Who Am I?: Identity Formation, Youth, and Therapeutic Recreation

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During adolescence, the development of sense of identity is a crucial task (Erikson, 1959/1980). Although identity development is not a primary treatment goal for most TR clients, many benefits of identity development mirror desired outcomes of TR services: reduced substance abuse, increased adjustment to disability, reduced anxiety, and increased self-esteem (Coyle, Kinney, Riley, & Shank, 1991). Identity development in adolescence also has been associated with long term optimal health and well-being (Baumeister, 1995), which is a focus of TR services (Austin, 1998). This paper presents an application of Marcia's (1966) ego identity status paradigm to assist TR professionals to facilitate identity development in adolescents as a primary or secondary treatment goal.

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Over the last 40 years, research has consistently found a relationship between identity and a number of positive psychological and social outcomes (e.g., Marcia, 1993; Meeus, 1996; Waterman, 1992). Youth who have a positive identity are more optimistic about their future, report higher self-esteem, are less likely to use drugs and alcohol, and exhibit a greater sense of autonomy and responsibility (Marcia, 1993; Meeus, 1996; Search Institute, 2000). Waterman (1992) stated, "...a clear sense of personal identity constitutes an aspect of optimal psychological functioning" (p. 50). Given the positive outcomes associated with
identity development and the fact that identity development is a crucial developmental task of adolescence (Erikson, 1959/1980; Santrock, 1996), therapeutic recreation (TR) interventions which facilitate identity development as a primary or secondary treatment goal could benefit adolescent clients. Therefore, the purposes of this paper are to: (a) discuss the relevance of identity development to therapeutic recreation professionals, (b) present one theoretical perspective on identity development, and (c) offer implications and recommendations for therapeutic recreation practice and research.

Relevance of Identity to Therapeutic Recreation

Research indicates that the critical task of adolescence and young adulthood is the formation of identity (e.g., Erikson, 1959/1980; Kleiber, 1999; Santrock, 1996). This critical task (i.e., identity development) does not cease when adolescents experience problems (e.g., substance abuse, eating disorders, spinal cord injury, adjudication). Although experts recommend structuring youth interventions to address the developmental tasks of adolescence (Carnegie Council on Adolescent Development, 1992; Jones, 1994), identity development is not a primary treatment goal for most adolescent clients served by TR professionals.

Many benefits of identity development, however, mirror desired outcomes of TR services. For example, Coyle, Kinney, Riley, and Shank (1991) listed six areas of benefits of TR services: physical health and health maintenance, cognitive functioning, psychosocial health, growth and personal development, societal and health care system outcomes, and personal and life satisfaction. Identity development has been associated with four of these areas: (a) psychosocial health (e.g., lower anxiety, ability to cope with stress); (b) growth and personal development (e.g., development of personal values, interpersonal skills); (c) societal and health care system outcomes (e.g., reduced substance use, school performance); and (d) personal and life satisfaction (Archer, 1994; Baumeister, 1995; Marcia, 1993; Meeus, 1996). Therefore, to facilitate identity development would not only address primary TR treatment goals, but also would address expert recommendations regarding adolescent interventions.

The purpose of TR interventions is not only to alleviate illness or minimize the negative impacts of injury or disease, but to promote optimal health and well-being (Austin, 1998; Van Andel, 1998). Optimal health includes the ability to participate in and enjoy leisure experiences, the ability to find purpose and meaning in life, the ability to enjoy meaningful relationships, a sense of personal well-being, and spirituality (Van Andel, 1998; Waterman, 1992). Research has demonstrated that personal identity contributes to and is an aspect of optimal psychological functioning (Waterman, 1992). People who have scored high on measures of identity development have consistently scored better on measures of psychological and social outcomes such as high self-esteem, health maintenance, and greater intimacy in and higher satisfaction with interpersonal relationships (Baumeister, 1995; Meeus, 1996; Waterman, 1992).

In contrast to the positive outcomes associated with achieving an identity in adolescence, the absence of a relatively stable sense of identity may contribute to negative consequences such as low self-esteem, depression, and anxiety (Marcia, 1980, 1993). Baumeister (1995) emphasized this point when he stated, "People with low self-esteem have self-concepts that are confused, self-contradictory, inconsistent, incomplete, and ill-defined" (p. 80). The difference between psychological well-being of individuals who have and have not been successful at developing an integrated, relatively stable identity becomes even greater as individuals become older (Meeus, 1996). Taken together, these research findings emphasize that identity development contributes not only to health and well-being in adolescence, but also to adult health and well-being. As Marcia stated (1980), "Individuals
‘do’ better and feel better about themselves and others when they ‘have’ it [identity]” (p. 181). Thus, identity development is a treatment goal that would facilitate the TR goal to promote optimal health and well-being in clients they serve (Austin, 1998; Austin & Crawford, 2001; Coyle, Kinney, Riley, & Shank, 1991).

Theoretical Perspectives on Identity Development

Devine and Wilhite (1999) recommended that therapeutic recreation professionals, “use theoretical perspectives as the framework for development of interventions, services, and research” (p. 30). The following section presents the ego-identity status paradigm (Marcia, 1966) as one theoretical framework that could guide the development and implementation of TR interventions to facilitate identity development. There are other models of identity development (see Muuss, 1996; Santrock, 1996); however, Marcia’s ego-identity status paradigm has been the basis for the majority of empirical research on identity development and psychosocial outcomes in the past 30 years (Lavoie, 1994; Meeus, 1996).

Marcia’s ego-identity status paradigm is an extension of Erikson’s (1950) eight stage theory of psychosocial development. Erikson (1959/1980) defined identity as “a persistent sameness within oneself (self-sameness) and a persistent sharing of some kind of essential character with others” (p. 109). He recognized that individuals have many different personalities depending on the people they are with and the various contexts they are in (e.g., home with family, work, leisure with peers), however, he emphasized the necessity of one’s identity to include a degree of coherent organization of different domains of identity. He stated, “The sense of ego identity, then, is the accrued confidence [in] one’s ability to maintain inner sameness and continuity” (Erikson, 1959/1980, p. 95). Radical for his time, he emphasized that identity was not only an intrapsychic process but also an interpersonal process that was imbedded in a social context (Erikson, 1968). In the last 20 years, researchers have emphasized this duality of identity development as both individuation and social relatedness (Adams & Marshall, 1996; Archer, 1994; Josselson, 1980; Kroger, 1993, 1996). Individuation is the sense of one’s own individuality, uniqueness, or separateness (Adams & Marshall, 1996), including perception of one’s own body, name, and various assigned and chosen labels such as one’s sex or race (Baumeister, 1995). Social relatedness refers to the need for group identification, a sense of belongingness, and ability to develop relationships with other people (Adams & Marshall, 1996). A clear, coherent sense of identity enables people to make choices and decisions, to self-regulate (i.e., take care of one’s body, manage responsibilities, manage emotions) and to maintain on-going relationships with others (Baumeister, 1995). Successful identity development also contributes to increased confidence and ability to deal with both negative and positive life events and changes (Baumeister, 1995; Waterman, 1992).

In Erikson’s (1950) eight stage theory of psychosocial development, each stage consists of a unique developmental task or crisis that must be successfully resolved for optimal psychosocial development. Failure or incomplete resolution of the developmental task in one stage results in negative impacts in developmental tasks of later stages. The fifth developmental stage in Erikson’s theory is experienced during the mid to late adolescent years. During this stage the developmental issue is resolving the crisis or task of “identity versus identity confusion” (Erikson, 1959/1980, p. 94). Erikson believed that, although identity formation continues throughout the life cycle, the formation of a strong and coherent sense of identity represents the crucial developmental step associated with the transition from adolescence to adulthood (1959/1980, 1968).

Marcia (1966) operationalized Erikson’s concept of identity versus identity confusion with the development of the Ego Identity Status Paradigm. Marcia (1980) defined identity
as "... a self-structure—an internal, self-constructed, dynamic organization of drives, abilities, beliefs, and individual history" (p. 161). This internal organization of drives, goals, beliefs, and personal history guides individuals in their decisions and behavior as they encounter situations in their lives. The Identity Status Paradigm includes (a) the process of forming an identity (exploration and commitment) and (b) four possible "statuses" or outcomes of the resolution of the identity versus identity diffusion stage.

According to Marcia (1966, 1980) the two major processes involved in identity development are the exploration of alternative beliefs in various domains (e.g., leisure, gender roles, sexuality, religion) and commitment to personally chosen identity, beliefs, and values regarding these domains (e.g., seeing oneself as a kayaker, feminist, lesbian, or Muslim). Exploration of alternative beliefs refers to the process of encountering and examining beliefs or values that differ from those with which one was raised or that are dominant within their society. Commitment refers to the process of either (a) retaining those beliefs handed down from parents, authority figures, or society; (b) rejecting previous beliefs in favor of embracing some new beliefs discovered during the exploration process; or (c) retaining some of one's original beliefs while rejecting others in favor of new beliefs. Commitment also implies a decision to pursue actions and activities that are in keeping with claimed values or beliefs (i.e., identity). Furthermore, the processes of exploration and commitment will occur in various domains or areas of life (e.g., recreation/leisure, friendship, sex roles, dating, religion, vocation). As previously stated, for optimal development and coping, these multiple identities (beliefs/values in these different domains) must be incorporated and organized into some meaningful, coherent identity in a minimally contradictory manner (Baumeister, 1995; McAdams, 1997).

Based on the processes of exploration of alternative beliefs and commitment to personally held beliefs and values, Marcia (1966) proposed that individuals could be classified into one of four identity statuses at any given point in time. The four identity statuses in Marcia's model are identity diffusion, identity foreclosure, identity moratorium, and identity achievement. Individuals in the identity diffusion status have not explored alternative roles, beliefs, or values, nor have they made any commitments to such roles, beliefs, or values. They are not only undecided regarding their identity but are also not concerned about pursuing such matters. Individuals in the identity foreclosure status have made a commitment to a set of beliefs, values, and roles, but have not engaged in the exploration process. Rather, these adolescents have adopted the values, beliefs, and or occupational choices designated as appropriate by their parents, society, or other authority figures in their lives. Individuals in the identity moratorium status are in the midst of exploration but have either not committed or have only vaguely defined their commitments. These adolescents are actively questioning alternatives and options through a variety of means but have yet to solidify their commitment to an identity. Individuals who have been through the exploration process and who have made a commitment are said to be in the identity achieved status. These people have a relatively stable sense of self and have come to their beliefs, values, and goals as a result of exploring various alternatives and choosing for themselves. Archer (1994) emphasized the benefit of engaging in the processes of exploration and commitment as described by Marcia when she stated:

Individuals who explore alternatives and subsequently arrive at self-definitional commitments are more likely to express personality characteristics, cognitive and interpersonal stages, and other behaviors that are deemed healthy and sophisticated relative to individuals who do not make commitments or do so without considering alternatives. (p. 4)
An example may increase understanding of Marcia's paradigm. A common issue for adolescents is dating and relationships. The Carnegie Council on Adolescent Development (1992) stated, "teens consistently voice their need for help in understanding and exploring this topic [human sexuality]" (p. 78). For some adolescents, sexual orientation is a complex issue that may result in them being seen by TR professionals. In the United States, most adolescents are raised with the assumption that they will be heterosexual. Adolescents (particularly male) who are either not sure of their sexual identity, or have realized that they are not heterosexual, are often at risk of experiencing a variety of problem behaviors (Caldwell, Kivel, Smith & Hayes, 1998). For example, individuals who are not heterosexual are more likely to be physically assaulted in places of public leisure (Compton, 1991), to miss school because they fear for their safety (ACLU, 2000), and to attempt suicide (Remafedi, Farrow, & Deisher, 1991) as compared to heterosexuals. Thus, TR professionals are likely to work with gay, lesbian, or bisexual (GLB) adolescents who have acquired a physical disability as a result of being assaulted, have been adjudicated for truancy, are experiencing depression, or have been hospitalized following a suicide attempt.

Identity Development and Implications for TR Practice

Marcia's (1966) identity status paradigm can be used to inform and guide TR professionals during the TR assessment, planning, and implementation phases of service delivery. During the TR assessment process, knowledge and understanding of the four identity statuses can provide an additional lens through which to understand adolescent behaviors. During the implementation phase, TR professionals can facilitate identity development by using TR interventions as a context in which to facilitate the processes of exploration and commitment. The following section discusses some of the ways TR can incorporate issues of identity formation into TR practice.

Implications for TR Assessment and Planning

TR professionals would most likely encounter adolescents in the identity diffusion (exploration absent, commitment absent), identity moratorium (exploration present, commitment absent), or identity foreclosure (exploration absent, commitment present) statuses. These identity statuses are the most common in adolescents under 18 years of age and they are more often associated with less healthy psychosocial and physical outcomes as compared to the identity achievement status (Marcia, 1980, 1993; Meeus, 1996; Waterman, 1992).

Adolescents in the identity diffusion status have not firmly committed to a set of values, goals, and beliefs associated with that identity, so they are more likely to have an external locus of control and be more susceptible to peer pressure (Marcia, 1980, 1993). TR professionals may see these adolescents, especially in correctional facilities or juvenile detention centers, because they engaged in some activity (e.g., substance use, skipping school, skateboarding in a prohibited area) because "all of my friends were doing it." Possible treatment goals for adolescents in the identity diffusion status would be: (a) to identify personal goals; (b) to develop a personal value system that would guide behavior; and (c) to use leisure in ways that contribute to, versus impede, progress toward personal goals. These interventions would facilitate identity development as well as achieve desired TR outcomes such as participation in legal leisure behaviors and reduced recidivism (Austin & Crawford, 2001).

Individuals in the identity moratorium status report the highest anxiety among the four statuses and have a tendency toward rebellion (Marcia, 1980, 1993). TR professionals may encounter adolescents in this status because they are rebelling against the wishes of their
parents or guardians while engaging in the identity development process of exploration or because of issues related to anxiety disorders (e.g., self-harm, substance abuse). In attempts to explore beliefs, values, or identities that are different from those of parents or guardians, tremendous conflict between adolescents and adults may result. This conflict could escalate to the point that adolescents become severely depressed, lie to parents about their whereabouts, or blatantly disobey parents’ wishes/rules. These behaviors could lead to placement in a psychiatric hospital with a diagnosis of depression or oppositional-defiant disorder.

TR professionals who assess adolescent behaviors with respect to identity development could develop treatment goals that help youth deal with their issues of identity development and facilitate that development through less problematic means. For example, some possible treatment goals for adolescents in the identity diffusion status could be to (a) communicate with parents regarding wishes to develop own identity and (b) use leisure contexts to engage in the process of exploration in ways that are acceptable to parents/guardians.

Individuals in the identity foreclosure status typically have an external locus of control, score highly on measures of socially stereotypical and authoritarian thinking, and are less able to deal with complex tasks or situations (Marcia, 1980, 1993). TR professionals may encounter clients in the identity foreclosure status because of two general reasons. First, perhaps the beliefs and associated behavior patterns with which an individual has been raised are in opposition to those of the dominant culture. For example, adolescents raised in abusive or violent homes may learn that aggression and violence are ways to resolve problems. Alternatively, it may be that an adolescent has feelings or wants to engage in behaviors that are contrary to those condoned by one’s parents and becomes depressed or suicidal as a result of the conflicting feelings and beliefs (e.g., a male adolescent recognizes he is sexually attracted to other males but has been raised to believe that this is evil). Some possible treatment goals in this example could be to: (a) consider viewpoints that are different from those currently held by the adolescent, (b) engage in processes of exploration and consideration of various alternative viewpoints, and (c) express commitment to stated values and identity that will guide future leisure related behavior.

Individuals in the identity achievement status are less likely to be seen by TR professionals for treatment purposes because, as mentioned previously, this status has been consistently associated with healthier psychosocial and health related outcomes (Marcia, 1980, 1993; Waterman, 1992). However, individuals who are identity achieved may experience greater levels of difficulty if they acquire an injury or illness that substantially alters their identity (e.g., SCI, traumatic brain injury, schizophrenia) precisely because of the commitment to that established identity (e.g., athlete, homecoming queen). An example of this is where an adolescent, whose identity, values, and goals all center around her identity as a basketball player, acquires an SCI resulting in paraplegia. A TR professional would have to facilitate the grieving of her old identity and development of a new identity in order to help the adolescent adjust to her disability. In this case, possible treatment goals would be to: (a) integrate pre and post injury identity, (b) identify ways to continue participation in basketball related activities, and (c) identify community resources to participate in wheelchair basketball.

Implications for TR Intervention

Recent literature provides evidence that leisure is a context to explore identity related issues (e.g., Hutchinson, 1997; Kivel, 1996; Kleiber, 1999; Kleiber & Kirshnit, 1991), as well as to commit to and affirm claimed identities (Donnelly & Young, 1988; Haggard & Williams, 1992). TR professionals can facilitate identity development by structuring interventions to provide opportunities for exploration and commitment in areas relevant to their adolescent clients.
Facilitating the processes of exploration and commitment could be done through interventions already used by therapeutic recreation professionals. For example, therapeutic recreation professionals can and do use expressive art as a therapeutic medium (Datillo, 2000). Murray (1997) described journals as a way to process life-threatening illnesses, to make sense of family relationships, and to integrate ability/disability into one's identity. She stated, "participants remade their identities as persons recovering from illness or trauma by making coherent narratives in daily creative journal activities" (p. 71). Journals provide a way for adolescents to express and reflect upon issues such as body image, peer/family relationships, hobbies or leisure pursuits, dating, religion, or goals for their future (exploration) and clarify their own beliefs, goals, and identities (commitment). For example, adolescents who see little possibility or hope for a future (e.g., diagnosis of depression) could be directed to write an "imaginary autobiography." In such a narrative they would imagine themselves to be older (perhaps by 50–60 years) and write the biography they would ideally create. TR professionals can then help adolescents to find aspects of this life that could become reality and assist them in striving for such a future (e.g., provide encouragement, help develop action plan).

Another way to facilitate the processes of identity development as outlined by Marcia is through values clarification and moral development discussions. These facilitation techniques can be used in both inpatient and community based settings. During these discussions, TR professionals would need to facilitate a safe atmosphere for those involved and stimulate critical thought about as many different views as possible. The discussion of all points of view on a topic would facilitate the exploration process. A closing activity, wherein each adolescent reflects on all points of view and then states or writes her or his beliefs, would facilitate the commitment process. For example, TR professionals treating adolescents with eating disorders could use values clarification techniques to facilitate discussion and reflection about what it means to have a healthy body (e.g., does one have to be skinny, muscular, active, and so forth). Various beliefs could be discussed and debated and then adolescents could be directed to state or write which belief they would like to incorporate into their own identity and value system.

Recommendations for Therapeutic Recreation Professionals

One broad recommendation to TR professionals who strive to facilitate identity development among adolescents is to listen to what they have to say. Although setting may dictate to a degree the focus of TR interventions (e.g., substance abuse treatment would focus on drug/alcohol use), TR professionals can address many areas relevant to adolescent identity development. The Carnegie Corporation (1992) found that adolescents wanted youth interventions to address issues such as "vocation, sexual relationships, coping with violence, and issues of sexual orientation" (p. 79). TR professionals need to facilitate frank and open discussions and to help youth think critically about all aspects of these issues. Also, it is important to allow adolescents to freely express their views or beliefs, even if what they are saying seems trivial, convoluted, or "not appropriate." If adolescents are limited to what they can say during TR interventions, TR professionals will miss opportunities to help teens explore critical issues.

Some research supports the assertion that identity development is a treatment/program goal relevant specifically to TR (e.g., Hutchinson, 1997; Groff, 1999). However, additional research is needed regarding the utility of identity development as a TR intervention. Research on identity development as one TR outcome should follow the same recommendations as other research in TR. Coyle, Kinney, and Shank (1991), for example, encouraged collaboration between TR academicians and practitioners, among researchers, and the use of a variety of research designs. Case
studies and single-subject designs may be especially useful for inpatient settings because of the individualistic focus of treatment. These designs would be most beneficial if they included a longitudinal perspective.

To study the effects of identity development as an outcome relevant to substance abuse treatment, for example, a client's identity status could be determined using the Identity Status Interview (Marcia, 1966; Adams, Bennion, & Huh, 1989). Follow-up data on this client could be collected at six month and yearly intervals to determine if identity achievement resulted in, or contributed to, maintenance of sobriety. Community-based TR professionals could study the impact of identity development interventions on groups of adolescents. For example, TR professionals could implement programs to facilitate identity development through park and recreation community centers or after school programs. Adolescents participating in these programs, could be followed over a period of months or years to determine the outcomes associated with identity development programs. Research investigating the efficacy of identity development interventions on health promotion and wellness would directly address a documented priority in TR research (Coyle, Kinney, Riley, & Shank, 1991).

Identity development is a critical task of adolescence and is associated with healthy and successful outcomes (Marcia, 1993). Incorporating identity-related goals such as higher self-esteem, reduced susceptibility to peer pressure, increased satisfaction with interpersonal relationships, lower anxiety, and better coping skills into practice contributes to the long term TR goal of optimal health and well being. Marcia's (1966) identity status paradigm is one theoretical framework that can help TR professionals facilitate identity development.

References


