsequently discussed in terms of any indicators they may provide about the potential impact of mental health problems on identity development.

Impact of Other Conditions on Identity

Chronic Illnesses and Identity

A body of literature focusing specifically on how identity may be affected by the presence of chronic or life-threatening illnesses during adolescence is available (Gavaghan & Roach, 1987; Hosek, Harper, & Robinson, 2002). It appears that illness-related stressors associated with having a disability or chronic illness may negatively influence identity development in adolescents. Research in this area has specifically looked at cancer, diabetes and HIV but the findings summarised below may be relevant to all chronic illnesses. Eiser (1995) highlighted that although chronic illnesses vary greatly with regard to a variety of factors including aetiology,

stability and predictability, threat to life, restrictions etc., there are many similarities across different conditions which have a long duration and lack of a cure in common, and which may entail a life-time of hospital appointments, diagnostic procedures and painful treatments.

A number of authors have commented on how young people with a chronic disease may face very special difficulties attaining ego identity formation as proposed by Erikson (1968). Rainey (1982) highlighted several reasons why such difficulties may exist, including that adolescents with cancer are more likely than healthy adolescents to remain dependent on their parents; time spent socialising with peers is likely to be limited due to the constraints of the disease; and due to the uncertainty of the prognosis planning for the future may be curtailed.

Gavaghan and Roach (1987) set out to assess the level of ego identity achievement in adolescents with cancer as compared to healthy adolescents. Measures of identity development were administered including the Ego Identity Incomplete Sentences Blank (Marcia, 1966). 42 adolescents (23 females and 19 males) aged between 14 to 22 years who were receiving medical care for a range of cancers at a US children's hospital participated in this study. Length of illness ranged from 4 to 193 months and at the time of the study 26 of the participants were receiving some form of treatment. 42 healthy participants were matched with the above participants and drawn from two high schools and a university. The findings of this study clearly supported the theoretical assumptions made earlier (e.g. Eiser, 1995; Rainey, 1982), namely that chronic disease has a negative impact on adolescents and may impede normal development. Adolescents with cancer certainly struggled more with their

identity formation and were developmentally at a lower level than matched controls in terms of clarity of career, marriage, and children. Gavaghan and Roach (1987) concluded that illness-related factors such as prognosis which lead to uncertainty about the future meant that for these young people opportunities to explore values, formulate goals and make commitments were eclipsed by concerns about their illness. In addition, they suggest that peer socialisation, which Erikson (1968) argues is an important factor in identity formation, is frequently disrupted for these young people due to hospitalisation and treatment procedures. Interestingly in the area of religion there was no significant difference between healthy participants and participants with cancer. Gavaghan and Roach (1987) found that some adolescents with cancer had in fact been prompted to explore religious beliefs as a result of becoming unwell. They added that the area of religion was very different from areas of career, marriage and children as religion is based more on one's current beliefs, whereas the other areas rely heavily on the ability to project into the future.

A more recent study on adolescents with cancer focused on the long term psychological implications of survival of childhood cancer (Madan-Swain et al., 2000). They noted methodological limitations of previous studies, for example Gavaghan and Roach (1987), who failed to separate adolescents who were in the active phase of treatment from those were not receiving any treatment. They argued that an understanding of identity formation in survivors was justified in order to broaden the issues pertaining to identity formation. Madan-Swain et al. (2000) compared 52 cancer survivors (aged from 12 to 23 years old) and their mothers with a healthy matched comparison group of 42 participants. On average participants had completed treatment five years prior to taking part in the study. Participants and

their mothers completed an array of self report measures, including the EOM-EIS-II. Significantly greater numbers of survivors than healthy comparisons fell in the *foreclosure* status. The authors took this to suggest that adopting the views of significant others might serve as a protective function in assisting these young people to cope with the stress of the cancer experience. In contrast to Gavaghan and Roach's (1987) findings, Madan-Swain et al. (2000) did not find a difference between survivors and healthy controls in overall attainment of identity *achievement* status. They also found that progression of identity development is age dependent in that the older the adolescent is the more likely they are to have reached a higher identity status.

Hosek et al. (2002) studied eight young people aged 17 to 21 with a HIV+ diagnosis. In addition to the areas of illness-related stressors already highlighted, they were interested in exploring the impact of the knowledge of potential impending mortality and bodily changes on the process of forming an identity during adolescence. They hypothesised that individuals with HIV may have difficulties making future plans due to the uncertainty surrounding their prognosis. Furthermore, the stigmatisation of HIV may result in the young person either postponing or abandoning their future plans for fear of unintentional disclosure or discrimination, thus affecting identity statuses as defined by Marcia's (1966) theory.

Measures completed by participants were the OM-EIS (Adams et al., 1979), ISI (Marcia, 1966) and an unstructured qualitative interview, devised by the authors. Overall, they found that in some way participants either thought that, in relation to their goals and values HIV had a) made a difference; b) made no difference; or c)

made an initial difference which was temporary. Participants fell into two identity statuses, five in the *diffusion* status and three in the *achievement* status, which are at opposite ends of the identity status continuum. The way in which participants thought about and explored their illness was strongly related to their identity status. Those that fell in the *achievement* status responded to HIV with 'abstract thought', demonstrating awareness of their thought processes regarding HIV and seemingly gaining personal strength from this exploration. Whereas those in the *diffusion* status responded with 'future futility', by deliberately avoiding thinking about it and being rather dismissive in their approach. For those who had reached the *achievement* status, Hosek et al. (2002) speculated that the diagnosis of HIV had aided the identity development process, as the knowledge that life might end prematurely encouraged these young people to swiftly explore and commit earlier to ensure they achieved their goals. Conversely, the opposite may be true for those who reached the *diffusion* status, e.g. that awareness of a shortened life expectancy may result in avoidance of exploration and commitment due to fear that goals will not be realised. Hosek et al. (2002) highlighted the importance of exploring contextual factors to help us understand individuals' identity statuses, such as, environmental factors, family responsibilities and sexual orientation that may influence the young person's point of view and experiences. A major criticism of this piece of research is that due to a lack of reference by the participants to HIV it is difficult to identify the specific impact of a HIV diagnosis on identity development. Therefore it is difficult to know whether, for example, the group that denied any changes in their goals due to HIV might actually be the group that did not have set goals to begin with. In addition, in view of the very small numbers involved great caution should be exercised in generalising from these findings.

In summary, research exploring various chronic illnesses has tended to show negative effects on adolescent development. In addition, the findings of such studies have intimated that experiencing a chronic illness during adolescence puts the young person at considerable risk in terms of negotiating the various physical and psychological transitions which define adolescence (e.g. Gavaghan & Roach, 1987; Hosek et al., 2002). However, interestingly Hosek et al.'s (2002) finding that a sizeable number of their participants had reached an *achieved* identity status does not fit with previous findings. They suggested that for the HIV+ participants in their study the prospect of their own mortality in some way accelerated the identity development process, yet Madan-Swain et al. (2000) found that young cancer survivors were more likely to *foreclose*. Hence there are slight areas of ambiguity which point towards possible differences between different types of chronic illnesses. Furthermore the small number of participants in the studies reviewed makes both the reliability and generalisability of the findings questionable. Overall then there appears to be a clear need for further research to shed light on the differences in results identified and to test the initial findings outlined above.

Identity and Mental Health Problems

As noted, there is a dearth of research examining the impact of mental health problems on adolescents' identity development. Worthy of note is a recent paper by Tan, Hope and Stewart (2003). Although the focus of this paper was on issues of 'competence' to make treatment decisions, they did so by exploring the impact of having anorexia nervosa on sense of personal identity. They conducted qualitative interviews with 10 females aged from 13 to 22 years old who had a diagnosis of anorexia nervosa along with nine of their parents. The findings suggested that the

young people with anorexia nervosa perceived their eating disorder as being part of their identity. Consequently to accept treatment was a difficult decision to make as it would result in giving up part of who they perceived themselves to be.

One of the only studies that specifically investigated the impact of having a mental health problem on identity development is Kapfhammer, Neumeier and Scherer (1993). They examined identity development in young people with psychosis as compared to a control group. The EOM-EIS-II (Bennion & Adams, 1986) and a clinical interview were administered to 146 participants with psychosis aged 17 to 26 and 100 age matched controls. Kapfhammer et al. (1993) found that the young people with psychosis mostly fell in the *moratorium* status, both in terms of ideological and interpersonal identity. In contrast, the control group were mostly categorised as *achieved* identity status. Interestingly, both groups showed a strong rejection of the *foreclosed* identity status, this is in contrast to other research (e.g. Madan-Swain et al., 2000) which showed high agreement with the *foreclosed* identity status. Kapfhammer et al. (1993) pointed out that this may be due to the higher age of the participants and associated increased experience with age.

To conclude, the developmental tasks associated with adolescence are relatively well documented. There is a wealth of literature on 'identity' which emphasises the importance of the young person exploring and committing to goals, values and beliefs, in shaping one's sense of self. However there is a general lack of research on adolescents with mental health problems despite the fact that prevalence rates are increasing amongst this group. As a result our understanding of the impact of having

a mental health problem on identity development is seriously lacking and indicates a need for further research.

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Part 2

Empirical Paper

Abstract

The aim of this study was to explore how the presence of a mental health problem may impact on the development of identity during adolescence. Ten young people aged between 14 and 18 receiving input from a Tier 3 Child and Adolescent Mental Health Service participated in this study. Participants' personal accounts of having a mental health problem were explored through in-depth semi-structured interviews, specifically focusing on sense of self, future plans, values and relationships. In addition, participants completed a standardised self report questionnaire (Objective Measure of Ego Identity Status, OM-EIS; Adams, Shea & Fitch, 1979), which categorises individuals into one of four identity statuses: *diffusion, foreclosure, moratorium* and *achievement,* as described by Marcia (1966).

Interview data was analysed using an interpretative phenomenological approach (IPA; Smith, 2003). Six overarching categories were identified including *'the importance of understanding'* and *'getting in the way'*. On the OM-EIS seven participants were categorised as in the *diffusion* status, the other three in *moratorium.* The present findings indicate that mental health problems during the adolescent years can have a negative impact on identity development in the young person concerned.

Introduction

Adolescence

Adolescence is defined as the 'transition' between childhood and adulthood and several developmental tasks have been highlighted as pivotal to a 'successful' transition being made by the young person (Coleman & Hendry, 1999). With the onset of adolescence the young person deals with multiple developmental tasks concurrently. During this period the young person has to negotiate enormous changes, including physical changes and development of sexuality; an increase in intellectual abilities; and increased independence from family in favour of closer peer relationships, all of which contribute to the young person's developing 'sense of self'. This study explored adolescents' identity development, and how this process may be affected by the presence of a mental health problem.

Prevalence of mental health problems amongst adolescence

A variety of different terms have been used to describe the various kinds of personal and social problems encountered by young people. The term 'mental health problem' is used here to refer to marked distress, confusion and disturbance that a young person may experience, persistency of which impacts on day-to-day functioning and of a severity to require help from services. Common types of disorders in childhood and adolescence include emotional disorders such as anxiety, depression and obsessions; hyperactivity disorders involving inattention and overactivity; and conduct disorders characterised by awkward, troublesome, aggressive and antisocial behaviours (Meltzer, Gatward, Goodman & Ford, 2000).

Rutter and Smith (1995) reported that there has been a growth in psychiatric disturbance among young people over the past 50 years in Western Europe, including depression, eating disorders, self harm and suicide. A national survey of over 10,000 five to 15 year olds looked at the mental health of children and adolescents in Great Britain (Meltzer et al., 2000). They found significant mental health disorders in over 10% of five to 15 year olds and an increased prevalence rate amongst boys. Accordingly the National Service Framework (DOH, 2004) points out that this implies that approximately 1.1 million children under the age of 18 would gain from the input of specialist services. Petersen and Leffert (1995) added that mental health problems tend to get more complex and serious as young people get older. Additionally, the Department of Health (1995) reported that 2-8% of adolescents experience major depression; 1.9% have OCD; 0.5-1% of 12 to 19 year olds (mainly girls) have anorexia nervosa and 1% bulimia nervosa.

Identity development theory

Erikson (1968) conceptualised the life-cycle as a series of eight stages, each associated with a conflict that needs to be resolved. Adolescence is the fifth stage and the task is the establishment of a 'coherent identity'. Failure to successfully resolve this task results in role confusion. According to Erikson, for the young person to achieve a sense of identity they go through a 'crisis' period which is the exploration of goals, values and beliefs held by significant others e.g. parents. The 'I' is created when the young person becomes aware of their personal set of goals, values and beliefs in relation to those held by others and commits to them.

Marcia's identity statuses

Marcia elaborated on Erikson's concept of identity versus role confusion conflict and described four empirically based modes of identity resolution: *diffusion, foreclosure, moratorium and achievement.* Each status is based on levels of 'exploration' and 'commitment' toward the domains deemed indicative of a more or less successful identity resolution during adolescence. The domains are vocational plans, religious and political views, sexual expression and sex role beliefs. Exploration pertains to information seeking behaviour for the purpose of making decisions and choices. Commitment refers to the consolidation of such explorations by making a firm decision. Marcia (1966) proposed that young people in the *achievement* and *foreclosure* identity statuses have both made commitments to these domains however individuals in the *achievement* status have done so following a decision-making period, while those in the *foreclosure* status have merely adopted roles and values of significant others. Those categorised within *Moratorium* and *diffusion* identity statuses both are lacking commitment but young people in the *moratorium* status are undergoing an evaluative process in search of suitable social roles, while individuals in the *diffusion* status are not.

Impact of other conditions on identity

While scant literature to date has focused on the impact of having a mental health problem on identity development during adolescence, several studies have examined the impact of a chronic or life-threatening physical illness on identity development in young people. A number of authors (e.g. Eiser, 1995; Rainey, 1982) have observed that young people with a chronic illness may face difficulties in successfully resolving the identity conflict as proposed by Erikson (1968). Rainey (1982)

highlighted several reasons why such difficulties may exist, including that adolescents with cancer are more likely than healthy adolescents to remain dependent on their parents for longer; time spent socialising with peers is limited due to the constraints of their illness; and uncertainty of the prognosis may curtail making plans for the future.

Gavaghan and Roach (1987) set out to assess the level of identity achievement in adolescents with cancer as compared to healthy adolescents. The findings of this study clearly support the above, as adolescents with cancer were found to struggle more with identity formation and were developmentally at a lower level than matched controls on clarity of career, marriage, and children. Gavaghan and Roach (1987) concluded that illness-related factors such as prognosis, which lead to uncertainty about the future, meant that for these young people opportunities to explore values, formulate goals and make commitments were overshadowed by concerns about their illness. In addition, they highlighted that peer socialisation is disrupted for these young people due to hospitalisation and treatment procedures. Interestingly in the area of religion there was no significant difference between healthy participants and participants with cancer as they found that some adolescents with cancer had indeed explored religious beliefs as a result of becoming unwell. They also added that the area of religion was very different from areas of career, marriage and children as religion is based more on one's current situation, whereas the other areas rely heavily on the ability to project into the future. Madan-Swain et al. (2000) compared identity development in childhood cancer survivors with a matched healthy group and found significantly greater number of survivors than healthy comparisons fell in the *foreclosure* status. In contrast to Gavaghan and

Roach (1987), Madan-Swain et al. (2000) did not find a difference between survivors and healthy controls in overall attainment of *achievement* identity status.

Hosek, Harper and Robinson (2002) studied eight young people who were HIV+ between the ages of 17 to 21. In addition to the areas of illness-related stressors already highlighted, they were interested in exploring the impact of the knowledge of impending mortality and bodily changes on the process of forming an identity during adolescence. They hypothesised that the stigmatisation connected with HIV may result in the young person either postponing or abandoning their future plans for fear of discrimination or unintentional disclosure, thus altering identity statuses as defined by Marcia's (1966) theory. Participants fell almost equally into two identity statuses (five participants fell in the *diffusion* identity status and 3 in the *achievement* status), which are at opposite ends of the continuum. The way in which participants thought about and explored their illness was strongly related to their identity status. Those that fell in the *achievement* status responded to HIV with an increased awareness of their thoughts about their diagnosis and seemingly gained personal strength from this. Whereas the approach adopted by those in the *diffusion* status was one of deliberate avoidance and apathy. For those who reached the achievement status, Hosek et al. (2002) speculated that the diagnosis of HIV had aided the identity development process, as the knowledge that life might end prematurely encouraged these young people to explore and commit to ensure they achieved their goals. Conversely, the opposite may be true for those that reached the *diffusion* status, namely that awareness of a shortened life expectancy may result in avoidance of exploration and commitment due to fears that goals will not be realised. A major criticism of this piece of research is that the methodology makes it difficult to

identify the specific impact of a HIV diagnosis on identity development, not least due to the lack of a control group and a lack of direct references to HIV by the participants. Therefore it is difficult to know whether the findings are due to HIV or other factors. In addition, in view of the very small numbers involved great caution should be exercised in generalising from these findings.

Identity and mental health problems

As noted, there is a dearth of research examining the impact of mental health problems on adolescents' identity development. One of the only studies that specifically investigated the impact of having a mental health problem on identity development is Kapfhammer, Neumeier and Scherer (1993). They examined the extent to which in-patients with psychosis followed a developmental path based on experimentation and decision-making in forming their identity status as compared to a control group. Kapfhammer et al. (1993) found that the patient group fell mostly in the *moratorium* identity status. In contrast, the control group fell mostly in the *achieved* identity status. Interestingly, both groups showed a strong rejection of the *foreclosed* identity status, which is in contrast to other research (e.g. Madan-Swain et al., 2000) which showed high agreement with the *foreclosed* identity status. Kapfhammer et al. (1993) pointed out that this may be due to the participants being older and consequently associated with increased experience.

The enormity of the various tasks of adolescence i.e. becoming autonomous from parents whilst maintaining links to the family, making career choices, finding a partner etc. can present as a challenge for any young person. We know from the research conducted on young people with chronic illnesses that identity development

is compromised due to a variety of illness-related factors such as limited contact with peers etc. This clearly overlaps with the experiences of people with a mental health problems. In addition, these young people are also dealing with the stigma associated with mental health problems (Chung & Chan, 2004) which is likely to have a negative impact on sense of self and identity. Thus the challenges of the adolescent period are likely to be inflated for a young person with a mental health problem.

Aims of the study and research questions

In light of the above empirical evidence adolescence is a time when an individual struggles to develop a strong 'sense of self', and to consolidate a series of choices into a coherent whole which make up the person and how they see themselves. Hence the aim of this study is to explore the impact of having a mental health problem on this process. As there has been little research in this area to date the present study has taken an exploratory approach using qualitative analysis of data derived from semi-structured interviews. A qualitative approach is advocated when conducting research on understudied populations due to the possible richness of information available (Fiese & Bickham, 1998). This study addresses key issues suggested by the existing literature, including:

- Adolescents' perceptions of the way in which their mental health problem has impacted on their identity, specifically exploring the following areas:
    - relationships with family and friends, including sexual relationships
    - activities including school and socialising
    - perceptions of the future including career plans and hopes and fears
    - sense of self including body image, self-esteem, negative and positive selves

- How young people make sense of, explain and manage their experience of having a mental health problem.

In addition, a self report measure, the Objective Measure of Ego Identity Status (OM-EIS; Adams, Shea and Fitch, 1979), was administered in order to be able to quantitatively utilise Marcia's conceptualisation of the four distinct modes of dealing with identity. Given that this measure and the EOM-EIS-II (Bennion & Adams, 1986), also based on Erikson and Marcia have been used in many studies on adolescent identity development, I also aim to draw some tentative comparisons between the current results and other studies.

Method

Design

The study incorporated both qualitative and quantitative methodologies as it included a semi-structured interview and a standardised self-report measure.

Recruitment Process and Procedure

Recruitment of participants

Recruitment took place over a period of nine months between August 2004 and April 2005. Participants were recruited through two NHS Trusts which covered three Tier 3 child and adolescent mental health services (CAMHS).

This study included young people who met the following inclusion criteria:

1. Males and females aged between 14 to18 years old.
2. Presence of a mental health problem of a severity requiring input from CAMHS Tier 3 (including outreach services).
3. Difficulties have been present for at least six months.
4. Participants' mental health difficulties must be sufficiently contained to allow participation in a one-to-one in-depth interview.
5. Formal psychiatric diagnosis is not necessary.

Additionally, participants needed to be able to speak English to take part in the interviews. Exclusion criteria for the study were young people diagnosed with psychosis or a learning disability and looked after children. This was because it was anticipated that the difficulties experienced and their potential impact on identity

development may be markedly different amongst these groups and there would be insufficient numbers to examine any of them as a separate cohort.

Procedure

Potential participants were initially approached by a member of the multidisciplinary team (MDT), known to them, who handed out the 'Participant Information Sheet' (see Appendix 1) to young people who met the above inclusion criteria. The information sheet gave details of the aim of the study, the procedure and issues of confidentiality. Bearing in mind the target audience, the information was presented in an attractive and straightforward question and answer format in order to reduce any confusion. The young person was then asked if he/she gave permission for their name and contact details to be passed onto the researcher. It was made clear that by agreeing to this they merely agreed to find out more about the study but not necessarily to participate. Alternatively the researcher's contact telephone number was on the information sheet enabling potential participants to contact the researcher directly. In addition, during the recruitment phase posters (see Appendix 2) were displayed on notice boards in waiting areas inviting young people to contact the researcher directly if they were interested in finding out more about the study.

Young people who gave permission for their contact details to be passed onto the researcher were contacted within a week by telephone to discuss the study in more detail and answer any questions. Of 17 potential participants, 10 participated in the study, four did not meet the inclusion criteria and three declined to participate following an initial contact; they were thanked for their interest and those who did

not participate were informed that their contact details would be destroyed. All 10 participants were seen at the CAMHS base.

One individual meeting lasting up to two hours long was arranged with each participant. The first part of the meeting focused on reviewing the information sheet, providing another opportunity for the participant to ask questions and discussing issues of confidentiality and consent. It was made clear that all data collected would be kept confidential and all personal information would be anonymised. Participants were informed that the study would be written-up as a part of a professional qualification and that the researcher intended to disseminate the results of the study in an academic journal. Participants were then invited to sign the consent form and those under the age of sixteen were informed that they would also need to obtain consent from a parent or guardian (see Appendix 3). All participants were informed that they could withdraw from the study at any time without having to give a reason and that this would not affect the current service they were receiving.

The semi structured interview was then conducted and lasted between 45 minutes to one hour and 45 minutes. Once the interview was completed each participant was asked to fill in the Objective Measure of Ego Identity Status questionnaire (OM-EIS; Adams et al., 1979). The questionnaire was always administered after the interview in order to ensure that the content did not influence the participants' personal accounts and views. At the end of the meeting participants were asked if they wanted to receive a summary of the results in due course.

Participants

10 young people took part in this study, all of whom were receiving input from a CAMHS Tier 3 service. Information about participants is presented in table 1:

Table 1: Demographic details of participants

Participant	Age	Gender	Ethnicity	Mental health problem **(primary diagnosis)**	Self harm Yes / No	In education Yes / No
P1	15	Female	White UK	**Depression**	yes	no
P2	14	Female	White European	**Depression** Social Anxiety	no	no
P3	15	Male	White UK	**Obsessive Compulsive Disorder**	no	yes
P4	15	Female	White UK	**Anorexia** Bulimia	no	yes
P5	15	Female	White UK	**Depression**	yes	no
P6	17	Female	White UK	**Depression** Anxiety	no	no
P7	14	Female	White UK	**Behavioural difficulties**	no	yes
P8	14	Female	White UK	**Anorexia**	no	yes
P9	18	Female	White UK	**Depression** Anorexia Anxiety	yes	yes
P10	18	Female	Asian	**Depression** PTSD Anxiety	yes	yes

Of the 10, nine were female and one was male, and eight were of white UK origin, one white European and one Asian. The mean participant age was 15 ½ years old and ranged from 14 to 18 years old. The 10 participants reported being diagnosed with 17 disorders in total; five participants had received two or three diagnoses and five had received a single diagnosis. Six participants had been diagnosed with depression; one with social anxiety; one with obsessive compulsive disorder; three with anorexia and one with bulimia; three with anxiety; one with behavioural/conduct problems and one with post traumatic stress disorder. Four participants reported suicidal ideation or self harm and four had left school before the age of sixteen.

Data Collection

Semi-structured Interview

Interviews were used to gain a detailed narrative of the experiences and thoughts of the young people who participated in the study. The semi-structured interview format served as a guide enabling the researcher to follow the participant's lead and pursue relevant and possibly unforeseen avenues that emerged during the interview. Such an exploratory approach lends itself well to subject areas where little is already known.

Smith (2003) recommends that the interview schedule is based around a number of key areas. For the purposes of the present study these were derived from the existing literature on adolescence, mental health problems and identity development.

The topics covered were:

1. Getting to know the participant. The first topic was primarily devised in order to engage the young person and establish rapport.
2. Understanding of their mental health problem. The aim of this topic was to explore participants' experiences of their mental health problems.
3. Managing difficulties. This section provided an opportunity to discover what help had been offered and what participants had found helpful or unhelpful in dealing with their difficulties.
4. The impact of mental health problems. This topic asked how the difficulties experienced by the young person had impacted on various aspects of his/her life, focusing specifically on areas that are likely to influence the young person's conceptualisation of his/her identity;
    a. identity and self concept
    b. family and relationships
    c. future plans
    d. activities
5. Closing the interview.

A copy of the interview schedule can be found in Appendix 4.

Standardised Questionnaire

The Objective Measure of Ego Identity Status (OM-EIS; Adams et al., 1979) was administered in order to be able to quantitatively utilise Marcia's conceptualisation of the four distinct modes of dealing with identity and to draw some tentative comparisons between the current results and other studies. The OM-EIS (see Appendix 5) contains 24 items covering the areas of occupation, religion and politics with six items reflecting each of the four identity statuses (diffusion, foreclosure,

moratorium and achievement). Adams et al. (1979) based the items on previous types of responses to interview questions (Marcia, 1966), which reflected the extent of 'exploration' and 'commitment' that would be typical for each identity status. Participants rate the extent to which statements are self-descriptive on a 6-point Likert scale (from 1 = strongly disagree to 6 = strongly agree).

There are three different rules with which an identity status is assigned; if the individual's sub-score exceeds the cut-off for only one of the four identity statuses and the other three sub-scales fall below the cut-offs then this is referred to as a 'pure' identity status type; when all four sub-scales fall below all the cut-offs these individuals are scored as 'low profile'; and when two of the four sub-scales are above the cut-off this is referred to as a 'transitional-status' category. If an individual scored above three cut-offs then according to Adams (1998) this data should be disregarded. The psychometric properties of the OM-EIS have been evaluated by several studies investigating the reliability and validity of this measure, as reported by Adams (1998). Median internal consistency estimates across six studies, as measured by Cronbach's alpha, were reported to be 0.66 and median test-retest reliabilities 0.76 (Adams, 1998).

Analysis of interview data

All interviews were tape recorded and then transcribed verbatim. All identifiable information was removed in order to protect confidentiality. Analysis of data was performed using Interpretative Phenomenological Analysis (IPA; Smith, 2003).

Rationale for using IPA

When conducting qualitative research it is possible to adopt a range of theoretical positions. A positivist position assumes that the data derived from a person's responses in an interview is a 'factual' testimony and can be independently verified. In contrast, a relativist position would argue that a person's responses are a creation of the interactive functions of a particular social context, such as that adopted in discourse analysis (Potter & Wetherall, 1987). An interpretative phenomenological approach takes a more midpoint position as it acknowledges that a person's responses have some durability across settings, whilst also appreciating that meanings are influenced by the social context.

This study adopts an interpretative phenomenological approach as the researcher was interested in the young people's subjective accounts of their experience of having a mental health problem and its impact on their sense of self, whilst also recognising that these accounts may be influenced by their context at a particular point in time.

Data Analysis

Analysis of interview data was carried out following Smith's (2003) recommendations for conducting IPA. Firstly, each transcript was read several times in order to become familiar with the content, see Appendix 6 for an excerpt from a transcript. One interview was then taken and key points were written in the margin, which remained as close as possible to the words of the participant (see Appendix 7). A summary list of the key points was then compiled (see Appendix 8 for an example from one transcript). Emerging themes were then generated by using key words to capture ideas found in the text and illustrated with quotes. The list of themes from

the first interview was then used as a framework to begin the analysis of the remaining transcripts, which resulted in new themes emerging and current themes being redefined.

A list was then compiled of the emergent themes across the interviews. At this point themes that appeared related were clustered together to arrive at overarching categories (please see appendix 9). This list was also reviewed in order to look for patterns of similarities and differences across participants' accounts. This stage was conducted jointly by the researcher and supervisor and any discrepancies were discussed until agreement was reached.

Credibility checks

Credibility checks were made throughout the analysis process by following guidelines set out by Elliott, Fischer and Rennie (1999). The initial three transcripts were read independently by the researcher and the research supervisors, subsequently ideas and potential themes were discussed and any differences dealt with through further conversations. The list of emerging themes compiled by the researcher was also checked by the supervisor and the initial clustering of themes was completed jointly. Once all the overarching categories and sub-themes had been compiled, this was reviewed again with the supervisor in order to ensure the themes reflected participants' accounts. Appropriate modifications were then made.

The Researcher's Perspective

An interpretative phenomenological approach acknowledges that the researcher's own ideas and thoughts inevitably influence meaning derived from participants'

responses (Elliott et al., 1999). Therefore it is good practice to make clear any possible biases or assumptions that may have influenced this process. I have worked with adolescents in a variety of settings across CAMHS tiers 2 to 4 and within non-mental health settings such as local authority play services. During the course of this work I became aware of the challenges and struggles faced by some young people who seemed to be going through a major transition in their lives. Of particular interest were issues related to how young people make sense of who they are in relation to their surroundings and in the face of various difficulties. I gained from later clinical placements a sense that significant mental health problems during adolescence, coupled with the stigma associated with it can have a negative effect on an individual's sense of who they are. In light of the wealth of literature on the importance of this time period coupled with the adult literature on mental health problems I became curious about how adolescents make sense of their experiences. More specifically, how these constructions shape the ways in which they see themselves.

Ethical Issues

Ethical approval was obtained from East and North Hertfordshire Local Research Ethics Committee. A copy of the letter of approval can be found in Appendix 10.

As noted, written consent was sought from all participants taking part and a copy was placed in the young person's CAMHS file. In accordance with the Children's Act 1989 and specifically 'parental responsibility', all participants aged 14 and 15 needed their parent/guardian's permission to take part in the research project in addition to giving consent themselves.

Results

Analysis of interview data

Key points related to the participants' stories of having a mental health problem were extracted from the interview transcripts. The process of analysis continued with the clustering together of related themes. From this six overarching categories emerged from the IPA analysis. A summary of how each overarching category was constructed in terms of the sub-themes can be found in table 1, overleaf.

In the following each overarching category and its sub-themes will be briefly summarised and illustrated with reference to direct quotations from interviews.

Table 2: Summary of overarching categories and sub-themes

Overarching Categories	Sub-Themes
1. The importance of understanding	▪ Trying to make sense of what is happening ▪ Keeping it a secret ▪ "I felt better knowing what it was" ▪ Wanting others to understand
2. Uncertainty about the future	▪ "It is never going to go away" ▪ Having to start over again ▪ Wanting it to be the way it was before ▪ "I don't see myself with a future" ▪ Ambivalent feelings about the future ▪ "I'm hoping"
3. Getting in the way	▪ Isolation from peers ▪ Lack of motivation ▪ "My school work has been affected"
4. Negative view of self	▪ "I was embarrassed by it" ▪ "I thought I was going crazy" ▪ "Others might think I'm crazy" ▪ "I don't really like myself"
5. "It' rules everything"	▪ "I see it as me" ▪ "It has taken over my life"
6. "I understand where they are coming from"	▪ Knowing how to help others ▪ Becoming a good listener

1. The importance of understanding

This theme refers to a strong desire for understanding, not least when mental health problems were first experienced. It emerged as a central issue in all participants' accounts and was made up of several sub-themes. The theme covers key factors including how participants developed their understanding of their mental health problem and their perception of how others understood their difficulties.

Trying to make sense of what is happening

A key theme which emerged during interviews for virtually all of the young people was a need to try and make sense of what they were going through. They recalled noticing various changes, for example in their behaviour and relationships that were often distressing for them as they did not understand what was happening. It appeared that most of the young people had spent time contemplating their experiences and had made endeavours to understand the changes that they had noticed:

> *"For a long time I didn't really know, I knew something was wrong with me and I needed to do something about it but I didn't know what it was" (P10)*
>
> *"I felt quite lost and I thought what's wrong with me?" (P2)*
>
> *"It wasn't normal, it was like I was possessed by something" (P1)*

Various hypotheses were developed by some of the young people as to how they had come to experience such difficulties. A couple of young people thought that they had a predisposition to their difficulties in that they had, from a younger age, always responded to situations with undue sensitivity or worry:

> *"I have always been quite sensitive anyway..... ....I'm always crying" (P6)*

In contrast, other participants held others responsible for their difficulties:

> *"It annoyed me actually quite a bit. I was like I can't believe I've let them do this to me they made me get depression but obviously it isn't just their fault, I've let them do it" (P5)*

Of note, although the two participants with a primary eating disorder also wanted to understand the causes of their difficulties, they seemed less concerned about this than the other participants. They did not convey the same level of distress as others and seemed to gain something that they thought was positive:

> *"I had something that I was good at, that I could do" (P4)*
>
> *"Well I knew I was losing weight but I wanted to, so I was not concerned" (P4)*

Keeping it a secret

Half of the participants talked about how they kept their difficulties a secret from others by either pretending they were fine or by avoiding others. The young people had different reasons for this which included denial and embarrassment:

> *"Well I did know but I just did not want to admit it" (P8)*
>
> *"It was something that I did not want them (parents) to see because I was embarrassed by it.....so I would keep that away from them" (P6)*

At times, secrets were kept between specific members of the family, particularly with siblings. These seemed to arise from a wish by the young person and/or their parents to deny difficulties, protect siblings from potential upset and maintain the status quo, e.g. in terms of family life and daily routines:

"They (parents) deny there's a problem just to kind of move on" (P9)

"I don't really like my sisters to know what is going on....I don't want to upset my little sister so I try and keep things as normal as possible" (P4)

In addition, the young people with anorexia seemed to have another motivation apart from those mentioned above for keeping their difficulties a secret, namely an apparent alliance with their 'illness':

"I felt like I'd betray my illness if I did admit it" (P6)

"I felt better knowing what it was"

This sub-theme relates to participants' responses to receiving a formal diagnosis. Most of the young people who talked about receiving a diagnosis did so in favourable terms. Being given a diagnosis was considered to be helpful in a number of ways, not least because it contributed to their own understanding of what was going on. In addition, it validated their experiences by highlighting they were not alone and that there was help available for their condition:

"If there is a name for it then it means that it's not so kind of unusual and it can be helped" (P8)

"It kinda helped a little bit because I felt quite lost and I thought what's wrong with me and when they said it was social anxiety I was quite relieved to know what it was" (P2)

Some participants felt that having a label made it easier to explain their difficulties to others. A few of the young people expressed a sense of being empowered as they

were able to find out more information for themselves once they had a name for their difficulties:

> *"It is easier to say 'bulimia' rather than explain the whole thing" (P4)*
>
> *"He gave me some information and we looked it up on the internet" (P3)*

Wanting others to understand

This sub-theme is made up of two topics each of which will be described in turn. The first topic is *the wish for understanding,* and refers to the young people's desire that others (primarily family, friends and teachers) understand what they are going through. Being understood appeared to be very important for virtually all of the participants:

> *"I was really angry because it did not matter how many ways I tried to explain it to them (family,) you know about everything that is going on with me they did not understand" (P10)*
>
> *"My teachers don't really understand.....one of them in particular always shouts at me...so half the time if I'm not being thrown out I walk out, so it's quite difficult" (P9)*

Where participants felt that others understood their experience, a sense of closeness or being able to talk more openly to them was achieved:

> *"With my parents I think it's a bit better now because they sort of understand more, so it feels that I can talk to them" (P8)*

Conversely when the individual felt that they were not understood by others, this seemed to forge a distance between them:

"It got to my dad quite a bit and he did actually hit me once...he doesn't understand it .....it just sort of winds him up" (P3)

The second topic relates to *other people's experiences,* namely a sense expressed by some of the young people that in order for others to understand what they were going through they had to have experienced similar difficulties at a similar age. Consequently a few participants did not expect others to understand what they were going through as they did not have a personal experience to reflect upon:

"A lot of my friends won't know what to say to me because they've not been in that situation" (P9)

However, when participants felt that other young people had experienced similar difficulties, they appeared to be comforted by this as such knowledge seemed to provide them with a sense of belonging:

"So it was quite nice to know that there were people my age as well that were like me a little bit" (P6)

"I feel like it's not just me there are other people like that" (P10)

2. Uncertainty about the future

This overarching theme relates to the participants' reports of how they see their future in light of their mental health problem. Whilst there were divergent views about the prospects of the future, some clear sub-themes emerged from the data:

"It is never going to go away"

Most young people talked about their difficulties as something that would always be with them to varying degrees, for some this related to the lack of help available:

> *"I know that there is no cure for it and I will have it all my life" (P3)*
>
> *"If they (medication) don't help then that means I'm kinda unhelpable" (P4)*

Most participants described the impact their difficulties had had on previously held plans and hopes for the future, usually in negative terms. It appeared that a few young people had abandoned previously held plans such as chosen careers and having a family as they now believed that either they would not be good at it or others (e.g. prospective partner) would reject them due to their difficulties:

> *"I don't know what I'm going to do now because I don't want to be a teacher because I haven't got the patience anymore whereas I did before, I loved being with children" (P9)*
>
> *"Before everything started I used to think that I would have a boyfriend and children when I got older but I can't really see it happening now....I can't imagine that somebody is going to be interested in having a relationship with me" (P4)*

Having to start over again

A few young people felt that in order to progress they would need to make a completely new start as their current problems were an integral part of their lives. A key factor appeared to be that they perceived their problem to be integrated within both relationships with others and their daily routines. Consequently it seemed to them that their problems were entrenched, thus requiring drastic reorganisation of

themselves and/or their relationships in order to have a life without their current difficulties:

> *"My whole way of life is all really built up around food so I guess I'd kind of have to start again how to go about my life" (P4)*

Wanting it to be the way it was before

Some participants talked about the future with reference to how their lives had been before their difficulties started and expressed a wish to return to that time:

> *"When I think of my future I don't think about my illness so I sort of imagine myself as I was before" (P8)*

"I don't see myself with a future"

Almost half of the participants reported that they had either attempted suicide or had previously had suicidal thoughts:

> *"I used to sit on the window ledge, I was gonna throw myself out of the window" (P5)*

Discussing future plans appeared to be rather difficult for some of these participants in particular as they either could not see themselves in the future or it seemed uncertain in some way:

> *"God knows it's quite hard to think about the future. I don't really see myself like with a future at the moment so I haven't got a clue" (P9)*

Ambivalent feelings about the future

Once again the two participants with a primary eating disorder (and the participant with behavioural problems), appeared to give a rather different account from the other participants about how they wanted things to be. They appeared reluctant to let go of their difficulties and rather ambivalent about the future:

> *"I'm a bit like in two minds about it because I wouldn't be, I don't want to let go of my illness but I don't want my life to be like this. I want to be like how I used to be but I don't want to go through what I have to, to get better" (P8)*
>
> *"Although part of me would like to have a life without it another part of me, it's kinda become my life so I can't see how I wouldn't have it" (P4)*
>
> *"Well I liked the way I was when I was younger but I like the way I am now sort of thing" (P 7)*

"I'm hoping"

Generally most of the participants' thoughts and feelings regarding the future seemed to be fairly unenthusiastic largely due to a collective notion that their current difficulties would never truly leave them. However a thread of hope appeared to be woven through a few of the participants' accounts:

> *"I'm hoping that like they will get my medication sorted and it'll stabilise my mood and maybe the therapy will help" (P9)*
>
> *"What's gonna happen and that still worries me but you just have to try not to let it" (P6)*

3. Getting in the way

This overarching theme encompasses several sub-themes that cover how participants perceived their difficulties as impacting on interactions with their peers, education and activities.

Isolation from peers

When talking about friendships, most of the young people seemed to report that either they did not have any friends or had less interaction with their friends than they used to have before their difficulties:

> *"I just find it harder to involve myself how I used to so I don't" (P8)*
>
> *"I don't really go out with my friends as much" (P4)*

The few young people who talked of not having any friends at all expressed a wish to have friends:

> *"I think it's because I want it so much, I want to be able to go down there and have friends and speak to them and go back to their house and things and stay there" (P1)*

However this seemed to be mediated by concerns that they would be judged negatively and a lack of knowledge about how one makes friends:

> *"I automatically go thinking are they gonna like me...I'm insecure" (P1)*
>
> *"I'll probably have to make a brand new friend and where do I find one and what do I do when I have one?" (P6)*

Limited contact with peers also appeared to contribute to feelings of loneliness and isolation which were expressed by the participants:

> *"It feels like you're not wanted really, no one wants you around, no one wants to know you, everyone's always got a problem with you" (P5)*

In contrast, the young people who said they had friends talked about the importance of their friendships and the support gained from having close friends:

> *"They are constantly trying to do things to make me happy and that....I know I've always got them there" (P9)*

Lack of motivation

Whilst on the one hand most young people expressed a desire to fit in with their peers, most described either a lack of motivation to do things or an unwillingness to get involved due to not being well enough yet:

> *"I only want to do this when I've got my health back in order and everything's okay" (P10)*

"My school work has been affected"

This sub-theme incorporates school attendance and academic attainment. All participants conveyed that their difficulties negatively affected their education. This was related to a variety of factors including problems getting to school on time for reasons due to the side effects of medication and not wanting to be at school:

> *"When I was given medication to help me get to sleep I couldn't wake up early enough in the morning. It knocked me out and I think sometimes school was a bit not understanding" (P10)*

"I hated school and I didn't know why, I wasn't being bullied or didn't have no friends I just didn't know" (P6)

Most participants were concerned that their difficulties were having a detrimental impact on their educational attainment. Their concerns were based on the following key factors: not attending school; finding it difficult to concentrate whilst at school; and encountering problems attempting to balance the demands of school whilst dealing with a mental health problem:

"With everything going on it's affected my school work quite a lot like my grades have dropped.... I ain't got no concentration my mind will just drift off" (P9)

"I've had so much time off hum I haven't been able to like get good enough marks" (P5)

Consequently one young participant felt that studying was a waste of time as she thought that she would inevitably fail:

"It's going to be like two hours sitting an exam looking at others passing whilst I'm not writing anything (P9)"

4. Negative view of self

This overarching theme focuses on how participants viewed themselves and how they thought others viewed them.

"I was embarrassed by it"

Half of the participants spoke of either feeling personally embarrassed by their problems or that their parents were embarrassed by it:

> *"They might poke fun at me I'd rather they didn't know" (P3)*
>
> *"My mum and dad have made me feel quite ashamed of stuff that has happened because the way they have reacted" (P9)*

It seemed that this aroused a sense of shame amongst some of the participants particularly those who had engaged in self harming behaviour. A few of the young people pointed out that physical marks left as a result of self harming were visible to others and they conveyed a sense of feeling vulnerable particularly in relation to being negatively evaluated by others:

> *"I always wore long sleeve tops, if by chance I rolled my sleeves up and somebody was there my dad was like what are you doing pull your sleeve down....he'd say to me are you not embarrassed?" (P9)*
>
> *"Actually I'm quite glad I don't have any scars....otherwise people are like where did you get them scars...they'd probably think I'm nuts" (P5)*

"I thought I was going crazy"

With reference to the first overarching theme 'the importance of understanding,' in a bid to make sense of their experiences, many young people contended that they were in some way losing control over their behaviour, thoughts and ultimately their lives. They described this using different labels such as 'crazy', 'mad', 'insane', 'psychopath' etc.

"I'm pretty crazy....the whole suicide thing and self harm and the eating I don't see it's exactly sane" (P9)

"I was 15 and I thought that I was going insane" (P6)

A few young people also talked about their fears of being admitted to a psychiatric hospital as they thought that others would think that their problems warranted in-patient care. In addition, one young person thought that 'crazy' people were sectioned and involuntarily taken to hospital and she feared that was going to happen to her:

"I always used to worry 'oh my god they are going to put me in a mental institution if I say this to them'" (P10)

"Others might think I'm crazy"

Several of the young people were also concerned that as they thought they were going 'crazy' other people would also think they were 'crazy'. This was often informed by others e.g. parents, friends etc. making negative comments as well as the participants' own fears:

"My dad called me a psychopath when he found out I was self harming and that's always stuck with me and that's probably contributed to the way I feel now" (P9)

"I don't want to scare them off or make them think 'oh my god this girl's a lunatic or something because obviously I'm not" (P10)

"Like they'd think I'm psycho or something like going on one of them special wards" (P5)

"I don't really like myself"

This sub-theme comprises of participants' views about themselves and their unfavourable comparisons with their peers. Half of the participants expressed negative views of themselves in relation to their achievements, strengths, relationships and sense of self:

> *"Somebody did ask me recently list what's good about yourself...and I just stood there and I didn't know what to say" (P10)*
>
> *"I wouldn't say I was good at anything" (P2)*

Most of the young people expressed a sense that they were in some way different from their peers or felt that they were not accepted by others:

> *"I'd kind of see myself fit into the group whereas now....I've always got more stuff going on so I feel that I don't fit in much" (P9)*
>
> *"I wish I was just like everyone else" (P1)*

5. "It rules everything"

The young people spoke of their mental health problem as defining who they are and influencing what they do. Once again there appeared to be divergent views within this theme as some participants viewed this more negatively than others.

"I see it as me"

Participants described their difficulties as integral to their personal identity. The two participants with anorexia conveyed this as being positive whereas other participants tended to see it as an affliction. The young people had different reasons for considering their problems to be part of who they were; this related to issues

previously discussed, such as a prevailing sense that their problems would never go away, to a desire not to betray their 'illness'.

"If I didn't have it I wouldn't know who I was supposed to be" (P8)

"It takes over my life"

Unlike the sense of gain experienced in the accounts given by the two young people with anorexia, other participants described an overwhelming feeling of their difficulties having taken over their lives. They described feeling 'ruled' by their problems and associated lack of control over their lives to this:

"I am always thinking what can I do, what I can't do, whether I got to wash my hand before I can do certain things" (P3)

"It's annoying because it like takes over my life really" (P9)

6. I understand where they are coming from

This overarching category denotes the sense expressed by some of the young people that having a mental health problem has had at least some positive effects in that they now felt in a position to help others.

Knowing how to help others

As a result of having experienced serious difficulties themselves a few of the young people felt that they were now in a better position to recognise, understand and help others going through similar experiences:

"I was thinking about maybe going to work in mental health myself because I think if you have had like an experience yourself then you're more likely to be able to relate to someone else" (P4).

"A lot of the times it helps because with my friends if they're upset I kind of know how to deal with them" (P9)

Becoming a good listener

In light of their own experiences some young people talked about gaining attributes such as becoming good at listening to others' problems in a non-judgemental way:

"I don't think I'm as judgemental now of people because I realise that everybody's got their own individual stresses and not everybody is the same way" (P10)

"I can be a lot more sensitive and I can understand a lot more like other people's difficulties" (P4)

Analysis of self-report measure: Objective Measure of Ego Identity Status (OM-EIS)

In order to ascertain each participant's current identity status as described by Marcia (1966) the OM-EIS questionnaire (Adams et al., 1979) was administered. In table 3 each participant's identity status is outlines and the way it which it was derived highlighted.

Table 3: Identity status of participants as defined by the OM-EIS questionnaire

Participant	Status Rule Applied	Identity Status	Final Identity Status (collapsed)
P1	Transitional Status	Diffusion-Moratorium	Diffusion
P2	Transitional Status	Diffusion-Moratorium	Diffusion
P3	Transitional Status	Diffusion-Achievement	Diffusion
P4	Pure	Moratorium	Moratorium
P5	Transitional Status	Diffusion-Moratorium	Diffusion
P6	Transitional Status	Diffusion-Moratorium	Diffusion
P7	Low-Profile	Low profile moratorium	Moratorium
P8	Pure	Diffusion	Diffusion
P9	Transitional Status	Diffusion-Moratorium	Diffusion
P10	Transitional Status	Moratorium-Achievement	Moratorium

Table 3 illustrates 'identity statuses' of the participants as defined by the OM-EIS. The above table shows, almost all of the participants were within a 'transitional-status' category, that means that their scores were above the cut-off on two of the four sub-scales; half of the participants were identified as *diffusion-moratorium*, one as *diffusion-achievement* and one as *moratorium-achievement*. Two participants fell within 'pure' identity statuses, one *moratorium* and the other *diffusion* as their scores were above the cut-off on only one of the four sub-scales. One participant's scores fell below the cut-off for all the four sub-scales and hence obtained a low-profile score. The two participants with a 'pure' identity status were the young people with a primary eating disorder and the participant with a low-profile score had a behavioural problem.

'Transitional statuses', are collapsed into a single identity by using a rank ordering procedure, whereby the individual is categorised by the least achieved status. Therefore overall, of the ten young people that participated in this study, seven were categorised as *diffusion* and three as *moratorium.*

Discussion

The present findings suggest that, as one might expect, mental health problems during the adolescent years appear to have a negative impact on identity development in the young person concerned. The analysis of the participants' narratives generated six central themes, with the 'desire to understand' emerging as central for most participants. The young people often welcomed receiving a diagnosis and reported that it helped them make sense of what was going on at a time when they felt very confused. With regards to identity development in particular, the young people interviewed described their experience of mental health problems as disrupting peer relationships, education and participation in "typical" adolescent activities. They also conveyed a prevailing sense of alienation from their peers and inability to confide in them due to fears of being negatively evaluated. Importantly several of the young people felt that their mental health problems "rule everything" and had taken over their lives. Uncertainty about the future also emerged from all accounts. On a more positive note several interviewees noted their increased capacity for empathy and a belief that they were now more able to help others.

With further reference to identity development, the findings indicate that the adolescents perceived their mental health problem as the most salient aspect of who they are, as they seemingly based their identity on their illness. They described their difficulties as all encompassing as they are now not the same person they were before. Consequently they are unable to have a 'normal' adolescent life in conjunction with having a mental health problem. Due to the lack of optimism these young people demonstrated about their situation changing in the future, there was a

sense that their identity was permanently fixed. It appeared, however, that the young people with a primary eating disorder were not as distressed as the others about this as they conveyed a sense of positive gain from their difficulties e.g. knowing who they are.

These qualitative results are strongly supported by the data emerging from the OM-EIS questionnaire (Adams et al. 1979) which indicates that identity development, as described by Erikson (1968) and Marcia (1966), is compromised in young people with mental health problems. The four identity statuses outlined by Marcia (1966) are seen to lie on a continuum with *diffusion* at the lower end of the spectrum, *achievement* at the higher end and *foreclosure* and *moratorium* in the middle. In general, it is expected that the older the adolescent is the more opportunity he or she has had to explore and make commitments and hence reach a higher level of identity status *(i.e. achievement);* thus identity status is not seen as static but evolving.

The participants in this study fell into two identity statuses, namely *diffusion* and *moratorium,* with the majority within the former, lowest level of identity status according to Marcia (1966). The interview data suggests that this "failure" to reach higher identity statuses may be due to difficulties exploring different possibilities and committing to values, beliefs and goals because of superseding concerns about the trajectory of their current problems and the future. Numerous uncertainties regarding the future could explain why the young people avoided making future plans and commitments out of fear that these might not be realised. Moreover, many of these adolescents encountered barriers which restricted their opportunities to socialise with peers and move towards independence from their parents, all of which have been

described as imperative in identity development (Erikson, 1968). Therefore the adolescent 'crisis' which Erikson (1968) described, involving attempts to establish a coherent identity versus role confusion, would appear as yet to be unresolved for the participants in this study.

To date very little empirical evidence is available on the impact of mental health problems on adolescent identity development. Kapfhammer et al. (1993) found that young people admitted to a psychiatric clinic had reached a slightly lower identity status compared to healthy controls. However, unlike the current study Kapfhammer et al. (1993) identified very few patients within the *diffusion* identity status. This difference may at least in part be due to the fact that participants' upper age limit in the current study was 18 but 26 in Kapfhammer et al.'s (1993) study.

Looking to the literature on physical health problems we find some similarities but also marked differences regarding the impact on identity formation. Gavaghan and Roach (1987) found that adolescents with cancer mostly fell within the *diffusion* and *foreclosure* identity statuses whereas most healthy participants had reached *achievement* and *moratorium.* The authors explained these differences in terms of difficulties exploring values, devising goals and making commitments as a result of the young people affected by cancer being preoccupied with their illness and the future. Similar preoccupations were evident for the young people with mental health problems who participated in the present study.

In contrast, Madan-Swain et al. (2000) found a greater number of cancer survivors, as compared to a healthy control group, in the *foreclosure* identity status. The

authors suggested that as a result of having cancer these young people may have had less opportunity to explore alternatives and hence *foreclosed* earlier, by accepting the values and expectations of their parents or significant others. Hosek et al. (2002) found that the majority of adolescents diagnosed as HIV+ fell into the *diffusion* status, similar to the present findings. In contrast though, just under half of Hosek et al.'s (2002) HIV+ participants had reached the *achievement* status. The different findings may at least partly result from differences in participants' ages; participants in the current study were younger than in the studies cited and hence less likely to have reached the *achieved* identity status. Alternatively it is possible that young people with potentially life limiting conditions may feel pressure to accelerate the process of exploration and commitment, while those with mental health problems delay or put off the process of exploring their own values and making commitments. Importantly, possible consequences for these young people is that they get left behind their peers leading to further isolation, or maybe if their mental health problems persist they never engage is such processes. Clearly these conclusions are tentative and further research would be useful to examine the different impact of different mental and physical health conditions on adolescent identity development.

Methodological issues

A number of methodological issues need to be considered in interpreting the results of this study. Firstly, all participants were initially approached by a clinician and had to "opt in". Hence there could be a sampling bias, in that, for example, clinicians may have pre-selected potential participants and those with some types of mental health problem may have been more or less likely to opt to participate. In addition, females are over-represented in the present study, whether they were more willing to

participate or whether those approaching potential participants perhaps held some prior assumptions that females would be more likely to want to talk to a researcher is unclear. Hence the findings may not be representative of all types of mental health problems for both males and females, as almost entirely all those that participated were females with emotional problems. However, the aim of IPA analysis is to capture in detail the experiences of individuals and it does not claim to generalise to the entire population of adolescents with mental health problems. Posters were placed in waiting rooms in a bid to address possible biases but unfortunately no one responded to the advert. Indicating, that perhaps one reason why there is a lack of in-depth research with this population is because they are inaccessible for a variety of reasons.

Also consideration needs to be given to the heterogeneity of the sample; the age range of participants was from 14 to 18 which spanned middle to late adolescence. Although the age group was a lot closer matched than previous studies (e.g. Kapfhammer et al., 1993), one might still expect younger adolescents to report less exploration and commitment than older ones who have had more opportunity to do so. Other factors such as the type of mental health problem, length of presenting problem and contact with services etc. were not controlled for which is likely to have had a strong impact on identity status. One might also expect contextual factors such as family, culture and gender to affect the process of identity development but it was not within the scope of the present exploratory study to examine their impact.

Furthermore without a non mental health comparison group it was not possible to distinguish developmental changes which are due to having a mental health problem

from those which are not. Similarly there is a risk that some participants may have attributed difficulties which many adolescents struggle with to their mental health problems. Without a non mental health control group it is impossible, for example, to establish whether a global dissatisfaction over physical appearance which emerged in participants' accounts is in any way specific to this group, or comparable to the majority of healthy adolescents for whom this is a critical issue (Eiser, 1995). Hence this data had to be excluded. As previously mentioned, the level of identity status achieved is also related to age thus a longitudinal study would permit evaluation of development over time. Lastly, even though the OM-EIS is a widely used valid and reliable standardised measure it is not without limitations. Firstly, the measure needs to be updated in order to incorporate relevant contemporary 21st century issues faced by adolescents today. Additionally, *it* provides a global score across the three domains (occupation, religion and politics), thus the individual score is collapsed and classified into a single identity status. Consequently this measure does not allow for possible differences in identity statuses across the different domains. An individual in principal may, for example fit *foreclosure* in terms of religion but *moratorium* in terms of occupation yet this is not acknowledged.

Recommendations for future research

This research project targeted a heterogeneous population of young people with mental health problems due to the very limited evidence base regarding the potential impact on identity development. As noted, the accounts provided by the young people with anorexia and behavioural difficulties were distinctly different from the other participants in certain areas. This finding indicates a need to distinguish different 'types' of mental health problems in future research, using the same

methodology, to look at their specific effects on identity development. In addition, a further area that warrants investigation is the possible long-term effects of having a mental health problem during adolescence on identity status. As previously mentioned a longitudinal study would have allowed evaluation of the possible effects over time. Such a study would make it possible to investigate important questions, such as, if the mental health problem is resolved does the young person subsequently show signs of successful identity development? Or do they show such signs in any case once they have entered adulthood, regardless of their mental health status?

Clinical implications

The findings of this study have a number of implications for clinical practice. This study clearly supports the hypothesis that mental health problems experienced during adolescence prevent the young person from developing a strong and positive sense of self and vision for the future during adolescence. This suggests that treatment should not only target specific symptoms but should also be directed toward prevention and remediation of developmental difficulties, for example cognitive therapy could address beliefs about self. In view of the suggestion that the young people concerned either avoid or lack opportunities for exploration, clinicians and services should consider providing a safe space via individual and group work in which values, possibilities and options for the future can be explored, including areas such as vocation, independence and relationships. Additionally, perhaps clinicians need to view such provision of missed opportunities as more integral to what they provide, rather than considering this as an "add on" or even outside the scope of treatment.

More generally, the narratives of the young people who participated in this study reflect a desire to have an understanding of what is going on for them and the importance of being understood by others. In addition, being given a diagnosis appears to be a validating and empowering experience at least for some. Conversely many clinicians are reluctant to give diagnoses to young people due to fears of the negative impact of labelling, for instance, that labels become permanent and can be stigmatising. The results of this study however add to the diagnostic debate as the young people themselves seem to value them. This suggests a need for clinicians to adopt a reflective approach with the young person, allowing them to be actively involved around what information is shared including diagnoses.

The results suggest that mental health problems remain stigmatised and consequently surrounded by many myths. The young people in this study talked about discontinuing their peer relationships and shying away from sharing their experiences with their peers out of fear of being negatively evaluated. Given that these processes may well enhance the difficulties and isolation experienced by young people with mental health problems there is a need for further challenging of the myths surrounding mental health problems by all who come into contact with young people, not least within education. The education system is uniquely placed as it has access to the majority of the population and subsequently can educate them on these issues. Furthermore such myths and fears can lead to barriers within therapy as participants expressed a reluctance to talk about certain issues due to concerns of being admitted to hospital. If clinicians are aware of these fears they can tackle them by being open and transparent with the young person and discussing such issues directly. This in turn may enhance the therapeutic relationship.

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Part 3

Critical Appraisal

Critical Appraisal

In taking a more detailed critical look at the present study I will begin by considering methodological issues that arose in more depth. I will then move on to reflect on my position as the researcher, in terms of how I approached the research and how the research experience in turn has influenced me.

Methodological issues

A number of methodological issues need to be borne in mind in interpreting the findings of this study. Firstly recruitment, potential participants for this study were approached by a member of the multidisciplinary team who was known to them, usually the treating clinician. This approach was adopted in order to protect the confidentiality of the young people attending CAMHS. A disadvantage of this method however was that recruitment largely relied upon the good will of clinicians, which seemed to raise several important issues. Firstly, clinicians may have pre-selected potential participants in line with their own ideas of what would make a 'good' participant, for example, according to 'type' of mental health problem and whether or not they thought the young person had anything relevant to say or was good at expressing themselves.

Secondly, from discussions with clinicians, there seemed to be a reluctance to approach young people due to usage of the term 'mental health problem' on the participant information sheet. This was conveyed as being problematic as it was highlighted that such a label may not have been previously used with the young person and thus would need to be broached specifically for the purposes of research

project. In addition, the term raised further issues for other clinicians who thought that even where a diagnosis such as 'anorexia' had been discussed, the young person concerned might not view this a 'mental health problem' and hence not want to participate in the study. Lastly, some clinicians were concerned that if they personally raised the research project with their clients this might interfere with the therapeutic relationship. In light of the above, it could be suggested that the sample is not representative of the target population as there is likely to be a sampling bias in the selection of possible participants. Posters were placed in waiting rooms in a bid to address some of the above outlined biases but unfortunately no one responded to the advert. Different approaches were adopted in order to increase the accessibility to participate in the study, yet the overall level of response and/or interest in this study was relatively low. This tells us something about the inherent difficulty conducting research with adolescents. In hindsight, further consideration needs to be given to more novel ways of approaching this population if we are to see an increase in research with this group.

At this point it would be important to reflect on the demographic characteristics of those young people that took part in this study. Out of the ten young people who participated in this study only one was male and only one was Asian, all other participants were White females. This immediately raises the question; were males and young people from ethnic minority groups less likely to be approached about the research project or were they more likely to decline to participate? Due to ethical issues I was not given any details of the young people who were informed about this study but only of those who agreed to be contacted about the study. Therefore, unfortunately it is not possible to answer this question. However as two of the three

CAMHS services were located within geographic areas where ethnic minorities groups made up almost half of the total population of 0-15 year olds (Census, 2001), it would appear that they have been under-represented in this study. Possible biases may in part relate to clinicians' assumptions and cultural values. It is possible that clinicians made assumptions about who they thought would want to participate in this study based on gender and cultural stereotypes e.g. the notion that girls are better at expressing themselves verbally than boys. Thus this resulted in fewer boys and young people from ethic minority groups than White girls being invited to participate. A further point for consideration is with the onset of psychosis occurring earlier in male adolescents than females (American Academy of Child and Adolescent Psychiatry, 2001) by excluding psychosis, this may have marginally reduced the number of potential male participants. The absence of male participants and young people from ethnic minority groups may therefore mean that the findings are not generalisable to them, as there may be important difference and influences over how they see themselves as compared to White females.

The average age of participants was 15½ which had several implications for this study. Firstly, with increasing age any adolescent will have had more opportunity to develop a coherent identity status. Secondly, an individual reflecting on their problems which may have spanned several years is thinking back to a period of time during early adolescence; hence one would expect that in relation to future plans etc. changes may have occurred which are independent of experiencing a mental health problem.

Heterogeneity of the sample and its implications

This research project targeted a heterogeneous population of young people with mental health problems due to the very limited evidence base regarding the potential impact on identity development. Therefore factors such as the type of mental health problem, duration of presenting problem, length of contact with services and type of intervention offered were not controlled. It is worth noting however that the aims of IPA (Smith, 2003) are to capture the experiences of 'individuals', consequently the concept of a 'control group' is not very meaningful in IPA. However all of the above issues did emerge during the interviews and analysis of the data but without a control group the possible impact on identity development is unknown. Of particular importance, as noted in the empirical paper, the accounts provided by the young people with anorexia and behavioural difficulties were distinctly different from the other participants in certain areas. Only one participant's primary reason for contact with CAMHS services was described as 'behavioural difficulties'. Much of the interview data collected from this participant was not included in this paper as, on the whole, it was fundamentally different from the accounts' of all other participants. With hindsight maybe this participant should have been excluded from the study as all the other participants had 'emotional' difficulties.

The accounts provided by the two young people with a primary eating disorder were distinctly different from the other participants as they conveyed more positive functions of their difficulties, including a sense of 'gain' and 'identity' in that they knew who they were. Consequently they appeared to have a vested interest in maintaining the status quo and expressed concerns over the possibility that their difficulties might be taken away from them, leaving them not knowing who they are.

This finding indicates a need to distinguish between different types of mental health problems in future research and to look at their specific effect on identity development. This will be discussed more when considering further research.

Participants in general described very different time frames of their current difficulties. Some talked about a clear and sudden onset whereas for others onset was more insidious and described as a 'life long journey', whereby it was felt by the young people that they had encountered many difficulties throughout their lives. Unfortunately, due to the small sample size and heterogeneity of the sample, it was not possible to analyse this information. This factor was particularly pertinent when considering the quality of the interview schedule. In order to ascertain how the young people thought their mental health problem had impacted on their identity I asked several 'before' and 'after' questions. The young people reported that, for them, their problems started between 1 to 13 years ago, with the average onset being just over four years ago. In view of this wide range of years one would expect that participants may have had different ways of defining and reporting their difficulties depending on their age at the time of onset. Additionally one might assume that the longer the problem has been present for the far more pervasive and lasting the impact is to be on development than compared with someone whose problems had an acute onset.

Additionally, the interview format required a certain level of intellectual skills and articulation, good memory and a capacity to reflect on one's experiences in some depth. Thus the conceptualisation of self in such a way may have been difficult for some of the younger participants who may not yet have reached 'formal operational

thinking' as discussed by Inhelder & Piaget (1958) please see literature review. In considering the interview process and my contribution to it a number of points are worth mentioning. With hindsight I feel that at times I stuck more rigidly to the interview schedule than is desirable when conducting qualitative research. When participants moved between topic areas, on occasion, I would bring the participant back to the question being discussed and inform them that I would come back to what they raised later. Reflecting on the reason for this I was keen to avoid missing out any issues which were central to this research. The potential impact however is that by following the interview guide in this way I reduced the possibility of unforeseen areas emerging during the interview. Furthermore qualitative approaches accept that it is impossible to completely set aside the researcher's personal views and experiences. Hence my understanding of what constitutes "key issues" in terms of the research questions is guided by my reading of the literature and my position as an adult some years removed from adolescence and as a health professional. Nevertheless, the process of self reflection on theoretical commitments and owning one's values facilitates the representation of the participants' narratives more adequately. It is conceivable that the young people interviewed may attribute importance to issues which did not figure in the interview schedule or attribute meaning to their experiences in ways which are incompatible with the format or contents of the schedule. Initially, focus groups had been considered as a possible methodology in a bid to address the above as they are less directed by the researcher. However concerns emerged about (a) recruitment as it was felt that recruitment to such a group might have been even more difficult as many young people might be reluctant to openly discuss their experiences in front of others and (b) in view of the

lack of literature in this area in-depth one-to-one interviews guided by the literature and psychological theory seemed the most appropriate first step.

Interpreting the results

In this study it was impossible to distinguish developmental changes which are attributable to having a mental health problem from those which are not. Similarly there is a risk that some participants may have attributed difficulties which many adolescents ordinarily struggle with to their mental health problems. Without a control group it is impossible, for example, to establish whether a global dissatisfaction over physical appearance which emerged in participants' accounts is in any way specific to this group, or comparable to the majority of healthy adolescents for whom this is a critical issue (Eiser, 1995).

Several issues are worth considering in relation to the use of the OM-EIS (Adams, Shea & Fitch, 1979) questionnaire in the present study. This was administered in order to categorise participants into one of four identity statuses, as outlined by Marcia (1966). The primary reason for the decision to use this measure was to allow some comparison of the present findings with previous research as most studies investigating adolescent identity development have used this measure or the extended version (Extended Objective Measure of Ego Identity Status-II; Bennion and Adams, 1986). While I had initial concerns about using this measure, personal reasons for this will be explored further below. The analysis of the OM-EIS responses turned out to be very interesting and surprisingly supportive of the qualitative data as it provided a valuable additional dimension to the findings of this study. Although it should be stressed that due to the small sample size and

heterogeneity of the sample one needs to very much err on the side of caution in generalising the findings.

Personal Reflections

I have a long standing interest in adolescent "issues" and have worked with young people in a variety of settings spanning CAMHS Tiers 2 to 4 and within non-mental health settings such as local authority play services. During the course of this work I became curious about the major struggles experienced by some young people during the adolescent years. Of particular interest to me were issues related to how such young people made sense of who they are in relation to their surroundings and in the face of various difficulties. The 'turmoil' of the adolescent years is well documented, although it has been argued that difficulties during adolescence are commonly overemphasised and the fact that the vast majority of young people negotiate this period without major difficulties is over-looked (Offer & Schnert-Reichl, 1992). Whilst working as an Assistant Psychologist within a Tier 4 specialist in-patient setting for adolescents with severe mental health problems I was introduced to the developmental issues of the adolescent period. Eriksonian ideas on life-span development and specifically 'identity development' were prominent. The theoretical framework of this research project was informed by and subsequently based upon Erikson's (1968) account of identity formation during adolescence.

I gained from later clinical placements a sense that for the small number of young people who experience significant mental health problems during adolescence, the difficulties themselves, coupled with the stigma associated with having a mental health problem can have a negative effect on an individual's sense of who they are.

In light of the wealth of literature on the importance of this time period coupled with the adult literature on mental health problems I became curious about how adolescents make sense of their experiences. More specifically, how these constructions shape the ways in which they see themselves.

In hindsight, my theoretical commitments placed parameters on the findings as the interview schedule was largely based on the areas outlined in this literature. Other possible relevant areas, for example intimate relationships and more contemporary issues such as drugs and homosexuality, were not investigated to the same extent. Although I did include questions in the interview schedule, around sexuality participants tended to shy away from the subject and I did not pursue it, possibly as a result of cultural taboos which surround this subject. Hence it could be argued that the findings fit the existing literature simply because they were heavily influenced by it.

My prime concern in clinical work and research is to approach people as 'individuals' and view their difficulties as unique and meaningful, which influenced the methodology of this study. I felt it was imperative that participants were given the opportunity to give their own 'expert' account of the impact of experiencing a mental health problem in an exploratory rather than fixed way. Such an approach was also important for me as I was interested in hearing in-depth personal accounts which were meaningful to the person telling them, rather than predetermined responses. Hence I adopted a qualitative approach as it seemed best suited to exploring this area.

Initially I was rather cautious about incorporating a standardised self-report measure, as suggested by the supervisor. With specific reference to the measure used my reservations were (1) the compatibility of a quantitative measure with a qualitative approach, as it was going to be time consuming; and (2) the appropriateness of some parts of the OM-EIS as they appeared to be 'out of date' (some items seem to be very conservative or based on a Christian ethos) and convoluted. The areas covered by the Objective Measure of Ego Identity Status (OM-EIS; Adams et al., 1979) are religion, politics and vocation. Bearing in mind the age of the participants (14 to 18) and contemporary young people, these domains did not seem as relevant or inclusive of all the issues that adolescents in the 21st century are dealing with. In addition, each item contains more than one element in a bid to ascertain the level of 'exploration' and 'commitment.' Consequently there are only very subtle differences between some items. However it was conveyed, to me, that the purpose of using this measure was to situate the sample and enable comparisons to previous research. Following repeated discussions a 'compromise' was agreed with my supervisor whereby to avoid any possible influence of the content of the questionnaire on the participants' personal accounts and views, the questionnaire would be administered after the interview. It was also agreed that given that interviews could last up to two hours the shorter version of the OM-EIS (24 items) as opposed to the longer (64 items) and newer version (Bennion & Adams, 1986) would be administered.

In addition to what has already been noted about the advantages of using the OM-EIS questionnaire, a personal gain has been an increased appreciation of the value of quantitative measures. My previous scepticisms of the worth, applicability and meaningfulness of the output of quantitative measures have been tempered.

Combining both qualitative and quantitative methodologies would appear to be a useful and productive methodology, which no doubt will be influential in the way in which I approach future research projects.

Further research

In addressing the limitations of this study already noted, the subject area could be expanded further by carrying out a study with a control group design or adopting a longitudinal approach. A control group design would require sufficient numbers of participants in order to distinguish and compare 'types' of mental health problems to a 'healthy' adolescent group to look at their specific effect on identity development. In light of the accounts provided by the young people with an eating disorder and the young girl with behavioural difficulties, this seems to be a useful way to expand on these findings.

The current study essentially took a snapshot of participants' identity development at a given moment in time. Bearing in mind that the development of an individual's identity status is not static but continually evolving, a longitudinal design would be very helpful in future research. By employing a longitudinal design one would be able to evaluate how identity progresses in young people with a mental health problem over time. If the mental health problem is resolved does the young person subsequently show signs of successful identity development? Or do they show such signs in any case once they have entered adulthood, regardless of their mental health status? A longitudinal design would also be beneficial as it might tap the 'journey' described by some of the young people, as previously touched upon in this paper but not covered within this study.

Clinical implications

Despite the above outlined limitations of this study the findings have a number of implications for clinical practice. Acknowledging the absence of a non mental health comparison group, this study clearly supports the hypothesis that mental health problems experienced during adolescence appears to impair the young person's capacity to develop a strong and positive sense of self. The accounts provided by the young people highlight that their mental health problems have often become an integral part of their sense of who they are, and have become entwined with aspects of everyday life, relationships and plans for the future. In addition, some of the young people reflected that their life had been an 'uphill struggle', as they had experienced various difficulties over several years, for example being bullied at school.

This study highlights two important considerations that should be taken into account by clinicians. Firstly, treatment should not exclusively focus on specific symptoms but should also be directed toward prevention and remediation of developmental difficulties. The areas covered in the interview schedule provide a useful 'map' for clinicians to explore with young people in a bid to detect any potential problems. Areas that this study has highlighted as being problematic such as lack of peer interaction, may be important for the clinician to focus on in an attempt to help young people to find ways of rectifying these. In view of the suggestion that the young people either avoid or lack opportunities for exploration, clinicians and services should consider providing a safe space via individual and group work in which values, goals and options for the future can be explored, including areas such as vocation, independence and relationships. Secondly, clinician need to be mindful

of the 'function' that certain 'problem' behaviours can serve and hence allow the young person to build something 'new' and valued for themselves before attempting to take the 'problem' away, depriving them of an important part of their identity. Furthermore such an issue, if not appropriately addressed, is likely to lead to barriers within therapy, as the young person may be reluctant to participate in therapy in an attempt to hold onto what they now.

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Appendices

Appendix 1

Participant Information Sheet

UCL

Participant Information Leaflet

Mental Health Problems in Adolescents: The impact on Self and Identity

"You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Feel free to ask any questions if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this."

Purpose of the study?

I am interested in talking to young people (aged between 14-18) about their experiences of having a mental health problem and how this may have impacted on different aspects of their lives, e.g. family, career plans etc.

Do I have to take part?

"It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form (and given a copy to keep). If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you are currently receiving".

What will happen to me if I take part?

I will arrange one individual meeting with you at a time which is convenient for you. This will consist of an interview and completing a questionnaire which may last up to two hours. The venue will be where you are currently receiving a service from Tier 3 or a place of your choice.

What are the possible disadvantages and risks of taking part?

Talking about personal issues can sometimes be upsetting. Therefore we will discuss at the outset what we should do in the unlikely event of this happening e.g. end the interview, tell someone else (with your consent).

What are the possible benefits of taking part?

Having an opportunity to talk (and be listened to) about your own personal experiences in relation to having a mental health problem can be very valuable.

Will my taking part in this study be kept confidential?

"All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you which leaves these premises will have your name and address removed so that you cannot be recognised from it".

What will happen to the results of the research study?

When the research project is completed (June 2005) you will be given a summary of the results (if you want them).

The results of this study will be written up as part of a professional qualification. It is also hoped that the study will be published in a journal. Once again no names will be used!

Further Information

This study has been agreed by Local Research Ethics Committee.

If you want more information please contact:

Lisa Shanahan at

Thank your very much for considering to take part in this study!

Appendix 2

Advertisement Poster

Mental Health Problems in Adolescents: The impact on Self and Identity

Are you interested in taking part in a research project?

To: Young people (boys and girls) aged 14-19 years old.

"I am interested in talking to young people about their experiences of having a mental health problem and how this may have impacted on different aspects of their lives."

How: Individual interviews and a questionnaire.

When/Where? Time & place to be arranged that suits you.

Interested?

If you are interested in finding out more information please contact me (Lisa Shanahan) on ?

Or talk to the clinician you know at this clinic.

Information received from the interviews will be confidential - no names will be used.

Appendix 3

Participant Consent Form

Centre Number: Participant ID:

CONSENT FORM

Title of Project:

Mental Health Problems in Adolescents: The impact on self and identity

Name of Researcher: Lisa Shanahan

Please initial box

1. I confirm that I have read and understood the information sheet dated ..... (version .....) for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that sections of any of my medical notes may be looked at by the researcher. I give permission for the researcher to have access to my records. ☐

4. I agree to take part in the above study, which I know includes a tape recorded interview and completing a questionnaire. ☐

5. I am or am not (delete as appropriate) involved in any other research project at this point in time. ☐

Name of Participant	Date	Signature
(Parent/guardian if under sixteen)	Date	Signature
Researcher	Date	Signature

Copies for participant, researcher and participant's notes.

Appendix 4

Interview Schedule

Semi-structured Interview Schedule

Mental health problems in Adolescents:
The impact on Self & Identity

Before tape recorder is turned on:

- Introduction about interview & questionnaire:
  - Re: possible distress & the procedure
  - Confidentiality
  - Consent form

Turn tape on:

1. Getting to know the participant

- Tell me a bit about your family: What do your parents do? Siblings: ages & what do they do?
- How would you describe your (and your family's) religious background?
- How would you describe your (and your family's) cultural background?
- Who do you live with?
- Friendships - who are your friends? What do they do? What do you do with them?
- Do you have a girl/boyfriend?

I will ascertain participant's 'name/label' for their current m.h.p.
'X' = their own label e.g. depression, problem, difficulty etc.

2. Understanding of their mental health problem

- Can you tell me a bit about why you are here (e.g. how did you get seen by CAMHS)? What happened when you saw Dr?
- Who was first worried about 'X'? Who else noticed? If you were the first to notice who did you initially turn to?
- How did you react to finding out about 'X'? discuss it with anyone?
- Can you tell me a bit about 'X'?
  - Prompts: mood, behaviour etc.
- Who did you or others (e.g. parents) first turn to for help? What happened? Prompt: can you tell me a bit about it? What was it like trying to get help?
- When you think about your current difficulties what did you think <u>at the time</u> and what do you think <u>now</u>?
- Which services/people have you been in contact with? Prompt: how long for and what was offered?
- What was the most useful help you received?
- Has anything like this happened before to you? Or anyone you know?

3. Managing Difficulties

"I'd like to find out a bit about how you have tried to manage with 'X'".

- What kind of things have you tried to cope with your difficulties?
- Which of these strategies or ideas have helped make things better?
- Which strategies or ideas seemed to have made it worse?
- How successful do you think this has been?
- Have you learnt anything about yourself?

4. Impact of mental health problem on

4a. Identity & self-concept

- How was your life different before you experienced 'X'?
- How would you describe yourself now?
- If I meet you before 'X' what were you like?
- Has having 'X' impacted on the way you now describe yourself? If so how?
- Is this how you'd like things to be?
- How do others see you Before X and now?
- What are you good at? What would other people say are your positive attributes?
- How do you feel/think about your physical appearance (before 'X' and now)?
- Is there anything you'd like to change about yourself?

4b. Family & Relationships

- Has 'X' changed how you get on with others e.g. family, friends, teachers/employers & intimate relationships
- Has it changed the way you see other people?
- What was your family life like before 'X'? Describe a typical day/weekend/evening
- What is your family life like now? Again describe.
- Have you ever had a girlfriend/boyfriend? Do you have one now? Is that how you want things to be?
- (need to ascertain issues around attractiveness, shame, interest & stigma)
- How do you feel about your sexuality?
- Do you mind telling me about your sexual relationships? Have you had sex?
- Has 'X' changed your relationship with him/her (use the name if given it)?

4c. Future Plans

- What are your plans & hopes for the future? Prompt: further education, aspirations and dreams etc?
- Have they changed since 'X'?
- What do you think your life might look like when you are 20? 30? Prompt: activities, relationships, lifestyle, dreams etc.
- Prompt: Vision of adult life (Living situation, married, children)

4d. Activities

- What do you do with your time? Prompt: education, job, typical day/weekend
- What activities do you engage in? Prompt: was that different before 'X'?
- How has 'X' affected your daytime activities?
- Is that how you want things to be?

Closing the interview

"We have been talking a lot about the impact of 'X' on your life..."

- What has that been like for you?
- Do you have any questions that you'd like to ask me?
- Are there any other areas that you think are important that I've left out?
- What have you got planned for the rest of today?

Give questionnaire

Appendix 5

Self-report measure:

Objective Measure of Ego Identity Status

Participant ID:

APPENDIX A: PROTOTYPE OMEIS
ADAMS, SHEA & FITCH (1979)

Please tick the most appropriate response

Response Scale:

A = strongly agree B = moderately agree C = agree
D = disagree E = moderately disagree F = strongly disagree

	A = strongly agree	B = moderately agree	C = agree	D = disagree	E = moderately disagree	F = strongly disagree
1. I haven't really considered politics. It just doesn't excite me much.	1	A	B	C	D	E	F
2. I might have thought about a lot of different jobs, but there's never really been any question since my parents said what they wanted.	2	A	B	C	D	E	F
3. When it comes to religion I just haven't found any that appeals and I don't really feel the need to look.	3	A	B	C	D	E	F
4. My parents decided a long time ago what I should go into for employment and I'm following through their plans.	4	A	B	C	D	E	F
5. There are so many different political parties and ideals. I can't decide which to follow until I figure it all out.	5	A	B	C	D	E	F
6. I don't give religion much thought and it doesn't bother me one way or the other.	6	A	B	C	D	E	F
7. I guess I'm pretty much like my parents when it comes to politics. I follow what they do in terms of voting and such.	7	A	B	C	D	E	F
8. I haven't chosen the occupation I really want to get into, and I'm working at what is available until something better comes along.	8	A	B	C	D	E	F
9. A person's faith is unique to each individual. I've considered and reconsidered it myself and know what I can believe.	9	A	B	C	D	E	F
10. It took me a while to figure it out but now I really know what I want for a career.	10	A	B	C	D	E	F
11. I really never was involved in politics enough to have to make a firm stand one way or the other.	11	A	B	C	D	E	F

Response Scale:

A = strongly agree B = moderately agree C = agree
D = disagree E = moderately disagree F = strongly disagree

A = strongly agree	B = moderately agree	C = agree	D = disagree	E = moderately disagree	F = strongly disagree

12. I'm not sure what religion means to me. I'd like to make up my mind but I'm not done looking yet.

12	A	B	C	D	E	F

13. I've thought my political beliefs through and realise I can agree with some and not other aspects of what my parents believe.

13	A	B	C	D	E	F

14. It took me awhile to decide but now I know for sure what direction to move in for a career.

14	A	B	C	D	E	F

15. Religion is confusing to me right now. I keep changing my views on what is right and wrong for me.

15	A	B	C	D	E	F

16. I'm sure it will be pretty easy for me to change my occupational goals when something better comes along.

16	A	B	C	D	E	F

17. My parents have always had their own political and moral beliefs about issues like abortion and mercy killing and I've always gone along accepting what they have.

17	A	B	C	D	E	F

18. I've gone through a period of serious questioning about faith and can now say I understand what I believe in as an individual.

18	A	B	C	D	E	F

19. I'm not sure about my political beliefs, but I'm trying to figure out what I can truly believe in.

19	A	B	C	D	E	F

20. I'm still trying to decide how capable I am as a person and what work will be right for me.

20	A	B	C	D	E	F

21. I attend the same church as my family has always attended. I've never really questioned why.

21	A	B	C	D	E	F

22. I just can't decide what to do for an occupation. There are so many possibilities.

22	A	B	C	D	E	F

23. I've never really questioned my religion. If it's right for my parents it must be right for me.

23	A	B	C	D	E	F

24. Politics is something that I can never be too sure about because things change so fast but I do think it's important to know what I can politically stand for and believe in.

24	A	B	C	D	E	F

Appendix 6

Excerpt from Transcript

R how do you want things to be?

6 hum, I don't know you know I have been asked that questions by everybody that I've seen and I still don't know. It's just a difficult question because it's like basically saying 'what do you want from your life' and I don't know you know. I've seen 3 different counsellors and I still don't know it's a difficult one. It is a really big question in my sense in my point of view it is because hum I don't really know what I want to do or where I want to live, what I want or anything like that I just don't know. I suppose the thing I want is to sort of stop being depressed I don't think I'm ever going to be not depressed because I think once you've had it once you are never going to get rid of it.

R what makes you think that?

6 I just think that there is something obviously in you that sort of bring it out do you know what I mean. So I think it's never going to go away unless you make it go away and I don't think you can make it go away. I think I confused it a bit but I know what I mean. I don't think for me it's ever going to go away. I mean if something terrible happens to me I'll probably slip back into it knowing me (laughs) but I probably would. Now I know me and I probably would but I hope I don't it's just hoping for the best really but I know I'm not as bad as I was and I don't want to be back in that place again but I think I will probably at some point even if it's just for a day, an hour or

a minute you know you are gonna experience it because it's in your mind your memory you're gonna do it. So whether you want to or not you just are.

R Thinking back to that 'big question', what if I turn it around and ask you 'the way your life is now is that how you want it to be?'

6 Hum, no no because I'm not really that happy at the moment you know I'm living at home still, I know I'm only 17, I have no friends, hum I don't have a job, hum I'm not doing anything for school, hum I don't know what I want to do, and that's one of the worst feelings that you don't know what you want because what do you do what do you work from that. So no not really.

R You said you have no friends have you had friends in the past?

6 When I was at school but I didn't feel like they we were friends you know because if they were real friends I would have trusted them with my problems and I couldn't do that because I was embarrassed by it. If they were real friends I would have told them and that why I think if I was sort of a bit depressed I probably would have told them before anybody else and I couldn't do that. That's why I don't think they were really. I didn't really see them much outside of school because even when I left school I didn't usually go out so I don't think they were real friends because I would have gone out with them more or told them.

Appendix 7

Example of key points from Transcript

Excerpts from interview with participant 6 and noted key points

P6: Yeah, I don't think for me it's ever going to go away. I mean if something terrible happens to me I'll probably slip back into it knowing me (laughs) but I probably would. I don't want to be back in that place again but I think I will probably at some point even if it's just for a day, an hour or a minute you know you are gonna experience it because it's in your mind your memory you're gonna do it. So whether you want to or not you just are.	• It's never going to go away • I'll probably slip back • You are going to experience it again

P6: I didn't want them to think that there was that I was a bit weird I suppose because I just thought that it they know I'm going to counselling they'll see it as therapy and they'll think I'm mad or something. I didn't want them to think I was insane, and that was it really I didn't want them to think that I was mad because I thought I was going mad cos I didn't know what was wrong with me. I was 15 and I thought that I was going insane, so I think probably I thought I was so they thought I would too.	• I didn't want them to think I was weird • They'll think I'm mad / insane • I thought I going mad • I didn't know what was wrong with me

hum, mostly for me it was what am I gonna become because I didn't want to be depressed for the rest of life you know, I didn't want to be ill. I didn't want to be ill at all and it was just what am I gonna be like you know 10 years from now am I still gonna be here or in this place or still having to take (medication) or what you know, what's gonna happen and that still worries me but you just have to try not to let you.	• What am I going to become? • I don't want to be depressed for the rest of my life • I didn't want to be ill • Am I still going to be here • You have to try not to let it worry you

it's helpful to talk here but hum it would be nice to talk at home to people but they don't really understand it, it's like I can't explain it to them as well as I'd like to how I feel most of the time because I don't expect them to understand because they don't know. My dad kind of gets it but his was much different to mine and he was older I think 20's 30's when his started. So he still has to take medication if he's feeling a bit panicky, he can't go on tubes still. I think he understands it a little bit but my mum doesn't get it at all, she tries but she doesn't.	• It's helpful to talk • They (family) don't really understand it. • I can't explain it to them • I don't expect them to understand because they don't know • My dad kind of gets it – he still has to take medication • My mum doesn't understand it at all

yeah, it was I didn't know much about it you know I didn't know what was the matter with me I hated going to school and I didn't know why, you know I wasn't being bullied or didn't have no friends, I just didn't know.	• I didn't know what the matter was • I hated going to school and I did not know why

Appendix 8

Summary list of the key points

Summary list of key themes from participant 6 as related to the excerpts provided in appendix 7

It's never going to go away

Others might think I'm crazy

I thought that others might think I was going crazy

Trying to make sense of what is happening

What am I going to become?

I don't want to be depressed for the rest of my life

I didn't want to be ill

Am I still going to be here?

You have to try not to let it worry you

It's helpful to talk

They (family) don't really understand it

I can't explain it to them

I don't expect them to understand because they don't know

My dad kind of gets it – he still has to take medication

My mum doesn't understand it at all

I didn't know what the matter was

I hated going to school and I did not know why

Appendix 9

Clustering of themes from Excerpt of Transcript

Clustering of themes and overarching categories

Overarching Categories	Sub-Themes
1. The importance of understanding	▪ Trying to make sense of what is happening *Trying to make sense of what is happening* *I didn't know what the matter was* ▪ Keeping it a secret ▪ "I felt better knowing what it was" ▪ Wanting others to understand *It's helpful to talk* *They (family) don't really understand it* *I can't explain it to them* *I don't expect them to understand because they don't know* *My dad kind of gets it – he still has to take medication* *My mum doesn't understand it at all*
2. Uncertainty about the future	▪ "It is never going to go away" *It's never going to go away* *I don't want to be depressed for the rest of my life* *Am I still going to be here* ▪ Having to start over again ▪ Wanting it to be the way it was before ▪ "I don't see myself with a future" ▪ Ambivalent feelings about the future ▪ "I'm hoping" *You have to try not to let it worry you*
3. Getting in the way	▪ Isolated from peers ▪ Lack of motivation ▪ "My school work has been affected" *I hated going to school and I did not know why*
4. Negative view of self	▪ "I was embarrassed by it" ▪ "I thought I was going crazy" ▪ ▪ "Others might think I'm crazy" *Others might think I'm crazy* *I thought that others might think I was going crazy* ▪ "I don't really like myself"
5. "It rules everything"	▪ "I see it as me" ▪ "It has taken over my life" *What am I going to become?* *I didn't want to be ill*
6. "I understand where they are coming from"	▪ Knowing how to help others ▪ Becoming a good listener

Appendix 10

Letter of Ethical Approval

East & North Hertfordshire Hospitals
Local Research Ethics Committee

Location Code Q7
QEII Hospital
Howlands
Welwyn Garden City
Herts
AL7 4HQ
or
Fax: 01707 369010 or ext 5078

12 July 2004

Ms Lisa Shanahan

Dear Ms Shanahan,

Full title of study: ***Mental Health Problems in Adolescents: The impact on self and identity***
REC reference number: ***04/Q0204/27***
Protocol number: ***2***

The Research Ethics Committee reviewed the above application at the meeting held on 28 July 2004.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion to the above research on the basis described in the application form, protocol and supporting documentation.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The documents reviewed and approved at the meeting were:

Document Type: Application
Version: 1
Dated: 06/07/2004
Date Received: 12/07/2004

Document Type: Investigator CV
Version:
Dated:
Date Received: 12/07/2004

Document Type: Protocol
Version: 2
Dated: 18/06/2004
Date Received: 12/07/2004

Document Type: Covering Letter
Version:
Dated: 06/07/2004
Date Received: 12/07/2004

Document Type: Peer Review
Version:
Dated: 21/04/2004
Date Received: 12/07/2004

Document Type: Interview Schedules/Topic Guides
Version: 3
Dated: 11/07/2004
Date Received: 12/07/2004

Document Type: Copy of Questionnaire
Version: Appendix B: EOMEIS -2 (Revision)
Dated:
Date Received: 12/07/2004

Document Type: Copies of Advertisements
Version: 1
Dated: 16/06/2004
Date Received: 12/07/2004

Document Type: Letters of Invitation to Participants
Version: 1
Dated: 14/05/2004
Date Received: 12/07/2004

Document Type: Participant Information Sheet
Version: 2
Dated: 18/06/2004
Date Received: 12/07/2004

Document Type: Participant Information Sheet
Version:
Dated:
Date Received: 12/07/2004

Document Type: Participant Consent Form
Version: 2
Dated: 18/06/2004
Date Received: 12/07/2004

Document Type: CV for Supervisor
Date Received: 12/07/2004

Management approval

You should arrange for all relevant host organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain management approval from the relevant host organisation before commencing any research procedures. Where a substantive contract is not held with the host organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Notification of other bodies

We shall notify the research sponsor, Camden & Islington Mental Health & Social Trust that the study has a favourable ethical opinion.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

REC reference number: 04/Q0204/27	**Please quote this number on all correspondence**

Yours sincerely,

Mrs Jenny Austin
Committee Administrator

Enclosures List of names and professions of members who were present at the meeting and those who submitted written comments

Standard approval conditions [SL-AC2]