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Adolescent depressive versus aggressive symptomatology and Eriksonian psychosocial stage resolution

McAdams, Janis, Psy.D.

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ADOLESCENT DEPRESSIVE VERSUS AGGRESSIVE SYMPTOMATOLOGY AND ERIKSONIAN PSYCHOSOCIAL STAGE RESOLUTION

by

Janis McAdams

A Doctoral Project Presented in Partial Fulfillment of the Requirements for the Degree of Doctor of Psychology

Pace University
New York City, New York
September, 1992

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PSYCHOLOGY DEPARTMENT
PSY.D. PROJECT
FINAL APPROVAL FORM

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I have read the final version of the doctoral project and certify that it meets the relevant requirements for the Psy.D. degree in School-Community Psychology.

Beth Hart — 9/23/92
(Project Advisor's Signature) (Date)

John Stokes — 9/23/92
(Project Consultant's Signature) (Date)

Table of Contents

List of Tables

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Abstract

The present study sought to understand adolescent depression and aggression, as expressed in behavioral symptomatology, in the context of Erikson's theory of personality development.

One hundred thirty six adolescents in the 9th through 12th grade were administered the Erikson Psychosocial Stage Inventory (EPSI) and the problem scale of the Youth Self Report Profile (YSR). Cutoff criteria applied to the Anxious/Depressed and Aggressive Behavior subscales of the YSR were used to categorize subjects into 4 groups of behavioral symptomatology; (1) "control"; (2) "aggressive group"; (3) "depressed"; and (4) "mixed" group in which individuals demonstrated elevated scores on both Aggressive and Anxious/Depressed subscales. Resolution of the first six psychosocial stages as measured by the EPSI were compared across groups.

Results of MANOVA procedure with post-hoc Scheffe supported the first hypothesis with results showing significant differences ($p. < .001$) in positive resolution among the four groups. The "control" group demonstrated the highest positive resolutions on all EPSI subscales and the "mixed" group the lowest. The depressive and aggressive groups reported significant differences in resolution of

Trust and Autonomy only. In general, those who rated themselves as high on both types of pathology were more similar to the Depressed group than to the Aggressive group supporting the construct of "masked depression".

The second hypothesis, that subjects reporting extremes of positive or negative EPSI resolution would be greatest in those reporting highest levels of symptomatology was not supported in MANOVA analysis using absolute values of EPSI scores converted into values reflecting deviance from the mean. Contrary to theory, both control and mixed symptomatology subjects demonstrated the greatest extremes of positive or negative resolution. Results supported the third hypothesis with the Depressed and Mixed groups agreeing with negative EPSI statements significantly more strongly than positive statements. Auxiliary analysis by gender was performed demonstrating significant differences between groups for males on the Intimacy subscale, females did not demonstrate significant differences. These results were discussed in terms of criticisms of Erikson's theory as describing male development only.

Overall, findings suggest that depressive and aggressive symptomatology generally arise from different early experiences suggesting that they represent different ego organizations. However, those reporting a combination of aggressive and depressive symptomatology are most likely vulnerable to ego weakness, impulsive behavior, and possibly

suicide. Results were discussed in the context of Eriksonian psychosocial stage resolution.

CHAPTER 1

INTRODUCTION

The theories of adolescent development and psychopathology have been the subject of considerable controversy in the field of psychology. Many theorists who concentrate on the inner life of the adolescent consider the time to be one of considerable strife and turmoil as earlier developmental conflicts are reawakened and reworked. The act of repudiating the previous generation and denigration of their authority is an aggressive act which is often accompanied by mourning. These theorists consider this preferable to the state that adolescence be a peaceful time. (Blos, 1967 ;Jacobson, 1961) Other authors have taken a more cultural/sociological approach (Czickzenmihalyi and Larson, 1984) and suggest that adolescents do indeed experience more frequent and intense changes of mood than do adults, however, they view this phenomena as the result of social and cultural demands placed on the adolescent. In yet another contrasting view, more recent empirical studies have shown that it is often a relatively peaceful time (i.e., Offer & Offer, 1975) and suggest that those adolescents who present with emotional and behavioral problems are not expressing normative developmental trends but psychopathological symptomatology.

Recent studies have shown disturbingly high rates of depression among adolescents, as high as 20% among those who are clinically referred. (Costello & Angold, 1988) Studies of nonclinical samples show prevalence rates of depressive symptomatology (as opposed to depressive syndrome) ranging from 46% for boys and 59% for girls in grades 9 to 12 using standard criteria (cut off of 16) on the CESD-C (Roberts, Andres, Lewinsohn, and Hops, 1990), 33%% using the Beck Depression Inventory (BDI) reported by Albert and Beck (1975), and 22% of junior and senior high school students reporting mild to severe symptoms of depression using the BDI (Kaplan, Hong, & Weinhold, 1984). It is likely that depressive symptomatology in clinically referred samples differs significantly from that of non-clinical samples. (Costello & Angold, 1988) Additionally, the incidence of suicide, both attempted and successful, among adolescents has also risen. Affective disorder and depression are frequent among suicidal adolescents and the severity of suicidal ideation and depressive symptomatology have been correlated. (Apter, Bleich, Plutchik, Mendelsohn, and Tyano, 1988)

In a study of one hundred and forty adolescent inpatients aged 12 to 17 years, Apter, et.al. (1988) have demonstrated that adolescents diagnosed with conduct disorder obtained significantly higher suicidality scores on the K-SADS than those diagnosed as having major depressive

disorder, even though the conduct disordered patients were less depressed than those with major depressive disorder. This suggested that factors other than depression accounted for suicidality. The authors propose an interpretation of the results based on the assumption that aggression is an important variable influencing suicidality. They note that most of their conduct disordered subjects had been hospitalized on the basis of court orders for aggressive acts and had demonstrated marked aggressive behavior toward staff and patients on the unit. They noted also that the conduct disordered patients who actually attempted suicide often denied depression and related their suicidal behavior to frustration and unrelieved aggressive tension, rather than to depression.

Further, Shaffer (1974) found that 50% of adolescents who succeed at killing themselves had never been referred for psychiatric evaluation or treatment. Carlson and Cantwell (1982) have suggested that the relationship between depression and suicidal behavior is complex and that it is unclear whether the depression is caused by major affective disorder or being overwhelmed by untenable social situations. Pfeffer, Plutchik andMizruchi (1983) have suggested that assaultiveness may also be an important correlate of adolescent suicidal behavior, especially in combination with depression.

Numerous authors have noted the difficulties of making a diagnosis of depression in adolescents. Several factors appear to contribute to the confusion. Many clinically referred adolescents show a high degree of comorbidity with other disorders, complicating the picture. (Costello & Angold, 1988; Malmquist, 1971) In particular, there is a debate over whether depression underlies a great deal of adolescent psychopathology. Psychodynamic authors have conceptualized adolescence as a time of separation from the past and the family, requiring the emerging adult to leave behind the pleasures of childhood. There is a natural mourning of the loss of these pleasures, even as the adolescent gains those of adulthood. This "mourning" of the loss of childhood and its pleasures can appear as a depressive reaction. Secondly, separation is often thought to be accomplished by self-assertive aggression. Finally, numerous authors have commented on the presence of a "masked depression", whereby in defense against the depression, the adolescent engages in omnipotent states of defense which appear more like aggression than depression.

When discussing the problems of diagnosing and classifying depression in adolescents, authors have noted that development complicates the picture. In contrast, others have noted that understanding developmental processes is crucial to understanding the processes involved in creating psychopathology. Eisenberg noted that,

"Development has been described as the 'unifying concept' in the study of psychopathology, the 'crucial link' between biological and psychological causation and genetic and environmental determinents of mental disorders." (cited in Garmezy, Masten, & Tellegen, 1984) Achenbach (1979) in ennumerating the research needs in child psychopathology, encourages researchers to consider "the need to view children as continually changing with respect to biological, cognitive, social, educational and emotional development, the need to assess behavior in relation to development that is normal and adaptive within the child's culture...." (p. 443).

The purpose of this study is to examine depression and aggression in a nonclinical adolescent population within a developmental context. Erikson's psychosocial stage theory was used as the developmental framework through which these psychopathological behaviors were explored. Erikson's theory recognizes the impact of interpersonal relationships and socio/cultural influences on development. In particular, Erikson wrote extensively about the issues confronting adolescence and the basic conflicts of that stage. Thus, using a measure of Eriksonian developmental conflict resolution will help to shed light on some of the developmental influences in the formation of depressive and aggressive symptomatology.

CHAPTER II

REVIEW OF THE LITERATURE

Three areas of literature relevant to the question of using a developmental framework to describe the relationship of aggression and depression in adolescence will be addressed in this section: 1) the relationship of aggression and depression, both theoretically and in research , 2) depression in adolescence, within the framework of a discussion of adolescent development and problems in the diagnosis of depression in children and adolescents , and 3) Erikson's theory of psychosocial development, including a discussion of Erikson's theory itself as well as a discussion of previous research on the constructs of Eriksonian development.

The relationship of depression and aggression

At this point, a discussion of the relationship between aggression and depression will be presented. In addition to exploring the relationship between these two behaviors from a psychodynamic viewpoint, the discussion will attempt to help explain the processes at work in adolescence leading to aggressive or depressive behavior or comorbidity.

Psychoanalytic Views

Freud's Classical Psychanalytic Theory - In his initial paper on depression, Mourning and Melancholia, Freud (1917) first defines the symptoms of depression, or melancholia, as "profoundly painful dejection, cessation of interest in the outside world, loss of the capacity to love, inhibition of all activity, and a lowering of the self-regarding feelings to a degree that finds utterance in self-reproaches and self-revilings, and culminates in a delusional expectation of punishment." (p. 244) This expectation of punishment is the turning of aggression against the self. In an earlier writing to his friend, Fliess, he explains the underlying process which defines the relationship of aggression to depression.

> "Hostile impulses against parents (a wish that they should die) are also an integral constituent of neuroses. They come to light consciously as obsessional ideas. In paranoia what is worst in delusions of persecution (pathological distrust of rulers and monarchs) corresponds to these impulses. They are repressed at times when compassion for the parents is active-at times of their illness or death. On such occasions it is a manifestation of mourning to reproach oneself for their death (what is known as melancholia) or to punish oneself in a hysterical fashion (through the medium of the idea of retribution) with the same state [of illness] that

they have had. The identification which occurs here is, as we can see, nothing other than a mode of thinking and does not relieve us of the necessity for looking for the motive." (Editor's note, Standard Edition, p. 241)

In Mourning and Melancholia, Freud further describes the process by which aggression contributes to depression as he attempts to differentiate grief from melancholia. Both involve the loss of an object resulting in withdrawal of interest in the world, loss of capacity to love, inhibition of all activities and painful dejection. Freud's use of the term "object" is broad enough to include the object as a person, an ideal, a position or previous state of the self. However, in grief there are no ambivalent feelings toward the object. The individual knows what has been lost and therefore reactions and feelings occur on a more conscious level during the process of separating from the lost object.To the mourner the world seems empty and barren. In melancholia (depression), the individual experiences a profound lowering of self-esteem in connection with the loss and as if it were the ego itself rather than the world that seems empty and barren. As a result of early indentifications and ambivalence toward the lost object, the melancholic does not adequately separate from the lost object but invokes earlier oral incorporative defenses. The lost object comes to represent the state of the ego. In this schema, depression involves three hypothetical areas of the