# Psychiatric Disorders In Emerging Adulthood

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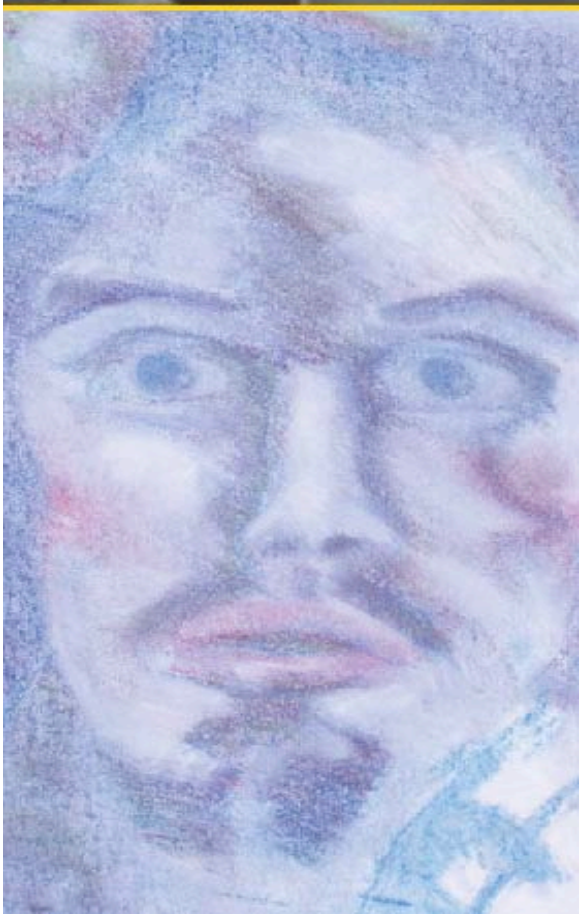
Emerging adults are particularly at-risk for psychiatric disorder. In a given year, over 40% of U.S. 18 to 29 year-olds meets criteria for psychiatric disorder, a higher rate than for any other adult age group. The most common disorders are anxiety (22.3%), substance use (22.0%), and mood disorders (22.0%). Among emerging adults who experience anxiety disorders, specific phobia is most common (10.3%). However, approximately 1 in 10 (9.3%) meet criteria for social phobia, a particular challenge during this stage of life when they are expected to make connections in the adult world—meet new people, make co-worker acquaintances, and explore intimate relationships. While nicotine dependence accounts for a substantial proportion of the 18-to-29 year-old population meeting criteria for substance disorder, 16.7%, a full 7% meet criteria for alcohol abuse/ dependence and almost 4% meet criteria for drug abuse/dependence. Major depressive disorder is the most common of the mood disorders, 8.3% (Kessler, Berglund, Demler, Jin, & Walters, 2005; Table 2).

In emerging adulthood we are also more likely to see first diagnoses of less common, but more severe and chronic disorders. By definition, personality disorders are first diagnosed in the early adult years; approximately 20% of U.S. emerging adults (18 to 25) meet criteria for at least one personality disorder (Blanco et al., 2008). Disorders with psychotic features also commonly onset during emerging adulthood. One of the main features of schizophrenia is onset in early adulthood when prevalence is .5 to 1.5% and incidence is .5 to 5.0% (APA, 2000). Onset of psychotic symptoms specified with bipolar and major depressive disorder, is also primarily localized to emerging adulthood (Baldwin et al., 2005). The relative homogeneity of onset of psychotic disorders in emerging adulthood, specifically, suggests stage-specific neurobiological triggers and susceptibility genes. Distinct developmental courses of these disorders may begin in the earliest moments of development with delayed expression until emerging adulthood (Craddock, O'Donovan, & Owen, 2005; Keshavan, Berger, Zipursky, Wood, & Pantelis, 2005).

Psychopathology in emerging adulthood undermines adaptation and reduces the likelihood of successful transitions to adulthood. For example, psychiatric disorder predicts lower educational attainment (Breslau, Lane, Sampson, & Kessler, 2008), significantly reduced earnings (Kessler, Heeringa, et al., 2008), attenuated occupational productivity (Wittchen et al., 1998), marital instability (Kessler et al., 1998), and impaired parenting (Johnson, Cohen, Kasen, & Brook, 2008). Meeting criteria

for any disorder increases risk for impaired global functioning. In addition, specific disorders relate to specific impairments in specific domains. For example, in a community sample looking at the role of current and past episodes of psychopathology on functioning at age 30, one pathway was found linking major depression and phobia to interpersonal problems; a second, linking alcohol and drug abuse/dependence to lower socioeconomic status (Tanner et al., 2007). Personality disorders in emerging adulthood have a negative impact on the long-term quality of life adults experience above and beyond the influence of Axis I disorders, demographics, or physical disease (Chen et al., 2006).



The high prevalence and associated burdens of psychopathology in emerging adulthood evoke the notion that the features of emerging adulthood may increase vulnerability to disorder. However, for most emerging adults dealing with psychopathology and associated impairments, these experiences are unlikely to be their first. Of those who meet criteria for psychiatric disorder in their twenties, 75% have a history of at least one prior episode (Kim-Cohen et al., 2003). This is not surprising given that 75% of all psychiatric disorders onset before age 24 (Kessler, Berglund, Demler, Jin, & Walters, 2005). Estimates of lifetime disorder exceed 50% in emerging adulthood (52.4%; Kessler, Chiu, Demler, Merikangas, & Walters, 2005) indicating that half of all emerging adults have a developmental history of psychiatric disorder. Emotional and behavioral problems in childhood and adolescence increase odds of personality disorder in emerging adulthood (Helgeland, Kjelsberg, & Torgerson, 2005; Kasen, Cohen, Skodol, Johnson, & Brook, 1999).

Youth who age into emerging adulthood already having had a psychiatric episode are much more likely than their peers without disorder to have difficulties meeting the challenge of "taking hold of some kind of life." Early onset of disorder, particularly in childhood or adolescence, is considered a risk factor for recurrent, persistent, and increasingly severe episodes (Alpert et al., 1999; Last et al., 1997). Adolescent–era episodes are associated with impaired functioning across a wide variety of domains in emerging adulthood (Paradis, Reinherz, Giaconia, & Fitzmaurice, 2006; Fergusson & Woodward, 2002; Lewinsohn, Rohde, Seeley, Klein, & Gotlib, 2000, 2003). Compared to adolescents without psychiatric disorder, those with psychopathology are estimated to be almost 14 times less likely to complete secondary school, 4 times less likely to be employed or in college or trade school in emerging adulthood, 3 times more likely to have been involved in criminal activity, and over 6 times more likely to have gotten themselves or someone else pregnant (Stoep, Beresford, Weiss, McKnight, Cauce, & Cohen, 2000). Suicide remains the 2nd leading cause of death in emerging adulthood, outpaced by accidents which most often include alcohol. For every successful suicide, there are 40 failed attempts. Nine times again as many college students at some point seriously consider killing themselves (CDC, 2005).

A gap between need for and use of mental health services explains some of the high risk for psychiatric disorder in first decade of adulthood. In a given year, 80% of 6-17 year-olds identified as needing mental health services go untreated (Kataoka, Zhang, & Wells, 2002). Thus, a significant proportion of emerging adults enter adulthood with untreated psychopathology. Then, in emerging adulthood, mental health service utilization drops almost in half after age 17, from 34 cases per 1,000 among 16 to 17 year-olds to 18 per 1,000 cases for those 18 to 19 (Pottick, Bilder, Vander Stoep, Warner, & Alvarez, 2008). Further accentuating the gap between need and service use—there are barriers to mental health treatment unique to emerging adults (e.g., lack of access to health insurance). Compared to older adults, odds of accessing treatment for mental health services is significantly lower for 18 to 24 year-olds (Kessler, Demler, et al., 2005).

In sum, half of emerging adults meet criteria for current psychiatric disorder, past disorder, or both. However, emerging adulthood, as a developmental stage with unique developmental features, does not, fundamentally "set the stage" for psychiatric disorder. More accurately, most disorders onset during childhood and adolescence. Given that onset of psychiatric disorder before age 30 is a key predictor of non-receipt and delay of receipt of mental health services (Druss et al., 2007), emerging adulthood may be understood as a vulnerable stage for the detection of psychiatric disorder. Recent advances in theory and research suggest that emerging adulthood is a window of opportunity for interrupting the persistence of mental health problems from childhood to adulthood. Translating this

opportunity into effective, developmentally-informed treatment programs is a viable target for reducing the burdens of mental health problems across adulthood.

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