Developmental stages and transitions essay sample

Life, Childhood

1) Critically compare the key concepts of models/theories associated with childhood and adolescence (1. 1) – Bowlby, Winnicott, Klein, Erikson.

In the first part of my essay I will critically compare the key concepts of theories of Klein, Winnicott, Bowlby and Erikson associated with childhood and adolescence and also relate them to Freud and his theories.

Melanie Klein regarded herself as a Freud's orthodox follower, however, despite her claim, there are certain differences in her work compared to Freud (Hough, 2014). She noticed processes in pre-oedipal children similar to the oedipal conflicts of older children and she concluded that the superego was active long before the age Freud assigned to it – she thought it belonged to the oral phase. This observation led her to radically rethink Freud's developmental theory and ultimately theories of how does adult's mind work, as well (Howard, 2012).

Klein created her theories based on her direct observation of working with children, whereas Freud's theory had emerged mainly from his work with adults and his experience of children was limited. We could assume that the information gained about childhood by listening to adults inevitably won't be the most accurate account of childhood experience (Howard, 2012).

According to Freud mental illness develops at the oedipal stage at around three to five years – Klein dated it during the first year of life, as baby enters the world and begins to relate to people straight away, already displaying a significant level of cognitive complexity (Howard, 2012).

According to Klein the internalization of the early object relationships determined the child's inner world and thus – psychological wellbeing. An implication of this was that mother was a crucial figure for child's development, whereas Freud considered father to have the most important impact on child's personality development. The result of this change of emphasis was that in the second half of the twentieth century fathers' contribution to child development became relatively overseen and neglected (Howard, 2012).

Klein also believed that an infant has, even before it is born, some kind of innate, unconscious knowledge of the mother, which resembles Jung's ideas of the collective unconscious (Hough, 2014).

Klein developed Freud's concept of the death instinct – she thought that a particularly malignant form of it is innate envy, which seeks to destroy that which is good. Her proposal that envy is innate, rather than a result of bad parenting or a frustrating environment, caused disagreement not only among Freudians but also with later Object Relation Theorists (Howard, 2012).

To sum up, Klein transformed some of Freud's ideas but also extended his theory. Perhaps the most important of her contributions was the emphasis on early infancy and the importance of mother in child's development, the primitive phantasies or unconscious mental images experienced by a small baby in relation to the mother (Hough, 2014).

Some of Klein’s critics suggest that she did not fully recognise the importance of mother and child’s real experience of her in the child’s development. Later Kleinian theorists believed that there is much more complex interaction between mother and child than Klein originally claimed (Howard, 2012).

Donald Winnicott was a paediatrician and psychoanalyst known for concepts like ‘ good enough parenting’, ‘ true and false self’ or ‘ transitional objects’. Like Klein, he had a vast experience with children and, also like Klein, he gave mothers a central place in children’s development, as opposed to Freud’s emphasis on father. However, unlike Klein, he emphasised the position of father in relation to the supportive family environment, which he needs to assist creating (Hough, 2014).

Winnicott disagreed with Freud on that our primary need is to seek pleasure – instead he claimed that it is intimacy and connection with other people. He also di not agree with Klein on the importance of child’s fantasy in development, especially the death instinct – he believed that fantasies are developed in the context of parent-child relationship. According to Winnicott, envy and other manifestations of aggression was a result of faulty environment rather than innate (Howard, 2012).

Winnicott argued that baby’s psychological existence depends on a mother who mirrors his experience and adapts herself to him. Unlike Klein, he proposed a true two-person psychology. He stressed that it is important for mother to be there when she is needed, highlighting the need for continuity

of care in childhood. He also said that it is equally important for a mother to give a child space when she is not needed and to recede into the background (Hough, 2014).

John Bowlby, who created an attachment theory, also believed that human nature is largely directed towards relationships with other people. Like Winnicott, he did not agree with Klein that aggression is innate. Instead, he argued that people only become aggressive when they are in danger and at threat. Unlike Winnicott who believed that mother should give child space when she is not needed, Bowlby claimed that an infant needs a continuous bond with a mother in the first two years of life. He also argued that mother (or mother substitute) – infant bond is essentially different from all other relationships. Bowlby argued that any changes of one mother figure to another in the first 3 – 4 years would cause emotional problems for young children. Bowlby's views were largely controversial and have been disputed by other childcare experts, but they have certainly influenced childcare practice (Hough, 2014).

Bowlby believed that the actual experience was much more important in child's development than fantasy. In particular, he argued that psychological problems result from deficiencies in the child's emotional environment rather than unconscious conflicts. Bowlby was more uncompromising than Winnicott in his disagreement with the dominant thinking at the time influenced by Klein. Winnicott was proposing similar ideas to Bowlby, but still using many of the theoretical concepts of psychoanalysis (Howard, 2012).

Compared to Freud, objects relation theorists do accept the concept of the Oedipus complex, however they differ from Freud in the way that they emphasise the importance of the overall relationship with parents, rather than just the sexual dimension (Hough, 2014).

Erik Erikson was an ego psychologist who created a theory of psychosocial development. This theory emphasises difficulties which people experience during the whole lifespan, not just the early life. He differed from the object relation theorists in that he examined aging as a stage of development (Hough, 2014).

Similarly to Freud, Erikson highlighted the idea of stages, however he placed more emphasis on the social aspects of development. He also put more focus on conflicts of adolescence, adulthood and old age (Hough, 2014).

2) Explain the main issues affecting the use and application of counselling skills for children and young people (2. 1).

In the second part of this essay I will try to address the main issues that affect the use and application of counselling skills for children and young people. I will first focus on the cognitive development of children and young people, and then describe the issues encountered in different approaches to counselling – humanistic, psychodynamic and CBT.

The main factor affecting the use of counselling skills when working with children and young people is their cognitive development. Children in the age group of 9 – 11 years old have a quite good command of spoken

language, numeracy and literacy already. They may not understand the full range of emotions (like frustrated, content) but act them out. They strongly identify with their peer group and want to fit in (being the same as other girls or boys is crucial). They become more independent and get a bit more responsibility. They also start developing interest in other sex, as well as become more inhibited and withdrawn. They are more capable of talking, they have more ability to process and reflect – therefore the counsellor can use more talking therapy.

This is a transitional stage of development and the difference in emotional development between boys and girls are quite big (McLeod, 2009). In the age group of 12-16 years old children/young people this is a stage where many physical and hormonal changes occur and this affects their feelings. Friends and loyalty become very important for them, they become self-conscious of what others say about them and are desperate to fit in – if others self-harm I will self-harm too). They also start hiding things from people and from themselves (especially boys as it's socially not accepted to be soft and cry for them). Therefore what young people in this age group present is usually not what is underneath. They start facing internal battles and conflicts like identity conflict (who am I?). Everyone tells them how they should be and who they should not be and very often this is pivotal stage in identity formation for them. Responsibility and loyalty to other people becomes very important at this stage.

Their language is very well developed, however most of them will talk about someone else and it could be challenging for the counsellor to get them open

up and talk what's really bothering them therefore the relationships between the client and the counsellor is very crucial at this stage (building trust, acceptance, confidence) (McLeod, 2009). The child's cognitive development affects skills we would use with them. With the younger children the counsellor would ask many open questions (how/, why?) and immediacy – instead of reflecting and managing the silence. They would use play therapy to enable child to explore their thoughts and feelings in a safe and familiar settings.

As they get older they would develop their vocabulary and do more talking therapy, they would be able to process their thoughts and reflect upon them – hence the counsellor would use skills like listening, reflecting, paraphrasing, summarising. They would also be able to understand that silence means that they are given space to think and process. It's very important to highlight the boundaries (time, place, how often) and confidentiality of the therapeutic process – in a very simple language accustomed to the level of the child.

Professionals working with children and young people in a humanistic way may often encounter issues of making fast judgements or tendency to ' identify' and label child's problems. The danger here is that we might somehow direct a child to fit our understandings and assumptions. By doing this we are less likely to truly listen to the young person and to see the world the way they see it and experience it – instead we are more likely to guide and advise, or just see their world from other perspective, different from theirs. A person-centred counsellor, in essence, should not be concerned

with trying to find out why the client – a young person – feels or behaves in a certain way. Instead, they should seek to work with the client's experience and to enter their personal, subjective world, without making judgements (Smyth, 2013).

It is often not easy when working with children and young people, because sometimes our instincts may lead us to act in a parental role – to guide, protect or even save. Sometimes counsellor might find it hard to relate to certain things, that young clients might tell them that could seem odd, fanciful, distorted or perhaps destructive. However, it is important to understand that this is how the young person sees their world and this should be respected. Person-centred counsellor believes that if we provide the right conditions for child's growth within and authentic and non-judgemental relationship, the child will find his own way forward and their solutions to problems (Smyth, 2013).

Working with children and young people in person-centred approach is truly about meeting together of two people. In non-therapeutic context we often try to guide behaviour in children young people, however, when we offer therapeutic help, we should avoid initiating direction, assessing, quantifying or judging. This may not be easy, considering many years of our own socialisation and conditioning. Therefore, the person-centred approach requires a huge suspension of ' normal' beliefs about young people – that they cannot decide for themselves what is best for them. Through the emphasis on respect, acceptance, realness, empathy and self-actualisation, this approach stands in contrast to young people's sense of having very little

control or autonomy in their lives, where they are constantly guided and controlled by adults around them, at school and at home (Smyth, 2013).

It might be also difficult for an adult supporting a child or young person in a person-centred way to find the unconditional positive regard, because we all bring with us a set of values and beliefs, which are part of us. To be able to suspend judgement and accept the young client as they really are is a precious ability. Most likely, the young person, who is used to labelling, criticism, advice and encouragement to conform, will receive it in an empowering way (Smyth, 2013).

From a psychodynamic perspective the counsellor must provide the child and young person the freedom to play or talk in a way that will enable young client to access deeper awareness of themselves, which could be experienced an a good or bad way, and to provide a space for them to express their emotions without fear. Psychodynamic counsellor believes that each patient is unique and that it cannot be predicted how the symptoms will unfold. The danger here is the temptation of predictability when presented with similar conflicts and symptoms as other children. Therefore, the counsellor needs to be alert on how to best assist the child in identifying the conflicts that have disturbed their development. His role is also to teach them how to use healthier defence mechanisms (Delgado, 2008).

These are the characteristics of children who would benefit from psychodynamic therapy are: 1) children, who have conflict-free areas of functioning, 2) children, who can relate to and communicate well with others

at age-appropriate level, 3) children, who demonstrate interest in school or hobbies, 4) children, who are aware of their symptoms and wish for change, 5) children, who are able to use metaphor (Delgado, 2008).

Another issue when working with children and young people in a psychodynamic way is to ‘ befriend’ countertransference, without fear or shame. The most common countertransference reactions to children and young people is feeling as a ‘ better parent’, not tolerating aggression in the session, colluding with the young client, feeling that the parents are too critical towards the child or overly indulgent (Delgado, 2008). It is also important to cooperate with the child’s parents in order to avoid unexpected interruption in the process of therapy. Usually child’s symptoms reflect their fear that if they express their repressed emotions openly, their parent will criticise them. Most of the time parents view their child as a ‘ perfect child’ until the symptoms or behaviour are noticed. If the alliance with parents is well established, they can learn to tolerate the developmentally appropriate expressions of emotions like anger in their children (Delgado, 2008).

The cognitive-behavioural therapy in working with children and young people must be adapted to child’s cognitive development, as in pacing the content and the speed of therapy at a level, which is appropriate for the child. CBT therapist needs to understand the younger child’s limitations in labelling feelings and metacognition. Most likely, with younger children the therapist will tend to be more active and use more behavioural than cognitive techniques (Bailey, 2001).

Most children have deficits in social skills or interpersonal problem solving. Social skills training and problem solving training are part of interventions used for children with conduct disorder, attention-deficit hyperactivity disorder (ADHD), empathy disorders, as well as for children with depression or anxiety (Bailey, 2001).

Adult-type CBT principles or techniques can be rapidly grasped by a bright and well-motivated adolescent, which can be rewarding for both adolescent and therapist. However, younger children may find the adult materials, such as thought diaries, beyond their cognitive abilities, unless they are modified to suit children. Developmental limitations may not develop in children until middle adolescence – which means that until then they might not be bale to reflect on hypothesis or evaluate evidence (Bailey, 2001).

Children and young adolescents might also benefit from a period of emotional education, in which they could learn about different emotional states and link emotions with thoughts and events, prior to the actual therapy (Bailey, 2001).

CBT, because of its simplicity, clarity and high validity, may give the impression of an easy therapy that might be carried out by someone with little experience or inexperienced, which certainly is not true. CBT therapist needs to be able to engage their patients in creating a collaborative working alliance in order to enable them to use the therapy effectively (Bailey, 2001).

As we can see, there are many issues that can impact the use of therapeutic skills when working with children and young people. The problems also vary

according to an approach. However, when these issues are addresses and considered carefully, counselling in any of those approaches may help young people to resolve their problems and difficulties.

References

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