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Group Intervention for Young Adults with Mood and Anxiety Disorders Transitioning to College

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Abstract

Young adults with chronic mood and anxiety disorders may receive a range of services in pediatric care (eg, psychiatry, therapy) and within the school system (eg, individualized education plans). Such services rely on the involvement of parents or guardians to support youth (eg, attending appointments, administering medications). However, in college, young adults are often on their own and need to assume responsibility for scheduling appointments, obtaining and taking medications, and seeking out additional services (eg, accommodations). Unfortunately, many young adults may not have developed the skills needed to navigate campus and healthcare systems effectively, which can often lead to dire consequences. Adding to these difficulties are the high rates of depression and suicidal ideation observed in today's college students. Many students need intermediate levels of care to stay in school successfully, although not all have the maturity and skills to navigate healthcare without a transition plan. To address the needs of young adults transitioning out of pediatric mental health care, we developed a brief group intervention delivered to young adults and their parents during the 6 months prior to college or transition to living independently in the community. The transition group program structured sessions focused on scaffolding knowledge about one's own skills (and deficits) related to independent living, successful transition to college or community, and ability to independently manage a chronic mental health disorder. All young adults and parents reported that they would recommend or strongly recommend the group to a friend, and the majority found the group to be acceptable with regard to length and frequency. For both young adults and parents, future outlook also improved from pre- to post-group.

Keywords

transition care; mood disorders; anxiety disorders; emerging adults; college mental health

Psychiatric disorders such as depression and anxiety, and conditions that are often comorbid with depression and anxiety among high school youth, may profoundly affect successful

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transition to college. Youth treated for these conditions in childhood or adolescence often receive a range of services (eg, psychotherapy, medication management, individualized education plan) that almost inevitably include parental involvement. The locus of responsibility for these services shifts dramatically once youth transition into adulthood. In college, students are responsible for seeking academic accommodations, scheduling and attending appointments, and obtaining, refilling, and administering medications. Developing skills to recognize the need for specific services and appropriately navigate systems to achieve one's goals can be challenging.

Mental health problems are prevalent on college campuses, and suicide is the second leading cause of death among college students.[1] Recent research has found that, internationally, a third of college freshmen screen positive for at least 1 mood, anxiety, or substance use disorder on the basis of criteria in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*.[2] When surveyed about their mental health over the last year, the proportion of U.S. college students who screened positive for depression increased from 24.8% in 2009 to 29.9% in 2016.[3] Similarly, the proportion of U.S. college students who endorsed seriously thinking about attempting suicide in the past year increased from 5.8% in 2007 to 10.8% in 2016.[3] Depression and anxiety rank among the top 4 factors reported by college students that interfere with their academic performance,[4] and most students who leave college without graduating do so due to mental health reasons (most commonly mood and anxiety disorders).[5] Despite the prevalence of and impairment associated with mental health problems among college students, treatment rates are low. Among students with depression, rates of treatment over the preceding year ranged from 43% in 2009 to 56% in 2016.[3] Moreover, while youth may receive treatment before they go to college, they do not always receive services on campus—a particularly troubling issue given that earlier onset of psychiatric disorders is associated with poorer outcomes and greater symptom severity.[6] Younger adults are also more likely to self-discontinue antidepressants than older adults,[7] often because they are feeling better and believe they no longer need them, or because they want to have a clean slate. While college students are legally able to make such treatment decisions for themselves, these students may vary greatly in terms of their developmental maturity to make healthcare decisions that will be in their long-term best interests.

Disclosure is a key step in accessing services in college and may be critical given the enduring nature of mental health problems for most students. Research shows that 60% of students with a mental health problem report the same problem 2 years later and, within this group (ie, those whose conditions have persisted for at least 2 years), less than half received treatment during that same period of time.[8] Unfortunately, students with mental health conditions often do not disclose their conditions to their school because of concerns about stigma or lack of awareness that this type of condition can qualify for accommodations. College students with mental health conditions have been found to be 3.1 times more likely not to disclose their conditions compared with students with other types of issues that can interfere with their learning; students under 25 are also twice as likely not to disclose compared with older students.[9] Because young adults may be away from home, not in regular contact with parents or mental health providers, and in a new system in which they are no longer "identified" as a student with mental health concerns, intervention may not occur until the situation becomes severe. Unfortunately, the consequences of such

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difficulties are dire, including hospitalization, academic probation or failure, and even suicide. Therefore, more research is needed to support young adults with mental health disorders in successful transitions to college and adulthood, including building the skills to independently access and navigate mental health and medical service systems.

This article outlines the development and pilot testing of an adjunctive, billable, group program designed to assist young adults with mood and anxiety disorders in building the necessary skills for successful transition to adulthood. The group was developed in the context of the Services for Teens at Risk (STAR) Center, housed within the Division of Child and Adolescent Services, Western Psychiatric Institute and Clinic and the Department of Psychiatry, University of Pittsburgh. The STAR center is a suicide prevention program and provides outpatient assessment, treatment, and intensive outpatient services for youth aged 12 to 18. The group program presented here grew out of our experience supporting youth maturing out of our services and transitioning into adulthood (including transition to adult services, college, the workforce, and/or independent living in the community).

METHODS

Content Development

We searched the literature for programs that aim to support the transition from adolescence to adulthood in medical[10,11] and mental health settings.[12,13] The content development was based on several key areas identified in the literature as common themes and recommended steps in the transition process, as well as our clinical experiences regarding specific challenges among depressed and suicidal youth encountered in our more than 30 years of clinical experience with this population. Each of these areas is outlined in detail in Table 1. We attempted to distill essential information into 6 monthly group sessions with young adults and 3 concurrent parent sessions.

Group Content

The overarching theme of the groups for both young adults and parents is independence as a continuum. Didactics and discussion focus on ways young adults can *gradually* build toward greater independence, while parents simultaneously help scaffold their children during the transition. Furthermore, we highlight the critical concept that independence consists of multiple domains. Table 1 presents an overview of the group content organized by domain for both young adults and parents. Before new content is taught in each session, members complete a brief self-assessment pertinent to the skills to be learned in that session. This exercise is designed to increase members' awareness of their current level of independence and identify areas in which they can build toward greater independence.

Group Structure and Timing

For young adults, we offer a monthly 60-minute group that begins in March and ends in August of the final year of high school. Three concurrent parent sessions are offered in March, May, and August. Parents and young adults join together for the final group to celebrate and conclude treatment. Each group session begins with an icebreaker activity and snacks, solicitation of feedback and questions related to the previous session, completion of

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a pre-session self-assessment, and new session content. We finish each session with homework and wrap-up. The manual for the transition group is freely available at the STAR Center's website (https://www.starcenter.pitt.edu).

Participants

Over 4 consecutive years, 39 young adults participated in the group (9 in 2014, 13 in 2015, 7 in 2016, and 10 in 2017). Nearly half of the young adults had at least 1 parent participate in a concurrent parent session ($n = 19$), 12 parents did not participate, and 8 parents' participation status was unknown (electronic medical record notes were written for young adults only). The individuals whose parents did not participate most often cited scheduling conflicts as the reason. Young adults were currently receiving outpatient treatment at STAR or at Child and Adolescent Bipolar Spectrum Services (CABS; a University of Pittsburgh Medical Center clinic). All of the participants signed an IRB-approved registry consent at treatment initiation allowing de-identified data to be used for clinical research purposes. Demographic and clinical characteristics of the participants are shown in Table 2.

Inclusion Criteria

We determined that the young adults who were most likely to benefit from an adjunctive transition service would be those who were engaged in ongoing psychiatric treatment and had achieved an adequate and sustained response to treatment (ie, moderate symptom stability, not acutely symptomatic or suicidal). Thus, eligible young adults in the transition group were 1) planning to graduate from high school at the end of the academic year; 2) not acutely suicidal and able to agree to a safety plan; and 3) concurrently engaged in outpatient treatment (including medication management and/or individual therapy). Eligible young adults were approached about group participation by members of their treatment team (ie, psychiatrist, nurse, and/or therapist).

Measures

At the conclusion of the final group session, young adults and their parents provided anonymous feedback about their experience, including overall satisfaction, acceptability, and outlook for their future. Overall satisfaction with the program was rated on a 7-point Likert scale ranging from 1 (very dissatisfied) to 7 (very satisfied). Satisfaction was also assessed by asking participants if they would recommend the program to a friend or relative (rated on a scale from 1- strongly not recommend to 7- strongly recommend). Acceptability regarding program length and frequency was evaluated using the following categories: much too short/infrequent, too short/infrequent, slightly too short/infrequent, appropriate, slightly too long/frequent, too long/frequent, and much too long/frequent. Lastly, participants reported on their future outlook before beginning the group and at the final group on a scale from 1 (very pessimistic) to 7 (very optimistic). Satisfaction and acceptability data from 6 young adults and 5 parents from the 2014 and 2016 cohorts were available.

RESULTS

On average, the young adults ($N = 39$) attended 3 of the 6 sessions (mean = 2.92 sessions, SD = 1.69). Table 3 presents the acceptability and feasibility ratings from the 6 young adults

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and the 5 parents for whom this information was available. All of these youth and parents reported that they would recommend or strongly recommend the program to a friend or relative. The majority of youth (67%) and all parents reported that the group length was appropriate, while 1 youth reported it was slightly too short and 1 youth reported that it was slightly too long. Similarly, 50% of youth and 80% of parents reported that the session frequency was appropriate. Two youth reported that the session frequency was slightly too infrequent or too infrequent, and 1 reported that it was slightly too frequent. Finally, the future outlook of both youth and parents improved from the pre- to the post-assessment. Before the group, the mean rating for future outlook among the young adults was 3.67, which increased to 5.83 at the post-group assessment. Before the group, the mean rating for future outlook among the adults was 3.40, which increased to 6.20 at the post-group assessment.

DISCUSSION

Our data offer preliminary evidence regarding the feasibility and acceptability of an adjunctive group program focused on successful transition to college for youth receiving outpatient care for mood and anxiety disorders. Young adults and parents were satisfied with the program and some of them expressed a desire to meet even more frequently. Young adults and parents also reported that their future outlook became more optimistic from the beginning to the end of the program. While more research is needed to demonstrate the effectiveness of this program (including follow-up during subsequent years in college or the community, eg, number of appointments scheduled/attended or prescriptions filled independently), the need for programs supporting the success of youth with chronic mental illness in their transition to adulthood is clear.

Lessons Learned and Future Directions

As we delivered this program, our understanding of the needs of these emerging adults evolved. In responding to their needs and to enhance the quality and sustainability of the program, we have employed a number of additional strategies related to recruitment, evaluation, and college-specific services. These suggestions were based on iterative modifications we made that were found to enhance recruitment, attendance, and acceptability over the 4 years of program delivery. Regarding recruitment, we found that youth were more likely to engage in the program when they participated in commitment-building sessions using principles of motivational interviewing before the program. Commitment sessions were typically conducted by a group leader and included both an orientation to the program as well as discussions of the importance of strategically building skills for independence grounded in the context of the youth’s treatment needs and goals for the future. These sessions also focused on problem-solving barriers to attendance, as conflicts are common for participants who are completing their senior year of high school. Commitment was further reinforced by the outpatient team (ie, psychiatrist, nurse, therapist) in regularly scheduled sessions. In addition, we recommend beginning to identify youth who may benefit well ahead of time, such as at the beginning of their senior year of high school to enhance commitment to the program. Finally, while we have not yet implemented this strategy, we have considered the idea of working with high schools (especially alternative

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programs and online schools catering to students with mental health and behavioral concerns) to offer this program in a more universal format.

Given the pilot nature of the transition program, we also encourage the solicitation of regular feedback from all participants. In addition to pre- and post-group rating forms, we now invite verbal feedback from all group participants after each session related to their likes/dislikes as well as topics on which they would like to spend more or less time. Paper evaluations, such as those including rating scales for relevance and acceptability of content in addition to qualitative comments, would likely also be useful. Finally, while the group provides basic education related to navigating campus-based community health services (eg, discussion of what services are available and how to find out more information about them), we have learned that the diversity within each group (ie, schools, regions, future plans) often makes it more effective to work through specific plans for care at the individual level with the outpatient treatment team. In this regard, we view each group as starting out with a "blank slate." As participants share their goals and concerns, we discuss and strategize together how to best navigate the issues within the context of that individual's treatment needs, environment, and plans for the future. Bridging calls (ie, calling to check in with youth to ensure that they have followed up with services as planned) may also be useful.

This study was not without limitations, including the pilot nature of the program, lack of follow-up data, and the low number of participants for whom outcome data were available. Nonetheless, the need to support young adults with chronic mental health disorders in successfully transitioning from pediatric mental health services and into their next steps as independent adults is clear. We conclude that adjunctive programs focused on mental health and wellness for transition age youth with mood and anxiety disorders are important services that can be feasibly offered in a psychiatric clinic before transition as an additional support to youth and their families.

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Table 1.

Overview of Group Content for Young Adult and Parent Sessions

Young Adult Sessions	Content/Focus
1. Knowing my body and mind	Knowing diagnosis, symptoms, baseline behavioral patterns (eg, eating, sleeping), current/past treatment, warning signs, and coping skills. Creation of a health portfolio including personal/treatment and family history, emergency contact information, previous 504/IEP plans, safety plan, and insurance information
2. Advocating for myself	Learning how to self-advocate, communication with new providers, handling emergencies/crises, finding services on campus or in the community, talking about one's mental health condition with others (whom to tell), and making independent decisions
3. Managing my academics	Academic accommodations, differences between high school and college, note taking, structuring time, and asking for help
4. Living independently	Managing money and time, doing laundry, and grocery shopping.
5. Managing my relationships	Relationships with parents, relationships with friends from high school, and building new relationships.
6. Graduation (with parents)	Presentation of health portfolio, review of lessons learned, and graduation party
Parent Sessions	**Content/Focus**
1. Before college	Planning for continued mental health care (including an overview of the health portfolio that youth will create during their group), communication and monitoring with your child, and how to intervene if needed
2. College counseling centers	Services offered, timeline (how/when services can be accessed), limitations, and common pitfalls. (This group is often presented in partnership with a staff member of our university counseling center.)
3. Graduation	Same as above.

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Table 2.

Demographic and Clinical Characteristics of the Participants (*N* = 39)

Demographic variable	Value
Age (mean)	18.1 yrs, range = 17.3 to 19.3 yrs
Female sex (*n*, %)	31 (79)%
Primary diagnosis*	*n* (%)
Depressive disorder	34 (87%)
Bipolar disorder	3 (8%)
Anxiety disorder	2 (5%)
Postgraduation plans	*n* (%)
Higher education	32 (82%)
Employment	4 (10%)
Unknown	2 (5%)
Join military	1 (3%)
Residential plans	*n* (%)
Outside the home	32 (82%)
Inside the home	6 (15%)
Unknown	1 (3%)

*Note that the majority of participants also had comorbid conditions, including anxiety, eating, and behavioral disorders, posttraumatic stress disorder, or attention-deficit/hyperactivity disorder.

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Table 3.

Feasibility and Acceptability Ratings From Young Adults and Parents

	Young Adults (n = 6)	Parents (n = 5)
Program Evaluation	***n* (%)**	
Recommend program		
Strongly not recommend	-	-
Not recommend	-	-
Slightly not recommend	-	-
Neutral	-	-
Slightly recommend	-	-
Recommend	6 (100)	1 (20)
Strongly recommend	-	4 (80)
Group length		
Much too short	-	-
Too short	-	-
Slightly too short	1 (17%)	-
Appropriate	4 (67%)	5 (100)
Slightly too long	1 (17%)	-
Too long	-	-
Much too long	-	-
Session frequency		
Much too frequent	-	-
Too frequent	-	-
Slightly too frequent	1 (17)	-
Appropriate	4 (50%)	4 (80)
Slightly too infrequent	1 (17)	1 (20)
Too infrequent	1 (17%)	-
Much too infrequent	-	-
Satisfaction and Outlook	**Mean (SD)**	
Satisfaction with program	6.33 (0.52)	6.80 (0.45)
Future outlook (pregroup)	3.67 (1.37)	3.40 (1.67)
Future outlook (postgroup)	5.83 (0.75)	6.20 (0.84)

Satisfaction with the program was rated on a 7-point scale ranging from 1 (very dissatisfied) to 7 (very satisfied). Future outlook was rated on a scale from 1 (very pessimistic) to 7 (very optimistic).