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Adolescent And Caregiver Identity Distress, Identity Status, And Their Relationship To Psychological Adjustment

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ADOLESCENT AND CAREGIVER IDENTITY DISTRESS, IDENTITY STATUS, AND THEIR RELATIONSHIP TO PSYCHOLOGICAL ADJUSTMENT

by

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ABSTRACT

The present study addresses identity distress and identity status in adolescents with clinical diagnoses, and their caregivers. There were 88 adolescent participants (43.2% female) ranging in age from 11 to 20 (mean =14.96; SD =1.85) who were recruited from community mental health centers in Volusia and Orange Counties. The 63 caregiver participants included mothers (82.5%), fathers (7.9%), grandmothers (7.9%), and grandfathers (1.6%), ranging in age from 28-70 (mean = 40.24; SD = 9.16).

A significant proportion of adolescents (22.7%) met criteria for Identity Problem in the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; American Psychiatric Association, 2000) and 9.5% of the adolescents' caregivers met criteria for Identity Problem. Regarding identity status, 68.2% of adolescents and 27.0% of caregivers reported being in the diffused status. Additionally, 25.0% of adolescents and 54.0% of caregivers met criteria for the foreclosed status.

Significant associations were found among adolescent and caregiver psychological symptoms and identity variables. Further examination of the psychological symptom variables found that obsessive-compulsive and paranoid ideation symptoms significantly predicted identity distress. In addition, caregiver identity commitment significantly predicted adolescent identity distress over and above the adolescents' identity variables. These findings and implications are discussed in further detail.

To my parents for always believing in me, providing encouraging words, inspiring me throughout my life, and offering unconditional love and support.

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INTRODUCTION

Adolescence, the transitional period between childhood and adulthood, is a key developmental phase for identity formation (Erikson, 1968), which brings with it many challenges. For example, one challenge is that modern society has become more multifaceted, diverse, and pluralistic which has led to adolescents having more alternatives related to their values system, behaviors, and lifestyle choices (Berman, Montgomery, & Kurtines, 2004). The resolution of these challenges can be influential in their overall development (Besser & Blatt, 2007). Due to this vulnerable developmental period in which adolescents are at risk, there is an ever-increasing need to understand significant factors that may affect adolescent development.

Even though Erikson's life span theory of development is not limited to specific age ranges, adolescence is the time when the process may meet considerable problems, and where its outcome can have consequences in future phases of identity development (Berman, Kennerly, & Kennerly, 2008). Erikson (1986) also emphasizes that the ability to successfully resolve a sense of identity is based on mastering earlier critical stages of development. Thus, a cohesive, stable, and coherent identity development is a central developmental task, although not all adolescents are equally successful in negotiating this task. Some adolescents have little difficulties arriving at a clear and integrated identity, whereas others end up in a state of identity confusion.

A sense of confusion and discomfort caused by inner turmoil may present itself in the form of behavioral disturbances (Protinsky, 1988). Adams (1996) discussed the possibility of identity, as being a psychological structure, a self-regulatory system which functions to direct attention, filter or process information, manage impressions, and select appropriate behaviors.

Due to the possibility of identity having a strong link to psychological disturbances and well being, it is important to address adolescent mental health concerns.

Adolescent Psychopathology

Adolescent psychopathology has been viewed as a disruption or breakdown in normal development (Blos, 1970; Lamb, 1978; Weisberg, 1979). However, apart from a small handful of recognizable conditions (for example, anorexia nervosa or schizophrenia), the assessment of psychological symptoms in adolescents can be an arduous task due to the difficulties determining if an adolescent's behaviors fall within the spectrum of normative behavior or whether psychopathology is present. Thus, the strict classification of adolescent psychiatric disorders has proven to be quite difficult, and studies have found considerable overlap and comorbidity in categories of internalizing and externalizing behaviors (Achenbach, 1991a, 1991b), and psychiatric diagnostic entities (Caron & Rutter, 1991).

Comorbid symptoms and diagnoses can also add to the difficulties of assessing adolescents for psychopathology. The first line of care received by a troubled adolescent is usually that of the pediatrician or primary care physician. These physicians must conduct a thorough evaluation, which considers multiple clinical factors and criteria in order to provide an adequate diagnosis from the DSM-IV-TR (American Psychiatric Association, 2000). Many physicians and clinicians argue that the potential to lose the complexity of the individual is a reason to reduce the use of diagnostic categories. While problems may exist with categorical diagnoses, empirical research uses them in order to study psychopathology in a systematic manner (Nastasi, 2000). In the current study, adolescents were given clinical diagnoses by their psychiatrist and/or mental health counselor. In the field, some clinicians continue to believe that

diagnoses are too stigmatizing to clients and prefer not to use them in clinical practice. Indeed, Leavey (2003) found that youth with a mental illness felt stigmatized and labeled, and as a result, experienced multiple losses of identity, family, career choices, and educational and social standing. Despite this reality, mandates by managed care and other entities make diagnosing a requirement for treatment reimbursement, and therefore, a necessary element in the mental health system.

Some families and physicians are opposed to referring adolescents for mental health services due to the belief that they may experience a form of social stigma. Additionally, individuals often believe that some emotional turmoil is normal and expected during adolescence (Blotcky, 1984) and should not be harshly pathologized. The view of *Sturm-und-Drang* (storm-and-stress) was proposed by Hall (1964) to describe the difficulties of adolescence. Early theorists reported the impossibility to differentiate between normal adolescent symptom formation and the formation of pathology (Blos, 1962; Erickson, 1956; Josselyn, 1954). Later theorists challenged these views with findings that dispute the storm-and-stress hypothesis (Douvan & Adelson, 1966; Offer, 1969; Masterson, 1967), to be the exception rather than the rule (Coleman, 1993; Steinberg, 2001).

Most researchers consider adolescence to begin around the age of 12 and to end in the late teen years to the early twenties. Chronological age alone does not accurately represent an adolescent's developmental status in relation to emotional, physical, social, and cognitive functioning (Holmbeck, Greenley, & Franks, 2003). This age group has been described as a period of marked risk for various mental health and behavioral problems (Greig, 2003). There is also a growing consensus that mental health problems in general, and psychiatric disorders in particular, have shown a recent increase in youth (Mental Health Foundation, 1999). Both

internalizing (e.g., anxiety, depression, somatization) and externalizing (e.g., aggression, delinquency) problems have been found to increase in prevalence during adolescence (Achenbach, 1991 a, b; Andrews, Lewinsohn, & Hops, 1990; Kessler, Avenevoli, & Merikangas, 2001; Lewinsohn, Clark, Seeley, & Rohde, 1994; Moffitt, 1993). For instance, adolescents appear to have the highest anxiety levels compared to both younger children and young adults (Arnett, 1999; Bardwick, 1976; Buchanan, Eccles, & Becker, 1992).

Two major epidemiological studies on the prevalence of psychiatric disorders in the United States reported the onset of a variety of psychological symptoms within childhood and adolescence. The Epidemiological Catchment Area (ECA) study and the National Comorbidity Survey (NCS) reported simple phobia beginning most often during middle or late childhood, social phobia typically occurring during late childhood and early adolescence, substance abuse typically starting in the late teens to early 20s, and a large percentage of respondents reporting their first episode of major depression or dysthymia occurring before the age of 20 (Kessler & Zhao, 1999).

Several studies have confirmed adolescent reports of experiencing fewer positive emotions and more depressive symptoms than their younger counterparts (Larson and Asmussen 1991; Larson and Lampman-Petraitis 1989; Larson, Raffaelli, Richards, Ham, and Jewell 1990; Simmons, Rosenberg, & Rosenberg, 1973). High school students have been studied in relation to psychological symptoms including the use of alcohol and marijuana, as well as reported depression rates that reach typical adult levels (Centers for Disease Control, 2000; Lewinsohn, Rohde, & Seeley, 1998; Greig, 2003). The National Survey on Drug Use and Health reported an annual average of 8.5% of adolescents aged 12 to 17 (an estimated 2.1 million youths) experienced at least one Major Depressive Episode in the last year and 48% reported severe

impairment in at least one domain of home, school/work, family relationships, and social life. Less than 1% of the participants reported having no impairment in one of these domains (Centers for Disease Control, 2008).

The important task of adolescent development is the evolution and consolidation of identity or in other words, a sense of self, requiring both cognitive and affective mastery. This may be thwarted when the adolescent has a mental disability (Crowe et al., 2008) because emotion is at the core of internal and interpersonal processes, which in turn, are used to create their subjective sense of self. Therefore, the development and organization of their identity greatly depends upon the emotion regulation of the individual (Siegel, 1999), presumably making this experience difficult for an adolescent with a mood disturbance. This developmental task requires a certain level of stability and coherence, which may not be readily available to an adolescent with unstable moods (Crowe et al., 2008).

Due to the theoretical implications that psychopathology may have an effect on identity, the relationship between different psychopathological variables, diagnostic categories, and identity variables is examined.

Caregiver and Adolescent Psychopathology

It is commonly recognized that parent socialization strategies are implicated in the development of early forms of psychopathology but also that children play an active role in influencing their own social environments (Bell, 1968; Belsky, 1984; Crouter & Booth, 2003; Lytton, 1990; Scarr & McCartney, 1983). Many studies treat children as passive recipients of socialization practices from their parents and assume that parental socialization influences

children's behaviors more so than the evocative influences that children have on their parents' behavior (Pardini, 2008).

Parental psychopathology has received considerable attention regarding its linkage to children's psychopathology. One such study by Calvo and colleagues (2007) reported an excess of psychopathology in parents of children with obsessive-compulsive disorder as compared to parents of pediatric and non-psychiatric patients. Children of depressed parents have been found to have an elevated risk for both internalizing disorders and externalizing disorders (Downey & Coyne, 1990; Fergusson & Lynskey, 1993) as well as a higher risk for comorbid disorders such as anxiety and conduct disorder (Beardslee et al., 1987; Hammen et al, 1987; Poiltano et al., 1992; Weissman et al., 1987). Paternal psychopathology has consistently been related to externalizing disorders, whereas maternal psychopathology has been more consistently related to internalizing disorders (Ohannessian et al., 2005; Phares & Compas, 1992). It is important to consider hereditary factors involved in psychopathology, and evidence indicates that these findings may be partially due to genetic influences (Slutske et al., 1997; Thapar & McGuffin, 1994; Wierzbicki, 1987). These studies also have limitations related to their correlational nature in which causality cannot be inferred.

The active influence on the child may increase in strength over time as adolescents gain greater independence (Scarr & McCartney, 1983). This suggests that adolescents exert a greater influence on parenting than young children. For example, adolescent depression has been significantly associated with an elevated rate of having a depressed mother (Essau, 2004). Parenting factors have been associated with adolescent mental health problems and empirical studies suggest that adolescents with parents who fail to show affection and attachment, are more likely to be depressed than their peers (Armsden, McCauley, Greenberg, Burke, & Mitchell,

1990; Essau, 2004; Nada, McGee, & Stanton, 1992; Rey, 1995), have poor self-regard, aggression towards others, (Everall, Bostik, & Paulson, 2005; Goldsmith, Fyer, & Frances, 1990; Noack & Puschner, 1990) and higher levels of problem behaviors (Laible, Carlo, & Rafaelli, 2000; Marcus & Betzer, 1996; Raja, McGee, & Stanton, 1992). Children in a clinical sample also reported lower rates of parental emotional availability than children in a nonclinical sample (Lum & Phares, 2005). In addition, parents who have negative dispositions tend to have more depressed adolescents (Pike & Plomin, 1996).

On the other hand, warm, loving, empathetic parents decrease the likelihood of depression in their children (McFarlane, Bellissimo, & Norman, 1995) and adolescents exhibit lower levels of problem behaviors (Barnes & Farrell, 1992; Dekovic, 1999; LeCroy, 1988). Plentiful research supports the notion that having a confiding relationship with someone is the single best protector against psychological and social risk for adolescents (Masten 1994, Masten & Coatsworth, 1998; Resnick et al., 1997; Rutter, 1990; Wang, Haertel, & Walberg, 1994; Way & Chu, 2004; Werner & Smith, 1982).

Belsky (1984) studied bi-directional parent-child effects and how characteristics of children may make them more or less difficult to take care of and may shape the parental care they receive. Negative child behavior was proposed to have little to no impact on parenting behavior if the parent had a good support network and good personal psychological resources. Many theoretical models have emphasized the importance of considering bi-directional parent-child effects across development however empirical studies are relatively rare (Pardini, 2008b). A longitudinal study of boys was used to examine the strength of the bi-directional associations between child conduct problems and various parenting behaviors and found that the influence of child behavior on changes in parenting was as strong as the influence that parenting had on

changes in child behavior (Pardini, 2008a). This study will look at the relationship of caregiver psychopathology and their adolescent's psychopathology.

Ethnic, Gender, and Socioeconomic Differences in Psychopathology

Ethnic identity is another aspect of identity that is developing during adolescence (Phinney, 1992; Tajfel, 1981). A substantial part of the U.S. population is made up of ethnic minority groups as approximately 12% of Hispanics and 13% of African Americans reside in the United States (U.S. Census Bureau, 2000). Research has consistently shown that being an ethnic minority does not lead to problems with mental health. Both the National Co-Morbidity Study and the Epidemiologic Catchment Area Study found that African Americans report similar or less current and lifetime prevalence rates of psychiatric disorders than White Americans (Hughes & Thomas, 1998). Some reports of ethnicity differences in psychological distress have been inconsistent, with studies showing that African Americans report greater distress than White Americans and others reporting similar levels of distress (Vega & Rumbaut, 1991; Williams & Harris-Reid, 1999).

Turner and Gil (2002) reported lower rates of all disorders among African Americans, and higher rates of externalizing disorders among U.S. born Hispanics. Greig (2003) reported that adolescents who achieve a secure identity as an ethnic group member have higher self-esteem and better overall mental health whereas lower levels of ethnic identity were associated with higher levels of mental health outcomes among youth (Mendoza-Denton, Downey, Purdie, Davis, & Pietrzak, 2002). Some studies report that African Americans have higher base-line levels of psychological distress, which may be a result of group differences in socioeconomic status (SES) (Kessler & Neighbors, 1986; Warheit, Holzer, & Schwab, 1973).

Research shows that racial differences in psychological distress are linked to SES (Aneshensel, 1992; Robert, 1999; Mirowsky & Ross, 1989) for example; low SES status is a risk factor for poor psychological health (Williams & Collins, 1995) even more so for ethnic minorities, and especially African Americans (Kessler & Neighbors, 1986; Ulbrich, Warheit, & Zimmerman, 1989). Some studies have found lower neighborhood SES being associated with higher levels of externalizing behaviors (Brooks-Gunn, Duncan, Klebanov, & Sealand, 1993; Chase-Lansdale, Gordon, Brooks-Gunn, & Klebanov, 1997; Coleman, 1988; Duncan, Brooks-Gunn, & Klebanov, 1994; Sampson & Groves, 1989). For example, neighborhood poverty has been associated with higher levels of conduct problems, crime, delinquency, and psychological distress (Hill, Bromell, Tyson, & Flint, 2007; Peeples & Loeber, 1994; Sampson & Groves, 1989; Simons, Johnson, Beaman, Conger, & Whitneck, 1996; Veysey & Messner, 1999). Thus, economically disadvantaged adolescents may experience more events that are undesirable, more adverse conditions (McLoyd, 1998) and exposures to multiple and chronic stressors which may also be related to developmental difficulties and disorganized family relationships. Therefore, having low social class standing may have negative effects on adolescents' psychological well being and identity development (Elder & Caspi, 1988; Phillips & Pittman, 2003).

The sample in this study is made up of economically disadvantaged families who are receiving government assistance. This sample will enable the examination of the prevalence of Identity Problem among this population.

Other findings report that differences in distress between African Americans and White Americans are greater at the higher end of the economic spectrum and not the lower end (Bratter & Eschbach, 2005; Cockerham, 1990; Williams, Takeuchi, and Adair, 1992). Mexicans and other Hispanics in low SES categories also had lower distress compared to whites (Bratter &

Eschbach, 2005). Thus, while some minority groups may be exposed more frequently to stressful life events, they are not necessarily more vulnerable to the effects of these stressors on the quality of their mental health (Ulbrich, Warheit, & Zimmerman, 1989). Due to the mixed findings of whether there are ethnic differences in mental health problems, this study will examine the prevalence of psychopathology among the ethnic groups that participated.

Overall, boys and girls alike, experience adolescence as a challenging time. Particular experiences, including mental health problems, tend to differ among boys and girls. Little is known about the factors that lead to the development of internalizing and externalizing disorders in children; however, gender differences appear in the rates of internalizing and externalizing disorders in early adolescence. Girls typically report more internalizing symptoms (Achenbach, 1991a, 1991b; Besser & Blatt, 2007; Cohen et al., 1993; Fleming & Offord, 1990; Rutter, 1986; Walden & Garber, 1994) and boys more externalizing symptoms (Allgood-Merten, Lewinsohn, & Hops, 1990; Horwitz & White, 1987; Huselid & Cooper, 1994; Offord, Boyle, & Racine, 1991; Payne, 1987; Whitley & Gridley, 1993). These gender differences appear to emerge in early adolescence (Cohen, et al., 1993; Fleming & Offord, 1990; Rutter, 1986; Walden & Garber, 1994).

Considerable attention has been given to internalizing distress among girls during early adolescence (Cyranowski, Frank, Young, & Shear, 2000; Galambos, 2004; Graber, 2004; Petersen et al., 1993; Roeser et al., 2008). Dornbusch and colleagues (1991) reported that adolescent girls experienced more psychological symptoms in response to stress than adolescent boys. Fombonne (1998) reports increasing levels of depressive disorder in youth and more specifically, psychological distress being pertinent amongst females from the middle class and skilled manual backgrounds. Hyperactivity is more common among boys and this gender

difference is present during childhood (Offord, Boyle, & Racine, 1989), whereas the gender difference in depression does not appear until adolescence (Nolen-Hoeksma, 1990).

For the most part, gender differences regarding psychological and behavioral problems are similar to those found in adults. Boys report experiencing higher levels of anger, boredom, and conduct problems including delinquency, drinking, and problem behavior at school, while girls report more irritability, awkwardness, worry, depression, anxiety, suicidal feelings, and general mental and physical symptoms (Colten, Gore, & Aseltine, 1991; Dornbusch, Mont-Reynaud, Ritter, Chen, & Steinberg, 1991; Evenson, 2006; Larson & Asmussen, 1991; Lewis & Michalson, 1983; Nolen-Hoeksma & Girgus, 1994; Peterson, Sarigiani, & Kennedy, 1991). Gender differences within psychological categories (internalizing, externalizing, and psychotic) will be examined in this study.

Identity Formation

Identity development is an extensive process that neither begins nor ends in adolescence (Santrock, 1996). Erikson (1968) postulates that identity formation is the most central issue in adolescence and it is during this stage in life that the developmental task of identity formation is most often mastered. He articulately stated that identity formation is a process of simultaneous reflection and observation that occurs, partly unconsciously, on all levels of mental functioning. Therefore, adolescents with unstable mental functioning may face even more difficulties forming a coherent identity in comparison to adolescents without mental health problems. Typically, transitional periods such as adolescence and midlife are defined as going from one relatively stable state to another. Adolescents attempt to form a stable identity and avoid role confusion however; some adolescents are not successful with this task leading to difficulties with their

identity. Although these stages can lead to crisis, the result of a resolved developmental stage can be quite positive (Leavey, 2003; Papalia & Olds, 1981). It is still widely unknown how psychopathology may affect these developmental stages because this area has received limited empirical research.

Erikson (1968) and Marcia (1967) are the originators of the concept of identity formation, and both have been highly influential in the field. Marcia (1966) operationalized Erikson's construct of identity formation into two basic dimensions: exploration and commitment. He proposed that adolescents must work through a variety of struggles to establish a sense of identity. Specifically, individuals are classified as being in the exploration dimension when they are actively seeking, questioning, and weighing various identity alternatives before resolving issues about their life's direction and purpose. Committed individuals are conceptualized as having resolved their identity issues and as having developed a sense of identity. For example, committed individuals are more secure in their selection of an occupation, relationship, group membership religion, etc., and are more at ease when they engage in activities to implement their choices. Marcia further described four clearly differentiated identity statuses, based on the amount of these two dimensions in adolescents (depending on what they have experienced or are currently experiencing).

The four categories are known as the following identity statuses: diffusion, foreclosure, moratorium, and achievement. Diffused individuals (low in exploration and commitment) are not actively seeking or exploring different alternatives and have not committed to any particular goals, roles, or beliefs. Foreclosed individuals (low in exploration, but high in commitment) are somewhat committed, most often to goals, roles, and beliefs that are suggested by others, such as parents or friends, and are attained more from modeling, rather than from actively questioning or

exploring alternatives. Individuals in the moratorium status (high in exploration, low in commitment) are considered to be in a crisis due to their active exploration of different options, desperate searching to make a decision, and having not yet chosen from their alternatives. Finally, achieved individuals (high in exploration and commitment) are those who are able to move beyond the moratorium "crisis", have explored various alternatives, and are able to make a commitment that they currently implement or desire to implement in the near future.

The identity statuses theoretically follow a developmental trajectory in which all individuals start in the diffused status. The typical path is to then proceed through moratorium status to achievement, however some individuals take a detour on this path and find themselves in a foreclosed status. Longitudinal and cross-sectional studies have revealed this hierarchy of identity statuses from diffuse and foreclosed levels to statuses of moratorium and achievement (Erlanger, 1998; Fitch & Adams, 1983; Kroger & Haslett, 1988; Marcia, 1976; Waterman & Goldman, 1976).

Gender differences in identity development have been widely inconsistent, with some research studies finding differences (Grotevant and Thorbecke, 1982; Basak & Ghosh, 2008) and others finding no significant differences (Archer, 1982; Streitmatter, 1993). Cramer (2000) reported similar findings of adolescent boys and girls within achieved and foreclosed statuses and Streitmatter, (1987) reported gender differences within moratorium and diffused identity statuses. Ethnicity within the different identity status categories has also yielded inconsistent differences. For example, ethnic minority adolescents were found to report more foreclosed statuses than their Caucasian peers (Abraham, 1986; Streitmatter, 1988). Conversely, several studies have found no differences in the identity statuses displayed by adolescents of different ethnicities (Branch, Tayal, & Triplett, 2000; Grove, 1991; Rotheram-Borus, 1989). Due to the

mixed findings, it remains uncertain whether ethnic minority groups may report differing identity status membership. Phinney & Tarver, (1988) reported a trend for more searching and exploration in African-American female adolescents compared to Caucasian female and male counterparts, and African-American males. Thus, the study of gender and ethnicity differences within identity statuses in this sample is warranted.

Adolescent Identity Formation and Psychopathology

Adolescent identity exploration is characterized by an identity crisis in which adolescents experience considerable discomfort, confusion, impulsive and acting-out behavior, mood swings, and impaired coping. Research has supported Marcia's (1966) theory in which changes in identity formation have been related to changes in the frequency and the degree of problem behaviors (Schwartz, Mason, Pantin, & Szapocznik, 2008). Similarly, Besser & Blatt, (2007) reported that if fundamental capacities are attained during childhood, the child will be well equipped to handle the physical, emotional, and social pressures that occur within their adolescent years but if diffusion occurs in identity formation, it can create turmoil that will be expressed in behavioral disturbances. In comparison to individuals who have not resolved their identity issues, individuals who have made commitments in the achieved and foreclosed identities report higher levels of psychological well-being, adjustment, emotional stability (Crocetti, Rubini, & Meeus, 2008; Kroger, 2007; Luyckx, Goossens, Soenens, Beyers, & Vansteenkiste, 2005; Meeus, 1996; Meeus, Iedema, Helsen, & Vollebergh, 1999; O'Connor, 1995) and report experiencing less anxiety (Marcia, 1966; Marcia, 1967; Marcia & Friedman, 1970; Schenkel & Marcia, 1972).

Since moratorium is described as the status in which an "identity crisis" is indicative, there have been numerous studies regarding psychological disturbances that occur during this status. For example, Meeus, Iedema, Helsen, and Vollebergh (1999) concluded that the moratorium status was associated with low levels of psychological well-being. Additionally, individuals in the moratorium status report elevated levels of depression (Luyckx et al., 2008; Meeus, 1996) and anxiety (Marcia 1967; Marcia & Friedman, 1970; Oshman & Manosevitz, 1974; Rotheram-Borus, 1989; Schenkel & Marcia, 1972; Sterling & Van Horn, 1989). Research on diffused status has also shown problems with psychological well being (e.g., Archer, 2008; Jones and Hartmann, 1988; Jones, 1992, 1994; Marcia, Waterman, Matteson, Archer & Orlofsky, 1993; Waterman, 1999; White, 2000). In fact, the diffused identity group is often seen as the most pathological (Hamilton, 1996). Vleioras & Bosma (2005) report that these findings lead one to believe that in terms of well-being, it is more preferable to have identity commitments, rather than not having any at all.

On the contrary, Kidwell & Dunham (1995) compared low-exploring adolescents to high-exploring adolescents and found that participants actively involved in identity exploration showed greater levels of inner confusion, agitation, dissatisfaction, and depression. Crocetti, Rubini, & Meeus (2008) found that reconsideration of commitment was related to depressive and anxiety symptoms, delinquent behaviors, and poorer family relationships. Additionally, Vleioras and Bosma (2005) reported findings that individuals who were not dealing with identity issues (similar to diffused status) had less psychological well-being and individuals dealing with identity issues, resulting in commitments, had more psychological well-being.

Thus, research supports Erikson's view that identity formation is a challenging process and substantial evidence points to a positive correlation between overall psychological

adjustment and progress toward identity formation. Marcia (1966) concluded that the harder adolescents work to resolve their identity crisis, the stronger their overall identity and sense of self will be. Erikson's stages and Marcia's identity statuses articulate identity formation and the typical crises that adolescents face, but they assume that the individuals have the skills to move through the challenges. However, if an adolescent has a mental disability, the challenge can be greater and may disrupt the individual's progress permanently (Leavey, 2003; McGorry, Edwards, Mihalopoulos, Harrigan, & Jackson, 1996). This study of adolescents that have been given clinical diagnoses, will examine the relationship of identity status and psychopathology.

Caregiver Influence on Identity Formation

Parents are considered to play a significant role in the socialization of developing adolescents because they have the most opportunity over the longest period of time to act and impact their children's lives (Bary, 1978). Parents are a salient influence in their adolescent's development as they serve as role models and sounding boards (Steinberg, 1996). For this reason, parents are considered dynamically interlinked to their adolescent's identity formation (Beyers, 2008; Beyers & Goossens, 2008; Crocetti, Rubini, Meeus, 2008; Sabatier, 2008; Smits et al., 2008).

Positive adolescent–parent relationships have been found to foster identity commitments (Meeus, Oosterwegel, Vollebergh, 2002; Samuolis, Layburn, & Schiaffino, 2001). Moreover, adolescents who strongly identified with their commitments reported trusting their parents more and having a good relationship with them (Crocetti, Rubini, & Meeus, 2008). Parents who lack autonomy, support, and encouragement, have adolescents with lower commitment and exploration (Fullinwider-Bush & Jacobvitz, 1993). Conversely, the experience of parental

support and attachment were found to be related to greater achievement and less diffusion in identity (Campbell, Adams, & Dobson, 1984; Jackson, Dunham, & Kidwell, 1990; O'Connor, 1995; Schulteiss & Blustein, 1994). The diffusion status is typified as having poor parent-adolescent relationships (Marcia, 1993). Specifically, identity diffused adolescents describe their parents as uninvolved in their lives, overly permissive, and failing to understand them, they feel rejected and distant from their parents, (Adams & Jones, 1983; Donovan, 1975; Howard, 1964; Marcia, 1987), and report the least emotionally attached to their parents, compared to the other identity statuses (Campbell et al., 1984).

Adolescents in the achieved status have reported parents who were warm, supportive, and consistently enforced the rules while non-achieved adolescents had restrictive or permissive parents (Douvan & Adelson, 1966). Sartor & Youniss (2002) reported that achieved adolescents were associated with parental knowledge of adolescent daily activities and emotional support from their parents. Greater parental support and attachment have also been related to the foreclosure status (Campbell et al., 1984; O'Connor, 1995; Schulteiss & Blustein, 1994), however these findings may only show a preference of commitments to their parents' beliefs and values.

Silverberg and Steinberg (1990) found only modest relations between parental well-being and signs of adolescent development, however, Schwartz and colleagues (2008) found family functioning to be, in part, responsible for changes in identity confusion. Researchers have also suggested that clear boundaries between family members, with adolescents maintaining their own separate sense of self, appear to achieve more mature commitments (Anderson & Fleming, 1986; Fullinwider-Bush & Jacobvitz, 1993; Perosa, Perosa, & Tam, 2002). On the other hand, adolescents in the identity foreclosure status, a relatively mature status in that some form of

commitment is embraced, have tendencies to over-identify with their parents (Adams, Dyk, & Bennion, 1987; Coˆte´ and Levine, 1983). Foreclosed adolescents report feeling guilty when parents have disagreements, but also report loving and affectionate parents who tend to be controlling and critical (Adams & Jones, 1983; Donovan, 1975). Moratorium status is characterized as having ambivalent family relationships (Marcia, 1993) as well as loving, supportive parents who encourage independence (Adams, 1985; Adams & Jones, 1983; Campbell et al., 1984; Grotevant & Cooper, 1985b).

A gender difference has emerged in that secure attachments to mothers predict stronger identity achievement for females, though no relationships were found between attachment to fathers and identity status (Benson, Harris, & Rogers, 1992; Samuolis, Layburn, & Schiaffino, 2001). Ethnic differences have also been studied, showing greater parental support as a predictor of achievement scores for Hispanic participants, foreclosure and moratorium for Caucasian participants, and diffusion for African American participants. Additionally, in a low SES sample of African American adolescents, parents appeared to support diffusion in identity as evidenced by skepticism about available opportunities and either consciously or subconsciously trying to protect their children from being disappointed (Hall & Brassard, 2008).

Research clearly shows that nurturing parents promote identity exploration and commitment. A combination of a warm, intimate relationship among parents and adolescents involving emotional support, guidance, intimacy, and secure attachment, as well as encouragement to become autonomous, valuing independence, and individuation from family is associated with healthy identity development and achievement (e.g., Beyers & Goossens, 2008; Blustein, Walbridge, Friedlander, & Palladino, 1991; Quintana & Lapsley, 1990; Tokar, Withrow, Hall, & Moradi, 2003). The understanding of identity statuses can assist parents and

clinicians working with adolescents to become more aware of their needs in relation to their developmental stage (Allison, 1997). Attachment and parent-adolescent relationships have received abundant research in relation to adolescent identity formation, yet their parent's identity status and identity distress have not been examined regarding their effects on their adolescent's identity variables. This study aims to look more specifically at these relationships.

Identity Distress, Identity Disorder, and Identity Problem

Adolescents experience a variety of stress and anxiety as they explore their strengths, skills, values, beliefs, and feelings while seeking out a personal identity (Amett, 1999), therefore, individuals who already have symptoms of stress and anxiety related to psychopathology, may experience considerable distress related to their identity as well. Unfortunately, this area of research is infinitesimal in relation to the research available on identity development, even though high levels of identity distress have been associated with increased levels of internalizing and externalizing behavior problems (Hernandez, Montgomery, & Kurtines, 2006) that may also decrease adolescents' ability to resolve important developmental tasks (Albrecht, 2007). Stillion and McDowell (1991) suggest that problems using appropriate coping skills may be related to identity difficulties which may be a risk factor for increased suicidality among adolescents. The little research available regarding identity distress has suggested that it can be deleterious to adolescents in both development of identity and psychopathology.

Albrecht (2007) has proposed that although developmental theory might suggest that a decrease in identity distress will be related to a positive identity development, there is currently little research to support this idea as well. He proposes a different supposition, that positive identity development may be related to increased identity distress, due to the challenges of

leaving a somewhat secure identity status, and moving towards personal growth in an unfamiliar area, which could potentially lead to a more stressful process. However, adolescence is already understood as a stressful time, therefore, the experience of a disruption in identity may become more of a normative process of self-development. For example, increased exploration may result in adolescents being confronted with new identity-relevant situations and choices, which is distressful, but not necessarily detrimental to their identity formation. Thus, a slight increase in identity distress could be an indicator that an adolescent is actively engaged in identity exploration. However, the relationship between identity distress and identity development remains an empirical question and deserves much needed attention.

As adolescents explore different elements of their lives, some distress related to their identity is normal and expected, however, some adolescents experience an identity crisis (Erikson, 1963). This crisis period might also affect normal development and possibly lead to increased problems in internalizing and externalizing symptoms. Waterman (1988), reports that identity disturbances can be within a normal range for adolescents, but it can also become intense and cause individual dysfunctions.

The American Psychiatric Association (1980) recognized identity related distress to psychological adjustment and provided Identity Disorder as a diagnostic category in the DSM-III. This disorder was described as severe subjective distress and difficulties resolving different aspects of ones identity into a coherent sense of self. This diagnosis was moved to the v-codes section known as "other conditions that may be a focus of clinical attention" in the DSM-IV (American Psychiatric Association, 1994) and reclassified as Identity Problem with the general criteria that it may be presented as having uncertainties about multiple issues in relation to identity (Berman et al., 2009). Reasons for this downgrade include: limited research on the topic,

not having assessment instruments to appropriately determine Identity Disorder (Shaffer, Campbell, Cantwell, & Bradley, 1989), and the belief that symptoms may be related to normal developmental challenges or a manifestation of another disorder (American Psychiatric Association, 1991). This change also suggests that experiencing distress during identity development may have become more of an expectation rather than a symptom due to the increasing complexity and prolonged nature of this developmental period. Unfortunately, these changes do not reflect changes in the prevalence of identity distress and may lead to more individuals experiencing unresolved distress about their identity (Montgomery, Hernandez, & Ferrer-Wreder, 2008).

In the current DSM-IV-TR (American Psychiatric Association, 2000), only three disorders (other than the Identity Problem v-code), Borderline Personality Disorder, Eating Disorders, and Dissociative Identity Disorder, have identity disturbances as one of the core features of the diagnosis. Symptoms of identity distress may be a part of several other disorders, however, research has rarely studied whether identity distress is a unique and distinct problem and the downgrade from a diagnostic category to a v-code problem area, affects research funding, treatment reimbursement, and possible neglect of these problems within clinical services (Berman et al., 2009).

However, identity distress is clearly a problem for some adolescents, as 14.3% of a high school sample with 140 students aged 15-18, met DSM IV criteria for Identity Problem. The participants' Identity Problem symptoms predicted psychological symptom scores beyond their identity status. In addition, their identity status accounted for less variance in psychological symptom severity when controlling for Identity Problem symptoms (Berman et al., 2008). In another study, Berman and colleagues (2004) studied 331 university students and found 12% of

the participants met criteria for Identity Disorder. Another university study in a psychiatric outpatient clinic retrospectively reviewed how many students were diagnosed with Identity Disorder. They found that 3.8% of their participants met criteria for Identity Disorder thus suggesting that it was relatively rare for a student to be diagnosed with this problem, but these findings may not reflect the actual amount of students who present with identity related distress (Strangler & Printz, 1980).

Another study examining the potential severity of identity distress was conducted by Burket and collegaues (1994) using retrospective review of 157 consecutive adolescent psychiatric patients and found that 19.1% of adolescents involved in witchcraft and Satanism met criteria for Identity Disorder, and 50% of individuals deeply involved in these practices met criteria for this disorder. Hernandez and colleagues (2006) found links between identity distress and poor psychological adjustment in high school students at-risk for dropping out of school. A significant proportion (34%) of their adolescent sample met criteria for Identity Problem. A gender difference also emerged in that girls reported more identity distress. Researchers suggested that boys may have responded in a socially desirable way or were less inclined to admit their distress or, that adolescent girls may experience more distressful identity problems. Their research suggests that identity distress co-occurs with poor psychological adjustment. In this study, the prevalence of Identity Problem will be examined among the adolescent and caregiver participants, as well as the relationship between identity distress symptoms and psychopathology.

Adolescent Identity Distress and Psychopathology

The impact of mental illness on the identity and development of adolescence is largely unknown (Leavey, 2003). What is known, is that about one in ten children and adolescents have mental health problems severe enough to cause some level of impairment, yet fewer than one in five receives treatment (National Institute of Mental Health, 2004) possibly perpetuating their struggle to master developmental issues. Adolescents with mental health issues may face the challenge of dealing with instability of the self and problems finding a meaningful direction in their lives (Hermans & Dimaggio, 2007).

Shiner & Capsi (2003) report that because identity and a sense of self are developing throughout childhood and adolescence, they may be vulnerable to the negative effects of psychopathology that emerge early in the life course. Likewise, adolescents who are unsuccessful in developing a sense of identity are more vulnerable to experiencing psychological and behavioral problems (Montgomery, Hernandez, & Ferrer-Wreder, 2008). Besser & Blatt's (2007) findings suggest that boys' risk for externalizing problems and girls' risk for internalizing problems are a result of impairments in their identity consolidation. On the other hand, a healthy identity is linked to adults' psychological well being by maintaining a sense of continuity in their lives and dealing effectively with age-related changes (Brandstadter & Greve, 1994). The health-promoting effects of a coherent sense of identity are evident throughout the life span, thus justifying the need to assist adolescents resolve identity related distress early on.

Few studies have been conducted to reveal deleterious levels of identity problems and its relationship to mental health problems. One example is a study conducted in Sweden assessing adolescents in grades 7-9. They found that the self-destructive/identity problem scale of Achenbach's self-report questionnaire significantly predicted suicidality (Ivarrson, Gillberg, Arvidsson, & Broberg, 2002).

Questions have been raised as to whether current mental health diagnostic categories such as Generalized Anxiety Disorder and other mood disorders have adequately described identity related symptoms of distress that may occur in these disorders, or if certain DSM mental disorder descriptions should be expanded to include these symptoms (Berman, Weems, & Petkus, 2009). Berman and colleagues (2009) found Identity Problem to be a significant predictor of other psychosocial variables and to better account for the variance in psychological symptom score above and beyond identity exploration and commitment. Other than the previous study mentioned, The Task Force on DSM-IV (American Psychological Association, 1991) call for more research examining whether identity distress is part of a normative developmental process, has received minimal acknowledgement. Therefore, this study will look at how identity distress, identity status, and psychopathology are related and the specific prevalence rates of identity distress among different mental health diagnostic categories.

Caregiver Identity Distress

As adolescents are growing and developing, their parents are also encountering a new transitional phase of moving into middle adulthood. There is a wide age range classifying midlife, however ages 40-65 is most commonly known as this transitional time in adults lives (Lachman, Lewkowicz, Marcus, & Peng, 1994; Lachman & James 1997), although it is not uncommon for someone to consider middle age to begin at 30 and even end at 75 (Lachman, 2001). Brim, Ryff, and Kessler (2004) found most of the reported crises occurring before the age of 40 or after the age of 50. Kuper and Marmot (2003) report that individuals in lower socioeconomic statuses state earlier entry and exit years for midlife which could be related to

differences in health (Marmot, Ryff, Bumpass, & Shipley, 1997) or to transitions occurring earlier including becoming a grandparent or retirement (Lachman, 2001).

Parenting adolescents has been described as a difficult time, more so than parenting children of other ages. Speculations of reasons for these difficulties include adolescent mood changes, increased desire for independence from parents, and disciplinary difficulties (Ballenski & Cook, 1982). During middle adulthood, parents must adjust to the changes related not only to their adolescents' development but also to themselves, in their relationships, economic and career status, health, and responsibilities for elderly parents (Allison, 1998; Walsh, 1982). Changes in physical and mental functioning, were reported as the worst aspects of midlife in a national survey conducted by the American Board of Family Practice (1990). Therefore, while adolescents and family development continue to change, they are likely to influence each other in a reciprocal manner (Hamilton, 1996).

Erikson's (1950, 1968) developmental stages are not limited to the specific age period of each psychosocial crisis. Most researchers believe that the elaboration and consolidation of a sense of identity is a lifelong process, thus the psychosocial crisis of identity confusion may continue into adulthood as individuals re-explore and redefine their identity commitments throughout their life (Berman et al., 2008; Stephen, Fraser, & Marcia, 1992). Empirical research suggests that most individuals progress toward identity achievement throughout adolescence (e.g., Waterman, 1993). For example, women within the identity achieved and identity diffused statuses, tended to stay in those identity statuses throughout adulthood (Josselson, 1996). Waterman and Waterman (1974) used a perceptual task as a stimulus, and found that achiever and moratorium men tend to consider alternatives before committing to a particular choice and were overall more reflective on their options. Foreclosed and diffused men tend to be more

impulsive and make quick decisions without considering all options. Farrell and Rosenberg (1981b) found that middle-aged men reported more distress than older men, however, young adult men experienced the most distress. These findings are consistent with Erikson's (1968) in which the older the age, the lower level of distress reported.

In contrast, Levinson (1974) and Sheehy (1974) report theoretical arguments and data to support that a crisis occurs in mid-life and is similar to that of an Eriksonian psychosocial crisis. Although mid-life is not characterized as a period of psychological distress and extreme crisis for most individuals (Nydegger, 1976), research suggests that middle adulthood may bring with it stress, reappraisal of life commitments, diminished marital satisfaction, and increased exploration of identity (Anderson, Russell, & Schumm, 1983; Farrell & Rosenberg, 1981; Rubin, 1979; Silverberg & Steinberg, 1987, 1990; Vaillant, 1977). Brim, Ryff, and Kessler (2004) found parents to show both gains and losses in their psychology as individuals with adolescents had more psychological distress than individuals without children, but they also had greater psychological wellness and generativity. Parents' evaluations of their own lives and their well-being are affected by their children's outcomes (Lachman, 2004).

Middle adulthood for men, has been studied by Levinson (1978) who proposed that a heightened period of stress or crisis occurs during this transitional period. McGill (1980) reported that one-third of the 700 middle-aged male participants go through a midlife crisis which he describes as a dramatic and significant change in personality and behavior. However, Beaumont & Zukanovic (2005) did not find higher levels of distress among middle aged men compared to younger and older aged men. Additionally, several studies have only found between 2% to 5% of middle-aged adults who experience midlife problems (Cooper & Gutman, 1987; Farrell & Rosenberg, 1981; Krystal & Chiriboga, 1979; Schlossberg, 1987). Though research

findings are inconsistent, it is apparent that some adults do go through a time of crisis during their midlife as different life changes may occur which may lead to a time of re-exploration or renewed evaluation of their previous identity commitments (Berman et al., 2008). This study examines identity distress and identity status among the adolescent's caregivers.

The Current Study

The current study aims to expand knowledge of identity distress and its symptoms in the transitional phases of adolescence and middle adulthood. The prevalence of DSM-IV-TR Identity Problem was studied in this adolescent clinical population and their middle adulthood caregivers. In addition, the relationship among identity variables including identity distress, identity commitment, and identity exploration was examined. Different types of psychopathology were studied to see if one was more significantly related to identity distress and identity status, over the others. Psychopathology was also examined to look at relations among adolescents and caregivers. Parental identity variables were studied in relation to their adolescents' identity variables to determine whether parental identity problems are related to their adolescents' identity distress.

This exploratory study examined whether certain types of psychopathology are more related to identity issues than others. It is predicted that the adolescents in this sample would report higher levels of identity distress than previously studied adolescents without psychopathology. Another prediction is that adolescent identity and psychopathology variables would be significantly related to caregiver identity and psychopathology variables. Finally, caregiver identity variables are hypothesized to predict adolescent identity distress over and above adolescent variables.

METHOD

Participants

Adolescents were recruited from community mental health centers in the central region of a southeastern state where they were receiving services. These facilities draw predominantly low socioeconomic families who receive Medicaid and other government assistance. There were 88 adolescent participants (43.2% female and 56.8% male) ranging in age from 11 to 20 with a mean age of 14.96 and a standard deviation of 1.85. Adolescents identified themselves as belonging to the following ethnic/racial groups: African American (35.2%), Caucasian (33%), Hispanic (23.9%), Mixed Ethnicity (5.7%) and Native American or Alaskan Native (2.3%). The participants reported being currently enrolled in the following grades: 5th (1.1%), 6th (9.1%), 7th (18.2%), 8th (18.2%), 9th (18.2%), 10th (11.4%), 11th (14.8%), and 12th (9.1%).

There were numerous variations regarding comorbid diagnoses given by the participants' psychiatrist and mental health counselor. To eliminate the large amount of diagnostic disparity, the primary diagnosis given by the mental health counselor, was used in this study. The therapists may have a better understanding of their client's symptoms because they meet with their client's for a longer period of time, usually one hour a week for a minimum of three months. Whereas, the psychiatrist typically only meets with the client for about fifteen minutes during their once a month medication management appointments. However, if the client was not currently receiving counseling services, the psychiatrist's primary diagnosis was used in this study. When discussing diagnoses with the participants' therapist and psychiatrist, they reported the frequent use of "not otherwise specified" (NOS) due to the difficulties of determining

whether the client is experiencing a particular diagnosis or a reaction to developmental problems related to being an adolescent. Information regarding the adolescents' clinical diagnoses was derived from their outpatient medical charts. Adolescents in this sample were diagnosed with Adjustment Disorder (6.8%), Attention Deficit/Hyperactivity Disorder (18.2%), Bipolar Disorder NOS (13.6%), Depressive Disorder NOS (20.5%), Major Depressive Disorder (8%), Mood Disorder NOS (23.9%), Posttraumatic Stress Disorder (4.5%), Psychotic Disorder NOS (2.3%), and Oppositional Defiant Disorder (2.3%).

To further examine these adolescents, we grouped specific diagnoses into three different categories, each containing: internalizing symptoms, externalizing behaviors, and psychotic or severe disturbances. Participants diagnosed as Adjustment Disorder with Depressed Mood, Depressive Disorder NOS, Major Depressive Disorder, Posttraumatic Stress Disorder, and Mood Disorder NOS, were placed in the internalizing group. The externalizing group had participants with diagnoses of Attention Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, Adjustment Disorder with Disturbance of Conduct, and Adjustment Disorder with mixed Disturbance of Emotions and Conduct. Finally, the psychotic or severe disturbances group consisted of adolescents diagnosed with Bipolar Disorder NOS and Psychotic Disorder NOS. Within these three categories, there were 58.0% of the participants in the internalizing symptoms category, 26.1% in the externalizing behaviors group, and 15.9% in the psychotic or severe disturbances group (see Table 1).

There were 63 caregivers who participated in the study, including mothers (82.5%), fathers (7.9%), grandmothers (7.9%), and grandfathers (1.6%) ranging in age from 28-70 with a mean age of 40.24 and a standard deviation of 9.16. Caregivers identified themselves as belonging to the following ethnic/racial groups: African American (36.5%), Caucasian (41.3%),

and Hispanic (22.2%) (see Table 2). It is believed that fewer fathers and grandfathers participated since it was most often mothers and grandmothers who were with their adolescents for their appointments.

Measures

The Ego Identity Process Questionnaire (EIPQ; Balistreri, Busch-Rossnagel, & Geisinger, 1995) was used to measure the participants' identity status. There are 32 items in which participants are asked to rate their responses as strongly disagree, disagree, neutral, agree, or strongly agree on questions like "My beliefs about dating are firmly held" and "I will always vote for the same political party". Two subscales are included in the EIPQ: identity exploration and identity commitment. Cronbach's alpha for the exploration subscales has been reported to be 0.86 with test-retest reliability of 0.76 and 0.80 Cronbach's alpha and 0.90 test-retest reliability for the commitment subscale. The questionnaire creators used median splits on the two subscales to assign one of four identity statuses to the participants (Balistreri, Busch-Rossnagel, & Geisinger, 1995), therefore, new median splits were used in this study. As was previously used by Berman et al., (2009), participants who scored low on exploration and commitment were classified as diffused, those low in exploration but high in commitment were classified as foreclosed, high scores in exploration but low in commitment were classified as moratorium, and those high in both exploration and commitment were classified as achieved. In this sample, the internal consistency reliability estimate (coefficient alpha) for the exploration scale item was 0.77 and for the commitment scale was 0.74 within the adolescent sample and 0.79 for the exploration scale item and 0.74 for the commitment scale within the parent sample.

The Identity Distress Survey (IDS; Berman et al., 2004) is a 10-item brief self-report diagnostic questionnaire that was used to measure distress associated with unresolved identity issues. The survey was modeled on the DSM III-R criteria for Identity Disorder, but can also be used to assess DSM-IV criteria for Identity Problem. Participants are asked to rate on a scale from 1 (Not at all) to 5 (Very Severely) "To what degree have you recently been upset, distressed, or worried over the following issues in your life." These issues are long-term goals, career choice, friendships, sexual orientation and behavior, religion, values and beliefs, and group loyalties. These seven items are listed with examples, for instance, "Career choice? (e.g., deciding on a trade or profession, etc.)" to provide further information regarding each item. Following these seven items are three additional questions including a rating of the overall level of discomfort they felt about the seven areas, how much uncertainty over these issues as a whole, have interfered with their life, and how long they have felt distressed. Internal consistency has been reported as 0.84 with test-retest reliability of 0.82. In this sample, the internal consistency (alpha) was 0.80 for adolescents and 0.85 for parents.

The Brief-Symptom Inventory (BSI; Derogatis, 1993) is a self-report measure that consists of 53 items assessing psychological symptoms. Items are rated on a 5-point scale (not at all to extremely) to reflect the level of distress experienced by each symptom during the previous month, for example, "Feelings of worthlessness" and "Spells of terror or panic." The test measures nine primary symptom dimensions (somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism) as well as total global severity. Internal consistency has ranged from 0.71 to 0.85 with test-retest reliability of 0.90. In this sample, the internal consistency (alpha) for the adolescent sample and the caregiver sample was 0.97.

Procedure

Upon receipt of the Institutional Review Board approval from the University of Central Florida and approval from the participating community mental health centers, the investigator met with adolescents and caregivers during their outpatient appointments. The recruitment strategy was a clinical series in which adolescents waiting for their outpatient appointments were approached and asked if they were interested in participating. Participants younger than the age of 11, individuals who could not adequately read or write, and individuals who had low cognitive functioning, were not asked to participate in this study.

Adolescents were read an assent script describing the purpose of the research. They were informed that the investigator was conducting research on identity development, people's sense of self and their mood problems, anxiety, and other problems. Participants were informed that the survey contained 95 statements such as, "I have definitely decided on a career" to which they would respond by rating how much they agree or disagree with each statement. They were also informed that their answers were confidential and would be used for research purposes of this study only and would not be shared with their parents, teachers, physicians, or counselors. Participants were informed that if they chose to take part, they could stop at any time and did not have to answer any questions that they did not want to answer. They were also informed that taking part in this study would not affect services with the agency.

Participants were asked if they would prefer an English or Spanish version of the consent form and survey. Although all participants were able to speak and understand English, there were six participants who requested the survey in the Spanish form. The investigator reviewed the consent forms with the adolescents and caregivers and received their consent to participate. The

caregivers also completed a consent form for their adolescents if they agreed to allow them to participate. Thus, one consent form was received from the adolescent and 2 were received from the caregiver for themselves and their adolescent(s) to participate. Participant consent was obtained and survey data was collected. Caregivers completed surveys in response to their own identity development, distress, and psychological symptoms. Achenbach, McConaughy, & Howell (1987) believe that adolescent-reported outcomes may be a more accurate representation of their actual behaviors rather than parental reports.

A small proportion of adolescents (n = 4) and caregivers (n =16) either declined to participate in the study or did not complete the survey. Adolescents who discontinued the survey after consenting to participate reported that it was either too long or they no longer wanted to participate. Reasons for the high participation rate is possibly due to the nature of the testing environment, as adolescents had to sit in the waiting room of their outpatient appointments for 30-45 minutes, allowing for adequate time to complete the survey without interruption. Surveys took approximately thirty minutes to complete and the primary researcher was there to answer any questions.

Participants were given self-report measures to assess their own levels of identity development (Ego Identity Process Questionnaire), distress associated with unresolved identity issues (The Identity Distress Survey), and psychological symptoms (Brief Symptom Inventory). When participants completed the surveys, the consent forms were removed, making them completely anonymous. All information was stored in a locked file cabinet in the locked research laboratory of the faculty supervising this project. Additionally, no personally identifying information was requested on the survey. Therefore, once the consent form was removed, the

only way to link the questionnaire to the identity of the participant was through a participant number.

RESULTS

Descriptive Information

Based on the DSM IV-TR, 22.7% of adolescents met criteria for Identity Problem. A Chi-square analysis revealed no significant gender, ethnic, or psychological category (internalizing, externalizing, and psychotic) differences within diagnostic status. An independent samples t-test reported no significant differences in age between identity problem and non-identity problem groups. In addition, a one-way analysis of variance (ANOVA) yielded no significant differences between psychological category and identity distress. To examine the relative standing of the adolescents on the variables in this study means and standard deviations were calculated. The possible average distress rating for the IDS ranges from 1.00 to 5.00. The sample range was 1.00-4.71 with a mean of 2.38 and a standard deviation of .84. For the total identity exploration variable, the possible range is 16.00 to 80.00 and the sample range was 39.00-70.00 with a mean of 49.44 and a standard deviation of 6.49. The possible total identity commitment score for the EIPQ ranges from 16.00 to 80.00. The actual range for this sample was 39.00 to 66.00 with a mean of 52.53 and a standard deviation of 6.24. Finally, the psychological symptom severity index has a possible range of .00 to 4.00 and the actual range for this sample was .00-3.23 with a mean score of 1.21 and a standard deviation of .83.

To examine the adolescents' responses on the identity distress variables, percentages by rating were calculated (see Table 3 for more details). On average, they reported more symptoms of identity distress within the variables of long term goals (30.7%), career goals (23.0%), and friendships (25.0%). Within the psychological symptom variables in this study, adolescents

reported more symptoms of feeling easily annoyed (30.7%), difficulties making decisions (25.0%), trouble concentrating (22.7%), not trusting others (21.6%), and temper outbursts (20.5%) (see Table 4).

Regarding the specific identity status of the adolescent sample, 68.2% were in the diffused status, 25% were in the foreclosed status, 4.5% were in the moratorium status, and 2.3% were in the achieved status. A Chi-square analysis revealed no significant gender or ethnic differences within adolescent identity statuses. To further examine gender differences in identity distress, identity status, and psychological symptoms, the continuous scores were used, however no gender differences were found among their average identity distress ratings, total identity exploration, total identity commitment, and psychological severity index. A one-way analysis of variance (ANOVA) yielded significant differences between mean age of status groups $F(3, 84) = 2.77$, $p = .047$. An LSD post hoc analysis revealed that individuals in the achieved status were significantly older than the individuals in the diffused ($p = .013$) and foreclosed ($p = .034$) statuses. A one-way ANOVA did not reveal significant differences between ethnic groups and mean levels of identity distress, psychological severity index, total identity exploration, or total identity commitment.

In regards to psychological problems, adolescent participants who met criteria for Identity Problem reported significantly more symptoms of phobias ($t(86) = -3.02$; $p = .004$), psychoticism ($t(86) = -3.09$; $p = .023$), somatization ($t(86) = -2.68$; $p = .005$), obsessive-compulsive ($t(86) = -3.04$; $p = .023$), interpersonal sensitivity ($t(86) = -2.96$; $p = .007$), and depression ($t(86) = -2.20$; $p = .006$). Hostility, anxiety, and paranoid ideation were not significant. To better examine the significant relationships between psychological symptom

variables and identity distress variables, a correlation table was created depicting these results (See Table 5).

Additional Pearson correlations were used to examine the relationship among psychological symptom variables and the average identity distress ratings. Significant correlations were found among all psychological problem subscales ranging from $r = .37$ ($p < .001$) for phobias and paranoid ideations, to $r = .52$ ($p < .001$) for obsessive-compulsive, with a global severity score of $r = .54$ ($p < .001$). Average identity distress rating was also significantly related to adolescent identity exploration ($r = .22$, $p < .05$). Age was significantly related to identity exploration ($r = .24$, $p < .05$). Identity exploration and identity commitment variables were significantly related to most of the psychological symptom variables. To view detailed information on these correlations, see Table 6. In regards to identity exploration, significant and positive correlations were only found among the variables of career ($r = .25$, $p < .05$), religion ($r = .21$, $p < .05$), and length of time they were experiencing distressed feelings ($r = .36$, $p < .001$). Identity commitment was significantly and negatively related to values ($r = -.22$, $p < .05$) and length of time they were experiencing distressed feelings ($r = -.32$, $p < .01$). For more detailed information on these correlations, see Table 7.

For the adolescents' caregivers, 9.5% met criteria for the DSM-IV-TR v-code of Identity Problem. In regards to their identity status, 27.0% were in the diffused status, 54.0% were in the foreclosed status, 11.1% in the moratorium status, and 7.9% in the achieved status. To examine the relative standing of the caregivers on the variables in this study means and standard deviations were calculated. The possible average distress rating for the IDS ranges from 1 to 5. The sample range was 1.00 -3.86 with a mean of 1.87 and a standard deviation of .72. For the total identity exploration variable, the possible range is 16.00 to 80.00 and the sample range was

37.00-69.00 with a mean of 53.52 and standard deviation of 6.93. The possible total identity commitment score for the EIPQ ranges from 16.00 to 80.00. The actual range for this sample was 46.00 to 73.00 with a mean of 58.46 and a standard deviation of 6.67. Finally, the psychological symptom severity index has a possible range of .00 to 4.00 and the actual range for this sample was .00-3.26 with a mean score of .76 and a standard deviation of .77. Those who met criteria for Identity Problem reported significantly more psychological symptoms of interpersonal sensitivity ($t(61) = -2.40$; $p = .005$), anxiety ($t(61) = -2.02$; $p = .002$), phobias ($t(61) = -2.98$; $p = .006$), and psychoticism ($t(61) = -2.17$; $p = .000$). Hostility, somatization, obsessive-compulsive, depression, and paranoid ideation were not significant.

To better examine the significant relationships between psychological symptom variables and identity distress variables, a correlation table was created depicting these correlations (See Table 8). The caregiver's average identity distress was significantly related to their psychological symptom severity ($r = .35$, $p < .01$), identity exploration ($r = .31$, $p < .05$), and identity commitment ($r = -.38$, $p < .001$). Significant correlations were found among most of the caregiver's psychological problem subscales and average identity distress, with a global severity score of $r = .35$ ($p < .01$). Identity exploration was significantly related to depression ($r = .26$, $p < .05$) and hostility ($r = .29$, $p < .05$). See Table 9 for more information. Identity exploration was significantly related to goals ($r = .39$, $p < .01$), religion ($r = .32$, $p < .01$), and the length of time they felt distressed ($r = .29$, $p < .01$). Identity commitment was also significantly related to specific identity distress domains of goals ($r = -.38$, $p < .001$), career ($r = -.27$, $p < .05$), friends ($r = -.31$, $p < .05$), and religion ($r = -.28$, $p < .05$). For more information, see Table 10.

Correlations were also used to examine the relationships among adolescent and caregiver identity variables. Adolescent identity distress was significantly related to their caregiver's

identity commitment ($r = .36$, $p < .01$). See Table 11 for more details. The adolescent psychological variable of hostility was significantly related to their caregivers' psychological symptoms of interpersonal sensitivity ($r = .30$, $p < .05$) and adolescent paranoid ideation was significantly related to their caregivers' somatization ($r = -.27$, $p < .05$). These were the only BSI variables that were related among the adolescent and caregiver sample.

Predicting Identity Distress

Two regression analyses were conducted to test the main hypotheses of this study. First, a stepwise regression equation was used to examine identity distress within the specific psychological symptom variables on the BSI. On step one, the adolescent's demographics of age and sex were entered and on step two the nine BSI variables of somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism were entered. The analysis revealed an overall significance of F (4, 83) = 9.43, $p < .001$ with standardized beta coefficients reaching significance for obsessive-compulsive ($\beta = .37$, $t = 3.22$, $p < .01$) and for paranoid ideation ($\beta = .24$, $t = 2.03$, $p < .05$). This analysis was repeated for the caregivers and revealed an overall significance of F (3, 42) = 5.87, $p < .01$ with standardized beta coefficients reaching significance for interpersonal sensitivity ($\beta = .45$, $t = 3.32$, $p < .01$).

The second regression analysis was used to determine if parental identity variables predict the adolescent's level of identity distress. A multiple regression analysis was calculated with the adolescent's demographic variables of sex and age entered in the first step, the adolescent's global psychological symptom severity index from the BSI entered in the second step, the adolescent's total identity commitment and total exploration in the third step, the

caregiver's global psychological symptom severity index from the BSI entered on the fourth step, and the caregiver's identity variables of identity distress, total identity commitment, and total exploration in the fifth step, with the adolescent's average identity distress rating as the dependent variable. Results indicated that the overall model was significant $R^2 = .42$, Adjusted $R^2 = .31$, F (9, 50) = 3.98, $p = .001$. At step five, the change in R^2 was significant [change in F (3, 50) = 3.48, $p = .022$; change in $R^2 = .12$] with standardized beta coefficients reaching significance for the adolescent symptom severity ($\beta = .54$, $t = 4.17$, $p < .001$) and for parent's identity commitment score ($\beta = .33$, $t = 2.60$, $p = .012$).

DISCUSSION

The findings of this study extend the current research on adolescent identity distress and identity status, and their relationship to psychological adjustment. A unique aspect of this study is the examination of identity variables of adolescents with clinical diagnoses and their caregivers as well as the specificity of this sample of families with low socioeconomic status. In this sample there were no significant differences found within the demographic characteristics of age, gender, or ethnicity within Identity Problem diagnostic status. Additionally, there were no significant differences in average identity distress rating and adolescent gender and ethnic groups.

As was hypothesized, this clinical adolescent sample reported elevated identity distress symptoms in comparison to adolescents without clinical diagnoses (Berman et al., 2009) thus demonstrating the fact that identity distress continues to be a problem area for many adolescents and especially those with mental disabilities. In addition, the adolescents' caregivers reported elevated identity distress symptoms possibly suggesting that either the difficulties of caring for an adolescent with psychological problems can cause distress in their own lives or that adolescent's with identity distressed parents are more likely to experience psychological symptoms and identity distress themselves.

Using the IDS measure, adolescents reported more symptoms of identity distress within the specific domains of long term goals, career goals, and friendships. Leavey (2003) reported that youth with a mental illness felt stigmatized and labeled and experienced multiple losses of identity, family, career choices, and educational and social standing. Therefore, these findings may be related to the adolescent's psychological distress as these specific identity variables were

significantly related to several variables of psychopathology including interpersonal sensitivity, depression, hostility, and paranoid ideation, among other psychological symptom variables.

The adolescents in this sample reported more psychological symptoms within the specific questions regarding annoyed feelings, difficulties making decisions, trouble concentrating, temper outbursts, and not trusting others. These specific responses may be related to the sample's elevated level of identity distress. Research shows that friendships and peer groups become a prominent focus for adolescents (Akers, Jones, & Coyl, 1998), however, mental illness may affect their ability to form appropriate, trusting, relationships with others, leading to more identity distress in relation to their friendships. Symptoms related to temper outbursts and feeling easily annoyed, may affect the evolution and consolidation of their identity, which requires both cognitive and affective mastery. As reported by Crowe and colleagues (2008) a sense of self may be thwarted when the adolescent has a mental disability, because emotion is at the core of internal and interpersonal processes. Development and organization of adolescent identity, greatly depends upon their ability to regulate their emotions (Siegel, 1999) presumably making this experience difficult for an adolescent with mood disturbances. Difficulties making decisions and trouble concentrating may have been elevated symptoms within this sample, due to difficulties dealing with instability of the self and problems finding a meaningful direction in their lives (Hermans & Dimaggio, 2007).

Unlike previous studies found in the literature review suggesting unique gender and ethnicity differences among psychological categories (internalizing, externalizing, and psychotic), for this study, these variables did not reveal significant differences in gender (e.g., Achenbach, 1991a, 1991b; Cohen, et al., 1993; Fleming & Offord, 1990), Identity Problem diagnostic status, and ethnic groups (e.g., Kessler & Neighbors, 1986; Turner and Gil, 2002;

Williams & Harris-Reid, 1999; Vega & Rumbaut, 1991). A possible reason why this diverse sample did not show these differences within psychopathological categories may be due to the overall low SES status of the sample, which has been shown to be a risk factor for poor psychological health (Williams & Collins, 1995). Given that all of the participants were low SES, fewer differences within the sample might be noted since economically disadvantaged adolescents often experience more undesirable and adverse conditions (McLoyd, 1998) that may lead to developmental difficulties, disorganized family relationships, and higher levels of psychopathology, regardless of their gender or ethnicity.

The primary researcher examined whether adolescents within specific psychological categories (internalizing, externalizing, or psychotic) would report different levels of identity distress, identity exploration, and identity commitment and no significant differences were found. However, further examination of the BSI variables, found that obsessive-compulsive and paranoid ideation symptoms significantly predicted identity distress. This finding suggests that among all of the psychological symptoms studied, the diagnostic categories of obsessive-compulsive disorder and diagnostic categories with symptoms of paranoid ideation such as paranoid personality disorder and paranoid type of schizophrenia warrant the need for further investigation regarding whether they adequately describe identity related symptoms of distress.

The adolescents who met criteria for Identity Problem had significantly more symptoms of phobias, psychoticism, somatization, obsessive-compulsive symptoms, interpersonal sensitivity, and depression and significant relationships were found among all the psychological problem subscales and identity distress. These results suggest that a number of psychological variables are related to identity distress therefore several different types of psychological symptoms may be deleterious to adolescent's sense of self, rather than a select few.

In regards to identity development, adolescents and caregivers in this sample were predominantly in the diffused or foreclosed status suggesting that they were not actively seeking or exploring different alternatives. In comparison to the identity status distribution of a normal high school population (Berman et al., 2009), a greater amount of adolescents in this clinical sample (68.2%) were found in the diffused status than the normal high school sample (18.6%). The foreclosed status was similar in rate (25% clinical; 30.7% nonclinical) however another major difference was found among the moratorium status (4.5% clinical; 30% nonclinical) and achieved statuses (2.3% clinical, 20.7% nonclinical). Although these samples were not comparable on all demographic characteristics (e.g., older age, higher SES status, less ethnic diversity) these comparisons reveal large differences in identity status within these clinical and nonclinical samples.

For this adolescent sample, these findings are not surprising, as previous research has shown that diffused status is closely related to problems with psychological well being (e.g., Archer, 2008; Jones, 1992, 1994; Vleioras and Bosma, 2005; Waterman, 1999; White, 2000) and is often seen as the most pathological (Hamilton, 1996). Adolescents with a mental disability may experience more challenges in identity formation and their psychopathological symptoms may disrupt the individual's progress permanently (Leavey, 2003; McGorry, Edwards, Mihalopoulos, Harrigan, & Jackson, 1996). However, this information raises the question as to what risk factors may lead to a larger proportion of diffused individuals. It is possible that psychopathology or lower SES status could be risk factors for identity diffusion, or that these results are just a reflection of normal adolescent identity status for young adolescents who are not yet exploring different alternatives.

These findings are unexpected for the caregiver sample, as it is believed that adults may continue to re-explore and redefine their identity commitments throughout their life (Berman et al., 2008; Stephen, Fraser, & Marcia, 1992) leading to identity achievement rather than diffusion or foreclosure. Perhaps the caregivers' lack of identity commitment contributes to their adolescent's psychopathology, as research has suggested that parents play a significant role as models, sounding boards (Steinberg, 1996), and socialization for developing adolescents (Bary, 1978).

Significant differences were found between the adolescents' age and identity statuses, with older adolescents found in the achieved status than individuals in the diffused and foreclosed status. In addition, identity exploration was significantly related to the adolescents' age confirming empirical results (Erlanger, 1998; Fitch & Adams, 1983; Kroger & Haslett, 1988; Marcia, 1976; Waterman & Goldman, 1976) that older individuals are related to experiences of exploring their options. Similar to previous research on gender (e.g., Archer, 1982; Streitmatter, 1993) and ethnicity (Branch, Tayal, & Triplett, 2000; Grove, 1991; Rotheram-Borus, 1989) within identity statuses, this sample revealed no significant differences in total identity exploration or total identity commitment within gender and ethnicity.

Identity exploration was significantly related to identity distress, thus suggesting that exploring ones identity possibilities may be a painful experience but a necessary process in order to reach achievement. Identity exploration was significantly related to the specific identity distress domains of career, religion, and length of time they had been feeling distressed. Therefore, when one is exploring different choices and alternatives, they may experience distress in specific areas of their lives that are under exploration. Identity exploration was also

significantly related to most of the psychological symptoms on the BSI suggesting that exploring ones choices is a challenging process even more so for individuals with psychological problems.

On the other hand, identity commitment was significantly and negatively related to values and length of time feeling distressed suggesting that individuals who are committed to their choices, may experience overall less identity distress. Identity commitment was also significantly and negatively related to most of the psychological symptoms on the BSI suggesting that identity committed adolescents might experience fewer psychological symptoms. These results are consistent with past research findings (e.g., Crocetti, Rubini, & Meeus, 2008; Kroger, 2007; Luyckx, Goossens, Soenens, Beyers, & Vansteenkiste, 2005) that individuals who have made identity commitments report higher levels of psychological well-being, adjustment and emotional stability.

Caregivers that met criteria for Identity Problem reported significantly more psychological symptoms of interpersonal sensitivity, anxiety, phobias, and psychoticism. Significant correlations were found among all psychological problem subscales and identity distress, showing similar results to their adolescents. Caregiver identity distress rating was also significantly related to identity exploration suggesting that the more they were exploring their choices, the more identity distress they experienced. Their identity distress was significantly and negatively related to identity commitment suggesting that the more committed the caregivers were, the less identity distressed they were as well.

Another prediction was that adolescent identity and psychopathology variables would be related to their caregiver's identity and psychopathology variables. As hypothesized, there were significant correlations among the adolescents' identity variables and their caregivers' identity variables. Adolescent identity distress was significantly related to caregiver identity

commitment. Therefore, the more distressed the adolescents were the more identity committed their caregivers were. This finding is quite surprising and counter intuitive, as one would assume that caregiver identity exploration rather than identity commitment would be related to adolescent identity distress. It is possible that the adolescents perceived themselves to be more problematic or distressed due to their lack of identity commitment, in comparison to their parents' commitments. These adolescents may receive pressure from their parents to make decisions regarding their future, which may cause increased distress. There were also psychological symptoms on the BSI that were significantly related among the adolescents and caregivers. Significant correlations were found among adolescent hostility and caregiver interpersonal sensitivity. Adolescent paranoid ideation was also significantly related to caregiver somatization. Adolescents may feel as though they are to blame for their caregivers' problems and become paranoid or hostile about how their behaviors are affecting their caregivers.

Caregiver identity variables were hypothesized to predict adolescent identity distress over and above adolescent variables. Only the caregiver's identity commitment, significantly predicted adolescent identity distress over and above the adolescents' variables. Therefore, caregiver identity commitments may contribute to their adolescents' identity distress. Possible reasons for this may be that the adolescents feel pressured to commit to particular goals, roles, or beliefs however, due to their psychological problems and other risk factors, they may not be equipped with the essential skills to become more committed in their identity, thus leading to identity distress. Caregivers may not be supportive of their adolescents identity exploration and may be skeptical about available opportunities related to occupations, groups, friends, and other domains related to identity and either consciously or subconsciously try to protect their children

from being disappointed with identity related issues they themselves have been able to commit to, thus leading to identity distress for their adolescents.

Hamilton's (1996) theory reports that adolescents and family development continually change, and they are likely to influence each other in a reciprocal manner. Thus, it is difficult to determine the direction of these results and whether it is the caregiver who contributes more to their adolescent's identity problems or the adolescent contributing more to their caregiver's identity variables. In order to look more closely at this relationship, a longitudinal study would need to be conducted. For example, Pardini (2008a) who used a longitudinal sample of boys, found that the influence of child behavior on changes in parenting was as strong as the influence that parenting had on changes in child behavior.

The findings of this study should be interpreted within the context of its limitations. Correlational data cannot determine the specific influence of identity variables on psychological symptoms or vice versa, thus no causal statements can be made. Prospective research that follows participants over a longer time frame would provide more information regarding the causal associations between identity variables and psychopathology among adolescents and their caregivers.

In addition, the self-report measures used in this study may not accurately determine participants' identity distress and psychopathology as they may have responded in a socially desirable way or defensively to questions, due to the personal nature of these questions and the fact that their caregivers were present during data collection. Shared method variance might in part account for the obtained effects, however, questionnaires are the most appropriate to gather information regarding internal and subjective processes such as identity distress and identity development. Direct observations and the use of interviews rather than strictly using

questionnaires, would add additional information about the identity variables and psychopathology assessed in this study. However, these measurement tools were not feasible for the time limits of this study. Future researchers may also want to explore avenues of longitudinal studies and diary-based approaches that can assess these variables over a short or long interval of time. Another limitation to this study was the inability to establish inter-rater reliability of clinical diagnoses since adolescents were diagnosed by a number of different mental health counselors and psychiatrists. Although all clinicians used DSM-IV-TR (American Psychiatric Association, 2000) to diagnose the adolescents in this study, the inter-rater reliability was not assessed.

Furthermore, these findings are limited in generalizability to the specific population of low SES adolescents with clinical diagnoses and caregivers of adolescents with clinical diagnoses. On the other hand, the study population consisted of a diverse set of families in regards to age and ethnicity groups. Ethnicity was not found to be related to identity variables, which increases our confidence in the generalizability of the findings. Also, all the caregivers in this study have sought out mental health services for their adolescents, therefore, they may not be representative of caregivers within the general population. Another limitation concerns the small amount of fathers who participated in this study.

To expand the findings of this study, future research is warranted using longitudinal data looking at additional risk factors of psychopathology, identity distress, and lower levels of identity status across age groups and among adolescents and their caregivers. Other mediating and moderating variables such as attachment or personality disorders would be appropriate for future studies. Research looking at caregivers of adolescents without psychopathology would

also provide information regarding the bi-directional association in comparison to that of caregivers for adolescents with mental health issues.

Qualitative Discussion

The primary researcher made a thorough review of the medical charts for individuals who met criteria for Identity Problem, in order to look for possible similarities and differences among these participants. A strong similarity among these adolescents was the self-report of abuse and/or neglect with the majority of adolescents who met criteria for Identity Problem reporting some form of abuse. Berntsen and Rubin (2006) have demonstrated the long-lasting effects of trauma on personal identity in relation to PTSD symptoms. They have found that a traumatic memory forms a central component of personal identity, a turning point in the life story and a reference point for everyday inferences. Therefore, further research regarding identity distress among adolescents with an abuse history is warranted.

This qualitative analysis further confirms the results from Hernandez and colleagues (2006) that there are links between identity distress and poor psychological adjustment in at-risk adolescents. In their sample, adolescents were recruited from alternative high schools for teens "at-risk" of poor academic success and dropping out of school, which may possibly explain their higher prevalence of Identity Problem (34%) in comparison to the adolescents in this sample (22.7%). Although these adolescents were not comparable in demographic characteristics and sample size, these findings suggest that adolescents at risk of psychological and behavioral problems may experience more distress related to their identity. The adolescents who met criteria for Identity Problem appeared to be very troubled in comparison to other adolescents in this study. For example, they reported frequent suicidal ideations, drug use, hallucinations, poor

family relationships, and frequent family stressors. With this additional information, it appears as though further analysis regarding identity variables with adolescents who are at risk for delinquency, drug use, and severe behavioral disturbances, is needed to explore the linkage regarding these variables and identity distress.

Table 1. *Adolescent Demographic Information*

Variables	*Adolescents*
Age (in years)	
Range	11-20
Mean (Standard Deviation)	14.96 (1.85)
Ethnicity (percent)	
African American	35.2
Caucasian	33.0
Hispanic American	23.9
Native American or Alaskan Native	2.3
Mixed Ethnicity	5.7
Grade (percent)	
5^{th}	1.1
6^{th}	9.1
7^{th}	18.2
8^{th}	18.2
9^{th}	18.2
10^{th}	11.4
11^{th}	14.8
12^{th}	9.1
Clinical Diagnoses (percent)	
Adjustment Disorder	6.8
Attention Deficit/Hyperactivity Disorder	18.2
Bipolar Disorder (NOS)	13.6
Depressive Disorder (NOS)	20.5
Major Depressive Disorder	8.0
Mood Disorder (NOS)	23.9
Posttraumatic Stress Disorder	4.5
Psychotic Disorder (NOS)	2.3
Oppositional Defiant Disorder (NOS)	2.3
Symptom Category (percent)	
Internalizing	58.0
Externalizing	26.1
Psychotic/Severe Disturbance	15.9

Table 2. *Caregiver Demographic Information*

Variables	*Caregivers*
Age (in years)	
Range	28-70
Mean (Standard Deviation)	40.24(9.16)
Ethnicity (percent)	
African American	36.5
Caucasian	41.3
Hispanic American	22.2
Native American or Alaskan	-
Native	-
Mixed Ethnicity	
Relationship (percent)	
Mothers	82.5
Fathers	7.9
Grandmothers	7.9
Grandfathers	1.6

Table 3. *Percentage of Adolescent Identity Distress Variables*

Variables	*None*	*Mild*	*Moderate*	*Severe*	*Very Severe*
Long Term Goals	20.5	15.9	30.7	15.9	17.0
Career Choice	28.7	14.9	23.0	18.4	14.9
Friendships	23.9	17.0	19.3	14.8	25.0
Sexual Orientation and Behavior	64.4	8.0	9.2	8.0	10.3
Religion	59.1	14.8	12.5	4.5	9.1
Values and Beliefs	40.9	23.9	15.9	11.4	8.0
Group Loyalties	53.4	17.0	14.8	10.2	4.5

Table 4. *Percentage of Adolescent Psychological Symptoms*

Questions	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Nervousness Inside	30.7	29.5	18.2	15.9	5.7
2. Faintness	60.2	21.6	8.0	8.0	2.3
3. Controlled Thoughts	67.0	10.2	5.7	6.8	10.2
4. Blaming Others for Problems	46.6	20.5	13.6	9.1	10.2
5. Trouble Remembering Things	34.9	22.1	11.6	17.4	14.0
6. Easily Annoyed	19.3	13.6	12.5	30.7	23.9
7. Heart or Chest Pains	58.0	19.3	8.0	11.4	3.4
8. Afraid of Open Spaces	61.4	17.0	9.1	4.5	8.0
9. Thoughts of Ending Life	66.7	13.8	8.0	3.4	8.0
10. Not Trusting Others	27.3	13.6	21.6	17.0	20.5
11. Poor Appetite	44.3	22.7	12.5	9.1	11.4
12. Suddenly Scared	60.2	12.5	9.1	10.2	8.0
13. Temper Outbursts	38.6	13.6	11.4	14.8	21.6
14. Feeling Lonely With Others	37.5	18.2	10.2	17.0	17.0
15. Feeling Blocked with Tasks	41.4	17.2	19.5	13.8	8.0
16. Feeling Lonely	37.5	19.3	13.6	12.5	17.0
17. Feeling Blue	49.4	21.8	8.0	11.5	9.2
18. No Interest in Things	35.2	19.3	14.8	14.8	15.9
19. Feeling Fearful	54.0	12.6	12.6	6.9	13.8
20. Feelings Easily Hurt	34.5	18.4	19.5	10.3	17.2
21. People are Unfriendly	35.2	23.9	14.8	6.8	19.3
22. Feeling Inferior	51.1	15.9	12.5	9.1	11.4
23. Nausea	46.6	25.0	13.6	4.5	10.2
24. Watched by Others	35.2	17.0	18.2	14.8	14.8
25. Trouble Falling Asleep	33.0	22.7	15.9	8.0	20.5
26. Double Checking Things	31.8	23.9	22.7	9.1	12.5
27. Difficulty Making Decisions	31.8	13.6	19.3	25.0	10.2
28. Afraid of Travel	69.3	13.6	9.1	4.5	3.4
29. Trouble Getting Breath	52.3	25.0	14.8	3.4	4.5
30. Hot or Cold Spells	70.5	12.5	9.1	2.3	5.7
31. Avoiding Things/Places	62.5	6.8	14.8	8.0	8.0
32. Mind Going Blank	45.5	17.0	13.6	11.4	12.5
33. Numbness in Body	51.1	21.6	11.4	5.7	10.2
34. Punished for Sins	54.0	17.2	11.5	8.0	9.2
35. Hopeless about Future	56.8	12.5	12.5	4.5	13.6
36. Trouble Concentrating	23.9	19.3	20.5	13.6	22.7
37. Weak in Body	42.5	20.7	12.6	11.5	12.6
38. Tense of Keyed Up	47.7	17.0	14.8	12.5	8.0
39. Thoughts of Death	59.8	18.4	4.6	6.9	10.3
40. Urges to Injure Others	50.0	18.2	9.1	8.0	14.8

Table 4 Continued. *Percentage of Adolescent Psychological Symptoms*

Questions	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
41. Urge to Break/Smash Things	42.5	9.2	18.4	11.5	18.4
42. Self-Conscious	51.1	23.9	12.5	5.7	6.8
43. Uneasy in Crowds	67.0	10.2	8.0	8.0	6.8
44. Never Close to Another	56.8	13.6	13.6	9.1	6.8
45. Spells of Panic	70.5	13.6	5.7	3.4	6.8
46. Frequent Arguments	29.5	25.0	11.4	17.0	17.0
47. Nervous When Left Alone	58.0	13.6	12.5	6.8	9.1
48. No Credit for Things	42.0	17.0	14.8	14.8	11.4
49. Restless	44.3	25.0	13.6	4.5	12.5
50. Worthlessness	56.8	15.9	6.8	10.2	10.2
51. Taken Advantage of	35.6	25.3	17.2	8.0	13.8
52. Guilt	53.4	18.2	13.6	6.8	8.0
53. Something Wrong with Mind	58.0	11.4	13.6	5.7	11.4

Table 5. *Correlations Among Adolescent Identity Distress Domains and Psychological Subscale Variables*

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
1. Goals	-																		
2. Career	**.66**[3]	-																	
3. Friends	**.38**[3]	**.34**[3]	-																
4. Sexual	**.30**[2]	**.26**[1]	**.21**[1]	-															
5. Religion	.04	.05	.06	**.28**[2]	-														
6. Values	**.31**[2]	**.30**[2]	.20	**.23**[1]	**.46**[3]	-													
7. Groups	**.34**[3]	.17	.12	**.34**[3]	**.25**[1]	**.35**[3]	-												
8. Distress	**.48**[3]	**.31**[2]	**.25**[1]	**.33**[2]	**.29**[2]	**.38**[3]	**.33**[2]	-											
9. Life Interf.	**.40**[3]	**.27**[1]	**.31**[2]	**.34**[3]	.10	**.26**[1]	**.26**[1]	**.63**[3]	-										
10. Length Di.	**.28**[2]	**.25**[1]	.13	**.24**[1]	**.25**[1]	.16	.12	**.41**[3]	**.34**[3]	-									
11. Somatizat.	**.27**[1]	**.30**[2]	.15	**.38**[3]	**.35**[3]	**.25**[1]	**.26**[1]	**.44**[3]	**.53**[3]	**.48**[3]	-								
12. Obs/Comp	**.41**[3]	**.41**[3]	**.28**[2]	**.32**[2]	**.33**[2]	**.27**[1]	.21	**.48**[3]	**.54**[3]	**.40**[3]	**.67**[3]	-							
13. Inter. Sens.	**.25**[1]	**.35**[3]	**.22**[1]	**.35**[3]	**.27**[1]	**.38**[3]	.16	**.43**[3]	**.35**[3]	**.49**[3]	**.64**[3]	**.65**[3]	-						
14. Depression	**.25**[1]	**.38**[3]	**.28**[2]	**.26**[1]	**.32**[2]	**.32**[2]	.08	**.42**[3]	**.42**[3]	**.52**[3]	**.68**[3]	**.68**[3]	**.77**[3]	-					
15. Anxiety	**.30**[2]	**.27**[1]	.20	**.20**	**.27**[1]	**.37**[3]	**.24**[1]	**.42**[3]	**.48**[3]	**.42**[3]	**.78**[3]	**.60**[3]	**.70**[3]	**.71**[3]	-				
16. Hostility	**.33**[2]	**.33**[2]	**.24**[1]	**.30**[2]	.18	**.23**[1]	.21	**.51**[3]	**.34**[3]	**.41**[3]	**.52**[3]	**.60**[3]	**.57**[3]	**.61**[3]	**.51**[3]	-			
17. Phobias	**.22**[1]	.14	.09	**.39**[3]	**.31**[2]	-.27	**.26**[1]	**.36**[3]	**.47**[3]	**.40**[3]	**.60**[3]	**.56**[3]	**.65**[3]	**.54**[3]	**.69**[3]	**.40**[3]	-		
18. Paranoid	**.38**[3]	**.42**[3]	**.30**[2]	**.30**[2]	.13	**.30**[2]	.09	**.48**[3]	**.48**[3]	**.44**[3]	**.52**[3]	**.62**[3]	**.78**[3]	**.68**[3]	**.60**[3]	**.58**[3]	**.54**[3]	-	
19. Psychotic	.19	**.30**[2]	**.25**[1]	**.31**[2]	**.28**[2]	**.40**[3]	**.22**[1]	**.37**[3]	**.42**[3]	**.47**[3]	**.65**[3]	**.61**[3]	**.83**[3]	**.83**[3]	**.73**[3]	**.60**[3]	**.68**[3]	**.70**[3]	-

Note. [1] **= p < .05** [2] **= p < .01** [3] **= p < .001**

Table 6. *Correlations Among Adolescent Identity Distress, Global Psychological Symptoms, Identity Status, and BSI Subscales*

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Age	-													
2. Average Distress Rating	-.01	-												
3. Global Symptom Severity	-.13	**.54**[3]	-											
4. Identity Exploration	**.24**[1]	**.22**[1]	*.29*	-										
5. Identity Commitment	.06	-.14	**-.31**[2]	-.003	-									
6. Somatization	-.10	**.45**[3]	**.84**[3]	**.30**[2]	-.19	-								
7. Obsessive Compulsive	-.07	**.52**[3]	**.82**[3]	**.25**[1]	-.19	**.67**[3]	-							
8. Interpersonal Sensitivity	-.13	**.46**[3]	**.87**[3]	**.23**[1]	**-.30**[2]	**.64**[3]	**.65**[3]	-						
9. Depression	-.04	**.45**[3]	**.88**[3]	**.27**[1]	**-.39**[3]	**.68**[3]	**.68**[3]	**.77**[3]	-					
10. Anxiety	-.15	**.42**[3]	**.85**[3]	**.23**[1]	**-.26**[1]	**.78**[3]	**.60**[3]	**.70**[3]	**.71**[3]	-				
11. Hostility	-.07	**.42**[3]	**.73**[3]	**.26**[1]	-.13	**.52**[3]	**.60**[3]	**.57**[3]	**.61**[3]	**.51**[3]	-			
12. Phobias	-.12	**.38**[3]	**.74**[3]	.08	**-.27**[1]	**.60**[3]	**.60**[3]	**.65**[3]	**.54**[3]	**.69**[3]	**.40**[3]	-		
13. Paranoid Ideation	-.18	**.46**[3]	**.80**[3]	**.24**[1]	**-.28**[2]	**.52**[3]	**.62**[3]	**.78**[3]	**.68**[3]	**.60**[3]	**.58**[3]	**.54**[3]	-	
14. Psychoticism	-.14	**.45**[3]	**.87**[3]	.19	**-.27**[1]	**.65**[3]	**.61**[3]	**.83**[3]	**.83**[3]	**.73**[3]	**.60**[3]	**.68**[3]	**.70**[3]	-

Note. [1] = **p < .05** [2] = **p < .01** [3] = **p < .001**

Table 7. *Correlations Among Adolescent Identity Distress, Global Psychological Symptoms, Identity Status, and IDS Domains*

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. Age	-														
2. Average Distress Rating	-.01	-													
3. Global Symptom Sev.	-.13	**.54**[3]	-												
4. Identity Exploration	**.24**[1]	**.22**[1]	**.29**[2]	-											
5. Identity Commitment	.06	-.14	**-.35**[3]	-.003	-										
6. Goals	-.04	**.72**[3]	**.35**[3]	.18	-.10	-									
7. Career	.07	**.67**[3]	**.39**[3]	**.25**[1]	-.07	**.66**[3]	-								
8. Friends	-.10	**.57**[3]	**.26**[2]	.17	-.09	**.38**[3]	**.34**[3]	-							
9. Sexual	.05	**.62**[3]	**.37**[3]	.06	-.18	**.30**[2]	**.26**[1]	**.21**[1]	-						
10. Religion	-.08	**.48**[3]	**.34**[3]	**.21**[1]	-.16	.04	.05	.06	**.28**[2]	-					
11. Values	.08	**.65**[3]	**.36**[3]	.13	**-.22**[1]	**.31**[2]	**.30**[2]	.20	**.23**[1]	**.46**[3]	-				
12. Groups	-.04	**.59**[3]	**.23**[2]	-.07	-.02	**.34**[3]	.17	.12	**.34**[3]	**.25**[1]	**.35**[3]	-			
13. Distress	-.12	**.54**[3]	**.53**[3]	.21	-.11	**.48**[3]	**.31**[2]	**.25**[3]	**.33**[2]	**.29**[2]	**.38**[3]	**.33**[2]	-		
14. Interference with Life	.05	**.48**[3]	**.55**[3]	.18	-.02	**.40**[3]	**.27**[2]	**.31**[2]	**.34**[3]	.10	**.26**[1]	**.26**[1]	**.63**[3]	-	
15. Length of Distress	-.24	**.33**[3]	**.55**[3]	**.36**[3]	**-.32**[2]	**.28**[2]	**.25**[2]	.13	**.24**[1]	**.24**[1]	.16	.16	**.41**[3]	**.36**[3]	-

Note. [1] = **p < .05** [2] = **p < .01** [3] = **p < .001**

Table 8. *Correlations Among Caregiver Identity Distress Domains and Psychological Subscale Variables*

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
1. Goals	-																		
2. Career	**.64**[3]	-																	
3. Friends	**.44**[3]	**.35**[2]	-																
4. Sexual	**.38**[2]	**.44**[3]	**.35**[2]	-															
5. Religion	**.43**[3]	**.31**[1]	.19	**.39**[2]	-														
6. Values	**.27**[1]	**.25**[1]	.15	.18	**.49**[3]	-													
7. Groups	.17	.23	**.26**[1]	**.41**[3]	**.39**[2]	**.40**[3]	-												
8. Distress	**.51**[3]	**.47**[3]	**.50**[3]	**.53**[3]	**.28**[1]	**.34**[2]	**.31**[1]	-											
9. Life Interf.	**.51**[3]	**.46**[3]	**.34**[3]	.20	.21	**.51**[3]	**.26**[1]	**.59**[3]	-										
10. Length Di.	**.54**[3]	**.39**[2]	.23	**.29**[1]	.03	.22	.16	**.53**[3]	**.50**[3]	-									
11. Somatizat.	.18	.12	.18	.11	.05	**.29**[1]	.22	**.36**[2]	**.43**[3]	.21	-								
12. Obs/Comp	**.29**[1]	.19	.17	.05	.07	**.37**[2]	.14	**.35**[2]	**.42**[3]	.24	**.70**[3]	-							
13. Inter. Sens.	**.37**[2]	**.32**[3]	**.32**[1]	.16	.13	**.31**[1]	.22	**.48**[3]	**.46**[3]	**.38**[2]	**.59**[3]	**.72**[3]	-						
14. Depression	**.26**[1]	.22	.23	.10	.04	**.26**[1]	.14	**.41**[3]	**.41**[3]	**.31**[1]	**.62**[3]	**.78**[3]	**.81**[3]	-					
15. Anxiety	.24	.24	**.25**[1]	.08	.08	**.37**[3]	.13	**.45**[3]	**.47**[3]	**.27**[1]	**.72**[3]	**.84**[3]	**.84**[3]	**.83**[3]	-				
16. Hostility	**.38**[2]	.24	**.26**[1]	.09	.05	.23	.17	**.35**[2]	**.36**[3]	.25	**.59**[3]	**.78**[3]	**.78**[3]	**.78**[3]	**.72**[3]	-			
17. Phobias	**.29**[1]	**.27**[1]	**.27**[1]	.19	.19	**.36**[2]	**.26**[1]	**.45**[3]	**.40**[3]	.20	**.60**[3]	**.71**[3]	**.81**[3]	**.75**[3]	**.84**[3]	**.72**[3]	-		
18. Paranoid	.21	.16	**.26**[1]	.05	-.01	.15	.12	**.42**[3]	**.21**[3]	**.33**[2]	**.47**[3]	**.66**[3]	**.74**[3]	**.78**[3]	**.72**[3]	**.65**[3]	**.69**[3]	-	
19. Psychotic	**.28**[1]	**.28**[1]	**.33**[2]	.16	.05	.22	.18	**.53**[3]	**.45**[3]	**.31**[1]	**.65**[3]	**.77**[3]	**.87**[3]	**.87**[3]	**.90**[3]	**.77**[3]	**.88**[3]	**.81**[3]	-

Note. [1] = **p < .05** [2] = **p < .01** [3] = **p < .001**

Table 9. *Correlations Among Caregiver Identity Distress, Global Psychological Symptoms, and Identity Status*

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Age	-													
2. Average Distress Rating	.02	-												
3. Global Symptom Severity	-.11	**.35**[2]	-											
4. Identity Exploration	-.19	**.31**[1]	.22	-										
5. Identity Commitment	.06	**-.38**[2]	.01	-.24	-									
6. Somatization	.03	.25	**.76**[3]	.03	.16	-								
7. Obsessive Compulsive	-.07	**.29**[1]	**.89**[3]	.23	.12	**.70**[3]	-							
8. Interpersonal Sensitivity	-.20	**.41**[3]	**.89**[3]	.22	-.14	**.59**[3]	**.72**[3]	-						
9. Depression	-.12	**.28**[1]	**.92**[3]	**.26**[1]	.01	**.62**[3]	**.78**[3]	**.81**[3]	-					
10. Anxiety	-.07	**.31**[1]	**.94**[3]	.13	-.04	**.72**[3]	**.84**[3]	**.84**[3]	**.83**[3]	-				
11. Hostility	-.12	**.33**[2]	**.85**[3]	**.29**[1]	.03	**.59**[3]	**.78**[3]	**.78**[3]	**.78**[3]	**.72**[3]	-			
12. Phobias	-.12	**.42**[3]	**.87**[3]	.19	-.08	**.60**[3]	**.71**[3]	**.81**[3]	**.75**[3]	**.84**[3]	**.72**[3]	-		
13. Paranoid	-.21	.22	**.82**[3]	.15	-.01	**.47**[3]	**.66**[3]	**.74**[3]	**.78**[3]	**.72**[3]	**.65**[3]	**.69**[3]	-	
14. Psychoticism	-.08	**.34**[2]	**.94**[3]	.19	-.02	**.65**[3]	**.77**[3]	**.87**[3]	**.87**[3]	**.90**[3]	**.77**[3]	**.88**[3]	**.81**[3]	-

Note. [1] = **p < .05** [2] = **p < .01** [3] = **p < .001**

Table 10. *Correlations Among Caregiver Identity Distress, Global Psychological Symptoms, Identity Status, and IDS Domains*

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. Age	-														
2. Average Distress Rating	.02	-													
3. Global Symptom Sev.	-.11	**.35**[2]	-												
4. Identity Exploration	-.19	**.31**[1]	.22	-											
5. Identity Commitment	.06	**-.38**[2]	.01	-.24	-										
6. Goals	-.003	**.78**[3]	**.31**[1]	**.39**[2]	**-.38**[2]	-									
7. Career	.11	**.73**[3]	**.27**[1]	.11	**-.27**[1]	**.64**[3]	-								
8. Friends	.25	**.62**[3]	**.27**[1]	.12	**-.31**[1]	**.44**[3]	**.35**[2]	-							
9. Sexual	-.07	**.64**[3]	.12	.21	-.21	**.38**[2]	**.44**[3]	**.35**[2]	-						
10. Religion	-.14	**.69**[3]	.07	**.32**[2]	**-.28**[1]	**.43**[3]	**.31**[2]	.19	**.39**[2]	-					
11. Values	-.11	**.58**[3]	**.32**[1]	.10	-.19	**.27**[1]	**.25**[1]	.15	.18	**.49**[3]	-				
12. Groups	-.08	**.55**[3]	.18	.12	-.03	.17	.23	**.26**[1]	**.41**[3]	**.39**[2]	**.40**[3]	-			
13. Distress	.09	**.64**[3]	**.47**[3]	.06	-.24	**.51**[3]	**.47**[3]	**.50**[3]	.53	**.28**[1]	**.34**[2]	**.31**[1]	-		
14. Interference with Life	.24	**.56**[3]	**.46**[3]	.16	-.22	**.51**[3]	**.46**[3]	**.34**[2]	.20	.21	**.51**[3]	**.26**[1]	**.59**[3]	-	
15. Length of Distress	-.09	**.43**[3]	**.31**[1]	.*29*	-.23	**.54**[3]	**.39**[2]	.23	**.29**[1]	.03	.22	.16	**.53**[3]	**.50**[3]	-

Note. [1] **= p < .05** [2] **= p < .01** [3] **= p < .001**

Table 11. *Correlations Among Adolescent and Caregiver Identity Distress, Identity Status, and Psychological Symptoms*

Variables	1	2	3	4	5	6	7	8
1. Adolescent Identity Distress	-							
2. Adolescent Psychological Symptoms	**.51**[3]	-						
3. Adolescent Total Exploration	**.27**[1]	**.35**[2]	-					
4. Adolescent Total Commitment	-.06	**-.34**[2]	-.06	-				
5. Caregiver Average Distress Rating	-.06	.06	.12	.14	-			
6. Caregiver Psychological Symptoms	.01	.02	.22	.07	**.33**[2]	-		
7. Caregiver Total Exploration	-.09	.23	-.03	.01	**.36**[2]	**.27**[2]	-	
8. Caregiver Total Commitment	**.36**[2]	.03	.01	.02	**-.40**[3]	.01	**-.31**[1]	-

Note. [1] = **p < .05** [2] = **p < .01** [3] = **p < .001**

APPENDIX A: FIRST EXPEDITED INSTITUTIONAL REVIEW BOARD CONTINUING REVIEW APPROVAL NOTICE

University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901, 407-882-2012 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

EXPEDITED CONTINUING REVIEW APPROVAL NOTICE

From : **UCF Institutional Review Board**
FWA00000351, Exp. 5/07/10, IRB00001138

To : **Steven L. Berman**

Date : **August 03, 2007**

IRB Number: **SBE-06-03627**

Study Title: **Identity Development in Clinical Population**

Dear Researcher,

This letter serves to notify you that the continuing review application for the above study was reviewed and approved by the IRB Vice-chair on **8/2/2007** through the expedited review process according to 45 CFR 46 (and/or 21 CFR 50/56 if FDA-regulated).

Continuation of this study has been approved for a one-year period. The expiration date is 8/1/2008. This study was determined to be no more than minimal risk and the category for which this study qualified for expedited review is:

7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

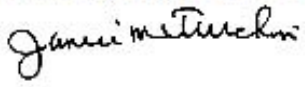
Use of the approved, stamped consent document(s) is required. The new form(s) supersedes all previous versions, which are now invalid for further use. Only approved investigators (or other approved key study personnel) may solicit consent for research participation. Subjects or their representatives must receive a copy of the consent form(s).

All data must be retained in a locked file cabinet for a minimum of three years (six if HIPAA applies) past the completion of this research. Any links to the identification of participants should be maintained on a password-protected computer if electronic information is used. Additional requirements may be imposed by your funding agency, your department, or other entities. Access to data is limited to authorized individuals listed as key study personnel.

To continue this research beyond the expiration date, a Continuing Review Form must be submitted 2 – 4 weeks prior to the expiration date. Use the Unanticipated Problem Report Form or the Serious Adverse Event Form (within 5 working days of event or knowledge of event) to report problems or events to the IRB. Do not make changes to the study (i.e., protocol methodology, consent form, personnel, site, etc.) before obtaining IRB approval. Changes can be submitted for IRB review using the Addendum/Modification Request Form. An Addendum/Modification Request Form **cannot** be used to extend the approval period of a study. All forms may be completed and submitted online at https://iris.research.ucf.edu .

On behalf of Tracy Dietz, Ph.D., UCF IRB Chair, this letter is signed by:

Signature applied by Janice Turchin on 08/03/2007 10:42:21 AM EDT



APPENDIX B: NOTICE OF EXPEDITED REVIEW AND APPROVAL OF REQUESTED ADDENDUM/MODIFICATION CHANGES

University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901, 407-882-2012 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Notice of Expedited Review and Approval of Requested Addendum/Modification Changes

From: **UCF Institutional Review Board**
FWA00000351, Exp. 5/07/10, IRB00001138

To: **Steven L. Berman** and Co-PIs: **Rachel E Wiley, Zuzana Segev**

Date: **June 23, 2008**

IRB Number: **SBE-06-03627**

Study Title: **Identity Development in Clinical Population**

Dear Researcher:

Your requested addendum/modification changes to your study noted above which were submitted to the IRB on 06/23/2008 were approved by **expedited** review on 6/23/2008.

Per federal regulations, 45 CFR 46.110, the expeditable modifications were determined to be minor changes in previously approved research during the period for which approval was authorized.

Use of the approved, stamped consent document(s) is required. The new form supersedes all previous versions, which are now invalid for further use. Only approved investigators (or other approved key study personnel) may solicit consent for research participation. Subjects or their representatives must receive a copy of the consent form(s).

This addendum approval does NOT extend the IRB approval period or replace the Continuing Review form for renewal of the study.

On behalf of Tracy Dietz, Ph.D., IRB Chair, this letter is signed by:

Signature applied by Joanne Muratori on 06/23/2008 03:32:19 PM EDT

Joanne Muratori

IRB Coordinator

Internal IRB Submission Reference Number: 003280

APPENDIX C: INSTITUTIONAL REVIEW BOARD SECOND EXPEDITED CONTINUING REVIEW APPROVAL

University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901, 407-882-2012 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

EXPEDITED CONTINUING REVIEW APPROVAL

From : **UCF Institutional Review Board**
FWA00000351, Exp. 6/24/11, IRB00001138

To : **Steven L. Berman, Rachel E. Wiley, Zuzana Segev**

Date : **August 18, 2008**

IRB Number: **SBE-06-03627**

Study Title: **Identity Development in Clinical Population**

Dear Researcher,

This letter serves to notify you that the continuing review application for the above study was reviewed and approved by the IRB Vice-chair on 8/18/2008 through the expedited review process according to 45 CFR 46.

Continuation of this study has been approved for a one-year period. The expiration date is 8/17/2009. Because the previous IRB approval for this study expired, there was a period of time when there was no IRB approval in place. You may not use any data collected during that lapse between 8/2/2008 and 8/17/2008, and any data that may have been collected during that period must be destroyed.

This study was determined to be no more than minimal risk and the category for which this study qualified for expedited review is:

6. Collection of data from voice, video, digital, or image recordings made for research purposes.

7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Use of the approved, stamped consent document(s) is required. The new form supersedes all previous versions, which are now invalid for further use. Only approved investigators (or other approved key study personnel) may solicit consent for research participation. Subjects or their representatives must receive a copy of the consent form(s).

All data must be retained in a locked file cabinet for a minimum of three years (six if HIPAA applies) past the completion of this research. Any links to the identification of participants should be maintained on a password-protected computer if electronic information is used. Additional requirements may be imposed by your funding agency, your department, or other entities. Access to data is limited to authorized individuals listed as key study personnel.

To continue this research beyond the expiration date, a Continuing Review Form must be submitted 2 – 4 weeks prior to the expiration date. Use the Unanticipated Problem Report Form or the Serious Adverse Event Form (within 5 working days of event or knowledge of event) to report problems or events to the IRB. Do not make changes to the study (i.e., protocol methodology, consent form, personnel, site, etc.) before obtaining IRB approval. Changes can be submitted for IRB review using the Addendum/Modification Request Form. An Addendum/Modification Request Form **cannot** be used to extend the approval period of a study. All forms may be completed and submitted online at https://iris.research.ucf.edu .

On behalf of Tracy Dietz, Ph.D., UCF IRB Chair, this letter is signed by:
Signature applied by Janice Turchin on 08/18/2008 04:41:51 PM EDT

Janice M. Turchin

APPENDIX D: ENGLISH ADOLESCENT ASSENT SCRIPT

Adolescent Assent Script

My name is Rachel Wiley, and I am a psychology student at the University of Central Florida. I am conducting research on identity development among adolescents. The purpose of the research is to study people's sense of self and their mood problems, anxiety, and other problems. I would like to ask you to complete a survey containing 95 statements such as, "I have definitely decided on a career" to which you will respond by rating how much you agree or disagree with each statement. The survey will take approximately 30-minutes to complete. The survey is confidential. Your answers will be used for research purposes of this study only and will not be shared with your parents, teachers, physicians, or counselors. If you choose to take part, you may stop at any time and you will not have to answer any questions you do not want to answer. Only overall results of the study will be shared with your parents. Taking part in this exercise will not affect services with this agency or placement in any programs. Would you like to participate?

University of Central Florida IRB
IRB NUMBER: SBE-06-03627
IRB APPROVAL DATE: 8/18/2008
IRB EXPIRATION DATE: 8/17/2009

APPENDIX E: SPANISH ADOLESCENT ASSENT SCRIPT

Adolescent Assent Script

Mi nombre es Rachel Wiley, y yo soy estudiante de psicología en la Universidad de Central Florida. Estoy realizando una investigación sobre el desarrollo de la identidad entre los adolescentes. El objetivo de la investigación es estudiar el sentimiento de sí mismo y sus problemas de ánimo, ansiedad, entre otros. Me gustaría pedirle que complete una encuesta que contiene 95 declaraciones (por ejemplo, "he decidido definitivamente en una carrera") en la cual usted daría una calificación de cuánto está de acuerdo o en desacuerdo con cada declaración. La encuesta le tomará aproximadamente 30 minutos para completar. La encuesta es confidencial. Sus respuestas se utilizarán para esta investigación solamente y no será compartida con sus padres, maestros, médicos o consejeros. Si decide participar, usted puede parar en cualquier momento y no tendrá que responder a cualquier pregunta que usted no desee responder. Sólo los resultados generales del estudio se darán a conocer a sus padres. Tomando parte en este ejercicio no afectará a los servicios con esta agencia o la colocación en todos los programas. ¿Le gustaría participar?

APPENDIX F: ENGLISH PARENT/GUARDIAN CONSENT FORM

University of Central Florida

Psychology Department

Dear Parent/Guardian:

I am a graduate student in the Clinical Psychology Masters Program at the University of Central Florida. I am conducting research on identity development among adolescents who enter services in mental health agencies. The purpose of this study is to explore the association between young people's sense of self and their mood problems, anxiety, anger, and other problems that lead them to seek help in mental health services. We also want to explore possible relationships between identity concerns in parents and their adolescents. The results of the study may be used to help develop intervention programs aimed at helping teenagers who are struggling with identity issues. These results may not directly help your adolescent today, but may benefit future teenagers.

The participating adolescent will be asked to complete a survey containing 95 statements (for example, "I have definitely decided on a career") to which they will respond by rating how much they agree with each statement on a 1 (strongly disagree) to 5 (strongly agree) scale. The survey will take approximately 30-minutes to complete. The surveys are strictly confidential and will be used for research purposes of this study only. The study is not associated with the agency in any way. Participation or nonparticipation will not affect services with the agency.

There are no known risks or immediate benefits to the participants. Although it is possible that by answering questions about his or her feelings your adolescent may experience some mild distress, but such reactions tend to be very mild and short lived. If however your adolescent reports feeling distressed in any way while completing this survey, either you or your adolescent should discuss these feelings with the counselor who is administering this survey. In addition, your adolescent has the right to skip any questions he or she does not want to answer and you have the right to withdraw consent for your adolescent's participation at any time without consequence. In addition, your adolescent has the right to stop answering the survey at any time without consequence. No compensation is offered for participation. Group results of this study will be available in August 2009 upon request. If you have any questions about this research project, please contact me at (561)309-7515 or my supervisor, Dr. Steven Berman at (386)506-4049. Questions or concerns about research participants' rights may be directed to the UCFIRB office, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246. The hours of operation are 8:00 am until 5:00 pm, Monday through Friday except on University of Central Florida official holidays. The phone number is (407) 823-2901 or (407) 882-2012.

Sincerely,

Rachel Wiley
Psychology Department
University of Central Florida, Daytona Beach

___I have read the procedure described above.

___I voluntarily give consent for my adolescent, _____ to participate in this study of adolescent identity development

_____/_____
Parent/Guardian signature Date

_____I would like to receive a copy of the procedure description.

_____/_____
2nd Parent/Guardian signature/Witness Date

UCF **University of Central Florida IRB**
IRB NUMBER: SBE-06-03627
IRB APPROVAL DATE: 8/18/2008
IRB EXPIRATION DATE: 8/17/2009

APPENDIX G: SPANISH PARENT/GUARDIAN CONSENT FORM

Departamento de Psicología

Estimado Padre / Guardián:

Yo soy una estudiante graduada en el Programa de Psicología Clínica de Maestría en la Universidad de Central Florida. Estoy realizando una investigación sobre el desarrollo de la identidad entre los adolescentes que están en servicio con agencias de salud mental. El objetivo de este estudio es explorar la asociación entre el sentimiento propio de los jóvenes y sus problemas de ánimo, ansiedad, enojo y otros que les llevan a buscar ayuda en los servicios de salud mental. También queremos explorar la identidad concerniente a los padres y la concerniente a los adolecentes y sus posibles relaciones. Los resultados del estudio pueden ser utilizados para ayudar a desarrollar programas de intervención que ayuden a los adolescentes que están luchando por cuestiones de identidad. Estos resultados pueden no directamente ayudar a su adolescente hoy, pero puede beneficiar a futuros adolescentes.

A los participantes se les pedirá que complete una encuesta que contiene 95 declaraciones (por ejemplo, "he decidido definitivamente en una carrera") y los adolescentes responderían cuánto están de acuerdo con cada declaración en una escala del 1 al 5, 1 (muy en desacuerdo), 5 (muy de acuerdo). La encuesta le tomará aproximadamente 30 minutos para completar. Las encuestas son estrictamente confidenciales y serán utilizados solamente para esta la investigación de este estudio. El estudio no está asociado con la agencia de ninguna manera. Su participación o no participación no afectará a los servicios con la agencia.

No se conocen los riesgos o beneficios inmediatos para los participantes de este estudio. Aunque es posible que las preguntas y respuestas de la encuesta puedan causar angustia o inquietud, estas reacciones tienden ser muy leve y de corta duración. Sin embargo, si su adolescente le informa de la sensación de angustia al completar esta encuesta, ya sea usted o su adolescente, debe discutir estos sentimientos con la administradora o consejera de esta encuesta. Además, su adolescente tiene el derecho de saltar cualquier pregunta que él o ella no quiera responder y usted o su adolescente tiene el derecho de retirar su consentimiento en cualquier momento y sin consecuencia. No se ofrece una compensación por su participación. Los resultados de este estudio estarán disponibles en agosto de 2009, cuando sea solicitado. Si usted tiene alguna pregunta acerca de este proyecto de investigación, por favor póngase en contacto conmigo al (561) 309-7515 o mi supervisor, el doctor Steven Berman al (386) 506-4049. Si tiene preguntas o preocupaciones acerca de los derechos de los participantes en esta investigación, puede dirigirse a la oficina UCFIRB, la Oficina de Investigación y Comercialización, 12201 Parkway, Suite 501, Orlando, FL 32826-3246. El horario de atencion es entre las 8:00 am hasta las 5:00 pm, de lunes a viernes, excepto en los días feriados de la Universidad de Florida Central. El número de teléfono es (407) 823-2901 o (407) 882-2012.

Atentamente,

Rachel Wiley
Departamento de Psicología,
Universidad de Central Florida, Daytona Beach

___He leído el procedimiento anteriormente descrito.
___Yo, voluntariamente doy consentimiento para que mi adolescente, _____, participe en este estudio de desarrollo de la identidad de adolescentes.

_____/_____
Firme de la madre o guardián Fecha
___Me gustaría recibir una copia de la descripción de procedimiento.

_____/_____
Firma del padre o guardián Fecha

University of Central Florida IRB
IRB NUMBER: SBE-06-03627
IRB APPROVAL DATE: 8/18/2008
IRB EXPIRATION DATE: 8/17/2009

APPENDIX H: ENGLISH PARTICIPANT CONSENT FORM

University of Central Florida

Psychology Department

Dear Participant:

I am a graduate student in Clinical Psychology Masters Program at the University of Central Florida. I am conducting research on identity development among adolescents who enter services in mental health agencies. The purpose of this study is to explore the association between young people's sense of self and their mood problems, anxiety, anger, and other problems that lead them to seek help in mental health services. We also want to explore possible relationships between identity concerns in parents and their adolescents. The results of the study may be used to help develop intervention programs aimed at helping teenagers who are struggling with identity issues. These results may not directly help you today, but may benefit future parents and adolescents.

Participants will be asked to complete a survey containing 95 statements (for example, "I have definitely decided on a career") to which they will respond by rating how much they agree with each statement on a 1 (strongly disagree) to 5 (strongly agree) scale. The survey will take approximately 30-minutes to complete. The surveys are strictly confidential and will be used for research purposes of this study only. The study is not associated with the agency in any way. Participation or nonparticipation will not affect services with the agency.

There are no known risks or immediate benefits to the participants. Although it is possible that by answering questions about your feelings you may experience some mild distress, but such reactions tend to be very mild and short lived. If however you are feeling distressed in any way while completing this survey, you should discuss these feelings with the counselor who is administering this survey. In addition, you have the right to skip any questions you do not want to answer and/or withdraw consent for participation and stop answering the survey at any time without consequence. No compensation is offered for participation. Group results of this study will be available in August 2009 upon request. If you have any questions about this research project, please contact me at (561)309-7515 or my supervisor, Dr. Steven Berman at (386)506-4049. Questions or concerns about research participants' rights may be directed to the UCFIRB office, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246. The hours of operation are 8:00 am until 5:00 pm, Monday through Friday except on University of Central Florida official holidays. The phone number is (407) 823-2901 or (407) 882-2012.

Sincerely,

Rachel Wiley
Psychology Department
University of Central Florida, Daytona Beach

_____I have read the procedure described above.

_____I voluntarily give my consent to participate in Rachel Wiley's study of identity development

_____ / _____ / _____

Print your name Signature Date

UCF **University of Central Florida IRB**
IRB NUMBER: SBE-06-03627
IRB APPROVAL DATE: 8/18/2008
IRB EXPIRATION DATE: 8/17/2009

APPENDIX I: SPANISH PARTICIPANT CONSENT FORM

University of Central Florida

Departamento de Psicología

Estimado Participant:

Yo soy una estudiante graduada en el Programa de Psicología Clínica de Maestría en la Universidad de Central Florida. Estoy realizando una investigación sobre el desarrollo de la identidad entre los adolescentes que están en servicio con agencias de salud mental. El objetivo de este estudio es explorar la asociación entre el sentimiento propio de los jóvenes y sus problemas de ánimo, ansiedad, enojo, entre y otros que les llevan a buscar ayuda en los servicios de salud mental. También queremos explorar la identidad concerniente a los padres y la concerniente a los adolecentes y sus posibles relaciones. Los resultados del estudio pueden ser utilizados para ayudar a desarrollar programas de intervención que ayuden a los adolescentes que están luchando por cuestiones de identidad. Estos resultados pueden no directamente ayudar a su adolescente hoy, pero puede beneficiar a futuros adolescentes.

A los participantes se les pedirá que complete una encuesta que contiene 95 declaraciones (por ejemplo, "he decidido definitivamente en una carrera") y los adolescentes responderían cuánto están de acuerdo con cada declaración en una escala del 1 al 5, 1 (muy en desacuerdo), 5 (muy de acuerdo). La encuesta le tomará aproximadamente 30 minutos para completar. Las encuestas son estrictamente confidenciales y serán utilizadas solamente para la investigación de este estudio. El estudio no está asociado con la agencia de ninguna manera. Su participación o no participación no afectará a los servicios con la agencia.

No se conocen los riesgos o beneficios inmediatos para los participantes de este estudio. Aunque es posible que las preguntas y respuestas de la encuesta puedan causar angustia o inquietud, estas reacciones tienden ser muy leve y de corta duración. Sin embargo, si su adolescente le informa de la sensación de angustia al completar esta encuesta, ya sea usted o su adolescente, debe discutir estos sentimientos con la administradora o consejera de esta encuesta. Además, su adolescente tiene el derecho de saltar cualquier pregunta que él o ella no quiera responder y usted o su adolescente tiene el derecho de retirar su consentimiento en cualquier momento y sin consecuencia. No se ofrece una compensación por su participación. Los resultados de este estudio estarán disponibles en agosto de 2009, cuando sea solicitado. Si usted tiene alguna pregunta acerca de este proyecto de investigación, por favor póngase en contacto conmigo al (561) 309-7515 o mi supervisor, el doctor Steven Berman al (386) 506-4049. Si tiene preguntas o preocupaciones acerca de los derechos de los participantes en esta investigación, puede dirigirse a la oficina UCFIRB, la Oficina de Investigación y Comercialización, 12201 Parkway, Suite 501, Orlando, FL 32826-3246. El horario de atencion es entre las 8:00 am hasta las 5:00 pm, de lunes a viernes, excepto en los días feriados de la Universidad de Florida Central. El número de teléfono es (407) 823-2901 o (407) 882-2012.

Atentamente,

Rachel Wiley
Departamento de Psicología,
Universidad de Central Florida, Daytona Beach

___He leído el procedimiento anteriormente descrito.

___Yo, voluntariamente doy mi consentimiento para participar en el estudio que Rachel Wiley esta realizado en el area de desarrollo e identidad.

_____ _____ / _____
Imprime su nombre Firma Fecha

UCF **University of Central Florida IRB**
IRB NUMBER: SBE-06-03627
IRB APPROVAL DATE: 8/18/2008
IRB EXPIRATION DATE: 8/17/2009

APPENDIX J: ENGLISH RESEARCH SURVEY

BACKGROUND QUESTIONNAIRE

SEX: circle one: MALE FEMALE

GRADE: _____

AGE: ____

IDENTIFICATION NO: _____

Check off the ethnic/racial identifier that best describes you:

___White, non-Hispanic
___Black, non-Hispanic
___Hispanic
___Asian or Pacific Islander
___Native American or Alaskan Native
___Mixed ethnicity, specify: _____
___Other, specify: _____

EIPQ - Read each statement carefully and indicate the degree to which you agree or disagree with each item by circling the answer that best describes you. Please do not omit any items.

SD = Strongly Disagree D = Disagree N = Neutral A = Agree SA = Strongly Agree

1.	I have definitely decided on the occupation (job) I want to pursue…….	**SD**	**D**	**N**	**A**	**SA**
2.	I don't expect to change my political principles and ideals…… …..	**SD**	**D**	**N**	**A**	**SA**
3.	I have considered adopting different kinds of religious beliefs……..	**SD**	**D**	**N**	**A**	**SA**
4.	There has never been a need to question my values (beliefs about what is right and wrong)……	**SD**	**D**	**N**	**A**	**SA**
5.	I am very confident (certain) about which kinds of friends are best for me…….	**SD**	**D**	**N**	**A**	**SA**
6.	My ideas about men's and women's roles have never changed as I became older……..	**SD**	**D**	**N**	**A**	**SA**
7.	I will always vote for the same political party……..	**SD**	**D**	**N**	**A**	**SA**
8.	I have firmly held views concerning my role in my family…….	**SD**	**D**	**N**	**A**	**SA**
9.	I have engaged in several discussions concerning behaviors involved in dating relationships……...	**SD**	**D**	**N**	**A**	**SA**
10.	I have considered different political views thoughtfully……	**SD**	**D**	**N**	**A**	**SA**
11.	I have never questioned my views concerning what kind of friend is best for me……..	**SD**	**D**	**N**	**A**	**SA**
12.	My values (beliefs about what is right and wrong) are likely to change in the future…….	**SD**	**D**	**N**	**A**	**SA**
13.	When I talk to people about religion, I make sure to voice my opinion……..	**SD**	**D**	**N**	**A**	**SA**
14.	I am not sure about what type of dating relationship is best for me…….	**SD**	**D**	**N**	**A**	**SA**
15.	I have not felt the need to reflect on the importance I place on my family……	**SD**	**D**	**N**	**A**	**SA**
16.	Regarding religion, my views are likely to change in the near future……	**SD**	**D**	**N**	**A**	**SA**
17.	I have definite views regarding the ways in which men and women should behave……..	**SD**	**D**	**N**	**A**	**SA**

SD = Strongly Disagree **D = Disagree** **N = Neutral** **A = Agree** **SA = Strongly Agree**

18.	I have tried to learn about different occupational (work) fields to find the one best for me……	**SD**	**D**	**N**	**A**	**SA**
19.	I have undergone several experiences that made me change my views on men's and women's roles...	**SD**	**D**	**N**	**A**	**SA**
20.	I have re-examined many different values (beliefs) in order to find the ones which are best for me…..	**SD**	**D**	**N**	**A**	**SA**
21.	I think that what I look for in a friend could change in the future……	**SD**	**D**	**N**	**A**	**SA**
22.	I have questioned what kind of date is right for me…….	**SD**	**D**	**N**	**A**	**SA**
23.	I am unlikely to alter my vocational (work) goals……	**SD**	**D**	**N**	**A**	**SA**
24.	I have evaluated many ways in which I fit into my family structure……..	**SD**	**D**	**N**	**A**	**SA**
25.	My ideas about men's and women's roles will never change…….	**SD**	**D**	**N**	**A**	**SA**
26.	I have never questioned my political beliefs……..	**SD**	**D**	**N**	**A**	**SA**
27.	I have had many experiences that led me to review the qualities that I would like my friends to have.	**SD**	**D**	**N**	**A**	**SA**
28.	I have discussed religious matters with a number of people who believe differently than I do…….	**SD**	**D**	**N**	**A**	**SA**
29.	I am not sure that the values (beliefs about what is right and wrong) I hold are right for me…….	**SD**	**D**	**N**	**A**	**SA**
30.	I have never questioned my occupational (job) aspirations (goals)…….……	**SD**	**D**	**N**	**A**	**SA**
31.	The extent to which I value my family is likely to change in the future…….	**SD**	**D**	**N**	**A**	**SA**
32.	My beliefs about dating are firmly held……..	**SD**	**D**	**N**	**A**	**SA**

IDS - To what degree have you recently been **upset, distressed,** or **worried** over any of the following issues in your life? (Please select the appropriate response, using the following scale).

NONE **1**	*MILD* **2**	*MODERATE* **3**	*SEVERE* **4**	*VERY SEVERE* **5**

33.	Long term goals? (e.g., finding a good job, being in a romantic relationship, etc.)…….....	**1**	**2**	**3**	**4**	**5**
34.	Career choice? (e.g., deciding on a trade or profession, etc.)……...	**1**	**2**	**3**	**4**	**5**
35.	Friendships? (e.g., experiencing a loss of friends, change in friends, etc.)…….	**1**	**2**	**3**	**4**	**5**
36.	Sexual orientation and behavior? (eg.feeling confused about sexual preferences, intensity of sexual needs)	**1**	**2**	**3**	**4**	**5**
37.	Religion? (e.g., stopped believing, changed your belief in God/religion, etc.)……..……...	**1**	**2**	**3**	**4**	**5**
38.	Values or beliefs? (e.g., feeling confused about what is right or wrong, etc.)……..…….	**1**	**2**	**3**	**4**	**5**
39.	Group loyalties? (e.g., belonging to a club, school group, gang, etc.)……..…….	**1**	**2**	**3**	**4**	**5**
40.	Rate your overall level of ***discomfort*** (how bad they made you feel) about the above issues as a whole…...	**1**	**2**	**3**	**4**	**5**
41.	Please rate how much uncertainty over these issues as a whole has interfered with your life (for example, stopped you from doing things you wanted to do, or being happy)…….....	**1**	**2**	**3**	**4**	**5**

BSI 53 - Below is a list of problems people sometimes have. Read each one carefully and fill in the circle that best describes HOW MUCH THAT PROBLEM HAS **DISTRESSED** OR **BOTHERED** YOU DURING THE **PAST 7 DAYS** INCLUDING TODAY.

1	**2**	**3**	**4**	**5**
Not at all	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**

43. Nervousness or shakiness inside…….	**1**	**2**	**3**	**4**	**5**
44. Faintness or dizziness……..	**1**	**2**	**3**	**4**	**5**
45. The idea that someone else can control your thoughts……	**1**	**2**	**3**	**4**	**5**
46. Feeling others are to blame for most of your troubles…….	**1**	**2**	**3**	**4**	**5**
47. Trouble remembering things……	**1**	**2**	**3**	**4**	**5**
48. Feeling easily annoyed or irritated……...	**1**	**2**	**3**	**4**	**5**
49. Pains in heart or chest……...	**1**	**2**	**3**	**4**	**5**
50. Feeling afraid in open spaces or on the streets…….	**1**	**2**	**3**	**4**	**5**
51. Thoughts of ending your life……	**1**	**2**	**3**	**4**	**5**
52. Feeling that most people cannot be trusted……..	**1**	**2**	**3**	**4**	**5**
53. Poor appetite……..	**1**	**2**	**3**	**4**	**5**
54. Suddenly scared for no reason……..	**1**	**2**	**3**	**4**	**5**
55. Temper outbursts that you could not control……	**1**	**2**	**3**	**4**	**5**
56. Feeling lonely even when you are with people……	**1**	**2**	**3**	**4**	**5**
57. Feeling blocked in getting things done…….	**1**	**2**	**3**	**4**	**5**
58. Feeling lonely……...	**1**	**2**	**3**	**4**	**5**
59. Feeling blue……..	**1**	**2**	**3**	**4**	**5**
60. Feeling no interest in things……	**1**	**2**	**3**	**4**	**5**
61. Feeling fearful……..	**1**	**2**	**3**	**4**	**5**
62. Your feelings being easily hurt……	**1**	**2**	**3**	**4**	**5**
63. Feeling that people are unfriendly or dislike you……	**1**	**2**	**3**	**4**	**5**
64. Feeling inferior to others…….	**1**	**2**	**3**	**4**	**5**
65. Nausea or upset stomach……	**1**	**2**	**3**	**4**	**5**
66. Feeling that you are watched or talked about by others……..	**1**	**2**	**3**	**4**	**5**
67. Trouble falling asleep…….	**1**	**2**	**3**	**4**	**5**
68. Having to check and double-check what you do……...	**1**	**2**	**3**	**4**	**5**

1 Not at all	2 A little bit	3 Moderately	4 Quite a bit	5 Extremely

69. Difficulty making decisions……...**1 2 3 4 5**

70. Feeling afraid to travel on buses, subways, or trains……**1 2 3 4 5**

71. Trouble getting your breath……...**1 2 3 4 5**

72. Hot or cold spells……...**1 2 3 4 5**

73. Having to avoid certain things, places, or activities, because they frighten you……...**1 2 3 4 5**

74. Your mind going blank……..**1 2 3 4 5**

75. Numbness or tingling in parts of your body……**1 2 3 4 5**

76. The idea that you should be punished for your sins……**1 2 3 4 5**

77. Feeling hopeless about the future……**1 2 3 4 5**

78. Trouble concentrating……..**1 2 3 4 5**

79. Feeling weak in parts of your body……**1 2 3 4 5**

80. Feeling tense or keyed up……**1 2 3 4 5**

81. Thoughts of death or dying……**1 2 3 4 5**

82. Having urges to beat, injure, or harm someone……..**1 2 3 4 5**

83. Having urges to break or smash things……...**1 2 3 4 5**

84. Feeling very self-conscious with others……..**1 2 3 4 5**

85. Feeling uneasy in crowds, such as shopping or at a movie……**1 2 3 4 5**

86. Never feeling close to another person……**1 2 3 4 5**

87. Spells of terror or panic…….....**1 2 3 4 5**

88. Getting into frequent arguments……..**1 2 3 4 5**

89. Feeling nervous when you are left alone……**1 2 3 4 5**

90. Others not giving you proper credit for your achievements…….....**1 2 3 4 5**

91. Feeling so restless you couldn't sit still……...**1 2 3 4 5**

92. Feelings of worthlessness…….....**1 2 3 4 5**

93. Feeling that people will take advantage of you if you let them……...**1 2 3 4 5**

94. Feelings of guilt……**1 2 3 4 5**

95. The idea that something is wrong with your mind……...**1 2 3 4 5**

APPENDIX K: SPANISH RESEARCH SURVEY

CUESTIONARIO DEMOGRAFICO

Seleccion: Femenino_____ Masculino_____

Nivel educativo _____

Edad: ____

EIPQ – Usando la siguiente escala indique su grado de acuerdo o desacuerdo con los siguientes comentarios:

TD = Totalmente en Desacuerdo D = Mas o menos en Desacuerdo N = Neutral A = Mas o menos de Acuerdo

TA = Totalmente de Acuerdo

---

1. He decidido definitivamente la ocupación a la que deseo dedicarme.……..……**TD D N A TA**
2. No espero cambiar mis principios políticos o ideales.……...….**TD D N A TA**
3. He considerado adoptar creencias religiosas diferentes a las que actualmente tengo.…….…...**TD D N A TA**
4. Nunca ha habido necesidad de cuestionar mis valores.……**TD D N A TA**
5. Me siento muy seguro de las amistades que más me convienen.…….**TD D N A TA**
6. A medida que he crecido, mis ideas acerca de los roles de los hombres y las mujeres nunca ha cambiado. **TD D N A TA**
7. Siempre votaré por el mismo partido político.……..**TD D N A TA**
8. He mantenido ideas firmes frente al rol que desempeño dentro de mi familia.……..……..**TD D N A TA**
9. He participado en varias discusiones acerca de comportamientos involucrados en relaciones de pareja **TD D N A TA**
10. He considerado seriamente diferentes perspectivas políticas.……...**TD D N A TA**
11. Nunca he cuestionado mi posición frente a las amistades que mas me convienen.……..…**TD D N A TA**
12. Es posible que mis valores cambien en un futuro.……..**TD D N A TA**
13. Cuando hablo con la gente de religión, me aseguro de expresar mi opinión.……..……..**TD D N A TA**
14. No estoy seguro del tipo de relación amorosa que conviene.…….……**TD D N A TA**
15. No he sentido la necesidad de reflexionar a cerca de la importancia de mi rol dentro de mi familia....**TD D N A TA**
16. Respecto a la religión, es posible que cambie mi posición frente a ésta en un futuro cercano.…….….**TD D N A TA**
17. Tengo una posición clara frente a los comportamientos que deberían presentar los hombres y las mujeres. **TD D N A TA**
18. He intentado aprender acerca de las diferentes ocupaciones y encontrar la mejor para mi.……**TD D N A TA**
19. He vivido determinadas experiencias que me han llevado a cambiar mi posición frente a los roles masculinos y femeninos. **TD D N A TA**
20. He reexaminado constantemente diferentes valores con el fin de encontrar aquellos mas adecuados para mí. **TD D N A TA**
21. Pienso que en un futuro podría cambiar aquellas cosas que busco en un amigo.…… **TD D N A TA**

22. He cuestionado el tipo de relación amorosa que es adecuada para mí.……**TD D N A TA**

23. Es poco probable que cambie mis metas vocacionales.……..……**TD D N A TA**

24. He evaluado las muchas maneras en las que encajo dentro de mi estructura familiar……..**TD D N A TA**

25. Mis ideas acerca de los roles masculinos y femeninos nunca cambiaran.……..**TD D N A TA**

26. Nunca he cuestionado mis creencias políticas.…….……..…..**TD D N A TA**

27. He tenido muchas experiencias que me han llevado a replantear las cualidades que me gustaría encontrar en mis amigos.
TD D N A TA

28. He discutido temas religiosos con personas que tienen creencias diferentes a las mías.……**TD D N A TA**

29. No estoy seguro de que los valores que actualmente tengo son los adecuados para mi.……....**TD D N A TA**

30. Nunca he cuestionado mis aspiraciones ocupacionales.……..…**TD D N A TA**

31. Es probable que cambie en el futuro el grado que valoro mi familia.……... **TD D N A TA**

32. Mis creencias frente a las relaciones amorosas son firmes.……..……..**TD D N A TA**

IDS - A que grado ha estado recientemente preocupado de las siguientes situaciones de su vida?

NUNCA	**UN POCO**	**MODERADO**	**SEVERO**	**MUY SEVERO**
1	**2**	**3**	**4**	**5**

33. Metas de largo plazo? (e.g. encontrando un buen trabajo, estando en una relación romántica, etc.).…..**1 2 3 4 5**

34. Carrera? (e.g. decidiendo escojer un profesión o negocio, etc.)……..……..**1 2 3 4 5**

35. Amistades? (e.g. experiencas perdiendo un amigo, cambios de amigos, etc.)…….…….**1 2 3 4 5**

36. Conducta y orientación sexual? (e.g. sentiendo confusión con preferencias sexual o intensida de necesidades sexual, etc.)
1 2 3 4 5

37. Religión? (e.g. dejó de creer, cambió su creencia en Dios/religión, etc.)……..……...**1 2 3 4 5**

38. Valores o creencias? (e.g. sentiéndose confuso sobre qué es correcto o incorrecto, etc.)……..….**1 2 3 4 5**

39. Lealtad de grupo? (e.g. perteneciendo a un club, grupo de escuela, pandilla, etc.)……..……..….**1 2 3 4 5**

40. Por favor clasifique su nivel de incomodidad (cuan mal te han echo sentir) sobre éstas situaciones a nivel general.
1 2 3 4 5

41. Por favor clasifique a qué nivel su estado de inconformidad general ha interferido con su vida (por ej: si impidió que ud. hiziera cosas que deseaba hacer, o le afectó en su felicidad). ……..……..**1 2 3 4 5**

42. Por cuánto tiempo te has sentido (trastornado, maybe tensionado o preocupado, sobre estas situaciones a nivel general?

Nunca o menos de un mes	**1-3 Meses**	**3-6 Meses**	**6-12 Meses**
1	**2**	**3**	**4**

BSI 53 - A continuación se encuentra una lista de problemas que la gente presentan en ocasiones. Responda indicando cuánto le ha afectado cada problema durante la última semana, incluyendo el día de hoy.

1 Para Nada	2 Un Poco	3 Moderadamente	4 Bastante	5 Extremadamente

43. Nerviosismo o temblores internos.……**1 2 3 4 5**

44. Debilidad o mareos ……....**1 2 3 4 5**

45. La idea de que otra persona puede controlar tus pensamientos ……..…**1 2 3 4 5**

46. Sentimientos de que otros son culpables de la mayoría de tus problemas. ……**1 2 3 4 5**

47. Dificultad para recordar cosas ……..…**1 2 3 4 5**

48. Sentirse molesto(a) o irritado(a) fácilmente ……..……...**1 2 3 4 5**

49. Dolores en el corazón o en el pecho ……...**1 2 3 4 5**

50. Sentimientos de miedo en espacios abiertos o en la calle. ……**1 2 3 4 5**

51. Pensamientos de terminar con tu vida. ……**1 2 3 4 5**

52. Sentimientos de que no se puede confiar en la mayoría de la gente. ……...**1 2 3 4 5**

53. Poco apetito ……..…**1 2 3 4 5**

54. Asustarse repentinamente sin razón ……..……...**1 2 3 4 5**

55. Explosiones de mal genio que no puedes controlar. ……**1 2 3 4 5**

56. Sentimientos de soledad aunque estés acompañado(a). ……**1 2 3 4 5**

57. Sentirse bloqueado(a) al intentar hacer cosas ……**1 2 3 4 5**

58. Sentirse solo (a). …..……...**1 2 3 4 5**

59. Sentirse triste. ……...**1 2 3 4 5**

60. Sentir desinterés frente a las cosas. ……**1 2 3 4 5**

61. Sentimientos de miedo ……..……...**1 2 3 4 5**

62. Tus sentimientos se hieren fácilmente. ……...……**1 2 3 4 5**

63. Sentimientos que la gente no es amigable contigo. ……**1 2 3 4 5**

64. Sentimientos de inferioridad frente a los demás.……**1 2 3 4 5**

65. Nauseas o molestias estomacales. ……**1 2 3 4 5**

66. Sentimientos de ser observado o que la gente habla de ti. ……...……..**1 2 3 4 5**

67. Dificultad para quedarse dormido. ……**1 2 3 4 5**

68. Necesidad de revisar varias veces lo que haces. ……...**1 2 3 4 5**

69. Dificultad para tomar decisiones. ……...**1 2 3 4 5**

1 2 3 4 5

Para Nada	Un Poco	Moderadamente	Bastante	Extremadamente

70. Miedo al viajar en buses o trenes ……...……**1 2 3 4 5**

71. Dificultad para respirar ……...**1 2 3 4 5**

72. Ataques de calor o frío. ……...**1 2 3 4 5**

73. La necesidad de evitar ciertas cosas, sitios o actividades por miedo ……...……...**1 2 3 4 5**

74. Sentir que tu mente queda en blanco ……..**1 2 3 4 5**

75. Sentir partes de tu cuerpo entumecidas o dormidas. ……...……**1 2 3 4 5**

76. Tener ideas de que deberías ser castigado por tus pecados ……..**1 2 3 4 5**

77. Sentirse sin esperanzas frente al futuro ……...……**1 2 3 4 5**

78. Dificultad para concentrarse ……...……..**1 2 3 4 5**

79. Sentir debilidad en partes del cuerpo ……...……**1 2 3 4 5**

80. Sentirse tenso(a). ……...……**1 2 3 4 5**

81. Pensamientos sobre la muerte o sobre morirse ……**1 2 3 4 5**

82. Tener el impulso de golpear o herir a alguien. ……..**1 2 3 4 5**

83. Tener el impulso de romper o dañar cosas. ……...**1 2 3 4 5**

84. Sentimientos de estar cohibido por otras personas.……...……..**1 2 3 4 5**

85. Sentimientos de incomodidad en sitios donde hay muchas personas, como en centros comerciales o en cine.
1 2 3 4 5

86. Nunca sentirse cercano(a) a otra persona. ……**1 2 3 4 5**

87. Ataques de terror o pánico ..……..**1 2 3 4 5**

88. Involucrarse en discusiones frecuentemente. ……...……..**1 2 3 4 5**

89. Sentimientos de nerviosismo cuando te dejan solo(a). ……..……**1 2 3 4 5**

90. No recibir crédito por parte de otros frente a tus logros ……..**1 2 3 4 5**

91. Sentimientos de intranquilidad que te impiden estar quieto(a). ……..……...**1 2 3 4 5**

92. Sentimientos de que no vales nada ……..……..**1 2 3 4 5**

93. Sentimientos de que la gente se va aprovechar de ti si los dejas. ……...**1 2 3 4 5**

94. Sentimientos de culpa……**1 2 3 4 5**

95. Tener la idea de que algo está mal con tu mente. .....……...**1 2 3 4 5**

APPENDIX L: DEFINITION OF THE BRIEF-SYMPTOM INVENTORY SYMPTOM DIMENSIONS

1: Somatization (SOM)

The Somatization dimension reflects distress arising from perceptions of bodily dysfunction. Items focus on cardiovascular, gastrointestinal, and respiratory complaints; other symptoms with strong autonomic mediation are included as well. Pain and discomfort of the gross musculature and additional somatic equivalents of anxiety are also components of somatization.

Symptoms of the Somatization Dimension

Item	Symptom
2	Faintness or dizziness
7	Pains in heart or chest
23	Nausea or upset stomach
29	Trouble getting breath
30	Hot or cold spells
33	Numbness or tingling in parts of your body
37	Feeling weak in parts of your body

2: Obsessive Compulsive (O-C)

The Obsessive-Compulsive dimension includes symptoms that are often identified with the standard clinical syndrome of the same name. This measures focuses on thoughts, impulses, and actions that are experienced as unremitting and irresistible by the individual, but are of an ego-alien or unwanted nature. Behavior and experiences of a more general cognitive performance deficit are also included in this measure.

Symptoms of the Obsessive-Compulsive Dimension

Item	Symptom
5	Trouble remembering things
15	Feeling blocked in getting things done
26	Having to check and double-check what you do
27	Difficulty making decisions
32	Your mind going blank
36	Trouble concentrating

3. Interpersonal Sensitivity (I-S)

The Interpersonal Sensitivity dimension centers on feelings of personal inadequacy and inferiority, particularly in comparison with others. Self-deprecation, self-doubt, and marked discomfort during interpersonal interactions are characteristic manifestations of this syndrome.

Symptoms of the Interpersonal Sensitivity Dimension

Item	Symptom
20	Your feelings being easily hurt
21	Feeling that people are unfriendly or dislike you
22	Feeling inferior to others
42	Feeling very self-conscious with others

4: Depression (DEP)

The symptoms of the Depression dimension reflect a representative range of the indications of clinical depression. Symptoms of dysphoric mood and affect are represented as are lack of motivation and loss of interest in life.

Symptoms of the Depression Dimension

Item	Symptom
9	Thoughts of ending your life
16	Feeling lonely
17	Feeling blue
18	Feeling no interest in things
35	Feeling hopeless abut the future
50	Feelings of worthlessness

5: Anxiety (ANX)

General signs such as nervousness and tension are included in the Anxiety dimension, as are panic attacks and feelings of terror. Cognitive components involving feelings of apprehension and some somatic correlates of anxiety are also included as dimensional components.

Symptoms of the Anxiety Dimension

Item	Symptom
1	Nervousness or shakiness inside
12	Suddenly scared for no reason
19	Feeling Fearful
38	Feeling tense or keyed up
45	Spells of terror or panic
49	Feeling so restless you couldn't sit still

6: Hostility (HOS)

The Hostility dimension includes thoughts, feelings, or actions that are characteristic of the negative affect state of anger.

Symptoms of the Hostility Dimension

Item	Symptom
6	Feeling easily annoyed or irritated
13	Temper outbursts that you could not control
40	Having urges to beat, injure, or harm someone
41	Having urges to break or smash things
46	Getting into frequent arguments

7: Phobic Anxiety (PHOB)

Phobic Anxiety is defined as a persistent fear response – to a specific person, place, object, or situation – that is irrational and disproportionate to the stimulus and leads to avoidance or escape behavior. The items of this dimension focus on the more pathognomonic and disruptive manifestations of phobic behavior. Phobic anxiety is very similar to agoraphobia, and has been termed "phobic anxiety depersonalization syndrome.

Symptoms of the Phobic Anxiety Dimension

Item	Symptom
8	Feeling afraid in open spaces or on the streets
28	Feeling afraid to travel on buses, subways, or trains
31	Having to avoid certain things, places, or activities because they frighten you
43	Feeling uneasy in crowds, such as shopping or at a movie
47	Feeling nervous when you are left alone

8: Paranoid Ideation (PAR)

The Paranoid Ideation dimension represents paranoid behavior fundamentally as a disordered mode of thinking. The cardinal characteristics of projective thought, hostility, suspiciousness, grandiosity, centrality, fear of loss of autonomy, and delusions are viewed as primary aspects of this disorder. Item selection was oriented toward representing this conceptualization.

Symptoms of the Paranoid Ideation Dimension

Item	Symptom
4	Feeling others are to blame for most of your troubles
10	Feeling that most people cannot be trusted
24	Feeling that you are watched or talked about by others
48	Others not giving you proper credit for your achievements
51	Feeling that people will take advantage of you if you let them

9: Psychoticism (PSY)

The Psychoticism scale was developed to represent the construct as a continuous dimension of human experience. Items indicative of a withdrawn, isolated, schizoid lifestyle were included, as were first-rank symptoms of schizophrenia, such as thought control. This scale provides for a graduated continuum from mild interpersonal alienation to dramatic psychosis.

Symptoms of the Psychoticism Dimension

Item	Symptom
3	The idea that someone else can control your thoughts
14	Feeling lonely even when you are with people
34	The idea that you should be punished for your sins
44	Never feeling close to another person
53	The idea that something is wrong with your mind

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