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Profiles of Adolescent Identity Development: Response to an Intervention for Alcohol/Other Drug Problems

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Abstract

The purpose of this study was to examine identity development among adolescents participating in an after-school alcohol/other drug (AOD) abuse intervention program (8 females and 12 males, ages 14–17) to identify how identity development was associated with intervention success. To achieve this goal we (a) garnered information from two identity interviews conducted during the first week of the intervention and 6 to 8 weeks later; (b) adopted a qualitative, person-centered analytical strategy to identify identity profiles; and (c) examined the intervention response of the adolescents, as recorded in intervention documents, in the different identity profile groups. Analyses revealed five identity profiles wherein adolescents differed in their responses to the "identity challenges" encountered in the intervention. Implications for AOD interventions are discussed.

KEYWORDS Adolescent identity formation, troubled youth, intervention response, person-centered approach

Experimentation with alcohol and other drugs (AOD) is common during adolescence (Substance Abuse and Mental Health Services Administration

[SAMHSA], Office of Applied Statistics, 2007), the period when identity issues first come to the forefront (Erikson, 1968). For some adolescents, experimentation leads to AOD problems that may be severe enough to gain the attention of others and result in the adolescent's placement in treatment or other intervention settings. Both public and private health care systems provide help for adolescents with AOD problems; however, many adolescents who are treated relapse within 3 to 6 months (Brown, Anderson, Ramo, & Tomlinson, 2006). Although gains have been made in improving adolescent interventions (see Wagner, Brown, Monti, Myers, & Waldron, 1999), some argue that the field would benefit from integrating AOD intervention research and applied developmental science research (Holmbeck, Greenley, & Franks, 2003). This integration would serve to promote the availability of AOD interventions that are optimally effective because they are developmentally appropriate for adolescents (e.g., tailored to the skills, limitations, and needs of adolescents at different stages of development; Lowman, 2004; Montgomery, Hernandez, & Ferrer-Wreder, 2008). At the same time, the integration of AOD intervention research and applied development research would help to evaluate under what developmental conditions current interventions are successful (Arnett, Montgomery, & Kurtines, 2008; Holmbeck et al., 2003; Mason et al., 2007). This study focuses on the second initiative. Specifically we sought to evaluate how amenability to a typical AOD intervention differs, based on the adolescent's level of identity development.

IDENTITY DEVELOPMENT

During adolescence, changes in biological, psychological, and social domains converge to enhance the individual's capacity for self-definition and self-direction. Scholars who study adolescent psychosocial development have framed this capacity for self-direction and the resulting self-definition that occurs as "identity." The questions of who one is and what one will become are salient for most adolescents (Erikson, 1968), and according to psychosocial theory and research, an adolescent's experimentation with various roles and behaviors fosters one's sense of self and identity. Along with identity questions, young people are faced with personal decisions about when, where, how much, and with whom they will explore and experiment. While most adolescents eventually commit to a positive, coherent identity that will guide them in making choices leading to a healthy adulthood, some will instead cultivate a deviant or "negative" identity (Erikson, 1968) which may include an identity as a "user."

Operationalizing Erikson's psychosocial theory of identity development, Marcia (1993) developed the identity status model, which evaluates two relevant identity processes: exploration and commitment. Exploration refers to the process whereby adolescents question previous identifications and

explore personally meaningful social roles and ideals. Commitment refers to the degree of personal investment in chosen roles and ideals and reflects the outcome of the exploration process. Each person can be classified as having one of four identity statuses: (1) identity achievement, which is characterized by either past or present active, meaningful exploration followed by a high degree of commitment; (2) identity moratorium, which reflects the quest for personal achievement but lacks the personal investment; (3) identity foreclosure, which is characterized by strong commitments with little meaningful exploration; and (4) identity diffusion, which is characterized by neither commitment nor exploration.

The range of identity resolutions, from diffuse to achieved, have been shown to be related to AOD use among adolescents. Across studies, the diffuse identity status is most highly associated with problem behaviors commonly presented to intervention settings (e.g., AOD use, delinquency; Jones, 1992). These findings suggest that diffuse individuals, who often lack impulse control and who look outside the self for solutions to current problems, are more likely to engage in AOD use (Jones & Hartmann, 1988). On the other hand, the foreclosed status is least likely to be associated with AOD use, possibly due to the tendency of foreclosed adolescents to commit (without exploration) to normative roles and values (Christopherson, Jones, & Sales, 1988). Among adolescents classified as achieved or moratorium, AOD use is typically occasional or moderate. This may be explained by the fact that those classified in an achievement or moratorium identity status often attribute their AOD use to curiosity and recreation motives (Christopherson et al., 1988). Given these differences in the prevalence and frequency of AOD use among adolescents in different identity statuses, one's level of identity development may also play a role in the success of AOD treatment.

IDENTITY AND INTERVENTION

Identity theory and research appears to be promising for informing AOD use interventions and adolescents' differential response to them (Cantor, 2000; Lowe & Mascher, 2002). AOD interventions encourage adolescents to not only change their AOD behaviors, but, ultimately, how they see themselves (Kellogg, 1993; Stall & Biernacki, 1986). However, treatment interventions that implicitly target identity restructuring may not take into account the developmental needs of the adolescent or the long-term impact of their interventions. Instead, the focus is on short-term behavioral gains and reductions in risk behaviors (Schulenberg, Maggs, Steinman, & Zucker, 2001). The importance of focusing on identity development was demonstrated in a recent study where individuals in intervention programs who had a diffuse identity had shorter lengths of continuous abstinence, fewer recovery-oriented behaviors, lower quality of recovery, and less recovery progress,

suggesting an important relationship between identity and intervention outcomes (White, Montgomery, Wampler, & Fischer, 2003).

PURPOSE OF THE STUDY

The purpose of this study was to assess how troubled adolescents respond to an AOD intervention based on their identity development. To achieve this goal we adopted a qualitative, person-centered analytical strategy to classify adolescents into distinct identity profiles, similar to an identity status. Although the identity status model provides a framework for such analyses, very little attention has been devoted to the types of "negative" identities that adolescents may develop. Therefore a new approach was adopted to help to uncover these unique processes. Person-centered analyses have been recently applied in developmental psychopathology research in order to examine individual development and the various trajectories that development may take (Bergman & Magnusson, 1997). When using a person-centered analysis, attention is drawn to the individual as a "gestalt," dynamically interacting within the context in which he or she is embedded. In this study, identity exploration and commitment were evaluated in the context of parents and friends and were used to identify developmentally unique identify profiles.

The identification of identity profiles was the first step in this research process and is presented in detail elsewhere (see Forthun, Montgomery, & Bell, 2006). For this article, we sought to take the next step and examine differences in intervention processes and outcomes based on identity profiles. Participant records were evaluated to identify themes that characterized the adolescents' experiences in the intervention program. Themes were then compared within and between profiles to evaluate commonalities. In this manner, differential processes and outcomes of the intervention could be evaluated based on the adolescents' profiles of identity development.

METHOD

Sample and Procedures

The sample included 20 adolescents (8 females, 12 males) between the ages of 14 and 17 who completed interviews near the beginning and end of their involvement in an after-school community-based intervention program designed to reduce teens' AOD use and other troubling behaviors. The first and second interviews were approximately 6 to 8 weeks apart. The racial composition of the sample was primarily non-Hispanic White (11 participants), with four Hispanic, two African American, and three adolescents of

mixed heritage. Most ($n = 16$) reported living with a parent, while three reported living with other relatives. One resided in the county youth detention center. All but one reported attending school. The study was approved by the local institutional review board (IRB) and followed American Psychological Association (APA) guidelines for ethical research practices.

Overview of AOD Intervention

The adolescents participated in program activities after school, 4 days a week for 3 hours a day. During the first hour, the adolescents participated as a group in AOD counseling using a 12-step approach. To complete the program, participants had to "work" the first step (e.g., complete a written and oral activity that encouraged them to examine their sense of control over their use of AOD). The second hour generally involved separate psychoeducational groups that focused on issues relevant to the adolescents (i.e., self-esteem, coping/decision making, family, friends, and dating), and these were often separated by sex. The third hour was relatively unstructured and activities varied, from doing homework, to playing sports outside, to additional group processing sessions. The program also included a mentoring component, where college student interns were matched with youth with the goal of nurturing a positive relationship. Parents and other family members were encouraged to participate in weekly family group meetings; these meetings were semistructured and involved parenting education and support. The average length of participation in the program was 6 to 8 weeks, with an open invitation for participants to return if they felt they needed extra support or encouragement.

Measurement

Groningen Identity Development Scale (GIDS). The GIDS is a modification of the original identity status interview (Marcia, 1993) and includes an identity interview and questionnaire in each domain (Bosma, 1992). For this study, two of the original four identity-relevant domains (see Forthun et al., 2006) were examined: relationships with parents and relationships with peers. For confidentiality reasons, the interview was not tape recorded, but responses were summarized by both the interviewee and interviewer on an index card (cf. Bassett, Beagan, Ristovski-Slijepcevic, & Chapman, 2008). The GIDS questionnaire for each interview domain contained 32 items with two subscales: commitment (18 items, Cronbach's alpha ranged from .75 to .93) and exploration (14 items, Cronbach's alpha ranged from .62 to .80).

Intervention documents. Intervention documents included demographic information, a brief psychosocial history, and weekly summaries documenting relevant information regarding each adolescent's participation in program activities. Weekly summaries written by the program counselors included

information regarding the adolescent's participation and interaction style in the counseling groups, treatment information including relationships with parents and peers, and progress toward recovery from AOD use. Because many program activities were group oriented, the weekly summaries did not offer the depth of content typical in psychotherapy case notes, but did contain notable issues that arose in group sessions.

Analytical Strategy

A qualitative analysis of the interview and questionnaire responses was conducted by the first author and focused on the patterns and relationships between the identity processes of exploration and commitment across identity domains over time. The analysis began using a constant comparative method (Lincoln & Guba, 1985), but diverged in later stages to identify categories that meaningfully differentiated individual profiles of characteristics (Patton, 2002; for a detailed description see Forthun et al., 2006). When meaningful conceptual themes converged with previous empirical and theoretical work in the identity literature (Archer & Waterman, 1990; Josselson, 1994; Kroger, 1995), the literature was consulted and served to further clarify the emerging taxonomy. Initially eight profiles were identified. The results were shared with the coauthor and other identity experts who thoroughly scrutinized the transcripts, notes, and coding and offered several challenges to the initial taxonomy. Following extended discussions, five profiles emerged as a best fit to the data. Analysis of the intervention documents focused on content in three areas: the adolescent's beliefs about AOD use as a problem, the level of engagement in the intervention, and AOD use behavior (including occasional documentation of drug screenings).

RESULTS AND SUMMARY

Identity Restructuring Profile

The Identity Restructuring profile included the largest number of adolescents (3 females, 3 males). The identity profile was characterized by a period of reexamination and challenging of existing negative identity commitments, followed by a strengthening of positive identity commitments (Forthun et al., 2006). This was particularly evident in their willingness to initiate new friendships with nondeviant peers. Most expressed a motivation to change friendship groups in order avoid further AOD use and regain the trust of their parents. Each reported a close and secure relationship with at least one parent, which not only provided support during the transition between friendships, but also the motivation to regain trust. A 16-year-old male summed up the predominant sentiment of the restructuring adolescents when he said, "But

he's just a friend; family comes first." In sum, the adolescents in this profile demonstrated that they were questioning their previous identities as AOD users and moving toward a restructured, positive identity characterized by meaningful identity exploration, positive identity commitments, and healthy interpersonal relationships.

From intervention documents, the drugs of choice for most of the Identity Restructuring adolescents included alcohol and marijuana, with almost daily use leading to problems with the law, parents, peers, and school. In addition, two general themes emerged that distinguished this group of adolescents from the rest. Both of these themes are consistent with their open style of self-exploration and the close and supportive relationship with at least one parent. First, when entering the program, most acknowledged that their AOD use had become a "problem" (two only "partially acknowledged" their AOD use as a problem), and each expressed a desire to change their AOD use. This desire was matched by a motivation to remain abstinent and was evident in their regular attendance at program activities, including extracurricular activities such as Alcoholics Anonymous (AA) meetings and the completion of intervention-related assignments. Not all the Identity Restructuring adolescents were successful at remaining abstinent throughout the course of the program; however, when relapses did occur, they were viewed as obstacles to overcome rather than as barriers to progress. For example, a relapse experience by a 17-year-old male was recorded as:

> He took responsibility for his past behaviors but states that he "feels" bad when others are saying they have 6 or 9 months clean and he has 3 days. Patient is very involved in recovery but was concerned about recent dreams of relapse. He was reassured that it is common and "normal in early recovery."

A second theme that emerged from the intervention documents was the adolescents' willingness to self-disclose, provide feedback, and confront their peers in the counseling/education groups. More often than not, the weekly progress notes for the Identity Restructuring adolescents contained language indicating their active and constructive involvement, such as patient was active and engaged in group process, patient confronted peer in group, patient gave good feedback to peers and accepted feedback well, patient expressed [feelings], patient discussed [relationship issues], and patient was willing to support [others].

Few concerns were noted about the behavior of the adolescents in this profile and most remained abstinent throughout their participation. They recognized the consequences of their behavior and acknowledged their problems with AOD use. As a result, they began the process of restructuring their negative identity to a positive identity that included better interpersonal relationships with parents and peers, and more realistic educational and

occupational goals. This process was fueled by the support from parents coupled with the adolescents' openness and flexibility in examining alternative, positive selves.

Unexamined Commitments Profile

The Unexamined Commitments profile (2 males, 2 females) was characterized by adolescents with relatively low levels of self-exploration and strong, stable identity commitments (Forthun et al., 2006). Similar to the identity foreclosed status (e.g., low exploration, high commitment), the primary identity process theme was unexamined identity commitment. However, unlike the foreclosed identity status, adolescents in this profile had both negative and positive identity commitments. They were strongly committed to continuing their AOD use and associations with AOD-using friends while also remaining strongly committed to close relationships with parents and conventional academic and occupational goals. The lack of identity exploration characterizing adolescents in this profile led to a failure to recognize this conflict. They believed that the strained relationships with parents and poor achievement in school could be repaired whether or not they continued to use AOD or associate with AOD-using friends. They believed that they just had to work harder at school and talk to their parents more. Overall, there was an overreliance on identity commitments, with adolescents preferring to maintain a sense of self-continuity rather than sacrifice stability for self-exploration.

Intervention documents revealed that most of the Unexamined Commitments adolescents were regular participants in the program and all were referred primarily for problems related to AOD use. Consistent with their profile, none of the adolescents entered the program acknowledging an AOD problem (noted in documents as "denial"). In addition, the adolescents in this profile had difficulty recognizing the importance of abstinence from AOD use, even those who were on probation and were court ordered to abstain. The attitudes toward abstinence were typically referred to in the weekly progress notes as "a lack of insight into the consequences of use . . . believes he can control [AOD use] without problem." Only after the threat of negative consequences did the AOD use change.

For example, weekly progress notes label one of the adolescent's mothers, with whom he had a close but conflictual relationship, as "enabling." That is, she helped her son avoid the negative consequences of his behavior:

> [Week 5] Patient's mom bought him a brand new Jeep this week as a reward for having 7 clean days.
>
> [Week 6] Patient reported that he can still control his mom in regards to his alcohol consumption. Patient says he can get his mom to buy alcohol for him.

This adolescent was able to avoid changing his AOD behavior until his mother decided to join with the counselors and probation officer in sending a clear message and enforcing consequences. Only then did he, reluctantly, reduce his AOD use.

Counselors also noted the unwillingness of the adolescents in this profile to discontinue associations with AOD-using friends. The adolescents were strongly committed to their friends and believed they could both continue their friendships and remain abstinent from AOD. Weekly progress notes documented that although some were successful at reducing their AOD use, others were not.

In sum, the adolescents in this profile were similar to those in the Identity Restructuring profile in that most were cooperative and regular participants in intervention groups. This was promoted by stable identity commitments that provided them with a sense of continuity and security. They differed, however, in that they lacked the insight garnered from self-reflective identity exploration. This shallowness was reflected in their belief that they did not have an AOD problem (e.g., denial), and in their unwillingness to change until they were threatened with negative consequences. Although unwillingness to change is characteristic of other profiles, in this profile it was not manifested as defiant or oppositional behavior. Most continued to engage in the intervention process and were not disruptive to others (with one exception). Their passive resistance persisted only until negative consequences motivated them to change their behavior.

Exaggerated Autonomy Profile

The Exaggerated Autonomy profile (3 males) was similar to the Unexamined Commitments profile in that the key identity process theme was rigid identity commitments. However, unlike the Unexamined Commitments youth, each adolescent in this profile had a highly conflictual relationship with his parents. Rather than ruminate about the conflict, the adolescents responded by cutting themselves off emotionally from their parents in order to become more autonomous (Forthun et al., 2006). Their exaggerated sense of autonomy led to overly rigid commitments. For example, a 16-year-old male commented at the second interview:

> I am very committed [to] my values and beliefs. If someone else doesn't like them then they can take their values and beliefs and shove them up their [butt].

The Exaggerated Autonomy adolescents also described idealized goals for the future, generally focused on success and material wealth. However, to achieve these goals they relied almost exclusively on their own abilities, suggesting that they will achieve their goals "in spite" of what their parents want for them. Although this autonomous orientation was related to

strong identity commitments, the rigidity of the commitments made their autonomous identity fragile. For example, one of the adolescents in this profile was unable to achieve his goal of readmittance into the school of his choice. Rather than sparking renewed exploration into other school or occupational alternatives, he fell into a period of identity confusion marked by increased AOD use. However, when his reapplication was approved, his confidence returned and he reduced his AOD use to avoid jeopardizing his readmittance.

For the adolescents in this profile, the primary presenting problem was AOD use, with most reporting a history of AOD abuse in their extended family. All expressed a desire to stop using AOD, and two remained abstinent throughout the duration of the program. Each understood that continued use of AOD would interfere with important life goals (e.g., returning to school, getting a job). Therefore remaining drug free was a personal decision, independent of the wishes and desires of their parents. For one of the adolescents, participation in intervention activities was also an opportunity to focus on himself. Counselors noted in weekly progress notes that:

> Patient was very self-focused this week on problems. Gave feedback in group when it would result in topic turning to him.
>
> Confronted peers on how they treat parents but did not want to accept it as the way he acts towards [his] parents.

The overly exaggerated autonomous identity orientation among these adolescents was also manifested in intervention behavior marked by an unwillingness to accept feedback. Although they were more than willing to offer feedback to others, they became defensive when the counselors encouraged personal reflection. Overall, this profile was characterized by rigid identity commitments, an exaggerated sense of autonomy, and apathy toward parents. In their attempt to be independent, AOD use may have been a means to mimic adult behavior (precocity). However, when AOD use began to interfere with their autonomy, they reduced their levels of use. Similar to adolescents in the Unexamined Commitments profile, negative consequences were important motivators for reducing AOD use, although for different reasons.

Self-Focused Rumination Profile

The primary theme in this profile was self-rumination in response to an identity crisis. Each adolescent (1 female, 2 males) in this profile was faced with identity challenges that focused on one particular theme: the struggle to balance their growing autonomy with their emotional needs for family support (Forthun et al., 2006). This developmental struggle is often referred

to as "individuation" and is defined as the process by which an individual comes to understand the unique self in relation to others (Anderson & Sabatelli, 1990). For the adolescents in this profile, relationships with parents were characterized by conflict or disengagement that led to identity distress. Specifically, identity distress was linked to their perceptions of how their AOD use and other troubling behaviors were affecting the relationships with their parents. Several adolescents in this profile expressed a belief that by changing their behaviors, their relationships with their parents and other family members would become idyllic. However, when parents did not respond to brief improvements in their child's behavior in the expected fashion, the adolescents would become frustrated, and subsequently overly self-conscious or self-critical. This was expressed best by a 14-year-old adolescent when she wrote:

> I look at life and at myself as *bad* because I am always getting into trouble with friends and at school and stuff.

Based on intervention documents, each of the Self-Focused Rumination adolescents were on probation and under the supervision of a juvenile officer and none believed that their own AOD use was a problem. However, they recognized that abstinence was expected as a part of their probation. When they entered the program, all three (none of whom were currently living with their parents) reported that both of their parents were AOD abusers. Both males in this group had a history of gang involvement and had been in and out of juvenile detention or residential treatment for the past several years.

The experiences in the program differed based on gender. For the males, participation was infrequent and both were antagonistic toward counselors and other peers. Both were reprimanded several times for inappropriate behavior and, as a result, were banned from program participation on several occasions. Weekly progress notes recorded:

> [Male #1] Patient does not want to accept criticism. Patient got kicked out before 3rd group for cussing out another patient.

> [Male #1] Patient continued resistance to accepting responsibility, as well as perpetuate arguments. Cussing staff on more than one occasion.

> [Male #2] Patient is highly disruptive. Abusive to female peers. Frequently engages in aside conversations with peers not engaged in group process.

> [Male #2] Seems as if patient does not care about peers. Patient spends most of time in groups staring at the ground.

In contrast, counselors commented that the female adolescent was "moderately open and opulently candid for someone beginning" treatment. Dur-

ing the first few weeks she interacted well with her peers and attended the program regularly. Toward the end of her participation, the counselors noted some defensiveness regarding her continued use of marijuana, but the defensiveness did not lead to inappropriate group behavior.

In sum, the Self-Focused Rumination profile was characterized by an identity crisis that focused primarily on issues surrounding the process of individuating from parents. Unmet needs for parental guidance and support combined with self-critical introspectiveness served to promote a ruminative cognitive style. This ruminative style interfered with the exploration into new positive identities and behaviors and led to oppositional and disruptive behavior in the intervention program, especially among the males in this profile. This also provoked continued AOD use. Given their identity confusion, this behavior is not surprising. Instability over time in one's sense of identity, coupled with self-rumination about unmet relationship needs, may result in emotional or behavioral instability, mistrust of others, and defensiveness.

Diffuse Profile

This profile is similar to the identity diffuse status and included 2 males and 2 females. Each adolescent in this profile expressed little exploration in any identity domain and had made few meaningful identity commitments (Forthun et al., 2006). However, for one adolescent female, identity commitments were strong in one identity domain: friends. Conflict and disengagement with her parents led to a sense of alienation and an overreliance on friends for social support. According to Archer and Waterman (1990), an alienated identity diffuse adolescent is characterized by anger that is "directed against others for either blocking the individual's path toward meaningful identity commitments or failing to make available options worthy of providing a basis for commitment" (p. 103). For this 15-year-old female, her relationship with her parents was too conflictual to assist and support successful individuation. As a result, social support was provided by friends. She wrote:

> Me and my dad don't get along at all. We are always fighting from dusk 'til dawn.
>
> [My best friend] is number 1 . . . I can say anything and do anything and she'll be cool with it . . . I'm way committed to my friends. I love them.

The presenting problem for all of the diffuse adolescents was AOD use. The program experiences for those in this profile varied. For the males ($n = 2$), the program documents report minimal participation in group counseling sessions, with frequent use of denial and avoidance. For example, the following accounts were reported in one youth's program documents:

[Week 3] Patient admitted to smoking marijuana over the weekend. When confronted by staff he got up and moved to another table. [avoidance]

[Week 5] Patient's urine analysis was positive for cocaine and marijuana and patient was very upset and denied ever using cocaine saying, "I don't do that stuff!" [denial]

For one of the females, early hesitation to become involved in groups gave way to more active participation by the end of the program. Although she continued to report AOD use, her use became less frequent when she discovered she was pregnant.

The experience of the other, more alienated female adolescent was characterized by active participation but frequent "relapses." The active participation in intervention groups may have been a reflection of her strong commitments to peers, who provided a key reference group in the absence of family. However, as her family situation failed to improve, her AOD use persisted and she was referred for residential treatment.

In sum, the intervention experiences appeared to have little effect on encouraging identity exploration and commitment, or changing AOD use for these youth. For the most part, the diffuse adolescents were difficult to engage in the intervention, were often defensive and avoidant, and lacked insight into the consequences of their AOD use.

CONCLUSIONS AND IMPLICATIONS

The purpose of this study was to examine identity development among adolescents participating in an after-school AOD intervention program to identify the developmental processes that were associated with intervention success. Using person-centered analyses, five identity profiles were identified, each differentiated by unique individual and contextual processes. Of particular interest was the examination of transformations from a negative to a positive identity and how this was associated with intervention success. The identity profiles ranged from the Identity Restructuring profile, where youth were most successful in transforming their identity from negative to positive, to the Diffuse profile, where adolescents were uncommitted to any identity orientation (either positive or negative). The profiles in between may represent a continuum in the process of change, with some showing difficulty giving up their existing identity commitments to explore alternative identity options (Unexamined Commitments and Exaggerated Autonomy profiles), and some having difficulty moving beyond the immediate awareness of their own troubled families (Self-Focused Rumination profile). Examining these attributes yields several implications for practitioners who struggle to promote positive identity development among troubled youth.

First, it is clear that identity transformations are supported by healthy relationships with parents or caregivers. Both the identity development literature (e.g., Grotevant & Cooper, 1986) and the AOD treatment literature (e.g., Austin, Macgowan, & Wagner, 2005) demonstrate the importance of the parent-child relationship in the promotion of change. An adolescent's healthy sense of identity is fostered when parents are able to flexibly renegotiate the rules of the family system to support individuality while providing a secure base from which to explore (Grotevant & Cooper, 1986). The families of the restructuring adolescents appeared to be the most successful at this. Although mistrust led to behavioral restrictions that threatened autonomy, the support and guidance from parents provided the "freedom" to dissociate from AOD using friends and connect or reconnect with non-AOD-using friends. This combination of parental strictness and closeness emerged as critical to the adolescents' identity restructuring. Parent-child relationship themes from the other profiles suggest that interventions that include a family-based component should also specifically target (a) reducing parent-child conflict and alienation, (b) eliminating parent behaviors that "enable" the child to continue her or his troubling behaviors, and (c) reducing emotional cutoff while nurturing closeness and security.

Success in reducing AOD use was also marked by the quality of identity exploration. Identity exploration can occur on many levels (intrapersonal, interpersonal, and contextual) and along several dimensions of breadth and depth (Grotevant, 1987; Luyckx, Goossens, Soenens, Beyers, & Vansteenkiste, 2005). In this study there were several qualities of identity exploration that characterized successful identity transformations among the adolescents in the Identity Restructuring profile. The first could be described as *openness to experience* (Grotevant, 1987). Exploration characterized by openness reflects an orientation that actively seeks out, processes, and evaluates important identity information (Berzonsky, 1989). The Identity Restructuring adolescents demonstrated this quality in their openness to exploring alternative positive identities as well as their willingness to acknowledge the consequences of their AOD use.

Another quality of exploration differentiating the Identity Restructuring profile from the other profiles was a measure of *flexibility* (Grotevant, 1987). Flexibility in exploration was evident in these adolescents' responses to challenges to their emerging identity. For example, several of the adolescents relapsed during their participation in the program. Based on program documents, adolescents in the Unexamined Commitments profile and the Exaggerated Autonomy profile tended to downplay the impact of relapse, while adolescents in the Self-Focused Rumination profile tended to respond with anger or become despondent. The Identity Restructuring adolescents, on the other hand, responded with disappointment, but were optimistic that they could eventually remain abstinent and that they would not let this setback disrupt their reemerging sense of identity.

These results suggest that interventions that promote open and flexible identity exploration should include more than just the exploration of participants' triggers for and consequences of AOD use. Adopting a restructured positive identity involves meaningful exploration in a variety of important psychosocial domains, including those evaluated in this study (e.g., parents and peers) and those not evaluated in this study (e.g., gender identity, philosophy of life, religion/spirituality, race/ethnicity, and sexuality; see Schwartz, Montgomery, & Briones, 2006). For example, adolescents in the Unexamined Commitments profile lacked open and flexible identity exploration which resulted in conflicting commitments (both positive and negative) that interfered with intervention success. Although the adolescents in this profile were motivated by negative consequences, they lacked insight, not only into the causes and consequences of their AOD use, but also with respect to how their current negative identity commitments precluded the development of a positive identity.

Finally, recent evidence has suggested that forming stable identity commitments involves two processes: making commitments and identifying with those commitments (Luyckx et al., 2005). Making commitments refers to the process of making choices about one's occupation, personal philosophy, relationship roles, and use of AOD. However, identifying with those commitments involves integrating the chosen commitments into one's overall sense of identity. Adolescents whose sense of identity is coherent and stable develop confidence in their ability to achieve chosen objectives or goals. But this self-confidence can only emerge if the adolescent identifies with their commitments and integrates the commitments across relevant domains. This suggests that it is not enough to encourage adolescents to "choose" to be drug free; rather, the adolescent must come to identify with that choice (Brown et al., 2006). Investing in a new identity as a "nonuser" requires the reevaluation and modification of previous identity-related goals and commitments, as well as reliance on significant others for support and encouragement.

Limitations

The sample for this study was small, drawn from only one community, and consisted of adolescents who were participants in an after-school community-based intervention program. The sample cannot be considered a normative sample of adolescents participating in an intervention for AOD use. Although the intervention program appeared to be typical of many community-based programs with respect to its goals and procedures, it was not administered via a strict treatment protocol or evaluated with respect to its effectiveness in meeting its program goals. Future intervention programs devoting explicit attention to adolescent psychosocial needs, including identity development, may achieve different results in AOD use reduction goals.

In conclusion, there is a dearth of knowledge about the impact of developmental factors on intervention outcomes for adolescents. The view of positive identity as guiding the unfolding of one's life in adaptive ways provides a conceptual link between the skills and competencies that AOD use interventions often target, and the developmental (and intervention) outcomes that these skills and competencies serve. Individuals do not acquire skills and competencies in a vacuum. Positive development involves the acquisition and use of skills and competencies in the service of life goals and values that the individual deems worthy of commitment. Consequently the next generation of interventions for adolescents should be designed to enhance multiple developmental components, including identity.

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