

Mental Health in Emerging Adulthood

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Within a span of six months, *People* magazines' covers asked, "Britney's Mental Illness: What's Behind Her Disturbing Behavior?" spotlighted Lindsay Lohan's struggle, "From Rehab to Arrest in 11 days"; and attributed "Heath Ledger's Tragic Death" to suicide.¹ Each of these emerging adults can be said to have achieved a great deal, yet their struggles are apparent. Perhaps a "quarterlife crisis" is to blame. Perhaps too much self-esteem enhancement left them unprepared for the realities of adulthood and that is "why today's young Americans are more confident, assertive, entitled—and more miserable than ever before (Twenge, 2006)." Perhaps the new, longer road to adulthood is to blame for their troubles; perhaps their celebrity?

Stories of young people suffering through their 20s are not new. In the 1970s, Jimi Hendrix, Janis Joplin, and Jim Morrison all died at age 27 as a result of mood disorders and addiction. These incidents four decades ago suggest that mental health problems have been a consistent threat to emerging adults. Since the 1930s, psychiatric opinion has been that emerging adulthood is "the age for neuroses."²

MTV, the premier television network engaging the 18- to 25-year-old demographic, has long recognized that mental health problems are part of the fabric of their lives. Since 1992, MTV has produced *The Real World*, a reality show about emerging adults telling the "true story . . . of seven strangers . . . picked to live in a house, . . . work together and have their lives taped." Through 22 seasons, we've witnessed how Kevin's out-of-control anger, Puck's unpredictable behavior, and Ruthie's excessive drinking interfere with growing up. MTV's newer documentary series *True Life* has put psychiatric disorders center-stage, beginning with the episode "Fatal

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Dose,” a close look at heroin addiction among 20-somethings. Airing since 1998, over 140 episodes of *True Life* have delivered emerging adults’ first-person accounts of experiences with mental health problems, including “I’m in Therapy,” “I Have a Phobia,” “I Have Obsessive Compulsive Disorder,” “I’m Addicted to Crystal Meth,” “I Self-Injure,” “I Panic,” and “I’m Addicted to Porn.”

Recent, large-scale population counts confirm that psychiatric disorders are most prevalent from ages 18 through 25. They are so common, in fact, that they are normative—in a 12-month period, almost 50% of emerging adults between the ages of 18 and 25 experience at least one psychiatric disorder;³ rates are the same for college students and their nonattending peers. After the mid-20s, 12-month prevalence declines: 44% among 18- to 29-year-olds, 37% among 30- to 44-year-olds, 31% among 45- to 59-year-olds, and 16% among those 60 and older (Kessler and Merikangas, 2004). Despite the commonness of psychiatric disorders in emerging adulthood, normative is not “normal.” Dealing with a psychiatric disorder is a struggle with patterns of dysfunctional moods, thoughts, and behaviors. Psychiatric illness is also abnormal in the sense that, by definition, psychopathology causes distress. For those of us interested in helping 18- to 29-year-olds make successful transitions to adulthood, a first step in being effective is recognizing that many are dealing with mental health problems. A second step is differentiating developmental success from mental health as two distinct, yet correlated, measures of adaptation.

Education and training in mental health is historically restricted. There is little training in mental health for those who do not work primarily in mental health service jobs. Yet there is an unfilled need for mental health information and training among those who work with emerging adults in other capacities. Any college professor has a number of stories to tell about the student who was depressed, had ADHD, confessed an eating disorder, or dropped out because of a mental health problem. But helping students in this capacity is outside of the domain of teaching, mentoring, or advising. Professors are discouraged from talking to students about these problems. This is true in other capacities as well. How are managers trained to deal with young people’s mental health problems? They’re not. For good reason—talking about mental health problems opens the door to medical privacy and legal issues. Parents, too, are torn

between taking the responsibility to help their suffering 20-something children and legal policy, which prohibits including parents in the mental health care of their adult child unless that child consents.

What we can do is become educated about the mental health problems that commonly threaten the well-being of emerging adults. Dealing with mental health issues is an essential component of programs designed to help this age group. The following is an overview of the most common features of psychopathology in emerging adulthood. I use case studies, familiar films, and book characters to illustrate ways that emerging adults experience disorders. I then explore risk factors that contribute to the psychopathology we see in emerging adulthood. In conclusion, I discuss ways in which we can draw on recent advances in developmental theory to inform our attempts to help emerging adults achieve success and flounder less on their pathways to adulthood.

Psychiatric Disorders in Emerging Adulthood: A Primer

What we know about psychiatric disorders from popular films doesn't necessarily reflect the common experiences of emerging adults with mental illness. In *A Beautiful Mind*, we follow John Nash's descent into full-blown schizophrenia in his 20s, while he also achieves a Princeton professorship and eventually a Nobel prize. But schizophrenia occurs in less than 1% of the emerging adult population, and schizophrenia occurring in the context of Nash's genius is rare. In *St. Elmo's Fire* and *Less than Zero*, cocaine addiction is balanced by fabulous cars, careers, and relationships. Presenting an upside to cocaine use obscures reality via omission. The short-term euphoria, energy, and excitement of stimulants opens the door to heart problems, heart attacks, respiratory failure, strokes, and seizures.

Rather than these spectacular Hollywood versions of mental health issues, the most common psychiatric disorders are relatively familiar to us because they are deviations from normal and expected patterns of coping, mood, and behavior. Anxiety is a normal response to an unfamiliar or undesirable object, event, or experience. But in the case of anxiety disorders, anxiety becomes disproportionate to the stressor and the adaptive process by which anxiety triggers effective coping does not work. Substance use turns harmful when a person's focus and behavior shifts away from meeting daily

responsibilities and working to meet one's life goals; energy is increasingly committed to getting and using substances. Mood disorders occur when mood vacillates out of the normal range; the highs and lows, ups and downs of emotion cause significant distress. Last, impulse control disorders are diagnosed when emerging adults fail at regulating their behavior and reactions, and impulsive and aggressive behavior interferes with their ability to function.

Because these common behaviors have a "normal" counterpart, the line between mental health and mental illness is blurry. Young people who experience psychiatric disorders, or those who care about them, do not have an easy time differentiating normal from abnormal. Persons who are not mental health professionals have little understanding of the symptoms that constitute specific psychiatric disorders. However, regardless of the specific disorder an emerging adult may be dealing with, there is one shared, key feature that all emerging adults with a psychiatric disorder will experience. That criterion is impaired functioning. When a pattern of thoughts, feelings, or behaviors interferes with an emerging adult's ability to meet the demands of his or her daily responsibilities, this is an indicator of psychiatric disorder.

Anxiety Disorders

Almost 1 of every 5 emerging adults (19%) meets criteria for an anxiety disorder. Anxiety disorders interfere with emerging adults' thinking (e.g., confusion, difficulty focusing), feeling (e.g., uncontrollable anger, intense fear), behavior (e.g., fighting, self-harming), and physiology (e.g., rapid heartbeat, sweating, sleep issues, fatigue, soreness). Emerging adults with anxiety disorders feel that their reactions are proportionate to a perceived threat. Others, however, may experience that person's reactions as out-of-proportion to a stimulus.

Several features of emerging adulthood heighten the risk for anxiety disorders. Because the majority of soldiers enter the military between 18 and 25, the risk for war-associated post-traumatic stress disorder is elevated. *True Life's* Arthur, "I Have PTSD," relays the rage that consumes him after he fights in the battle of Fallujah:

One day you're just home and you're just supposed to be some regular person. . . .
When I first got home I was depressed, really depressed. I was medically

discharged with post-traumatic stress. They gave me \$13,000, some pills, and I was on my way. But then, me getting out of the Army (he cries), it was like, what the f*** is this? But everything is different. . . . I've been gone for 5 years. . . . I can't work right now, because I don't have anything stable in my life. PTSD totally changes your personality. . . . The worst thing, I would say, is not being able to control my feelings. I want to get back to myself. I used to be this people-person, lovable guy, and now I'm like just . . . don't talk to me. I just want to be myself again.

Other situations more common in emerging than later adulthood also elevate the risk for PTSD, including interpersonal violence and traumatic childbirth.

Anxiety disorders interfere with emerging adult development because they inhibit exploration. Social phobia, for example, may manifest as an intense fear of public speaking, dealing with authority, attending social events, or writing or eating in public. Generalized and separation anxiety disorders are likely to limit trying new things because of feeling generally fearful, cautious, and overattuned to risk. Panic attacks occur when anxiety overwhelms physiology, resulting in what feels like a heart attack. Agoraphobia may develop, a fear of leaving a safe place in fear of having a panic attack. Obsessive-compulsive disorder also limits the experiences of emerging adults because of irrational thoughts and urges that have to be controlled to avoid a (perceived) negative consequence. For example, if I don't read every word in my textbook, I will fail.

Substance Disorders

Substance use is common in emerging adulthood. In 2008 about 70% of 21- to 25-year-olds reported that they drank alcohol in any given month, 37% smoked cigarettes, and 20% reported illicit drug use: pot, 16%; psychotherapeutics (e.g., stimulants), 6%; cocaine, <2%; and hallucinogens (e.g., acid, mushrooms), <2%.

By the clinical, diagnostic definition, substance use crosses the line to substance abuse disorder when use impairs "functioning." Approximately 7% of emerging adults meet criteria for alcohol abuse disorder; 4% meet criteria for drug abuse disorder. Substance disorders are difficult to diagnose in emerging adults because a significant proportion of users are classified as high-functioning. That is, their substance use does

not interfere with the maintenance of their lives—they attend school or work and have friends and intimate relationships, a place to live, and food to eat. The ability to maintain, however, is often temporary; heavy substance use is a risk factor for progression to substance disorder.

Substance dependence, a more serious form of substance disorder, is diagnosed when physiological symptoms develop, for example, tolerance, withdrawal, or blackouts. *True Life's* Christina, 24, giggles when she tells her parents that she woke up with her pants off. She thinks she parked her car behind the garage, but her father informs her, “There’s no car there.” Chasing a night-binge on alcohol, she tames her headache the next morning with a beer. She exits her parents’ kitchen telling them, “I hope I’m alive tomorrow. Bye!” Christina watches her hands shake in the elevator, on her way to party. Later into her next night of drinking, we hear her tell a new male friend, “I’ll lay down right now. Do whatever you want.” Viewers are disturbed, watching her cry as she drives away from the hotel the next morning. Her drinking, risky behavior, and sadness depict the common complications of substance disorders; they often occur with depression and heighten the risk for suicide and accidental death.

Mood Disorders

Rates of anxiety and substance disorders decrease across emerging adulthood, while the rate of mood disorders, such as depression and bipolar disorder, increases.

Approximately 1 in 10 emerging adults has a mood disorder. Similar to the ways in which anxiety and substance disorders interfere with daily life, mood disorders significantly impede emerging adult functioning. Different from anxiety and substance disorders, however, mood disorders are internalizing disorders that are often hidden from others, leaving the emerging adult alone to struggle with the disorder.

The key clinical feature of depression is a low, sad, and withdrawn mood persisting for at least two weeks. Physical symptoms are often present as well.

Daniela: During my freshman year at college I became very depressed and suffered from severe anxiety, to the point where making a simple decision was almost impossible. I slept all day, had a very poor appetite, and was not attending any of my classes.

Others may misinterpret emerging adults' symptoms of depression. Emerging adults' withdrawal from life might be misinterpreted as a desire to be left alone; this may intensify feelings of loneliness and alienation. Apathy, a lack of interest, might be interpreted as laziness, lack of direction, poor motivation, or refusal to become self-sufficient. Depression makes individuals sensitive to the negative opinions others have of them. These judgments endorse feelings of worthlessness, inappropriate guilt or regret, helplessness, hopelessness, and self-hatred.

Bipolar disorder, characterized by fluctuating lows and highs, is less common but potentially destructive. Addicted to the highs, emerging adults with bipolar disorder are tempted away from mood-stabilizing medication. But this is troublesome given the potential for extremes of mood to manifest in risk-taking and self-harming behaviors, including suicide attempts. Moreover, without treatment, bipolar disorder can progress in severity. For example, during extreme manic episodes the emerging adult may experience psychotic symptoms, breaks from reality, experienced as delusions and hallucinations.

Impulse Control and Personality Disorders

As young people enter adulthood, it is increasingly expected that they will conform their behavior and personality to social expectations. Normatively, emerging adults make gains in self-regulation and self-control. Among emerging adults who have impulse control disorders, we see a lack of ability to direct their behavior in socially desirable ways. This impairment may manifest itself as oppositional behavior: they make break laws or explode on others with little provocation. *True Life's* "I Need Anger Management" introduces us to the ways that impulse control disorders might play out: John loses control at work and gets fired; Anna lashes out at her boyfriend and is subsequently rejected; and Madison loses her temper, repeatedly, at home, so her mother kicks her out. Impulse control disorders also occur in less overt symptom patterns, as in the case of attention deficit hyperactivity disorder, which is characterized by a lack of focus, concentration, and organization.

As identity is shaped during emerging adulthood, there is the potential for personality to consolidate or organize into a structure that does not serve the emerging

adult well. Healthy personality is flexible and responsive to social norms, expectations, and change. Personality disorders are diagnosed when an individual is inflexible and acts inconsistently with social and cultural expectations. Personality disorders are common in emerging adulthood, occurring in over 20% of 18- to 29-year-olds. Yet they are rarely diagnosed unless another disorder is present. Personality disorders are difficult to treat. They commonly arise in close, intimate relationships (e.g., marriage or parent-child relations) which require adaptation to the needs and expectations of others.

The Context of Emerging Adulthood

Because development is dynamic and changes as a function of new experiences, opportunities, and person-context fit, it is important to consider how the developmental stage of emerging adulthood, with its unique qualities, affects pathways of mental health. The high rate of psychopathology between ages 18 and 29 suggests that something about the age period may heighten the risk for psychopathology. The underlying assumption of this perspective is that stage-specific risk or stress triggers psychopathology. There is, however, little evidence to support this stage-stress hypothesis; to the contrary, emerging adulthood appears to be associated with improvements in mental health.

In general, well-being increases from late adolescence through the 20s in nonclinical, community populations. Self-reported life satisfaction, perceived social support, self-efficacy, and self-esteem rise in the post-high-school years. Moreover, loneliness, fatalism, self-derogation, substance use, anger, and depressive symptoms all decrease. How do these trends coincide with high rates of psychopathology?

Predicting how well an emerging adult will fare in the transition to adulthood has much to do with their developmental histories of mental health problems. Psychiatric disorders, “the chronic diseases of youth,” spill over into emerging adulthood. The majority of the psychopathology we see in emerging adulthood represents recurrent or persistent disorders that have roots in adolescence or even childhood. We know that 75% of emerging adults with a psychiatric disorder experience a first episode before age 18. Second, developmental histories of mental health problems affect the likelihood that

well-being will increase in emerging adulthood. Well-being increases the most for those who had few, if any, problems before emerging adulthood. But those who have moderate to severe problems report only modest to no increases in well-being. Third, emerging adults with developmental histories of mental health problems experience a greater number of stressors in emerging adulthood, including problems in their families, their own mental health problems, moving or residential problems, drug and alcohol problems, and substance abuse problems of someone else in their lives.

In sum, emerging adulthood is associated with increasing mental health in general, at the aggregate level. Upon further examination, however, we find that the constructive forces of the age period have a stronger effect on those who had few, if any, mental health problems prior to emerging adulthood. Those who have histories of mental health problems are less likely to benefit from the conditions that promote increasing well-being. Thus, early psychopathology is a triple whammy: it (a) interferes with adjustment in the early years, (b) increases the risk both for psychopathology and stress exposure in emerging adulthood, and (c) reduces the positive effects that emerging adulthood has on those who do not struggle with mental health problems. What we can understand from these findings is the need for a clinical-developmental approach in efforts to facilitate change. The integrated approach respects the fact that mental health prior to emerging adulthood has some predictive effect on the extent to which normal, even optimal, development and adjustment can occur during emerging adulthood.

Helping Emerging Adults

Few programs are designed to meet emerging adults' unique need for integrated services that combine goals of providing mental health care and developmental support. In fact, there are very few programs that help with either. In terms of mental health services, their age puts them at risk for falling through the cracks. As they turn 18, they "age out" of traditional services designed for children and teens. While they may be expected to "age into" mental health services designed for adults, they don't. Emerging adults use mental health services less and they use different resources. Emerging adults see psychiatrists and psychologists less; they turn to friends and family more often and are more likely to seek information from the internet. Emerging adults use social services to

meet their mental health needs more often than adults do. This makes sense given that emerging adults are more likely than older adults to be poor, unemployed or underemployed, on public assistance, and without health care. Thus, they may delay or deny needs for mental health services in order to devote efforts to procuring basic needs such as shelter, food, and protection.

We have far to go in learning how we can best help emerging adults access the help that they need. However, evidence suggests that there is much potential to help. A number of factors suggest that the transition to adulthood is a unique window of opportunity. First, because wellness increases when there is little risk involved, we can be optimistic that mental health can improve. Second, unique brain maturation results in new strengths under good enough conditions. Third, emerging adults establish patterns of health behaviors during these years. Thus, health education is one strengths-based initiative that may prove helpful to this age group. Fourth, as dependence on family declines, emerging adults can be empowered to choose relationships and situations that contribute to their health. Fifth, emerging adults are naturally constructing an adult identity. It may be possible to support the construction of identity to reflect an adult self who is mentally healthy despite developmental histories of problems.

In sum, these features of emerging adulthood suggest that we have a great deal to work with if we plan to help emerging adults achieve success, both in terms of becoming independent and also with regard to being mentally healthy. The need for services in emerging adulthood thus requires a focus on both the developmental tasks and the mental health needs of this age group. Facilitating one without helping the other is likely to reduce the effectiveness of efforts to help them.

¹ *People* magazine covers: Britney Spears (January 21, 2008); Lindsey Lohan (August 6, 2007); and Heath Ledger (February 4, 2008).

² M. Shepherd and E. M. Guenberg (1957), The age for neuroses, *Milbank Memorial Fund Quarterly*, 35 (3): 258–265.

³ Dr. Thomas Insel, director of the National Institute of Mental Health, used this phrase to characterize the initial findings from the NCS-R in 2005, which (a) demonstrated that a

majority of adults who meet criteria for a psychiatric disorder had experienced their first symptoms in childhood or adolescence and (b) revealed significant delays in diagnosing psychiatric disorders.

Annotated Bibliography

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: American Psychiatric Association.

The *Diagnostic and Statistical Manual* (4th text revision; DSM-IV-R) is the gold-standard text used for diagnosing psychiatric disorders. This diagnostic classification system is published by the American Psychiatric Association and reflects the dominant, medical view that psychiatric disorders are mental illnesses that can be identified both by the pattern of symptoms and the impairment in functioning the illness causes.

Arnett, J. J. (2007). Suffering, selfish, slackers? Myths and realities about emerging adults. *Journal of Youth and Adolescence*, 36 (1): 23–29.

Arnett published this article to refute the overblown myth that emerging adults experience a normative crisis. The term *quarterlife crisis* refers to an emotional and psychological experience of doubting the idealism of youth when confronted with the realities of adulthood. The term was publicly coined in a 2001 book, *Quarterlife Crisis*, written by Alexandra Robbins and Abby Wilner (Tarcher) to generalize their experiences as recent college graduates launched into the adult world, only to find significant barriers between themselves and the goals they had set for themselves. The book generated much attention among young people who strongly identify with the struggles of the age period (and which are cataloged on message boards at www.quarterlifecrisis.com). A workshop has been developed to help young people face and overcome their quarterlife crises. A song by John Mayer, released in 2003, “Why Georgia,” referenced the quarterlife crisis literally and figuratively and became

the anthem of emerging adults who came of age during this era.

Blanco, C., et al. (2008). Mental health of college students and their non-college-attending peers. *Archives of General Psychiatry*, 65 (12): 1429–1437.

This study by Blanco and colleagues compares features of college student mental health to the mental health of their peers not attending college. Fundamental to the theory of emerging adulthood is the proposition that the features of development between ages 18 and 29 (e.g., exploration, identity development) are not limited to the college student population. However, the fields and literature that cover college student mental health (see www.collegecounseling.org/) and college student development (www.jcsdonline.org/) provide us with insight into the issues that college student, emerging adults experience.

Grant, J. E., and Potenza, M. N. (Eds.) (2010). *Young adult mental health*. New York: Oxford University Press.

This volume is a comprehensive study of mental health in young adults, defined as individuals ages 18 to 29. In 26 chapters the authors provide overviews of the major mental health problems that appear in emerging adulthood, focusing on the issues these disorders present specifically to young adults. They also include chapters on factors that contribute to variation in the way that mental health problems are experienced: gender, cultural, and ethnic considerations. The impact of mental health problems of young adults is discussed in the context of college and career, intimate romantic relationships, marriage, and parenting. They include a chapter on mental health service use. A number of the chapters include “Practice Guidelines” in their summaries.

Humphrey, L., and Tanner, J. (Eds.) (2009). *Yellowbrick Journal of Emerging Adulthood*, 1 (1): 1–16.

Yellowbrick is a first-of-its-kind, cutting-edge psychiatric treatment program whose mission is to provide a full-spectrum, specialized approach to the emotional, psychological, and developmental challenges of emerging adults. The Yellowbrick

Foundation biannually publishes *Yellowbrick Journal*, presenting original theory, research, and evidence-based practice articles devoted to the treatment and mental health care of emerging adults. *Yellowbrick Journal* is available for public access at www.yellowbrickprogram.com/yellowbrick_journal.html.

Johnston, L. D., O'Malley, P. M., Bachman, J. G., and Schulenberg, J. E. (2009). *Monitoring the Future national survey results on drug use, 1975–2008*. Vol. 1: *Secondary school students* (NIH publication no. 09-7402). Bethesda, MD: National Institute on Drug Abuse.

Monitoring the Future is a cross-sectional study of the behaviors, attitudes, and values of high school and college students. Some cohorts are followed into emerging adulthood. Each year, approximately 50,000 8th-, 10th-, and 12th-grade students are surveyed and annual follow-up questionnaires are mailed to a sample of graduates for a number of years after their initial participation. Monitoring the Future is funded by NIDA, the National Institute on Drug Abuse, and focuses primarily on substance use of adolescents and emerging adults. Broad indicators of mental health and well-being are also included in their surveys. Hundreds of reports detail changes in substance use across cohorts and the impact of substance use on the lives of young people. These publications can be found at www.monitoringthefuture.org/pubs.html.

Kessler, R. C., and Merikangas, K. R. (2004). The National Comorbidity Survey-Replication (NCS-R): Background and aims. *International Journal of Methods in Psychiatric Research*, 13 (2): 60–68.

Prevalence estimates included in this article are based on a U.S. population survey of individuals 18 and older, collected and reported as part of the National Comorbidity Survey-Replication (NCS-R). The initial reports, published in 2005, included prevalence and age-of-onset estimates. Several recent reports (2009) link childhood adversities to adult psychopathology. References to all NCS-R publications are available at www.hcp.med.harvard.edu/ncs/ncs_data.php.

Pepper, B., Kirshner, M. C., and Ryglewicz, H. (1981). The young adult chronic patient: Overview of a population. *Hospital and Community Psychiatry, 32*, 463–469.

In the 1980s, psychiatrist Dr. Bert Pepper identified a group of “chronic young adults” characterized as 18- to 29-year-olds in need of mental health services for serious mental health problems who were underserved by the community mental health system. His work, published primarily in mental health services journals, detailed the inadequate nature of mental health services that were designed for adults of all ages. He contended that adults with longer histories of severe psychopathology represented a very different group from young adults, even those with serious mental health problems. He was among the first to argue for segmenting services designed to treat 18- to 29-year-olds with a focus on their unique mental health and developmental needs.

True Life, MTV.

True Life is a documentary series produced by MTV for their target demographic, 18- to 29-year-olds. A number of episodes in this series present stories of emerging adults dealing with mental health problems. Episodes can be accessed at www.mtv.com/shows/truelife/series.jhtml. Other reality programs popular among emerging adults also confront the mental health issues they deal with, including *Intervention* on A & E (www.aetv.com/intervention/index.jsp) and Dr. Drew Pinsky’s television and radio shows, which deal with sex and substance addictions, many of them in emerging adults.

Twenge, J. (2006). *Generation me: Why today’s young Americans are more confident, assertive, entitled—and more miserable than ever before*. New York: Free Press.

In this book Jean Twenge argues that many of the problems that emerging adults experience are a product of their unique socialization through the 1970s and 1980s. Twenge’s work can be interpreted as a counterargument to the claim that mental health problems are not unique to this generation of 18- to 29-year-olds. The thesis of her work is based on personality tests that distinguish more recent cohorts (Gen-Xs and Gen- Ys) from cohorts who came of age before the self-esteem movement

(Boomers). She concludes that emerging adults are suffering the effects of socialized narcissism.