

University of Pretoria etd - Coetzee, J C (2003)

**The psychosocial themes in adolescents
diagnosed with a co-morbid Disruptive
Behavior and Mood Disorder**

by

J.C. Coetzee

**A mini-dissertation submitted in partial fulfillment
of the requirements for the
Masters degree
in
Clinical Psychology
at the
Department of Psychology
University of Pretoria**

Supervisor: Prof. D. Beyers

March 2003

Acknowledgements

First and foremost I would like to thank my supervisor Professor Dave Beyers for his inspiration and guidance during the writing of this dissertation.

I would also like to thank my family and friends for their support and understanding.

A big thanks to the University of Pretoria for providing excellent resources making this research possible.

Finally I would like to thank my God, Jesus Christ for his guidance and strength.

Abstract

This study is an investigation into the psychosocial themes present in the DSM-IV diagnosis of adolescents diagnosed with a comorbid Disruptive Behavior and Mood Disorder. These themes are viewed from a psychosocial theoretical perspective. The study focuses on answering four questions.

- Firstly, what are the psychosocial themes present in the diagnosis of adolescents diagnosed with a comorbid Disruptive Behavior and Mood Disorder?
- Secondly, how does these themes impact the adolescents psychosocial development?
- Thirdly, what role does these themes play as causative factors of Disruptive Behavior and Mood Disorder symptoms in adolescence?
- and lastly does these themes represent interactional processes reinforcing a reciprocal pattern of behavior and mood disorder symptoms?

These questions are all viewed taking the psychosocial development of the adolescent into account.

Index

Chapter 1: Introduction	1
Chapter 2: Psychosocial theory and literature survey	2
1. Introduction	2
2. Psychosocial theory	2
3. Psychosocial development of early adolescence	5
3.1 The life stage of early adolescence	6
3.2 Developmental tasks	6
3.2.1 Physical maturity	7
3.2.2 Formal operations	8
3.2.3 Emotional development	9
3.2.3.1 Adolescents and behavior problems	9
3.2.3.2 Adolescents and depression	11
3.2.4 Membership in the peer group	13
3.2.5 Sexual relationships	15
3.3 Psychosocial crisis	16
3.4 Resolving the psychosocial crisis	18
3.5 Radius of significant relationships	19
3.5.1 Adolescents and their parents	19
3.6 Coping behavior	22
3.7 Ego quality vs. core pathology	22
3.8 Personal identity	23
4. Psychosocial theory evaluated	25
Chapter 3: Research method	27
1. Introduction	27
2. Research problems and aims	27
3. Research method	28

4. Research design	28
4.1 The multi disciplinary team	29
4.2 Selection of cases	29
4.2 Data collection techniques	30
5. The diagnosis	30
5.1 The Diagnostic and Statistical Manual of Mental Disorders	31
5.2 The diagnostic criteria	33
5.2.1 Mood disorders	33
5.2.1.1 The depressive spectrum disorders	34
5.2.1.2 The bipolar spectrum disorders	37
5.2.2 Disruptive behavior disorders	43
5.3 Validity of the DSM-IV diagnosis	45
5.4 Reliability of the DSM-IV diagnosis	46
6. The sample population	46
7. Ethical implications	47
Chapter 4: Results: Psychosocial themes identified	47
1. Introduction	47
2. Prevalence of psychosocial themes in 14 cases	47
3. Common denominators	49
4. Interactional factors	49
Chapter 5: Discussion	50
1. Introduction	50
2. Psychosocial implications	51
2.1 The psychosocial crisis	52
3. Psychosocial themes as causative factors in behavior and mood disorders	55
5. Psychosocial themes as interactional processes reinforcing a reciprocal pattern of behavior and mood disorder symptoms	57

Chapter 6: Conclusion	58
1. Introduction	58
2. Critique and recommendations	60
References	62
Appendix	69

Index

Chapter 1: Introduction	1
Chapter 2: Psychosocial theory and literature survey	2
1. Introduction	2
2. Psychosocial theory	2
3. Psychosocial development of early adolescence	5
3.1 The life stage of early adolescence	6
3.2 Developmental tasks	6
3.2.1 Physical maturity	7
3.2.2 Formal operations	8
3.2.3 Emotional development	9
3.2.3.1 Adolescents and behavior problems	9
3.2.3.2 Adolescents and depression	11
3.2.4 Membership in the peer group	13
3.2.5 Sexual relationships	15
3.3 Psychosocial crisis	16
3.4 Resolving the psychosocial crisis	18
3.5 Radius of significant relationships	19
3.5.1 Adolescents and their parents	19
3.6 Coping behavior	22
3.7 Ego quality vs. core pathology	22
3.8 Personal identity	23
4. Psychosocial theory evaluated	25
Chapter 3: Research method	27
6. Introduction	27
7. Research problems and aims	27
8. Research method	28

9. Research design	28
4.1 The multi disciplinary team	29
4.2 Selection of cases	29
4.2 Data collection techniques	30
5. The diagnosis	30
5.1 The Diagnostic and Statistical Manual of Mental Disorders	31
5.2 The diagnostic criteria	33
5.2.1 Mood disorders	33
5.2.1.1 The depressive spectrum disorders	34
5.2.1.2 The bipolar spectrum disorders	37
5.2.2 Disruptive behavior disorders	43
5.3 Validity of the DSM-IV diagnosis	45
5.4 Reliability of the DSM-IV diagnosis	46
6. The sample population	46
7. Ethical implications	47
Chapter 4: Results: Psychosocial themes identified	47
1. Introduction	47
2. Prevalence of psychosocial themes in 14 cases	47
3. Common denominators	49
4. Interactional factors	49
Chapter 5: Discussion	50
1. Introduction	50
2. Psychosocial implications	51
2.1 The psychosocial crisis	52
3. Psychosocial themes as causative factors in behavior and mood disorders	55
10. Psychosocial themes as interactional processes reinforcing a reciprocal pattern of behavior and mood disorder symptoms	57

Chapter 6: Conclusion	58
1. Introduction	58
2. Critique and recommendations	60
References	62
Appendix	69

Chapter 1

Introduction

The inspiration for this study was gained through the experiences of the researcher while working as an intern psychologist in the adolescent unit of a psychiatric hospital. Certain adolescents were diagnosed with a comorbid mood and behavior disorder and certain similarities in psychosocial themes on axis IV of the DSM-IV diagnoses were noticed. The researcher focuses on axis IV because of the belief that the axis IV diagnosis plays an important role in the identification, understanding and treatment of both mood and behavior disorders in adolescence.

The observations raised the following questions:

- What are the psychosocial and environmental themes in the DSM-IV diagnosis of adolescents that can be identified and associated with a comorbid mood and behavior disorder?
- How does the identified themes fit into the overall psychosocial developmental picture of the adolescent?
- Are these themes indicative of causal factors and not just a result of the disorder?
- Does these themes represent interactional processes which reinforces a reciprocal pattern of behavioral and mood disorder symptoms.

The study will attempt to address these questions from both the literature and the researchers view.

In chapter two psychosocial theory and a literature review will be discussed. Chapter three will focus on the research method employed in this study. Chapter

four will be concerned with the results and the psychosocial themes identified. In chapter five there will be a discussion addressing the specific research questions and will be followed by chapter six with the concluding remarks.

Chapter 2

Psychosocial theory and literature survey

1. Introduction

In this chapter the assumptions underlying psychosocial theory is briefly described. Concepts explaining the theory will be addressed and the psychosocial development of adolescence are explained.

2. Psychosocial theory

In psychosocial theory growth across the life span is addressed. Issues of central importance from infancy through old age are identified and differentiated. This perspective allows one to consider changes that take place during childhood that affect functioning in later life. The impact of relationships at various life stages is also highlighted, emphasizing that the quality of a child's environment and development of psychosocial competence depend on those who are responsible for the child's care.

The assumption is that individuals have the capacity to contribute to their own psychological development at every stage of their lives. People integrate, organize, and conceptualize their own experiences in order to protect themselves, to cope with the challenges they face, and to direct the course of

their own lives. Therefore, the development is not entirely dependent upon biological and/or environmental influences.

This view also takes into account the active contribution of culture to individual growth. At each life stage, cultural goals, aspirations, opportunities, and social expectations make demands on individuals. These demands pose a challenge to the individual to work through it successfully and in so doing lays the groundwork of the next developmental stage. This working through influences the social systems within which the person's capabilities will be developed.

According to Newman and Newman (1997) psychosocial theory presents human development as a product of the interaction between the individual's mental representations, needs and abilities (psycho) and societal resources, expectations, and demands (social).

Psychosocial theory then as it will be applied it in this particular study is based on six organizing concepts:

- 1. Stages of development

A stage of development is a period of life that is characterized by a specific underlying organization. Every life stage has unique characteristics that differentiate it from previous and following life stages. In the working through of each life stage different skills are developed that serves as resources for mastering the challenges presented by the developmental tasks, psychosocial crises, central process and significant relationships of the following life stages.

- 2. Developmental tasks

The developmental tasks consist of competencies and skills that assist the individual in mastering the environment. They reflect areas of accomplishment in physical, cognitive, social, emotional and self-developing

during each life stage. These developmental tasks build on one another, success in learning the tasks of one stage leads to development and greater chances of success in learning the tasks of later stages, failure though in learning the tasks of one stage will make it more difficult to master the tasks of later stages.

- 3. Psychosocial crises

The psychosocial crises involve the person making psychological adjustments to social demands in each life stage. Crises here refer to normal stressors and strains experienced in a certain life stage. At each stage society has certain social demands and expectations of the individual. During each stage the individual tries to resolve this tension by adjusting to society's demands and views them in terms of personal experience.

- 4. A central process of resolving the crisis of each life stage

Every psychosocial crisis involves some discrepancy between a person's developmental competencies at the beginning of the stage and societal pressures for more effective, integrated functioning.

The central process then refers to a mechanism that links the individual's needs with cultural requirements or expectations at each life stage. Significant relationships and relevant competencies change at every life stage, so stage specific modes of psychological work and social interaction must occur if a person is to continue on the next stage.

- 5. A radiating network of significant relationships

Erikson (1982) recognized a radius of significant relationships at each stage of development. At first a person focuses on a small number of significant relationships. During childhood, adolescence, and early adulthood, the number of significant relationships expands. In middle and later adulthood

the person often returns to a small number of significant, and important relationships that provide opportunities for great depth and intimacy.

- 6. Coping behavior, that people generate to meet new challenges
Coping behavior involves the active attempt to resolve stress and find solutions to the developmental challenges of each stage. Coping behavior allows for the development and growth of the individual by exploring new, original, creative, and unique ways of dealing with problems and challenges.

(In Newman & Newman, 1997)

For the purpose of this study the focus is on aspects concerning early adolescent development that ranges from age 12 to 18. A brief overview of development during adolescence is given below.

3. Psychosocial development of early adolescence

Kail and Cavanaugh (1996) say that adolescence is a "recent cultural invention". The reason is that for much of recorded history, "children moved directly into adulthood when they attained puberty; they were considered to be young adults".

Today in modern western culture the transition towards adulthood is gradual and spans the teenage or adolescent years. During this period of adolescence various stages of development are recognized.

3.1 The life stage of early adolescence

The life stage of early adolescence is characterized by an increase in responsibility and higher expectations for performance, with new opportunities for independent decision-making. These characteristics inevitably produce new challenges for the adolescent.

Male and female adolescents experience rapid physical changes in these years. These changes also influence the way the different sexes view each other and awaken new urges previously foreign to the adolescent. This life stage is also often associated with conflict between adolescents and their parents, teachers and the community. In the midst of these personal and social changes adolescents seek support, validation and protection from both parents and peers. The results of peer group relations and parental relations can have both a positive and negative impact on the adolescent's development (Louw, Van Ede & Louw, 1998; Newman & Newman, 1997).

3.2 Developmental Tasks

Most psychologists are in agreement that adolescents have to confront two major tasks:

- 1) "Achieving a measure of autonomy and independence from one's parents.
- 2) Forming an identity, creating an integrated self that harmoniously combines different elements of the personality" (Craig, 1996; Kail & Cavanaugh, 1996).

During an individual's development each life stage can be seen as a window of opportunity where the individual is sensitive for acquiring certain skills and mastering certain developmental tasks, when a certain stage has been worked through the individual continues to further develop these tasks.

The new challenges in early adolescence are physical maturation, formal operational thinking, emotional development, membership in peer groups and sexual relationships.

Life stage

Early adolescence:

Developmental tasks

Physical maturation

Formal operations

Emotional development

Membership in the peer group

Sexual relationships

(In Newman & Newman, 1997)

3.2.1 Physical maturation

Physical maturation in the adolescent includes an increase in weight and muscle strength. Weiten (2001) calls it the "growth spurt". It also entails the maturation of the reproductive system, the appearance of secondary sex characteristics, and changes in body shape. These changes generally begin at around age 11 for females and 13 for males (Kail & Cavanaugh, 1996).

Pubertal development can influence psychological and social development in three major ways. Firstly physical growth alters a person's actual ability to perform tasks. In early adolescents the adolescents are taller and physically stronger than they were in the middle childhood phase and thus have greater coordination and endurance. Secondly physical growth alters the way the adolescent is perceived by others. Thirdly physical growth also influences the ways in which adolescents perceive themselves. They may feel ashamed by their physical changes or view themselves as being closer to adulthood than childhood (Louw, Van Ede & Louw, 1998; Weiten, 2001).

Physical development enables adolescents to think of themselves as approaching adulthood. Kail and Cavanaugh (1996) speaks of development for adolescents during teenage years as "rites of passage to young adulthood". It also influences the adolescent's identification with the role of man or woman. The developing adolescent becomes more egocentric and self-involved as physical maturation progresses. These physical changes produce ambivalence in the adolescent. If the family and peer group are not supportive, negative feelings and conflicts are likely to result (Weiten, 2001).

3.2.2 Formal operations

As physical maturation takes place so also does mental development. Early adolescents start thinking different about the world. Thought processes also become more abstract. Thinking becomes more reflective, and adolescents are increasingly more aware of their own thoughts.

According to Inhelder and Piaget (1958) formal-operational thinking is the highest level of thinking that can be reached and is seen by Graig (1996) as the hallmark of adolescent cognitive change. This level of thinking is reached by adolescents between ages 12 and 15 and is characterized by the ability of abstract thinking, hypothetical-deductive thinking, the ability to reason from the possible to the real, scientific thought, reflective abstraction and inter-proportional reasoning.

Formal operational thought can be described as a second-order process (Watzlawick, Weakland & Fisch, 1974). For Inhelder and Piaget (1958) first order is to discover and examine relationships between objects. Second order involves thinking about one's thoughts, finding links between relationships and maneuvers between reality and possibility.

3.2.3 Emotional development

Early adolescence is often referred to as a time of emotional instability, moodiness and emotional outbursts. Adolescents become more aware of their own emotions and faces the challenge of coping with these newly experienced emotions.

Two common psychosocial phenomena, which seem to surface during adolescence is adolescents presenting with problem behavior and adolescents that becomes depressed.

3.2.3.1 Adolescents and behavior problems

Some adolescents experience difficulty in controlling their emotions and this can then manifests in impulsive and/ or deviant behaviour. The impulsiveness and deviant behaviour may lead to adolescents being involved in delinquent acts.

Research however (Steinberg, 1990; Offer, Ostrov, Howard & Atkinson, 1998) is in agreement that adolescence is not necessarily a period of rebelliousness and delinquency. Steinberg's research concludes that most adolescents admire and love their parents; they rely on them for advice, embrace most of their values and feel loved by their parents. Kail and Cavanaugh (1996) even suggests that rebelliousness during adolescence is a myth and that the description of "storm and stress" is an unfair judgment on adolescence.

Yet when adolescents present with behavioral problems a chain reaction may follow. Society starts to view the adolescent as troublesome and therefore starts to treat him or her differently than other adolescents. The adolescent might experience this as rejection. If we take into account that rejection from the parents or peer group might play a causative factor in adolescents displaying behavior problems, rejection by society will only reinforce the pattern of behavior

problems and delinquency. If adolescents with behavioral problems aren't treated effectively this might lead to more serious problems and further problems with the law up until adulthood.

Substance abuse is increasingly becoming a problem amongst adolescents. Various factors play a causative role in adolescent substance abuse; these include emotional problems, physical or emotional abuse, lack of supervision, peer group pressure and rebelliousness. Adalbjarnardottir (2002) found that adolescents' psychosocial maturity, in particular their degree of awareness of personal meaning, and the individual themes they raise may be critical in understanding adolescent drinking behavior. In general the higher the level of psychosocial maturity the less alcohol abuse takes place.

Garcia, Shaw, Winslow, and Yaggi (2000) are of opinion that adolescents who experienced high levels of parental rejection and high levels of sibling conflict have higher levels of aggressive behavior as reported by mothers and teachers. It seems then that interaction within the family plays a significant role in adolescents developing behavior problems. Parental rejection and sibling conflict may create in the adolescent an irritable mood, which might lead to behavior problems.

Pope and Bierman (1999) stated that a pattern of irritable and inattentive behaviors plays a key role in predicting the stability and severity of elementary school peer-relations problems and adolescent social maladjustment. Although aggressive and withdrawn behaviors showed stability and made contributions to peer difficulties in elementary school and in adolescence, the developmental risks for social maladjustment were greatest in boys who showed problem profiles that included irritable-inattentive behaviors.

3.2.3.2 Adolescents and depression

Depression seems to be of particular concern in adolescence and is often associated with adolescent suicide. This may be a particular problem with adolescents with a depressed mood and who lacks impulse control. They might attempt suicide without realizing the potentially fatal consequences. There is also a link between depression and alcohol and drug abuse. This is sometimes referred to as self-medication (Kaplan & Sadock, 1998). In an attempt to alleviate the unwanted feelings of associated with depression the adolescent might turn towards drugs and alcohol as an escape from these feelings. Alcohol and drug abuse have severe consequences for the lives of adolescents. These consequences include a physical and psychological dependence and socialization with negative peer groups. Adolescents might even fall into a deeper depression because a great number of substances used to alleviate depressive feelings are in fact themselves central nervous system depressants; therefore the end effect is the adolescent becoming more depressed.

Other negative effects of depression include the lack of motivation and drive which can have a devastating effect on the adolescent's school performance and can also effect the social interactions so crucial to adolescent development. Adolescent depression can be a forerunner of severe adult depression.

Certain factors have been associated with depression in adolescence. Experiences of parental loss or parental rejection have been found to increase an adolescent's vulnerability to depression (Robertson & Simons, 1989). Adolescence is also a period in which loss, failure and rejection may be encountered more often than in previous life stages. As an adolescents circle of relationships increase so too does social expectations. Adolescents report experiencing problems in the following domains: social alienation, excessive demands, romantic concerns, decisions about the future, loneliness and

unpopularity, assorted annoyances and concerns, social mistreatment and academic challenge (Kohn & Milrose, 1993). Peer rejection and social isolation place adolescents at risk for depression. Depressed adolescents also describe their families as more conflictual, negative, and controlling and less cohesive and supportive (Kaslow, Deering, and Racusin, 1994).

Adolescents have to learn coping strategies to deal with these new stressors. According to Larson and Ham (1993) the combination of pressures from parents, especially marital conflicts and economic pressures, and the adolescent's exposure to failures, disappointments, and loss of relationships with peers and in school, are linked to negative mood, especially sadness and depression. Adolescents may become convinced of their worthlessness and this distortion of thought may lead them toward social withdrawal or self-destructive behavior.

Experiences of depression appear to be more common in adolescent girls than in adolescent boys. Although prepubescent boys are somewhat more likely to show signs of depression than prepubescent girls this pattern reverses during adolescence (Newman & Newman, 1997) .

Eamon (2002) found that poverty plays a significant role in adolescents reporting depressive symptoms. She concluded that poor adolescents were more likely to reside with mothers who themselves exhibited symptoms of depression, which, in turn predicted young adolescent's depressive symptoms. Living in economic hardship also places stress on families that can erupt into parent-youth conflict and physical forms of punishment.

Cicchetti and Toth (1998) found that 40 to 70 percent of depressed children and adolescents displayed symptoms of another disorder as well. One third of depressed boys also have conduct disorder, and engaged in aggressive activities. Co-morbid conduct disorder and aggression were also associated with a more

negative outcome (Harrington, Fudge, Rutter, Pickles, & Hill, 1991). According to Hammen and Rudolph (1996) patterns of comorbidity also changed with age. Depressed preschoolers were likely to demonstrate separation anxiety; depressed school-age children may also have conduct disorder; and depressed adolescents tended to show substance abuse or eating disorders. This raises the question of the link between depression and behavior disorders and the impact such disorders might have on the adolescent.

Nevertheless, research (Richters & Cicchetti, 1993; Blumstein, Cohen & Farrington, 1988) which have been consistently replicated, seem to accept the following: 1) problem behavior rates shoot up dramatically at the onset of adolescence; 2) it declines almost as precipitously by the end of adolescence, and 3) delinquency rates are highest among adolescents with troubled family backgrounds (Allen, Moore & Kupermine, 1997).

3.2.4 Membership in the peer group

Peer group interactions are vital for psychological development. Effective interaction with age-mates and satisfaction in companionship and closeness with friends provide a support structure for the developing adolescent. Adolescents experience peer relations on a more intimate level with new importance, emphasis is placed on peer approval and to belong to a definable group. Adolescent friendships provide opportunities for emotional intimacy, support, and understanding, as well as companionship and fun.

According to Cavior and Dokecki (1973) as mentioned in Newman and Newman (1997) popularity and acceptance into a peer group in high school may be based on one or more of the following characteristics: good looks, athletic ability, social class, academic performance, future goals, affiliation with a religious, racial, or ethnic group, sexual orientation, special talents, involvement with drugs or

deviant behavior, or general alienation from school. Although the criteria for membership may not be publicly articulated, groups tend to include or exclude members according to consistent standards. Physical attractiveness continues to be a powerful force in determining popularity. Especially for very attractive and unattractive adolescents, physical appearance may be a primary determinant of social acceptance or rejection.

Kiesner, Cadinu, Poulin, and Bucci (2002) stated that adolescents bonding with deviant peers play a significant role in delinquency. They concluded that it is the interaction between identification and the characteristics of the group with which the adolescent identifies that determines the type of effect that the group may have on the adolescent.

Maxwell (2002) in a study conducted about the role of peer influence across adolescent risk behaviors found that same sex friends' influences adolescents to change his or her risk activity level. Adolescents are twice as likely to participate in risk taking behavior if their friends participate in risk taking behavior. Hussong (2002) also supports these findings, especially related to adolescent substance abuse.

According to Fuligni, Eccles, Barber, & Clements (2001) adolescents who were willing to forgo their parents' rules, their schoolwork, and their own talents in order to keep and be popular with their peers exhibited greater problem behavior and lower academic performance. Those adolescents who exhibit extreme orientation toward peers tend to become involved in delinquent peer groups and have more difficulty during high school.

3.2.5 Sexual Relationships

During adolescence interest in sexual relationships stems from social expectations as well as sexual maturation. Sexual transition can take place in very different contexts for adolescents. It can be a planned event, or an unplanned impulse, often associated with drug and alcohol use. It can also be viewed as a marker of independence or as an act of rebellion and defiance against the family. It can take place in the context of an ongoing close relationship or as part of a casual encounter (Newman & Newman 1997).

According to Buga, Amok and Ncayiyana (1996) and Heaven (1994) adolescents are becoming more sexually active as well as engaging in sexual activities earlier in their lives. Flanery, Rowe and Gulley (1993) and Ketterlinus, Lamb, Nitz and Elster (1992) stated that the earlier the entry into sexual activity and intercourse, the more likely the act is to be part of a profile of high risk behaviour, including alcohol use, drug use, and delinquent activity. The later the entry into a sexual relationship the more likely it is to be seen as a marker of the transition into adulthood or as a planned aspect of deepening commitment in an ongoing relationship. Later entry into sexual relationships may even be a sign of a person's ability to make a conscious decision, which links to the process of formal operational thinking.

Adolescents with higher rates of conduct disorder and substance abuse are particularly prone to be highly sexually active and to engage in unprotected intercourse (Brain & Stallings, 2002).

Sexual relationships do not necessarily imply intercourse. Many levels of sexual activity is involved in becoming a sexually active adult.

Research by Bell, Weinberg and Hammersmith (1981) as well as Patterson (1992) exploring the roots of a person's sexual orientation, has shown the following to be false regarding sexual development:

- 1) Sons become gay as the result of a domineering mother and a weak father.
- 2) Girls become lesbian when they have their fathers as a primary role model.
- 3) Children reared by gay and lesbian parents end up as either gay or lesbian, adopting their parents' sexual orientation.
- 4) Gay and lesbian adults were seduced during childhood by an older person of their own sex.

3.3 Psychosocial crisis

The term psychosocial implies that the crisis is a result of cultural pressures and expectations. In the process of normal development, individuals will experience tension regardless of their culture because of society's need to socialize and integrate its members. The tension itself may not be solely a result of personal inadequacies, an individual's failure to resolve it can seriously limit future growth.

During adolescence the psychosocial crisis is that of group identity versus alienation. Erikson's (1968) account of identity formation contributed to our understanding of adolescence. He speaks of the challenge for the adolescent, a crisis between identity and role confusion. The early adolescent becomes aware of both a desire to belong to a group and of a desire to express his or her individuality.

Group identity refers to an individual's focus on membership and connection within social groups. Newman and Newman (1997) stated that group identity is an extension of the ego system's sense of "we", which originates in the first

attachment relationship of infancy. It is an elaboration of the very early sense of trust, in which an infant establishes a foundation of social connection through which both self and other are defined. The "we" includes the deep desire for and belief in connection with others. The "we" can be compared with the "I" which includes the deep desire to be an independent individual with a sense of personal significance and value. The "we" and the "I" are thus complementary aspects of the ego system, although at times they may be in conflict.

In the process of seeking group affiliation, adolescents are at times confronted with opposing differences between personal and group needs and values. The process of self-evaluation takes place within the context of the meaningful groups with which adolescents identify. Individual needs for social approval, affiliation, leadership, power and status are expressed by the group identifications that are made and rejected during early adolescence (Newman & Newman, 1997).

A positive resolution of the conflict of group identity versus alienation is one in which adolescents associate with an existing group that meets their social needs and provides them with a sense of belonging. In order to experience group identification, a person must be engaged in activities associated with the group. In addition, the group must be positively evaluated by the person for the central role it plays in providing personal meaning and structure.

Alienation refers to a sense of social estrangement, an absence of social support or meaningful social connection. An alienated adolescent does not experience a sense of belonging to a group; rather, he or she is continually uneasy in the presence of peers. A negative resolution of the conflict, which leaves an adolescent with a pervasive sense of alienation from peers, may result from at least three different circumstances. First, adolescents whose parents pressure them to join a particular peer group that does not accept them will probably

experience alienation. Second, adolescents become alienated when they cannot find a group that really meets their personal needs. These adolescents may never become members of a group. A third possibility for a negative outcome occurs when adolescents are rejected by all peer groups. Other adolescents have poor social skills; they are both overly aggressive and domineering or overly withdrawn and socially inept. It is not unusual for adolescents to identify such students as loners or outcasts. All adolescents experience alienation of some sort because of the awareness of their own feelings and thoughts which is also accompanied by a new realization of their own vulnerability, therefore they approach group affiliation with caution (Newman & Newman, 1997).

The tension between expectations for group affiliation and barriers to group commitment is a product of the self-consciousness and egocentrism typical of this life stage, as well as the possibility of group rejection. The lack of peer social support that may result from a negative resolution of this crisis can have significant implications for adjustment in school, self-esteem, and subsequent psychosocial development. Chronic conflict about integration into a meaningful reference group can lead to lifelong difficulties in personal health, work, and the formation of intimate family bonds.

2.4 Resolving the psychosocial crises

The process of affiliation with a peer group requires an adolescent to open up to the pressure and social influence imposed by the group. This process provides the context within which the crises of group identity versus alienation are resolved. Peer pressure might have a positive effect on the adolescent's self-image and self-esteem, serving as a motive for group identification. As members of a peer group adolescents have more influence than they would have as individuals. The peer group expands the adolescent's feelings of connection and protects them from loneliness. At times when family conflicts arise adolescents

seeks comfort and intimacy among peers. For the adolescent to benefit in these ways from affiliation with a peer group they need to focus on attributes that they share with their peers and less on their individuality (Newman & Newman, 1997).

Adolescents experience tension and conflict as peer-group pressure alters adolescents' personal values and beliefs to make them more similar to those of the group members. Adolescents thus have to try and resolve this conflict by reaching a balance between the changes involved in peer group membership and the cost of abandoning personal beliefs.

3.5 Radius of significant relationships

The adolescent stands in various relationships, ranging from those that is more intimate for example with parents and friends to those that is more distant like with teachers and other members of society.

3.5.1 Adolescents and their parents

The importance of parental support during adolescence cannot be understated. Adolescents may evidence a variety of overt signs of independence from their family but they still maintain an emotional attachment to their families and to their family's value orientations. Supportive loving parenting contributes positively to the adolescent's emotional development, giving the adolescent a sense of belonging and support from the parent's side. Robertson and Simons (1989) found that experiences of parental rejection or neglect are closely linked to low self-esteem and depression.

Parent- adolescent relationships are often thought of as characterized by conflict. A parent-adolescent relationship undergoes significant change during early

adolescence. These changes are characterized by the questioning of parental values, moral rules and regulations; distancing, when the adolescent starts spending more time with his friends than with his family, and arguments. Parents often gets upset by these changes and as a result may become even more controlling which could lead to more conflict (Steinberg & Meyer, 1995).

Steinberg (1990) found that conflict between adolescents and their mothers is more common than conflict between adolescents and their fathers. This is most likely due to the fact that the mother is more involved in day to day living than the father.

According to Newman and Newman (1997) adolescents are preoccupied with expressing their own point of view and asserting behavioral and emotional autonomy from parents. They tend to be especially sensitive to parental control, and even mild expressions of parental disapproval or efforts by parents to redirect their behavior are perceived as intrusive. Conflict does not necessarily have a negative impact on the parent-adolescent relationship. A certain amount of conflict is inevitable and even necessary for personality growth. Young adolescents are very attached to their parents and need their emotional support and approval. Parent-child conflict can then be seen as one means for adolescents to achieve autonomy while preserving the bonds of affection and goodwill that have been formed earlier with parents.

When families interact in a frequent reasonable manner and allow for the expression of conflict, parents can communicate more effectively their expectations and adolescents have the opportunity to explain their points of view. As a result, parents and adolescents learn one another's opinions on most issues. Typically though parents may not have as much information about their children's peer relations as about other important topics, and adolescents are

likely to perceive their parents as having little understanding about their social life.

The quality of the home environment has implications for the adolescent's peer relationships as well as for the quality of parent-child interactions. Parents tend to view their children's adolescence as extremely trying. Adolescents are likely to strive for a great deal of behavioral independence. As adolescents gain in physical stature and cognitive skills, they are likely to challenge parental authority. During this time the principles that parents have emphasized as important for responsible, moral behavior are frequently tested. Parents must maintain a degree of authority about standards or limits while permitting their children to exercise their judgment. Parents must also be ready to give support when children fail to meet adult expectations or when they show poor judgment.

A balance of freedom, support and limit setting allows children to become increasingly independent while still being able to rely on an atmosphere of family security. Parents who can respond to their adolescents in an open, supportive way may benefit from the opportunity to clarify their own values. They can begin building a new parent-child relationship that will carry over to their children's adulthood.

Field, Diego and Sanders (2002) conducted a study of high school seniors from a suburban private high school to determine differences between adolescents who rated the quality of their parent and peer relationships as high or low. They found that adolescents with high parent and high peer relationship scores had more friends, greater family togetherness, lower levels of depression and drug use, and a higher grade point average.

Field, Lang, Yando and Bendell (1995) in a study conducted on adolescents' intimacy with parents and friends found that adolescents who had greater self-

esteem, less depressive feelings and no suicidal thoughts felt more intimate with their parents. Those with low danger risk-taking behavior were especially more intimate with their mothers.

3.6 Coping behavior

At each stage of development, those individuals who cope effectively with the challenges and resolve the particular crises in a positive way will gain new psychological strengths and will broaden their range of coping skills. This is referred to as the prime adaptive ego qualities (Newman & Newman, 1997). Those individuals who fail in devising effective coping styles are more likely to develop core pathologies. According to Erikson's (1950) view an adolescent may develop identity confusion instead of a personal identity, which may give rise to significant difficulties in later developmental stages.

Effective coping behavior will aid the adolescent in overcoming the difficult hurdles that lies ahead in his or her further development towards adulthood. As an adolescent successfully copes with life's demands he/she will gain more confidence to face more difficult challenges, this will eventually lead an adolescent to a positive view of themselves as being able to face up to the demands of daily living.

3.7 Ego quality vs. core pathology

A positive resolution of the psychosocial crisis of group identity versus alienation results in achievement of the prime adaptive ego quality referred to as fidelity to others; the capacity to pledge loyalty to a group and to be faithful to one's promises and commitments. Fidelity to others lays the foundation for ensuring

long-term faithfulness in later life to friends, marital partners, children, aging parents, and other groups (Newman & Newman, 1997).

The loyalty to the above-mentioned groups could also result in a social support system, both for the individual as for others. People who function as sources of social support have the ability to remain compassionately connected to others during periods of success and prosperity as well as through periods of hardship and loss.

Isolation refers to the lack of companions, withdrawal from others, and an inability to experience the bond of mutual commitment. Adolescents who experience social isolation are at risk for developing emotional problems. They lack the social support and the group affiliation necessary to develop the coping skills to deal with life struggles. Their social skills, such as communication and commitment might also be impaired.

3.8 Personal identity

According to psychosocial theory identity formation provides the critical foundation for performing the roles and meeting the challenges of adulthood.

The structure of identity has two components: content and evaluation. The content refers to what the adolescent thinks about, values, believes in, and the traits or characteristics by which the adolescent is organized and known by others. The content can then also be divided into the inner or private self and the public self. The private self refers to the adolescent's inner uniqueness and unity, a subjective experience of being the originator of his/her own thoughts and actions and of being self-reflective. The private self recognizes the range of values and beliefs to which the adolescent is committed and can assess the

extent to which certain thoughts and actions are consistent with those beliefs (Glodis & Blasi, 1993).

The public self consists of the many roles the adolescent plays as well as the expectations of others. It develops with greatest intensity during early adolescence. The personal identity is achieved by a synthesis between the private sense of self and the public self derived from the adolescent's many different roles and relationships. The evaluation component of the identity refers to the significance placed on various aspects of the identity content. By emphasizing different aspects of the personal identity, such as certain values or beliefs the adolescent will achieve a unique sense of identity.

Both the content and the evaluation component of identity change over the life course. The basic psychosocial conflict of later adolescence is identity formation vs. identity confusion (Erikson, 1950). This conflict results from the enormous difficulty of pulling together the many components of the self, including changing beliefs and values and changing social demands into a meaningful whole. The result will be an integrated identity that will enable the young adult to act in a positive goal directed manner.

Stage five in Erikson's development theory is adolescence, beginning with puberty and ending around 18 or 20 years old. The task during adolescence is to achieve ego identity and avoid role confusion.

Erikson (1959) stated that the young individual must learn to be most himself where he means the most to others, those others who have come to mean most to him. The term identity expresses such a mutual relation in that it connotes both a persistent sameness within oneself and a persistent sharing of some kind of essential character with others. Ego identity means that adolescents know who they are and how they fit into the rest of society. It requires that they take

all they have learned about life and themselves and mold it into a unified self-image, one that their community finds meaningful.

Johnson (1993) found that negative resolutions of Stages 1-5 of Erikson's theory of psychosocial development might predict the presence of personality disorder symptomatology during late adolescence.

The lack of identity will lead to much difficulty for the adolescent, and Erikson refers to the malignant tendency here as repudiation. They repudiate their membership in the world of adults and, they repudiate their need for an identity. Some adolescents allow themselves to "fuse" with a group, especially the kind of group that is particularly eager to provide the details of your identity: religious cults, militaristic organizations, groups founded on hatred, groups that have divorced themselves from the painful demands of mainstream society. They may become involved in destructive activities, drugs, or alcohol, or they may withdraw into their own psychotic fantasies.

If adolescents successfully negotiate this stage, they will have the virtue of fidelity. Fidelity means loyalty, the ability to live by societies standards despite the adolescent's imperfections and incompleteness and inconsistencies. This does not refer to blind loyalty or accepting the imperfections. If the adolescent feels affiliated to their community, they would want to see it become the best it can be. But fidelity means that the adolescent has found a place in the community, a place that will allow him/her to contribute positively to the community as a whole.

4. Psychosocial theory evaluated

Psychosocial theory provides a broad context, linking development in various stages of life to the resources of society. It also emphasizes ego development

and directions for healthy development across the life span. It therefore provides an effective set of constructs for examining the tension between the individual and society (Newman & Newman, 1997).

When the adolescent is viewed from a psychosocial theoretical perspective it also provides a useful framework for psychotherapy as it views the adolescent in his/her world from the context to the challenges and difficulties adolescents face during their development. The theory also leaves room for psychodynamic factors that play a role in human development.

Weaknesses of psychosocial theory include that the concepts of the theory are abstract and difficult to put in practice. The theory seems to lack on the social side, being much more focused on individual processes than on social processes and expectations. Society's as a whole influences adolescent development significantly. As society changes so to does the demands that society places on the adolescent. Thus the interaction between society and the adolescent's psychosocial development could receive more attention.

Although Smetana (2002) in a cross-cultural study found that freedom in establishing autonomy is important in a variety of cultures for healthy psychosocial development and that mothers from a variety of cultures view the development of an arena of personal discretion as a desired developmental goal, the theory could be further developed especially concerning cultural specific demands at each life stage, emphasizing different expectations amongst different cultures. In one culture the adolescent might be expected to function independently much earlier than in other cultures, as culture differ so too does the demands and expectations they have of their youths.

A further aspect that could receive more attention is the interplay between facets of adolescent psychosocial development. For example, how does adolescent

sexual maturation influence their emotional development and how does peer group interaction influence the aspects of identity development or parental relations. All these questions need to be addressed in order to understand adolescent development as a dynamic interaction between various facets of development.

Chapter 3

Research method

1. Introduction

It is the aim of this study to examine psychosocial themes in the DSM-IV axis IV file diagnosis of adolescents treated at a psychiatric hospital. With psychosocial themes is meant the axis IV DSM-IV diagnosis where psychosocial and environmental problems are noted. The specific focus was on adolescents diagnosed with a comorbid behaviour and mood disorder.

A qualitative content analysis of information gained from the patients' DSM-IV file diagnosis is to be made and compared with those of the qualitative research done on psychosocial theory and adolescent development.

2. Research problem and aims

The hypothesis of the study is that psychosocial themes identified as problem areas, in the DSM-IV diagnosis, are indicative of causal factors in the development of both behaviour- and mood disorder symptoms during adolescence.

Thus the research questions posed is:

- What are the psychosocial and environmental themes in the DSM-IV diagnosis of adolescents that can be identified and associated with a comorbid mood and behavior disorder?

The possible discovery of specific or certain psychosocial themes will be addressed and argued in the discussion of the results taking the following questions into consideration:

- a) How does the identified themes fit into the overall psychosocial developmental picture of the adolescent.
- b) Are these themes indicative of causal factors and not just a result of the disorder?
- c) Does these themes represent interactional processes which reinforces a reciprocal pattern of behavioral and mood disorder symptoms.

3. Research method

The DSM-IV diagnosis, as it appears in the hospital files of adolescents treated at a psychiatric hospital, were investigated. Special attention was given to the axis IV diagnosis as this axis serves the purpose of noting psychosocial or environmental problems present in the patient's life, which is of interest to this study.

4. Research design

An exploratory research was conducted through the use of content analysis.

The research design was mainly qualitative in nature. With regard to a quantitative investigation, only percentages of the number of psychosocial themes as diagnosed on axis IV of the DSM IV diagnosis of the adolescents were calculated.

The patient's files will be used as the main source of information concerning the patients with the above-mentioned diagnosis, as the patients themselves has been already discharged at the time the study was conducted. These files contained the DSM-IV diagnosis.

4.1 The multi disciplinary team

A multi disciplinary team made the DSM-IV diagnoses in the hospital files. The multi disciplinary team consists of a psychiatrist, a registrar (medical doctor specializing in psychiatry), a clinical psychologist, an intern psychologist, an occupational therapist, a social worker and psychiatric nursing staff. The multi disciplinary team decides on the diagnosis in a ward round after carefully reviewing all the available information concerning the patient and discussing it amongst the team members with every team member giving his/her view of the patient. The multi disciplinary team follows a bio-psycho-social approach in the treatment of the patients to ensure, to the best of their ability, that all the treatment needs of the patients are met.

4.2 Selection of cases

The selection of cases was done along the following criteria:

1. The hospital files of both
2. male and female
3. adolescents (aged between 13 and 18 years)

4. of all race's
5. with a DSM-IV diagnosis of both a Depressive Disorder and a
6. Behavior Disorder that were
7. treated at a psychiatric hospital
8. during the period 2001-2002

4.2 Data collection techniques

Content/thematic analysis was used as a data collection technique. Common themes in the above-mentioned patients' five axis DSM-IV diagnosis were identified.

From the files the information from fourteen adolescents, treated for a comorbid behavior and mood disorder between 2001 and 2002 were chosen at random. All fourteen files were analyzed and the DSM-IV diagnosis noted. Particular attention was given to the diagnosis on axis-IV that indicates the psychosocial and environmental problems present in the lives of the patients this study is concerned with.

5. The diagnosis

The multidisciplinary team diagnosed the adolescents using the Diagnostic and Statistical Manual of Mental Disorders (DSM IV, 1994). The following is a description of the DSM IV's exposition of mental disorders, specifically the criteria for behavioral and mood disorders.

5.1 The Diagnostic and Statistical Manual of Mental Disorders

The DSM- IV (1994) is to be used as a tool to distinguish between different mental illnesses and in particular in this study to focus on adolescents with depressive and problem behavior symptomatology.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) first appeared in 1952 and represented a significant diagnostic advance. It was a comprehensive syndromal system that enabled mental health professionals to use a common diagnostic language for the first time. The DSM has been revised ever since. The DSM-IV published in 1994 is the official coding system in the United States, and also in South Africa. The approach to DSM-IV is atheoretical with regard to causes. Thus DSM-IV attempts to describe the manifestations of the mental disorders and only rarely attempts to account for how the disturbances come about. The definition of the disorders usually consists of descriptions of clinical features. Specified diagnostic criteria are provided for each specific mental disorder. These criteria include a list of features that must be present for the diagnosis to be made. Such criteria increase the reliability of clinicians' process of diagnosis.

The DSM-IV is a multi-axial system that evaluates patients along several variables and contains five axes:

- Axis I consists of clinical disorders and other conditions that may be a focus of clinical attention.
- Axis II consists of personality disorders and mental retardation.
- Axis III lists any physical disorder or general medical condition that is present in addition to the mental disorder. The physical condition may be causative, the result of a mental disorder, or unrelated to the mental disorder.

- Axis IV is used to code the psychosocial and environmental problems that significantly contribute to the development or exacerbation of the current disorder. The evaluation of stressors is based on a clinicians' assessment of the stress that an average person with similar sociocultural values and circumstances would experience from the psychosocial stressors. This judgment is based on the amount of change that the stressor causes in the person's life, the degree to which the event is desired and under the person's control, and the number of stressors. Stressors may be positive or negative. Information about stressors may be important in formulating a treatment plan that includes attempts to remove the psychosocial stressors or to help the patient cope with them (DSM-IV, 1994).

The psychosocial and environmental problems are as follows:

- **Problems with primary support group:** These include death of a family member, health problems in family; disruption of family by separation, divorce, or estrangement; removal from the home; remarriage of parent; sexual or physical abuse; parental overprotection; neglect of child; inadequate discipline; discord with siblings; birth of a sibling.
- **Problems Related to the social environment:** These include death or loss of friend; social isolation; living alone; difficulty with acculturation; discrimination.
- **Educational problems:** These include: literacy; academic problems; discord with teachers or classmates; inadequate school environment.
- **Occupational problems:** These include unemployment; threat of job loss; stressful work schedule; difficult work condition; job dissatisfaction; job change; discord with boss or coworkers.
- **Housing problems:** These include homelessness; inadequate housing, unsafe neighborhood.

- **Economic problems:** These include extreme poverty; inadequate finances; insufficient welfare support.
- **Problems with Access to health care services:** These include inadequate health care services; unavailability of transportation to health care facilities; inadequate health insurance.
- **Problems related to interaction with the legal system:** These include arrest; incarceration; victim of crime.
- **Other psychosocial problems:** These include exposure to disasters, war, other hostilities; discord with non-family caregivers; unavailability of social service agencies.

(In Wenar & Kerig, 2000)

In this study particular attention will be given to the diagnosis on this Axis. It is on this axis that the psychosocial and environmental problems that presents in the lives of the adolescent patients, which is the focus of this study, are indicated.

- Axis V is a global assessment of functioning scale in which clinicians judge patients' overall levels of functioning during a particular time. Functioning is considered a composite of three major areas: social functioning, occupational functioning, and psychological functioning. The GAF scale, based on a continuum of mental health and mental illness, is a 100-point scale, 100 representing the highest level of functioning in all areas.

5.2 The diagnostic criteria

5.2.1 Mood disorders (DSM-IV, 1994)

The DSM-IV identifies two major categories for diagnosing mood disorders. These are depressive disorders and Bipolar disorders. In the depressive disorder

group the two main disorders are Major Depressive disorder and Dysthymic Disorder. In the Bipolar disorder group the three main disorders are Bipolar I disorder, Bipolar II disorder and Cyclothymic disorder (DSM-IV, 1994).

The DSM-IV diagnostic criteria for the above mentioned mood disorders are as follows:

5.2.1.1 The depressive spectrum disorders

Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

- 1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: in children and adolescents, can be irritable mood.
- 2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day nearly every day (as indicated either by subjective account or observations made by others).
- 3) Significant weight loss or weight gain when not dieting (e.g., more than 5% of body weight in a month), or decrease in appetite nearly every day. Note: in children, consider failure to make expected weight gains.
- 4) Insomnia or hypersomnia nearly every day.
- 5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

- 6) Fatigue or loss of energy nearly every day.
 - 7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
 - 8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
 - 9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- B. The symptoms do not meet criteria for a mixed episode.
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).
- E. The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

(In Diagnostic and Statistical Manual of Mental Disorders (4th ed.), 1994)

Major Depressive Disorder (DSM-IV, 1994)

- 1) Presence of a single or two or more depressive episodes. Note: To be considered separate episodes, there must be an interval of at least 2 consecutive months in which criteria are not met for a major depressive episode.

- 2) The major depressive episodes are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.
- 3) There has never been a manic episode, a mixed episode, or a hypomanic episode. Note: This exclusion does not apply if all of the manic-like, mixed –like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

(In Diagnostic and Statistical Manual of Mental Disorders (4th ed.), 1994)

Dysthymic Disorder (DSM-IV, 1994)

- A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years. Note: In children and adolescents, mood can be irritable and duration must be at least 1 year.

Presence, while depressed, of two (or more) of the following:

- 1) Poor appetite or overeating
- 2) Insomnia or hypersomnia
- 3) Low energy or fatigue
- 4) Low self-esteem
- 5) Poor concentration or difficulty making decisions
- 6) Feelings of hopelessness

(In Diagnostic and Statistical Manual of Mental Disorders (4th ed.), 1994)

5.2.1.2 The bipolar spectrum disorders (DSM-IV, 1994)

Manic Episode

- A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).
- B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
 - 1) Inflated self-esteem or grandiosity
 - 2) Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
 - 3) More talkative than usual or pressure to keep talking
 - 4) Flight of ideas or subjective experience that thoughts are racing
 - 5) Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
 - 6) Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
 - 7) Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
- C. The symptoms do not meet criteria for a mixed episode.
- D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

- E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

(In Diagnostic and Statistical Manual of Mental Disorders (4th ed.), 1994)

Hypomanic Episode

- A. A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout 4 days, that is clearly different from the usual non-depressed mood.
- B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
 - 1) Inflated self-esteem or grandiosity
 - 2) Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
 - 3) More talkative than usual or pressure to keep talking
 - 4) Flight of ideas or subjective experience that thoughts are racing
 - 5) Distractibility (i.e., attention too easily drawn to unimportant or irrelevant stimuli)
 - 6) Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
 - 7) Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
- F. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.

- G. The disturbance in mood and the change in functioning are observable by others.
- H. The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features.
- I. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

(In Diagnostic and Statistical Manual of Mental Disorders (4th ed.), 1994)

Mixed Episode

- A. The criteria are met both for a manic episode and for a major depressive episode (except for duration) nearly every day during at least a 1-week period.
- B. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
- C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

(In Diagnostic and Statistical Manual of Mental Disorders (4th ed.), 1994)

Bipolar I Disorder, Single Manic Episode

- A. Presence of only one manic episode and no past major depressive episodes. Note: Recurrence is defined as either a change in polarity from depression or an interval of at least 2 months without manic symptoms.
- B. The manic episode is not better accounted for by schizoaffective disorder, and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.

(In Diagnostic and Statistical Manual of Mental Disorders (4th ed.), 1994)

Bipolar I Disorder, Most recent episode Hypomanic

- A. Currently (or most recently) in a hypomanic episode.
- B. There has previously been at least one manic episode or mixed episode.
- C. The mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The mood episodes in criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.

(In Diagnostic and Statistical Manual of Mental Disorders (4th ed.), 1994)

Bipolar I Disorder, Most recent Episode Manic

- A. Currently (or most recently) in a manic episode.
- B. There has previously been at least one major depressive episode, manic episode or mixed episode.

- C. The mood episodes in criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.

(In Diagnostic and Statistical Manual of Mental Disorders (4th ed.), 1994)

Bipolar I Disorder, Most recent Episode Mixed

- A. Currently (or most recently) in a mixed episode.
- B. There has previously been at least one major depressive episode, manic episode or mixed episode.
- C. The mood episodes in criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.

(In Diagnostic and Statistical Manual of Mental Disorders (4th ed.), 1994)

Bipolar I Disorder, Most Recent Episode Depressed

- A. Currently (or most recently) in a major depressive episode.
- B. There has previously been at least one manic episode or mixed episode.
- C. The mood episodes in criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.

(In Diagnostic and Statistical Manual of Mental Disorders (4th ed.), 1994)

Cyclothymic Disorder

- A. For at least 2 years, the presence of numerous periods with hypomanic symptoms and numerous periods with depressive symptoms that do not meet criteria for a major depressive episode. Note: In children and adolescents, the duration must be at least 1 year.
- B. During the above 2-year period (1 year in children and adolescents), the person has not been without the symptoms in criterion A for more than 2 months at a time.
- C. No major depressive episode, manic episode, or mixed episode has been present during the first 2 years of the disturbance. Note: After the initial 2 years (1 year in children and adolescents) of Cyclothymic disorder, there may be superimposed manic or mixed episodes (in which case both bipolar I disorder and Cyclothymic disorder may be diagnosed) or major depressive episodes (in which case both bipolar I and cyclothymic disorder may be diagnosed).
- D. The symptoms of criterion A are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.
- E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).
- F. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

(In Diagnostic and Statistical Manual of Mental Disorders (4th ed.), 1994)

5.2.2 Disruptive Behavior Disorders (DSM-IV, 1994)

Oppositional Defiant Disorder (DSM-IV, 1994)

- A. A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:
- (1) often loses temper
 - (2) often argues with adults
 - (3) often actively defies or refuses to comply with adults requests or rules
 - (4) often deliberately annoys people
 - (5) often blames others for his or her mistakes or misbehavior
 - (6) is often touchy or easily annoyed by others
 - (7) is often angry and resentful
 - (8) is often spiteful or vindictive

Note: Consider a criterion only met if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.

- B. The disturbance in behavior causes significant impairment in social, academic or occupational functioning.
- C. The behaviors do not occur exclusively during the course of a psychotic or mood disorder.
- D. Criteria are not met for conduct disorder and, if individual is age 18 or older, criteria are not met for antisocial personality disorder.

(In Diagnostic and Statistical Manual of Mental Disorders (4th ed.), 1994)

Conduct Disorder (DSM-IV, 1994)

- A. A repetitive and persistent pattern of behavior in which either the basic rights of others or major age- appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months:
- 1) Aggression to people and animals
 - a) often bullies, threatens, or intimidates others
 - b) often initiates physical fights
 - c) has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
 - d) has been physically cruel to people
 - e) has been physically cruel to animals
 - f) has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
 - g) has forced someone into sexual activity
 - 2) Destruction of property
 - a) has deliberately engaged in fire setting with the intention of causing serious damage
 - b) has deliberately destroyed others' property (other than by fire setting)
 - 3) Deceitfulness or theft
 - a) has broken into someone else's house, building or car
 - b) often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)
 - c) has stolen items of non-trivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)
 - 4) Serious violation of rules
 - a) often stays out at night despite parental prohibitions, beginning before age 13 years

- b) has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
 - c) often truant from school, beginning before age 13 years
- B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.
- C. If the individual is age 18 years or older, criteria are not met for antisocial personality disorder.

(In Diagnostic and Statistical Manual of Mental Disorders (4th ed.), 1994)

Disruptive behavior disorder not otherwise specified (DSM-IV, 1994)

This category is for disorders characterized by conduct or oppositional-defiant behaviors that do not meet the criteria for conduct disorder or oppositional defiant disorder. For example, include clinical presentations that do not meet full criteria either for oppositional defiant disorder or conduct disorder, but in which there is clinically significant impairment.

5.3 Validity of the DSM-IV diagnosis

The validity of the DSM-IV diagnosis on the patients' hospital files rests on the one hand on a multi disciplinary team agreeing in the context of a hospital ward round (where diagnosis treatment and prognosis of a particular patient are typically discussed) on the best possible diagnosis of the patient.

The diagnosis on the hospital files are made by a multidisciplinary team which follows a bio-psycho-social approach in treating patients. The multi disciplinary team consists of a Psychiatrist, a Registrar (Doctor specializing in psychiatry), a

Clinical Psychologist, an Intern Psychologist, an Occupational Therapist, and a Social Worker and Psychiatric Nursing Staff.

On the other hand it will rest on the Diagnostic and Statistical Manual of Mental Disorders diagnosis. The results of a number of DSM-IV field trials have been published including those of oppositional defiant disorder and conduct disorder in children and adolescents (Lahey, Applegate, Barkley, Garfinkel, McBurnett, Kerdyk, Greenhill, Hynd, Frick, Newcorn, Biederman, Ollendick, Hart, Perez, Waldman & Shaffer, 1994), and mood disorders (Keller, Klein, Hirschfeld, Kocsis, McCullough, Miller, First, Holzer, Keitner, Martin, & Shea, 1995). In general these field trials found that the diagnostic criteria in the DSM-IV is an improvement on its predecessor the DSM-III-R (DSM-IV, 1994).

5.4 Reliability of the DSM-IV Diagnosis

The field trial reports describe work group efforts to enhance the reliability and validity of the DSM-IV: by modifying the wording of the diagnostic criteria to increase their clarity and more accurately reflect clinical reality, by deleting or adding items when field trial data suggested that this be done, and by altering diagnostic cut off points and duration criteria, again, when data suggested that doing so would improve diagnostic sensitivity and specificity (DSM-IV, 1994).

6. The sample population

The sample population consisted of 14 hospital files of both male and female adolescents between ages 12 and 18, of all races treated at a psychiatric hospital in the time frame of January 2001 up until December 2002. The sample population was diagnosed with both a behaviour and mood disorder.

7. Ethical implications

The information in the hospital files was obtained with permission from the superintendent of the hospital, the information were treated confidentially. The study is only concerned with the DSM-IV diagnoses of the patients, therefore no identifying data were used that could identify or compromise the confidentiality of the patients.

Chapter 4 Results: Psychosocial themes identified

1. Introduction

The main aim of this study was to identify the psychosocial and environmental themes in the DSM-IV diagnosis of adolescents that can be associated with a comorbid mood and behavior disorder.

After analysis of the axis IV DSM-IV diagnosis in fourteen files the following psychosocial themes were identified:

2. Prevalence of psychosocial themes in 14 cases:

Relationship problems with parental figures and/or family

In thirteen of the fourteen cases adolescents had problems with their relationships with their parents. This represents 93% of the cases. This includes problematic relationships with parents, problematic relationships in the family, relationship problems with guardian, mother child relationship problems.

School/ Academic problems

From the information gained from the files, eight cases out of the fourteen reported that the adolescent had school and academic problems. This includes poor academic performance and problems relating to coping with schoolwork and responsibilities at school. School truancy also falls in this category. The eight cases are equivalent to 64% of the cases.

Peer group relationship problems

In five of the fourteen cases peer group relationships were a problem. This includes any problems in relationships with the peer group from adjustment problems, absent peer group relations or association with a negative peer groups. It seems that the majority of adolescents as represented by the cases had good relationships with their peers.

Loss of significant other

In this category the specific losses were the loss of a father in one case and the loss of a mother in another case. In only two of the fourteen cases losses of a significant others were reported, this amounts to 14% of the cases.

Traumatic incidents

Themes of trauma were discovered in two cases. This means that some adolescents were exposed to incidents shock and emotional upheaval, situations for which they were unprepared. The traumatic incidents were a rape incident in one case and the experience of sexual abuse in another. These themes of trauma constitute 14% of the cases.

Problems with primary support group

In only one case problems with the primary support group were found. This includes problems related to the support structure the adolescent has. This constitutes 7% of the cases examined.

Problems with authority figures

In one out of the fourteen cases problems with authority figures were noted. This refers to extreme rebelliousness towards authority figures in the adolescent's life. This theme was present in 7% of the cases.

The male to female ratio were 8:6, with no major differences in psychosocial themes present.

3. Common denominators

Thus ninety three percent of the sample population had problems in their relationship with parental figures and with family members. Thus this seems to be the most common psychosocial problem in adolescents diagnosed with a co-morbid behavior and mood disorder. The second most common psychosocial problem was school/ academic problems. This theme can be seen as a result of the emotional and behavioral problems the adolescent experiences, as one of the criteria for depression is a lack of interest in most activities, including schoolwork.

Peer group relationship problems seem to be the third most common theme followed by the loss of a significant other and experience of a traumatic event. The least common themes are problems with primary support group and authority figures.

4. Interactional factors

If the cases and their representing themes are grouped into smaller theme units or categories, because the similarities between the themes are more than the differences, e.g. relationship problems with parental figures and family together with the problem with authority figures then the following emerges. In all of the

fourteen cases then adolescents had problems with regards to their relationship with adults.

If peer group relationship problems are grouped together with primary support group problems then in six of the fourteen cases adolescents had problems with supportive relationships. If we take into account that the family plays an important function as a source of support, and the lack thereof has significant implications during adolescence (Garcia et. al., 2000), we can also add this category to the above. The result is then that in all of the cases there is a significant lacking in supportive relationships. Thus all of the adolescents in this study had to cope with their mental illness without sufficient support from the significant others in their lives.

School and academic problems may also be linked with the problem of authority and relationship problems, as mentioned earlier academic problems are often the result of a breakdown in relationships (Field et. al., 2002; Fuligni et. al., 2001). Nevertheless for the sake of this study, the academic problems, being a problem with study, lack of motivation, achievement, academic progress, are kept separately because of a lack of a clear connection as found in the files.

Chapter 5 Discussion

1. Introduction

From the data analysis three important aspects of adolescent psychosocial development seems to be problematic in adolescents diagnosed with a co-morbid Disruptive Behavior and Mood Disorder. They are: problems with parental figures and family relationships together with problems with authority figures; school

and academic problems; and peer group relationship problems. The loss of a significant other and traumatic incidents were present in only a few cases.

These themes will be discussed focusing on how these themes fit into the overall psychosocial developmental picture of the adolescent; what role these themes might play as causal factors of behavior and mood disorder symptoms in adolescence and how these themes may represent interactional processes reinforcing a reciprocal pattern of behavior and mood disorder symptoms.

2. Psychosocial Implications

As mentioned earlier depression and behavior problems play a significant role in adolescent development. It is evident that these symptoms affect an adolescent's development to a great extent. All of the developmental tasks of early adolescence are influenced by depression and behavior problems.

In formal operational thinking depressed adolescents can develop negative thought patterns that may lead to a negative view of themselves and the world they live in (See chapter 2; 3.2.2).

Depressed adolescents are at risk for suicide and drug abuse (Kaplan & Sadock, 1998). Thus depression can either terminate psychosocial development indefinitely or when substance abuse becomes a problem it can complicate an adolescents psychosocial development by hampering emotional growth and leading to association with negative peer groups.

Depression and behavior problems can influence sexual relations as well, it can either play a role in the depressed adolescent not being interested in sexual relations or it may change sexual relations as part of healthy development into a

problem area if sexual relations becomes part of problem behavior (Ketterlinus et. al., 1992).

The possible effects of being labeled as a problem adolescent, whether it is because of depression or behavior problems, were discussed earlier but can now be taken further in thinking about how this labeling interferes with an adolescent reaching psychosocial maturity. Erikson viewed identity formation as an integral part of adolescent development. If an adolescent is depressed and has behavioral problems it is only fair to say that these aspects of their lives can become part of their identity, of who they are. Therefore they might continue to be depressed and have behavioral problems through to adulthood. The end result may even be that the adolescent becomes confused with who they are, unable to achieve a personal identity.

2.1 The psychosocial crisis

The psychosocial crisis the adolescent is faced with is group identity versus alienation (Newman & Newman, 1997). The adolescent wishes to express his/her individuality but at the same time desires to be closely affiliated to a group. As mentioned earlier a process of self-evaluation takes place within the context of a meaningful group with which the adolescent identifies. The positive resolution of the psychosocial crisis of group identity versus alienation is when the adolescent is able to identify with a group that meets their social needs and provides them with a sense of belonging. The group also acts as a support base for the adolescent, providing a sense of security and emotional connection. Being part of a group also implies engaging in activities associated with the group.

Peer group relationship problems were identified as a problem area in some of the cases examined in this study. This will affect the psychosocial crisis of group identity versus alienation to a great extent. When the adolescent has difficulty

identifying and becoming part of a group he/she may experience trouble in self-evaluation, because of the lack of the group context. The self-evaluation may even become negative when the adolescent views him-/herself as not being liked by their peers or that something must be wrong with them for not being accepted into a group. This will also reflect in the development of a personal identity. According to Erikson (1950) this may cause the adolescent to experience identity confusion instead of developing a personal identity. The negative resolution of stages 1-5 of Erikson's theory of psychosocial development might predict the presence of personality disorder symptomatology during late adolescence (Johnson, 1993). These adolescents will also lack the social support and emotional connectedness that is so crucial during adolescence.

In an attempt to belong to a group some adolescents may even be willing to forgo their parents' rules, their schoolwork, and their own talents in order to be popular with their peers. In a study done by Fuligni et. al. (2001) they found that these adolescents exhibited greater problem behavior and lower academic performance than adolescents who were still true to themselves and their upbringing. Those adolescents who exhibit extreme orientation toward peers tend to become involved in delinquent peer groups and have more difficulty during high school. Adolescents are also twice as likely to participate in risk taking behavior of their friends participate in risk taking behavior (Maxwell, 2002; Hussong, 2002). Thus affiliation to a negative peer group may introduce the adolescent to a variety of factors that places his/her psychosocial development at risk.

The negative resolution of this psychosocial crisis leads to alienation. An alienated adolescent does not experience a sense of belonging to a group, they are continually uneasy in the presence of peers. This negative resolution of the crisis can have significant implications for adjustment in school, self-esteem, and subsequent psychosocial development. Adolescents who experiences social

isolation are at risk for developing emotional problems. They lack the social support and the group affiliation necessary to develop the coping skills to deal with life struggles. Their social skills, such as communication and commitment might also be impaired.

When, as is the case in this study, there is difficulties in the adolescents relationship with his/her parents it only worsens the situation. The relationship of the adolescent with his/her parents plays an important role in healthy development. Parents provide a support structure, which should be able to contain the adolescent throughout his/her development (Newman & Newman, 1997).

The adolescent experiences first and foremost group affiliation in the family. The family provides the context in which the adolescent learns what it means to belong to a group, in this case the family. If the adolescent experiences the family as rejecting or if the family is unable to give the adolescent the necessary emotional support that is so crucial for the adolescents emotional development, the adolescent might look for this support exclusively in peer group relationships, rejecting the family, which may result in further deterioration of the parent adolescent relationship. The adolescent might even become involved in negative peer group relationships.

Thus difficulties in peer group and family relationships puts the adolescent at risk for the negative resolution of the psychosocial crisis of group identity versus alienation as well as the developing of a personal identity versus identity confusion. The supportive function that both peer group relations and family relations play in the adolescents' life cannot be understated. Without the necessary support and group affiliation the challenges the adolescent faces in their development might appear overwhelming and puts the adolescent at risk for a variety of psychological problems.

3. Psychosocial themes as causative factors in behavior and mood disorders

In this section the discussion turns to the question of how much of a causal factor does the psychosocial themes play in the development of depressive and problem behavior symptomatology during adolescence.

It is well known that peer group and parental relations can have both a positive and negative impact on the adolescent's development (Louw, Van Ede & Louw, 1998; Newman & Newman, 1997). Field et al. (2002) found that adolescents who rate their parent and peer relationships as good has more friends, greater family togetherness, lower levels of depression and drug use, and a higher grade point average. Adolescents who felt more intimate with their parents also have greater levels of self-esteem, less depressive feelings and no suicidal thoughts.

From the research mentioned and the findings in this study it is clear that there exists a link between the quality of parent-adolescent relationships and adolescent depression and behavior problems. Studies found that delinquency rates are highest among adolescents with troubled family backgrounds and peer rejection and social isolation place adolescents at risk for depression. Depressed adolescents also describe their families as more conflictual, negative, and controlling and less cohesive and supportive (Field et al., 1995; Kaslow et al 1994; Allen et al., 1997).

It seems that the adolescents with a comorbid behavior and mood disorder had significant difficulty in their relationship with parents or guardians. Firstly one must take into account that adolescence is often marked by conflict in parent-adolescent relationships though this conflict is present in most adolescents lives it is not part of healthy development if this conflict escalates into interpersonal estrangement of the adolescent from the parents. Adolescents have to learn

coping strategies to deal with these new stressors. With a diagnosis of both a mood disorder and a behavior disorder the adolescent will find it difficult to cope with the challenges and responsibilities that come with school education. The combination of pressures from parents, especially marital conflicts and economic pressures, and the adolescent's exposure to failures, disappointments, and loss of relationships with peers and in school, are linked to negative mood, especially sadness and depression (Larson & Ham, 1993).

Physical changes produce ambivalence in the adolescent. If the family and peer group are not supportive, negative feelings and conflicts are likely to result (Weiten, 2001). Research identified certain factors associated with depression in adolescence. Experiences of parental loss or parental rejection have been found to increase an adolescent's vulnerability to depression (Robertson & Simons, 1989).

One of the symptoms of depression is the loss of interest in all or most activities. Schoolwork may be one of these. If an adolescent becomes depressed he/she may lose interest in schoolwork not feeling motivated to do their part in achieving academic goals. The loss of concentration characteristic of depression may also play a role here. If adolescents find it difficult to concentrate together with the lack of motivation towards academic responsibilities, their schoolwork and academic performance will surely not be on standard.

As discussed earlier the parent-adolescent relationship contributes to the adolescents' development as a whole. The adolescent-parent relationship provides support, also in terms of academic and school performance. Also in the case of adolescent suffering from such disorders as depression and behavior disorders the parent or guardians plays a very important role as support structure for the adolescent. An adolescent suffering from a mental illness who has good relationships with his/her parents has a better prognosis for recovery

compared to an adolescent with a poor relationship with his/her parents. This if the adolescent has poor relationships with his/her parents or guardians this will inevitably reflect in the adolescent's schoolwork. A behavior disorder only worsens the situation. Disruptive behavior are being dealt firmly with in most school settings, there always exists the possibility of the adolescent being labeled as naughty or oppositional which will indefinitely contribute to a negative attitude not only towards the adolescent but also from the adolescents' towards the school and academic environment.

Thus it seems possible that the psychosocial themes identified in this study does play a causative role in the development of depressive and problem behavior symptomatology.

4. Psychosocial themes as interactional processes reinforcing a reciprocal pattern of behavior and mood disorder symptoms.

The hypothesis here is that the psychosocial themes identified as a problem area in the live's of the adolescents are reinforced by reciprocal patterns of behavior in both the family system and in the peer group.

Adolescents who experienced high levels of parental rejection and high levels of sibling conflict have higher levels of aggressive behavior. It seems then that interaction within the family plays a significant role in adolescents developing behavior problems. Parental rejection and sibling conflict may create in the adolescent an irritable mood, which might lead to behavior problems (Garcia et. al., 2000).

When an adolescent becomes depressed or displays problem behavior they are often rejected by family and friends. This rejection may encourage rebellious behavior, which is again rejected, and the adolescent is labeled as naughty or a

problem child. The rejection experienced by the adolescent can worsen their feelings of depression this could also lead to further rejection from both parents and the peer group.

Parent- adolescent relationships are often thought of as characterized by conflict. A parent-adolescent relationship undergoes significant change during early adolescence. These changes are characterized by the questioning of parental values, moral rules and regulations; distancing, when the adolescent starts spending more time with his friends than with his family, and arguments. Parents often gets upset by these changes and as a result may become even more controlling which could lead to more conflict (Steinberg & Meyer, 1995).

This conflict can again contribute to behavioral problems displayed by the adolescent. When one thinks of the academic or school context an adolescent who becomes depressed does have a lack of motivation in all or most activities, this will contribute to difficulties experienced in academic performance. When an adolescent performs poorly at school this may contribute to depressive feelings or may cause the adolescent to loose interest in schoolwork and become involved in delinquent activities. Thus one can see how the one type of behavior can lead to the other until the process becomes reciprocal.

Chapter 6 Conclusion

1. Introduction

This study aimed to address four aspects:

- What are the psychosocial themes present in the DSM-IV axis IV diagnosis of adolescent diagnosed with a comorbid behavior and mood disorder.

- How these themes fit into the overall psychosocial developmental picture of the adolescent.
- What role these themes might play as causal factors of behavior and mood disorder symptoms in adolescence.
- How these themes may represent interactional processes reinforcing a reciprocal pattern of behavior and mood disorder symptoms.

Adolescents treated at a psychiatric hospital for a diagnosis of both a mood and behavior disorder had similarities in the psychosocial themes present in their lives. The most common themes were, family relationship problems and problems with relationship with authority figures; peer group relationship problems; and academic/school related problems.

The study discussed the psychosocial impact these themes have on the adolescents development and concluded that the difficulties in peer group and family relationships puts the adolescent at risk for the negative resolution of the psychosocial crisis of group identity versus alienation as well as the developing of a personal identity versus that of identity confusion. The supportive function that both peer group relations and family relations play in the adolescents' life cannot be understated. Without the necessary support and group affiliation the challenges the adolescent faces in their development might appear overwhelming and puts the adolescent at risk for a variety of psychological problems.

It was also argued that these psychosocial themes play a causative role in behavior and mood disorders. Negative relationships with both parents and peers leave the adolescent without the necessary support structure needed for healthy development. Rejection experienced from the family and peer group also puts the adolescent at risk for depression and behavior problems. When an adolescent identifies with a negative peer group that is involved in delinquent

activities the adolescent may join in the delinquent behavior that will cause significant problems in his/ her life. Thus the lack of social and family support, and the lack of positive peer group and parental relationships seems to put an adolescent at risk for developing mood and behavior disorder symptomatology.

Adolescents with troubled family backgrounds are more prone to delinquent behavior and depression. When an adolescent becomes depressed the family and peer groups' negative reaction could isolate the adolescent leading to feelings of becoming even more depressed. When an adolescent presents with problem behavior he/she might also experience rejection and a lack of support from the family or peer group. This may foster rebelliousness in the adolescent and the problem behavior might escalate. These interactions between adolescent and his/her family and peer group might represent a reciprocal process that sustains the depression and problem behavior within the context of family and peer group relations.

2. Critique and recommendations

Critique against the study is that only a small amount of cases were used which might influence the results, it is suggested that this study be conducted using a larger sample population in order to be able to generalize more to the psychiatric population as a whole. Possibly the use of interviews in this case might produce more specific information regarding the effect these psychosocial themes have on the adolescents. Aspect that was not the purpose of this study was not attended to, this includes the interactions and specific differences between the DSM-IV axis I and axis IV diagnosis, the specific ethnical backgrounds of the subjects and the adolescents subjective experiences of the psychosocial themes identified as problem areas in their lives.

A concluding remark is that this study focuses on the DSM-IV axis IV diagnosis as it is the experience of the researcher that this particular axis sometimes receives particularly little attention in the diagnostic process. And it is argued here that this axis is of the utmost importance in understanding the particular situation that the adolescent finds him-/herself in as having a mood and behavior disorder. This axis may give the treating team clues of the developmental impact of the disorder on the adolescent, it may help in identifying certain possible causes or causal factors that contributes to the adolescent's particular condition and lastly it may also represent interactional processes reinforcing a reciprocal pattern of behavior and mood disorder symptoms.

References

Adalbjarnardottir, S. (2002). Adolescent psychosocial maturity and alcohol use: Quantitative and qualitative analysis of longitudinal data. **Adolescence**, **37** (145), 19- 53.

Allen, J.P., Moore, C.M. & Kupermine, G.P. (1997). **Developmental approaches to understanding adolescent deviance**. In Luthar, S.S., Burack, J.A., Cicchetti, D. & Weisz, J.R. (Eds). *Developmental Psychopathology: Perspectives on adjustment, risk and disorder*. Cambridge: University press.

American Psychiatric Association: **Diagnostic and Statistical Manual of Mental Disorders** (4th ed.). (1994). Washington: American Psychiatric Association.

Bell, A.P., Weinberg, M.S. & Hammersmith, S.K. (1981). **Sexual preference: its development in men and women**. New York: Simon and Schuster.

Blumstein, A., Cohen, J. & Farrington, D.P. (1988). Criminal career research: Its value for criminology. **Criminology**, **26**, 1-35.

Brian, A. & Stallings, M.C. (2002). A Case Control Study of Adolescent Risky Sexual Behavior and Its Relationship to Personality Dimensions, Conduct Disorder and Substance Use. **Journal of Youth and Adolescence**, **31**(5), 387-396.

Buga, G.A.B., Amoko, D.H.A., & Ncayiyana, D.J. (1996). Sexual behaviour, contraceptive practice and reproductive health among school adolescents in rural Transkei. **South African Medical Journal**, **86**, 523-527.

Cavior, N. & Dokecki, P.R. (1973). Physical attractiveness, perceived attitude similarity, and academic achievement as contributors to interpersonal attractions among adolescents. **Developmental Psychology, 9**, 44-54.

Cicchetti, D., & Toth, S. L. (1998). The development of depression in children and adolescents. **American Psychologist, 53**, 221-241.

Craig, G.J. (1996). **Human Development**. New Jersey: Prentice Hall.

Eamon, K. M. (2002). Influences and Mediators of the Effect of Poverty on Young Adolescent Depressive Symptoms. **Journal of Youth and Adolescence, 31**, 3, 231-242.

Erikson, E.H. (1950). **Childhood and society**. New York: W.W Norton.

Erikson, E.H. (1959). The problem of ego identity. **Psychological issues, 1**, 101-164.

Erikson, E.H. (1968). **Identity: Youth and crisis**. New York: W.W. Norton

Erikson, E.H. (1982). **The life cycle completed: A review**. New York: W.W Norton.

Field, T., Lang, C., Yando, R. & Bendell, D. (1995) Adolescents' intimacy with parents and friends. **Adolescence, 30**(117), 133-141.

Field, T., Diego, M. & Sanders, C. (2002). Adolescents' parent and peer relationships. **Adolescence, 37**(145), 121-130.

Flannery, D.J., Rowe, D.C. & Gulley, B.L. (1993). Impact of pubertal status, timing, and age on adolescent sexual experience and delinquency. **Journal of Adolescent Research, 8**, 21-40. As in Newman, P.R. & Newman, B.R. (1997). *Childhood and Adolescence*. Pacific Grove: Brooks/ Cole Publishing Company.

Fuligni, A.J., Eccles, J.S., Barber, B.L., & Clements, P. (2001). Early Adolescent Peer Orientation and Adjustment During High School. **Developmental Psychology, 37**(1), 28-36.

Garcia, M. M., Shaw, D. S., Winslow, E. B., & Yaggi, K. E. (2000). **Developmental Psychology, 36**(1), 44-53.

Glodis, K.A. & Blasi, A. (1993). The sense of self and identity among adolescents and adults. **Journal of Adolescent Research, 8**, 365-380. As in Newman, P.R. & Newman, B.R. (1997). *Childhood and Adolescence*. Pacific Grove: Brooks/ Cole Publishing Company

Hammen, C., & Rudolph, K. D. (1996). Childhood depression. In E. J. Mash & R. A. Barkley (Eds.), **Child psychopathology** (pp. 153-195). New York: Guilford.

Harrington, R., Fudge, H., Rutter, M., Pickles, A., & Hill, J. (1991). Adult outcomes of childhood and adolescent depression: II. Risk for antisocial disorders. **Journal of the American Academy of Child Psychiatry, 30**, 434-439.

Heaven, P.C.L., (1994). **Contemporary adolescence. A social psychological approach**. Melbourne: Macmillan Educational Australia.

Hussong, A.M. (2002). Differentiating Peer Contexts and Risk for Adolescent Substance Use. **Journal of Youth and Adolescence, 31**,3,207-220.

Inhelder, B., & Piaget, J. (1958). **The growth of logical thinking from childhood to adolescence.** London: Routledge and Keagan Paul.

Johnson, J.G., (1993). Relationship between psychosocial development and personality disorder symptomatology in late adolescents. **Journal of Youth and Adolescence, 22**(1),33- 41.

Kail, R.V. & Cavanaugh, J.C. (1996). **Human Development.** Brooks/Cole Publishing Company.

Kaslow, N.J., Deering, C.G., & Rascun, G.R. (1994). Depressed children and Their families. **Clinical Psychology Review,14**, 39-59. In Wenar, C., & Kerig, P. (2000). *Developmental Psychopathology* (4th ed.). Boston: McGraw-Hill Higher Education.

Kaplan, H. I. & Sadock, B.J. (1998). **Synopsis of Psychiatry** (8th ed.). Baltimore: Williams & Wilkins.

Keller, M. B., Klein, D.N., Hirschfeld, R.M.A., Kocsis, J.H., McCullough, J.P., Miller, I., First, M.B., Holzer, C.P., Keitner, G.I., Martin, D.B., & Shea, T. (1995). Results of the DSM-IV mood disorders field trial. **American Journal of Psychiatry, 152**, 843-849.

Ketterlinus, R.D., Lamb, M.E., Nitz, K. & Elster, A.B. (1992). Adolescent nonsexual and sex-related problem behaviors. **Journal of Adolescent research, 7**, 431-456. As in Newman, P.R. & Newman, B.R. (1997). *Childhood and Adolescence.* Pacific Grove: Brooks/ Cole Publishing Company

Kiesner, J., Cadinu, M. Poulin, F. & Bucci, M. (2002). Group Identification in Early Adolescence: Its Relation with Peer Adjustment and Its Moderator Effects on Peer Influence. **Child Development, 73**(1), 196-208.

Kohn, P.M. & Milrose, J.A. (1993). The inventory of high-school students' recent life experiences: A decontaminated measure of adolescents' life hassles. **Journal of Youth and Adolescence, 22**, 43-55.

Lahey, B.B., Applegate, B., Barkley, R.A., Garfinkel, B., McBurnett, K., Kerdyk, L., Greenhill, L., Hynd, G.W., Frick, P.J., Newcorn, J., Biederman, J., Ollendick, T., Hart, E.L., Perez, D., Waldman, I., & Shaffer, D. (1994). DSM-IV field trials for oppositional defiant disorder and conduct disorder in children and adolescents. **American Journal of Psychiatry, 151**, 1163-1171.

Larson, R & Ham, M. (1993). Stress and "storm and stress" in early adolescence: The relationship of negative events with dysphoric affect. **Developmental Psychology, 29**, 130-140.

Louw, D.A., Van Ede, D.M. & Louw, A.E. (1998). **Menslike Ontwikkeling** (3rd ed.). Pretoria: Kagiso Uitgewers.

Maxwell, K. M. (2002). Friends: The Role of Peer Influence Across Adolescent Risk Behaviors. **Journal of Youth and Adolescence, 31**(4), 267-277.

Newman, P.R. & Newman, B.R. (1997). **Childhood and Adolescence**. Pacific Grove: Brooks/ Cole Publishing Company

Offer, D., Ostrov, E., Howard, K.L. & Atkinson, R. (1988). **The teenage world: Adolescents' self-image in ten countries**. New York: Plenum

Pope, A. W., & Bierman, K. L. (1999). Predicting Adolescent Peer Problems and Antisocial Activities: The Relative Roles of Aggression and Dysregulation. **Developmental Psychology, 35**(2), 335-346.

Patterson, C.J. (1992). Children of lesbian and gay parents. **Child development, 63**, 1025-1042.

Richters, J.E. & Cicchetti, D. (1993). Mark Twain meets DSM-III-R: Conduct disorder, and the concept of harmful dysfunction. Special Issue: Towards a developmental perspective on conduct disorder. **Development and Psychopathology, 5**, 5-29.

Robertson, J.F. & Simons, R.L. (1989). Family factors, self-esteem, and adolescent depression. **Journal of Marriage and the Family, 51**, 125-138.

Smetana, J. (2002). Culture, Autonomy, and Personal Jurisdiction in Adolescent-Parent Relationships. **Advances in Child Development and Behavior, 29**, 51-81.

Steinberg, L. (1990). **Autonomy, conflict and harmony in the family relationship**. In S. Fieldman & G. Elliot (Eds.) (1990). *At the threshold: The developing adolescent*. Cambridge, MA: Harvard University Press.

Steinberg, L., & Meyer, R. (1995). **Childhood**. New York: McGraw-Hill

Watzlawick, P., Weakland, J. and Fisch, R. (1974). **Change: Principles of problem formation and problem resolution**. New York: W.W. Norton & Co.

Weiten, W. (2001). **Psychology, Themes and Variations**. Belmont: Wadsworth.

Wenar, C., & Kerig, P. (2000). **Developmental Psychopathology** (4th ed.). Boston: McGraw-Hill Higher Education.

Appendix

Data

File Number:	Admission Date:	Sex:	Age:	Race:	Axis I:	Axis IV:
1	30-07-2001	Female	15	White	<ul style="list-style-type: none"> • Bipolar II Disorder • Disruptive Behaviour • Disorder NOS 	<ul style="list-style-type: none"> • School Problems • Problems with primary support group • Problematic relationship with parents
2	15-06-2001	Female	17	White	<ul style="list-style-type: none"> • Conduct Disorder • Disthymic Disorder 	<ul style="list-style-type: none"> • School Problems • Peer group relation problems • Problematic relationships in the family
3	27-02-2001	Male	12	White	<ul style="list-style-type: none"> • Disruptive Behaviour Disorder • ADHD • Depressive Disorder NOS 	<ul style="list-style-type: none"> • Mother-child relationship problems • Peer group relationship problems
4	12-12-2001	Female	17	White	<ul style="list-style-type: none"> • Disthymic Disorder • Disruptive Behaviour • Disorder NOS 	<ul style="list-style-type: none"> • Family relationship problems • Peer group relationship problems
5	24-04-2001	Male	16	White	<ul style="list-style-type: none"> • Bipolar II Disorder • Conduct Disorder 	<ul style="list-style-type: none"> • School/ academic problems • Mother-child relationship problems

6	10-06-2002	Female	17	Black	<ul style="list-style-type: none"> • Major Depressive Disorder • Disruptive behaviour Disorder NOS • Substance Abuse 	<ul style="list-style-type: none"> • School/ academic problems • Relationship problems with gardian • Loss of significant other, mother died in the previous year
7	08-11-2001	Female	14	White	<ul style="list-style-type: none"> • Major Depressive Disorder • Disruptive Behaviour • Disorder NOS 	<ul style="list-style-type: none"> • Mother child relationship problems • Relationship problems with siblings • School problems, i.e. stressor • Traumatic incident, i.e. rape
8	24-04-2002	Male	16	White	<ul style="list-style-type: none"> • Conduct Disorder • Mood Disorder NOS • Substance Abuse 	<ul style="list-style-type: none"> • Mother child relationship problems • Relationship problems with biological father • School/ academic problems
9	23-05-2002	Male	16	White	<ul style="list-style-type: none"> • Conduct Disorder • Major Depressive Disorder 	<ul style="list-style-type: none"> • Relationship problems with gardians • School/ academic problems
10	27-05-2002	Male	14	White	<ul style="list-style-type: none"> • Mood Disorder NOS • Disruptive Behaviour Disorder NOS • ADHD 	<ul style="list-style-type: none"> • Mother-child relationship problems • School/ academic problems • Loss of significant other, i.e. father died
11	29-12-2001	Female	15	White	<ul style="list-style-type: none"> • Bipolar Mood Disorder II • Conduct Disorder 	<ul style="list-style-type: none"> • Relationship problems with guardians • Sexual abuse

12	21-01-2002	Male	17	White	<ul style="list-style-type: none"> • Disruptive Behaviour Disorder • Major Depressive Disorder 	<ul style="list-style-type: none"> • Physical abuse • Mother-child relationship problems • Peer group relationship problems • Problems with family relations
13	13-02-2001	Male	13	White	<ul style="list-style-type: none"> • Bipolar Mood Disorder I • Disruptive Behaviour Disorder NOS 	<ul style="list-style-type: none"> • Absent father figure • Mother-child relationship problems • Peer group relationship problems
14	11-10-2002	Male	15	White	<ul style="list-style-type: none"> • Mood Disorder • Disruptive Behaviour Disorder NOS 	<ul style="list-style-type: none"> • Problems with authority figures • School/ academic problems