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Identity Development and Intervention Studies: The Right Time for a Marriage?

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Abstract

A cohesive identity plays a key role in mental health and well-being. Yet, few studies involving identity have been intervention studies, and few intervention studies have included identity-related variables. In this article, we speculate about why this might be so. We argue that intervention research with young people will be more informative when variables tapping key developmental processes and outcomes such as identity cohesion, style, distress, and turning points are included. Such research can (a) promote positive identity development as an important aim, (b) illuminate processes of identity-related change, and (c) add knowledge about for whom interventions work and why they work, through identity's mediating or moderating effects. We argue that these integrative steps will make treatment and prevention interventions for young people more effective and potent.

Each year, governments spend billions of dollars on research to develop intervention programs that prevent and treat diseases and mental disorders and promote physical and mental health. These costly efforts are funded year after year by governing bodies that see such knowledge development as vital to the public interest. The "burden of disease," whether of body or mind, costs individuals and societies in real dollars; ill health has ripple effects throughout society and results in tangi-

ble costs for hospitalization, medication and treatment, rehabilitation, and incarceration. Just as tragic are the intangible but very real costs of lost productivity, civic malaise, and unrealized individual and collective potentials.

Adults are, of course, not the only ones who suffer. One in 10 children and adolescents have problems severe enough to cause some level of impairment, yet fewer than 1 in 5 receives treatment (National Institute of Mental Health, 2004). This is particularly problematic because young people are on developmental trajectories of rapid change in many domains—physical, social, emotional, and cognitive. Hence, problems and impairments that emerge early can compound into deficiencies and comorbid patterns that make healthy functioning across many domains increasingly less likely. Lost opportunities to activate healthy potentials can be difficult to reclaim.

Unfortunately, the greatest amount of financial support for developing and translating interventions that promote the welfare of developing young people is currently channeled toward treating problems or disorders that have already arisen, rather than fostering healthy mental and emotional functioning or positive development. Contributing to this state of affairs is the fact that a conceptually integrated and empirically supported definition of healthy psychosocial functioning has been much more elusive than have classification systems of symptoms and maladaptive functioning. For example, the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* ([*DSM–IV*], American Psychiatric Association, 1994) is primarily an atheoretical catalogue of mental "diseases." However, because of the disease-model orientation from which it arose—and which it reifies—our nationally funded research programs have yielded many more interventions for treating or preventing symptoms, diseases, and disorders (typically with modest success; see Ollendick & King, 2004) than for promoting well-being (a much broader notion; see Lerner, Fisher & Weinberg, 2000).

IDENTITY AND MENTAL HEALTH

Modern self-psychological theorists emphasize the experiential aspects of lifelong identity formation and maintenance, depicting the "self" as an active agent with shifting motivations and aims and the self's "identity" as a broad unifier of these experiences (Lichtenberg, Lachmann, & Fosshage, 1992). In this view, a coherent identity functions as a center of initiative that directs the mutual relationship of self-regulation and regulation between self and environment. The phenomenological "sense of identity" is shaped by how we experience this process of initiating, organizing, sustaining, directing, and integrating psychological or physical action or both (Goldenson, 1984). Similarly, as noted earlier in this issue, sociologists Giele and Elder (1998) see identity as a "steering mechanism" or rudder that a

person uses to direct his or her life course (Berman, Kennerley, & Kennerley, this issue; Kurtines et al., this issue).

A strong and positive sense of identity contributes to a sense of well-being (Pulkkinen & Rönkä, 1994). Further, recent research studies have added empirical evidence to the clinical support for the notion that a positive personal identity fosters positive mental health outcomes. In adolescence, healthy identity development appears to protect against depression (Koteskey, Little, & Matthews, 1991), drug use (Dollinger, 1995), and other maladies (Adams et al., 2001), and encourages optimism and self-esteem (Roberts et al., 1999). A healthy identity is also linked to adults' psychological well-being; for example, older people with healthy identities maintain a sense of continuity in their lives and deal effectively with age-related changes (Brandstadter & Greve, 1994). In essence, the health-promoting effects of a coherent sense of identity are evident throughout the life span.

A Negative or Prescribed Sense of Identity

While many young people are able to successfully navigate the challenges and transitions posed in adolescence (Arnett, 1999), others are not. When young people fail to develop or consolidate a sense of identity, they are more vulnerable to psychological and behavioral problems. They are also more likely to develop what Erikson termed a "negative identity," as they are more open to influence from those who seek out young people who they can mold to fit their own proprietary (and often political) agendas (Erikson, 1968). Some clinicians and prevention researchers have argued that identities prescribed by gangs or radical nationalistic groups are adopted and elaborated by adolescents who have a preexisting identity problem (e.g., a negative, confused, or diffused sense of self). The identity bestowed (whether socially sanctioned or not) is thus a solution to an adolescent's identity problem and its concomitant subjective distress (Sugar, 2004; Walle, 2004). While the young person is in the group, the identity problem or disorder is masked as the dominant identity organizes all commitments and role involvements, and identity distress declines. However, from a mental health perspective, the reduction in immediate identity distress is a poor compromise. Such identities involve high psychological and physical risk for the individual. If the young person survives this time, the sequelae may continue years after active involvement in the group is over.

An Incoherent Sense of Identity

Some young people display avoidance of this psychosocial developmental task altogether. This stance was termed "identity diffusion" by Erikson. Diffuse youth do not explore their self-potential and do not make commitments to identity-relevant roles or values; rather, they procrastinate and avoid making decisions that might lead toward such self-clarification, and lack an orientation toward the future

(Erikson, 1968). Some with a diffuse/avoidant identity direct their anger against others for either blocking their path toward meaningful identity commitments or failing to make available options worthy of commitment (Archer & Waterman, 1990). Others display the problem behaviors most commonly addressed in intervention settings (e.g., internalizing and externalizing behaviors, Hernandez, Montgomery, & Kurtines, 2006; substance use and delinquency, Jones & Hartmann, 1988; Jones, Hartmann, Grochowski, & Glider, 1989; White, Wampler, & Winn, 1998). In these instances, adults are the ones who have reported distress in dealing with the young people who seem unable to get themselves together to succeed in school or stay out of trouble. These youth may not present clinically with subjective distress that they can articulate and attribute to a lack of a cohesive identity, yet their difficulty with developing one is obvious.

IDENTITY AND MENTAL HEALTH RESEARCH

Our field now faces the challenge of bringing notions of identity, which we and much of the lay public find enriching and helpful, to inform broadscale efforts that promote human welfare. However, notions of "identity" and "sense of self" tend to be regarded by scientists as "mushy"—imprecise and immeasurable—and therefore unworthy of attention in studies that depend on psychological instrumentation to capture attitudinal, behavioral, and symptom change. "Identity" has been left out of the assessment battery and hence out of continually emerging notions of mental functioning and treatment, at least those informed by well-funded research. However, we would all do well to remember the first axiom of law—absence of evidence is not evidence of absence. In this case, that means the relative dearth of funded research studies that integrate identity into conceptualizations of either adaptive or maladaptive psychosocial functioning does not mean that identity is not a potentially important focus in prevention, treatment, or development-enhancing interventions.

Conceptualizing, Assessing, and Treating Identity Problems

As early as 1957, Erikson and Erikson (1957) remarked on the importance of intervening during adolescence in order to redirect the energies of young people toward productive styles of living and prevent society's confirmation of, and a young person's commitment to, a socially marginalized identity. However, the identity research we know, done with the conceptualizations and measures that we currently have at our disposal, has provided correlational evidence for the importance of identity to well-being, but does not optimally address the aspects of identity that would be most helpful in clinical or prevention studies. The burden is on identity scholars to articulate conceptualizations of identity that would

be most helpful, and to design or refine efficient, reliable, and culturally appropriate measures for them (see Berman, Montgomery, & Kurtines, 2003, for one attempt to do so).

National Institutes of Health–supported treatment studies have focused on symptom reduction or disease remission as defined by the widely used *DSM–IV*. Currently, the *DSM–IV* gives credence to the term *identity problems* by listing them under the heading of "Other Conditions That May Be a Focus of Clinical Attention," with the liberal criteria of "uncertainty about multiple issues relating to identity" (p. 685). However, the third edition, of the *Diagnostic and Statistical Manual of Mental Disorders* ([*DSM–III–R*], American Psychiatric Association, 1987), which preceded *DSM–IV*, included a diagnostic category termed *identity disorder* (a pathological "identity crisis"). The essential feature of identity disorder was severe subjective distress or excessive and prolonged uncertainty that interfered with normal adaptive functioning, with an inability to integrate aspects of the self into a relatively coherent and acceptable sense of self associated with specific roles, relationships, and social commitments.

The reasons for discontinuing the diagnosis of "identity disorder" and substituting "identity problems" are unclear. Presumably, the change reflects the notion that experiencing a certain amount of distress in the process of defining one's identity can be expected in contemporary societies in which the developmental period of adolescence has become more prolonged and complex. Nevertheless, in the current state of affairs, the distress resulting from the prolonged and unresolved uncertainty about identity issues—sometimes severe and disruptive to day-to-day functioning—must now be subsumed under an anxiety diagnosis or dealt with outside treatment settings in Internet chat rooms, bars, or coffeehouses (or in unreimbursed therapy sessions, for patients who can afford them). Recently, as mental health practitioners around the world have more frequently encountered clinical cases involving young people with identity experiences in military and paramilitary organizations, gangs, terrorist organizations, and nationalist youth organizations, many have argued for reinstating the diagnosis of identity disorder (e.g., Sugar, 2004).

To summarize, although the *DSM–IV* category for identity mental health issues has changed, identity problems have not gone away. Identity distress and identity diffusion can still represent a serious problem for many young people. Reconsideration of the diagnostic criteria of severe subjective distress may be needed in order to helpfully identify adolescents and emerging adults who could benefit from an identity-focused intervention.

Does Identity Belong in Intervention Studies?

Urie Bronfenbrenner (1979) often quoted his mentor as saying, "If you really want to understand something, try to change it." What happens when interventions at-

tempt to change negative identity trajectories into positive ones, increase identity cohesion, decrease identity distress, or promote a self-supporting identity style? What can we learn about identity when we try to change it or foster it?

Healthy identity development—or the lack of it—involves more than the presence or absence of distress around identity issues. While government funding has been prioritized around reducing the burden of disease, private funding sources and university-community partnerships have often targeted broader goals for human welfare. These intervention contexts present opportunities to enhance competencies, positive behaviors, and well-being. Enhancing positive outcomes is particularly important during adolescence, a time of rapid development and change, and heightened amenability for change (for good or for ill).

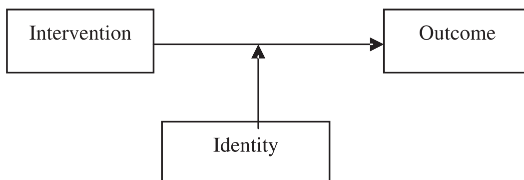
Recently, there has been a growing recognition of the need to systematically integrate lessons gained from developmental science into risk-and-protective prevention models (Catalano, Berglund, Ryan, Lonczak, & Hawkins, 1999; Small & Memmo, 2004). Specifically, developmental science has suggested developmentally appropriate competencies that should be enhanced to move at-risk youth into more adaptive developmental trajectories. Fittingly, then, the recognition of the importance of the concept of a mature identity (i.e., a self-constructed, coherent, and dynamic organization of the self) as an appropriate positive intervention outcome has grown (see Berman et al., this issue; Kurtines et al., this issue). Conversely, difficulties in consolidating a coherent sense of personal identity—for example, the identity diffusion or negative identity formation that Erikson (1968) described as the less propitious outcomes for youth—may be associated with less salience and surety about a young person's cultural identification, or with the inability to define for himself or herself distinct and desirable elements with which to identify (Berry, Phinney, Sam, & Vedder, 2006). It is time for us to build on what we know about identity development by articulating how we can help more youth get there—by working with individuals, groups, schools, communities, and even nations.

WHY SHOULD INTERVENTION RESEARCHERS EXAMINE IDENTITY?

Given identity's place in current *DSM–IV* nosology, it is unlikely that there will be many studies funded to promote identity outcomes. But this does not preclude intervention researchers from introducing identity measures into intervention studies in order to explore how identity constructs illuminate the mechanisms of intervention change (see Figure 1). For example, Kerpelman, Pittman, and Adler-Baeder (this issue) illustrated how aspects of identity can interact with intervention-related change in a funded evaluation of a school-based relationships curriculum.

A. Identity as an outcome

B. Identity as a moderator



C. Identity as a mediator

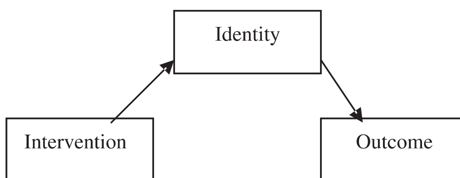


FIGURE 1 Identity as an outcome, moderator, and mediator.

Leading treatment and prevention researchers have agreed that examining the impact of developmentally relevant variables on adolescent treatment response is critically important (e.g., Holmbeck, Greenley, & Franks, 2003; Kazdin, 2003; Wagner, 2003). Because adolescence involves rapid and profound changes, taking developmental change into account while also examining intervention-related change is particularly important for understanding intervention impact. However, much treatment and prevention research with adolescents has ignored the influence of developmental variables by relying on the downward extension of models and methods borrowed from the adult literature; thus, virtually nothing is known about how developmental and intervention-related trajectories might influence one another (Holmbeck et al., 2003).

Including at least one variable that indicates participants' developmental status in adolescent intervention research would allow us to note the influence of devel-

opmental status on treatment outcomes. To date, most treatment literature has used age to represent a participant's developmental status. However, for adolescents, age inaccurately represents key aspects of developmental status because adolescents of the same chronological age may vary greatly with respect to emotional, physical, social, and cognitive functioning (Holmbeck et al., 2003). Psychosocial variables such as identity status, style, cohesion, and distress go beyond age and capture progress with a key developmental task.

If the central process for self-development for adolescents is identity formation, and adolescents explore various identity choices through their self-directed behavior (Erikson, 1968), identity formation processes have clear implications for interventions with adolescents. However, literature articulating the possible links between identity formation processes and intervention efforts has just begun to emerge. New knowledge about these links has the potential to contribute to our overall knowledge about the role of identity development in adolescents' intervention response.

Specifically, as shown in Figure 1, we can gain knowledge about: (a) aspects of young people's identity development (distress, cohesion, style, or status) that moderate the intervention impact (i.e., when the intervention works for some youth better than others depending on aspects of their identity development), and (b) a developmentally salient process that may help explain why interventions are working (i.e., when the intervention promotes psychosocial development, which in turn mediates the more positive outcomes that result from intervention).[1] Hence, including identity variables in intervention studies will add to knowledge about two critically important issues in prevention and treatment studies: for whom interventions work, and why or how they work.

CONCLUSION

This Special Issue has focused on the concepts of identity cohesion, identity confusion, identity styles, and identity turning points as potential mediators, moderators, or target outcomes of intervention studies. We have argued for its inclusion in research on emotional and mental health and well-being because, as Catalano (1999) noted, it is an overarching concept that frames personality development and functioning, and it is useful in understanding the developmental trajectories of

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[1]With respect to increasing knowledge about how and why treatment works, Kazdin and Nock (2003) made specific recommendations: (a) include measures of potential mediators in treatment studies—preferably, more than one, (b) assess how the gradient in treatment response is related to the mediator, (c) intervene to change the proposed mediator (and see what happens to outcome), and (d) design studies to address the measurement timepoints required to demonstrate causality with pre-, mid-, and postintervention.

young people. We have also argued for its inclusion in treatments for various maladies and disorders because, as a steering mechanism, identity is involved when individuals change their life course toward greater health and well-being.

Although identity is a complex aspect of life that has not been easy to operationalize, its inclusion in intervention studies has begun and these efforts have yielded useful information for both identity researchers and prevention and treatment specialists. As a "steering mechanism" guiding the individual's life course, identity provides a conceptual link between the skills and competencies that intervention efforts often target and the developmental outcomes that these skills and competencies serve. It is the right time for a marriage, and the preparations for it have already begun.

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