

TAY Psycho-Social Development: How to create an environment and treatment plans that truly meet TAY where they are to maximize their success.

Overview

Transition Age Youth, or TAY, are defined as youth that are 16-25 years-old that are traversing the roles of childhood into more mature responsibilities. TAY encountered in mental health programs are not able to meet the challenges that are expected of people their age. TAY can be a particularly challenging population to help in the mental health setting. It is of the utmost importance to consider how the experiences of the youth have affected their cognitive development and use this information to help them grow. Staff can do this by first creating a safe environment for them, then providing the amount of guidance that will help them progress towards their goals confidently, by setting them up to succeed and allowing room for continued growth. A major difficulty for staff can be coping with countertransference, or the emotions that come up for them while they try to help a TAY. One purpose of this chapter is to elicit, normalize and diminish reactivity to countertransference in the staff working with a Transition-Age Youth in a mental health setting. A second goal of this chapter is to offer one paradigm that has been useful in helping both clinical and non-clinical staff conceptualize and treat members in a way that minimizes negative countertransference, maximizes their members' successes, and reduces frustration and burnout in the youth and staff alike. The third purpose is to guide staff in creating developmentally appropriate treatment plans that will help ensure the success of the youth being treated.

Transition Age Youth are a dynamic group that often elicits particularly strong countertransference, or feelings in the clinician working with them. They are frequently survivors of severe trauma and have many defenses in place to repel people that they fear will only hurt them, abandon them, or ultimately reject them. They are often myopic and focused on self-preservation. Some practitioners react emotionally to these behaviors, and rather refer these youth to other service providers. Others are compelled by what they perceive as helplessness and vulnerability, and feel obligated to protect the youth from their environment and themselves which can impede the maturation process. In addition to these defenses, most clinicians will agree that the majority of Transition-Age Youth that have been encountered at Full Service Partnerships have a variety of pathological immature personality traits that are not attributed to Axis I mental illness. Clinicians would be correct in diagnosing many of these youth with Personality disorders since someone over 18 with those traits would be classified as such by that paradigm. In the Recovery model however, the focus is on the strengths of the clients, and build on what they can do, rather than classify and label deficits. Diagnosing these youth as personality disordered is often to their detriment, since it evokes a belief that the way they act is a permanent pattern of behavior, which can lead staff to feel hopeless. While some indeed have solidified personality disorders, others are displaying symptoms of a delay in cognitive, emotional, and social development. More simply, many of the youth seen in treatment are cognitively much younger than 18-25 years old, which in turn causes the difficulties in assuming adult roles. Conceptualizing the youth in this way, allows for the practitioner to evaluate strengths and areas that can be worked on, and feel hopeful in helping the youth recover and lead a fulfilling life.

Development of Cognition and Behavior:

While there are many brilliant and useful developmental models that can be utilized for this purpose, such as those by Erik Erikson and Margaret Mahler, the Cognitive-emotional developmental model developed by Jean Piaget is an easily accessible and applicable model even for non-clinicians. Piaget divided development into 4 stages:

1. **Sensorimotor:** (*birth to about age 2*)

During this stage, the child learns about himself and his environment through his five senses and largely reflexive motor responses. In the beginning he is completely enmeshed with mother with no singular identity for himself or others. During this stage he realizes his individual identity and learns object constancy.

2. **Preoperational:** (*about age 2 to about age 7*)

Child starts using language and symbols. Largely oriented to the present and has difficulty conceptualizing time beyond the present. Thinking is illogical and magical, driven by fantasy and a world view skewed towards his own experiences.

3. **Concrete:** (*about 7 to early adolescence*)

Child can think rationally and logically and begin to analyze information. Can begin to understand other's point of view if it resembles his own.

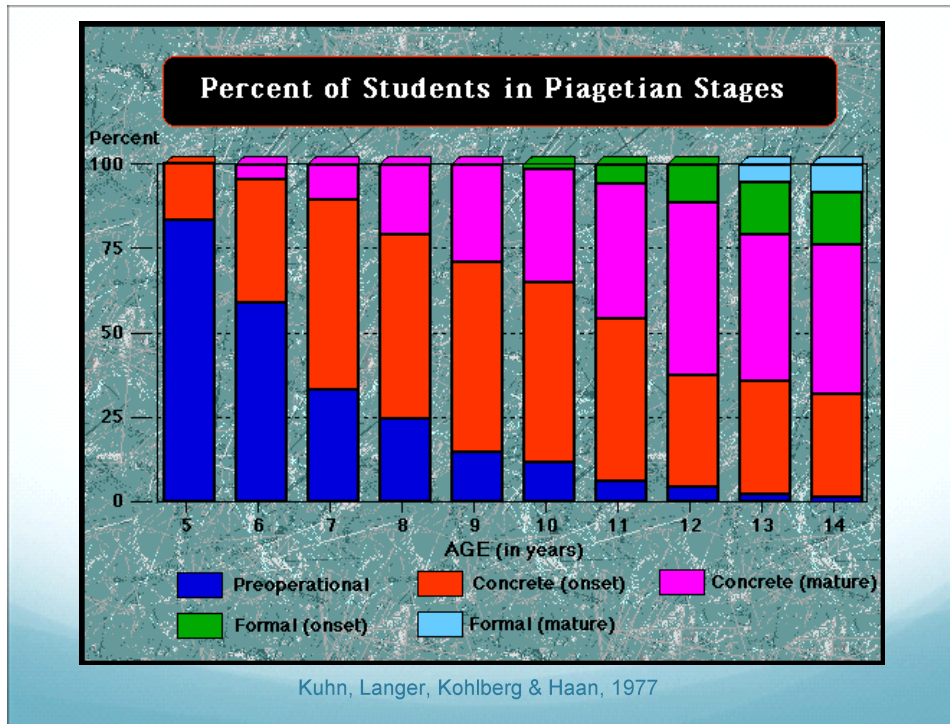
4. **Formal Operations:** (*adolescence*)

The person can utilize logical and abstract thinking to analyze the world. He will develop ability to see things from perspectives that may be widely different than his own.

Inherent to Piaget's theory is the assumption that a biologically normal child will progress along these domains at the expected times. However, research done in 1977 by Kuhn, Langer, Kohlberg and Haan elegantly demonstrated that children progress along Piaget's cognitive developmental domains at a widely varied pace. They evaluated subjects ages 5 through 14 years old that had normal IQ in terms of their developmental stage using Piaget's model.

Approximately 20% of subjects were exhibiting early signs of concrete operations as early as 5 years-old, while about 3% of 14 year-olds were still classified as preoperational. If one were to project where the study subjects would end up at 18 years-old, the majority would be concrete operations or above, while the latter group would likely be in the early concrete operations stage. In fact, research later showed that only 30-35 % of high school students attained formal operations as defined in the Piaget model.

Figure 1: Kuhn, Langer, Kohlberg and Haan, 1977



This research indicates that people do develop along certain domains in thinking and perception, but that they do so at different rates, and to the extent that their life experiences and environment allows it. Thus, Piaget’s model can be adapted by acknowledging that intellectual ability developed in stages based not only on biology, but on the environment, culture, and nurturing a person experiences as they develop. For example, if a child or his parents use drugs, or if a child does not have secure attachments, or has emerging mental illness, he will not be able to focus on the usual developmental tasks, and therefore may be developmentally arrested in this regard.

Keeping this in mind, it is possible to reinterpret the way Transition Age Youth are conceptualized in the minds of treatment providers. While it is pathological for an adult to be self-centered, demanding, and unreliable, it is within the normal expected behavior of a child. By considering the TAY to be children psychologically, it allows for two important outcomes; first it alleviates some of the negative countertransference, since it is easier to accept a child with such behaviors than someone one expects to behave as an adult, and second, it allows the practitioner and therefore the youth, to experience hope that the youth will recover by teaching them skills to facilitate their cognitive growth, since a child can still grow up.

Practitioners using this model have verified that this is indeed the case, that those youth who recover display signs of progressing along the Piaget cognitive developmental domains: by becoming self-responsible, exhibiting increased empathy, and improved morality. A graduate of the TAY Academy at Mental Health America in Long Beach, California, was working and had her own apartment. During her graduation ceremony, she was asked how she did it. She furrowed her brow and thought for a moment, then responded, “I grew up”.

There are multiple cognitive domains over which a young mind develops, 6 of which are the most strongly related to navigating the ordinary challenges of adulthood. These are individuality, empathy, morality, abstract vs. concrete thinking, and concept of time. The first two domains, individuality and empathy, are linked, for one must understand that everyone is an individual with their own thoughts and needs in order to have empathy for them. People who are

primitive in these domains tend to believe others exist to serve them in some way, and therefore are unable to consider another person's perspective. Empathy and morality are important to consider because they influence the counter transference, or feelings in the person working with the youth. For example, someone who is still primitive in the empathy and morality domains tends to be self-absorbed and only concerned with avoiding punishment. This person could steal your mobile phone off your desk because you obviously can afford a new one and he likes it! This person is not very likable, and would be more challenging to work with. Someone who is more mature in these domains would greet you by asking whether you have time for them, and may remind you to put your phone away so no one takes it. The second person would likely inspire you to spend more time with them, maybe even go out of your way for them. Thus these two domains are important because practitioners need to be aware of how their feelings influence their ability to provide treatment; they must be aware of both our positive and negative counter transference to be able to provide fair and effective treatment for all youth. Remember that the more likable youth probably has others in his life willing to help him, while the former is likely to be more alone and desperate for your help.

A significant amount of burnout occurs from frustration, when case managers don't see the youth they are treating progress according to their expectations. For example, a case manager may work very hard to help a TAY get a job, and then feel like a failure when the youth repeatedly shows up late to work or doesn't bother showing up at all. The reality may be that the member is not developmentally able to plan and organize himself to successfully navigate the new job. Perhaps a wake-up call or even a ride could ensure the youth's success at the new endeavor. After all, one would not expect a small child to get himself to school; one child might be able to go to the bus stop his mother alerts him it is time to do so, while a younger child might need a ride. Understanding the youth's developmental stage in these areas allows staff to set up their expectations for a youth based on what the youth are actually capable of doing at the moment, rather than on what one would expect a higher functioning young adult to be able to do. Below is a summary of the stages that has been used by both clinical and non-clinical staff to try to get a quick understanding of where a youth stands in terms of their development.

Figure 2: Summary of stages of cognitive-emotional development

Stage	Separateness	Empathy	Thinking	Time	Ethics
STAGE 1	It's all about me.	I can only think about myself.	I can't do it unless you do it for me/with me.	Magical – things will just work out without me doing/ planning anything.	Avoid getting caught.
STAGE 2	It's Less about me.	I can understand you if I have had same experiences. (Mirror empathy)	Concrete Logic: I can make a logical plan with some guidance.	If you help me with a schedule I can get there and get things done.	Win rewards
STAGE 3	We are both different and important.	I can truly understand what someone else is going through, even if they are different than me.	Abstract Thinking: I can make practical plans for myself.	I can manage my time on my own.	1. I try to do what's considered right in my social group. 2. I have my own personal values

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As one can see, the stages are simply labeled 1, 2, and 3, to remove any stigma that may be attached to the stages and the ages in which they are expected to be realized. Using this chart, case managers can quickly pinpoint where a young adult seems to lie in the different domains. The green arrow serves as a reminder of two ideas; that these stages are often achieved at different times, someone may progress in their thinking faster than they do in their empathy, etc, and that people can both progress and regress along the domains depending on their life experiences. For example, if you experienced a death in your family,

Treatment Plans Using The Development Stages:

These stages should be reviewed with the treatment teams during annual case reviews to help the team evaluate the cognitive level of functioning in the youth they are treating. On the forms, the case manager answers a series of questions about the youth that indicates their level of functioning in the different cognitive domains. For example looking at the ability to manage time and plan, the case manager considers whether the youth devise and execute his own plans, follow plans the case manager develops for him, or whether the youth needs the case manager to help prepare and carry out the intended action. Depending on the answer, one can calculate an approximate level of functioning and the team can use these answers to come up with a developmentally appropriate plan for accomplishing the youth's goals. This keeps the discussion focused and useful. AN example of a form used in a clinical case review at TAY Academy, Mental Health America is shown below.

Figure 2: Sample of Questions for discussion and review of TAY

Student Name _____	Date of review: _____
Circle One: Rollin In Tunin Up Rockin Out	
History (What brought them to TAY) (How long have they been here?):	
Are they in Survival Mode (homeless, in emotional crisis, high on drugs)?	
Circle one: *Self absorbed	
*Can have some consideration if they understand where you are coming from	
*Compassionate and respectful	
Circle one: * Irrational/illogical thinking- I am talking to a wall!	
* Logical thinker – they get it if I explain it simply.	
* Creative and logical thinker.	
Circle one: * Needs help to plan and execute plans	
* Can carry out plans we make together	
* Can make own plans and carry them out with minimal help	
Circle one: *Motivated by avoiding getting caught/getting punished	
*Motivated by rewards	
*Self-motivated	
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Take this example as an application of this technique. A case manager was trying to teach self-responsibility to a young woman in the program. She was homeless and did not have a job. The TAY program was paying for her housing, and in return she was instructed to simply show up at the program every morning at 10:00am as if she were showing up to a job. She failed to do so, often coming in late or not at all. She seemed nonplussed by the endless discussions staff had with her, and finally they decided a consequence was essential to motivating her. They tried punishment; for any day she did not come in she would have to spend the night in a shelter. She was very unhappy about this, but continued to come in late and spent many nights in the shelter. Her case manager got frustrated felt terrible every time he had to bring her to the shelter, but was at a loss for what to do. He brought the case to the team for assistance. The team used the cognitive developmental domains to focus the discussion, specifically the area of motivation and ethics. The question was whether she was no longer motivated by avoiding punishment, as seen in earlier cognitive stages, and perhaps would be more motivated by reward, as seen in the next stage. The team decided to try rewarding her on the days she came in by giving fake money created by the program that can be exchanged at local stores for food. That way she could experience showing up at TAY as a job for which she was paid. She responded immediately to this and although she occasionally ended up in the shelter for a night, it was far less often, and she showed obvious enthusiasm for the praise and reward she received when she arrived in the mornings. This is just one example among many in which addressing a youth's cognitive developmental stage effectively guided treatment. Once the staff has identified what stage a youth is in the different areas, they can determine how to advance the youth to the next stage, giving them opportunities to attempt tasks at a higher level in safe and supported ways, to leave room for growth. What one would expect, and what has indeed been observed, is that the members are moving along the cognitive developmental domains which is very satisfying for the staff and youth alike. Once staff has identified the stage, they can collaborate on how to help the

client navigate their current needs, and plan for how they will mature. For example, when TAY are stage 1 in their ability to manage time and thinking, they cannot plan for themselves. The treatment goal at this stage is to demonstrate proper planning and execution of tasks, such as meeting them at their residence and taking them where they need to go while verbalizing the tasks at hand and explaining what needs to be done while you do it with them. When they progress to stage 2, they have achieved concrete logic and can make a plan with some guidance. They can also keep to a schedule that was created with them. At this stage it would only promote regression to pick them up and do things for them. At this stage the treatment provider should join the member in planning to the tasks at hand, make a highly detailed schedule with them, ask them what they need help with and support, validate and praise them as they try. When someone is stage 3 in their thinking and sense of time, they can manage time and make practical plans on their own. At this point ask them their plans, offer advice and support when needed, and continue with praise, validation and support.

One other question staff must consider is whether the youth is in survival mode. This refers to any situation that is emotionally and psychologically stressful such as homelessness, drug addiction, and other crises. Someone in that state cannot focus on progressing in their cognitive domains. Remember that such conditions created the cognitive delay. If they are in survival mode, staff needs to focus on getting them safe and stable first. This is also something to consider if one observes a TAY moving backwards along the cognitive domains, since this can be observed in stressful times. By keeping mindful of these factors, staff can feel competent that they are using the best measures to help the youth.

Causes of Psycho-Social Delay in TAY

A logical question is why would such a delay exist? It is widely accepted that the brain develops in response to both biological and environmental stimuli. Therefore if one has a biological problem such as major medical and mental illness, cancer, schizophrenia, or autism for example, one would be unable to attend to the normative developmental tasks of one's peers. On the other hand, a healthy individual in an unfriendly environment, where one is abused or neglected, exposed to extreme poverty and hunger, the individual would be consumed with trying to survive the environment, and again not be able to focus on developmental milestones. An analogy would be a goldfish in a fish bowl. A goldfish is said to grow as large as his bowl. A biologically unhealthy fish may be in a large bowl, but will be unable to grow as large as his peers. A healthy fish in a small bowl will be small as well, since his environment will not allow him to grow to his potential. There is hope in both scenarios: the biologically impaired fish may not be able to reach full size in a large bowl, but may be able to grow larger than he is with some extra attention or nutrition, while the healthy confined fish may grow to full potential if placed in a larger bowl. This of course, is predicated by the assumption that the goldfish does not stop growing at a certain age, and can continue to grow if given the proper environment. Holding the same assumption for TAY, that turning 18 does not signify the end to their cognitive emotional development, then one can have hope, a vital ingredient in the success of treatments, for it is certain that patients only have hope for themselves if they see we have it for them as well.

Development-Based Treatment Strategies for TAY:

Since current date has indicated that human development is a continuum and therefore there is still hope for TAY to grow and mature helping them do so is at the crux of their healing.

Understanding the developmental stages and incorporating them into treatment planning is an important part of doing so. That aside, one of the most effective ways to mentor and heal a TAY is by being good role models for the youth. Young people learn more from watching others, then from being taught didactically. This is coded into our biology by mirror neurons in our brains, children learn by watching. One way in which treatment providers are role models, is that they demonstrate what it looks like to work. Therefore staff must be cognizant that they always look and act like respectful, kind and compassionate professionals, not for example, slamming the phone down when someone on the other end is frustrating. After role modeling, the next most important treatment is to use validation, praise, and limit setting to help the youth feel safe and understood. Validation requires asking many questions, using active listening, and trying not to make assumptions about how the youth feels. While it is really important that we validate and try to understand their experiences and emotions, staff must also set limits that keep both the youth and staff safe. These limits, or boundaries, allow the youth to feel safe in their environment, by providing structure. In addition, any medical or biological issues should be treated when possible, medication and therapy can be used to treat traumas and other psychiatric issues, and a safe and learning based environment should be provided.

Conclusion:

In summary, the population known as Transition-Age Youth is a widely varied group of 18-25 year olds that are transitioning from childhood roles into adult roles. The TAY treated in mental health programs are unable to successfully navigate the ordinary accomplishments of adulthood. The various assaults of mental illness, their environment, or both have led to a delay in development across various cognitive domains. By assessing and addressing these domains, in addition to the causes of their deficiency, treatment providers can cater treatments to individuals more successfully, while decreasing burnout. This also allows both practitioners and youth to feel accomplished and hopeful.

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