

FRAMEWORK

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CAREER DEVELOPMENT IN YOUNG ADULTS WITH PSYCHIATRIC DISABILITIES: FRAMEWORK FOR THE STATE OF THE SCIENCE PAPERS

This paper is part of a compilation of papers summarizing the state of the science in career development among young adults (ages 18-30) with psychiatric disabilities, entitled *Tools for System Transformation for Young Adults with Psychiatric Disabilities*. The purpose of these papers is to provide a summary of research-based knowledge about supports to help this population pursue postsecondary education and training and successfully move into adult working careers. These papers focus on knowledge that can inform the services these young adults can access in adult mental health and vocational rehabilitation systems, or other systems that provide them educational, training, or career supports at this age. These papers also propose future research agendas to strengthen this knowledge base.

Specifically, this paper is a “framing paper” that highlights issues shared across subsequent state of the science papers in three areas: one each on education, employment, and system/policy issues. For your convenience, these papers are available for download as individual papers. However, you will likely find it most useful to refer to all the papers available on our website at <http://labs.umassmed.edu/TransitionsRTC>.

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Introduction

The goal of this paper is to provide a general framework that shapes the discussion in the subsequent state of the science papers. This framework includes an overview of definitions that will be used in the subsequent papers, a description of some of the important characteristics of young adults with psychiatric disabilities related to supports for their career development, and a brief review of considerations for evaluating the knowledge generated through research.

Some Definitions

Young adults are also referred to as “emerging adults” (Arnett, 2000) or “transition-age youth” (Davis & Vander Stoep, 1997). Emerging adults are generally considered those who are age 18 up to some developmental point before “mature” adulthood, most consistently age 25 or 30. Transition-age youth begins at ages 15 or 16 and most commonly ends at age 25. **We will use the term *young adults* to mean individuals who are ages 18-30.**

There are numerous terms used to describe people who have mental health disorders that impair their functional capacities. *Mental health disorders* are mental, behavioral, or emotional disorders in the Diagnostic and Statistical Manual (DSM) with the exception of “V” codes (temporary conditions that may be the focus of treatment), substance use disorders, and developmental disorders (i.e. autism spectrum disorders, learning disorders, mental retardation). *Mental illness* is the most common term used for adults with mental health disorders, whereas *emotional disturbance* is the term most often used for children and youth. For a review of how these terms are used to define eligibility for public services see Davis, 2003 and Davis & Koroloff, 2005. *Mental illness* is sometimes used to define a narrow range of the most impairing mental health conditions (i.e. psychotic disorders, bipolar disorder, and major depressive disorder). *Psychiatric disability* is a term used to describe when mental health disorders have produced significant functional impairment in areas such as basic daily living skills, instrumental living skills or functioning in social, family, and vocational/ educational contexts. Typically, individuals in the early stages of schizophrenia do not qualify as having a psychiatric disability because the illness has not progressed sufficiently to produce various definitions of “significant functional impairment”. However, given the course of the illness, and that the early stages of it typically occur during young adulthood, we include this population in our considerations of the needed supports for this age group. **We will use the term *psychiatric disability* to describe those with mental health disorders that have caused significant functional impairment.**

Career development is comprised of the learning and cognitive elements that influence career choices, activities, performance and attainment. By definition, career development includes formal education or training, as well as the learning that comes from experience and the

influence of factors such as parental expectations and modeling. We use the term *career* to describe occupations with opportunities for growth that are undertaken for a significant period of a person's life. **We will use the term career development to refer to career activities, performance and attainment, and the learning and cognitive elements that influence them.**

Developmental Considerations

An essential characteristic of young adults is the ongoing change in psychosocial development. This includes cognitive, moral, social, and psychosexual development, and identity formation. These developmental changes allow young adults to meet society's expectations of them. Developmental characteristics that can affect young adult service provision include distrusting authority, experimentation, social immaturity, sexual behavior, concrete cognitive operations, *enacting* the good judgment they *understand* is appropriate, and needing to fit in with peers. The younger and more seriously an individual's psychiatric disability develops, the more delayed their psychosocial development will typically be. Typically, there is more rapid psychosocial development in the youngest period of adulthood, with a plateau having occurred by age 30.

Social roles also rapidly evolve in young adulthood. Roles as student, worker, spouse/partner, parent, and the like typically undergo many changes as they are picked up, changed, or are dropped on the path to established adult role functioning. Some of the most important developmental and role change considerations for educational, training, and vocational supports for young adults are described below.

Self-determination skills are developing during young adulthood. As the safety nets of childhood are withdrawn, one of the most important skills that young adults refine is self-determination (i.e. the ability to identify one's own needs, identify goals to address the needs, and set and pursue a course to achieve those goals). The cognitive maturation to accomplish each of these steps typically comes to fruition during this stage of life, but is not mature at the outset of it. Thus, young adults will need varying levels of support for the self-determination aspects of career development. Perhaps the most important implication of developing self-determination is the need for services and interventions to be appealing to young adults because they can easily walk away from those that aren't appealing, even when the service is viewed as critically important by others.

It is age-typical to pursue educational goals in young adulthood. It is important to keep in mind that young adulthood is a time when many young adults pursue postsecondary educational or training goals, and this greatly benefits their careers. Access to careers that allow for financial independence increasingly requires education or training

beyond high school (Settersten, Furstenberg, & Rumbaut, 2005). For many, especially those whose families cannot support their singular pursuit of postsecondary education/training, working is a concurrent goal. The pursuit of education/training concurrently with working is far less common in mature adults than in young adults.

Career development immaturity. Many mature adults with psychiatric disabilities have fairly extensive work histories (Baron & Salzer, 2000). As described earlier, the strongest predictor of vocational outcomes in adults with mental illness is their work history (Bond, Drake, & Becker, 2008; MacDonald-Wilson, Rogers, & Anthony, 2001). Young adulthood is when those positive work histories can begin. Thus, an obvious difference between mature and young adults is the immaturity of young adults' career development. Young adults will likely have less crystalized vocational identities, less informed outcome expectations, still need career exploration, and accumulate career activities to hone skills and cognitive elements of career development (e.g. career self-efficacy beliefs).

Family involvement. Families are important to career development in young adults in the general population, and family resources (emotional and instrumental) are increasingly important to young adult career success in the U.S. (Settersten et al., 2005). Young adults more frequently move back in with their families after some initial independent living (e.g. after college). The ability to move back home can give young adults an advantage in pursuing high achievements (e.g. pursuing higher degrees) and avoiding risk factors (e.g. homelessness). Family involvement is diverse among young adults with psychiatric disabilities, with some families very involved and others compromised, unavailable, or unhelpful. Families may view age 18 as a time for their young adult child to move out of the family home and take care of themselves. Other families view this as a time for greater involvement as the safety nets of childhood are systematically removed.

Peer influence. Peer influence is stronger in young than in mature adulthood, and strongly influences many aspects of career development choices including pursuit of postsecondary education/training opportunities, career exploration, occupational choices, and types and amount of career activities. Peer influence can also impact decisions to seek or remain in services or treatment. Group settings that have very few same-age peers are often unappealing.

Stigma. While mental health treatment is generally viewed more positively in younger age groups, there remains significant stigma associated with mental illness. This can influence help seeking and intervention completion. Young adults are generally more susceptible to perceived stigma from peers because of the central role of peer relations for them. Conversely, peer support for pursuing career development help can be a powerful factor in successfully accessing help.

Other important youthful factors. Other important factors that disproportionately impact young adults with mental illness include pregnancy (Vander Stoep et al., 2000), substance use (Sheidow, McCart, Zajac, & Davis, 2012), and arrests (Davis, Banks, Fisher, Gershenson, & Grudzinskas, 2007; Fisher et al., 2006), each of which can contribute to stunted career development in typical young adults (Green & Ensminger, 2006). Torres-Stone and colleagues (under review) also found that young adults in vocational support programs desire readily available workplace supports that are not provided by vocational program staff, and among the Latino young adults, social skills training.

The degree to which each of these aspects of young adulthood affects the success of career development supports is a matter for research to clarify. Until it is more closely examined, we consider it likely that the degree to which supports address these features will influence their effectiveness.

Research considerations

The strength of research evidence about a phenomenon is largely determined by the rigor of the research methods used to examine the phenomenon and by the amount of research conducted on the various aspects of the phenomenon. Thus, simply answering the question “how many young adults have a psychiatric disability in the U.S.?” requires a rigorous method to obtain a good representative sample of young adults in the U.S. (e.g. representing different geographic regions, racial/ethnic groups, subpopulations that are difficult to recruit) and a sound method for assessing psychiatric disability. “Sound” methods need to consider the information source (e.g. self-report only, inclusion of records or others’ reports), the measure used to obtain the information (e.g. the psychometric features of the “structured interview”), and the process (e.g. in-person, phone-based, or web-based “interviews”). The evidence from any single study generally requires replication to increase the strength of the evidence.

The strongest evidence comes from large randomized clinical trials in real-world settings. Typically we come to know scientifically if an intervention works through an established process that includes clearly describing the intervention in detail (through a manual), then applying that intervention to one group of individuals and comparing their 3 outcomes to those of another group of individuals that are not treated with that intervention (the other group may be treated with another intervention/s, not treated, be on a wait list for the intervention, or given a “placebo”). An *intervention* is a treatment, service, or other set of specific activities designed to change something for the individuals receiving it. The most rigorous way to compare the two groups is to randomly assign each study participant to the experimental or other group (essentially deciding which group the study participant is assigned to by a flip of a coin). The most rigorous way to ensure that the experimental

intervention has been provided as designed is to compare what the providers of the intervention actually did to what they were supposed to do. This is called assessing *fidelity*. This collective group of procedures is called clinical trials. It is through clinical trials that interventions' efficacy are directly tested.

Once an intervention has been shown through at least two randomized clinical trials conducted by different researchers to produce meaningfully better outcomes compared to a placebo or alternative treatment, or outcomes that are equivalent to interventions that are already *well established* for their efficacy, its efficacy is deemed *well established* (Lonigan, Elbert & Johnson, 1998). However, clinical trials are often conducted under “ideal” conditions, such as using only treatment providers who are well-trained, well-supervised, and enthusiastic regarding the treatment, and study participants that meet a narrow range of characteristics. Real life situations are rarely so simple and, for that reason, “effectiveness trials”, which most closely mimic the way interventions are conducted in ordinary settings, often follow efficacy trials. Many interventions, both psychosocial and pharmacological, that work well in efficacy trials sometimes fail to produce under these less ideal conditions.

Evidence from other types of studies is strengthened by replication and the accumulation of confirming findings from other study methods. Clinical trials research evidence about how well an intervention works is not always available for a given intervention. Sometimes randomization to intervention groups is not possible. Statistical methods can help reduce the impact of factors that shape which group an individual ends up in the absence of randomization. Sometimes groups are randomized, but the intervention is not well specified, or the fidelity of its implementation is not measured. Sometimes the research base comes only from the individuals who were exposed to the intervention, and the only comparison available is their status before the intervention compared to after the intervention is completed. The findings from these types of studies are weaker evidence about an intervention's efficacy, though the accumulation of several such studies using different methodologies increases confidence in the evidence.

Evidence is strongest when the research has focused on this population. Weaker evidence comes from other age, disability, vulnerability, or general populations. One final consideration about the research evidence on career development supports for young adults with psychiatric disabilities is the relevance of the samples that contribute to this knowledge. Though research specifically on this population has increased in recent years, studies of this specific population are still rare. Clinical trials that simply included this age group (e.g. studies of “adults” ages 18-55), or are of this age group but for a broader group of young adults with disabilities, are not sufficient to establish efficacy.

In order to establish efficacy, the sample size of young adults compared to that of older or younger age groups needs to be large enough to detect an age effect. Few published studies have presented age comparisons, though some report significant differences between younger and older adults in the outcomes or relative efficacy of psychosocial interventions (e.g. Haddock et al., 2006; Rice, Longabaugh, Beattie, & Noel, 1993; Uggen, 2000). We are often left connecting the dots of available research from other age groups or other disability or vulnerability groups to develop informed estimates for this population.

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