

# Identity Confusion and Psychopathology in Late Adolescence

Hadiye KAYNAK DEMİR<sup>1</sup>, Ferhan DEREBOY<sup>2</sup>, Çiğdem DEREBOY<sup>3</sup>

## Abstract

**Objective:** The aim of this study was to investigate the relationship of identity confusion with clinical diagnoses and personality pathology.

**Method:** Participants in the first part of the study were 950 high school students or graduates. The participants were 484 males and 466 females ranging in age between 16 and 25 years of age ( $X = 18.3$ ,  $sd = 0.8$ ). We first administered the Instrument for Assessing Identity Confusion (IFAIC), and following a random sampling procedure we selected 30 participants with an IFAIC score  $\geq 1$  standard deviation above the mean score to constitute the identity confusion group, and 30 participants with an IFAIC score  $\leq 1$  standard deviation below the mean score to constitute the non-confusion group. The 60 participants included in the second part of the study were clinically assessed by means of SCID-I and SCID-II interviews.

**Findings:** The percentage of the participants receiving at least one axis I diagnoses was 73.3 % in the identity confusion group as opposed to 6.6 % in the non-confusion group. Likewise, participants in the identity confusion group fulfilled more personality disorder criteria than those in the non-confusion group. When the groups were compared for each personality disorder criteria, significant differences were observed in terms of avoidant, dependent, obsessive-compulsive, self-defeating, borderline and schizotypal personality disorders.

**Conclusion:** Findings of the present study do not support the view that identity confusion is a condition emerging exclusively in adolescents with borderline or psychotic personality organization.

**Key Words:** Identity crisis, psychopathology, adolescence.

## INTRODUCTION

Erikson (1968) suggested that the development of ego in the context of gradually maturing relationships occurs in 3 stages: introjection, identification, and ego identity. Beginning with puberty, adolescence corresponds to ego development in terms of object relations, from the identification stage to the ego identity stage. This progression, conceptualized as identity formation, identity development or identity crisis is a relatively painless, secure, and unproblematic process for most adolescents; however, for some adolescents it may be a stressful, problematic, and sometimes even hopeless struggle for development. Erikson defined the condition of problematic adolescent identity development as latent identity confusion, un-

less significant disruptions in functionality are observed. He referred to abrupt emergence of latent disturbance in the form of a dramatic and paralyzing psychiatric picture as acute identity confusion. Additionally, while stating that some cases present with borderline symptomatology, he implicitly suggested that borderline disorder is an expression of severe identity confusion. In addition to listing the pathognomonic signs of confusion, Erikson provided numerous descriptions and clinical examples that help us differentiate latent from manifest, and mild from severe identity confusion in adolescents. Yet, he also repeatedly stated that, "identity confusion is not a descriptive diagnosis".

Therefore, it is not surprising that identity confu-

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<sup>1</sup>Psychologist/PhD, METU Health and Psychological Counseling Center, Psychiatry Dept., Ankara.

<sup>2</sup>MD/Prof., <sup>3</sup>Psychologist/Prof., Adnan Menderes University, Faculty of Medicine, Psychiatry Dept., Aydın.

Hadiye Kaynak Demir, e-mail: hadiye@mc.metu.edu.tr

sion is not included in ICD, a classification system with merely one axis that is reserved for descriptive diagnoses. What is surprising is that while identity confusion was being included in the multiaxial system of DSM, it was categorized in Axis I, which is reserved for descriptive diagnoses, and is tagged as the identity disorder to rhyme with the other diagnostic categories in this axis. Partly due to paucity of research addressing clinical features of identity disorder such as prevalence and prognosis, and partly due to inadequacy of the diagnostic criteria provided for this category in DSM-III and DSM-III-R, it has been included in the section "other conditions that may be a focus of clinical attention" in DSM-IV and DSM-IV-TR with a new tag: identity problem (Bleiberg, 2005).

Another factor contributing to the difficulty in categorizing identity confusion in diagnostic systems is the notion that it may occur only in individuals with borderline or psychotic personalities. This idea, as proposed by psychoanalytic theorists like Jacobson (1964) and Kernberg (1975, 1976), is based on the view that identity confusion or diffusion occurs when self representation is split due to the use of splitting as the main defensive mechanism. As such, individuals with neurotic or healthy personalities that use repression, not splitting, as the primary defensive operation are not expected to have identity diffusion. Owing to its solid theoretical foundation and authoritative proponents, this view has been so widely accepted that the identity disturbance has been included in DSM diagnostic systems as one of the nine diagnostic criteria of borderline personality disorder; however, what is meant by identity disturbance is merely "markedly and persistently unstable self-image or sense of self."

With the aim of improving this narrow definition, Akhtar (1984) defined the syndrome of identity diffusion consisting of 6 different clinical components; however, as Akhtar was psychoanalytically oriented, he considered identity diffusion an indication of severely disrupted object relations related to splitting and thought that it might occur only in individuals with borderline, narcissistic, antisocial, schizoid, and schizotypal personality disorders. He therefore emphasized the need for differential diagnosis between identity diffusion and adolescent identity crisis. Given that Erikson conceived of identity confusion no more than the pathological aspect of adolescent identity crisis, it is fair to say that Akhtar's views clearly dissipates from Erikson's.

Identity confusion is not a significant part of the

routine clinical assessment of young patients and this is partly a result of the lack of practical assessment tools. The definition of identity statuses developed by Marcia (1966) and the instruments that were developed based on that definition in order to give operational and measurable qualities to the concept of ego identity have been the dominant measurement tools in this domain for the last 30 years. In spite of its apparent problems, the most widely used tool based on the identity status construct is the Extended Objective Measure of Ego Identity Status (EOM-EIS) (Bennion and Adams, 1986). Psychometric studies on the Turkish version of the EOM-EIS conducted by several researchers repeatedly implicated that identity diffusion sub-scale suffers from inadequate reliability and questionable validity (Eryüksel, 1987; Varan, 1990; Dereboy et al., 1999). It is promising to note that the validity of Marcia's construct has been discussed more widely in recent years (van Hoof, 1999) and that research studies in this field have begun to leave behind the identity status paradigm (Moshman, 2005). To the best of our knowledge, aside from the scale developed by Wilkinson-Ryan and Westen (2000) to assess what clinicians perceive as identity disturbance, there are no scales designed to assess identity confusion in adolescents, either for clinical use or research purposes.

Identity confusion remains a contested clinical assessment category for adolescents for the following reasons: (1) Although it is not a descriptive diagnostic category it is considered a DSM Axis I diagnosis; (2) It is widely accepted that it may occur only in individuals with severe personality pathology, even though there is no supporting empirical evidence; (3) Ambiguous diagnostic criteria and the lack of widely accepted measurement tools; (4) Inadequate number of studies due to the lack of measurement tools; (5) Inadequate knowledge about its prevalence, prognosis, and relationship with various sociodemographic and clinical variables.

In Turkey, Dereboy (1993) discussed clinical components of identity confusion as divided into four groups (see Table 1) and on the basis of this discussion developed a 28-item self-report instrument that aims to systematically probe presence or absence of each of these components. Research on the Instrument for Assessing Identity Confusion (IFAIC), suggests it is an adequate instrument for assessing identity confusion (Dereboy et al., 1994, 1999). As such, there is a measurement tool in Turkish for empirically studying identity confusion and to increase our knowledge in this field. In fact, preliminary studies based on IFAIC report that adolescents with identity confusion have a higher prevalence of depres-

**TABLE 1.** Components of identity confusion and corresponding IFAIC items.

COMPONENTS OF IDENTITY CONFUSION		IFAIC Item #
<b>I. Problems with intrapsychic structures</b>		
Disorganization in self-representation		1
Disorganization in object-representations		2
Disorganization in ego ideal		3
Disordered superego functions		4
<b>II. Problems with Sense of Identity</b>		
Loss of sense of sameness and continuity of self in time and space		5
Loss of sense of sameness and continuity of self across psychosocial roles		6
Loss of sense of sameness and continuity of self in the eyes of others		7
Loss of sense of living in one's own way		8
Inability to envisage and follow the course of one's own life in a realistic manner		9, 10
Inability to be at ease with the way one is		11
Inability to gain recognition in his/her environment		12
<b>III. Problems Related to Developmental Stages</b>		
Infancy	Time confusion & Autistic isolation (Basic Mistrust, Withdrawal)	13, 14, 15
Early Childhood	Self-consciousness and Self-doubt (Shame and Doubt, Compulsion)	16, 17, 18
Play Age	Role Inhibition & Role-fixation (Guilt, Inhibition)	19, 20, 21
School Age	Sense of Futility & Work Paralysis (Sense of Inferiority, Inertia)	22, 23, 24
Adolescence	Inability to Commit with Fidelity	25
Young Adulthood	Bisexual Confusion	26
Adulthood	Authority Confusion	27
Old Age	Confusion of Values	28
<b>IV. Choosing Negative Identity</b>		-

sion (Çuhadaroğlu, 1999) and general symptom level (Türkbaş et al., 2005a) than those without. The present study aimed to advance the preliminary clinical findings provided by the above-mentioned studies by attempting to determine the following: (1) Which DSM Axis I pathologies accompany identity confusion and what their prevalence rates are; (2) What kind of personality pathologies occur in adolescents with identity confusion and what their prevalence rates are; (3) If there are significant differences between adolescents with and without identity confusion, in terms of clinical diagnosis, personality pathology, physical illness, psychosocial stressors, and level of functionality; (4) If identity confusion is associated with demographic variables such as age and gender.

## METHOD

### Participants and Procedure

The study included 2 parts. In the first part 1200 students that were preparing to take university entrance exams at 6 different university examination preparation schools in a western Turkish city were recruited without any pre-selection, and were administered the Personal Information Form and IFAIC. Teachers were informed in detail about the procedure and the scales, permission was granted by the exam schools, and informed consent was obtained from each participant. After examining the completed scales, 250 were excluded because they were completed without having been read or they were incomplete. Therefore, the first part of the study was conducted with 950 adolescents, of which 484 (50.9%)

were male and 466 (49.1%) were female. Age of these participants ranged between 16 and 25 years (mean:  $18.3 \pm 0.8$  years). In all, 747 (78.9%) of the students were high school seniors and 200 (21.2%) were high school graduates.

In the second part of the study mean IFAIC score of the 950 participants was calculated and from among those that scored 1 standard deviation below and above the mean 30 each were randomly selected and clinically examined. Mean IFAIC score of the 950 participants that took part in the first part of the study was  $58.92 \pm 18.54$ , and neither age nor gender significantly affected IFAIC scores. Thus, IFAIC scores of 77.5 and 40.4, which corresponded to 1 standard deviation above and below the mean, respectively, were selected as cut-off points in order to establish identity confusion and non-confusion groups, respectively. Of 157 students (16.6%) with IFAIC scores of  $\geq 77$ , 30 were picked, through random selection, for the second part of the study. Participants in the identity confusion group included 16 female and 14 male students with a mean age of  $18.63 \pm 1.09$  years. Similarly, 30 students randomly selected from among the 154 participants (16.3%) with IFAIC scores below 41 were included in the second part of the study. The non-confusion group thus comprised consisted of 30 participants (16 male and 14 female) with a mean age of  $18.50 \pm 0.86$  years. In all, 36 of the 60 participants that took part in the second part of the study were high school seniors and 24 were high school graduates. The SCID-I structured diagnostic interview was administered to participants in both groups by the first author, a psychologist with 5 years of clinical experience who is certified to administer SCID. Moreover, participants completed the SCID-II self-report scale and accuracy of the responses was checked via interviews. Adolescents assessed in the second part of the study that were determined to have a psychopathology were referred to a psychiatric clinic for treatment. Only 1 participant (psychotic disorder) had begun psychiatric treatment before the study began and continued treatment during the study.

## MATERIALS

**Personal Information Form:** A form for collecting sociodemographic data about the participants that was prepared by the researchers.

**Instrument for Assessing Identity Confusion (IFAIC):** A self-report scale developed by Dereboy et al. (1994) for evaluating identity problems. The scale consists of 28 items, each consisting of a few statements. Items are an-

swered on a 5-point Likert-type scale (1 = strongly disagree, 5 = strongly agree). Total score ranges between 28 and 140. High scores suggest presence of clinical components of identity confusion. The Cronbach's alpha internal reliability coefficient was about 0.90 in previous studies, suggesting that the scale is reliable enough for use in clinical assessment of individuals (Dereboy et al., 1994, 1999). A reliability analysis was conducted with the data collected from the 950 participants in the first part of the present study and Cronbach's alpha internal reliability coefficient was 0.91. Corrected item-total correlations were calculated in order to evaluate each item of the scale and for all the items, except item 26, correlation coefficients were over 0.30. With an item-total correlation of 0.19, the 26<sup>th</sup> item appeared to have an acceptable level of contribution to the total score, even though it was not at the expected level.

**Structured Clinical Interview for DSM Disorders (SCID-I):** SCID-I was developed by First et al. (1997) for diagnosing pathological entities as defined the DSM-IV. Çorapçioğlu et al. (1999) translated SCID-I into Turkish, and following a psychometric study reported that the Turkish version was a reliable instrument, and published a manual. In the present study, the Turkish version for the assessment of non-patients (SCID-I/NP) was utilized.

**Structured Clinical Interview for DSM-III-R Axis II Disorders (SCID-II):** SCID-II was developed for the assessment of personality disorders (Spitzer et al., 1990). The scale was translated into Turkish by Sorias et al. (1990) and was proved to have sufficient reliability by Coşkunol et al. (1994). SCID-II includes a 120-item self-report patient questionnaire (PQ) to be administered prior to the structured interview. This allows the interviewer to focus on the questions that are specifically endorsed by the respondent. In the 2<sup>nd</sup> part of the present study, following the administration of the PQ, the first author interviewed each participant to check the accuracy of their responses. The interviewer's ratings concerning certain criteria which are not covered by the PQ and which needs to be rated solely on the basis of clinical observations, however, were not systematically recorded and were not included in the data set. The diagnostic criteria for each personality disorder and the quantity of those criteria covered by the SCID-II PQ are presented in Table 3. As can be seen in Table 3, the diagnostic criteria for 9 of the 12 personality disorders are completely covered by the PQ whereas the criteria for the 3 categories are not. Because of this shortcoming and because some of the participants were younger than 18 years of age, participants were not given

**TABLE 2.** Distribution of DSM-III-R Axis I diagnoses in the identity confusion and non-confusion groups.

Axis I Diagnoses	Confusion (+) (n = 30)		Confusion (-) (n = 30)	
	n	%	n	%
No Axis I Diagnosis	8	26.7	27	90.0
Specific Phobia	5	16.7	2	6.7
Dysthymic Disorder	4	13.3	-	0.0
Adjustment Disorder	3	16.7	-	0.0
Social Phobia	3	10.0	1	3.3
Major Depression	3	10.0	-	0.0
Anxiety Disorder not Otherwise Specified	1	3.3	-	0.0
Schizophrenia	1	3.3	-	0.0

Axis II diagnoses; instead, each participant's total number of fulfilled criteria for each personality disorder were calculated and in this way criteria scores were obtained for the 12 personality disorders.

### Statistical Analyses

The relationship between IFAIC score and age was examined using Pearson's correlation analysis, whereas the difference between the IFAIC scores of male and female participants was examined by t-test. The chi-square test was used to examine if there were differences between the identity confusion and non-confusion groups in terms of the rate of Axis I and III diagnoses, and psychosocial and environmental problems categorized in Axis IV. The t-test was used to determine if there was a difference between the groups in terms of global functioning scores. Due to the ordinal variable quality of personality disorder criteria scores, the Mann-Whitney U test was used to compare the groups in terms of this variable. In addition to the 11 personality disorders in DSM-III-R, SCID-II also includes diagnostic criteria for self-defeating personality disorder. Because there was a need to compare the groups in terms of each of these 12 personality disorder criteria scores, Bonferroni correction was used in order to avoid inflated type I error and for each comparison the significance level was determined as  $\alpha=0.05/12 = 0.004$ . For other analyses it was accepted as  $\alpha=0.05$ . The  $\eta$  (eta) correlation ratio was used to examine the association between IFAIC scores and personality disorder scores more closely. SPSS was used for all statistical analyses.

### RESULTS

Correlation analysis based on the data of the 950 participants in the first part of the study showed that there was no significant relationship between IFAIC scores and age ( $r = -0.03$ ,  $P = 0.43$ ). The difference between the mean score of females ( $59.40 \pm 17.72$ ) and males ( $58.45 \pm 19.32$ ) was not significant ( $t = 0.787$ ,  $SD = 944$ ,  $P = 0.431$ ).

The distribution of DSM-IV Axis I diagnoses based on the SCID-I interview of 60 participants (30 identity confused and 30 non-confused) in the second part of the study is presented in Table 2. In the identity confusion group 22 of the 30 participants (73.3%) had an Axis I diagnosis, whereas only 3 participants (10.0%) in the non-confused group did; the difference between the groups was statistically significant ( $\chi^2 = 24.75$ ,  $SD = 1$ ,  $P < 0.001$ ).

Based on the SCID-II evaluations, mean number of criteria met for each of the 12 personality disorders in 2 study groups is summarized in Table 3. As can be seen in Table 3, participants in the identity confusion group had higher scores for all personality disorders than those in the non-confusion group. The results of the Mann-Whitney U test, which was used with each of the 12 personality disorders in order to examine the significance of the differences, were interpreted after Bonferroni correction with a significance level of  $P = 0.004$  for each test. Still, there were still significant differences between the groups in terms of 6 of the 12 personality disorders — avoidant PD, dependent PD, obsessive-compulsive PD,

**TABLE 3.** DSM-III-R Axis II criteria in the identity confusion and non-confusion groups.

Personality Disorder Diagnostic Categories	Number of SCID-II Criteria			Identity Confusion (+) (n = 30) (Mean ± SD)	Non-Confusion (-) (n = 30) (Mean ± SD)	z	P*
	Total	Assessed	Threshold				
Avoidant Personality	7	7	4	3.57 ± 1.67	1.70 ± 1.29	-4.11	0.000
Dependent Personality	9	9	5	3.63 ± 1.71	2.13 ± 1.41	-3.44	0.001
Obsessive-Compulsive Personality	9	9	5	4.53 ± 1.65	3.00 ± 1.84	-3.25	0.001
Passive Aggressive Personality	9	9	5	4.43 ± 1.59	3.43 ± 1.629	-2.35	0.019
Self-Defeating Personality	8	8	5	2.20 ± 1.37	1.03 ± 1.16	-3.52	0.000
Paranoid Personality	7	7	4	3.70 ± 1.82	2.97 ± 1.79	-1.50	0.135
Schizotypal Personality	9	6	5	2.23 ± 1.13	1.40 ± 0.81	-3.11	0.002
Schizoid Personality	7	6	4	2.23 ± 1.52	1.23 ± 1.25	-2.76	0.006
Histrionic Personality	8	7	4	3.87 ± 1.14	3.33 ± 1.32	-1.40	0.163
Narcissistic Personality	9	9	5	3.27 ± 1.87	2.00 ± 1.70	-2.58	0.010
Borderline Personality	8	8	5	4.33 ± 2.11	2.07 ± 1.86	-3.83	0.000
Antisocial Personality	12	12	5	1.30 ± 1.72	0.53 ± 1.07	-1.97	0.049

After Bonferroni correction, significance level was adopted as  $\alpha = 0.05/12=0.004$  for each comparison.

**TABLE 4.**  $\eta$  (Eta) correlation ratios between IFAIC score and personality disorder criteria scores.

Personality Disorder Criteria Scores	IFAIC Scores	
	Identity Confusion as Dependent Variable	Personality Disorder as Dependent Variable
Avoidant Personality	0.71	0.83
Dependent Personality	0.61	0.71
Obsessive-Compulsive Personality	0.55	0.68
Passive Aggressive Personality	0.35	0.67
Self-Defeating Personality	0.45	0.63
Paranoid Personality	0.45	0.62
Schizotypal Personality	0.47	0.75
Schizoid Personality	0.40	0.65
Histrionic Personality	0.28	0.67
Narcissistic Personality	0.40	0.66
Borderline Personality	0.54	0.72
Antisocial Personality	0.44	0.65

self-defeating PD, schizotypal PD, and borderline PD.

In order to examine more closely the relationship between identity confusion and personality disorders, eta correlation ratios between IFAIC and the 12 personality disorder criteria scores were calculated. Eta values, as summarized in Table 4, show that there were moderate or high levels of correlation between IFAIC scores and the 12 personality disorders' scores. The strongest correlations were between IFAIC scores and avoidant PD criteria scores no matter if IFAIC or personality disorder category is considered dependent variable.

There were 2 participants in the identity confusion group and none in the non-confusion group having an Axis III diagnoses; the difference between the 2 groups was not significant.

According to evaluations concerning Axis IV, there were psychosocial stressors present in 13 individuals (43.3%) in the identity confusion group and in 6 individuals (20.0%) in the non-confusion group. The difference between the groups approached the level of significance ( $\chi^2 = 3.77$ ,  $SD = 1$ ,  $P = 0.052$ ). In the identity confusion group there were 2 stressors observed in multiple cases: feeling that one is not understood by family members was a stress factor for 6 participants, while

breaking up with girlfriend/boyfriend was a stress factor for 3 participants. In the non-confusion group, these 2 stressors were observed in none of the participants and no stressor was observed in multiple cases.

Finally, with regard to the data concerning Axis V, while mean global functioning in the identity confusion group was  $87.5 \pm 8.4$ , it was  $96.1 \pm 5.3$  in the non-confusion group; the difference between the groups was significant ( $t = 4.73$ ,  $SD = 58$ ,  $P < 0.001$ ).

## DISCUSSION

Researchers have reported that about 15%-20% of adolescents have "silent disturbance" (Offer et al., 1988; Jessor, 1993). In the present study, 30 participants with identity confusion were selected from among 157 adolescents with IFAIC scores  $\geq 78$ , representing 16.6% of the 950-person total sample. Although previous studies reported that the frequency of depression (Çuhadaroğlu, 1999) and general symptom level (Türkbat et al., 2005a) were higher in adolescents with identity confusion than those in adolescents without, the present study is the first to systematically examine the relationship between identity confusion and DSM Axis I diagnoses. The present study's findings show that 73% of the adolescents with identity confusion had an Axis I diagnosis, which is about 7-fold greater than the 10% rate of psychiatric diagnosis in the non-confusion group. Most of the adolescents that were diagnosed had not previously sought psychiatric treatment. Thus, they are the youth that researchers think as the ones in silent disturbance; however, results of the present study show that they are not as silent as it was thought to be.

When the range of Axis I diagnoses were examined, in addition to anxiety and adjustment disorders, unipolar mood disorders, such as dysthymia and depression, were frequently observed in identity-confused participants. As the present study was cross-sectional, it is not clear if identity confusion or other clinical disorders were primary. It may be wise to think that both innate temperament characteristics and acquired character traits, that is to say, entire personality structure paves the way for identity confusion as well as Axis I disorders in adolescence.

Which personality structures pave the way for identity confusion? The most striking finding of the present study was that not only borderline personality characteristics, but almost all of the personality disorder characteristics were observed more frequently in the adolescents with identity confusion. If Bonferroni correction

had not been conducted and the significance level had been accepted as  $P = 0.05$  for each comparison, it might have been suggested that the identity confusion group met significantly more of the criteria for all the personality disorders, except passive-aggressive personality. The observed moderate-high correlations between IFAIC score and the 12 personality disorders' criteria scores is further evidence of the general association between identity confusion and personality problems.

When Bonferroni correction was applied and the level of significance was adopted as  $P = 0.004$ , differences between the groups were significant for 4 cluster C personality disorders, as well as for schizotypal and borderline personality disorders. In fact, whether or not it was necessary for us to conduct Bonferroni correction to keep the type I error rate at an acceptable level is debatable, because in these analyses the possibility of type II error could not be underestimated due to 2 factors. The first factor is the small number of participants in each group. The second factor is the application of relatively less sensitive nonparametric tests for between group comparisons

Our findings suggest that identity confusion accompanies not only borderline personality, but also neurotic personality. The pertinent literature includes 2 empirical studies on the relationship between borderline personality disorder and identity confusion. In the first study (from Europe) the findings support the idea that identity disturbance is not unique to borderline personality, but is associated with personality pathologies in general (Modestin et al., 1998). In that study researchers used the identity disturbance criterion of DSM borderline personality disorder in order to measure identity disturbance. In the other empirical study (from the US) the Identity Disturbance Questionnaire, a 35-item scale developed by the researchers to measure identity disturbance in borderline personality disorder (Wilkinson-Ryan and Westen, 2000), was used. This questionnaire was developed for research purposes and it is completed not by the patient or the interviewer, but by clinicians/therapists that know the patient well. The study's findings support the idea that there is a unique association between borderline personality and identity disturbance; however, given the design of that study and the fact that the Identity Disturbance Questionnaire is completed by clinicians, it might be that the unique association observed between borderline personality and identity disturbance reflects clinicians' subjective perceptions, rather than objective reality. It is not surprising that clinicians are prone to be under the influence of a widely accept-

ed view dominating diagnostic manuals and theoretical discussions about the subject.

As was stated in the results section, 43.3% of the adolescents with identity confusion and 20.0% of adolescents without identity confusion had psychosocial stressors, and the difference between the groups approached the level of significance. The most frequent stressors in the identity confusion group were thinking that one is not understood by family members and breaking up with a girlfriend/boyfriend. Based on Axis V data, it was observed that the level of functionality in the identity confusion group was significantly lower than that in the non-confusion group. In the identity confusion group, because Axis I and II problems were more prevalent, it might be erroneous to link the lower level of functionality exclusively to identity confusion. Yet, when Axis IV and V findings are considered together, it could be concluded that those in the identity confusion group (selected by IFAIC score) constituted a group that had more intense problems in their relationships and relatively lower functionality, as compared to the non-confusion group.

Finally, regarding the association between identity confusion, and age and gender, our findings suggest that neither variable had a significant effect on IFAIC scores;

however, one should consider that in this study the age range of the participants was quite narrow (16-25). Two previous studies conducted with adolescents similarly did not show any effect of age or gender on IFAIC scores (Dereboy et al., 1994; Çuhadaroğlu, 1999), whereas one study did (Türkbay et al., 2005b). Considering these findings, it might be concluded that there is insufficient evidence of a significant relationship between identity confusion measured by IFAIC, and age and gender.

The present study has some limitations that require careful consideration. The most important limitation is that the assessment of some criteria that were not addressed by the self-report scale are missing. Another limitation is that the second part of the study was conducted with only 60 participants, which might have increased the likelihood of Type II error. Despite this, it is striking to note that both Axis I diagnoses and personality disorder symptoms were observed in a significantly more frequent fashion in the identity confusion group.

IFAIC appears to be a reliable and valid measure for assessing identity confusion in Turkey. There is no accepted tool for use worldwide that evaluates identity confusion. Studies conducted with larger normal and clinical samples will serve to help us better understand the clinical aspects of identity confusion.

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