Lecture Objectives:

1. Understand and be able to differentiate the stages of development of Freud, Sullivan, Erikson, Piaget, and Mahler. Know which stage occurs at which age and the implications of failure to achieve the developmental tasks.
   a. Be able to associate age with developmental tasks for Erikson.
   b. Understand Freud’s first 3 stages in detail.
   c. Be able to utilize the stages of development of Piaget. In order!
   d. Be able to associate Mahler’s Phase III with psychological disorders.
   e. Know Kohlberg’s stages of development and ALSO the stage in which he believes most adults are.

2. Be prepared to compare Peplau’s Stages of Development with those of other theorists. Know the roles she advocated for nurses and how she utilized roles in the nursing process.

3. Be prepared to delineate the crucial developmental issues of infancy through the elderly, with emphasis on adolescence and the elderly.

Lecture Objectives for the GRIEF Section

4. Be able to define grief and grief work and differentiate between the outcomes of successful grief work.

5. List and be able to differentiate between normal and abnormal and understand the nursing implications of the abnormal symptoms of grieving.

6. Differentiate between the grieving demonstrated under various circumstances, to include the death of a child, sudden, death, perinatal death, and the grieving of children.

7. Explain anticipatory grieving, the symptoms, and nursing issues.

8. Describe the nurse’s role in assisting the family of a dying and patient and in working with the patient that is dying.

9. Understand the meaning of loss to the health professional and relate the coping mechanisms for nurses that are involved with a dying patient.

10. Be able to relate the appropriate nursing interventions, to include education, to the appropriate situations in dealing with families and patients that are dealing with death and dying.
Outline

I. Freud’s theory of development - 5 stages of psychosexual development. Believed characteristics developed during the first 5 years of life bear heavily on one’s adaptation patterns and personality traits in adulthood.
   A. Oral stage - birth to 18 months
      1. Behavior directed by id, goal is immediate gratification of needs
      2. Infant attached to mom, unable to differentiate self from mom at first. Feels the feelings mom feels, including anxiety.
      3. Beginning development of ego at 4-6 months, begins to separate self from mom.
      4. Sense of security and the ability to trust others is derived out of gratification from fulfillment of basic needs.
   B. Anal stage - 18 months to 3 years
      1. Major tasks - gaining independence and control, especially over excretory functions.
      2. Believed strict and rigid toilet training leads to (1) retention of feces by the child and later to adult retentive personality traits that include stubbornness, stinginess, and miserliness or (2) the expelling of feces in unacceptable manner or inappropriate times with adult patterns of malevolence, cruelty to others, destructiveness, disorganization, and untidiness.
      3. Permissive, accepting attitude re toilet training leads to extroverted, productive, and altruistic adults.
   C. Phallic stage - 3 years to 6 years
      1. Focus of energy shifts to genital area, children discover differences which results in heightened interest in the sexuality of self and others.
      2. Development of oedipus complex with resulting guilt feelings. Resolution occurs when child identifies with parent of same sex.
   D. Latency stage - 6 to 12 years
      1. Focus changes from egocentrism to one in which there is more interest in group activities, learning, and socialization with peers.
      2. Preference is same-sex relationships.
   E. Genital stage - 13 to 20 years
      1. Reawakening of libidinal drive.
      2. Focus is on relationships with members of opposite sex and preparations for selecting mate.
      3. Interpersonal relationships are based on genuine pleasure derived from interaction.

II. Sullivan’s Stages of Personality Development
   A. Infancy - birth to 18 months - Relief from anxiety through oral gratification of needs.
   B. Childhood - 18 months to 6 years - learn to accept delayed gratification without anxiety.
   C. Juvenile - 6 years to 9 years - Formation of satisfactory relationships within peer groups.
   D. Preadolescence - 9 years to 12 years - Develop relationships with persons of same sex. Collaborate with and show love and affection for others.
   E. Early adolescence - 12 to 14 years - major task is formation of satisfactory relationships with members of the opposite sex. Struggle with own identity. Lust emerges.
   F. Late adolescence - 14 years to 21 years - establish self-identity; work to develop last,
intimate opposite-sex relationship.

III. Erikson’s Stages of Personality Development
A. Trust vs. mistrust - birth to 18 months - primary care givers must respond to infant’s signal promptly and consistently - achievement of this task results in self-confidence, faith, and hope for future. Failure to develop trust in mom results in emotional dissatisfaction with others, suspiciousness, difficulty with interpersonal relationships.
B. Autonomy vs. shame and doubt - 18 months to 3 years - major developmental task - gain self-control and independence within environment. Autonomy achieved when parents encourage and provide opportunities for independent activities and do not have unrealistic expectations. Achievement of task results in self-confidence and ability to delay gratification. Failure results in lack of self-confidence and pride and rage against self.
C. Initiative vs. guilt - 3 to 6 years - Goal is to develop a sense of purpose and the ability to initiate and direct own activities. Failure results in feelings of inadequacy and guilt and the accepting of liability in situations for which he or she is not responsible.
D. Industry vs. inferiority - 6-12 years - Goal is to achieve a sense of self-confidence by learning, competing, performing successfully, and receiving recognition from significant others, peers, and acquaintances. Failure results in difficulty in interpersonal relationships because of feelings of inadequacy. May manipulate or violate rights of others or become workaholic with unrealistic expectations for personal achievement.
E. Identity vs. role confusion - 12-20 years - Goal is to integrate the tasks mastered in the previous stages into a secure sense of self. Failure results in a sense of self-consciousness, doubt, and confusion about one’s role in life; personal values and goal’s for one’s life are absent. Relationships are superficial and brief. Delinquent and rebellious behavior occurs.
F. Intimacy vs. isolation - 20-30 years - Goal is to form an intense, lasting relationship or a commitment to another person, a cause, an institution, or a creative effort. Failure results in withdrawal, social isolation, aloneness, and the inability to form lasting, intimate relationships. Individual may have numerous superficial sexual contacts. May have history of job changes, or may stay in an undesirable job situation.
G. Generativity vs. Stagnation or Self-absorption - 30-65 years - Goal is to achieve the life goals established for oneself while considering the welfare of future generations. Failure results in lack of concern for the welfare of others and total preoccupation with the self. May be withdrawn, isolated, highly self-indulgent.
H. Ego Integrity vs. Despair - 65 years to death - Goal: to review one’s life and derive meaning from both positive and negative events, while achieving a positive sense of self-worth. Have dignity and do not fear death. Failure results in a sense of self-contempt and disgust with how life has progressed. Individual feels worthless and helpless to change. Anger, depression, loneliness are evident. May fear death, or suicide may result.

IV. Mahler’s Developmental Theory
A. Phase I: Autistic Phase - birth to 1 month - Goal: fulfillment of basic needs for survival and comfort. Fixation at this level can predispose to autistic disorder.
B. Phase II: Symbiosis - 1 to 5 months - At first views self as extension of mother, but is
becoming aware of external source of need fulfillment. Lack of expected nurturing in this phase may lead to symbiotic psychosis, including adolescent or adult-onset schizophrenia.

C. Phase III: Separation-individuation - 5-36 months - the "psychological" birth of the child. The process of separating from mothering figure and the strengthening of the sense of self.

1. Subphase 1: Differentiation. A primary recognition of separateness from the mother begins.
2. Subphase 2: Practicing. Increased independence through locomotor functioning; increased sense of separateness of self.
3. Subphase 3: Rapprochement. Acute awareness of separateness of self; learning to see “emotional refueling” from mothering figure to maintain feeling of security. **Critical phase** – if emotional needs inconsistently met or mom rewards only dependent behaviors, sense of rage and fear of abandonment results - these feelings may persist into adulthood.
4. Subphase 4: Consolidation. Sense of separateness established; on the way to object constancy–able to internalize a sustained image of loved object/person when object/person is out of sight; resolution of separation anxiety.

V. Piaget’s Cognitive Development Stages

A. Stage 1 - sensorimotor - birth to 2 years - as increased mobility and awareness develops, a sense of self as separate from the external environment develops, also. The concept of **object permanence** occurs.

B. Stage 2 - preoperational - 2 to 6 years - characterized by egocentrism. The child is learning to express self with language, develops understanding of symbolic gestures, and achieves concept of object permanence.

C. Stage 3 - concrete operations - 6 to 12 years - logical thinking begins but concreteness predominates. Develops understanding of reversibility and spatiality; learns to differentiate and classify; child becomes more socialized and rule conscious.

D. Stage 4 - formal operations - 12 to 15+ years - Able to think and reason in abstract terms - Tests hypotheses using logical and orderly problem solving. Future idealized but can distinguish between ideal and real. **Cognitive maturity** achieved in middle to late adolescence.

VI. Kohlberg’s Stages of Moral Development

A. Level I: Preconvention level - 4 to 10 years

1. Stage 1 - punishment and obedience orientation. Behavior is motivated by fear of punishment.
2. Stage 2 - instrumental relativist orientation. Behavior is motivated by egocentrism and concern for self.

B. Level II: Conventional level - 10 to 13 years and into adulthood

1. Stage 3 - interpersonal concordance orientation. Behavior is motivated by the expectations of others; strong desire for approval and acceptance.
2. Stage 4 - law and order orientation. Behavior is motivated by respect for authority. Rules and laws override personal principles.

C. Level III: Postconventional level - can occur from adolescence on
1. Stage 5 - social contract legalistic orientation. Behavior is motivated by respect for universal laws and moral principles and guided by an internal set of values.

2. Stage 6 - universal ethical principle orientation. Behavior is motivated by internalized principles of honor, justice, and respect for human dignity and guided by the conscience. Laws are abstract and unwritten. Intense guilt can result from failure to meet self-expected behaviors.

VII. Infancy
   A. Attachment - emotional or affective tie
      1. Secure attachment - separation anxiety normal in new situations
      2. Insecure attachment - inappropriate parental response to infant leads to problems with future development of trust and healthy relationships
      3. Anxious resistant attachment - early parental inconsistency with frequent separations or threats of abandonment result in excessive separation anxiety.
      4. Anxious avoidant attachment - parent regularly rebuffs the infant when it seeks comfort - an extreme case of abuse or neglect.
   B. Assistance in the regulation of bodily states, emotion

VIII. Toddlerhood
   A. Development of symbolic representation and further self-other differentiation. At 18 mos., recognize self in mirror, retain and use mental symbols as precursor to language.
   B. Problem-solving (by trail and error), pride, motivation for mastery, ego-centric

IX. Preschool
   A. Development of self-control: the use of language to regulate impulses, emotions; and store information; ability to predict and make sense of the world.
   B. Development of verbally mediated or semantic memory
   C. Gender identity - aware of sex differences
   D. Development of social relationships beyond immediate family, and generalization of expectations about relationships
   E. Moral reasoning - sense of justice, inevitability of punishment, belief that guilt is determined by the amount of the damage caused by an act rather than the motivation or intent behind it.
   F. Play is critical - they can act out scenarios that previously they had no control over.

X. Latency age/middle childhood
   A. Peer relationships - can understand rules and function in groups
   B. Adaptation to school environment
   C. Moral reasoning (continued)

XI. Adolescence - Transitional period between childhood and adulthood characterized by more biological, psychological, and social role changes than any other stage of life except infancy.
   A. Psychological or cognitive - formal operational thinking with adult-level reasoning
   B. Re-negotiation of family roles
   C. Poor peer relationships during childhood and adolescence are a STRONG predictor of adult difficulties with relationships.
   D. "Chumship" at this time allows intimacy later.
E. School is a setting for changes in personality, values, and social relationships.
F. Work - become self-reliant but cynical. Nurses need to encourage balance between work and other aspects of adolescent's life.
G. Identity achievement - major goal. Different identities depending on domain.
H. Achievement - make decisions for future
I. Sexuality - sexually transmitted diseases a factor
J. Intimacy - adolescents with intimate friendships are more likely to have high self-esteem.
L. Attachment - parent-child relationship is transformed to one of mutuality and cooperation.

XII. Young adult
A. Continued differentiation from family
B. Refinement and integration of identity with particular focus on occupational choice and ultimate partners
C. Moral reasoning

XIII. Elderly
A. Conservation of strength and resources
B. Adaptation to those changes and losses that occur as part of normal aging process.
C. 15 to 25% incidence of mental disorders in those over age 65. 1/4 of the elderly in the community and >½ of those in nursing homes.
D. Mental and physical illness may occur simultaneously. Symptoms of one may mask symptoms of other.
E. Elderly often reluctant to seek assistance.
F. Depression is the most common psychiatric problem. Symptoms include loss of interest in pleasurable activities, irritability, anxiety, and anger. Memory function impairment results. May result from chemical imbalance or specific disease, such as hypothyroidism. Attempt suicide less often but are more successful.
G. Nursing care includes prevention and early detection and treatment of depression in the elderly.

GRIEF

XIV. Definition - emotional, physical, and social responses to the loss of a valued entity
XV. Major work - Kubler-Ross
A. Denial
B. Anger
C. Bargaining
D. Depression
E. Acceptance

XVI. Mourning - culturally defined rituals and behaviors that are usually performed after a death.
XVII. Grief work outcomes
A. Establishment of new reality
B. Establishment of new identity

XVIII. Reasons for grieving
A. Loss of health
B. Loss of finances
C. Loss of family and social network
D. Loss of work-place authority
E. Loss of feeling of productivity
F. Loss of inner resources
G. Loss of future

XIX. Normal grief
A. Symptoms - sadness, insomnia, poor appetite, weight loss.
B. Tasks
   1. Accepting the reality of the loss
   2. Working through the pain of grief
   3. Adjusting to the world without the loved one
   4. Re-investing emotional energy in a new relationship
C. Interventions
   1. Encourage expression of emotional pain
   2. Encourage health-promoting activities
   3. Stress management strategies
   4. Recognize emotions-discuss symptoms

XX. Anticipatory grieving
A. Definition - psychosocial and somatic reactions to predicted future loss. May be felt by
   the terminally ill individual as well as by significant others.
B. Symptoms
   1. As above, plus
   2. Depression
   3. Intensified concern for the terminally ill individual
   4. Rehearsal of the impending death
   5. Attempts to adjust to the death
C. Interventions
   1. For the terminally ill individual
      a. Active listening and being present with the terminally ill pt. - let them
         review their life and define meaning of it.
      b. Hope - (hope, for these individuals, is the ability to face life
         constructively) fostering strategies such as
         (1) attainable aims
         (2) spiritual base
         (3) personal attributes
         (4) light-heartedness
         (5) up-lifting memories
         (6) affirmation of worth
         (7) presence of caring relationship
      c. Create environment that allows pts to express their hopes, maintain
         significant relationships, and reflect on continuity between past, present
         and future.
2. For the family or significant other
   a. Children
      (1) Symptoms - depression, anxiety, diminished self-esteem, deficits in social competence, fear, guilt, concern that healthy parent might become ill, frequent somatic complaints that may be attention-getting behavior
      (2) Interventions
         (a) Social services referrals
         (b) Encourage honest discussion of terminal illness among adults and children. This will help decrease fantasizing.
         (c) Encourage families to share religious values, beliefs, and rituals.
         (d) Encourage families to discuss family integrity, the home and love despite sadness.
         (e) Never lie!
   b. Adults
      (1) Symptoms - see “normal grief”, plus depression and anxiety due to strain of financial resources, and worsening of family dynamics and family communication patterns due to stress.
      (2) Interventions
         (a) Social services consult
         (b) Recognition that dynamics and patterns and roles will change.
         (c) Encourage “non-illness related aspects of family life” – family continues to live as family.
         (d) Respite care, day care, sitters, support from church, hospice, extended family to provide relief to care providers.
         (e) Discuss uniqueness of each situation
         (f) Education - anticipatory guidance and stress management techniques taking one day at a time maintaining spiritual practices.

XXI. Other situations
   A. Death of child
      1. Robs parents of future hopes and dreams as well as loss of life.
      2. Marital conflict may result
   B. Miscarriage - normal acute grief response approximately 12 weeks
      1. Resolve physical changes
      2. Resolve loss of child
      3. Deal with reaction of spouse
      4. May perceive the death as a threat to her developing maternal self-worth
   C. Sudden death - shock and turmoil greater
   D. Dying patient
      1. May welcome death as relief from pain or fatigue
      2. May have fears related to loneliness and isolation of living in institution. May feel dehumanized, impersonalized and mechanized.
      3. Spiritual needs should be considered.
4. May feel loss of control, dependent
5. May have need to review life events
6. May need to talk about dying
7. May need to discuss advance directives or other events dealing with death

E. Death of client
   1. Must recognize own mortality and examine personal meaning of death
   2. Even nurses can never be prepared for actual death
   3. Seek support from other nurses, supervisors, other friends at hospital. May find support from family, including spouse, children, dogs, cats.
   4. Utilize stress-reducing strategies such as regular exercise, diversional activities, proper diet, adequate sleep.

F. Additional notes
   1. Nurses insure that communication for both family and patient during illness. The nurse is the liaison, clarifier, explainer, interpreter of symptoms, communicator of expectations and agency rules. Clients make better decisions, families make better decisions.
   2. During code-blues, keep family informed.
   3. Nurses must accept grief-related behaviors, which vary by culture and religion.
   4. Must be willing to listen to mourners talk about deceased.
   5. Help mourners understand that emotions are common, deep hurting does come to an end, what to expect in the near future. Help arrange for funeral home.
   6. Avoid cliches.

XXII. Abnormal grief

A. Symptoms
   1. Guilt about things other than actions taken or not taken by the survivor at the time of death
   2. Thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased
   3. Morbid preoccupation with worthlessness
   4. Marked psychomotor retardation
   5. Prolonged and marked functional impairment
   6. Hallucinatory experiences other than thinking that he or she hears the voice of, or transitly sees the image of, the deceased person
   7. Absence of grief response.

B. Goals for treating complicated bereavement
   1. Psychotropic drugs
      a. Treat major depression and anxiety disorders
      b. Alleviate symptoms that are subjectively overwhelming or that interfere with functioning.
   2. Psychotherapy
      a. Counter demoralization
      b. Provide psycho-education
      c. Solve problems
      d. Clarify interpersonal problems
      e. Elucidate maladaptive relationship patterns
      f. Clarify pessimistic cognitive schemas
      g. Desensitize the phobic avoidance
3. Mutual support groups
   a. Provide membership and friendship
   b. Exchange information about grief, coping and community resources
   c. Offer a milieu for practicing social skills
   d. Empower through publicity and advocacy
   e. Promote self-esteem

C. Interventions
1. Emotion centered therapy - Gestalt therapy - relive the loss. Client encouraged to have dialogue with deceased - even say goodbye.
2. Patient centered therapy - encourage expression of feelings using acceptance, empathy, genuineness, openness, and unconditional positive regard.
3. Family centered therapy - strengthen family interaction, communication, social and emotional involvement.
4. Cognitive and behavioral therapies
   a. Rational-emotive-therapy - encourage client to think rationally and show that the negative event is not the problem but rather how the client thinks about the event.
   b. TA - directs patient to recognize destructive thought patterns and encourages constructive behavior. May be particularly useful in patients with low self-esteem or those extremely dependent on the deceased.
   c. Behavior therapy
      (1) Aimed at changing specific behaviors that are impeding grief resolution. Helpful for excessive intake of alcohol, caffeine or nicotine. Healthy changes include physical activity, sexual contact, and stress reduction.
      (2) counseled to increase self-sufficiency and utilize assertiveness training
      (3) alter GI symptoms by eating small meals
   d. Group bereavement counseling - support groups