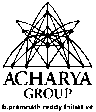
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**Developmental psychology**

**Development -**

Development refers to the progressive changes in size, shape, and function during the life of an organism by which its genetic potentials (genotype) are translated into functioning mature systems (phenotype). The term development means a progressive series of changes that as a result of maturation and experience.

**Definition of developmental psychology -**

The branch of psychology that studies how growth and physiological/ psychological/ social changes take place over the life span

Also called Life-span Psychology, it is concerned with the changes in cognitive, motivational, psycho physiological, and social functioning that occur throughout the human life span

The study of how and why people change over the course of the life span is called Developmental Psychology

**Developmental psychology** is concerned with both physical and psychological changes throughout life—from conception until death. Although theorists differ in their identification of developmental stages and the ages at which they occur

**Developmental Stages –**

| **Life Stage** | **Approximate Age** |
| --- | --- |
| Prenatal stage |  |
| Conception | Formation of zygote |
| Germinal | Conception–week 2 |
| Embryo Fetus | Week 2–week 8 |
| Fetus | Week 8–birth |
| Postnatal stage |  |
| Infancy | Birth–2 years |
| Toddler | 2–3 years |
| Early childhood | 3–6 years |
| Middle childhood | 6–13 years |
| Adolescence | 13–20 years |
| Young adulthood | 20–40 years |
| Middle adulthood | 40–65 years |
| Late adulthood | 65+ years |

**Nature and Nurture**

The relative contributions of **nature** (genetic and biological inheritance) and **nurture** (environmental factors) in developmental processes has been and continues to be debated. Psychologists investigate, by using both longitudinal and cross-sectional studies of subjects in each developmental period, how both nature and nurture influence behavior. When put together, the study data provide information about changes over the entire life span.

**Identical twins** are often studied in nature-nurture investigations (because identical twins develop from one egg, but fraternal twins develop from separate eggs and are genetically no more similar than are any brothers or sisters). Studies have shown that identical twins are more similar in personalities, abilities, and interests than are other siblings, even those identical twins separated at birth and reared apart, a fact that supports the contention that nature (heredity) may be more developmentally important than nurture.

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1. **Prenatal Development**

The **prenatal development** period covers the time from conception to birth and is sometimes described in terms of trimesters (first, second, and third) or of three stages (germinal, embryonic, and fetal).

**Conception**, which occurs when the father's sperm cell penetrates the mother's ovum (egg), marks the beginning of development. The sperm cell/ovum combination creates a **zygote**, a one-celled organism. All other cells in the body develop from this single cell. Each sperm and each egg cell carry 23 **chromosomes**, threadlike chains of DNA (deoxyribonucleic acid) that carry genetic information, which unite during fertilization to form 23 pairs of chromosomes. **Genes** are DNA segments that are functional units in hereditary transmission. After conception, all body cells except **gametes** (eggs or sperm) contain 23 pairs of chromosomes. The gender of the offspring is determined by the type of sex chromosome in the sperm that fertilizes the ovum; if it is Y bearing, the offspring will be male, and if it is X bearing, the offspring will be female.

The **germinal stage** extends from conception to two weeks. During this period, the cells in the zygote divide rapidly, and the mass of cells moves slowly along the mother's fallopian tube to the uterus, where it is implanted in the uterine lining. During the implantation process, the placenta is formed. The **placenta** is a structure that serves as a life-support system for the fetus, allowing oxygen and nutrients to pass into the fetus and waste products to pass out.

The **embryonic stage** begins after the cell mass is implanted in the uterus and lasts from two weeks through week eight. Most of the vital organs and body systems form at this time.

1. **The fetal stage**

The **fetal stage** is the third stage of prenatal development and covers the period from the end of week eight to birth. Cells continue to divide, body structures become functional, and the fetus becomes capable of movement. When a fetus is from 22 to 26 weeks old, it may survive if birth occurs, but chances for survival increase the closer the term is to 36 weeks.

**Prenatal risks -** Risks during the prenatal period include the following.

Adequate nutrition for the mother is imperative. Maternal **malnutrition** may affect not only the size of the infant but also the development of systems such as the immune system or the brain.

**Teratogens** are agents or substances that can produce developmental malformations. Many environmental pollutants (some pesticides, for example), as well as drugs, both therapeutic and recreational (for example, alcohol, cocaine, marijuana, and nicotine), can damage a developing fetus. Drugs such as marijuana remain in the fat cells of the body for as long as 30 days, and other drugs can enter the semen. Consequently, if a father or mother takes drugs prior to conception or if a mother takes drugs at any time during gestation, the fetus may be seriously damaged. A mother's ingestion of alcohol during pregnancy can produce **fetal alcohol syndrome**, a complex of birth defects including retardation, lower birth weight, and distinct facial features—a flat nose, wide-set eyes, lack of an indentation on the upper lip (philtrum), and a thin upper lip. Ingestion of cocaine (or crack) during this period may produce a **cocaine-exposed infant**, one who is hyperactive, so sensitive to environmental stimulation that it can't tolerate being held, and possibly retarded. Tobacco use during pregnancy and passive ingestion of smoke from other smokers can also damage the fetus and increase the risk for miscarriage and birth complications as can use of amphetamines, barbiturates, and some tranquilizers.

1. **Development in Infancy and Childhood**

**Physical development**

* In utero, the **brain** develops rapidly, and an infant is born with essentially all of the nerve cells it will ever have; brain development is particularly rapid during the third trimester. However, after birth, neural connections must form in order for the newborn ultimately to walk, talk, and remember. Mark Rosenweig and David Krech conducted an experiment to demonstrate the importance of **enriched environments** during development. They compared rats raised alone to those that were allowed to use a playground in the company of other rats. Those in the impoverished (solitary) environment developed a thinner cortex with fewer **glial cells**, cells that support and nourish the brain's neurons. Other studies have demonstrated that stimulation provided by touch or massage benefits both premature babies and infant rats, a fact that argues for providing an enriched environment for a developing organism.
* Infants are born with a surprising number of unlearned (innate) **reflexes**, that is, unlearned responses to stimuli.
  + The **Moro reflex** is an outstretching of the arms and legs in response to a loud noise or sudden change in the environment. The infant's body tenses; arms are extended and then drawn inward as if embracing.
  + The **Babinski reflex** is an outward projection of the big toe and fanning of the others when the sole of the foot is touched.
  + The **sucking reflex** occurs when an object touches the lips.
  + The **rooting reflex** is the turning of an infant's head toward a stimulus such as a breast or hand.
  + The **grasping reflex** is the vigorous grasping of an object that touches the palm.
  + The **plantar reflex** is the curling under of the toes when the ball of the foot is touched. Physicians sometimes use these reflexes to assess the rate of development. Gradually, learned responses replace the reflex actions as an infant becomes more responsive to the environment.
* Although the rate of **motor development** can vary, the developmental sequence is the same. On average, an infant will learn to roll over at 2-1/2 months, sit without support at 6 months, and walk alone at 12 months. The growth and body development from infant to child occurs in a **cephalocaudal direction;** that is, the head and upper trunk develop before the lower trunk and feet.

**Sensory and perceptual development** Newborn infants can and do respond to a wide range of environmental stimuli. All human senses function to some degree at birth; touch is the most highly developed and vision is the least developed sense. At the age of 3 months, however, most infants can recognize a photograph of their mother. An infant's ability to perceive depth has been studied extensively with an apparatus called a **visual cliff**, a box with a glass platform that extends over a drop of several feet. An adult (mother or experimenter) stands on one side of the glass bridge and calls to the child, who is on the other. Eleanor Gibson and Richard Walk, in a well-known study, found that at about 6 months babies balk at crawling over the edge of the “cliff.” Such a response indicates that depth perception is present at this age.

**Cognitive development.** The term **cognitive development** refers to the development of the ability to think and to mentally represent events and to manipulate symbols.

Jean Piaget, a pioneer in the study of children's thinking, was concerned with the way a child organizes information from the environment and adapts to it. He believed that every behavioral act requires two dynamic processes of adaptation: assimilation and accommodation. **Assimilation** is the process of acquiring new information about the world and fitting it to already acquired information. A child who calls all grown males “daddy,” based on the child's perception that they and “daddy” are in some way similar, is practicing assimilation. **Accommodation** is the process of creating a new concept to handle new information; for example, children come to realize that all toys don't belong to them, that some belong to other children.

Piaget, who had a strong biological background, proposed four stages of development: sensorimotor, preoperational, concrete operational, and formal operational. According to Piaget,

* During the **sensorimotor stage** (birth to age 2) infants develop their ability to coordinate motor actions with sensory activity. At the start of this stage, children's behavior is dominated by reflexes, but by the end of it, they can use mental images. Also during this stage, children acquire the concept of **object permanence**, realizing that objects still exist even when the objects are not present.
* During the **preoperational stage** (ages 2 to 7 years), children improve in the use of mental images and symbolic thought. Most of the thinking of children of this age, however, is **egocentric** (self-centered).
* During the **concrete operational stage** (ages 7 to 11 years), children begin to develop many concepts and to organize the concepts into classes and categories.
* During the **formal operational stage** (ages 11 years and beyond), children learn to use and to manipulate abstract symbolic concepts, develop and mentally test hypotheses, and work mental problems. That is, they can reason.

Although Piaget's theories are subject to some criticism, they are widely used and important in guiding research in childhood cognitive development.

**Language development - Language acquisition** is one of the most important aspects of a child's development.

**Moral development -** Lawrence Kohlberg proposed that **moral development** occurs in three levels, with two stages at each level.

* **The preconventional level**:
  + At **stage 1, punishment orientation**, judgments are guided by the prospect of punishment.
  + At **stage 2, pleasure-seeking orientation**, activities are undertaken primarily to satisfy one's own needs; needs of others are important only as they relate to one's own needs.
* **The conventional level**:
  + At **stage 3, good girl/good boy orientation**, behavior is engaged in that brings approval or pleases others in a child's immediate group.
  + At **stage 4, authority orientation**, behavior is influenced by respect for authority, performing one's duty, and doing what is right.
* **The postconventional level**:
  + At stage **5, contract and legal orientation**, behavior is based on support of rules and regulations because society's right to exact such support is accepted.
  + At **stage 6, ethical and moral principles orientation**, behavior is directed by self-chosen ethical and moral principles.

Kohlberg found that the first two stages are reached by most children, that stages 3 and 4 are reached by older children and most adults, but that the stage 6 is reached by only 20% of the population.

Carol Gilligan examined certain differences between the moral development of males and that of females. In younger children, she found that girls are more concerned with a morality based on caring and boys with a morality based on justice. Gilligan proposed that this **gender difference** is in part due to children's relationship with their mother.

**Social development -** Social development begins at birth as a child forms an **attachment** (a strong emotional bond) with the primary caregiver(s), usually the mother. Harry Harlow studied **attachment deprivation** with baby monkeys raised in isolation. Although their physical needs were met and they were given surrogate mothers made of cloth, these monkeys suffered severe behavior pathologies. They recovered if the isolation was limited to three months, but longer periods produced abnormal adults. Ethically, this type of study could not be conducted with humans, but parallels have been found with children reared in cold, isolated, emotionally deprived environments. Emotional attachments to caregivers are thought to be essential for social development.

Konrad Lorenz studied **imprinting**, a rapid and relatively permanent type of learning that occurs for a limited time (called a **critical period**) early in life, particularly in birds. Baby ducks learn to follow their mother if they see her moving during the first 30-hour period after their birth. If, however, they don't see their mother, they can imprint on and follow a human or even a moving object instead. Imprinting demonstrates that attachments by the young to a parent can occur early and can have lifelong consequences.

The term **gender stereotyping** refers to patterns of behavior expected of people according to their gender. The development of gender-related differences is complex. Gender stereotyping occurs not only because of parental differences in rearing children of each gender but also because of socialization experiences. Eleanor Maccoby has observed that children with widely different personalities play together simply because they are of the same gender.

**Personality development -** Developmental psychologists also study personality development in children.

1. **Development in Adolescence**

**Adolescence** is the transition period from childhood to adulthood, a period that brings sometimes tumultuous physical, social, and emotional changes. Adolescence begins with the onset of **puberty** and extends to adulthood, usually spanning the years between 12 and 20. **Puberty** is the period during which the reproductive system matures, a process characterized by a marked increase in sex hormones.

**Physical development -** Physical development in adolescence includes a growth spurt as the body fills out, voice changes (especially in males), and an increase in sex hormones. Secondary sex characteristics, such as breasts in females and beards in males, appear. Girls' first menstruation ( **menarche**) usually occurs between the ages of 11 and 14.

**Social development -** According to Erik Erikson, appropriate social development in adolescence requires solving the major challenge of **ego-identity vs. role diffusion.** To resolve this life crisis, adolescents must form an ego-identity, a strong sense of “who I am and what I stand for,” or they may suffer role diffusion (running from activity to activity), with the increased likelihood of succumbing to peer pressure.

**Gender**

* **Gender differences** in behaviors or mental processes continue to develop during adolescence. Research has indicated that experience and learning have a greater impact on such behaviors than do biological factors.
* **Gender identity**, the recognition of being male or female, develops by age 3. Once they have established gender identity, children usually try to adapt their behavior and thoughts to accepted gender-specific roles.
* **A gender role** consists of the behaviors associated with one's gender. Gender-related activities help an individual to establish an identity. Sometimes a person adopts **gender-role stereotypes**, beliefs about the “typical” behavior of males and females expected by society.
* One meaning of the term **androgynous** is having adopted both behaviors associated with males and those associated with females. Androgynous males can do hard physical labor and yet care for babies; androgynous females can be homemakers and yet fix cars or drive taxis.

**Peer pressure. Peer pressure**, a term used to denote legitimization of activities by a peer group, has been used to explain many adolescent societal difficulties. Although a peer group rarely forces an adolescent to try new activities, it may legitimize those activities by indulging in them.

**Sexual behavior -** During the past few decades, the **sexual behavior** of adolescents has been heavily investigated. While the threat of AIDS (acquired immune deficiency syndrome) has changed some behaviors, many surveys indicate a dramatic increase in adolescent sexual activity through the twentieth century. The famous Kinsey survey in the 1940s reported that 50% of the men and 20% of the women surveyed reported having engaged in premarital intercourse by age 20. Three surveys in the 1980s found a substantial increase in the activity, with premarital intercourse reported by 68% of college men and 59% percent of college women. Studies have also shown that teenagers are still largely uninformed about contraception.

**Problems during adolescence -** Adolescent problems are many and often involve the adolescents' relationships with their peer group as well as their search for identity. These problems not only may affect physical survival in adolescents but also may have lifelong physical and psychological effects.

* **Substance abuse** is a major health threat. Legal and illegal substances available to adolescents include tobacco, caffeine, alcohol, glue, paint vapors, and pills. In one survey, 30% of the adolescents reported using illicit drugs, such as amphetamine and cocaine. The spread of AIDS infections by use of dirty needles increases the seriousness of this health threat.
* **Eating disorders** have increased dramatically among adolescents, particularly females. **Anorexia nervosa** is a voluntary weight loss of at least 25% of body weight; the extreme thinness may lead to other health problems such as cessation of menstruation. **Bulimia** is an eating disorder characterized by binges, purges with laxatives, and self-induced vomiting. Some people have alternating patterns of the two problems. A prolonged period of either eating disorder can result in serious health problems.
* **Suicides and attempted suicides** have increased among adolescents at alarming rates in recent decades. Research findings suggest that the suicidal adolescent has usually had, since childhood, a history of stress and personal problems. Attempts to resolve the problems, including running away from home and increasing social isolation, may precipitate an attempted suicide. Early professional help is often needed to prevent withdrawal and acting out of problems.

**Personality Development**

* Two widely cited approaches to **personality development** are those of Sigmund Freud and Erik Erikson.
* **Sigmund Freud's stages of psychosexual development.** Sigmund Freud developed a treatment theory called psychoanalysis, which is based upon a theory of **psychosexual stages** of development

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| |  |  | | --- | --- | |  |  |  | **Stage** | **Age** | **Erogenous Zone/Activities** | | --- | --- | --- | | Oral | 0 to 18 months | Mouth/sucking, biting, chewing | | Anal | 18 to 36 months | Anus/bowel and bladder control | | Phallic | 3 to 6 years | Genitals/masturbation | | Latency | 6 years to puberty | —/repression of sexual feelings | | Genital | puberty+ | Maturation of sexual orientation | |

* **Erik Erikson's stages of development.** Erik Erikson proposed a theory of development that continues throughout the life span. His theory states that there are universal **life stages** and that a specific **psychosocial dilemma** occurs at each phase of development. These problems (crises) must be resolved before an individual can move to the next developmental stage
* Erikson's theory has been credited for accounting for continuity and changes in personality development. It has also been criticized for vagueness and has not stimulated a great deal of empirical research.

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| |  |  | | --- | --- | |  |  |  | **Age** | **Psychological Stage** | **Period** | | --- | --- | --- | | Birth to 1 year | *Trust vs. Mistrust* Learning that the provider of comfort is reliable, consistent, and predictable | Oral-sensory | | 2 to 3 years | *Autonomy vs. Shame and Doubt* Learning to exercise independence and freedom of choice along with self-control | Muscular-anal | | 3 to 5 years | *Initiative vs. Guilt* Planning and executing a task for the sake of actively doing it | Locomotor-genital | | 6 to 11 years | *Industry vs. Inferiority* Developing as a worker and producer | Latency | | Adolescence | *Identity vs. Role Confusion* Evolving a sense of self that is reliable and consistent, both for oneself and for others | Puberty | | Young adulthood | *Intimacy vs. Isolation* Preparing for a commitment to affiliation with others and developing the ethical strength to abide by such commitments | Young adulthood | | Middle age | *Generativity vs. Stagnation* Finding a way to support in the establishment and guidance of the next generation | Adulthood | | Old age | *Integrity vs. Despair* Integrating the earlier stages into an acceptance of oneself and a sense of fulfillment rather than looking back in regret at what might have been |  | |

1. **Development in Early & Middle Adulthood**

**Adulthood** has no signpost to announce its onset (as adolescence is announced by puberty). In technologically advanced nations, the life span is more than 70 years. Developmental psychologists usually consider early adulthood to cover approximately age 20 to age 40 and middle adulthood approximately 40 to 65.

**Early adulthood** an individual is concerned with developing the ability to share intimacy, seeking to form relationships and find intimate love. Long-term relationships are formed, and often marriage and children result. The young adult is also faced with career decisions.

* Choices concerning **marriage** and **family** are often made during this period. Research shows that divorce is more likely among people who marry during adolescence, those whose parents were divorced, and those who are dissimilar in age, intelligence, personality, or attractiveness. Separation is also more frequent among those who do not have children. Most people who have divorced remarry; consequently, children may experience more than one set of parents.
* Such alternatives to marriage as “living together” ( **cohabitation**) have become more common. In 1997, the Census Bureau estimated that 4.13 million unwed couples lived in the United States.
* **Work/career choice** affects not only socioeconomic status but also friends, political values, residence location, child care, job stress, and many other aspects of life. And while income is important in both career selection and career longevity, so are achievement, recognition, satisfaction, security, and challenge. In the modern cultures of many nations, the careers of both spouses or partners frequently must be considered in making job choices.

**Middle adulthood** an important challenge is to develop a genuine concern for the welfare of future generations and to contribute to the world through family and work. Erik Erikson refers to the problem posed at this stage as **generativity vs. self-absorption**.

Robert Havighurst lists seven **major tasks** in the middle years.

* accepting and adjusting to physiological changes, such as menopause
* reaching and maintaining satisfaction in one's occupation
* adjusting to and possibly caring for aging parents
* helping teenage children to become responsible adults
* achieving adult social and civic responsibility
* relating to one's spouse as a person
* developing leisure-time activities

While a **midlife crisis** is not regarded as a universal phenomenon, during one's 40s and 50s comes the recognition that more than half of one's life is gone. That recognition may prompt some to feel that the clock is ticking and that they must make sudden, drastic changes in order to achieve their goals, while others focus on finding satisfaction with the present course of their lives.

1. **Development in Late Adulthood**

**Late adulthood** (old age) is generally considered to begin at about age 65. Erik Erikson suggests that at this time it is important to find meaning and satisfaction in life rather than to become bitter and disillusioned, that is, to resolve the conflict of **integrity vs. despair**. It has been estimated that by the year 2030, Americans over 65 will make up 20% of the population. Despite the problems associated with longevity, studies of people in their 70s have shown that growing old is not necessarily synonymous with substantial mental or physical deterioration. Many older people are happy and engaged in a variety of activities. **Gerontology**, an interdisciplinary field that studies the process of aging and the aging population, involves psychology, biology, sociology, and other fields.

**Theories of successful aging -** Theories of successful aging include the following:

* The **disengagement theory** states that as people age, their withdrawal from society is normal and desirable as it relieves them of responsibilities and roles that have become difficult. This process also opens up opportunities for younger people; society benefits as more-energetic young people fill the vacated positions.
* The **activity theory** contends that activity is necessary to maintain a “life of quality,” that is, that one must “use it or lose it” no matter what one's age and that people who remain active in all respects—physically, mentally, and socially—adjust better to the aging process. Proponents of this theory believe that activities of earlier years should be maintained as long as possible.

1. **Ageism –**

May be defined as the prejudice or discrimination that occurs on the basis of age. Although it can be used against people of all ages, older people are most frequently its target and it may often result in forced retirement. Stereotyping of the elderly is also an aspect of ageism, as seen in such a statement as “He drives like a little old lady.”

**Physical changes -** People typically reach the peak of their physical strength and endurance during their twenties and then gradually decline. In later adulthood, a variety of physiological changes may occur, including some degree of atrophy of the brain and a decrease in the rate of neural processes. The respiratory and circulatory systems are less efficient, and changes in the gastrointestinal tract may lead to increased constipation. Bone mass diminishes, especially among women, leading to bone density disorders such as osteoporosis. Muscles become weaker unless exercise programs are followed. The skin dries and becomes less flexible. Hair loss occurs in both sexes. There is also decreased sensitivity in all of the sensory modalities, including olfaction, taste, touch, hearing, and vision.

**Cognitive changes -** The study of cognitive changes in the older population is complex. Response speeds (neural and motor) have been reported to decline; some researchers believe that age-related decrease in working memory is the crucial factor underlying poorer performance by the elderly on cognitive tasks.

* **Intellectual changes** in late adulthood do not always result in reduction of ability. While **fluid intelligence** (the ability to see and to use patterns and relationships to solve problems) does decline in later years, **crystallized intelligence** (the ability to use accumulated information to solve problems and make decisions) has been shown to rise slightly over the entire life span. K. Warner Schaie and Sherry Willis reported that a decline in cognitive performance could be reversed in 40% to 60% of elderly people who were given remedial training.
* **Dementias** are usually responsible for cognitive defects seen in older people. These disorders, however, occur only in about 15% of people over 65. The leading cause of dementia in the United States is **Alzheimer's disease**, a progressive, eventually fatal disease that begins with confusion and memory lapses and ends with the loss of ability to care for oneself.

**Retirement -** at age 65 is the conventional choice for many people, although some work until much later. People have been found to be happier in retirement if they are not forced to retire before they are ready and if they have enough income to maintain an adequate living standard. Chronic health problems such as arthritis, rheumatism, and hypertension increasingly interfere with the quality of life of most individuals as they age.

**Widowhood -** Women tend to marry men older than they are and, on average, live 5 to 7 years longer than men. One study found ten times as many widows as widowers. Widowhood is particularly stressful if the death of the spouse occurs early in life; close support of friends, particularly other widows, can be very helpful.

**Death and dying -** Death and dying has been studied extensively by Elisabeth Kübler-Ross, who suggested that terminally ill patients display the following five basic reactions.

* **Denial**, an attempt to deny the reality and to isolate oneself from the event, is frequently the first reaction.
* **Anger** frequently follows, as the person envies the living and asks, “Why should I be the one to die?”
* **Bargaining** may occur; the person pleads to God or others for more time.
* As the end nears, recognition that death is inevitable and that separation from family will occur leads to feelings of exhaustion, futility, and deep **depression**.

**Acceptance** often follows if death is not sudden, and the person finds peace with the inevitable.

People who are dying are sometimes placed in a **hospice**, a hospital for the terminally ill that attempts to maintain a good quality of life for the patient and the family during the final days. In a predictable pattern after a loved one's death, initial shock is followed by grief, followed by apathy and depression, which may continue for weeks. Support groups and counseling can help in successfully working through this process.

**Hauighurst’s developmental tasks during the life span –**

* **Babyhood and early childhood –** 
  + Learning to take solid foods
  + Learning to walk and talk
  + Learning to control the elimination of body wastes
  + Learning sex differences
  + Getting ready to read
  + Learning to distinguish right and wrong
* **Late childhood –** 
  + Learning physical skills
  + Learning to get along with age mates
  + Developing fundamentals skills in reading, writing and calculations
  + Developing concepts necessary for everyday living
  + Developing attitudes towards social groups and institutions
  + Achieving personal independence
* **Adolescence –** 
  + Achieving new and more mature relations with age mates of both sexes
  + Achieving a masculine / feminine social role
  + Achieving emotional independence from parents and adults
  + Desiring, accepting and achieving socially responsible behaviour
  + Preparing for an economic career
  + Preparing for marriage and family life
* **Early adulthood –** 
  + Getting started in an occupation
  + Selecting a mate, starting a family
  + Rearing children, managing a home
  + Taking on civic responsibility
* **Middle age –** 
  + Achieving adult civil and social responsibility
  + Assisting teenage children to become responsible
  + Accepting and adjusting to the physiological changes
  + Adjusting to aging parents
* **Old age –** 
  + Adjusting to decreasing physical strength and health
  + Adjusting to retirement and reduced income
  + Adjusting to death of spouse / friend
  + Establishing satisfactory physical living arrangements

**Psychology of vulnerable groups –**

Mental / psychological disorders can arise in any age groups in any kind of people. People generally affected by psychological disorders fall under class of vulnerable groups.

The major groups of people falling are –

1. Physically handicapped persons
2. Children
3. Old age persons
4. Sick individuals
5. Women
6. **Physically handicapped persons –**

The physically handicapped may be congenital / acquired due to illness / injury. These handicaps are associated with emotional and psychological problems which may be of a varying degree.

**Types of physically handicapped –**

The physical handicaps may occur singly / combination

* + 1. Orthopedic handicaps resulting from the disease of the bones and joints
    2. Visual handicaps – total / partial
    3. Neurological handicaps resulting from disease of the central and peripheral nervous system
    4. Speech and hearing handicaps deaf, mutism, stammering, cleft palate
    5. Cardio vascular handicaps
    6. Other conditions like dwarfism, gigantism, short limb / absence of body part

**Common psychological reactions associated with physically handicapped –**

* + Negative emotional reactions like shame, guilt, grief, anger etc…
  + Personality traits like shyness, aloofness, attention seeking and aggressive behaviour pattern, inferiority complex, depressive and anxious, antisocial and dissocial behaviour, lazy and lethargic, over active and agitated ect…
  + Adjustment disorders and stress related syndrome

**Determinants of psychological reactions –**

* + Congenital / acquired handicapped
  + Temporary / permanent disability
  + Attitudes of the family members and relatives
  + Attitudes of the person – denial / non – acceptance
  + Attitudes of the society, available of the family and community support, socio – cultural and religious belief systems, government and non – government aided welfare programme.

1. **Children –**

**Classification of psychological illness –**

* + Organic – post encephalitis, meningitis, rheumatic cholera, paralysis
  + Functional – schizophrenia, depression, mania
  + Neurosis like anxiety reactions, phobic reactions, OCD, hysteria
  + Psychosomatic illness like bronchial asthma, MR, epilepsy
  + Behaviour problems
    1. Anti social – lying, stealing, loafing, drug addiction, alcoholism, delinquency
    2. Non anti social –
* Habit disorders – thumb sucking, nail biting, bed wetting, pica
* Personality disorders – shyness, day dreaming, temper tantrum
* Scholastic problems – refusal to go to school, truancy
* Specific learning disorders
* Psychosomatic complaints like anorexia, vomiting, diarrhea

**Causes of problems in children –**

* + Hereditary, physical defects and constitution
  + Low and high intelligence
  + Illness of the parents, insecurity
  + Disharmony between parents, broken families
  + Social and cultural factors
  + Physical environment like over crowding

**Children under peculiar circumstances –**

* + 1. Battered child syndrome
    2. Sibling jealousy
    3. Adopted child
    4. Mental retardation
    5. Deprivation effect among children
    6. **Battered child syndrome –**

The abuse of children is increasing day by day and has become a major health problem. It is also called ‘unrecognized trauma’, ‘maltreatment syndrome’.

**Causes –**

* + **Abusive parent:**

The parents who abuse their children are the victim of emotionally cripped / foster parent, had immature, egocentric, demanding, impulsive and aggressive personality.

* + **Children:**

Abused children are perceived by their parents as being different, slow in developmental / mentally retarded, bad, selfish / hard to discipline.

* + **Crisis situation:**

Divorce, alcoholism, drug addiction, teenage pregnancies, MR, mental illness, financial problems.

* + 1. **Sibling jealousy –**

Jealousy is an unpleasant feeling induced by any interference / attempt to wart the effort to gain a love object, either a person, power / position.

Jealousy is a condition which frequently occurs in children and is usually brought out when there is an element of competition.

It is also called ‘sibling rivalry’, ‘childhood hate’.

**Causes –**

* + Lack of constructive training
  + Children as objects of testing
  + A desire for monopoly of the mother
  + Arrival of new baby leading to parental neglect
  + Inferiority feelings, rudeness
  + Parental disappointment about new child gender
    1. **Adopted child –**

Adoption is defined as the process by which a child is being taken into a family by one / both of the parents but who are recognized by law / customs as the child’s parents. Majority of adopted children are born out of wed lock. Most of the placements occur before 12 months of age. The adopted child has 3 main areas of potential difficulty is the reaction of his adoptive parents to his being adopted, his own reaction to being adopted and the effort of his separation from his biological parents and placements prior to going to adoptive home.

If the child is adopted before the age of one year, the adverse problems are minimum but if the child is adopted after one / two years, he / she develops more behavioral problems, school difficulties, sexual acting out ect…

* + 1. **Mental retardation –**

There are about 15 million M.R in India. The highest incidence in school age children with peak at age’s 10-12 years.MR is not a disease but a condition in which the intellectual faculties are never manifested / have never been developed sufficiently to enable the retarded person to acquire such an amount of knowledge as persons of his own age.

**Causes –**

* + Down syndrome
  + Fragile x-syndrome
  + Klinefelter,s syndrome
  + Phenyl ketonuria
  + Turner’s syndrome
  + Patace syndrome
    1. **Deprivation effect among children –**

Maternal deprivation is one of the worst forms of deprivation. Children living in an institution – an orphanage / children showed less concern for other. People than a control group of children who had been brought up in a normal family situation with mother as primary care giver. The early years of life are critical but research with severely deprived children given an improved, enriched and loving environment are capable of almost complete recovery.

1. **Old age persons –**

In India, persons aged 60 and above are considered as aged. Old age can be considered as developmental phase in the life span of a person and is characteristics by deficits in the physical and psychological functioning.

**Types of psychosocial problems –**

* + Affective disorders like depression and mania
  + Organic mental disorders like dementia, mainly of the senile and Alzheimer’s type
  + Delirium
  + Paranoid status like paraphrenia and involutional psychosis
  + Suicidal tendencies
  + Alcohol, drug abuse and drug dependence
  + Adjustment disorders related to changes of aging process
  + Anxiety neurosis, phobic disorders, OCD, OC – neurosis, sleep and appetite disturbances of psychogenic origin
  + Psychosomatic illness including emotional reactions to physical illness
  + Psychosocial problems arising from personality changes of old age, family disorganization and interpersonal difficulties with family members.

**Contributing factors to old age problems –**

* + Physical illness, disability and handicaps like ophthalmological cataract, degenerative joint disease, neurological, CV, respiratory, dermatological, hearing and urinary problems, nutritional problems
  + Intellectual, cognitive, emotional and personality changes associated with the aging process
  + Social causes
* Disintegrating joint family system, death of the spouse / younger member of the family, generation gap, and behavior of the family members
* Socio – economic problems arising out of retirement, unemployment, limited income increasing cost and responsibilities.
* Absence of gainful occupation, socialization, recreation, hobbies, leisure time, proper physical activities and diet, planning for old age.
* Changes in the socio – cultural value system, religious norms
* Urbanization, housing problems, over – crowding, limited social interactions
* Absence of social security and organized welfare programme for the aged, lack of insecure, pension and absence of public health and medical facilities for the aged

**Changes due to old age –**

* + **Physiological changes –**

Fall in capacity of heart, kidney, liver, lungs, and decline in sleep, difficulty in eating because of loss of teeth

* + **Sensory changes –**

Fall in vision, hearing, smell and taste

* + **Changes in motor abilities –**

Fall in strength, speed, learning new skills etc…

* + **Sexual changes –**

Decline in sexual potency, secondary sexual characteristics etc…

* + **Changes in appearance –**

Wrinkles, grey hair, loss of teeth, posture changes

* + **Changes in mental abilities –**

Poor retention and recall process fall in learning capability and creativity, loss of sense of humor and rigid personality.

* + **Psychological problems –**

Retirement, isolation, and loneliness

1. **Sick individuals –**

Physically illness causes varying degree of stress on the child and the family and on each and every individual related to sickness.

**Individual reaction to acute illness –**

* + Immediate and direct effect : pain, discomfort, decreased appetite, insomnia, weakness and irritability, hyperactivity and restlessness, transient adjustment disorders
  + Chronic effects: withdrawal, regression, depression learning, maladaptive behaviour, threats to self – image and self – concept, delayed sexual maturation.

**Individual reaction to sickness, hospitalization and surgery –**

* + Individual age
  + Level of cognitive development
  + Premorbid person – family relationship
  + Families reaction to illness and ability to cope with it
  + Nature of illness
  + Types of medical – surgical treatment
  + Duration of hospitalization

**Stress of being hospitalization / sick –**

Two main sources associated with admission to hospital

* + Problems arising from illness is the stress attached to illness itself and its implication
  + The hospital environment is the stress brought about by aspects of hospital environment like admission procedure, treatment procedures ect…

**Emotional reactions to hospital –**

* + **Anxiety and fear:**

Anxiety is a feeling of uncertainty and helplessness in face of dangers. It can be due to lack of knowledge. Lack of trust, social, cultural and economic forces bearing directly on the affected individuals.

* + **Anger and hostility:**

The loss of financial security and economic effect of illness may cause the patient and family to feel threatened.

* + **Physiological disturbance:**

The hospitalization and changes in daily routine of the patient tend to show their impact on the psychology of the patient which in turn, are manifested in the form of physiological disturbances like insomnia, anorexia, frequency, irritability, inability to listen or to concentrate and defacement.

* + **Grief and mourning:**

Grief is a complex emotional response to the anticipated or actual loss of someone or something valued. The loss may be of a relative / friend, a job, health or life. Mourning refers to the process that follows the loss and ultimately results in overcoming the grief. Feeling of anxiety, helplessness, guilt, anger, depression, isolation etc… are all part of grief. Social sigma may be one of the aspects that may be a constant cause of physiological distress of the patient.

* + **Denial:**

A common response to a shift in health status is denial. It is an ego defense mechanism that protects the person from recognizing painful and disturbing aspects of reality.

1. **Women –**

Psychiatric disorders are more common in women. The disorders more commonly reported in females include major depression, neurotic depression, anxiety state, phobic neurosis, hypochondriasis, adjustment problems, attempted suicide, anorexia nervosa, senile dementia.

**Physical and psychological factors –**

* + Termination of the pregnancy (abortion)
  + Menopause
  + Endometriosis
  + Battered wife syndrome
* Family background
* Education and employment
* Social condition
* Psychiatric history
* Sexual and marital history
* Physical illness

**Psychology of groups**

Groups are the most basic units of any social system. They carry on the many organized activities which are necessary in a society. The term group may apply to social units varying in size from two persons to a large organization or major political party. Groups may be essentially be subcultures or categories, which describe members of a society or they may involve close face – to – face interaction directed at common goals of the kind found in the family, among playmates or in a committee.

**Kinds of groups –**

* 1. **Functional groups and grouping –**

Groups that get things done, typically held together by a common objective are called ‘functional groups’. The individuals participate in organized effort to attain goals that would not be available by solo activity.

The groups which are fewer goals – directed and not functional called ‘groupings’. It consists of two categories. One is a descriptive category which is made up of people who passes a common characteristic which can be used to describe them, such as sex. An aggregate is composed individual who share a time – space relationship, but who do not have a common goal, unless the situation creates one. Groupings may also have influence effects similar to but usually not as strong as, those produced by functional groups.

* 1. **Primary and secondary groups –**

In the primary group, members have close personal ties with one another. There is an emphasis on face – to – face interaction and spontaneous interpersonal behaviour. For example – family is the group which provides the first point of contact the child has with the society, has important societal functions, involving procreation and child rearing.

Secondary groups are more impersonal and are characterized by contractual relations among their members. Being identified with such groups is not a goal in itself. They are means by which other goals may be achieved, such as working to earn a livelihood.

* 1. **Formal and informal groups –**

These are determined by their source of structure outside or inside the group. A formal group is usually found in organizations and its goals and procedures are governed by factors outside of the group’s direct control.foe ex – a religious group, school.

An informal group arises spontaneously out of common interest and certain shared goals and are sustained by interpersonal attraction. For ex – peer group.

**Features of group structure –**

1. **Status, norms and communication:**

There are a number of different elements which comprise structure.

Status refers to the rank or hierarchical position which individual occupy with in a group.

Norms is an expectancy regarding the appropriate behaviour of members within a given activity.

A role can be thought of as a specialized norm applied to a person occupying a given status, in the sense of position.

Communication patterns have reference to who communicate with whom, particularly in formal organizations where such pattern is largely determined from above.

Different communication pattern or nets are arranged for these groups

* + Circle
  + Chain
  + Wheel
  + Y

1. **Interaction within the group –**

The group structure may change itself as a result of the events occurring in interaction. Past interactions will have an effect upon future interaction, and this will produce a change in structure

* + A leader in the group has status and influence which is more easily changed in some structure than others
  + People of low status within the group structure engage in more ego – defensive reactions. They also tend to overrate how much their superiors like them
  + The members with insecure positions in the groups structure engage in more irrelevant communication and are less satisfied with the group

1. **Physical arrangements –**

The way people are arranged or arrange themselves indicates something about their status relationship. For ex – in the conference room, the leader prefers to sit in the end positions at the rectangular table, the other subject prefer to sit at the corner position closet to the leader.

A group exerts influence over the psychological processes and behaviour of its members.

* + **Motivation to participate in a group –**

The more motivation means greater identification and influence.

* **Task motivation –** the individual is interested in joining with others for the sake of the goal of a mutual activity. They all depend upon one another in seeking its goal attainment. For ex – the nurse participate in serving earthquake victims for effective and efficient care at the site.
* **Affiliation motivation –** this operates clearly where the individuals is attracted to others as a source of social identity, social reality and social support. These psychological rewards are obtained when the individual accepts the group as a source of influence.
* **Rewards verses costs of the group –** it studies the combined operation of rewards and cost in producing net satisfaction and greater identification with the group.
  + **Cohesiveness –**

It means a greater sense of we feeling. The members of this group are more likely to stick together, to cooperate and to participate more fully in their common efforts.

* + **Conformity and communication –**

The communications towards conformity are increased by cohesiveness. When members of a cohesive group perceive the need for goal attainment, they are likely to put more pressure on those who are not conforming.

Conformity

Cohesiveness communication

1. **Provide social identity, social reality and social support –**

Social identity means that individuals become involved with one another and aware of each other as members of the same social unit. Socialization improves and the members feel the other members as real and their positions in the group.

1. **Groups affect the attitudes individuals express –**

Groups create expectancies for individuals to show approved attitudes. But the group may hold attitudes which differ from the expectancies. The group affect the attitudes shown in the members, so that to understand and cope with the environment.

1. **Social support helps to sustain individual’s activity –**

Group support is closely tied to the motivation to take part in the task of functional group. The members are rewarded by their attempts to achieve group goals; they will help towards the goal and will be supported by others.

1. **Group size affects individual participation and satisfaction –**

As the group increases in size, certain changes are likely to occur in the relationship among members. The number of relationships increases as the group size increases.

The formula for calculating this is (n2 – n) / 2.

N = the number of people in a group

1. **Characteristics of individuals in the group –**

The performance of a group depends upon the inter relationships of its task and the people who compose it, the qualities like competences and commitment to the group’s activity. For ex – staff nurses of cardiac ward must possess qualities like responsible, administrator, loyal, cooperative, and punctual so that everyone put their effort in patient care.

1. **Social movements to achieve influence –**

Achieving a change may involve group activities, which are parts of social movements involving collective action. A movement’s major task is to call issues to the attention of a wider public if it is to achieve influence.

**Sources of collective aggression –**

* **Symbolic modeling –**

Imitative learning may take the form of observing the behaviour of models in real life through symbolic modeling. For ex – aggressive action in the mass media

* **Conflict and frustration –**

The common causes are competition, lack of requisite effort, objective beyond one’s power, social and cultural obstacles, physical causes and political causes.

* **Intergroup and international hostility –**

When conflict and frustration exit, automatically the people become hostile to others. It disturbs not only mental health of other group but also among the members of the same group.

**Managing inter – group aggression –**

The management of inner group conflict and aggression is achieved by a variety of social mechanisms which contain and direct the conflict towards the productive ends.

* **Effective negotiation requires cooperation with a set of rules –**

The process of negotiation is perceived by the negotiators, the groups they represent or by outside to encourage cooperation.

* **The strategy used in dealing –**

One of the statergy is the conditional benevolence that is rewards for favorable actions and no reward for unfavorable ones proved to be most effective.

* **Conflict may be reduced by an appeal to common goals –**

By drawing the groups from an identical. Sample which was highly homogenous such factors as age, religion and socio – economic status. A mutual cooperation is developed when super ordinate goals are formed, which are common for groups.

* **Equal status contact –**

Hostility can reflect prejudices and discrimination such as skin color, or religion. Inter group tension can be prevented on the basis of a wide range personal qualities they possess, including their capacities and intelligence, possible interest in common and personality.

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