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# **MAJOR RESEARCH PROJECT**

**Rachel Gilbert BA (Hons), MSc**

## **Promoting Positive Identity Development in Young People**

Section A: Review: 'Identity Distress' and its Possible Implications for Young People

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Section B: How do Adolescents Admitted to a Psychiatric Ward Perceive its Impact on their Identity?

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A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology

June 2015

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

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## Summary of the MRP Portfolio

This portfolio investigates the factors that may influence identity development in young people, with particular emphasis on young people in receipt of mental health treatment in the UK.

Section A provides an overview and evaluation of the nascent research area of *Identity Distress*. This section describes the concept, its development and its association with indicators of maladjustment in adolescents and young (*‘emerging’*) adults. The review recommends that further research address a number of methodological limitations in order to demonstrate the conceptual and clinical validity of *Identity Distress*. Qualitative studies that situate potential identity formation difficulties in the contexts in which they have arisen would be welcomed, including the role that being a young user of mental health services could interact with identity and associated distress.

Section B describes a research study carried out in an adolescent psychiatric in-patient unit in the south of England. This section gives an introduction to the extant literature on the effects of psychiatric treatment on young people’s identity formation and the rationale for the research study. A theoretical model of the process of hospitalisation and the adolescent’s perceptions of how this impacted on their identity is presented. This suggested that a number of positive and potentially detrimental outcomes resulted from their experiences of hospitalisation, however longitudinal research is needed to determine the long-term impact of these perceived effects. Emphasizing formulation may offer a helpful framework for staff from different disciplines and young people to develop collaborative explanations for their difficulties that reduce the risk of self-stigma.

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**MAJOR RESEARCH PROJECT**

**RACHEL GILBERT BA (hons) MSc**

**SECTION A:**

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## **Abstract**

This review evaluates nine studies concerning the concept of Identity Distress in adolescents and young people between eighteen and thirty, described as 'Emerging Adults'. 'Identity Distress' is a relatively new construct developed from the defunct psychiatric diagnostic criteria of 'Identity Disorder'. It is defined by researchers as severe distress about the process of identity formation which results in disruption to day-to-day functioning and is measured by the Identity Distress Scale, first introduced and validated by Berman Montgomery and Kurtines in 2004. A brief introduction to the identity theories from which the Identity Distress construct arose is presented, followed by a discussion of the methodologies and findings of each study. Discussion of the methodological and theoretical issues identified in the studies poses a number of questions regarding the usefulness and validity of the Identity Distress construct. A number of recommendations for future research are suggested, including qualitative research into the subjective experience of 'Identity Distress' and the effects of particular contexts, such as being a user of psychiatric services. Caution is suggested in using the Identity Distress Scale clinically until further research is conducted.

As young people experience a longer period of uncertainty in a globalised culture with more choices for behaviour and lifestyles (Arnett, 2002) the process of identity development may have become more distressing (Waterman, 1988) and may lead to psychological maladjustment in young people who fail to develop a coherent identity (Marcia, Waterman, Matteson, Archer & Orlofsky, 1993). Berman and colleagues have argued that the concept of 'Identity Distress' offers a new way to capture young people in need of intervention and to measure progress (Berman, Montgomery & Kurtines, 2004). Indeed one published study with college students has already evaluated an identity intervention programme using reduction in 'Identity Distress' as an outcome measure (Berman, Kennerley & Kennerley, 2008). As such, it seems imperative that the concept of 'Identity Distress' in young people be thoroughly reviewed.

## **Layout of Review**

This paper offers a review of the literature on the concept of Identity Distress. It begins with a description of how the concept of Identity Distress in young people has emerged in the last ten years and is followed by a brief outline of its historical context in Eriksonian and post-Eriksonian Identity theories. Next, following recent developments in the area of identity development, a section considering the introduction of a new period of identity formation, "emerging adulthood", is discussed.

This is followed by a review of nine empirical studies on Identity Distress beginning with a discussion of the methodology used to identify and select papers for this review. This is broken into four sections. 1) The establishment and validation of the concept of identity distress 2) the relationship between identified identity distress

and psychopathology in adolescents 3) the same in emerging adults 4) family factors related to the identification of adolescent identity distress and psychopathology.

The final section offers an evaluation and critique of the identity distress concept. In light of the limitations of the methodologies in the research body itself, in the context of the original theories out of which it has developed and given recent criticisms of identity research as a whole. Clinical implications and directions for future research are suggested.

### **The development of the Identity Distress Concept and its Historical Context**

**Identity Distress.** The concept of “Identity Distress” was first defined by Berman Montgomery and Kurtines (2004) as an exceptional level of distress associated with the process of identity formation resulting in disruption to daily functioning. It was developed from the DSM-III-R diagnosis “Identity Disorder” which was characterised by “severe subjective distress regarding the inability to integrate aspects of the self into a relatively coherent and acceptable sense of self” (American Psychiatric Association, 1987). This included uncertainty about long-term goals, career choice, friendships, sexual orientation and behaviour, religious identity, moral value systems and group loyalties. For a diagnosis to be made, distress had to be rated as moderate to severe overall and to have been experienced for three months or more.

“Identity Disorder” was later reclassified in the DSM-IV-TR as “Identity Problem” and downgraded from a diagnostic category to *Conditions that may be a focus of clinical attention* (American Psychiatric Association (APA), 2000). Berman, Weems

and Petkus (2009) suggest that this reflected a lack of research in the area and an assumption within the psychiatric community that identity development necessarily causes distress and should not be seen as a disorder. They posit that this led clinical research away from adolescent identity interventions and so failed to identify young people for whom targeting this may improve outcomes. To remedy this, they proposed the conceptualisation and measurement of Identity Distress as a way to classify those who would qualify as experiencing Identity Disorder (or even Identity Problem) and explore how this 'Identity Distress' relates to other common targets for therapeutic intervention (such as psychiatric symptoms). Interestingly, neither classification appears in the recently revised DSM-5, in which problems with identity appear only in relation to severe psychopathologies such as personality disorders and gender dysphoria (APA, 2013). As such, the most up to date psychiatric guidance would seem to identify only the most extreme difficulties with identity as relevant to clinical intervention.

Both the DSM classifications of Identity Disorder, Identity Problem and the construct of Identity Distress have a basis in Identity theories established by Erikson (1968) and elaborated on by theorists such as Marcia (1980) and Waterman (1982). These theories have focused on mapping and measuring aspects of the identity formation process and suggested the most important domains in which identity begins to develop in young people, for example occupational choices, political ideology, sex-roles and friendships/relationships.

**Identity Distress in its historical context: Erikson.** Erikson proposed an eight-stage model, of which adolescence is the fifth and final stage of childhood. Each

stage represents a “normative crisis” which the individual must resolve in order to progress successfully to the next stage of healthy identity development. During adolescence this involves the re-examination of all former identifications (that is, prior learning from parents and important people around the individual) which are reintegrated into a unique sense of self that moves beyond these. Although Erikson does not give an exact age range, during this stage peer and romantic relationships increase in importance for most young people and they are presented with a number of choices regarding relationships, their belief and value systems and their career choices. The task of adolescence, therefore, is to explore these possibilities and form commitments to various life-choices and values.

Although the process of identity formation may be re-visited throughout adulthood, a young person could be said to have “achieved” an identity if they have formed “a sense 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 who count” (Erikson, 1968: p. 165). By contrast, a state of “Identity Diffusion” is characterised by an inability to make these commitments. This affects the ability to form intimate relationships in later life (Adams & Archer, 1994) and predicts poorer occupational outcomes (Kroger, 2007).

Schwartz (2001) has characterised Erikson’s theory as tripartite. Not only does an individual develop a number of aspects of their identity based on their personal experiences, character and history. Two critical aspects are the way in which others perceive and identify the individual as uniquely ‘them’ and the extent to which the person is integrated into and valued by their social groups. For Erikson, the process of developing an identity during adolescence may be impacted by many social, cultural

and economic factors with an explicit responsibility for society to provide opportunities for occupational development and social 'belonging'.

**Marcia: Operationalising Erikson's theory.** Writing after Erikson, a number of researchers noted the difficulty in developing an empirical research base for such an all-encompassing social-developmental model (Cote, 1993; Cote & Levine, 1987). In 1966 Marcia proposed a four-status model which operationalised Erikson's concepts of exploration, commitment and diffusion into testable theoretical entities. Marcia defined a continuum between exploration and commitment. In line with Erikson's theory, to have "achieved" an identity a young person had to have been through a period of exploration before committing to certain choices and values. At the other end of the spectrum, a young person who has neither begun the process of exploration nor made coherent or firm commitments could be said to be "diffused". Drawing on descriptions from Erikson's writings, Marcia introduced two other statuses. Young people who were said to have entered into a state of exploration but had not yet made firm commitments were described as being in "moratorium". Finally those who had made firm commitments without a prior process of exploration could be said to have a "foreclosed" identity, or one that they had adopted from identifications with parents and authority figures without a process of questioning or trying alternatives.

Following research with male college students Marcia (1966) proposed that the statuses were observable by late adolescence and made a number of observations about the characteristics of each status group. Those in the "achieved" group were likely to have greater self-esteem and to set realistic long-term goals that were achievable. Those in the moratorium status were similar but prone to higher levels of anxiety and uncertainty. Those in the foreclosure group were most likely to endorse

authoritarian or conservative values and those in the diffused status were predicted to have the poorest psychosocial adjustment with difficulty making important life-choices. Though this original study was cross-sectional with a small sample heavily biased toward middle class, male experiences.

Marcia suggests that the status model offers an objective way to measure the process of identity formation (Marcia, 1980) and research has often supported that those classified in the “achieved” status show superior functioning in intimate relationships in later life (e.g. Orlofsky, Marcia & Lesser, 1973). However while the statuses are often set in context of wider social and economic changes (for example research showing that lacking exploration or commitments in times of austerity and low employment can be culturally adaptive) the model focuses mainly on processes within the individual (Sica, Sestito & Ragozini, 2014).

Carter and McGoldrick (1999) have criticised the status model as focusing too heavily on occupation and beliefs (which may be seen as traditionally masculine domains) above the importance of reciprocal interpersonal and family relationships (which may be more important in female identity development). Recent research has also suggested that the statuses are associated with personality characteristics and may better represent character aspects rather than developmental stages (Meeus, ledema, Helsen & Vollebergh, 1999).

**Other developments in Identity Theory.** One of the major criticisms of Marcia’s status model is that it provides a very narrow definition of identity (e.g. Cote & Levine, 1988). Several researchers have emphasised the importance Erikson

originally placed on the interaction between the individual and the social world and the importance of this to the identity formation process. Kurtines (1999) highlights the role that social institutions play in recognising and giving identity to individuals. Valuing those who 'fit in' with the expectations of the social institutions around them and alienating those that don't.

Côté (1996) locates identity firmly within a late-capitalist historical context and sees identity as an active exchange process whereby the individual negotiates for social resources within their social milieu. Like Erikson, Côté suggests that social institutions have a role to play in helping young people to avoid identity diffusion by offering guidance and opportunities for development/work but takes this further suggesting that the lack of this leaves young people with little 'identity capital' with which to negotiate their place in society, (Côté, 1996).

Other research has emphasised the importance of the domains of identity development. Grotevant and Cooper (1981; 1986), have argued that identity development occurs on two levels, the personal and the interpersonal. However Wanderman and Kurtines (1994) suggest three domains: the self, the self in relation to others and in relation to society and developed the Identity Domain Scale which, unlike measures based on the status model, assesses levels of overall distress in many areas of identity development across these domains.

The most common empirical measures used in identity research, some of which are used in the studies in this review, reflect the theoretical divergences described above. The majority are self-report or semi-structured interview measures looking at status assignments (e.g. achieved, diffused) or levels of exploration and commitment. The Ego Identity Process Questionnaire is a self-report tool commonly used which



measures levels of exploration and commitment across different identity areas and uses median splits to give an overall status assignment (Balistreri, Busch-Rossnagel & Geisinger, 1995).

Related to this, the Identity Style Inventory (Berzonsky, 1997) is a self-report questionnaire measuring the information processing styles that individuals use to make identity-related choices. These are characterised as, “diffuse/avoidant” (which maps onto the diffusion status) “normative” (maps onto the foreclosed status) and “informational” (representing active exploration of alternatives and flexible commitments).

On the whole these authors have reported adequate to good internal consistency and test-retest reliability with ranges from .66 - .90. However Van Hoof (1999) proposes caution given that the identity measures have not been standardized in a way that can be reliably compared with one another. Importantly, erroneous significant results may be obtained in regression analyses if one measure is inherently more reliable than the other (Berman, Weems & Petkus, 2009).

**Emerging Adulthood.** As Identity research has entered the 21<sup>st</sup> Century, researchers have questioned whether adolescence is the most important stage for identity development or whether social changes leading young people to spend longer in education and wait longer before entering into committed relationships and parenthood presents a key period for identity formation.

Refuting suggestions that young people in the late 20<sup>th</sup> century simply benefitted from an ‘extended adolescence’ Arnett (2000) suggested that real demographic differences exist between adolescents aged 12-17 and adults aged 18

to late twenties: a period which he termed “Emerging Adulthood”. For instance, the rate of residence-change for people in their early to mid-twenties is significantly higher than for adults in their thirties onwards and is often in relation to changing commitments (entering or leaving education, changing relationship status, employment). Arnett argues that this period involves an intensification of the exploration begun (for most young people) during adolescence yet moving toward the stability required to consolidate the tasks of adulthood.

In support of the development of this new stage, Arnett highlights evidence that the majority of adolescents have not reached an ‘achieved’ identity by the end of adolescence, nor have they usually made lasting commitments characteristic of Erikson’s ‘Young Adulthood’ stage (Waterman, 1982). However, although ‘Emerging Adulthood’ is suggested to be a culturally determined phenomenon, existing only in post-industrialized societies, this may also hold true for different classes and geographical areas in western societies. Arnett allows that some cultural groups in western societies may not afford their young people the extended “moratorium” proposed by the theory of emerging adulthood, however, entering into an apprenticeship at a young age or living in an area where employment opportunities are more scarce may also reduce the opportunity for this extension. With universal schooling up to 18 in the UK and observable biological changes during puberty, adolescence is a widely accepted stage occurring for every young person. ‘Emerging adulthood’ by contrast may be a developmental stage experienced only by a specific sub-section of western societies.

## **The Present Review**

Following the developments in post-Eriksonian identity theory, the following section offers a review of nine studies identifying and evaluating one of the most recent contributions to the field: the concept of 'Identity Distress'. The term "young people" will be used generally to refer to adolescents and/or 'emerging adults'.

### **Review of Empirical Papers**

#### **Methodology and terminology**

Using the search term ["Identity Distress"] in the title or abstract seventeen potential studies were identified. During the initial search phase, studies containing the words "identity distress" in the title or abstract were discounted immediately if they referred to sexual, gender or cultural identity as the words "identity distress" in this context do not refer to the concept of Identity Distress as defined by Berman Montgomery and Kurtines (2004) or the category of Identity Disorder in the DSM-III.

Of the seventeen studies on Identity Distress, eleven studies were identified first using the databases psychINFO, ASSIA, PubMed and Web of Science. A further six studies were identified by a Google Scholar search. Papers were cross-referenced for further relevant references which revealed no new papers. Using the search term ["Identity Problem"] following the same process revealed no new studies.

One study was discounted as it reported on the outcome of an intervention for identity distress, which is beyond the scope of this review (Berman, Kennerley & Kennerley, 2008). Four studies were excluded on the basis that they were not published in peer reviewed journals. Two studies were discounted on the basis that they included participants in their thirties and above. Figure 1. and Table 1. Show the search methodology in chart form and outline key information from the nine reviewed studies.

Erikson's original theory did not demarcate an age range for the adolescent identity formation stage, however a number of researchers have suggested that this stage begins around age twelve and lasts until seventeen or eighteen (Newman & Neman 1976; Kroger, 2007). Studies included in this review included participants in this age range however the majority of studies sampled college-age students between approximately eighteen and twenty six who might be said to be in the 'emerging adult' phase suggested by Arnett (2000). As Identity Distress is hypothesized to affect the identity formation process and given the research suggesting that the early and mid-twenties may be a key stage in the consolidation of an identity, studies concerning both age groups have been included in this review.

Figure 1. Flow Diagram showing search methodology

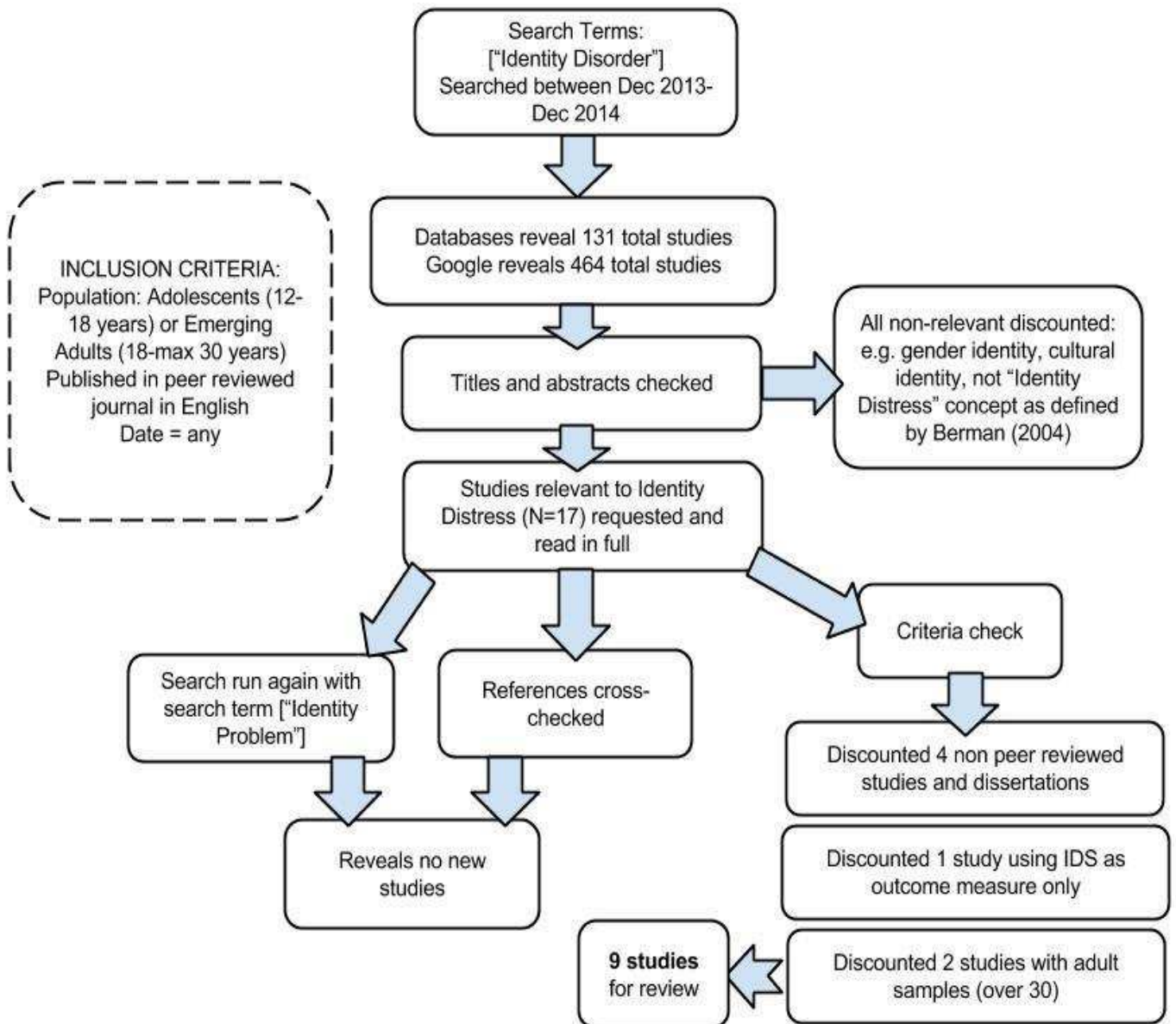


Table 1. Showing key information on reviewed studies

Study	Aims	Sample	Design & Analysis (All quantitative)	Measures	Main findings
<p><b>Berman, Montgomery &amp; Kurtines, 2004.</b> The development and validation of a measure of Identity Distress. (US)</p>	<p>Develop Identity Distress Survey (IDS) Investigate test-retest reliability Test associations between Identity Distress, identity status and identity style.</p>	<p>Study 1: 105 psychology students (83.5% female) mean age 25.5 (SD=8.6)  Study 2: 331 students (82.2% female) mean age 20.96 (SD=3.58)</p>	<p>Study 1: IDS administered twice with one week delay Internal consistency and Cohen's Kappa calculated  Study 2: Calculated the percentage of participants identified as Identity Disorder using IDS  Looked at correlations between global distress score (Qu. 8) on the IDS, the EIPQ and the ISI.</p>	<p>Study 1: Identity Distress scale created from defunct DSM III category "Identity Disorder"  Study 2: IDS, Ego Identity Process Questionnaire (exploration and commitment) and Identity Style Inventory Diffuse/avoidant; Normative; Informative)</p>	<p>Study 1: internal consistency in acceptable range (= .84) test-retest reliability fairly high (= .82)  Study 2: 12% sample met DSM criteria for Identity Disorder using IDS. Identity Distress (composite score) inversely related to commitment score Moratorium status and Informational style groups had highest number of people meeting criteria for Identity Disorder</p>
<p><b>Berman, You, Schwartz &amp; Teo, 2011.</b> Identity exploration, commitment and distress: A cross</p>	<p>To test factor invariance for three identity constructs (identity distress, exploration,</p>	<p>University students China n=85 Taiwan n=117 Japan n=117 US n=223</p>	<p>Questionnaires administered in four countries and compared.</p>	<p>Translated measures: IDS EIPQ</p>	<p>IDS showed factor invariance across cultures and was hypothesized to be cross- culturally valid.</p>

Table 1. Showing key information on reviewed studies

Study	Aims	Sample	Design & Analysis (All quantitative)	Measures	Main findings
national investigation  (China, Taiwan, Japan and the US).	commitment) across four nations.  This would demonstrate whether these measures have cross-cultural validity for use in different world populations	Mean age 21 (SD=3.8) US = 84% female China = 21% female	The authors do not report how they calculated a composite Identity Distress score  Analysed using statistical factor invariance modelling		Asian sample scored lower on Identity Distress and commitment than US participants. Exploration was not found to be a cross-culturally valid construct.
<b>Hernandez, Montgomery &amp; Kurtines, 2006.</b> Identity Distress and adjustment problems in at-risk adolescents  (US)	To investigate relationship between Identity Distress and psychological adjustment in adolescents	106 youths (70% female) from alternative high schools for adolescents 'at risk' of exclusion Mean age 16.28 (SD=.97) 11% Ethnicity White	Used scoring criteria for Identity Disorder and more liberal DSM-IV measure of "Identity Problem"  Calculated two subscales for the IDS: the IID (sum of items 1-7) and GID (sum of 8&9) and correlated with overall sum of scores on IDS	IDS  Zill Behaviour Items, Behaviour Problem Index (32-item self-report on behavioural problems in adolescents)	16% met criteria for identity disorder 34% met criteria for "Identity Problem"  IDS correlated with problem behaviours and psychiatric symptoms – Identity distress co-occurs with psychosocial problems.  GID measures a related but distinct aspect of identity distress/the IDS

Table 1. Showing key information on reviewed studies

Study	Aims	Sample	Design & Analysis (All quantitative)	Measures	Main findings
<p><b>Berman, Weems &amp; Petkus, 2009.</b> The prevalence and incremental validity of identity problem symptoms in a high school sample  (US)</p>	<p>To investigate the prevalence of “Identity Problem” in non-clinical adolescents To examine the incremental validity of the IDS over identity status on the EIPQ in predicting psychological symptoms</p>	<p>140 high school students (70% female) Mean age 16.72 (<i>SD</i>=0.88) 78.6% Ethnicity White</p>	<p>Correlations calculated between IID, GID and ZBI BPI scores</p> <p>Used scoring criteria for Identity Disorder and more liberal DSM-IV measure of “Identity Problem”</p> <p>Used a continuous measure of average Identity Problem score (sum of items 1-9) for correlational and regression analyses with EIPQ and BSI scores</p>	<p>IDS EIPQ Brief Symptom Inventory (BSI) 18-item self-report measure of depression, anxiety and somatization.</p>	<p>7.9% met criteria for Identity Disorder 14.3% for “Identity Problem”</p> <p>Identity problem symptoms predicted BSI scores beyond Identity status alone</p> <p>Identity Disorder may be a more robust categorisation than Identity Problem</p>



Study	Aims	Sample	Design & Analysis (All quantitative)	Measures	Main findings
<b>Wiley &amp; Berman, 2013</b> Adolescent identity development and distress in a clinical sample (US)	To examine relationships between identity status variables, identity distress and psychological adjustment.	88 adolescents receiving treatment at a community mental health centre 43.2% female Mean age 14.96 ( <i>SD</i> =1.85) NB: included ages 11-20 33% Ethnicity White	Calculated rates of "Identity Problem" Used a continuous measure of average Identity Distress score (same as Identity Problem continuous score - sum of items 1-9) for correlational and regression analyses	IDS EIPQ BSI	Do not report rates of Identity Disorder 22.7% met criteria for "Identity Problem" Identity problem scores were more strongly associated with psychological symptom severity than identity exploration and commitment. (But NB: these were still associated with symptom severity when controlling for identity distress) Exploration was positively related to IDS scores, commitment was negatively related to IDS scores.
<b>Wänqvist &amp; Frisé, 2011</b> Identity and psychological distress in emerging	To test a mediational model: whether identity distress mediates the relationship between identity	136 adults aged 24-26 years in the general Swedish population (50% female)	Calculated rates of participants meeting "Identity Problem" criteria	IDS Ego identity status interview	9.6% sample met criteria for "Identity Problem" Moratorium identity status was associated

adulthood in Sweden: Is it always distressing not to know who to be and what to do?  (Sweden)	status and psychological symptoms.	Mean age 24.9 ( <i>SD</i> =0.7) No ethnicity data	Calculated IID scores for continuous variables  Statistical mediation modelling	Symptom Checklist-90 (SCL-90) Inc. somatization, depression, anxiety, hostility, interpersonal, paranoia and psychoticism,	with distress and psychological symptoms but diffused identity status was not.  Identity distress scores mediated the relationship between moratorium and concurrent psychological symptom scores
<b>Study</b>	<b>Aims</b>	<b>Sample</b>	<b>Design &amp; Analysis (All quantitative)</b>	<b>Measures</b>	<b>Main findings</b>
<b>Gfellner &amp; Córdoba, 2011</b> Identity Distress, psychosocial maturity and adaptive functioning among university students  (Canada, Spain)	To examine relationships between Identity distress scores, Ego-strengths and various measures of adaptive functioning	Canada: 111 university students (85% female) Mean age 19 ( <i>SD</i> =1.7) 88% Ethnicity White  Spain: 209 university students 72% female Mean age 19.8 ( <i>SD</i> =1.5)	Calculated IID and GID for use in correlation and regression analyses	-IDS -Psychological Inventory of Ego-Strengths -Social Support Appraisal Scale  Adaptive functioning / outcome measures: (Modified) Student - Adjustment to College Scale	9.7% met criteria for Identity Disorder 18.8% for "Identity Problem"  IDS scores inversely related to Ego strengths and Social Support  Ego strengths accounted for most of the variance in the outcome measures

		98% Ethnicity White		-Academic Locus of Control Scale -Stress scale (not validated)	Ego strengths and IDS scores independently contributed equal variance to GID score (i.e. global level of distress about identity)
<b>Sica, Sestito &amp; Ragozini, 2014.</b> Identity coping in the first years of university: Identity diffusion, adjustment and Identity Distress.  (Italy)	To explore relationships between identity variables, sense of adulthood and psychosocial functioning  To define clusters/'profiles' of methods adopted to negotiate identity processes  To highlight whether and how Identity Distress contributes to these 'profiles'	332 university students in first two years of study 56% female Mean age 21.65 ( <i>SD</i> =2.28) No ethnicity data	Used continuous measure of IDS scores but do not state how this was computed  Correlational analyses and Hierarchical cluster analysis	(Translations)  IDS  Dimensions of Identity Development Scale (Identity variables) Identity Stage Resolution Index (sense of adulthood)  Rotter's Locus of Control Scale Rosenberg Self-Esteem Scale Depression and Anxiety Subscales from SCL-90	Identity distress was associated with two clusters:  1 Developmental diffusion (high exploration, high distress, poor locus of control and sense of adulthood, psychological symptoms)  2 Disturbed Diffusion (low exploration, commitment, adulthood but high <i>ruminative exploration</i> , depression and anxiety  Identity Distress may be related to ' <i>Ruminative Exploration</i> '

<p><b>Wiley &amp; Berman, 2012</b> The relationships among care-giver and adolescent identity status, identity distress and psychological adjustment.  (US)</p>	<p>Examine possible links between caregiver identity variables (Identity Distress, exploration and commitment) and adolescent Identity Distress and adjustment</p>	<p>60 Child-Caregiver dyads in treatment at a community mental health centre receiving Medicaid (Low SES)</p> <p>Young people 63.3% female Mean age 15.24 (SD=1.65) 31.7% Ethnicity White Diagnoses: adjustment disorder, ADHD, Bipolar, Mood disorders, PTSD, Psychosis, ODD</p> <p>Caregivers: 86% mothers, 6.7% fathers 41.7% Ethnicity White</p>	<p>Used a continuous measure of IDS scores for regression analyses but do not state how calculated</p> <p>Regression analyses</p> <p>1 Whether care-giver identity variables predict adolescent Identity Distress above the impact of their own variables</p> <p>2 Whether caregiver identity variables predict adolescent psychological symptom severity above the adolescents' own variables</p>	<p>IDS EIPQ BSI</p>	<p>Caregivers: 10% met criteria for "Identity Problem" Children: 21.7% "Identity Problem"</p> <p>Caregiver identity exploration predicted adolescents' Identity Distress above the adolescents' variables</p> <p>Caregiver identity commitment predicted adolescents' symptom severity above adolescent variables</p> <p>Caregiver exploration and commitment may impact on parenting in ways that lead to difficulties in identity development for adolescents.</p>
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## **What is Identity Distress? Papers Establishing Reliability and Validity**

Two papers are reviewed in this section. In the first published paper establishing the concept of Identity Distress, Berman Montgomery and Kurtines (2004) describe the creation of the Identity Distress Survey (IDS) and its reliability and validity. The survey transposes the DSM-III-R criteria for Identity Disorder into a questionnaire with nine items. The first seven questions require Likert-scale responses from 1 (not at all) to 5 (very severely) in answer to the question “To what degree have you currently been upset, distressed or worried over the following issues in your life?”. This question is asked in seven domains comprising long-term goals; career choices; friendships; sexual orientation; religion; values and beliefs and group loyalties. The final three questions in the survey ascertain how distressed the person has felt about this overall, to what extent this has affected their functioning and how long this has been problematic. The authors propose that the questionnaire can be used to make a DSM-III-R diagnosis of Identity Disorder if items 1-7 are rated as “severe” or “very severe”, if overall distress and impact on functioning (on questions 8-9) are rated “moderate” or higher and if the duration is more than 3 months on question 10.

Normed on a college population with a mean age of 25.5, the authors report test-retest reliability as good with a kappa value of .82 and internal consistency had an adequate alpha value of .85. Using a different sample, also of college students, the authors also compared rates of Identity Disorder (as diagnosed by the IDS) with scores on the Ego Identity Process Questionnaire (EIPQ: to determine identity status) and the Identity Style Inventory (ISI: suggesting which style of information processing a person uses when making identity-related decisions). Finding that rates of Identity Disorder were significantly higher in those identified as “Moratorium” (21.5% prevalence) and

also for those identified as having an 'Informational' processing style (related to the Moratorium and Achievement categories) the authors make several conclusions. Firstly that the IDS provides a reliable instrument for the measurement of Identity Distress and demonstrates validity when compared to predictions made by the Identity Status model that participants with high levels of exploration would show higher levels of distress about identity. Secondly that the process of identity development "seems to follow a rule of no pain no gain". Exploring one's identity (Moratorium) can lead to "extreme difficulties" for some of the young people experiencing it but making commitments (in Achievement or Foreclosure) seems to protect against this.

Certainly the finding that those in the foreclosed status (with the highest levels of commitment and lowest levels of exploration) were significantly lower in overall distress than the other three groups might seem to support this. However the authors don't acknowledge the relatively high rates of Identity Disorder found in the Achievement group (14.8% prevalence) compared to the Diffused (11.4%) and Foreclosed (5.0%).

The authors argue that the IDS offers a better way to identify those who might be extremely distressed by the process of identity exploration over and above predictions made by the status model. As the IDS suggested diagnoses of identity disorder across the statuses (although most in the Moratorium category) this may well be supported. However, given that the study did not follow up the participants diagnosed with Identity Disorder there remain questions as to whether this is lasting and whether it has long-term consequences for young people's identity development and other psychological or social outcomes.

Moreover, the authors do not at any point address the difference between what they have called 'Identity Distress' and the use of a DSM diagnostic category to identify this. In this study, they used a continuous measure of distress (global distress score rated at question 8, which correlated highly with composite scores on questions 1-7) as well as the rates of the full diagnosis to explore relationships with other identity variables. As such, it is unclear for researchers following this as to whether 'Identity Distress' is the same as Identity Disorder (and therefore must follow the criteria laid out by the DSM-III-R category) or whether scores on individual questions or parts of the questionnaire can also be said to reliably represent Identity Distress. Equally, the sample was limited to a predominantly female sample of university students and therefore it is unknown whether the findings can be generalised to more diverse or younger population.

**Cross Cultural Validity.** Berman, You, Schwartz, Teo and Mockizuki (2011) have also examined whether the concept of identity distress has cross-cultural validity. They compared exploration and commitment scores on the EIPQ and scores on the IDS in college students (mean age 21) in the US, Japan, Taiwan and China, arguing that their factor invariance analysis would demonstrate whether any differences in scores observed between samples were due to genuine differences between cultural groups (regarding the construct being assessed) and not the way in which the different groups may respond to the questionnaires differently. It appeared from the results that the concept of exploration is not valid in Asian countries and that a western conceptualisation of commitment is only partially valid in certain domains (family, occupation, dating, gender roles and religion). However the scores on the Identity Distress Survey demonstrated a very similar pattern of responses across the four

countries suggesting that concerns about identity may be something felt universally across cultures in similar domains.

Interestingly, despite the IDS showing a similar factor structure across cultures, Asian participants overall showed lower levels of both commitment and distress about their identity (distress measured by the average score across the first seven questions of the IDS) compared to US participants. The authors conclude that Asian participants are likely to follow a different trajectory of identity development that does not involve the 'identity crisis' predicted by Western models. Accordingly, although identity distress appeared to be present (but at lower levels) for Asian participants they suggest that current western interventions to increase identity exploration may not be helpful in this population as different cultures produce different identity formation processes.

In this light, the concept of identity distress could be helpfully used to identify those experiencing extreme difficulties across cultures and to demonstrate outcomes across culturally sensitive interventions. However, the measure of identity distress in this study (average distress across the seven identity domains) did not use the strict diagnostic criteria for Identity Disorder which stipulate that distress must have had a moderate to severe impact on overall distress and daily functioning which has lasted several months. In this study, mean 'Identity Distress' scores were between 2.14 in the Chinese sample and highest in the US sample at 2.96. These suggest that on average distress for participants as a whole was mild to moderately distressing and nothing is known about what proportion of the samples experienced higher levels of distress about identity and whether this has negative outcomes for the young people experiencing it.



The different methodologies used in both studies highlight a wider problem in the definition and the construct of Identity Distress. Although the following studies address some of the questions raised about associated outcomes for young people experiencing 'Identity Distress', the question as to what precisely is meant by Identity Distress affects the body of research as a whole and is revisited in detail in the Discussion.

### **How Does Identity Distress Relate to Psychological Distress in Young People?**

**Studies in adolescents.** Three studies in adolescent samples have been published looking at the potential relationship between identity distress and psychological maladjustment. In all three of the studies Identity Distress was defined in two ways, first by reporting the incidence of participants meeting the DSM-IV-TR criteria for 'Identity Problem' (a more liberal, non-diagnostic category which replaced the defunct category of 'Identity Disorder' and does not require the duration to be of three months). Secondly average distress ratings across various questions on the Identity Distress Survey (IDS) was also used in a similar way to the validation studies to test correlations between continuous variables (see Table 1.).

In a sample of young people attending a high school for pupils marked as 'at risk' due to absenteeism and poor educational performance, Hernandez, Montgomery and Kurtines (2006) found significant associations between average identity distress scores and both externalizing and internalizing symptoms (Behaviour Problem Index: Zill, 1985). Within their sample they suggested that 34% met the liberal criteria for Identity Problem and that the higher prevalence rate compared to other studies may

be due to extra difficulties for identity development associated with coming from a deprived background and having behavioural and 'motivational' difficulties.

Addressing questions as to the unique role of Identity Distress in the relationship between identity and psychological maladjustment, two of the studies suggested that Identity Distress scores predicted concurrent psychological problems (Brief Symptom Inventory: Derogatis, 2000) over and above identity status on the EIPQ in a sample of high school students (Berman, Weems & Petkus, 2009) and that Identity Distress scores and exploration and commitment scores on the EIPQ independently predicted psychological problems on the BSI in a clinical population of adolescents accessing outpatient mental health treatment (Wiley & Berman, 2013). Direction of causality cannot be demonstrated in these correlational studies. However, Wiley and Berman (2013) suggest that the relationship between identity distress and psychological problems may be reciprocal, arguing that this may lead to the disruption to the identity development process that they posit to underlie the identified Identity Distress symptoms.

Interestingly, two of the studies highlighted certain patterns relating to Identity Distress and gender. For instance, Berman and colleagues (2009) note that girls showed higher levels of distress overall in the areas of sexuality and values compared to boys. In the study by Hernandez and colleagues (2006) two girls who met the stringent criteria for Identity Disorder showed significantly higher levels of 'headstrong behaviour' and hyperactivity on the BPI compared to other females in the sample and the two boys meeting the criteria for Identity Problem in the sample had significantly higher levels of depression, peer problems and social withdrawal in comparison to their male peers.

Although a sample of four could be biased, it may be that some aspects of identity formation are more salient for females and males and therefore may lead to important social and gender interactions being masked by the identification of 'Identity Distress'. For example, it may be more problematic for girls to be headstrong and boys to be withdrawn as these may be characteristics typically associated with the opposite gender in western cultures. Equally, distress about sexuality and values may be more salient for adolescent females as awareness develops about societal attitudes to female sexuality (for example negative attitudes towards teenage pregnancy or female promiscuity).

Although these three studies reported no significant gender interactions in their main analyses, the above observations highlight the necessity to consider contextual factors when thinking about how or why Identity Distress and psychological problems may be identified in some young people and not others. For instance feeling as though you 'fit' or don't 'fit' into the world is hypothesised to have an impact on identity, interpersonal and societal functioning (Erikson, 1968). The IDS may therefore pick up on this distress, highlighting it as an internal state or problem requiring intervention when it may actually reflect experiences of difference and marginalization at a cultural and social level.

**Studies in Emerging Adults.** Two studies in emerging adults have taken a similar approach to the studies in adolescents to define the relationship between IDS scores, aspects of identity formation and maladjustment. Using slightly different measures, Wanqvist and Frisen (2011) also found that Identity Distress was related to concurrent psychological maladjustment on the Symptom Checklist (SCL-90:

Derogatis, 1994). However in this study of 136, 24-26 year old Swedish emerging adults only 43 participants categorised in the Moratorium status (according to Marcia's Objective Identity Status Interview, Marcia 1966) showed significantly higher levels of psychological problems and identity distress than the other status groups. When average Identity distress scores were accounted for, the effect of being in Moratorium ceased to predict psychological problems and thus the authors propose that Identity Distress mediates this relationship between Moratorium and psychological problems.

As being in the Diffused status was not significantly correlated with psychological problems they conclude that - for Swedish youth - "not knowing who you are" (Diffusion) is not the biggest risk for psychological distress. Rather it is the "not knowing but wanting to know" (Moratorium) that is associated with the highest risks for psychological problems and the perception of identity distress. Interestingly, the authors do not acknowledge that one third of the sample who met the criteria for 'Identity Problem' did not fall into the Moratorium category. Similarly that only 8 participants in Moratorium (and only 12 participants in the whole study) met these clinical criteria; highlighting issues with determining clinically significant distress in this study. Again this was a cross-sectional study.

Taking a slightly different approach to measuring maladjustment, Gfeller and Cordoba (2011) found that emerging adults who met the criteria for Identity Disorder had significantly poorer scores on measures of academic, social and emotional adjustment to college, stress and academic locus of control. Interestingly however this study also included a measure of Ego-strengths (Psychological Inventory of Ego Strengths: Markstrom, Sabino, Turner & Berman, 1997) which gives a measure of psychosocial functioning in the following areas: hope, will, purpose, confidence, fidelity, love, care and wisdom. These skills are theoretically linked to Erikson's

psychosocial stages model of development suggesting psychological maturity and the absence of pathology (Markstrom & Marshall, 2007).

The results in this study indicated that Ego strengths accounted for more of the variance in all of the adjustment measures than did Identity Distress, except for what they termed “General Identity Distress” which they calculated by averaging the scores for overall distress (item 8) and impact on functioning (item 9) on the IDS.

Distress about identity (average of the first seven questions on the IDS) and Ego-strengths accounted for equal variance in General Identity Distress (GID), suggesting a unique relationship between Identity Distress and its impact on functioning above the role of previous psychosocial development. The authors argue therefore that Identity Distress is a separate entity in itself yet may arise as a result of delay or interference in earlier stages of psychosocial development. Of course longitudinal research is necessary to determine the nature of the relationship.

They also highlight how differences in the way the IDS scores are calculated show different associations with other measures. In this study, only those meeting the criteria for ‘Identity Disorder’ showed the level of concurrent identity difficulties that might theoretically be predicted by the concept of Identity Distress (in this study: poor ego-strengths, psychological symptoms). Equally, only those meeting criteria for Identity Disorder were statistically different from the No Disorder group on all variables, highlighting again that the more liberal ‘Identity Problem’ criteria may be inappropriately identifying a ‘normal’ level of concern as a clinical problem.

Lastly, one study in first and second year university students in Italy, has taken a broader approach to exploring the concept of Identity Distress. Sica, Sestito and Ragozini (2013) present a study in which ‘Identity Distress’ is contextualised as a result

of different identity coping styles and individual contexts. They illuminate its relationship to different ways of exploring identity (or not) and relate this also to sense of adulthood, locus of control, self-esteem, anxiety and depression. Using a correlational design they identified five clusters of associations between the variables which represent these individual coping styles. Identity Distress was associated with two styles. The first, Developmental Diffusion, showed the second highest rate of Identity Distress and was characterised by high exploration, high distress, low sense of adulthood and poor locus of control, depression and anxiety. The authors therefore propose that what they term 'actively searching but without outcomes' may lead to Identity Distress and poorer psychological outcomes.

The highest level of identified Identity Distress was in the Disturbed Diffusion group characterised by very low levels of exploration, identifications with commitment or sense of adulthood, poor locus of control but high *ruminative exploration*, and depression and anxiety. *Ruminative exploration* featured in both clusters in which Identity Distress was high and was closely associated with it across all clusters (whether high or low). It is identified using the Dimensions of Identity Development Scale (DIDs: Luyckx et al., 2008) and refers to rumination about exploring identity but being unable to consolidate this into commitments. As Identity Distress was not associated with measures of exploration but only with the process of ruminative exploration, this seems to suggest that Identity Distress is not associated with exploration per se but with ruminating about the lack of a consolidated identity.

However, an alternative explanation may be that the young people in these clusters were depressed, which is associated with a sense of defeat or entrapment (see Gilbert, 2001). They may have experienced a lack of opportunities to explore their nascent identities due to economic and social circumstances. It is possible that the

latter may cause both depression (which is associated with rumination (Nolen-Hoeksema, Wisco & Lyubomirsky, 2008)) and Identity Distress in young people.

This may be supported by a third category of people identified in this study as being in a state of “Culturally Adaptive Diffusion”. These students were characterised by low levels of exploration, identification with commitments and sense of adulthood yet also low levels of rumination and distress. Levels of depression for this group were not reported. The authors suggest that for some young people it is adaptive to have no fixed commitments and, moreover, not to engage with identity concerns during times of continual economic and social shift, therefore avoiding distress. Nonetheless for the construct validity of Identity Distress, the absence of rumination and Identity Distress in this group (both of which had a clear association in this study) may be due to the absence of depression in this group. As again this was a cross-sectional study, it is difficult to suppose cause and effects.

Alternatively, the results of this study may help to explain why Moratorium in other studies has shown the highest IDS scores or psychological maladjustment. Using measures such as the EIPQ which have only four identity categories, it may be that young people with a “Developmental Diffused” coping style are categorised in Moratorium due to being high in exploration. As the ruminative aspect is not captured in these models this may explain why it appears in other studies that Moratorium is a risk for Identity Distress in some young people in Moratorium but not all.

Conversely, the close relationship between *Ruminative Exploration* and Identity Distress in this study may raise questions as to whether the Identity Distress Survey is capturing something independent (known as Identity Distress) or whether Identity Distress and *Ruminative Exploration* may be part of the same or another unknown

phenomenon. Further research is required to clarify the relationship between the two and to investigate whether these (or different categories) are found in non-university, clinical and adolescent populations.

**The role of caregiver identity variables.** One study published to date has investigated the relationship between caregiver identity and identity distress in adolescents (Wiley & Berman, 2012). In this study, caregiver levels of exploration (on the EIPQ) significantly predicted adolescents' psychological symptom severity on the BSI over and above their own variables (exploration, commitment and Identity Distress on the IDS). Interestingly, Caregiver levels of commitment also predicted adolescents' Identity Distress scores over and above the adolescent variables. The authors conclude that caregivers who are high in exploration may fail to provide a stable sense of self in their parenting, which may lead to confusion and psychological problems in their teenage children. Conversely, they tentatively suggest that care-givers too high in commitment may force choices onto their adolescent children before they have learned the skills to explore and integrate alternative identities, leading the adolescents to experience Identity Distress. Notwithstanding the concerns regarding the validity of the IDS (or indeed whether this is a valid measure in adults over thirty), further research in this area may clarify whether parent or family interventions may be more appropriate targets for young people struggling with their identity.



## Discussion

Overall the research studies reviewed in this paper generally support the theory that higher levels of commitment relate to lower Identity Distress (as measured by the IDS). However the evidence regarding the relationship between IDS scores and identity status present a potentially challenging picture in terms of Eriksonian identity theory and for the construct validity of Identity Distress.

For instance, the findings that Identity Distress was generally higher among those categorised in Moratorium was argued to be expected as this is the status most associated with exploration and uncertainty. However, as Moratorium is considered a normative crisis period which many (but not all) young people pass through in consolidating an identity, it is possible that higher rates of Identity Distress symptoms in this group represent a normatively high level of concern about identity (albeit some endorsing higher scores than others).

Similarly, the findings that Identity Disorder (or Identity Problem) could be identified across the statuses, is argued to highlight the superiority and necessity of the Identity Distress concept in identifying those in need of intervention. Yet none of the authors address in detail why an identity intervention in particular would be warranted (especially given the correlation between IDS scores and concurrent psychopathology). It is worth considering that 'Identity Disorder' was reported across the studies in young people in the Achieved status (e.g. 14.8% in Berman, Montgomery & Kurtines, 2004). Yet it remains unclear, theoretically, why those with an Achieved Identity should experience pathological distress about their identity, how an identity intervention (based on the status model paradigm at least) might resolve this and whether the IDS is measuring a phenomenon that may result from other

difficulties that would be effectively addressed in a different orientation. Of course, these theoretical issues are also influenced by the limitations of the status model and its measures (Schwartz, 2001).

The following sections outline several limitations of the research reviewed with further questions in relation to these issues. The review concludes with recommendations for further research and potential clinical implications.

## **Limitations**

One of the key difficulties in drawing conclusions from the research as a whole is the wide variation in the samples used. Across the emerging adult and adolescent populations gender proportion varied widely (often predominantly female) and many studies compared participants with very different demographics or didn't report them. Overall, adolescent studies tended to report more participants in the Diffused status and emerging adults more frequently in Moratorium. This may indicate measurable, normative differences in identity formation at different ages with potential differences in what the IDS scores represent in the two groups.

Similarly, the validity of conclusions made across studies is complicated by the methods used to calculate identity distress scores. Although most of the researchers reported on how they converted IDS scores into continuous variables for correlational analyses few discussed in detail why their particular method was chosen. As Hernandez and colleagues (2006) demonstrated distinct relationships between different scoring methods and psychopathology scores, it is likely that several different constructions of Identity Distress were tested across the research.

Importantly, studies showing statistical differences between groups often failed to report on the clinical significance of this with mean scores indicating only mild-moderate distress (which would not represent a clinical problem according to the DSM criteria on which the IDS was based). The validity of these criteria was considered in two of the studies who noted that the diagnostic criteria for Identity Disorder was likely to improve validity over 'Identity Problem' (although this continued to be used in further studies). However, none of the authors considered concerns about the reliability and validity of psychiatric diagnosis as potentially problematic to the construction of Identity Distress and therefore to the validity of their findings (e.g. National Institute of Mental Health, 2013).

Perhaps the most important limitation across the research body is the use of cross-sectional designs in all of the studies. Although the studies employed several different statistical analyses to show independent, predictive relationships between Identity Distress and variables such as psychological symptoms or adaptive functioning all of these relationships were co-occurring. As such, it remains unknown as to whether Identity Distress may be a distinct problem relating to identity formation that causes maladjustment, an under-identified part of the distress young people experience when they have a psychological problem (or maladaptive coping skills) or a symptom resulting from pre-existing psychosocial or adjustment problems.

Moreover, as the time-criteria of at least three months duration for a diagnosis of 'Identity Disorder' isn't used in statistical analyses in the majority of the studies, high scores on the IDS could result from young people passing through a brief and naturally distressing period (for example after a breakdown of a relationship) as much as representing a long-standing problem.

## Longitudinal Designs and Context

A recent critical piece notes similar limitations in study design across the identity literature as a whole. Bosma and Kunnen (2008) call for longitudinal designs in identity research to provide data on patterns of change over time, interaction with personal characteristics and interaction with context. In terms of the Identity Distress research, longitudinal designs could indicate when Identity Distress scores are first identifiable, the context or personal variables this relates to and whether it presents differently at different stages of development.

In particular for questions as to whether Identity Distress represents a clinical phenomenon, rates of spontaneous remission and interaction with other variables such as psychopathology and psychosocial adjustment could evidence who might be particularly likely to score highly on the IDS and whether this appears to be a cause or effect of other variables. Given the suggested link between IDS scores and Ego-strength development in childhood (Gfeller & Cordoba, 2011) longitudinal research should perhaps begin before adolescence and chart development into young adulthood. In the short-term, follow-up studies could offer some initial insight into patterns of Identity Distress scores and rates of change over a time period.

Furthermore, Bosma and Kunnen (2008) challenge identity theorists to consider developmental processes as continually changing and to treat age as a key context instead of forming broad theories across very different age ranges. They highlight the inadequacy of the status model in capturing the *process* of identity formation and propose a model that looks instead at individual trajectories. This, they argue, involves analysis of moment-to-moment strategies young people use to

process identity related information and interactions between the person and their context over a long period of time.

All of the studies reviewed in this paper discussed the hypothesised role of context on identity, especially economic and social changes in western societies (Arnett, 2000). However only Sica, Sestito and Ragozini (2014) attempted to demonstrate how this context might be interacting with individual coping styles to produce different identity outcomes (albeit still in a cross-sectional snapshot). Interestingly, this allowed the researchers to speculate how different personal contexts and identity variables (such as being in a state of diffusion) can be problematic or not in different circumstances.

Such contextual and personal differences may be key to explaining why some people endorse more difficulties on the IDS than others and may demonstrate person-specific avenues for intervention that may be more effective. Erikson's original theory highlights the ways in which identity development occurs as an interaction between a young person and the way they are recognised and valued (or not) by their society. Yet across the papers reviewed there is little consideration of the specific and detrimental ways in which society may impact on the experience of distress about our identity. For instance, for young people identified as 'at risk' of school exclusion (Hernandez, Montgomery & Kurtines, 2006) or receiving treatment in a mental health service (Wiley & Berman, 2012; 2013) it would seem highly relevant that these groups in society are often victims of stigma and discrimination known to have a distressing impact on identity (Goffman, 1963). As such, an intervention focusing on a perceived deficit in the individual may not address the socially constituted aspects of identity and associated distress.

Finally, this raises the issue of what Identity Distress in these studies means experientially for those in whom it is identified. Especially whether different young people may experience it differently despite similar scores and whether young people, if told that they meet the criteria for Identity Disorder/Problem, would agree with this description of their assumed distress.

### **Questions for Future Research**

Given the current directions in the research base and concerns raised about methodological differences, future research in this area should employ one method for calculating IDS scores as a continuous variable. The criteria for 'Identity Disorder' should be used as the sole criteria for identifying 'Identity Distress' as this appeared to elicit statistically significant results on two occasions when 'Identity Problem' did not (Berman, Weems & Petkus, 2009; Gfeller & Cordoba, 2011). The potential relationship between ruminative exploration and identity distress also needs to be elucidated as it is currently unclear whether they are the same phenomenon or possibly symptoms of depression.

As to the clinical relevance and utility of Identity Distress, longitudinal research is required to show whether the identified Identity Distress symptoms persist over time; whether different patterns are observed at different ages; whether the distress identified may be normative and remit over time and, lastly, whether Identity Distress symptoms pre-date, co-occur or occur in response to psychopathology or problems with identity formation.

As recommended by Bosma and Kunnen (2008) future research should rely less heavily on status model-based measures of identity development and focus on the interaction with context. Qualitative research offers an opportunity to look in detail at what identity distress means for those identified as experiencing it and illuminate the particular contexts or variables in which the hypothesised 'Identity Distress' may occur. As levels of 'Identity Distress' were noted to be higher in the samples of adolescent users of mental health or specialist schooling services, contexts known to be particularly stigmatizing may have a particular impact on identity and distress relating to this. Research in adult populations suggests that psychiatric treatment and diagnosis have a profound impact on aspects of identity development, however this has been only partially investigated in adolescents or emerging adults and has never been studied in terms of 'Identity Distress'.

A combination of qualitative and more robust quantitative data could highlight whether there are genuine differences – statistical and experiential - between those identified and not identified as experiencing Identity Distress.

## **Implications and Conclusion**

Owing to the issues raised in this review, 'Identity Distress' should perhaps be evaluated with some caution until further research is conducted. Nascent research using the IDS as an outcome measure in identity intervention studies (Berman, Kennerley & Kennerley, 2008) should ensure to use other measures alongside the IDS: evidencing what changed as a result of intervention and in which areas. As Identity Distress may be one feature of a complex picture of psychological symptoms and distress that young people may require support with, clinicians may wish to

consider Identity Distress as part of a formulation and treatment plan, in collaboration with the young people they work with.



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**MAJOR RESEARCH PROJECT**

**RACHEL GILBERT BA (hons) MSc**

**SECTION B:**

How do Adolescents Admitted to a Psychiatric Ward Perceive its Impact on their Identity?

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SALOMONS

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## **Abstract**

Background – Little research has looked in detail at the subjective experience of adolescents who have been admitted to psychiatric hospital and the potential impact of this on their developing identity.

Aims – To construct a theory of the perceived impact of hospitalisation on the identity of young people admitted to a psychiatric ward, the ways young people might manage threats to their identity and any perceived impact of diagnosis.

Methods – Nine young people aged 15-17 were interviewed in depth about their experience of admission and any perceived impact on their identity. Young people were current in-patients or ex-patients attending follow-up treatment in the community. Grounded theory methodology was employed in this study.

Results – A preliminary model is proposed showing the process from admission to post-discharge with hypothesised impacts on personal and social identity at each stage. Positive outcomes were associated with an improved sense of self and self-efficacy. In contrast, the development of an “illness” explanation for one’s difficulties while in hospital may be a risk for a more negative self-concept and a less favourable future outlook.

Conclusions – Longitudinal research is required to ascertain long-term outcomes of the proposed model. Emphasizing psychological formulation may ameliorate the perception of individual ‘deficit’ that appeared to be associated with diagnosis.

*Keywords: adolescence, identity, hospitalisation, diagnosis, experience*

The importance of positive identity development for child and adolescent wellbeing is well documented in the identity research literature. Recently, this has been acknowledged in a 2005 report by the World Health Organisation stating that a coherent personal identity and positive self-worth are pre-requisites to adolescent and adult mental health (WHO, 2005). However a decade on from this, identity development is notably absent in important policies such as *No Health Without Mental Health* (Department of Health, 2011) despite a growing body of research linking it to psychosocial adjustment. Equally there is a paucity of research into the effects of mental health treatment on identity in adolescents, despite a large literature for adults. As such, it seems imperative that identity research investigates identity development in young people who use mental health services and identifies issues for health and social care services to address.

## **Identity Theory, Adolescence and Mental Health Treatment**

**Psychosocial theories.** Erikson's psychosocial theory (1968; 1980) suggests that young people must form a coherent identity during adolescence which is recognised and valued by themselves and others. This involves engaging with developmental tasks associated with this period (exploring career choices, values and beliefs, gaining independence, developing interdependent relationships (Carter & McGoldrick, 1999)) and assimilating many possibilities into a coherent sense of self. Failure to achieve this, known as "identity diffusion", in adolescence may hinder the development of intimacy in relationships (Erikson, 1980) and is associated with psychopathology in later life (Goth et al., 2012; Marcia 2006).

Leavey (2005) suggests that the development of mental health problems in adolescence can have life-changing consequences for a person's identity by disrupting and delaying identity formation. Recent research in the area of *Identity Distress* suggests that distress about one's identity is higher in adolescent community mental health patients than non-clinical samples, although this nascent research area is limited by comparing adolescent with emerging adult populations and correlational designs which cannot determine the direction of causality (Hernandez, Montgomery & Kurtines, 2006; Wiley & Berman 2013).

**Sociocultural theories and stigma.** Sociocultural theorists largely agree that if a young person experiences a change in their social context and receives different messages from new, important others in that context, their identity will undergo changes in line with this (Kroger, 2007). Larsen (2004) reviews a number of studies linking the mental health service context with an increased tendency for adult service users to construct their identity as "mentally ill". He highlights the role that physical and social environment change (after discharge) may play in reducing the use of illness labels (Estroff, Lachicotte, Illingworth & Johnston, 1991) but also the moment-by-moment changes in a research interview that may elicit multiple or different self-conceptualisations depending on what is being talked about (Lindow, 1986).

A number of empirical papers have suggested that perceived social stigma and self-stigma (the internalization of social attitudes resulting in shame) is evident in adolescent service users and that diagnostic labelling may lead to a negative conception of themselves; a more negative outlook for their future and the adoption of an "illness identity" which may impede their recovery (Moses 2009a; 2009b; 2011; Wisdom & Green, 2004).

**Narrative theories.** Narrative Identity theorists suggest that personal and societal identity processes can be seen in the stories we construct about our lives (McAdams, 1988). These stories give meaning and a sense of coherence to our personal history and serve as the foundation for identity. As young people begin to script these 'identity' stories during adolescence (Habermas & Bluck, 2000) Dickerson and Zimmerman (1992) have warned that this presents an 'at-risk' time for young people in medical treatment. Medical discourses, they suggest, may saturate young people's stories with 'problem discourses' without providing access to alternative explorations and conceptions and therefore may force young people into a rigid or limited identity that focuses on deficits and problems.

### **Identity Studies in Adolescents Receiving Mental Health Treatment**

In comparison to the large body of research in adults (e.g. Estroff 1989), studies in adolescents admitted to psychiatric hospitals have predominantly focused on parent-rated satisfaction and clinical outcomes and rarely included detailed qualitative information or young people's perspectives (Moses, 2011). The following sections review a small number of qualitative studies indicating the ways in which psychiatric medical or hospital treatment may affect identity and concludes by highlighting the rationale for the present study.

**Psychiatric out-patient studies.** Elkington and colleagues (2011) proposed that the young people in their study developed a 'stigmatized identity' following experiences of rejection related to their mental health problems. The young people appeared to internalize a belief that they had an 'inner flaw' and, for young people diagnosed with psychosis, that they were inferior to their peers. These young people coped using withdrawal, non-disclosure to others, distancing themselves from service users with more severe symptoms, highlighting that 'everyone has something wrong with them', or conversely, being openly proud of their experiences.

Leavey (2005) suggested that being diagnosed with a mental illness led the young people in her study to experience a loss of their previous identity, to question whether they were a bad or less valuable person and to have to re-define their personal identity in line with adjusted expectations for the future. Leavey suggests that this process, being more disruptive than the vacillations normal for teenagers, delays identity development.

Interestingly, in their small study of five adolescent women, Brooks and Dallos (2013) observed that those who used a wide range of explanations of their difficulties displayed a more optimistic future-orientation in their thinking about themselves than those who used medical descriptions of their problems. All of the participants showed evidence of seeking narratives from important others (professional and social) to make sense of their personal stories.

**Psychiatric hospital studies.** Three peer-reviewed studies have looked at the experience of hospitalization for children and young people with findings that are potentially relevant to identity development (Moses, 2011; Haynes, Eivors & Crossley, 2013; Hepper, Weaver & Rose, 2005). Across the studies, young people reported that

being in close contact with others with similar problems had a normalising effect that made them feel more accepted. However, in line with the out-patient studies, some of the children and teenagers reported an awareness of stigmatizing attitudes toward them (being “mental” or “spastic”). The young people in Haynes and colleagues’ study were observed to be cut off from the normal roles and relationships that the authors suggest give a sense of coherence and continuity. Nonetheless, many of the young people reported feeling helped by professional staff to develop different, empowering views of themselves and to manage their difficulties.

### **The Present Study**

To date, no studies appear to have interviewed adolescents about how coming into psychiatric hospital may have affected their identity. Hepper and colleagues’ (2005) study only interviewed children between eight and thirteen for whom the experience of hospitalization may be different than for older teenagers (although many similar experiences were evident, as above). In their conclusion, Haynes, Eivors and Crossley (2013) suggest that future research should address whether and how hospitalization (and diagnosis) have a destabilizing effect on existing identity, how adolescents manage any potential threats to their identity and how staff might maximise positive identity development.

As such, the present study had the following primary aims. To determine:

1. The perceived effect of hospitalisation on a sample of adolescents’ sense of their identity
2. The ways in which the young people appeared to manage threats to their identity

3. The perceived impact or contribution of a diagnostic label (if given)

## **Methodology**

### **Design**

Given the small amount of research on adolescent experiences of hospitalization and identity, a qualitative methodology was chosen (Strauss & Corbin, 2008). This allows for the development of a theory, grounded in the data from participants, when little is known about a research area. It involves a process of “constant comparison” between the codes and categories that emerge from the data which allows researchers to look for similarities and differences across participants (Glaser & Strauss, 1967). Owing to the researcher’s constructionist epistemological stance and identity literature suggesting that identity may be presented in different ways based on context (Larsen, 2004), in this study the social constructionist methodology outlined by Charmaz (2006) was adopted. This methodology in particular suggests that the theory does not “emerge” from the data so much as it is co-constructed by the participants and the researcher in a particular context under particular conditions (Charmaz, 2006).

**Interview.** A semi-structured interview schedule (Appendix 4) was drawn up in consultation with the project supervisors, an adult service user consultant and two young people. The schedule covered a number of identity areas (future goals, relationships) and domains (self-related, social-related) from across the identity literature. Though these offered starting points as a guide only and interviews followed the participant’s lead in terms of how they perceived the issues raised. The interview



covered events leading up to hospital, in hospital (and since discharge) and whether these may or may not have changed the way participant saw themselves as a person. For accessibility, the concept of identity was referred to as “how you see/think about yourself” and allowed the young people to define it in their own terms.

## **Participants**

Participants were drawn from one adolescent psychiatric unit and one community child and adolescent mental health team in the South of England (Table 1). Table 2 shows the number of participants approached and who declined an interview. No participants withdrew after interview.

Table 1. Demographic data for study participants.

Age	15 n=1 16 n=4 17 n=4
Gender	Female n=8 Male n=1
Ethnicity	White British =7 Other = 2 (Mixed Race, White Other)
Diagnoses identified by young people	Depression Anxiety / Social anxiety disorder Post-traumatic stress disorder Borderline personality disorder Obsessive compulsive personality disorder Emerging personality disorder Tourettes disorder Psychotic episode
Participants taking medication	Antidepressants n=8 Antipsychotics n=2 Other=2
In-patients	n=7
Out/Day-patients	n=2
Number of young people with prior admission	n=3
Range of admission lengths	1 – 10 months
Average admission length	2 months 3 weeks

Table 2. Number of young people approached to participate

Number approached	32
Consented and participated	9
Declined (or parent declined consent)	12
Not well enough to participate	4
Did not meet criteria	1
Agreed, dropped out/not available on day	6

Inclusion/exclusion criteria were participants between 12 and 17 years old, deemed well enough by their care team to take part in an interview with no significant learning or social communication disability. For the community participant, the time since

discharge from hospital was approximately one year. The other out-patient was on long-term leave (6 weeks) from the hospital at the time of interview.

## **Procedure**

Ethical approval was granted by an NHS Research Ethics Committee (Appendix 5) and approved by the Research and Development department of the host NHS Trust for the project. A summary of the findings was sent to both following completion of the study (Appendix 7).

Participants meeting the study criteria (who were currently deemed well enough to participate) were identified by the multidisciplinary care team in each service and approached by the local supervisor for the project with information sheets. They were informed about the purpose of the study, the procedure and data protection and were assured that their participation was voluntary and would not affect their care. They were also advised to discuss potential participation with staff, friends or family before agreeing.

If provisional consent was given at this stage, an interview day and time was booked at the unit or clinic that the young person attended. For participants under 16, parent/guardian information giving and consent was also completed via telephone (or in person if possible) and signed-off by the local supervisor (Appendix 3). In these cases, agreement from both a parent/guardian and the child was essential to proceed and the young person was asked to sign an assent form. Interviews were booked with *at least 72* hours between provisional consent being given and the interview date to allow young people (or parents) to change their mind or ask for more information.

On the day of interview, the researcher repeated the information-giving process and took formal consent (ensuring informed consent, answering questions and signing the consent forms (Appendix 3)). This included reminding the young people that their recording would be encrypted and that all personal identifiable information from their interview would be changed. Demographic details (Table 1) were taken from all participants who consented (100%) and a contact address for the purposes of respondent validation. The average interview length was fifty-five minutes. Participants were able to take rest breaks or stop at any time.

**Data analysis.** Data were analysed in line with the methodology described by Charmaz (2006). Following transcription of the interviews by the researcher, three transcripts were line-by-line coded using initial memos to guide theoretical sampling. Codes were then expanded and refined at the focused coding stage with tentative categories emerging in memos. Theoretical memos, diagramming and constant comparison were used at the theory development stage to ensure the emerging theory reflected the original data (see appendices 10 and 11).

**Quality assurance.** Data analysis was independently audited by the primary supervisor for the project at all stages of coding and theory development (Mays & Pope, 2000). Differences were resolved through discussion and subsequent changes were made to the data analysis in line with this. A reflective journal was also kept throughout the research process and bracketing interviews were conducted with a colleague. This allowed the researcher to consider the influence of personal emotional responses during the process.

All participants consented to be contacted for respondent validation. The study results were summarised in a short, accessible format which was sent to the participants with a brief questionnaire regarding their opinion of the model and any significant inaccuracies (see Discussion; Appendix 6).

## **Results**

The model constructed from the data offered a broad conceptualisation of the process of hospitalisation as well as the aspects, before and after admission, that were perceived to have had an impact on identity. Seven core categories emerged. Figure 1. and Table 3. provide a summary of the theoretical model.

Figure 1. Theoretical Model Diagram

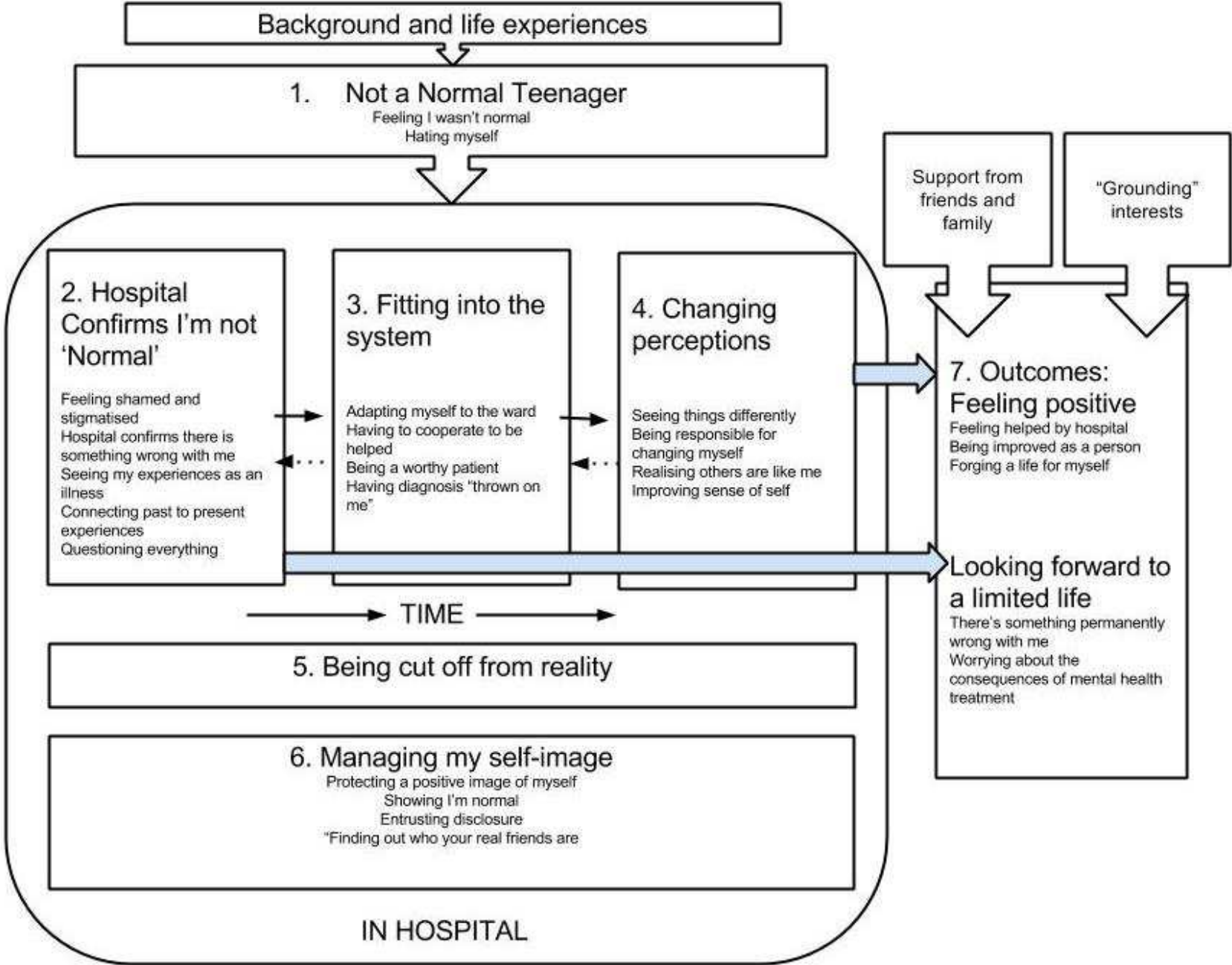


Table 3. Summary of theoretical model and results

Category	Summary
1	The first category indicated that young people came into hospital with a sense of being different to others (owing to experiences before admission). The issue of 'being normal' remained a preoccupation throughout their time in hospital.
2-4	In hospital, there appeared to be three key stages that the young people passed through. However not all participants reached all stages and their views of themselves were multiple and complex. Categories 2-4 suggested that coming into hospital was seen as a confirmation of being 'different' and raised questions about who they were and what they thought about themselves and their difficulties. As the young people adapted to life on the ward they developed a sense of having to accept professional constructions of illness and recovery in order to get well. There was evidence that the young people not only internalised stigma around being "attention seeking" but questioned their own and one another's worthiness in deserving help. As the young people moved toward discharge, some of them had an improved perception of themselves. A strong narrative of personal responsibility for recovery also emerged.

- 
- 5 Throughout the admission, young people bolstered a positive self-image by highlighting their 'normality' and by managing disclosure of their admission
- 
- 6 These processes described occurred in context of the young people feeling cut off from their usual interests and interpersonal relationships. These were seen as essential factors in looking ahead to a better future.
- 
- 7 The processes described resulted in a mixture of positive and negative outcomes. Many of the young people had an improved sense of self or their capabilities but nonetheless looked ahead toward a life that may be limited by illness or fear of the repercussions of their hospital stay.
-



## 1. Not Being a Normal Teenager

**Feeling I wasn't a normal teenager.** Before coming into hospital, most of the young people reported a sense already that they weren't a 'normal teenager' in comparison to their peer group. A number of the young people expressed personal inadequacy compared to others. Others talked about experiences that were frightening and felt out of their control and attempts to 'appear normal'.

I dunno prior to this I always knew that I did have a problem it was just I never considered bringing it up, I always felt very out of place... it was... quite hard to try and accept that, that you might be different from normal people and that's what made you kind of an outcast so to speak and that you wasn't fit for the world... (Sean)

I was just trying to sort out my life so I could live happily, it would be messed up but I would just happily plod along and it would be ok... (Cathy)

**Hating myself.** With the exception of Nina who spoke of positive and negative attributes, many of the other young people talked about themselves prior to being admitted in pejorative ways. This appeared to persist during their hospital stay:

... how I describe myself is just kind of like, nervous and anxious and sad ... that's how I've always described myself...I've always had quite a negative opinion about myself (Jane)

## 2. Hospital Confirms There is Something Wrong With Me

**Feeling shamed and stigmatised.** Many of the young people reported feeling shamed by having come into hospital, leading them to see themselves in a negative

light. Stigmatizing attitudes also appeared to be internalised, with many of the young people coming to believe that they may be 'deluded', dangerous or inhuman.

...my form tutor said I've been in hospital due to stress and that can only mean one thing can't it ... Well you don't go into hospital because you've got too much homework, you go into hospital because .... you're not safe (Erica)

...I'm not, almost like not a pure human anymore (Cathy)

**Hospital confirms there's something wrong with me.** Similarly, it appeared that many of the young people had internalised their admission as a sign of being "bad", "ill" or dangerous and some had come to view themselves more negatively as a result:

It's definitely changed how I behave and it's changed the way I think about myself ... so now I think everyone is normal, but not me...I think it's because I'm in a place, in an environment where I know something's wrong with me like before I just dismissed it but now I know that there's something wrong with me... (Nina)

However this could also be a validating experience for participants who felt their distress was questioned by their social network:

...one [friend] gave the impression that they thought I was just being a bit of a *special snow-flake* and I was a privileged person who thinks they've got all these problems ...knowing that I have come into hospital might show them that it was doctor's decision to put me in hospital, not mine and... therefore sort of validating the extent to which my problems... it just validates them a bit more.... (Erica)

**Seeing my experiences as an illness.** During this time, the majority of the young people described coming to see experiences that were different and emotionally difficult as an illness.

I was unwell...Just having emotions that were uncontrollable like, anger, normally and paranoia ... I think mental illness caused a lot of things... that shouldn't have happened... (Katie)

... the whole reason for being put in hospital itself is to try and subdue those... emotions or those illnesses (Sean)

**Connecting the past to my current difficulties.** Two participants who didn't describe their difficulties in medical terms emphasised the role their past experiences had played in their development. Interestingly, although Jane did identify herself as having a "mental illness" she also felt that:

[coming into hospital] made me realise that what happened wasn't my fault at all. Even though I've got problems because of it now, [my abuser was] the person who had the problem... (Jane)

**Questioning everything – what is wrong with me and is it me?** For some of the participants, coming into hospital raised questions about their past, present and future, causing them to question who they are:

It's... blurring my sense of sort of like my purpose as to what's actually going on and therefore... I don't really know who I am anymore...has my past made me different sort of thing? Is me coming in here going to affect what I'm like at school

from now on, are people going to judge me differently just because they've heard I'm in hospital...? (Cathy)

Some of the young people described feeling confused about the reasons they had come into hospital, whether they might be responsible for their problems and a search for answers that led some of them to feel relief but also ambivalence when a diagnosis was given:

...I just wanted an explanation for what I was feeling because it's so peculiar when you don't actually know what's going on but ...then you get to a point where... sometimes you don't really want to know because then that means you've been labelled with something that is 'abnormal' ... there are loads of teens that get depression and stuff but if it gets clinical enough that you need to have it written up on a record and people judge you for it in future then it can be very different to the way that staff perceive it. (Cathy)

Coming to see their experiences as an illness caused some of the young people to question what or where their illness was (i.e. something in their brain), whether it belonged to their sense of self or not and whether it was real. Some of the young people attributed characteristics they felt ashamed of to their illness:

...it was like, completely not me like I blame it on the voice that I hear... I could see myself looking back that she was influencing me...whenever I hear her, I kind of just think of something else because I don't want her anywhere near me or influencing me ...

### **3. Fitting into the System**

**Adapting myself to the ward environment.** Initially, the young people spent time fitting themselves into the ward environment. For some this meant getting used to unusual rules and routines. For others this had an impact on their personal identity as they adapted their behaviour to 'fit in' with the norms of staff and service users. For one young person, the culture of competing to be the 'most unwell' led her to feel:

I've adapted myself and I can join in with the quite unhelpful banter about self-harm (laughs) erm and I feel a bit ashamed of that but at the same time I know it's kind of necessary...(Erica)

The process of forming a social identity on the ward was personally challenging for the young people who identified a sense of having to 'earn' a place on the ward however this could result in forming a valued identity among the other young people eventually:

... if you don't keep your cool everyone's gonna see you as not fit to be here sort of thing and the thing is ...you have to sort of deserve it because when I first came here I was so shy, the first few days I put myself out of my comfort zone to create a new [identity] and ... after the few days ...it's almost like... not like I've become the baby of the group but everyone likes to look after me (Cathy)

**Having to cooperate to be helped.** Over the course of one or more admissions, many of the young people described a process of coming to view it as necessary that they accept help by cooperating with their care. This often involved agreeing to take medication and to attend groups but also a sense of having to deserve help by participating in it and a threat of having no alternative:

I always thought section was really scary and stuff...and then I thought no probably it is the best way because they've got control over me and they can do what they want and stuff... so some people moan about it and they have to appeal

and stuff and they don't want to do it but they don't really want help. I want the help and I just do it the way they want to do it and I might get it... (Gemma)

**Being a worthy patient.** This sense of 'earning' or 'deserving' care was also evident in the way the young people chose to delineate themselves as a 'genuine' patient, setting themselves apart from 'attention seekers':

Obviously like everyone's come here to get better but some people might just be here to get attention... I don't [self harm] for attention ...the people who don't do it for attention keep it a secret... (Emma)

**Having diagnosis "thrown on me".** A number of the young people described feeling unfairly labelled by their diagnoses and feeling that this took away their agency and ability to define their difficulties in a personally meaningful way:

It's a bit labelling in a way where you think some people might do things because it's just a part of who they are but I might do things because of that disorder and it makes me feel a bit labelled in a way...I don't think of it like that (Jane)

However for Sean this was seen as an inevitable process which young people have to bear graciously to fit in with professional explanatory frameworks:

...it's not taking pride in it not feeling sorry about it but just kind of accepting that fact and moving on... because I don't think there can be any other way ... it's like an inevitable process... but it's, you can disregard it... I suppose it's just how you're working with the staff there, it's just trying to make it more bearable... (Sean)

#### 4. Changing perceptions

**Seeing things differently.** Most of the young people reflected on how their perceptions of themselves and their illness had changed over the course of being in hospital. For a lot of the young people this involved receiving alternative perspectives from staff that fostered a more positive sense of self or being encouraged to take on different roles that promoted positive coping.

Whereas I used to think I was quite a horrible person where loads of nurses have made observations here and said that I'm quite ... supportive and always look like I want to help people and things like that ...(Jane)

**Being responsible for changing myself.** Over the course of hospitalisation many of the young people talked about having realised they must work hard to 'better themselves' toward recovery:

I'd say it's over the course of being admitted to hospital ...that's when you try and figure out what you've got to do, what efforts you've got to make to ... try and either get yourself back on track or try and better yourself for society (Sean)

Many of the young people reflected during their stay in hospital on the negative impact they perceive their problems to have had on other people and the need to change themselves as a result:

I've been exiled to this place supposedly to get better but just to... and it's not necessarily for my personal benefit it's for other people's benefit. (Cathy)

**Realising others are like me.** All of the young people spoke about the impact of making connections with other young people who normalised their experiences and make them feel less isolated:

I thought I was the only one before, like when you start doing stuff or start having these thoughts, you think oh god no one else does this but you come here and there's twenty two, twenty three of you on the ward and you're all basically exactly the same as each other (Gemma)

**Improving sense of self.** A number of the young people experienced a positive change in themselves during the hospital admission:

[before] I didn't have very much self-confidence and I literally thought everyone hates me! It was horrible...[now I'm] just seeing myself differently, like and seeing that even though I may hear things and I may see things and I may misjudge things I am still a person and I deserve the same respect as anyone with or without a mental illness... (Katie)

Although Nina talked about realising she wasn't a bad person after being in hospital, she was the only person who felt nonetheless that her illness had changed how she saw herself for the worst:

...before I was in here I thought of myself as funny erm... since I've started becoming ill my opinion changed of myself saying that I wasn't the average weight erm... that I wasn't funny ...I'm not sure [why] I think it's just my illness changed it (Nina)



**Having a resilient sense of myself and my problems.** By contrast, some of the young people appeared to actively resist some influences in the hospital environment that they felt may alter their existing self-concept. For instance, four of the young people held explanations for their difficulties that defied the explanations they received from professionals:

I don't think they're "*just intrusive thoughts*" I think they're necessary alarm bells for when I've done terrible things...I know I shouldn't label them that because a lot of people think that I'm just being self-deprecating and stuff but it's really not that it's .... I can't stop believing that I've done things and no one else needs to not believe it. (Erica)

Interestingly of these four, only Jane identified her experiences as an illness and felt she had something permanently wrong with her by discharge (see *Looking toward a limited life*) in comparison to Erica and Kerry who did not express this about themselves and who were able to make connections between their current problems and their past experiences (see Figure 2).

## **5. Being cut off from normality**

Some of the young people talked about the impact that being away from the normality of their lives had on them and their sense of self. This often involved being away from anchoring relationships, interests and hobbies that the young people relied on for support and continuity and concern that the artificiality of the ward environment stopped them from being able to live 'in the real world'. Nina and Erica spoke especially about their anxiety that being hospitalised cut them off from valued relationships which could lead others on the outside to "drift" away, to form stigmatised opinions of them, or not to know who they were anymore:

it's kind of made my relationship part of my life, quite, really difficult...I think that he might not like me anymore because I haven't seen him and that he might think that I'm... mad, so he might not want to be with me anymore... (Nina)

## 6. Managing Self-Image

Many of the young people engaged in a number of strategies to minimise threats to and maintain a positive sense of their identity.

**Protecting a positive image of myself.** For Sean and Katie, aggressive behaviour they displayed on the ward seemed to have posed a threat to the sense they had of themselves as peaceful, which they protected themselves against by citing the uncharacteristic nature of this behaviour and mitigating circumstances. Several of the young people talked about having to exonerate themselves in the eyes of others who had formed prejudicial views of them, and the effect this had on their sense of self.

...the doctor said because I'm not normally a very violent person ... it was very out of character which is true...it makes you realise that... these aren't normal people that you're mixing with ... being in hospital... (Sean)

I wasn't allowed to go on a music trip ...eventually my teacher let me go all the way up north just for one evening and then come all the way back, and I did it because I felt like I needed to make a good impression but sometimes it does feel like people are stipulating that I'm just bad at personhood (Erica)

**Entrusting disclosure.** Managing who knew about their hospital admission was a key strategy the young people used to maintain control over their self-image:

I just don't think it's something I can tell people because they all have different views on it and I don't want them to have a bad view on it ...it's happened with other people before and so I think that's what it'll be like with everyone (Nina)

**Showing I'm normal.** The majority of the young people spoke during the interviews in ways that emphasised their normality:

I don't get up to an awful lot, just... your average teenager... (Jane)

Or exploring their position in relation to received ideas about mental illness as on a spectrum of normality:

I mean, there's things wrong with everyone, no one's normal, no one's perfect (Gemma)

**Finding out who your real friends are.** Half of the young people talked about using disclosure of their difficulties as a way to measure the worthiness of their friends. By cutting off those who they felt judged by the young people could maintain an environment that validated a positive sense of self:

...some people will accept it in life and some people won't but I think the people that don't, they're not worth your time really because if they don't accept it they're not accepting you really... (Kerry)

## **7. Outcomes: Feeling Positive vs. Looking Ahead to a Limited Life**

After some time in the hospital, all of the young people noted at least one positive outcome of this. As the young people looked ahead, all of them felt that hospital had

either helped them to feel better (often about themselves), shown them role-models for getting well, improved them as a person or motivated them to make changes in their life.

I guess it's just the way that [staff] handle us and the way they talk to us and make us feel like not a bad person 'cause they talk through it with us to let it all out so you don't think you're a bad person inside because you talk it all out... (Nina)

if you're bad enough to have to come into a hospital and you can make it through that and get out and just return to supposedly normal then obviously you must be strong (Cathy)

even though my life is pretty rubbish that maybe I've seen people who've gone on from here to live... like their life again maybe so that shows me that maybe I can as well... (Kerry)

The pre-existing interests that many of the young people talked about often became more salient at this point as some of them thought about pursuing careers or using existing interests therapeutically:

I enjoy photography and things like that I might... because I find it quite therapeutic sometimes, I might carry on with that and see where it goes (Jane)

Support from friends, family and others outside was also a major source of feeling positive, especially where hospital had improved the young people's relationships and support networks:

...me and my dad, we don't get on and I don't really like him but when I came into hospital we started getting on and then I sort of fell out a little bit but now we're getting on now a lot better... (Emma)

Although Erica found aspects of the admission helpful, she talked about wanting more in her life than mental health. This was similar to Jane and Nina's desire to get back to "a more normal life" quickly:

I don't really want to only talk to people who are either in hospital or have been ... it gets very boring and it's not really, it's not really recovery focused if you're only thinking about it (Erica)

For Erica, this connected with having a resilient sense of self: feeling unchanged by her admission which she saw as keeping her from the 'normality' she saw as supporting her recovery. For Nina, this connected with seeing her difficulties as an illness which she must recover from to attain a normal life.

### **Looking Ahead to a Limited Life**

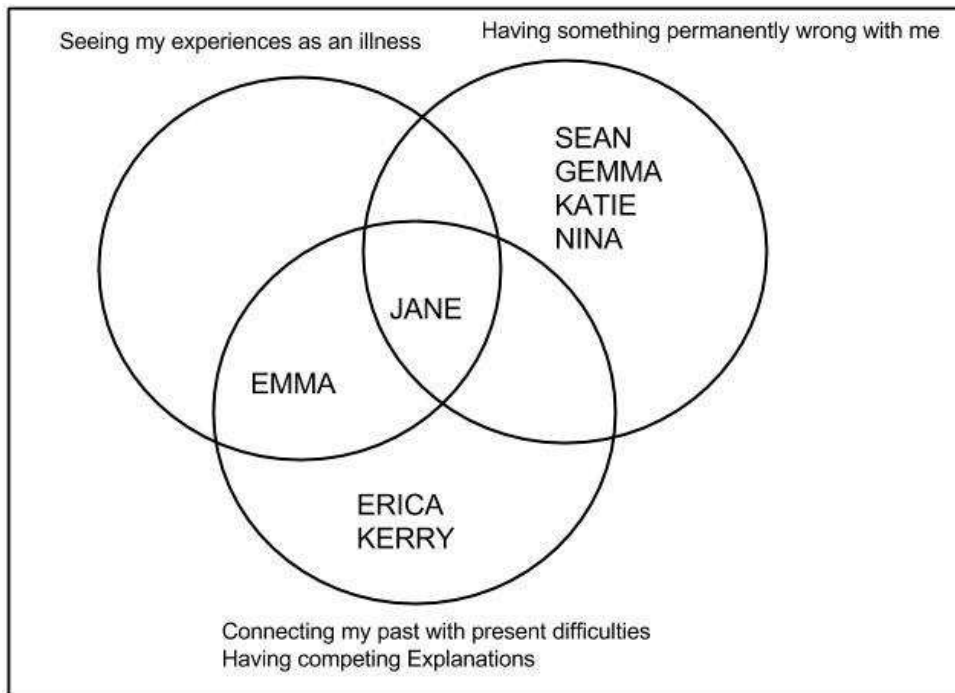
**There's something permanently wrong with me.** Five of the young people talked about feeling as though they have something wrong with them that this will be part of them permanently. Whereas some participants felt that the change in perspective they experienced in hospital had opened up possibilities for living with this, Nina's sense of the permanency of her illness seemed to lead her to devalue herself:

...there's really no point in me trying anymore because I'm always gonna be ... abnormal and I'm not going to be the same as other people, as my friends, so I've kind of... made myself... think bad about myself...Like I'm not really worth being here....(Nina)

Interestingly, all of the young people who spoke about themselves as having something permanently wrong with them also talked about seeing their experiences as an illness

during their hospital stay (or during prior treatment in CAMHS in Nina's case) (see figure 2).

Figure 2. Venn Diagram showing overlap between codes



For those who didn't speak about this outcome, it was interesting that Erica and Kerry were aware of connections between their current problems and past experiences and Emma, Erica and Kerry also showed evidence of challenging some of what they had been told by mental health professionals about their difficulties.

Jane was the only young person who described herself as suffering from a mental illness and spoke of alternative conceptions of this too. Thus it may be that having a sense that your difficulties are caused by a mental illness overrides alternative explanations which may prevent young people from developing this sense of inner 'wrongness'.

**Worrying about the consequences of mental health treatment.** The majority of the young people spoke about some anxiety relating to fears of a life limited by stigma, the possibility of relapse and the ‘fallout’ from their hospital admission.

For Erica, this was affected by the safety culture of the hospital and linked to her and other young people’s fears of developing an unhelpful dependency on this:

That’s quite uncomfortable really, I don't think, I don't want to think that I have to do that for the rest of my life... that I can go to the shops to buy a newspaper that's ...  
(exaggerated voice) "*community access*" (Erica)

Half of the young people worried about the life-limiting impact another admission would have. Katie in particular expressed a wish to see her admission as an aberration, forseeing longer-term consequences if this is not the case:

...they'll say I'm schizophrenic if I have another breakdown and I just want it to be something that happened to me in my teenage years and I got over it (Katie)

The majority of the young people talked about facing stigma and the prospect of being judged or discriminated against:

I think a lot of people have a stereotypical image of people who have got mental health they think 'oh we're really weird we're crazy' sort of... 'we're not right' like 'can't employ them because they've got mental health problems' and things could go wrong or we might act out and they don't want that (Kerry)

## **Discussion**

The present study proposed a provisional model outlining the ways in which a sample of young people experienced their admission to hospital, its perceived effect on their identity and the ways in which they managed threats to a positive self-conception. The

findings are consistent with a number of similar studies conducted with adolescents receiving mental health treatment.

Interestingly, findings in eight to thirteen year olds by Hepper and colleagues (2005) shared a number of similarities with the findings of this study, most notably the strong narrative of personal responsibility for recovery that emerged over the course of admission. In line with Leavey's (2005) findings, many of the young people also showed evidence of questioning who they were and experiencing a sense of loss of their previous identity. In the present study, it seemed the young people were already questioning this at admission, perhaps as a result of the extremity of their experiences in comparison to other teenagers and the reported findings that many of them had already experienced community mental health treatment.

The young people in this sample also appeared to report similar techniques for managing a stigmatized identity as those in Elkington and colleagues (2012) study. For instance highlighting their own normality, stating that other people have problems and distancing themselves from other patients seen as more severe. Although in the present study young people were more likely to distance themselves from the label of "attention seeker".

In-keeping with Brooks and Dallos (2009) hypothesis that dominant discourses and the opinions of valued others influence the 'storying' of identity during adolescence, this appeared to have some positive effects for the young people's identity in this study. In particular, where interactions with professionals was reported to have challenged negative conceptions of themselves, promoted positive coping strategies and boosted self-efficacy.

By contrast, a unique aspect of the present study was the emergence of the category *Fitting In*. Although Haynes and colleagues (2013) observed their participants to adapt



unusual ward norms, this category further suggested that the young people in this sample felt compelled to accept professional conceptions of illness and personal responsibility in order to fully benefit from treatment. This was linked to evidence that the young people questioned their own and others' deserving of help based on the appearance of 'making effort' and internalized the notion of being an "attention seeker" which it was imperative to shun. This seemed to contrast with the positive, normalising effect of being in contact with other service users: an important aspect that seemed to counteract feelings of abnormality and isolation.

The present study also suggested an explicit link between young people using medical discourses to describe problems or emotions and the sense of having something 'wrong' with oneself that would be long-term. Many of the young people held contradictory views as to whether this was part of them or not and, sometimes, whether this was real. However all of the participants who developed an illness view of their problems and emotions reported the sense of having something wrong with them later in their admission (and after-discharge) even if they also held alternative conceptions (such as being able to link their current "illness" to past experiences). This was not the case for the two young people who didn't see their experiences as an "illness" and who also talked about their problems in relation to things that had happened to them in the past.

Studies in adolescents and adults have suggested that medical discourses are linked to the development of an "illness identity" which Wisdom and Green (2004) and Brooks and Dallos (2009) found to impede recovery and engender a negative future outlook. Although recovery was not a direct focus of this study, the young people who identified as having something permanently wrong with them in this study were as likely as others to hold complex views about themselves and their future and to see

interpersonal relationships and pursuit of personal goals as key to positive development in general.

Larsen (2004) comments on the contradictory finding that good clinical outcomes are often observed despite the impact of stigmatizing psychiatric practices. Studies in adults by Estroff and colleagues (1991) and Sayre (2000) have also highlighted how people tend to 'un-label' themselves as "ill" over time. The fact that many of the young people most often described themselves as having something "wrong" rather than referring directly to an illness label was interesting. It may be that the adolescents in this study remained unsure about labels and the notion of illness and that their impact on identity may reduce over time as outside influences (like friends, family and personal pursuits) increase.

However as the three participants with the longest duration in treatment and post-discharge (Gemma, Sean and Katie) all showed evidence of an "illness identity" at the point of their interviews it may be as Dickerson and Zimmerman (1992) warn that deficit-focused discourses may lead to rigid, problem-focused self-conceptions. Alternatively, as belonging and 'fitting in' is a highly salient preoccupation in adolescence (Kroger, 1983) it may be that the experience of being admitted to hospital and developing an illness explanation cements existing anxiety about 'being different' that comes to be represented later by the sense of having 'something wrong'.

Modern identity theories, whether based in narrative or Eriksonian ideas generally support that young people should be given the opportunity to form and choose from multiple self-constructions in order to achieve an identity that fits with their values and beliefs (e.g. Erikson 1968). A number of recent researchers have also suggested that the numbers of adolescents reporting distress about their identity was higher in those

undergoing psychiatric treatment than those not (see Wiley & Berman, 2013). As such, it seems imperative that mental health services consider emerging evidence that psychiatric treatment may play a role in impairing or delaying 'normal' identity development – perhaps through restrictive narratives about illness as well as necessary restrictions on freedom - and to value the influences that were shown in this study to be important for developing positive self-conceptions. In particular, being given alternative views of the self by staff and developing and maintaining relationships and interests. These last two factors in particular are already widely supported by the identity literature as key to healthy adolescent identity development.

## **Limitations**

Given that the sample size was small for a grounded theory analysis the proposed model is a preliminary model only, although theoretical sampling and the richness of the participant data allowed the current model to reach theoretical sufficiency in spite of this limitation (Dey, 1999). Interview data relied on the accuracy of self-reports of participants looking back, rather than 'live' observation, although the aim of the study was to capture young people's views of their identity, which was achieved. Considering the impact that context has on adult 'identity talk' (Lindow, 1986) interviewing young people in the hospital or clinic setting is likely to have influenced the content of the interviews and it is possible that the focus on the contribution of the hospital admission to identity led to a narrow conception of the young people's identity processes. Although aspects such as interpersonal relationships and personal interests were present and often seemed limited by the hospital setting itself, which may destabilize pre-existing identities (Haynes Eivors & Crossley, 2013). All of the young people reported current or ongoing psychiatric symptoms, for which they were prescribed medication (often more than one type). It is

unknown what effect these symptoms or psychoactive substances may have on the construction of and reflection on identity given that low mood has a known interaction with memory recall and self-perception (Beck, 1976; Gotlib & Joorman, 2010).

Participant validation suggested that the model resonated well with the young people who responded. Of the four responses received, all indicated that the model offered a valid way of conceptualising their experiences overall and commented directly on their experience of the categories 'Fitting in' 'Seeing things differently' and 'Not being normal' or that being in hospital had affected how they or others saw themselves. Two respondents highlighted areas for further enquiry: the added impact of being sectioned on identity; the process of re-adjusting to 'normal' social expectations post-discharge and experiencing favouritism by staff.

### **Clinical Implications**

Positive outcomes in this study appeared to be associated with boosting self-efficacy, existing skills and promoting opportunities. Relationships with staff facilitated positive identity developments by offering positive observations about the young people and challenging feelings of worthlessness.

In contrast, the sense of having something permanently wrong with oneself appeared to be related to identifying one's experiences as a symptom of illness and, possibly, a lack of alternative ways to understand what had led to the hospital admission. Having an explanatory framework seemed to be important to the young people, many of whom felt relieved by a diagnostic explanation despite some negative perceived consequences of this. A small number of young people who did not express this feeling of having something permanently wrong did not talk about seeing their experiences as

an illness and seemed to hold some alternative explanations for their difficulties that showed resistance to accepting illness conceptions.

Consequently, psychological formulation which values a collaborative and non-pathologising stance to psychological problems could provide an alternative approach, potentially reducing beliefs about permanency and 'inner wrongness' by providing a developmental understanding of psychological difficulties, strengths and resources as a person and to identify any risks or opportunities for positive identity development when formulating an intervention strategy. As many of the young people in this study talked about interpersonal problems and alluded to early environmental adversity these are empirically and theoretically linked to psychopathology in later life and may benefit from a psychological approach to treatment (e.g. Kessler et al., 2010). Moreover, given the suggestion in this study that linking present problems to past experiences was largely linked with a lack of illness identity, a psychological approach which encourages this kind of reflection may avoid the harmful sense of having something permanently wrong that is located in the self. Given that the young people's self-conceptions in this study seemed to draw on medical, psychological and personal discourses, integrative psychological formulation offers an over-arching framework with which to support young people to explore and make sense of multiple contexts and these potentially confusing medical and societal discourses (British Psychological Society, 2011). Equally, this could also enable staff from other disciplines to think differently about behaviour (such as "attention-seeking") the labelling of which appeared to have a further stigmatizing effect on the young people interviewed.

## **Directions for future research**

Given that the present study captured only a snapshot of the young people's views in a particular time and context, longitudinal research could investigate whether some of the identity issues emerging in this study remain over time (for example whether the sense of having something permanently wrong with oneself persists). Further studies in this population could also indicate whether the findings from this small study are similar in other populations of young people in hospital; whether the same aspects of hospitalisation have similar perceived effects on identity and recovery (including the perceived effects of the discourse around "attention seeking") and whether different trajectories for individuals can be identified.

As a recent study has suggested that parental identity factors affect teenagers' distress about their identity, (Wiley & Berman, 2012) and friends and family support was valued highly by the young people in this study, future research could also investigate the qualitative aspects of this that are perceived as more (or less) conducive to positive identity development.

As this study included only two community participants and one male, further research might investigate any perceived impact of gender and compare the views of young people in hospital and post-discharge in more depth. Within the adolescent identity literature, the factors explaining why some young people more readily accept "illness" or medical labels than others are unknown (Moses, 2009a) thus the effect this may have had on young people's perceptions of their identity in this study remains unknown.

In line with recommendations to use psychological formulation in the assessment and treatment of young people in hospital, it would need to be evidenced as to whether

this promoted (a) broad, less stigmatizing understandings of distress (b) psychological and social skills development and (c) increased recognition of important factors in the young persons' wider system.

### **Conclusion**

The present study aimed to investigate the how young people admitted to a psychiatric hospital perceive this event's impact on their identity and how they manage this. The results of the study indicate that coming into hospital appeared to 'cement' a sense of having something wrong and being different, which the young people had to manage in order to maintain a positive view of themselves. Alongside this however, coming into hospital also provided positive opportunities to develop an understanding of oneself, one's autonomy and personal interests and to challenge existing negative self-conceptions. The findings point to the need for further research and may indicate a function for psychological formulation to provide a broad framework for working across professional disciplines and in supporting young people to explore and develop personally meaningful conceptions of themselves and their difficulties.

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**MAJOR RESEARCH PROJECT**

**RACHEL GILBERT**

**SECTION C:**

Appendices

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology

June 2015

**SALOMONS**

**CANTERBURY CHRIST CHURCH UNIVERSITY**

## Appendix 1. Sample Information Sheet (under 16s)

Information sheet for under 16s: [Research study: How does being admitted to an in-patient unit affect young people's identity?](#)

Hello. My name is Rachel and I am a trainee clinical psychologist. I would like you to take part in my research study. Here's what you need to know before you make up your mind.

### What is the research about?

I would like to interview you because I'm interested in what you think about your experience being in hospital and how you think it has affected you.

I will ask about ten people on the ward to have an interview with me over the next few months and I will also ask some young people who aren't in hospital anymore to talk to me about their experience too.



### Do I have to take part?

No – It is up to you to decide whether you want to have an interview with me.



If you do want to take part, I will ask you to sign a form called an "assent" form. This means you have said yes to take part in the interview.

I will ask your "responsible clinician" (that's your Consultant doctor) to make sure they think you are well enough to take part in an interview.

I will also ask your parents to sign something called a "consent" form to say that they have also said yes to you having an interview with me. This is really important because you are under 18.

If your parents say no, you cannot take part in the research study.

### What if I change my mind?

You can drop out of the research study if you change your mind later. If you do stop being in the study you can ask me to delete any information I have about you or anything you said to me in the interview (as long as you do this before it has already been analysed).



If you didn't want to be in the study anymore, this wouldn't affect how the staff in hospital treat you. Being in the study won't affect any of the treatment you get in hospital or any treatment after that.

### What will happen to me if I take part?



I would like you to meet with me for about an hour. I will have a list of questions I want to ask you but it isn't a test and there are no right or wrong answers – I'd just like to know what you think about your experiences.

I'll use a digital recorder to record what we say so that I can listen back to it afterwards.

You don't have to tell me anything you don't want to and you have control over anything you do or don't want us to talk about.

We would meet in a quiet room in the hospital. Sometimes people find it hard to talk about their experience in hospital. I might ask you some questions make you feel a bit emotional but we can stop or take a break if it gets a bit 'too much'. You can ask to stop the interview at any time. We could always meet later if that would be better for you.

The questions aren't meant to make you upset and I'll ask you a bit about things that you like and things that make you feel good too. I'll bring some food and drink with me too, to keep us going.

Everyone in the study will be asked roughly the same questions but because everyone's experience is different, it will be slightly different for each person.

In total the research will last for about 12 months. After your interview, I'd like to be able to send you a questionnaire in the post with the things I found out in the interviews to ask you whether you think the results make sense to you, from what you said in your interview.



You don't have to agree to this bit of the study if you don't want to.



### **What are the good things about taking part?**

At the moment there aren't enough studies that ask young people to talk about their experiences. Even though this research might not improve things for you straight away, if you take part you will be helping to improve the care that other young people get in future.

### **Are there any bad things about taking part?**

You might feel a little bit upset or emotional when we talk about some of the topics and you might want to speak to your named nurse on the day of the interview. Remember that the questions aren't designed to upset you and you have control all the time over what you feel ok to talk about

### **Will you tell anyone about what I said in my interview?**

No, not unless you asked me to. I don't have to tell your parents or your care team on the ward about anything you said. There are only some situations when I would have to break this rule, read the next part of the information sheet to find out more.



## **Part 2 of the information sheet**

### **What will happen if I don't want to carry on with the study?**

If you didn't want to be involved in the study anymore I would still like to use your interview for my research but if you want me to I can delete all of the information I have about you and your interview recording.

### **How will you keep all my information safe?**

Information with your name or address on it will be kept in a locked cabinet. Any information about you which leaves the hospital will have your name and address taken off and all your other details changed so that no one would know it was you.



When I record your interview, I'll keep the recording on a special memory stick which uses "encryption". This means it uses a really secure password that only I can open to play the files.

I will write out your interview recording into words (this is called "transcription") and I will ask you to pick a 'fake name' for yourself so that I can use this name instead of your real one. I will also change the names of anyone you talk about or anything you say that might tell someone else who you are.

Two other people might ask to look at this written file with your details changed. They are the research supervisors [REDACTED] and Dr Sue Holttum. I would not share any other details about you with the supervisors.

This file is also kept in a locked cabinet at Canterbury Christ Church University for 10 years. After 10 years it all gets destroyed and deleted. No one would be able to look at it except the administrator in charge of the cabinet and the researchers, Rachel Gilbert and Dr Sue Holttum.

You have the right to ask me to see all the information I have about you – any time. If you thought any of it was wrong you could change it.

### **When would you need to tell someone else about something I said in my interview?**

The only time I have to tell someone about something you told me is if you told me that you were going to harm yourself or if someone else would be hurt if I didn't tell someone about it. I wouldn't have to tell your parents but I would need to tell a member of staff on your ward (a nurse or a doctor who knows you). I wouldn't need to tell them anything else about what you said in the interview.



### **What will happen to the results of the research study?**





The results of the study get written up into a report. The report can be read by staff at the in-patient unit and the CAMHS services in the [REDACTED] Trust.

I will put quotes from some of the interviews into the report but remember that your name will be changed and the details of anything you talked about so no one would know what you said.

I will also send the report to a journal to be published. If this is accepted, it will be available for other psychologists to read.

I would like to be able to contact you once after interview. I'd like to share the results of the research with you before it goes into the report to ask you what you think of the results. If you think I've got something wrong you can ask me to change it. The results will be made up of some of the things you said and some things other people said too.

***Thank you for reading this information. You will be given a copy of this sheet and one of your signed assent forms to keep.***

### **Do you want some more help before you make a decision?**

Try talking this information sheet through with your family, a friend or someone on the ward.

If you want any help to understand anything in this information sheet or you want to ask some more questions, please contact me.

**Rachel Gilbert**, Trainee Clinical Psychologist  
Canterbury Christ Church University, Salomons Centre

You can leave a message for me on a **24-hour voicemail phone line at 01892 507673.**

**Please say that the message is for me [Rachel Gilbert] and leave a contact number so that I can get back to you.**

You can also look up this helpful link that explains more about research studies in the NHS [www.mhrn.info](http://www.mhrn.info)

### **Other things you need to know:**

#### **Who is organising and funding the research?**

This research will be paid for by Canterbury Christ Church University. Some of the psychologists in the in-patient and CAMHS services in [REDACTED] Trust are helping me to set the study up.

**Who has reviewed the study?**

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee. The committee have given this study a 'favourable opinion'. This means the committee have said that this study can go ahead.

**What if there is a problem?**

If you have any problems during the interview, please let me know. If I can't sort the problem out straight away, I can talk to the staff on your ward.

If you feel like the problem really hasn't been sorted out, you can make a formal complaint. You can do this by contacting the Research Director for the Doctorate in Clinical Psychology:

Dr Paul Camic

Research Director, Doctorate in Clinical Psychology

Department of Applied Psychology

Salomons Campus, Canterbury Christ Church University

Broomhill Road, Tonbridge, Kent, TN3 0TF

## Appendix 2. Consent/Assent Forms (Under 16s, Over 16s, Parent/Guardian)

### Assent form for Participants under 16

Title of Project: **Exploring the Effects of In-patient Admission on Adolescent Identity**

**Name of Researcher:** Rachel Gilbert

Please put your initials in each box

1. I have read the information sheet (version --) for this study. I had time to think about the information and to ask questions. I understand what I am being asked to do.
2. I understand that I don't have to participate if I don't want to. I can stop at any time without giving any reason. My medical care and legal rights would not be affected by this.
3. I understand that [REDACTED] and Dr Sue Holttum are allowed to read the data from my interview, which will be anonymised (given a fake name to protect your identity).
4. I agree that I can be contacted in future for one follow-up interview
5. I agree that I can be contacted in future for "respondent validation" (this means to confirm that the research matches what I told the researcher in my interview)
6. I agree that quotes from my interview can be used in published reports of the study as long as they are anonymised (given a fake name to protect your identity).
7. I agree to take part in the above study.

Name of Participant \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

Name of Person taking consent \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

Consent form for participants 16 and over

Title of Project: **Exploring the Effects of in-patient admission on Adolescent Identity**

**Name of Researcher:** Rachel Gilbert

Please put your initials in each box

1. I confirm that I have read the information sheet dated (version) for this study and I confirm that I understood it. I have had the opportunity to think about the information and to ask questions. I fully understand what I am being asked to do.

2. I understand that my participation is voluntary and that I can stop at any time without giving any reason. My medical care and legal rights would not be affected by this.

3. I understand that data collected during the study may be looked at by the lead supervisors [REDACTED, Dr Sue Holttum]. I give permission for these people to have access to this data in anonymous form.

4. I agree that I can be contacted in future for one follow-up interview

5. I agree that I can be contacted in future for the purpose of “respondent validation” (this means to confirm that the research matches what I told the researcher in my interview)

6. I agree that anonymous quotes from my interview may be used in published reports of the study findings

7. I agree to take part in the above study.

Name of Participant \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

Name of Person taking consent \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

Title of Project: **Exploring the Effects of In-patient Admission on Adolescent Identity**

**Name of Researcher:** Rachel Gilbert

Please put your initials in each box

1. I confirm that I have read the information sheet (version) for this study and I confirm that I understood it. I have had the opportunity to think about the information and to ask questions. I fully understand what my child will be asked to do.

2. I understand that my child's participation is voluntary and that s/he can stop at any time without giving any reason. My child's medical care and legal rights would not be affected by this.

3. I understand that data collected during the study may be looked at by the lead supervisors [██████████, Dr Sue Holttum]. I give permission for these people to have access to my child's data in anonymous form.

4. I agree that my child can be contacted in future for one follow-up interview

5. I agree that my child can be contacted in future for the purpose of "respondent validation" (this means to confirm that the research matches what s/he told the researcher in the interview)

6. I agree that anonymous quotes from my child's interview may be used in published reports of the study findings

7. I agree for my child \_\_\_\_\_ to take part in the above study.

Name of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

Name of Person taking consent \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

### Appendix 3. Initial discussion guide (in-patient version)

**1. Warm-up:** I'm going to ask you about your journey so far and how you've come into hospital but before we talk about that it might be nice for me to get to know a little bit about you and some of the things you like.

- Can I ask a little bit about you and your family? Who is in your family?
- Who do you live with normally?
- Who do you spend most of your time with? (family/friends/partner) / get on well with?
- What sort of things you like doing / do you do with your friends/family/partner?
- Who is most like you in your family / who likes some of the same things?
  
- Ok and is there is someone in your life that you really like or admire – it can be for any reason? (could be a character from tv/film, or a real person including family and friends)
- What do you like about them?
- Have you always liked them? / When did you start to like them?
- What are your interests / what else do you like doing?

### **2: Introduce Discussion (explain going to ask a bit more about their life and coming into hospital and remind the young person about taking breaks at any time)**

**A.** Can you tell me about the lead-up to coming into hospital? (*start wherever the young person would like to but give some guidance that the purpose isn't to start too far back or to take a full history*)

- What was the situation at the time?
- Had anything changed? What had changed?
  - (If talk about thoughts/behaviour) Was that something you'd done/thought before?
  - What led you to do/think that?
- Was this the first time that something like that happened? (if no)when was the first time? (repeat above)
- Anything else you remember?

**B.** Now that you are in hospital what has that been like for you?

- Was it different to what you expected or did you know what to expect?
  - Some people find it stressful... it was/wasn't for you?
  - How did you cope with that? Is that something you've done before to cope?
- Where do you feel you 'fit in' on the ward? /How do you get on with the other people?
  - Could you say more about that?
  - (if talks about one person) What about other people, how do you get on with them?
  - (if talks generally) What about you, how do you get on with other people?
  - What about in here, is it the same or different getting on with people in here?
- Are there (good / difficult) things about being in hospital?
  - (if yes) What are they?

- (if yes or no) Is it different from home?
  - (if yes) Do you think that's affected you in any way?
  - (if yes) Do you think that's affected the way you feel about yourself in any way, or not?
  - (if no) What is similar? Is that what you expected, or not?

**C. What about when you leave hospital?**

- Is there anything you're looking forward to?
- Is there anything you feel worried about leaving hospital?
- (if talk about other people's reactions) Will you tell other people about being in hospital? Why? Why not?
- What do you think you will say about your time in hospital?
  
- Do you think anything will have changed - or will it be the same?
- (if changed) What will be different?
- (if talk about perception of self) and what about other people, how do you think they will see you?
- (if talk about perception of others) and what about you, how do you see yourself?

**D. What about after that, what about your future?**

- What do you see yourself doing? What would you like to do?
- As you've got older, has this changed over time?

**E. Taking you back to your journey through life and how you came to be here today, could you say something about how you think you've become the person you are?**

- *OR: (This might be a tricky question to answer but what do you think has made you the person you are today?*
- *Can you think of any important things/people that have influenced you?*
- *What else?*
  
- (if talk generally) And coming into hospital, was that a good part or a difficult part of your journey?
- (if talk about changed directions) could you say more about what direction you were going in and what direction you're going in now?
  - Why do you think it changed?
- (if talk about being changed as a person) In what ways have you changed? What do you think the reasons are/were?
  - Do you think they are due to coming into hospital, or not?
  
- Have your relationships with other people changed over time?
  - (if yes) how/what has changed?
  - Why do you think that might be? / What led to those changes?

**(If haven't already covered this) F. It might not have, but do you think that going into hospital has brought about any changes in your life?**

- (if yes) What are the changes / How is life different now?
  - (if answer about how they see themselves) how do you think this has changed? What has led to this change?
  - What about in the future (do you think this will always be this way)?

Is anything the same?

- What do you think ?
- Is anything else the same?

**3. (Throughout) If the young person mentions diagnosis:**

- What did you think about this? / how did you react to this?
- Has your reaction to it always been the same?
- (if negative) Have there been any up-sides to having a diagnosis?
- (if positive) there may not be, but have there been any downsides to having a diagnosis?
- Had you thought of your difficulties in this way before? (e.g. as “depression”)
- (if no) How did you think about them before?
- It might not have done, but did being diagnosed change the way you thought about your difficulties? In what ways?
- How did other people react to it?
  - Has their reaction to it always been the same?
  - (If no) how has it changed over time?)

**4. Debrief**

- Anything you wanted to add, that we didn't cover?
- How did you find it? Are you feeling ok?
- Any bits really difficult?
- Any bits a bit easier?
- Can be hard to focus on self and answer questions about yourself, I asked you to do that a lot, how was that for you?



## **Appendix 4. Evidence of Ethical Approval**

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## Appendix 5. Participant Validation Feedback and Questionnaire (Responses have been removed from the electronic copy)



Salomons Centre for Applied Psychology

Thank you for taking part in an interview with me a few months ago. This is what I made of your interviews.

It would really help the research if you could read this short description and have a look at the diagram. Then fill in your response to it on the questionnaire I've attached and post it back **within the next 7 days** in the enclosed envelope. I'm interested in what you think of my theory and responses I receive in the next three weeks will affect my final write up.

Remember that not everything will be something you talked to me about – everyone had some similar and some different experiences to the other young people.

### Summary

The young people in the study told me that when they came into hospital they had already had some experiences that made them feel like they weren't a 'normal' teenager. Then when they came into hospital this confirmed this. Some of them questioned whether they were seen as dangerous and wondered who they really were. Lots of the young people began to see the difficulties they'd had as an illness for the first time.

A lot of the young people talked about having to get used to how things were done on the ward and to earn their way to getting better by accepting the ways that help was offered in hospital (like taking medication, going to groups, accepting a diagnosis). Some of them talked about how you can be seen as an 'attention seeker' and it was important not to behave or be seen that way.

As time went on a lot of young people started to see things differently, like seeing themselves as less of a bad or abnormal person – especially by speaking to other young people like them. A lot of the young people also talked about having to take responsibility for getting better themselves. All this time they had limited access to important or 'normal' things in their outside life, like hobbies and relationships.

Lots of the young people found ways to manage the ways that coming into hospital had impacted on their identity. Deciding who to tell and who not to tell about hospital was a big deal. It helped some people to stop friends from finding out and possibly having to face judgement from them. Some people found telling others helpful and stopped being friends with

those who didn't accept them. Some young people made themselves feel better about their difficulties by thinking about other people who were worse off than them.

There were positive and negative things about having been in hospital. The majority of the young people though felt that having an illness meant they would always have something wrong with them that would be there forever. Many of them worried about whether their future would be negatively affected by having been in hospital too.

For a lot of young people, seeing themselves in a more positive light and learning to take responsibility for recovery had led them to make plans and look forward to life after hospital. Support from friends and family and having personal interests were also important to feeling good and became more important as young people looked toward recovery and life outside.

Thank you for reading and again for taking part. I wish you the best of luck for the future,

Rachel Gilbert

Trainee Clinical Psychologist / Researcher  
Salomons Centre for Applied Psychology  
Tunbridge Wells  
March 2015

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## **Appendix 6. Report Sent to Research Ethics Committee/R&D**

### **Study: 14/LO/0417: Exploring the subjective effects of psychiatric hospitalisation on adolescent identity development**

#### **Background**

Relatively little previous research has studied the impact of mental health treatment on adolescent identity. The literature on the experience of mental health problems for adolescents who have accessed mental healthcare services suggests that young people are affected by stigma (from negative social attitudes and the internalisation of these to form negative ideas about the self) loss of previously valued identities, a sense of being less valuable than others and the need to re-define their identity following the disruptive effects of diagnosis and treatment (Elkington et al., 2012; Leavey, 2005).

No studies had investigated young people's perception of how the experience of being hospitalised contributed to their identity although one study suggested that the dislocation experienced by their young participants in a hospital environment could have a particularly destabilizing effect on their identity development (Haynes, Eivors & Crossley, 2013). In their conclusion, these authors suggested that future research should address whether and how hospitalization (and diagnosis) impacted on identity, how adolescents managed any threats posed to their identity by the effects of hospitalization and how staff could maximise positive identity development in this environment.

#### **Research Aims**

Drawing on the existing research base in hospital and community studies, the present study had the following primary aims. To determine:

4. The perceived effect that hospitalisation had on a sample of adolescents' sense of their identity
5. The ways in which the young people appeared to manage threats to their identity
6. The perceived impact or contribution of a diagnostic label (if given)

#### **Methods**

Seven young people in hospital at the time of interview, one day-patient who had been on leave for a month and one patient discharged over a year ago took part in a semi-structured interview about their experience of hospitalisation and any perceived impact on their sense of self. Grounded theory analysis was used with the aim to build a conceptual model of how different aspects of the experience and the young people's identity might be linked.

#### **Findings**

Seven core categories emerged. The first indicated that young people came into hospital with a sense of being different to others (owing to experiences before admission) and that the issue of 'being normal' remained a preoccupation throughout their time in hospital.

In hospital, there appeared to be three key stages that the young people passed through, although not all participants achieved all stages and participant's opinions and views of themselves were multiple and complex.

These categories indicated that coming into hospital was seen as a confirmation of being 'different to normal' and raised questions for the young people about who they were and what they thought about themselves and their difficulties.

As the young people adapted to life on the ward they developed a sense of having to accept professional constructions of illness and recovery in order to get well and there was evidence that the young people not only internalised stigma around being “attention seeking” but questioned their own and one another’s worthiness in deserving help.

As young people moved toward discharge, there was evidence that some had an improved perception of themselves and a strong narrative of personal responsibility for recovery also emerged.

Throughout the admission, young people bolstered a positive self-image by highlighting their ‘normality’ and by managing disclosure of their admission. These processes occurred in the context of feeling cut off from their usual interests and interpersonal relationships which were seen as essential factors in looking ahead to a better future.

These processes resulted in a mixture of positive and negative outcomes whereby many of the young people had an improved sense of self or their capabilities but nonetheless looked ahead toward a life that may be limited by illness or fear of the repercussions of their hospital stay.

### **Clinical Implications**

This study highlighted the potentially positive impact of hospital treatment for these young people; particularly developing supportive relationships with staff who helped to challenge negative conceptions of themselves and building skills and coping resources essential for pursuing personally meaningful goals after discharge.

Unfortunately, identifying themselves as having an “illness” appeared to be linked to a perception of having something permanently “wrong” with oneself that as perceived to be future-limiting, including for the two community participants. This study was not able to demonstrate what impact this perception may have long-term, or whether it persists or changes over time. Future research could helpfully address this.

Psychological formulation is suggested as a collaborative and less stigmatizing alternative to psychiatric diagnosis. Formulation offers a broad framework for conceptualising distress and can take into account multiple ways in which young people might want to make sense of theirs (British Psychological Society, 2011).

**Rachel Gilbert, Trainee Clinical Psychologist  
Canterbury Christ Church University  
April 2015**

### **References**

- British Psychological Society. (2011). *Good practice guidelines on the use of psychological formulation*. Leicester: author.
- Elkington, K. S., Hackler, D., McKinnon, K., Borges, C. Wright, E. R., Wainberg, M. L. (2012). Perceived mental illness stigma among youth in psychiatric outpatient treatment. *Journal of Adolescent Research*, 27, 290-317.
- Haynes, C., Eivors, A., Crossley, J. (2011). ‘Living in an alternative reality’: Adolescents’ experiences of psychiatric in-patient care. *Child and Adolescent Mental Health*, 16, 150-157.
- Leavey, J. E. (2005). Youth experience of living with mental health problems: Emergence, loss, adaptation and recovery (ELAR). *Canadian Journal of Community Mental Health*, 24(2), 109-126.

## **Appendix 7. Extracts from reflective journal**

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## Appendix 8. Extract from Bracketing Interview

Int: Do you have any expectations at this point about what you might find in your research?

RG: I think my feelings are probably quite skewed at this point toward finding fairly negative findings which actually probably won't be the case... Umm I guess at the moment I expect to find that a lot of the young people, whether they're still on the ward, or whether they're out of the ward – I'm sort of going to split the recruitment between those two groups – have quite mixed feelings about their time in hospital erm I guess I imagine that they will talk quite a bit about diagnosis but I don't know that and I suppose I'm finding it a bit hard at the moment to sort of de-fuse my own feelings about what it would be like to be told that you have "emerging personality disorder" and my own personal ...distaste for that sort of language from how they might talk about it and actually I guess my expectations are they might find that quite negative, confusing or... that they might latch onto it in a way that I personally find quite hard to hear and talk about it almost as if it's a medical fact whereas for me I don't necessarily subscribe to that mode of thinking umm so I guess I also have some expectations that I might find parts of the interview quite personally difficult... and that they might too, I guess I'm going to be asking them quite a bit about how it was that they came into hospital and I... I imagine that I expect to find that most of them have had some quite long-standing difficulties but again that may not be the case...

I: So alongside that question, are there any things that you're hoping not to find?

R: I guess given my own ideology I guess I would find it very hard if all the people I interview speak entirely positively about being told that they have a lifelong condition that is limiting to their whatever abilities in life and... I will find it very strange if they

see the hospitalisation experience as wholly positive in fact I'd probably feel a bit sceptical about that!

I: Do you have any idea at this stage what the results or outcomes might look like?

R: I guess I expect to find that it's probably more complicated than simply what I've set out to explore and through exploring it I'll probably find more questions than I do answers... I guess a qualitative question doesn't really set out to say one way or the other like 'is coming into hospital good or bad?' - I don't think it's as simple as that - but actually I think it might be even more complicated than just 'what do the young people say about it' I have a feeling that they might say lots of different things that might be quite difficult to... piece together... but at the same time I guess overall I have a sense that probably the research will come out that being hospitalised is seen by the young people as quite significant... erm... but that might not be the case at all - which would really surprise me!

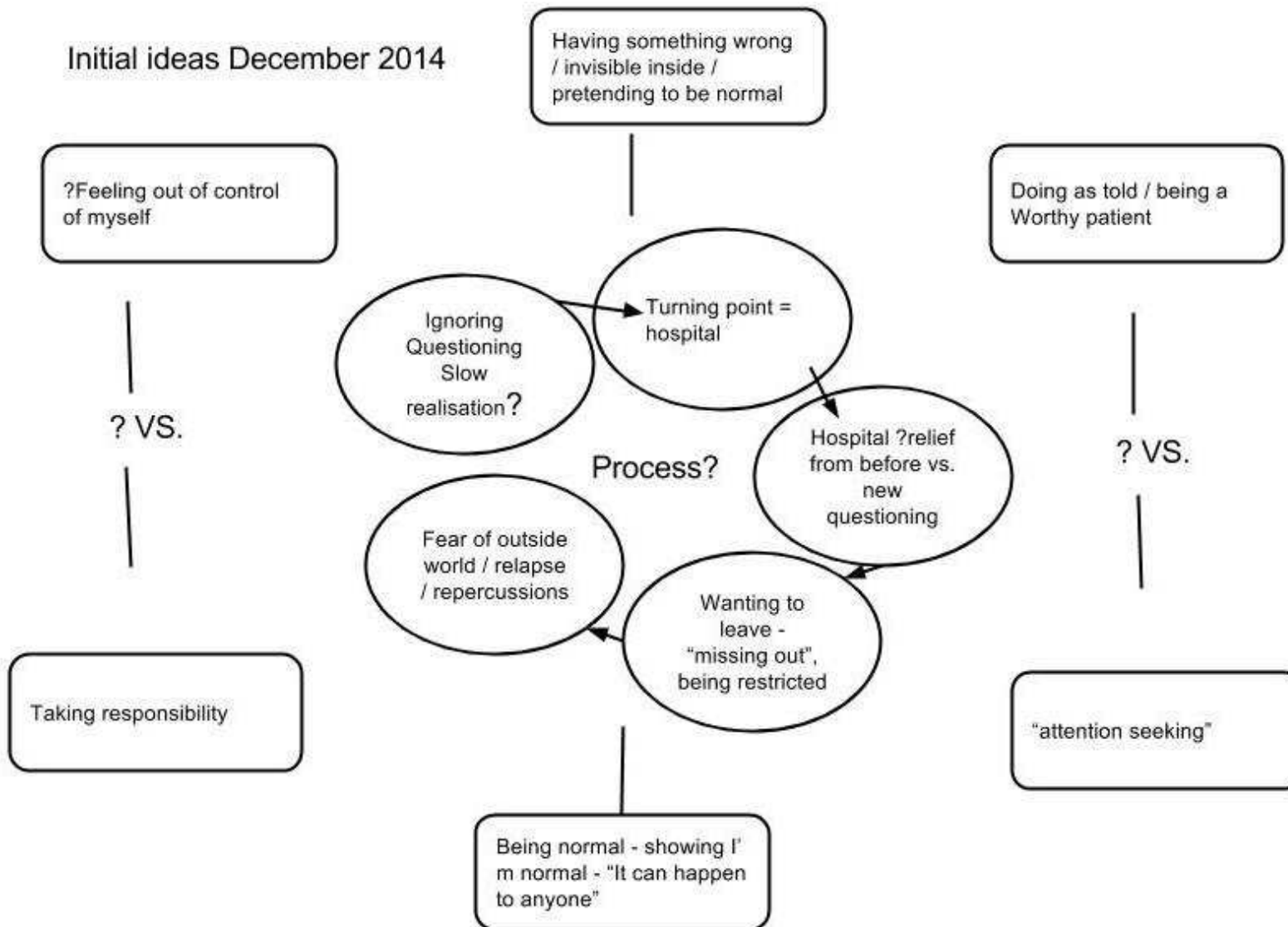
I: Has anything during your research so far surprised you?

R: I think erm it kind of surprises me so far that my MRP has never been done, something fairly similar has but kind of thinking about emotions and self-esteem or not the same setting... It really surprised me that so much of the identity literature is so quantitative and testable with models and questionnaires and that sort of thing... and how little there is about adolescents too, considering how important adolescence is meant to be to identity formation - recently I think there's been a shift toward early adulthood and studying adults I think has always probably been easier because perhaps they are more able to reflect on a longer period of development and have an ability to narrate for you the changes they've experienced for you... but it does surprise me...

## **Appendix 9. Example of Early Memo and Diagramming**

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## Early diagramming



## **Appendix 10. Example of a Theoretical Memo**

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## Appendix 11. Sample Category, Subcategories and Focused codes

<b>Category: Hospital confirms I'm not normal</b>	
<b>Sub-category</b>	<b>Focused codes</b>
<b>Hospital confirms something is wrong with me</b>	'Tipping points'
	Hospital confirms I'm not normal / there's something wrong
	Flipside: Hospital validates my problems to others
	Emotions being medicalized
	Seeing myself as having an illness
	Connecting the past with current problems
<b>Feeling shamed and stigmatized</b>	Feeling shamed by coming into hospital
	Exception: not feeling ashamed of hospital (Jane)
	Internalising negative feedback/stigma
	Being seen as dangerous
	Seeing myself as intrinsically dangerous
<b>Questioning myself/everything</b>	"I don't really know who I am anymore"
	Questioning everything
	My illness is my fault?
	Searching for answers
	Wanting hospital to change me
	Getting an answer: feeling relieved by diagnosis
	Questioning/delineating what's me/the person and what's the illness
Do I really want this (diagnosis)? Being cast as 'different'	

## **Appendix 12. Coded transcript extracts showing theme development**

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## Appendix 14. Journal Guidance for Contributors

*Child and Adolescent Mental Health: Author Guidelines*

### Notes for Contributors

1. Contributions from any discipline that further knowledge of the mental life and behaviour of children are welcomed. Papers are published in English, but submissions are welcomed from any country. Contributions should be of a standard that merits presentation before an international readership. Papers may assume any of the following forms: Review Articles; Original Articles; Measurement Issues; Innovations in Practice.

**Review Articles:** These papers are usually commissioned; they should survey an important area of interest within the general field.

**Original Articles:** These papers should consist of original research findings.

**Measurement Issues and Innovations in Practice:** Submission to these sections should conform to the specific guidelines, given in full below.

2. Submission of a paper to Child and Adolescent Mental Health will be held to imply that it represents an original article, not previously published; that it is not being considered for publication elsewhere; and that if accepted for publication it will not be published elsewhere without the consent of the Editors.

3. Manuscripts should be submitted via the [online submission portal](#): please also view [Submit to CAMH](#). Check for existing account on ScholarOne/ManuscriptCentral if you have submitted to or reviewed for the journal before, or have forgotten your details. If you are new to the journal Create a new account. Help with submitting online can be obtained from the [Editorial Office](#).

### 4. Authors' professional and ethical responsibilities

Disclosure of Interest Form: All authors will be asked to complete a full Disclosure of Interests form and acknowledge this and sources of funding in the manuscript at the point of final acceptance.

#### *Ethics*

Authors are reminded that the *Journal* adheres to the ethics of scientific publication as detailed in the [Ethical principles of psychologists and code of conduct](#) (American Psychological Association, 2010). These principles also imply that the piecemeal, or fragmented publication of small amounts of data from the same study is not acceptable. The Journal also generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors () and is also a member and subscribes to the principles of the Committee on Publication Ethics (COPE).

#### *Informed consent and ethics approval*

Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB) , including adherence to the legal requirements of the study county. Within the Methods section, authors should

indicate that ‘informed consent’ has been appropriately obtained and state the name of the REC, IRB or other body that provided ethical approval. When submitting a manuscript, the manuscript page number where these statements appear should be given.

#### *Recommended guidelines and standards*

The Journal requires authors to conform to CONSORT 2010 (see [CONSORT Statement](#)) in relation to the reporting of randomised controlled clinical trials; also recommended is the [Extensions of the CONSORT Statement](#) with regard to cluster randomised controlled trials). In particular, authors must include in their paper a flow chart illustrating the progress of subjects through the trial (CONSORT diagram) and the CONSORT checklist. The flow diagram should appear in the main paper, the checklist in the online Appendix. Trial registry name, registration identification number, and the URL for the registry should also be included at the end of the methods section of the Abstract and again in the Methods section of the main text, and in the online manuscript submission. Trials should be registered in one of the ICJME-recognised trial registries:

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Summary: Authors should include a brief **Abstract** highlighting the main points of their article. This abstract should not exceed 100 words and should be structured under the headings: Background; Method; Results; Conclusions. **Keywords** (3-6) should be given below the Abstract.

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Papers should follow the standard format for Original Articles but to a word limit at the point of the proposal being agreed.

## **Innovations in Practice**

Child and Adolescent Mental Health aspires to promote evidence-based practice, treatment and service models. In this rapidly evolving field, it is important to share knowledge on new

and interesting developments among our wide international multidisciplinary readership. In doing so, we recognise that, albeit desirable, new interventions and services can not be formally evaluated for some time. This should not preclude the dissemination of their underpinning principles and lessons learned that can be adapted or applied to other settings.

For this reason, we warmly welcome contributions on innovative aspects of practice, interventions or services. Some are planned, while others are responsive to need, evolution of existing services, or simply arise because of changing circumstances or technology.

It will be extremely valuable to share lessons from new services, described in the context of their culture, society, and welfare or health system. Even in the absence of formal evaluation, such discussion papers should still be considered in the light of existing evidence, and should be accompanied by supportive data as far as possible. The editors are happy to discuss ideas and suggestions for future contributions, which will greatly promote high quality practice among the child and adolescent mental health community.

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