IDENTITY CONFUSION AND DEPRESSION IN GROUPS OF ADOLESCENTS HAVING PSYCHIATRIC AND PHYSICAL SYMPTOMS*

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SUMMARY: Çuhadaroğlu F. (Department of Child and Adolescent Psychiatry, Hacettepe University Faculty of Medicine, Ankara, Turkey). Identity confusion and depression in groups of adolescents with psychiatric and physical symptoms. Turk J Pediatr 1999; 41: 73-79.

The aim of this study was to investigate the identity status of adolescents having psychiatric and physical symptoms and the relation of depression with identity problems in adolescence. Three groups of university students were given a sociodemographic questionnaire, Beck Depression Inventory (BDI) and Sense of Identity Assessment Form (SIAF). The first group consisted of 31 students who were seen by the consultant psychiatrist at the Student Health Center of a university in Ankara. The second group included 37 students who applied to the same center with various physical complaints but did not need to be consulted by the psychiatrist. The third group was a group of 50 healthy students at the same university. The analysis revealed that only those with psychiatric complaints had identity confusion and that for the males in this group depressive symptoms are significant predictors of identity confusion. *Key words: adolescence, depression, identity.*

The major developmental task of adolescence is identity formation. As Erikson[1] has stated, the adolescent gains a sense of identity by going through a crisis during which all past identifications and perceptions about oneself are mixed to form a unique integrated sense of identity. If an integrated sense of identity cannot be established by the end of adolescence, it leads to a state of identity confusion which is characterized by undecisiveness, giving up easily, inability to concentrate on tasks, self-consciousness, loss of self-esteem, avoidance of intimate relations, uncertainty about future aims, and inability to make a clear description of self. Marcia et al.[2] was the first to try measuring what Erikson has put forward about identity. As the result of their studies with adolescents they discriminated four identity status groups:

1. Achievers: Those who survived the identity crisis and developed an identity of their own with their own value systems.
2. Those in moratorium: Adolescents who are still living the identity crisis.
3. Foreclosures: Those who formed their identity by the values of their parents without going through an identity crisis.
4. Identity confusion: Those who could not finish the identity crisis and are having problems at a pathological level.

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The studies done using Marcia et al.'s identity status groups showed no gender difference in distribution of each identity status[3-5]; however, males were more often achievers and females, foreclosures[6].

Later Benion and Adams[7] developed the Scale for the Objective Measure of Ego Identity Status Validity and reliability studies of this scale have been done for Turkish adolescents[8], but is not used widely. In 1994 Dereboy and colleagues[9] developed the Sense of Identity Assessment Form (SIAF). Validity and reliability studies of this scale showed that it is efficient for clinical purposes[9].

Erikson[10] states that identity confusion is not a descriptive diagnosis but a psychodynamic condition; however, it may lead to different kinds of psychiatric disorders. The clinical importance of this subject is at the point of discriminating the underlying causes of psychiatric disorders seen in adolescents. Whether or not the psychiatric disorder is the manifestation of an underlying identity confusion is an important factor in determining the treatment plan for the youth. It was shown that adolescents with various psychiatric disorders treated only with medication had a recurrence of the symptoms in short period of time. Only when they were reexamined for underlying identity confusions and treated with both medication and psychotherapy for the resolution of the identity confusion were they cured[11].

Another important point in evaluating adolescent development from the aspect of identity status is in determining the psychiatric risk factors for adolescents. It was shown that adolescents with identity confusion are vulnerable to various psychiatric disorders[12]. In two studies with university students, it was found that 70-80 percent of university students with different psychiatric diagnoses were suffering from identity problems psychodynamically[13, 14]. Ten percent of those suffering from identity problems visited physicians with different kinds of somatic symptoms before they were consulted by the psychiatrist[13].

The aim of this study was to investigate the identity status and its relationship to psychopathology among adolescents. It is hypothesized that the psychiatric states seen among youth are related to underlying identity confusion.

Material and Methods

The sample consisted of three groups of adolescents: The research group consisted of 31 consecutive students (16 females, 15 males) who came to see the psychiatrist in the Health Center of Bilkent University in Ankara. The first control group was formed by 37 students (10 females, 27 males) who applied to the same center with only physical complaints and did not need to be consulted by the psychiatrist. The second control group was a group of 50 healthy students (27 females, 23 males) selected randomly in one of the faculties of the same university.

Each group was given a sociodemographical questionnaire, Beck Depression Inventory (BDI) and Sense of Identity Assesment Form (SIAF). Beck Depression Inventory (BDI) is made up of 21 items related to depression, each rated on a zero-to-three point scale. The reliability and validity of BDI was tested among Turkish university students and the cut-off point for depression was found to be 17[15]. The Sense of Identity Assessment Form (SIAF), developed in Turkey, consists of 28 items, each questioning different aspects of identity development. Its reliability and validity have been tested among university students using the Rosenberg Self-Esteem Scale[16] and the Offer Self-Image Questionnaire[17], which have been widely used in studies in this country[18-21]. The cut-off point for identity confusion is 70 on the SIAF[9].

All analyses were done on a personel computer using SPSS. Sociodemographical factors were analyzed by chi-square test. One way ANOVA was used in evaluating BDI and SIAF scores between groups, and post-hoc analyses were done by t-tests. T-tests were also applied for comparisons between genders in the same group. Correlation analysis was done to see the relation between BDI and SIAF scores.

Results

Sociodemographical factors

The average age of the two patient groups was 21 and of the control group was 20. School achievement was average for all groups. The majority of the two patient groups were living in the dormitory while most of the healthy students were with their families ($\chi^2 = 14.62$, $p = 0.02$).

The questions on family relations were evaluated as "no problems", "some problems" and "frequent problems". Those with psychiatric complaints considered their family relations more conflicting when compared to the other two groups ($\chi^2 = 10.28$, $p = 0.035$). Mother's educational level was lower in the research group ($\chi^2 = 26.54$, $p = 0.002$).

Factors such as socioeconomic status, number of siblings, birth order, structure of the family, age and profession of the parents, and father's educational level did not show any significant difference between groups.

BDI Results

Depressive symptom scores were above the cut-off point in the group with psychiatric complaints ($F = 19.20$, $p = 0.04$) (Table I). There was no difference between the females of the two patient groups. However, the males in the first group were differentiated from the other two groups of males by their high BDI scores ($F = 15.22$, $p = 0.00$). Within the two control groups, females had a

significantly higher score than males (t = 3.49, p = 0.001 and t = 3.36, p = 0.001). This gender difference disappeared in the first group due to the elevated BDI scores of the males (t = 61, p = 0.55).

Table I: BDI Scores Among Groups and Genders

Gender	Group 1	Group 2	Group 3	F	p
Females	21.43	18.11	12.64	8.66	0.001
Males	19.33	8.80	7.95	15.22	0.00
Total	20.42	11.36	10.62	19.20	0.04
t	0.61	3.49	3.36		
p	0.55	0.001	0.001		

SIAF Results

The distribution of SIAF scores among groups and genders is given in Table II. Sense of identity assessment form (SIAF) scores were above the cut-off point only in the research group; the difference of scores between the groups was found significant by variance analysis (F = 21.38, p = 0.000). This difference is reflected both in comparison of girls among groups (F = 8.30, p = 0.001) and in comparison of boys among groups (F = 15.28, p = 0.000).

Table II: SIAF Scores Among Groups and Genders

Gender	Group 1	Group 2	Group 3	F	p
Females	74	59	53	8.30	0.001
Males	76	50	48	15.28	0.00
Total	75	52	51	21.38	0.00
t	25	1.50	1.39		
p	0.80	0.142	0.16		

Correlations of SIAF with age and gender are given in Table III. No significant correlations were found between SIAF scores and either age or gender in either of the groups.

Table III: Correlations of SIAF with Age and Gender

Variable		Group I	Group 2	Group 3
Age	r	0.055	0.221	-0.036
	p	0.770	0.200	0.130
Gender	r	0.046	-0.253	-0.140
	p	0.800	0.140	0.170

Because SIAF scores were found to discriminate the psychiatric patients from the other two groups, the correlations of SIAF with sociodemographical factors discriminitive for the same group (educational level of the mother and family relations) were analyzed. The results revealed that SIAF is not correlated with these two variables ($r = 0.146$ and $r = 0.153$).

The only sociodemographical factor which showed a significant correlation with SIAF scores was family structure in the research group ($r = 0.378$, $p = 0.036$).

In all groups SIAF and BDI scores were significantly correlated.

Discussion

Sense of identity assessment form (SIAF) scores were found above the cut-off point for identity confusion only in the group of students having psychiatric complaints. This result confirms the hypothesis we made, that is, adolescents with psychiatric symptoms are suffering from identity confusion significantly more than those having only physical symptoms and healthy adolescents. It can be concluded that the state of identity development, or identity confusion in this research, is an important factor underlying the psychiatric symptoms of adolescents.

Sense of identity, measured by SIAF, is not related to age or gender differences. This result is compatible with the results of some other studies in the literature[8-10, 14]. This again shows that adolescents having psychiatric symptoms are discriminated from the other two groups by their state of identity confusion which is independent of age or gender.

The only sociodemographical factor correlated with SIAF in this group was the structure of the family (intact or broken). The anxiety provoked by separations within the family is thought to have an important impact on young people's perception of parental and self roles and on the development of a sense of identity, thus resulting in an increase of identity problems.

In all groups sense of identity is affected by depressive symptoms. This effect is more prominent among males with psychiatric problems. The ratio of SIAF scores between the two sexes was altered in this group. The SIAF scores of females were higher in the two control groups, whereas there was a significant increase in the scores of males with psychiatric problems. Also, these males were differentiated from the other two groups of males by their high depressive symptom scores; such a significant difference was not found for females. In most of the studies done with adolescents, females are found to be more depressive than males. However, in this study, when the genders were evaluated for depression in terms of the state of identity confusion, no difference of depressive symptoms between males and females having identity problems was found. The females in all three groups were alike in their depressiveness and there was not an increase

of depressive symptoms among girls having identity problems. However, in males with identity confusion, depressive symptoms increased to the level of clinical depression (only this group of males had BDI scores above the cut-off point for clinical depression). Thus, depression discriminates males having identity confusion both from the other groups of males and also from the females having identity problems. It can be concluded that the depression seen in male adolescents is an important factor in predicting the underlying identity diffusion. This result has clinical importance for pediatricians working with adolescents, showing a more severe indication of psychiatric consultation when there is a depressed boy. For psychiatrists working with adolescents, the results of this study point to the importance of identity problems underlying psychiatric symptoms in adolescents. These adolescents should be evaluated psychodynamically and treated by psychotherapy in addition to drug treatment. The second point is the predictive value of depression for identity problems in male adolescents. Since there is not much research data on the depressive symptoms of male adolescents, it can be suggested that future research involve surveys of depression and identity problems in normal male adolescents and the factors related to them. Another subject for future research research would be investigating predictive factors of identity problems among female adolescents.

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