Human Growth and Development

7:1 Life Stages

- Growth and development begins at birth and ends at death

- During an entire lifetime, individuals have needs that must be met

- Health care workers need to be aware of the various stages and needs of the individual to provide quality health care

Life Stages

- Infancy: birth to 1 year
- Early childhood: 1-6 years
- Late childhood: 6-12 years
- Adolescence: 12-20 years
- Early adulthood: 20-40 years
- Middle adulthood: 40-65 years
- Late adulthood: 65 years and up

Four main types of Growth and Development

- Physical: body growth
- Mental: mind development
- Emotional: feelings
- Social: interactions and relationships with others
- All four types above occur in each stage

Erikson's Stages of Psychosocial Development

- Erik Erikson was a psychoanalyst who identified eight stages of psychosocial development

- For each stage a basic conflict or need must be met

- See Table 7-1 in text

Infancy

- Age: birth to 1 year old
- Conflict – Trust vs. Mistrust
- Dramatic and rapid changes
- **Physical development**– roll over, crawl, walk, grasp objects
- **Mental development**—respond to cold, hunger, and pain by crying. Begin to recognize surroundings and become aware of surroundings and people

Infancy

- **Emotional development –** show anger, distrust, happiness, excitement, etc.
- **Social development** – self-centeredness concept of the newborn to recognition of others in their environment
  - Infants are dependent on others for all needs

Early Childhood

- Age: 1-6 years old
- Conflict:
    - Toddler 1 to 3 years - Autonomy vs. shame and doubt
    - Preschool 3 to 6 years – Initiative vs. guilt
- **Physical development** – growth slower than in infancy. Muscle coordination allows the child to run, climb, move freely. Can write, draw, use a fork and knife
- **Mental development** – verbal growth progresses, short attention span, at end of stage ask questions, recognize letters, and some words

Early Childhood

- **Emotional development** – develop self-awareness and recognize the effect they have on other people and things. Children feel impatience and frustration as they try to do things beyond their abilities. This lead to temper tantrums (the terrible two's)

- **Social development** – at beginning of stage very self-centered one year old to sociable six year old. Strong attachment to parents. Needs are food, shelter, protection, love and security.

Late Childhood

- Age: 6-12 years old
- Conflict – Industry vs. inferiority
- **Physical development**– slow but steady. Muscle coordination is well developed and children can engage in physical activity that require complex motor-sensory coordination
- **Mental development** – developing quickly and much of the child's life centers around school. Reading and writing skills are learned, understand abstract concepts like honesty, loyalty, values and morals

Late Childhood

- **Emotional development** -- the child achieves greater independence and a more distinct personality. Fears are replaced by the ability to cope.
- **Social development** – changes from activities by themselves to more group oriented. They are more ready to accept the opinions of others and learn to conform to rules, and standards of behavior. Needs are the same as infancy and early childhood along with the need for reassurance, parental approval, and peer acceptance.

Adolescence

- Age: 12-20 years old
- Conflict – Identity vs. Role Confusion
- **Physical development** – growth spurts, muscle coordination slows. Development of sexual organs and secondary sexual characteristics (puberty). Secretion of sex hormones leads to the onset of menstruation in girls and the production of sperm and semen in boys. Body shape and form changes.

Adolescence

- **Mental development** – most foundations have been set. Development primarily involves an increase in knowledge and sharpening of skills. Learn to make decisions and accept responsibility for actions.

- **Emotional development** – emotional development is often stormy and in conflict. Adolescents try to establish their identities and independence.   They respond more and more to peer group influences.

Adolescence

- **Social development** – spending less time with family and more time with peer groups. They attempt to develop self-identity and independence and seek security from their peers. Toward the end of this stage they develop a more mature attitude and develop patterns of behavior that they associate with adult behavior.
  - Need for reassurance, support and understanding. Problems that develop in this stage can be traced to conflict and feelings of inadequacy and insecurity.

Eating Disorders

- Often develop from an excessive concern for appearance
- Anorexia nervosa
- Bulimia
- More common in females
- Usually, psychological or psychiatric help is needed to treat these conditions

Substance Abuse

- Use of alcohol or drugs with the development of a physical and/or mental dependence on the chemical
- Can occur at any life stage, but frequently begins in adolescence
- Can lead to physical and mental disorders and diseases
- Treatment towards total rehabilitation

Reasons Chemicals Used

- Trying to relieve stress or anxiety
- Peer pressure
- Escape from emotional or psychological problems
- Experimentation
- Seeking "instant gratification"
- Hereditary traits or cultural influences

Suicide

- **One of the leading causes of death in adolescents**
    - Permanent solution to temporary problem
    - Impulsive nature of adolescents
    - Most give warning signs
    - Call for attention

Reasons for Suicide

- Depression
- Grief over a loss or love affair
- Failure in school
- Inability to meet expectations
- Influence of suicidal friends or parents
- Lack of self-esteem

Increased Risk of Suicide

- Family history of suicide

- A major loss or disappointment

- Previous suicide attempts

- Recent suicide of friends, family, or role models (heroes or idols)

Early Adulthood

- Age: 20-40 years old
- Conflict Intimacy vs. Isolation
- **Physical development** – basically complete. Muscles are developed, strong and motor coordination is at its peak.
- **Mental development** – young adults seek additional education, choose careers and independence.

Early Adulthood

- **Emotional development** – Young adults are subjected to many emotional stresses related to career, marriage, family, etc.

- **Social development** – moving away from peer group, and adults tend to associate with others who have similar ambitions. Most find a mate and begin a family.

Middle Adulthood

- Age: 40-65 years of age
- Conflict – Generosity vs. Stagnation
- **Physical development** – Hair grey's and thins, skin wrinkles, muscle tone decreases, hearing loss, visual acuity losses, weight gain. ☹
- **Mental development** – can continue to increase. Confident decision makers and excellent at analyzing situations.

Middle Adulthood

- **Emotional development –** can be a period of contentment and satisfaction.

- **Social development --** Family relationships can decline as children begin lives of their own and parents die. Divorce rates are high. Friendships are with people with similar interests and lifestyles.

Late Adulthood

- Age: 65 years of age and up
- Conflict – Ego integrity vs. despair
- **Physical development** – on the decline. Skin becomes dry and wrinkles, "age spots" appear. Hair thins, muscles lose tone and strength. Memory loss can occur and reasoning ability can diminish.

Late Adulthood

- **Mental development** – varies. People who remain mentally active and are willing to learn new things tend to show fewer signs of decreased mental ability
- **Emotional development** – Emotional stability also varies.
- **Social development** – retirement can lead to loss of self esteem, lost identity. Death of spouse and friends cause changes in social relationships.

7:2 Death and Dying

- Death is "the final stage of growth"
- Experienced by everyone and no one escapes
- Young people tend to ignore its existence
- Usually it is the elderly, who have lost others, who begin to think about their own death

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Research

- Dr. Elizabeth Kübler-Ross was the leading expert in the field of death and dying

- Results of her research

  - Most medical personnel now believe patient should be informed of approaching death

  - Patient should be left with some hope and know they will not be left alone

  - Staff need to know extent of information known by patient

Research
(continued)

- Dr. Kübler-Ross identified 5 stages of grieving
  - Dying patients and their families/friends may experience these stages
  - Stages may not occur in order
  - Some patients may not progress through them all, others may experience several stages at once

Stages of Death and Dying

- Denial – refuses to believe

- Anger – when no longer able to deny

- Bargaining – accepts death, but wants more time

- Depression – realizes death will come soon

- Acceptance – understands and accepts the fact they are going to die

Caring for the Dying Patient

- Very challenging, but rewarding work
- Supportive care
- Health care worker must have self-awareness
- Common to want to avoid feelings by avoiding dying patient

Hospice Care

- Palliative care only
- Often in patient's home
- Philosophy: allow patient to die with dignity and comfort
- Personal care
- Volunteers
- After death contact and services

Right to Die

- Health care workers must understand this issue
- Ethical issues must be addressed
- Allowing patients to die can cause conflict
- Specific actions to end life cannot be taken
- Laws allowing "right to die"

Summary

- Death is a part of life

- Health care workers will deal with death and dying patients

- Must understand death and dying process and think about needs of dying patients

- Then health care workers will be able to provide the special care these individuals need

7:3 Human Needs

- Needs: lack of something that is required or desired
- Needs exist from birth to death
- Needs influence our behavior
- Needs have a priority status
- Maslow's hierarchy of needs

Maslow's hierarchy of needs
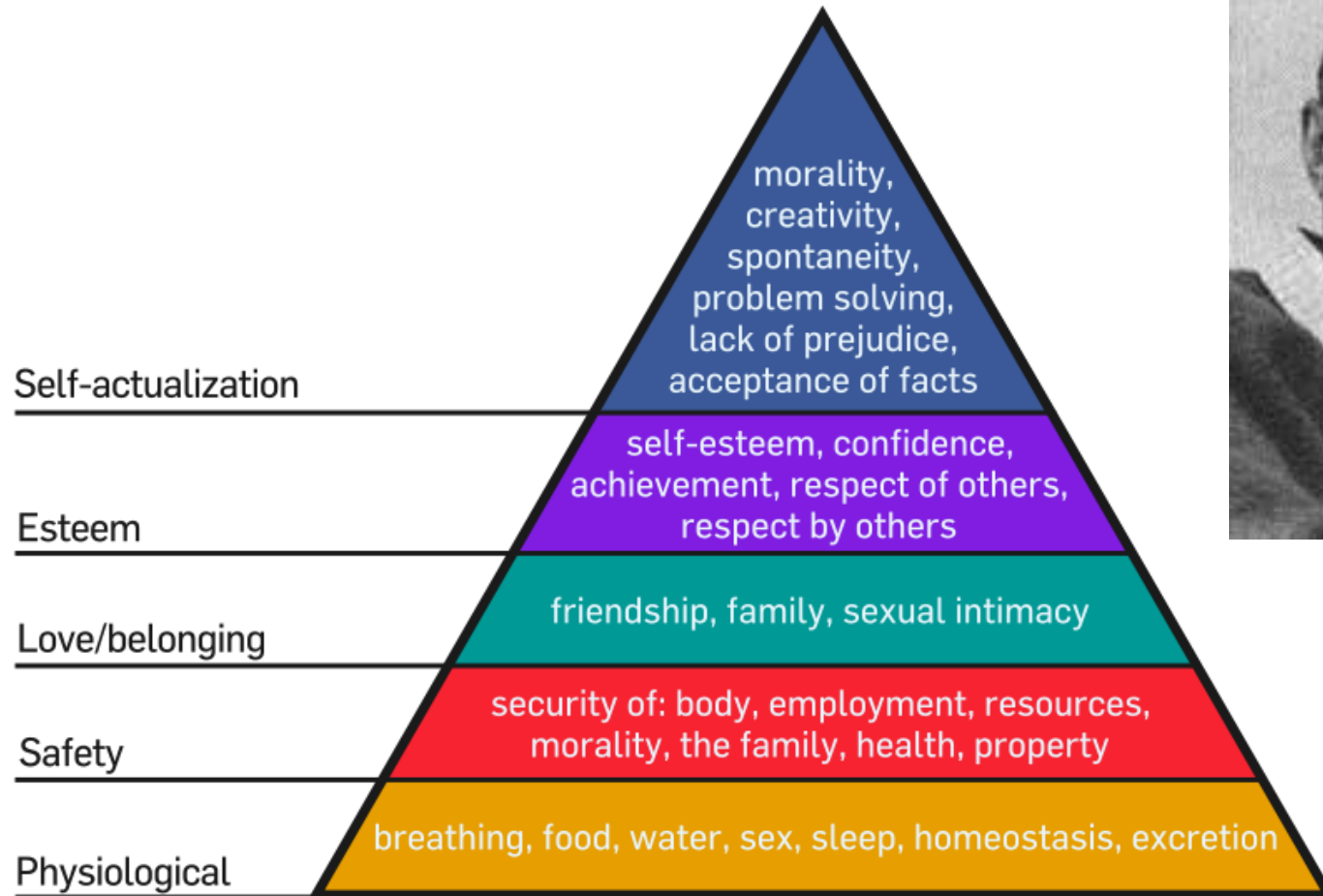
Meeting Needs

- Motivation to act when needs felt
- Sense of satisfaction when needs met
- Sense of frustration when needs not met
- Several needs can be felt at the same time
- Different needs can have different levels of intensity

Methods for Satisfying Needs

- Direct methods – meeting a need and obtaining satisfaction.
  - Hard work
  - Set realistic goals
  - Evaluate situation
  - Cooperate with others

Methods for Satisfying Needs

- Indirect methods of satisfying a need usually reduce the need and help relieve tension if need is unmet. The need is still there but its intensity decreases.
  - ☐ Rationalization
  - ☐ Projection
  - ☐ Displacement
  - ☐ Compensation
  - ☐ Daydreaming
  - ☐ Repression
  - ☐ Suppression
  - ☐ Denial
  - ☐ Withdrawal
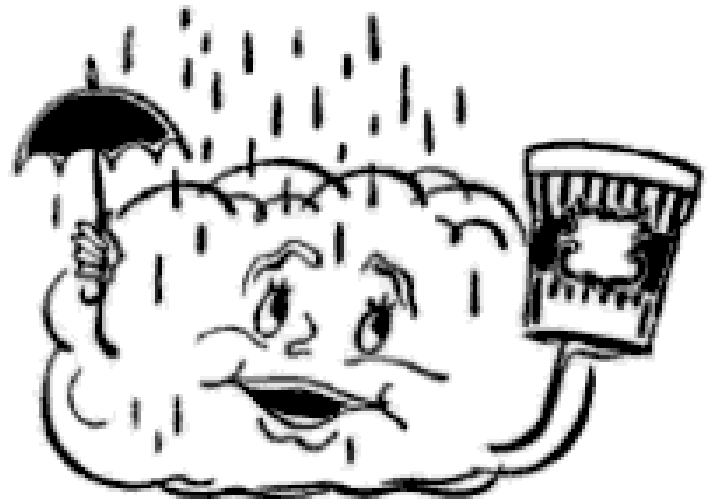
Most clouds carry an umbrella for irony, and a bucket of chicken with no definable purpose.

- What is the difference between direct and indirect methods of satisfying human needs?

Defense Mechanisms

- **Rationalization** is putting something into a different light or offering a different explanation for one's perceptions or behaviors in the face of a changing reality.

  - a woman who starts dating a man she really, really likes and thinks the world of is suddenly dumped by the man for no reason. She reframes the situation in her mind with, "I suspected he was a loser all along."

- **Projection** is the placing a person's undesired thoughts, feelings or impulses onto another person who does not have those thoughts, feelings or impulses.

  - a spouse may be angry at their significant other for not listening, when in fact it is the angry spouse who does not listen.

Defense Mechanisms

☐ **Displacement** is the redirecting of thoughts feelings and impulses directed at one person or object, but taken out upon another person or object. People often use displacement when they cannot express their feelings in a safe manner to the person they are directed at.

■ The classic example is the man who gets angry at his boss, but can't express his anger to his boss for fear of being fired. He instead comes home and kicks the dog or starts an argument with his wife. The man is redirecting his anger from his boss to his dog or wife.

Defense Mechanisms

- **Compensation** is a process of psychologically counterbalancing perceived weaknesses by emphasizing strength in other arenas. By emphasizing and focusing on one's strengths, a person is recognizing they cannot be strong at all things and in all areas in their lives.
  - When a person says, "I may not know how to cook, but I can sure do the dishes!," they're trying to compensate for their lack of cooking skills by emphasizing their cleaning skills instead.

- **Daydreaming** is a dream like thought process when the person is awake.
  - Daydreaming can be good or bad, it can lead to reaching our goals. Can be bad if person has the thoughts but don't take any action.

Defense Mechanisms

☐ **Repression** is the unconscious blocking of unacceptable thoughts, feelings and impulses. "Repressed memories" are memories that have been unconsciously blocked from access or view.

- Terrified of heights but don't know why

☐ **Suppression** like repression but the individual is aware of why they have unacceptable thoughts, feelings or impulses and refuses to deal with them. Form of avoidance.

- Avoid the doctor because you are afraid of what you will hear.

Defense Mechanisms

☐ **Denial** is the refusal to accept reality or fact, acting as if a painful event, thought or feeling did not exist.

- ■ a person who is a functioning alcoholic will often simply deny they have a drinking problem, pointing to how well they function in their job and relationships.

☐ **Withdrawal** is removing your self either physically or emotionally from an unwanted situation

- ■ Withdrawal is a healthy defense mechanism when you avoid an conflict or an unhappy situation.

Summary

- Be aware of own needs and patient's needs

- More efficient and quality care can be provided when know needs and understand motivations

- Better understanding of our behavior and that of others

7.4 Effective Communication

- Health care workers must be able to relate to patients, family, coworkers, and others
- Understanding communication skills assists in this process
- Communication is the exchange of information, thoughts, ideas, and feelings

Communication types

- Verbal: spoken words
- Written
- Nonverbal: facial expressions, body language, and touch

Communication Elements

- Sender– the individual who creates a message to convey information or an idea to another person

- Message– the information, idea, or thought

- Receiver– an individual who receives the message from the sender

Elements of effective communication

- The message must be clear
- The sender must deliver the message in a clear and concise manner
- The receiver must be able to hear and receive the message
- Avoid interruptions and distractions

Listening

- Essential for communication
- Attempt to HEAR what the other is really saying
- Good listening skills techniques (see list page 208)
- Observe speaker closely
- Reflect statements made by the speaker back to them

Barriers to communication

- Common barriers
  - Physical disabilities
  - Psychological attitudes and prejudice
  - Cultural diversity

Good communication

- Good communication skills allow development of good interpersonal relationships

- Health care worker also relates more effectively with coworkers and other individuals