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CHILD PSYCHIATRY

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UNBIASED INFORMATION FOR CHILD PSYCHIATRISTS

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Learning objectives for this issue: **1.** Effectively treat transitional age youth (TAY). **2.** Describe challenges to treat emerging adults who live at home with their families. **3.** Explain some of the ways you can help patients make a successful transition to college. **4.** Understand some of the current findings in the literature regarding psychiatric treatment.

Failure to Launch Syndrome

Susan L. Donner, MD
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Dr. Donner has disclosed that she has no relevant relationships or financial interests in any commercial company pertaining to this educational activity.

There was a time not too long ago when young adults who lived at home were seen as somehow developmentally stunted and "failures to launch." But the Great Recession and changing social norms have diminished much of the negative stigma associated with living with parents into adulthood. In fact, a whole new vocabulary has been built around young adults who either never left home or boomeranged back. They are now known as "emerging adults" and the family home that was once the "empty nest" is now called "the crowded nest," "the full nest," even "the refilled nest." Not since the 1950s has the percentage of young adults in the family home been so high, now at more than 22% according to a 2012 Pew Report (http://bit.ly/y3SSjT).

In light of these recent changes, what is now considered developmentally normal? Both developmental and psychoanalytic theory describe important milestones in the transition from adolescence to adulthood: gradual psychological and physical separation from parents with substitution of strong social and sexually intimate relationships, consolidation of identity, educational/occupational focus, financial independence, and eventual formation of a new family (Erickson E, *Childhood and Society* New York, NY: W. W. Norton & Company,1993; Colarusso C, *Psychoanalytic Stud Child* 1990;45:179–194). Given the fragile economy, how might a clinician help families determine what are now reasonable expectations, especially in adult children with special needs?

Mary, a 21-year-old woman with a

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Medication and Transitional Age Youth

Caroline Fisher, MD, PhD
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Dr. Fisher has disclosed that she has no relevant relationships or financial interests in any commercial company pertaining to this educational activity.

At first glance, treatment of the young adult seems comparatively easy: their metabolisms have slowed to the normal adult pace, most medications are FDA approved, and they (finally) tend to present with symptoms of just one or two diagnoses at a time. However, nature gets in the way, and the normal developmental tasks of transitional age youth (TAY) make the situation much, much harder than merely writing the prescription. In fact, just getting them to fill the prescription requires a finesse that treating younger kids doesn't. Treating TAY requires you to get patients to accept responsibility for their disorders, which means accepting their disorders as part of themselves.

Just who falls into the category of TAY? In general it is patients ages 16 to 24.

Adolescents are able to assess risk as well as anyone else, but they are not able to override their emotions while making decisions. In part this has to do with the trajectory of brain development: the nucleus accumbens develops much earlier than the prefrontal cortex. Not only does this explain adolescent risky behaviors around sex, alcohol, and cell phones, it means that if adolescents are prescribed medications, they often don't take their meds. One study found that in a group of kids ranging from 8–17, medication compliance is at its lowest among 16–17 year olds. Bullock and Patten looked at compliance with psychiatric

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Failure to Launch Syndrome
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history of ADHD and significant learning disabilities, came to my office with her parents following a grand-mal seizure from benzodiazepine, opiate, and alcohol withdrawal. She had been attending a local college, working part-time and, along with her 27-year-old brother and his girlfriend, living in her parents' home. Historically her family had helped to calm her and solve her problems and, as she began to take steps to separate emotionally from them, she used the drugs and alcohol to numb her anxieties about functioning independently. Her parents were confused about how active they should be in her recovery and treatment. How much of their intervention should be punitive and how much therapeutic? Should they drug test her? Should they monitor her expenditures? Should they impose rent, board, or chores? Essentially, should they treat her as an adolescent or as an adult?

Steps to Treatment

The first step in treatment is obtaining consent from the emerging adult for the parents to participate in family therapy and/or parent work, since the patient is over 18. In my experience, the financially dependent patient feels obligated to consent but can be assisted to think through the limits of confidentiality that might be imposed. Learning to set formal privacy limits and boundaries can give patients a view of themselves as independent adults able to make informed choices, not just as children being controlled or punished.

The next step is helping the family identify which adolescent behaviors need parental management and which symptoms and developmental conflicts can be addressed by the patient with therapeutic support. Acknowledging that health, safety, and legal issues, which were primarily parental responsibilities before the age of 18, now have been shifted to the young adult, can be a wake-up call for families. Clarifying that the parents are generous in choosing to extend such privileges as medical insurance and liability protection can further add a dose of reality. You could help the parents consider that the patient pass a routinely but randomly administered drug test in order to continue to be included on the family car insurance policy or to use a family vehicle. Depending on the family circumstances and the family's acceptance of the young adult's level of responsibility, he or she could participate in household chores and be asked to contribute money for room and board.

I have found that a mix of therapies customized to each patient works best with this group. These could include medication, interpersonal therapy, cognitive therapy, psychoanalytic psychotherapy, and family therapy.

In spite of initial family sessions and parent work, Mary's parents did not follow through with mutually agreed upon contingencies. Over a period of several weeks, Mary watched her parents become frozen in a kind of paralysis. As long as she didn't create any new crisis, they were content not to take action. It became clear that the household's goal was to maintain a fragile equilibrium and not aim towards growth, health, differentiation or acceptance of the inevitable aging of all the family members.

Some Guiding Questions

How can you predict which families might not be able to establish limits needed to promote development in the struggling young adult? Here are some guiding questions:

1. Does the emerging adult or another family member have a developmental, medical, psychiatric, educational, or legal history that would give reason for parents to be overly involved and/or anxious?
2. Does the family have a history of family losses, traumas, or stressors that would result in needing to avoid separation or circumvent conflict?
3. Developmental psychology and psychoanalytic theory point to multiple "moments" of separation-individuation, the first in toddlerhood, the second in adolescence, the third in parenthood, the final in death. How have these family members navigated these moments in their own past? What are their philosophies about trials and failures and their explicit and even implicit expectations about what "should" be happening?

If the parents are not able or willing to provide an environmental scaffold, it can be very difficult for many young adults to build their own internal set of rules and guidelines. Ideally, the goal of therapy would be to help the family feel confident enough to offer environmental demands in a supportive way, and to help the individual accept and internalize them. Not all families are able to do this, and so at times the goal has to be to create these within the individual *de novo.* Group therapy or other ways to learn about other people's expectations of them can be useful. In our case, Mary's family was not able to negotiate the transition. Mary, however, showed unexpected strength as she engaged in treatment. Along with a 12-step program and psychopharmacologic interventions, Mary participated in twice a week psychoanalytic psychotherapy where she discovered that her long standing difficulties with self-soothing and separation anxiety had been masked by her ADHD symptoms of distractibility and low frustration tolerance. She had been able to use her parents and friends as

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This CME/CE activity is intended for psychiatrists, psychiatric nurses, psychologists and other health care professionals with an interest in the diagnosis and treatment of psychiatric disorders.

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psychological supports but now, with therapeutic support, was able to observe her own feelings and behaviors. She also was able to perceive her family members' particular vulnerabilities that made creating boundaries and limits very difficult. She mourned the fact that they could or would not be firm with her and that she had to develop that ability herself, a huge developmental step in becoming a grown-up. Within months, it was clear to the entire household that Mary, even with an occasional setback, was maturing at a faster rate than her older sibling.

Mary was able to see that her drug use, just like the permeable boundaries in the family, served various tacit purposes and had had complex effects on her emotions and sense of self over time. Periodic work with her family allowed her parents to tolerate and eventually support Mary's independence in her work, social life, and judgment. She was even able to address financial issues with her father that allowed her to take greater responsibility. As she ended the two and a half years of treatment, she slowly orchestrated a move into an apartment with roommates while maintaining loving and caring relations with her family that did not compromise her competence, sobriety, or emotional stability. Her successful launching unlocked the rest of the family, and, 10 months later, her brother and his girlfriend found their own apartment. ❖ ❖ ❖

Medication and Transitional Age Youth
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medications in patients ages 15 to greater than 65, and found that adolescents have the highest rate of non-compliance (more than two thirds) and compliance steadily improves over the lifespan, dropping to a low of 27% among people older than 65 (still relatively poor compliance). (Bulloch AGM and Patten SB, *Soc Psychiat Epidemiol* 2010;45:47–56).

So why don't people take the medications we prescribe for them, after they have worked so hard to come see us? The three reasons that were most commonly cited in the Bullock study among patients of all ages were: they forgot, they felt better, and they wanted to try to change without medication. However, TAY have additional pressures that bring to bear. In a study of non-compliance among adolescents with ADHD, the most frequent reason for non-compliance was a sense that the medication would fundamentally change them in a way that was false (Charach A et al, *Harv Rev Psychiatry* 2008;16:126–135)—that it is a threat to their identity. Additional reasons given by TAY kidney transplant patients—who presumably were facing life threatening consequences for non-compliance—included "a sense of domination by their medical regimen," "resentment about feeling different," "lower self-esteem," "negative reaction by peers," "a loss of a sense of belonging," and "uncertainty about the future," all concerns we hear from our own patients regularly (Bell LE and Sawyer SM, *Pediatr Clin North Am* 2010;57(2):593–610).

Goals for Treatment

Therefore, the goal of the treatment team working with transitional age youth has to be to reconcile treatment with normal development and identity formation by addressing these needs directly.

First, your manner with the patient matters. Be serious and professional—they'll respect you more—but also warm and caring—they'll like you better. Make your explanations developmentally appropriate, both cognitively and by acknowledging that the adolescent has values about sex, drugs, and/or goals different from your own. Don't tell the patient never to drink alcohol "because of your meds" if drinking is what their friends are doing. They will stop taking their medications rather than be the odd man out. Instead, teach them the risks and benefits and help them decide ahead of time (before emotions get in the way) how to manage those risks in concrete terms. Help them decide what they will say to their friends if they choose not to drink, or how many drinks are okay, or how they can tell when they've had enough. Similarly, simplify regimens as much as possible to make it easier, and less public, for them to comply.

Self-determination is a driving need in TAY, so a smart practitioner will gear discussions of treatment to encourage patients to make their own choices. Offer options for patients and help them understand your reasoning. In turn, be sure you understand and address patients' reasoning and emotions that may come into play. Encourage them to ask questions and become savvy consumers of medical care. Being able to stump you with something they've researched on the Internet will go a long way toward helping them feel competent and in control. (Be sure the websites they're using are reliable.) Help them problem-solve rather than give them the answer.

Identity, desirability, and acceptability to peers are all driving forces for TAY, and they are quite intolerant of their own imperfections. Mental illness is, unfortunately, an imperfection of which our society is also quite intolerant, so helping TAY clients realize that their illness is merely a part of them, not the whole, is key. Ask about their entire life, and acknowledge their triumphs as well as their symptoms. I tell my patients their mental illness is like being tied to a large, ill-mannered dog. It gets in the way, it needs to be managed at all times, but in the end, it's not who they are. Peer education and peer recreation groups can be helpful to normalize the experience of mental illness.

Lessons for Your Patients

Management is power, and this is developmentally an opportune time to teach patients that careful management of their disease is not enslavement to the disorder but freedom. Now is the time to work on psychiatric advanced directives. Help them recognize the larger pattern of their own disease: what they look like when things are good, when they are starting to get worse, and when they are going badly. Get them to put down on paper how other people can recognize where in that cycle they are and how best to assist. If they have a mental illness that may leave them incapacitated at times, due to psychosis, suicidality, paralytic anxiety, or anything else, help the patient decide who should intervene and how. This gives them control even when they are out of control. It also gives you the advantage of being able to point to the advance directives when they are out of control and say, "Look, this is what you wanted. We are following your instructions. You are still the boss." For

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Q&A With the Expert

Expert Interview

Helping Your Patients Succeed in College
Jacqueline Alvarez, PhD

Director, counseling and psychological services
Oregon State University

Dr. Alvarez has disclosed that she has no relevant relationships or financial interests in any commercial company pertaining to this educational activity.

CCPR: Dr. Alvarez, I'd like to talk about strategies we can use to help our patients stay in college and succeed. Being the head of the counseling center at a university, I imagine you see students every day who are on the verge of dropping out.

Dr. Alvarez: I want to give a little bit of context because this is really a significant issue for many students. In some older longitudinal research done in 1993, it was found that of 2.4 million students who went to college, 1.5 million of them never made it past their first year. And out of that 1.5 million, 1.1 million never went on to get a two- or a four-year degree. There are occupational, financial, and societal implications for kids who drop out of college. So we really want to do everything in our power to help them stay in school.

CCPR: What are the most common reasons students leave college?

Dr. Alvarez: First, we should talk about the different ways of "leaving" college. There is the departure from school that is really about leaving an institution—for example, by transferring to another college. But then there is leaving higher education altogether. A student might actually be forced to leave because of academic suspension, or might voluntarily choose to leave because it is not a good fit. There are so many reasons students leave school, but there are some themes that we see again and again.

CCPR: What are those themes?

Dr. Alvarez: There are a couple of internal student factors that really are important as to whether somebody perseveres in school or not. One is intention: what kind of intention is a student bringing to the academic experience? Is the intention to get a degree or is the intention just to take a few classes? The other theme is commitment: how committed is a student to making it through the program? And people really vary on that. The other factors are more external: How well does the student transition to the college experience? How does the student handle academic difficulty? Is the student a good fit for the school and is the school a good fit for the student? Does the student have many external obligations like work and family? Are there financial factors making it particularly difficult for the student to stay in school? And finally, the social experience shouldn't be overlooked. Students who feel that they don't fit or feel isolated are more likely to drop out. For folks who struggle with mental illness, isolation is particularly challenging because we know that having social relationships is a protective factor in our overall well-being and our mental health.

CCPR: How can students' families help them stay in school?

Dr. Alvarez: For traditional 18- to 25-year-old undergraduates, family support is very important. This comes in lots of different ways. It can be emotional support, financial support, or knowledge-based support. If a student has parents who have been though the academic process themselves, they often know systems and resources that can help support the student, whereas if families haven't gone through college then they may not know what some of those resources are. In academia, we talk about "helicopter parents" being not particularly helpful to students launching themselves. But there is some literature showing that families that are actively involved in students' lives as they are getting an education do much better academically and socially than students who are isolated and on their own (Settersten, R. and Ray, B. 2010. *Not Quite Adults* Bantam Books, New York).

CCPR: What do you see as the most critical things that students need to succeed in college?

Dr. Alvarez: A good orientation to college is essential. Transfer students, who often don't get the same orientation to the university as students coming in as traditional first-year students, may be more vulnerable. It's important to know where to go for academic advising and counseling, where to go to register or change classes, and how to find financial aid resources and understand those resources. Involvement in student organizations or what we call experiential education opportunities—things like service learning classes, community service, studying abroad, internships—are very helpful to succeeding.

CCPR: And how about personal relationships?

Dr. Alvarez: Social connections, especially friendships in college, are critical. And interestingly the type of friendship really makes a difference. So if a student is maintaining friendships with friends from high school to the detriment of creating friendships in college, that predicts a greater likelihood that he or she is not going to make it in college (Tinto, V. 1993. *Leaving college: Rethinking the causes and cures of student attrition, 2nd Ed.* University of Chicago Press, Chicago and London). Also, having a relationship with a faculty member or staff member is very protective. It doesn't really matter who that is—it can be a work-study supervisor, an academic advisor, or a faculty member.

CCPR: Everything we've discussed is important for all kids entering college. What are the things that we as providers can do to better ensure successful transition to college for our patients who may have serious mental illnesses?

Dr. Alvarez: As providers, we can orient patients realistically to both the stress and expectations of college, especially if the patient doesn't have family members who have been to college or for another reason are not a good resource. It is helpful for them to know what difficulties they can expect to face—what the challenges are going to be in and outside of class; what will be expected

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Q&A With the Expert

Expert Interview

Programs to Help Transition Patients to Adulthood

MaryAnn Davis, PhD

Research associate professor, Center for Mental Health Services Research, Department of Psychiatry
Director, Learning and Working During the Transition to Adulthood Rehabilitation Research and Training Center (Transitions RTC), Center for Mental Health Services Research
University of Massachusetts Medical School

Dr. Davis has disclosed that she has no relevant relationships or financial interests in any commercial company pertaining to this educational activity.

CCPR: Dr. Davis, what is the goal of the Learning and Working During the Transition to Adulthood Center and other centers like it?

Dr. Davis: The focus of our work is developing interventions that assist young people with serious mental health conditions to succeed in schooling, training, and their early launch into adult work lives during the transition to adulthood. We work with ages 14 to 30—so not just those known as adolescents, but also young adults and emerging adults.

One of the key elements of this stage of life is having fun.

MaryAnn Davis, PhD

CCPR: And why is it important to pay special attention to this age group?

Dr. Davis: The key is to really help clinicians understand some of the developmental uniqueness at this stage of life and think about how that might affect the clinical treatment that they are offering. I think the group that particularly falls between the cracks is the 18- to 21-year-olds.

CCPR: What should we be thinking about when providing treatment to this group?

Dr. Davis: One of the major things about any treatment that you offer to adolescents is that behind that adolescent is some authority of parents. This is in contrast to more mature adults who have experience in making decisions and persisting in a task on their own. The 18- to 21-year-olds often don't have the decision making abilities of fully mature adults, but also don't have the authority of parents behind them anymore. We have to be aware that patients in this age group can make really unwise decisions and there is no authority of parents anymore to keep them from pursuing those decisions. This situation also applies to older young adults, and we need to assess each individual for where they are in their development of responsibility-taking, judgment, and emotional or peer influence.

CCPR: So what type approach do you take with these patients?

Dr. Davis: It's important to make their treatment relevant to their lives, from their perspective, and build on their motivation to make change. I think motivational interviewing is a great framework for trying to provide a respectful link to young people that elicits their perspectives. It is a respectful way of not being authoritative, which is very important. We try to get them to engage their own investment in their choices; all of that is very, very tenuous because we don't have that safety net of parents on the one hand or more mature cognitive psychosocial processes on the other.

CCPR: How would you go about designing the perfect program to help these kids? The perfect clubhouse or transitional age youth program for late adolescents/young adults with mental health issues, for example?

Dr. Davis: First, you want an active and meaningful young adult advisory group. Getting input from young adults in terms of individual treatment decisions, in terms of how a program is run, and in terms of policy I think at every level it is incredibly important. I would say this is a critical component.

CCPR: Anything else?

Dr. Davis: An ideal program or center should be able to address the comprehensive needs of youth and young adults, which would go beyond providing good mental health care, to include substance abuse care, medical care, OB/GYN care and also extend to providing supports around education and around vocation. Even having laundry services is great. And recreation: one of the key elements of this stage of life is having fun. And one of the things that happens when people have serious illnesses is that they are restricted in their access to doing fun stuff with peers.

CCPR: So the best clubhouse program might look something like a good fraternity or sorority.

Dr. Davis: Yes, in that there are good peer supports, it would be in an educational setting, and there are fun activities to do and plan together. One of the nice things about that kind of model is that we know attracting this age group into services that could be helpful for them is tough, particularly anything that is stigmatizing, like mental health or substance abuse services. So setting the opportunity to access those services in a place where walking through the door doesn't label you as a mental patient I think is incredibly important. They could be going there just to hang out; but, oh, by the way, while they're there they could sign up for some time with somebody who knows something about mental health.

CCPR: Now for the practical part: Do these places really exist?

Dr. Davis: Yes, and you would be doing such a service to your patients in this age group by helping them find a good transitional age youth program in your area. For example, there is a place out in Clark County, Washington called Youth House (www.clark.wa.gov/youth-family/house.html). This clubhouse is involved in civic activity and offers leadership training for young leaders in Vancouver. Plus, they have a pool table and interesting information and other fun stuff. This is the type of program that mixes a fun and social environment with skills training and mental health care to help youths with mental illness successfully transition

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Research Updates IN PSYCHIATRY

SUBSTANCE ABUSE

Mid-Teens Is Peak Age for Prescription Drug Abuse

It's been a growing trend for quite some time now for teens to abuse prescription drugs such as pain relievers and stimulants for recreational use. A new study has found that some kids start this practice before they even officially reach their teenage years, and the peak age for starting to misuse prescription drugs is 16, not the older early college years that many prevention programs are directed at.

Researchers studied data from the National Survey on Drug Use and Health (NSDUH), a nationwide survey of drug use in people age 12 and older. Using a sample of close to 120,000 12- to 21-year-olds over a four year time frame, the study authors sought to learn when youths are most likely to begin using prescription pain relievers for indications other than those they were prescribed for.

The most common age for starting "extramedical use" of prescription drugs was 16, with 2.8% of teens of that age trying a prescription pain reliever for a non-prescribed purpose. The risk is 2.5% at age 17 and 2.2% at ages 15 and 18. At age 12, 0.5% of children in the survey first used a prescription pain reliever to get high. The number jumped to 1.6% by age 14 (Meier EA et al, *Arch Pediatr Adolesc Med* 2012; May 7:online ahead of print).

CCPR's Take: This study had several limitations. First, the survey was a self-report format, which can lead to all kinds of problems with people over- or under-reporting their drug use. Second, this study only looked at the age teens began misusing prescription pain relievers, not continued use. Nonetheless, it reminds us that kids as young as 12 could benefit from prevention programs aimed at prescription drug misuse.

Expert interview: Alvarez

Continued from page 4

of them by their professors, by their work-study supervisors, and by their peers; and how they can access resources on campus that can help them. It is important for them simply to know that the academic demand is going to be higher than high school. Also, let them know that homesickness is really normal and to be expected, and even if they don't feel it in the beginning, at some point they are probably going to experience it. And, especially around mental health issues, it is useful to normalize them and let patients know to expect some regressions or symptom flare-ups because they are in a really stressful environment. It is important to come up with an action plan of what to do if symptoms do recur or get exacerbated in some way, such as 1) how do you recognize that? and 2) what are you going to do when that happens?

> **We really encourage students to look at issues of meaning and purpose in life.**
>
> Jacqueline Alvarez, PhD

CCPR: And what are some things our patients can do to prevent, prepare for, and respond to symptom flare-ups?

Dr. Alvarez: First, encourage them to do things that we know are protective factors, as we discussed before: go to orientation, get involved, understand academic resources, and create personal relationships with other students and faculty. Later on, we really encourage students to look at issues of meaning and purpose in life. This is highly correlated to happiness in general and life satisfaction, so if we can encourage dialogue around how their gifts and talents meet the world's deep needs, that is a protective factor for them. College age kids love existential questions anyway. And two really important factors: get enough sleep and minimize alcohol and drug use.

CCPR: Both very important, especially for kids with mental health issues?

Dr. Alvarez: We find students, especially if they are struggling with mental illness, are more vulnerable, more emotionally fragile, less cognitively strong, and less able to do their work when they aren't getting enough sleep. In terms of substance use, we have found that students who have conversations with their parents or with some important adult in their life about alcohol use tend to use in much more responsible ways. About a quarter of students don't drink at all, but for those three-quarters that are going to use, someone needs to teach them about how quickly alcohol is processed in the body. This is really important for kids who are on medication to know how alcohol will interact with their medication. Will it undo the effects of the medication? Will it exacerbate the side effects of the medication? Will it cause other side effects?

CCPR: For kids with mental illness how can we best set up support systems ahead of time?

Dr. Alvarez: Most colleges and universities have mental health resources on campus, and getting connected to those resources early on is very helpful for students who have chronic mental illness. One thing that we have found helpful is when providers contact us before the student even gets to campus to let us know about the student's history. Then when students arrive, if they can make contact early on when they're not in crisis, then they can establish relationships with mental health staff members. This makes it easier to come in for counseling if they do have that bad week or tough patch. Most colleges and universities use short-term or brief therapy models, so if you have a student who is stable and is 90% of the time on top of things, that is a great resource. But if you have somebody who needs more long-term or more ongoing service, then I would recommend contacting the counseling center to find some good off-campus referrals.

CCPR: What do you suggest we do to help our patients who might have just one bad week a year, but that happens to fall during midterms or finals because of the stress and has potential to have a major impact on his or her academics?

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CME Post-Test

CME Notice: The test below is intended to be for **practice only.** All subscribers must take their tests online at www.thecarlatchildreport.com. If you cannot take your test online, please call 866-348-9279 or email info@thecarlatreport.com.

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Below are the questions for this month's CME post test. This page is intended as a study guide. Please complete the test online at www.TheCarlatChildReport.com. Note: Learning objectives are listed on page 1.

1. A study found that in a group of kids ranging in age from 8-17, at what point was medication compliance at its lowest (Learning Objective #1)?
   [ ] a) Among 8–9 year olds   [ ] b) Among 10–11 year olds
   [ ] c) Among 12–15 year olds   [ ] d) Among 16–17 year olds

2. A 2012 Pew Report indicates the percentage of young adults living in the family home is now at more than what percent, a number which has not been so high since the 1950's (LO #2)?
   [ ] a) More than 5%   [ ] b) More than 16%   [ ] c) More than 22%   [ ] d) More than 34%

3. Developmental psychology and psychoanalytic theory point to multiple "moments" of separation-individualization. When does the first of these occur (LO #2)?
   [ ] a) At birth   [ ] b) At three to six months   [ ] c) In toddlerhood   [ ] d) In adolescence

4. According to Jacqueline Alvarez, PhD, older longitudinal research found that of 2.4 million students who went to college, how many never made it past their first year (LO #3)?
   [ ] a) 500,000   [ ] b) 1 million   [ ] c) 1.5 million   [ ] d) 2 million

5. A new study by Meier EA et al, found what was the most common age for young people starting to misuse prescription drugs (LO #4)?
   [ ] a) 12   [ ] b) 16   [ ] c) 18   [ ] d) 21

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Expert interview: Alvarez
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Dr. Alvarez: We almost always start by encouraging students to talk with their instructors directly, because the instructor is the one who ultimately has the ability to say, "Yes I will grant you an exception" or "No I am going to deny that exception." Most faculty understand mental health issues because they are so common on campuses, and most really want their students to succeed. If a student has had a chronic mental illness and knows that at times he or she will need accommodations, it is best to just go ahead and get established with the office of disability services on the campus.

CCPR: And doing that can offer some degree of protection, too, right?

Dr. Alvarez: The office of disability services can work with students to understand what their diagnosis is and what the appropriate accommodation are. For example, somebody who has bipolar disorder may need occasional extensions or priority registration. If it is determined that a student needs accommodations, then a faculty member cannot deny those accommodations because of the Americans with Disabilities Act.

CCPR: If you could give a "welcome to college" kit to patients, what would you suggest be in it?

Dr. Alvarez: First, I would say choose a college that has an outstanding first-year orientation experience that lasts for the full year. Then, some of the things I would put in a toolkit would be organizational tools like planners to help with everything from where classes are located to when papers are due, because organizational strategies are extremely important for new college students. I would also give them social tools, like a basic guide on how to make small talk. I would give them tools for managing loneliness because there are going to be periods of time where they feel incredibly alone, and if they can tolerate that it is much more likely that they will succeed. I would also give them a study guide. How do you study well? What are the tools that are going to be helpful in making it academically? I would give them a self-management guide as well, with guidelines on managing emotions, cognition, and distress. And finally, I would focus on campus resources. Most colleges and universities have what is called a division of student affairs that has things like counseling services, health services, academic support, disability services, and first year programs.

CCPR: Thank you, Dr. Alvarez.

Medication and Transitional Age Youth

Continued from page 3

more information about how to draft a psychiatric advance directive with your patient, see www.nrc-pad.org.

This is also the time to teach them how to manage the medical system. Help them get copies of their medical records and insurance information. Help them become responsible for making their own appointments and filling their own prescriptions, but don't let them fail. Be sure they know the names of their medications, what they look like, and what they are used for. Help them understand how their insurance works.

The key to treating transitional age youth is empowering them to become the prime mover. Help them see themselves as more than a disease, but a person first, then a person with a disease they want help managing so it doesn't get in the way of the more important stuff. Teach them to be an expert in their disease, not just well-informed but able to educate others. Most importantly, help them see themselves as in charge and everyone else, especially their treatment team, as in a supporting role.

Expert interview: Davis

Continued from page 5

to productive adult lives. Another such place is Tempo, in Framingham, MA (www.tempoyoungadults.org), which is a house that actually does have laundry services, very strong young adult voices at all levels, and lots of different resources and activities for youth and young adults, as well as easy connections to treatment and services.

CCPR: Thank you, Dr. Davis.

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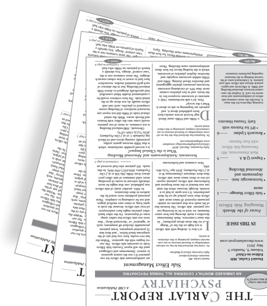

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