DIVERSIFIED HEALTH OCCUPATIONS

Seventh Edition

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CHAPTER 8

Human Growth and Development

Chapter Objectives

After completing this chapter,
you should be able to:

Observe Standard Precautions

Instructor's Check—Call Instructor at This Point

Safety—Proceed with Caution

OBRA Requirement—Based on Federal Law

Math Skill

Legal Responsibility

Science Skill

Career Information

Communications Skill

Technology

♦ Identify at least two physical, mental, emotional, and social developments that occur during each of the seven main life stages

♦ Explain the causes and treatments for eating disorders and chemical abuse

♦ Identify methods used to prevent suicide and list common warning signs

♦ Recognize ways that life stages affect an individual's needs

♦ Describe the five stages of grieving that occur in the dying patient and the role of the health care worker during each stage

♦ List two purposes of hospice care and provide justifications for the "right to die"

♦ Create examples for each of Maslow's Hierarchy of Needs

♦ Name the two main methods people use to meet or satisfy needs

♦ Describe a situation that shows the use of each of the following defense mechanisms: rationalization, projection, displacement, compensation, daydreaming, repression, suppression, denial, and withdrawal

♦ Define, pronounce, and spell all key terms

KEY TERMS

acceptance
adolescence
affection
Alzheimer's disease *(Altz'-high-merz)*
anger
anorexia nervosa *(an-oh-rex'-see-ah ner-voh'-sah)*
arteriosclerosis *(ar-tear"-ee-oh-skleh-row'-sis)*
bargaining
bulimarexia *(byou-lee"-mah-rex'-ee-ah)*
bulimia *(byou-lee'-me-ah)*
chemical abuse
cognitive
compensation *(cahm"-pen-say'-shun)*
daydreaming
defense mechanisms

denial
depression
development
displacement
early adulthood
early childhood
emotional
esteem
growth
hospice *(hoss'-pis)*
infancy
late adulthood
late childhood
life stages
mental
middle adulthood
motivated
needs
physical

physiological needs *(fizz"-ee-oh-lodg'-ih-kal)*
projection
puberty *(pew'-burr"-tee)*
rationalization *(rash"-en-nal-ih-zay'-shun)*
repression
right to die
safety
satisfaction
self-actualization
sexuality
social
suicide
suppression
tension
terminal illness
withdrawal

INTRODUCTION

Human growth and development is a process that begins at birth and does not end until death. **Growth** refers to the measurable physical changes that occur throughout a person's life. Examples include height, weight, body shape, head circumference, physical characteristics, development of sexual organs, and dentition (dental structure). **Development** refers to the changes in intellectual, mental, emotional, social, and functional skills that occur over time. Development is more difficult to measure, but usually proceeds from simple to complex tasks as maturation, or the process of becoming fully grown and developed, occurs. During all stages of growth and development, individuals have certain tasks that must be accomplished and needs that must be met. A health care worker must be aware of the various life stages and of individual needs to provide quality health care (figure 8-1).

8:1 INFORMATION

Life Stages

Even though individuals differ greatly, each person passes through certain stages of growth and development from birth to death. These stages are frequently called **life stages.** A common method of classifying life stages is as follows:

♦ **Infancy:** birth to 1 year
♦ **Early childhood:** 1–6 years
♦ **Late childhood:** 6–12 years
♦ **Adolescence:** 12–18 years
♦ **Early adulthood:** 19–40 years
♦ **Middle adulthood:** 40–65 years
♦ **Late adulthood:** 65 years and older

As individuals pass through these life stages, four main types of growth and development

FIGURE 8-1 An understanding of life stages is important for the health care worker, who may provide care to individuals of all ages; from the very young (left) to the elderly (right).

occur: physical, mental or cognitive, emotional, and social. **Physical** refers to body growth and includes height and weight changes, muscle and nerve development, and changes in body organs. **Mental** or **cognitive** refers to intellectual development and includes learning how to solve problems, make judgments, and deal with situations. **Emotional** refers to feelings and includes dealing with love, hate, joy, fear, excitement, and other similar feelings. **Social** refers to interactions and relationships with other people.

Each stage of growth and development has its own characteristics and has specific developmental tasks that an individual must master. These tasks progress from the simple to the more complex. For example, an individual first learns to sit, then crawl, then stand, then walk, and then, finally, run. Each stage establishes the foundation for the next stage. In this way, growth and development proceeds in an orderly pattern. It is important to remember, however, that the rate of progress varies among individuals. Some children master speech early, others master it later. Similarly, an individual may experience a sudden growth spurt and then maintain the same height for a period of time.

Erik Erikson, a psychoanalyst, has identified eight stages of psychosocial development. His eight stages of development, the basic conflict or need that must be resolved at each stage, and ways to resolve the conflict are shown in table 8-1. Erikson believes that if an individual is not able to resolve a conflict at the appropriate stage, the individual will struggle with the same conflict later in life. For example, if a toddler is not allowed

to learn and become independent by mastering basic tasks, the toddler may develop a sense of doubt in his or her abilities. This sense of doubt will interfere with later attempts at mastering independence.

Health care providers must understand that each life stage creates certain needs in individuals. Likewise, other factors can affect life stages and needs. An individual's sex, race, heredity (factors inherited from parents, such as hair color and body structure) culture, life experiences, and health status can influence needs. Injury or illness usually has a negative effect and can change needs or impair development.

INFANCY

Physical Development

The most dramatic and rapid changes in growth and development occur during the first year of life. A newborn baby usually weighs approximately 6–8 pounds (2.7–3.6 kg) and measures 18–22 inches (46–55 cm) (figure 8-2). By the end of the first year of life, weight has usually tripled, to 21–24 pounds (9.5–11 kg), and height has increased to approximately 29–30 inches (74–76 cm).

Muscular system and nervous system developments are also dramatic. The muscular and nervous systems are very immature at birth. Certain reflex actions present at birth allow the infant to respond to the environment. These include the Moro, or startle, reflex to a loud noise or sudden

TABLE 8-1 Erikson's Eight Stages of Psychosocial Development

STAGE OF DEVELOPMENT	BASIC CONFLICT	MAJOR LIFE EVENT	WAYS TO RESOLVE CONFLICT
Infancy Birth to 1 Year Oral–Sensory	Trust versus Mistrust	Feeding	Infant develops trust in self, others, and the environment when caregiver is responsive to basic needs and provides comfort; if needs are not met, infant becomes uncooperative and aggressive, and shows a decreased interest in the environment
Toddler 1–3 Years Muscular–Anal	Autonomy versus Shame/Doubt	Toilet Training	Toddler learns control while mastering skills such as feeding, toileting, and dressing when caregivers provide reassurance but avoid overprotection; if needs are not met, toddler feels ashamed and doubts own abilities, which leads to lack of self-confidence in later stages
Preschool 3–6 Years Locomotor	Initiative versus Guilt	Independence	Child begins to initiate activities in place of just imitating activities; uses imagination to play; learns what is allowed and what is not allowed to develop a conscience; caregivers must allow child to be responsible while providing reassurance; if needs are not met, child feels guilty and thinks everything he or she does is wrong, which leads to a hesitancy to try new tasks in later stages
School-Age 6–12 Years Latency	Industry versus Inferiority	School	Child becomes productive by mastering learning and obtaining success; child learns to deal with academics, group activities, and friends when others show acceptance of actions and praise success; if needs are not met, child develops a sense of inferiority and incompetence, which hinders future relationships and the ability to deal with life events
Adolescence 12–18 Years	Identity versus Role Confusion	Peer	Adolescent searches for self-identity by making choices about occupation, sexual orientation, lifestyle, and adult role; relies on peer group for support and reassurance to create a self-image separate from parents; if needs are not met, adolescent experiences role confusion and loss of self-belief
Young Adulthood 19–40 Years	Intimacy versus Isolation	Love Relationships	Young adult learns to make a personal commitment to others and share life events with others; if self-identity is lacking, adult may fear relationships and isolate self from others
Middle Adulthood 40–65 Years	Generativity versus Stagnation	Parenting	Adult seeks satisfaction and obtains success in life by using career, family, and civic interests to provide for others and the next generation; if adult does not deal with life issues, feels lack of purpose to life and sense of failure
Older Adulthood 65 Years to Death	Ego Integrity versus Despair	Reflection on and Acceptance of Life	Adult reflects on life in a positive manner, feels fulfillment with his or her own life and accomplishments, deals with losses, and prepares for death; if fulfillment is not felt, adult feels despair about life and fear of death

FIGURE 8-2 A newborn baby usually weighs approximately 6–8 pounds and measures 18–22 inches in length.

movement; the rooting reflex, in which a slight touch on the cheek causes the mouth to open and the head to turn; the sucking reflex, caused by a slight touch on the lips; and the grasp reflex, in which infants can grasp an object placed in the hand. Muscle coordination develops in stages. At first, infants are able to lift the head slightly. By 2–4 months, they can usually roll from side to back, support themselves on their forearms when prone, and grasp or try to reach objects. By 4–6 months, they can turn the body completely around, accept objects handed to them, grasp stationary objects such as a bottle, and with support, hold the head up while sitting. By 6–8 months, infants can sit unsupported, grasp moving objects, transfer objects from one hand to the other, and crawl on the stomach. By 8–10 months, they can crawl using their knees and hands, pull themselves to a sitting or standing position, and use good hand–mouth coordination to put things in their mouths. By 12 months, infants frequently can walk without assistance, grasp objects with the thumb and fingers, and throw small objects.

Other physical developments are also dramatic. Most infants are born without teeth, but usually have 10–12 teeth by the end of the first year of life. At birth, vision is poor and may be limited to black and white, and eye movements are not coordinated. By 1 year of age, however, close vision is good, in color, and can readily focus on small objects. Sensory abilities such as those of smell, taste, sensitivity to hot and cold, and hearing, while good at birth, become more refined and exact.

Mental Development

Mental development is also rapid during the first year. Newborns respond to discomforts such as pain, cold, or hunger by crying. As their needs are met, they gradually become more aware of their surroundings and begin to recognize individuals associated with their care. As infants respond to stimuli in the environment, learning activities grow. At birth, they are unable to speak. By 2–4 months, they coo or babble when spoken to, laugh out loud, and squeal with pleasure. By 6 months of age, infants understand some words and can make basic sounds, such as "mama" and "dada." By 12 months, infants understand many words and use single words in their vocabularies.

Emotional Development

Emotional development is observed early in life. Newborns show excitement. By 4–6 months of age, distress, delight, anger, disgust, and fear can often be seen. By 12 months of age, elation and affection for adults is evident. Events that occur in the first year of life when these emotions are first exhibited can have a strong influence on an individual's emotional behavior during adulthood.

Social Development

Social development progresses gradually from the self-centeredness concept of the newborn to the recognition of others in the environment. By 4 months of age, infants recognize their caregivers, smile readily, and stare intently at others (figure 8-3). By 6 months of age, infants watch the activities of others, show signs of possessiveness, and may become shy or withdraw when in the presence of strangers. By 12 months of age, infants may still be shy with strangers, but they socialize freely with familiar people, and mimic and imitate gestures, facial expressions, and vocal sounds.

FIGURE 8-3 By 4 months of age, infants recognize their caregivers and stare intently at others.

FIGURE 8-4 One to two-year-olds are interested in many different activities, but they have short attention spans.

Needs

Infants are dependent on others for all needs. Food, cleanliness, and rest are essential for physical growth. Love and security are essential for emotional and social growth. Stimulation is essential for mental growth.

EARLY CHILDHOOD

Physical Development

During early childhood, from 1–6 years of age, physical growth is slower than during infancy. By age 6, the average weight is 45 pounds (20.4 kg), and the average height is 46 inches (116 cm). Skeletal and muscle development helps the child assume a more adult appearance. The legs and lower body tend to grow more rapidly than do the head, arms, and chest. Muscle coordination allows the child to run, climb, and move freely. As muscles of the fingers develop, the child learns to write, draw, and use a fork and knife. By age 2 or 3, most teeth have erupted, and the digestive system is mature enough to handle most adult foods. Between 2 and 4 years of age, most children learn bladder and bowel control.

Mental Development

Mental development advances rapidly during early childhood. Verbal growth progresses from the use of several words at age 1 to a vocabulary of 1,500–2,500 words at age 6. Two-year-olds have short attention spans but are interested in many different activities (figure 8-4). They can remember details and begin to understand concepts. Four-year-olds ask frequent questions and usually recognize letters and some words. They begin to make decisions based on logic rather than on trial and error. By age 6, children are very verbal and want to learn how to read and write. Memory has developed to the point where the child can make decisions based on both past and present experiences.

Emotional Development

Emotional development also advances rapidly. At ages 1–2, children begin to develop self-awareness and to recognize the effect they have on other people and things. Limits are usually established for safety, leading the 1- or 2-year-old to either accept or defy such limits. By age 2, most children begin to gain self-confidence and are enthusiastic about learning new things (figure 8-5). However, children can feel impatient and frustrated as they try to do things beyond their abilities. Anger, often in the form of "temper tantrums," occurs when they cannot perform as desired. Children at this age also like routine and become stubborn, angry, or frustrated when changes occur. From ages 4–6, children begin to gain more control over their emotions. They understand the concept of right and wrong, and because they have achieved more independence, they are not frustrated as much by their lack of ability. By age 6, most children also show less anxiety when faced with new experiences, because they have learned they can deal with new situations.

FIGURE 8-5 By age two, most children begin to gain some self-confidence and are enthusiastic about learning new things.

FIGURE 8-6 Playing alongside and with other children allows preschoolers to learn how to interact with others.

Social Development

Social development expands from a self-centered 1-year-old to a sociable 6-year-old. In the early years, children are usually strongly attached to their parents (or to the individuals who provide their care), and they fear any separation. They begin to enjoy the company of others, but are still very possessive. Playing alongside other children is more common than playing with other children (figure 8-6). Gradually, children learn to put "self" aside and begin to take more of an interest in others. They learn to trust other people and make more of an effort to please others by becoming more agreeable and social. Friends of their own age are usually important to 6-year-olds.

Needs

The needs of early childhood still include food, rest, shelter, protection, love, and security. In addition, children need routine, order, and consistency in their daily lives. They must be taught to be responsible and must learn how to conform to rules. This can be accomplished by making reasonable demands based on the child's ability to comply.

LATE CHILDHOOD

Physical Development

The late childhood life stage, which covers ages 6–12, is also called *preadolescence.* Physical development is slow but steady. Weight gain averages 4–7 pounds (2.3–3.2 kg) per year, and height usually increases approximately 2–3 inches (5–7.5 cm) per year. Muscle coordination is well developed, and children can engage in physical activities that require complex motor-sensory coordination. During this age, most of the primary teeth are lost, and permanent teeth erupt. The eyes are well developed, and visual acuity is at its best. During ages 10–12, secondary sexual characteristics may begin to develop in some children.

Mental Development

Mental development increases rapidly because much of the child's life centers around school. Speech skills develop more completely, and reading and writing skills are learned. Children learn to use information to solve problems, and the memory becomes more complex. They begin to understand more abstract concepts such as loyalty, honesty, values, and morals. Children use more active thinking and become more adept at making judgments (figure 8-7).

FIGURE 8-7 In late childhood (ages 6–12), children become more adept at making judgments.

Emotional Development

Emotional development continues to help the child achieve a greater independence and a more distinct personality. At age 6, children are often frightened and uncertain as they begin school. Reassuring parents and success in school help children gain self-confidence. Gradually, fears are replaced by the ability to cope. Emotions are slowly brought under control and dealt with in a more effective manner. By ages 10–12, sexual maturation and changes in body functions can lead to periods of depression followed by periods of joy. These emotional changes can cause children to be restless, anxious, and difficult to understand.

Social Development

Social changes are evident during these years. Seven-year-olds tend to like activities they can do by themselves and do not usually like group activities. However, they want the approval of others, especially their parents and friends. Children from ages 8–10 tend to be more group oriented, and they typically form groups with members of their own sex. They are more ready to accept the opinions of others and learn to conform to rules and standards of behavior followed by the group. Toward the end of this period, chil-dren tend to make friends more easily, and they begin to develop an increasing awareness of the opposite sex. As children spend more time with others their own age, their dependency on their parent(s) lessens, as does the time they spend with their parents.

Needs

Needs of children in this age group include the same basic needs of infancy and early childhood, together with the need for reassurance, parental approval, and peer acceptance.

ADOLESCENCE

Physical Development

Adolescence, ages 12 to 18, is often a traumatic life stage. Physical changes occur most dramatically in the early period. A sudden "growth spurt" can cause rapid increases in weight and height. A weight gain of up to 25 pounds (11 kg) and a height increase of several inches can occur in a period of months. Muscle coordination does not advance as quickly. This can lead to awkwardness or clumsiness in motor coordination. This growth spurt usually occurs anywhere from ages 11 to 13 in girls and ages 13 to 15 in boys.

The most obvious physical changes in adolescents relate to the development of the sexual organs and secondary sexual characteristics, frequently called **puberty.** Secretion of sex hormones leads to the onset of menstruation in girls and the production of sperm and semen in boys. Secondary sexual characteristics in females include growth of pubic hair, development of breasts and wider hips, and distribution of body fat leading to the female shape. The male develops a deeper voice; attains more muscle mass and broader shoulders; and grows pubic, facial, and body hair.

Mental Development

Since most of the foundations have already been established, mental development primarily involves an increase in knowledge and a sharpening of skills. Adolescents learn to make decisions and to accept responsibility for their actions. At times, this causes conflict because they are

treated as both children and adults, or are told to "grow up" while being reminded that they are "still children."

Emotional Development

Emotional development is often stormy and in conflict. As adolescents try to establish their identities and independence, they are often uncertain and feel inadequate and insecure. They worry about their appearance, their abilities, and their relationships with others. They frequently respond more and more to peer group influences. At times, this leads to changes in attitude and behavior and conflict with values previously established. Toward the end of adolescence, self-identity has been established. At this point, teenagers feel more comfortable with who they are and turn attention toward what they may become. They gain more control of their feelings and become more mature emotionally.

Social Development

Social development usually involves spending less time with family and more time with peer groups. As adolescents attempt to develop self-identity and independence, they seek security in groups of people their own age who have similar problems and conflicts (figure 8-8). If these peer relationships help develop self-confidence through the approval of others, adolescents become more secure and satisfied. Toward the end of this life stage, adolescents develop a more mature attitude and begin to develop patterns of

FIGURE 8-8 Adolescents use the peer group as a safety net as they try to establish their identities and independence.

behavior that they associate with adult behavior or status.

Needs

In addition to basic needs, adolescents need reassurance, support, and understanding. Many problems that develop during this life stage can be traced to the conflict and feelings of inadequacy and insecurity that adolescents experience. Examples include eating disorders, drug and alcohol abuse, and suicide. Even though these types of problems also occur in earlier and later life stages, they are frequently associated with adolescence.

Eating disorders often develop from an excessive concern with appearance. Two common eating disorders are anorexia nervosa and bulimia. **Anorexia nervosa,** commonly called *anorexia,* is a psychological disorder in which a person drastically reduces food intake or refuses to eat at all. This results in metabolic disturbances, excessive weight loss, weakness, and if not treated, death. **Bulimia** is a psychological disorder in which a person alternately binges (eats excessively) and then fasts, or refuses to eat at all. When a person induces vomiting or uses laxatives to get rid of food that has been eaten, the condition is called **bulimarexia.** All three conditions are more common in female than male individuals. Psychological or psychiatric help is usually needed to treat these conditions.

Chemical abuse is the use of substances such as alcohol or drugs and the development of a physical and/or mental dependence on these chemicals. Chemical abuse can occur in any life stage, but it frequently begins in adolescence. Reasons for using chemicals include anxiety or stress relief, peer pressure, escape from emotional or psychological problems, experimentation with feelings the chemicals produce, desire for "instant gratification," hereditary traits, and cultural influences. Chemical abuse can lead to physical and mental disorders and disease. Treatment is directed toward total rehabilitation that allows the chemical abuser to return to a productive and meaningful life.

Suicide, found in many life stages, is one of the leading causes of death in adolescents. Suicide is always a permanent solution to a temporary problem. Reasons for suicide include depression, grief over a loss or love affair, failure in school, inability to meet expectations, influ-

ence of suicidal friends, or lack of self-esteem. The risk for suicide increases with a family history of suicide, a major loss or disappointment, previous suicide attempts, and/or the recent suicide of friends, family, or role models (heroes or idols). The impulsive nature of adolescents also increases the possibility of suicide. Most individuals who are thinking of suicide give warning signs such as verbal statements like "I'd rather be dead" or "You'd be better off without me." Other warning signs include:

♦ sudden changes in appetite and sleep habits

♦ withdrawal, depression, and moodiness

♦ excessive fatigue or agitation

♦ neglect of personal hygiene

♦ alcohol or drug abuse

♦ losing interest in hobbies and other aspects of life

♦ preoccupation with death

♦ injuring one's body

♦ giving away possessions

♦ social withdrawal from family and friends

These individuals are calling out for attention and help, and usually respond to efforts of assistance. Their direct and indirect pleas should never be ignored. Support, understanding, and psychological or psychiatric counseling are used to prevent suicide.

EARLY ADULTHOOD

Physical Development

Early adulthood, ages 19–40, is frequently the most productive life stage. Physical development is basically complete, muscles are developed and strong, and motor coordination is at its peak. This is also the prime childbearing time and usually produces the healthiest babies (figure 8-9). Both male and female sexual development is at its peak.

Mental Development

Mental development usually continues throughout this stage. Many young adults pursue additional education to establish and progress in their chosen careers. Frequently, formal education

FIGURE 8-9   Early adulthood is the prime childbearing time and usually produces the healthiest babies.

continues for many years. The young adult often also deals with independence, makes career choices, establishes a lifestyle, selects a marital partner, starts a family, and establishes values, all of which involve making many decisions and forming many judgments.

Emotional Development

Emotional development usually involves preserving the stability established during previous stages. Young adults are subjected to many emotional stresses related to career, marriage, family, and other similar situations. If emotional structure is strong, most young adults can cope with these worries. They find satisfaction in their achievements, take responsibility for their actions, and learn to accept criticism and to profit from mistakes.

Social Development

Social development frequently involves moving away from the peer group. Instead, young adults tend to associate with others who have similar ambitions and interests, regardless of age. The young adult often becomes involved with a mate and forms a family. Young adults do not necessarily accept traditional sex roles and frequently adopt nontraditional roles. For example, male individuals fill positions as nurses and secretaries, and female individuals enter administrative or construction positions. Such choices have caused and will continue to cause changes in the traditional patterns of society.

MIDDLE ADULTHOOD

Physical Development

Middle adulthood, ages 40–65, is frequently called *middle age.* Physical changes begin to occur during these years. The hair tends to gray and thin, the skin begins to wrinkle, muscle tone tends to decrease, hearing loss starts, visual acuity declines, and weight gain occurs. Women experience *menopause,* or the end of menstruation, along with decreased hormone production that causes physical and emotional changes. Men also experience a slowing of hormone production. This can lead to physical and psychological changes, a period frequently referred to as the *male climacteric.* However, except in cases of injury, disease, or surgery, men never lose the ability to produce sperm or to reproduce.

Mental Development

Mental ability can continue to increase during middle age, a fact that has been proved by the many individuals in this life stage who seek formal education. Middle adulthood is a period when individuals have acquired an understanding of life and have learned to cope with many different stresses. This allows them to be more confident in making decisions and to excel at analyzing situations.

FIGURE 8-10 Job stability and enjoyment during middle adulthood contribute to emotional satisfaction.

Emotional Development

Emotionally, middle age can be a period of contentment and satisfaction, or it can be a time of crisis. The emotional foundation of previous life stages and the situations that occur during middle age determine emotional status during this period. Job stability, financial success, the end of child rearing, and good health can all contribute to emotional satisfaction (figure 8-10). Stress, created by loss of job, fear of aging, loss of youth and vitality, illness, marital problems, or problems with children or aging parents, can contribute to emotional feelings of depression, insecurity, anxiety, and even anger. Therefore, emotional status varies in this age group and is largely determined by events that occur during this period.

Social Development

Social relationships also depend on many factors. Family relationships often see a decline as children begin lives of their own and parents die. Work relationships frequently replace family. Relationships between husband and wife can become stronger as they have more time together and opportunities to enjoy success. However, divorce rates are also high in this age group, as couples who have remained together "for the children's sake" now separate. Friendships are usually with people who have the same interests and lifestyles.

LATE ADULTHOOD

Physical Development

Late adulthood, age 65 and older, has many different terms associated with it. These include "elderly," "senior citizen," "golden ager," and "retired citizen." Much attention has been directed toward this life stage in recent years because people are living longer, and the number of people in this age group is increasing daily.

Physical development is on the decline. All body systems are usually affected. The skin becomes dry, wrinkled, and thinner. Brown or yellow spots (frequently called "age spots") appear. The hair becomes thin and frequently loses its luster or shine. Bones become brittle and porous, and are more likely to fracture or break. Cartilage between the vertebrae thins and can

lead to a stooping posture. Muscles lose tone and strength, which can lead to fatigue and poor coordination. A decline in the function of the nervous system leads to hearing loss, decreased visual acuity, and decreased tolerance for temperatures that are too hot or too cold. Memory loss can occur, and reasoning ability can diminish. The heart is less efficient, and circulation decreases. The kidney and bladder are less efficient. Breathing capacity decreases and causes shortness of breath. However, it is important to note that these changes usually occur slowly over a long period. Many individuals, because of better health and living conditions, do not show physical changes of aging until their seventies and even eighties.

Mental Development

Mental abilities vary among individuals. Elderly people who remain mentally active and are willing to learn new things tend to show fewer signs of decreased mental ability (figure 8-11). Although some 90-year-olds remain alert and well oriented, other elderly individuals show decreased mental capacities at much earlier ages. Short-term memory is usually first to decline. Many elderly individuals can clearly remember events that occurred 20 years ago, but do not remember yesterday's events. Diseases such as **Alzheimer's disease** can lead to irreversible loss of memory, deterioration of intellectual functions, speech and gait disturbances, and disorientation. **Arteriosclerosis,** a thickening and hardening of the walls of the arteries, can also decrease the blood supply to the brain and cause a decrease in mental

abilities. These diseases are discussed in greater detail in Chapter 10:4.

Emotional Development

Emotional stability also varies among individuals in this age group. Some elderly people cope well with the stresses presented by aging and remain happy and able to enjoy life. Others become lonely, frustrated, withdrawn, and depressed. Emotional adjustment is necessary throughout this cycle. Retirement, death of a spouse and friends, physical disabilities, financial problems, loss of independence, and knowledge that life must end all can cause emotional distress. The adjustments that the individual makes during this life stage are similar to those made throughout life.

Social Development

Social adjustment also occurs during late adulthood. Retirement can lead to a loss of self-esteem, especially if work is strongly associated with self-identity: "I am a teacher," instead of "I am Sandra Jones." Less contact with coworkers and a more limited circle of friends usually occur. Many elderly adults engage in other activities and continue to make new social contacts (figure 8-12). Others limit their social relationships. Death of a spouse and friends, and moving to a new environment can also cause changes in social rela-

FIGURE 8-11 Elderly adults who are willing to learn new things show fewer signs of decreased mental ability.

FIGURE 8-12 Social contacts and activities are important during late adulthood.

tionships. Development of new social contacts is important at this time. Senior centers, golden age groups, churches, and many other organizations help provide the elderly with the opportunity to find new social roles.

Needs

Needs of this life stage are the same as those of all other life stages. In addition to basic needs, the elderly need a sense of belonging, self-esteem, financial security, social acceptance, and love.

STUDENT: *Go to the workbook and complete the assignment sheet for 8:1, Life Stages.*

8:2 INFORMATION

Death and Dying

Death is often referred to as "the final stage of growth." It is experienced by everyone and cannot be avoided. In our society, the young tend to ignore its existence. It is usually the elderly, having lost spouses and/or friends, who begin to think of their own deaths.

When a patient is told that he or she has a **terminal illness,** a disease that cannot be cured and will result in death, the patient may react in different ways. Some patients react with fear and anxiety. They fear pain, abandonment, and loneliness. They fear the unknown. They become anxious about their loved ones and about unfinished work or dreams. Anxiety diminishes in patients who feel they have had full lives and who have strong religious beliefs regarding life after death. Some patients view death as a final peace. They know it will bring an end to loneliness, pain, and suffering.

STAGES OF DYING AND DEATH

Dr. Elizabeth Kübler-Ross has done extensive research on the process of death and dying, and is known as a leading expert on this topic. Because of her research, most medical personnel now believe patients should be told of their approaching deaths. However, patients should be left with "some hope" and the knowledge that they will "not be left alone." It is important that all staff

members who provide care to the dying patient know both the extent of information given to the patient and how the patient reacted.

Dr. Kübler-Ross has identified five stages of grieving that dying patients and their families/friends may experience in preparation for death. The stages may not occur in order, and they may overlap or be repeated several times. Some patients may not progress through all of the stages before death occurs. Other patients may be in several stages at the same time. The stages are denial, anger, bargaining, depression, and acceptance.

Denial is the "No, not me!" stage, which usually occurs when a person is first told of a terminal illness. It occurs when the person cannot accept the reality of death or when the person feels loved ones cannot accept the truth. The person may make statements such as "The doctor does not know what he is talking about" or "The tests have to be wrong." Some patients seek second medical opinions or request additional tests. Others refuse to discuss their situations and avoid any references to their illnesses. It is important for patients to discuss these feelings. The health care worker should listen to a patient and try to provide support without confirming or denying. Statements such as "It must be hard for you" or "You feel additional tests will help?" will allow the patient to express feelings and move on to the next stage.

Anger occurs when the patient is no longer able to deny death. Statements such as "Why me?" or "It's your fault" are common. Patients may strike out at anyone who comes in contact with them and become hostile and bitter. They may blame themselves, their loved ones, or health care personnel for their illnesses. It is important for the health care worker to understand that this anger is not a personal attack; the anger is caused by the situation the patient is experiencing. Providing understanding and support, listening, and making every attempt to respond to the patient's demands quickly and with kindness is essential during this stage. This stage continues until the anger is exhausted or the patient must attend to other concerns.

Bargaining occurs when patients accept death but want more time to live. Frequently, this is a period when patients turn to religion and spiritual beliefs. At this point, the will to live is strong, and patients fight hard to achieve goals set. They want to see their children graduate or get married, they want time to arrange care for

their families, they want to hold new grandchildren, or other similar desires. Patients make promises to God to obtain more time. Health care workers must again be supportive and be good listeners. Whenever possible, they should help patients meet their goals.

Depression occurs when patients realize that death will come soon and they will no longer be with their families or be able to complete their goals. They may express these regrets, or they may withdraw and become quiet (figure 8-13). They experience great sadness and, at times, overwhelming despair. It is important for health care workers to let patients know that it is "OK" to be depressed. Providing quiet understanding, support, and/or a simple touch, and allowing patients to cry or express grief are important during this stage.

Acceptance is the final stage. Patients understand and accept the fact that they are going to die. Patients may complete unfinished business and try to help those around them deal with the oncoming death. Gradually, patients separate themselves from the world and other people. At the end, they are at peace and can die with dignity. During this final stage, patients still need emotional support and the presence of others, even if it is just the touch of a hand (figure 8-14).

HOSPICE CARE

Providing care to dying patients can be very difficult, but very rewarding. Providing supportive care when families and patients require it most

FIGURE 8-13 Depression can be a normal stage of grieving in a dying patient.

FIGURE 8-14 The support and presence of others is important to the dying person.

can be one of the greatest satisfactions a health care worker can experience. To be able to provide this care, however, health care workers must first understand their own personal feelings about death and come to terms with these feelings. Feelings of fear, frustration, and uncertainty about death can cause workers to avoid dying patients or provide superficial, mechanical care. With experience, health care workers can find ways to deal with their feelings and learn to provide the supportive care needed by the dying.

Hospice care can play an important role in meeting the needs of the dying patient. Hospice care offers *palliative care,* or care that provides support and comfort. It can be offered in hospitals, medical centers, and special facilities, but most frequently it is offered in the patient's home. Hospice care is not limited to a specific time period in a patient's life. Usually it is not started until a physician declares that the patient has 6 months or less to live, but it can be started sooner. Most often patients and their families are reluctant to begin hospice care because they feel that this action recognizes the end of life. They seem to feel that if they do not use hospice care until later, death will not be as near as it actually is. The philosophy behind hospice care is to allow the patient to die with dignity and comfort. Using palliative measures of care and the philosophy of death with dignity provides patients and families with many comforts and provides an opportunity to find closure. Some of the comforts provided by hospice may include providing hospital equipment such as beds, wheelchairs, and bedside

commodes; offering psychological, spiritual, social, and financial counseling; and providing free or less expensive pain medication. Pain is controlled so that the patient can remain active as long as possible. In medical facilities, personal care of the patient is provided by the staff; in the home situation, this care is provided by home health aides and other health care professionals. Specially trained volunteers are an important part of many hospice programs. They make regular visits to the patient and family, stay with the patient while the family leaves the home for brief periods of time, and help provide the support and understanding that the patient and family need. When the time for death arrives, the patient is allowed to die with dignity and in peace. After the death of the patient, hospice personnel often maintain contact with the family during the initial period of mourning.

RIGHT TO DIE

The **right to die** is another issue that health care workers must understand. Because health care workers are ethically concerned with promoting life, allowing patients to die can cause conflict. However, a large number of surveys have shown that most people feel that an individual who has a terminal illness, with no hope of being cured, should be allowed to refuse measures that would prolong life. This is called the *right to die.* Most states have passed, or are now creating, laws that allow adults who have terminal illnesses to instruct their doctors, in writing, to withhold treatments that might prolong life. Most of the laws involve the use of advance directives, discussed in Chapter 5:4. Under these laws, specific actions to end life cannot be taken. However, the use of respirators, pacemakers, and other medical devices can be withheld, and the person can be allowed to die with dignity.

Hospices throughout the nation are encouraging individuals to make their end-of-life wishes known through the *LIVE* promise. This promise encourages individuals to:

♦ **L**earn about end-of-life services and care

♦ **I**mplement plans or advanced directives to ensure wishes are honored

♦ **V**oice decisions

♦ **E**ngage others in conversations about end-of-life care options

Health care workers must be aware that a dying person has rights that must be honored. A Dying Person's Bill of Rights was created at a workshop sponsored by the South Western Michigan Inservice Education Council. This bill of rights states:

♦ I have the right to be treated as a living human being until I die.

♦ I have the right to maintain a sense of hopefulness, however changing its focus may be.

♦ I have the right to be cared for by those who can maintain a sense of hopefulness, however challenging this might be.

♦ I have the right to express my feelings and emotions about my approaching death in my own way.

♦ I have the right to participate in decisions concerning my care.

♦ I have the right to expect continuing medical and nursing attention even though "cure" goals must be changed to "comfort" goals.

♦ I have the right not to die alone.

♦ I have the right to be free from pain.

♦ I have the right to have my questions answered honestly.

♦ I have the right not to be deceived.

♦ I have the right to have help from and for my family in accepting my death.

♦ I have the right to die in peace and with dignity.

♦ I have the right to maintain my individuality and not be judged for my decisions, which may be contrary to the beliefs of others.

♦ I have the right to expect that the sanctity of the human body will be respected after death.

♦ I have the right to be cared for by caring, sensitive, knowledgeable people who will attempt to understand my needs and will be able to gain some satisfaction in helping me face my death.

♦ I have the right to discuss and enlarge my religious and/or spiritual experiences, whatever these may mean to others.

Health care workers deal with death and with dying patients because death is a part of life. By understanding the process of death and by think-

ing about the needs of dying patients, the health care worker will be able to provide the special care needed by these individuals.

STUDENT: *Go to the workbook and complete the assignment sheet for 8:2, Death and Dying.*

8:3 INFORMATION

Human Needs

Needs are frequently defined as "a lack of something that is required or desired." From the moment of birth to the moment of death, every human being has needs. Needs motivate the individual to behave or act so that these needs will be met, if at all possible.

Certain needs have priority over other needs. For example, at times a need for food may take priority over a need for social approval, or the approval of others. If individuals have been without food for a period of time, they will direct most of their actions toward obtaining food. Even though they want social approval and the respect of others, they may steal for food, knowing that stealing may cause a loss of social approval or respect.

MASLOW'S HIERARCHY OF NEEDS

Abraham Maslow, a noted psychologist, developed a hierarchy of needs (figure 8-15). According to Maslow, the lower needs should be met before an individual can strive to meet higher needs. Only when satisfaction has been obtained at one level is an individual motivated toward meeting needs at a higher level. The levels of needs include physiological needs, safety, affection, esteem, and self-actualization.

Physiological Needs

Physiological needs are often called "physical," "biological," or "basic" needs. These needs are required by every human being to sustain life. They include food, water, oxygen, elimination of waste materials, sleep, and protection from extreme temperatures. These needs must be met for life to continue. If any of these needs goes unmet, death will occur. Even among these needs, a priority exists. For example, because lack of oxygen will cause death in a matter of minutes, the need for oxygen has priority over the need for
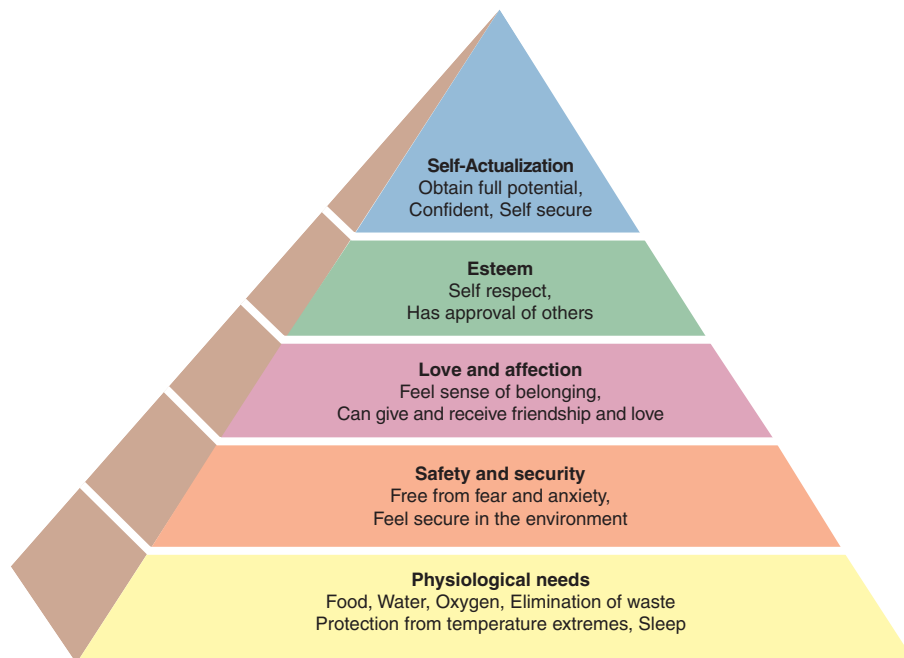
FIGURE 8-15 Maslow's Hierarchy of Needs: the lower needs should be met before the individual can try to meet higher needs.

food. A patient with severe lung disease who is gasping for every breath will not be concerned with food intake. This individual's main concern will be to obtain enough oxygen to live through the next minute.

Other physiological needs include sensory and motor needs. If these needs are not met, individuals may not die, but their body functions will be affected. Sensory needs include hearing, seeing, feeling, smelling, tasting, and mental stimulation. When these needs are met, they allow the individual to respond to the environment. If these needs are not met, the person may lose contact with the environment or with reality. An example is motor needs, which include the ability to move and respond to the individual's environment. If muscles are not stimulated, they will atrophy (waste away), and function will be lost.

Many of the physiological needs are automatically controlled by the body. The process of breathing is usually not part of the conscious thought process of the individual until something occurs to interfere with breathing. Another example is the functioning of the urinary bladder. The bladder fills automatically, and the individual only becomes aware of the bladder when it is full. If the individual does not respond and go to the restroom to empty the bladder, eventually control will be lost and the bladder will empty itself.

Health care workers must be aware of how an illness interferes with meeting physiological needs. A patient scheduled for surgery or laboratory tests may not be allowed to eat or drink before the procedure. Anxiety about an illness may interfere with a patient's sleep or elimination patterns. Medications may affect a patient's appetite. Elderly individuals are even more likely to have difficulty meeting physiological needs. A loss of vision or hearing due to aging may make it difficult for an elderly person to communicate with others. A decreased sense of smell and taste can affect appetite. Deterioration of muscles and joints can lead to poor coordination and difficulty in walking. Any of these factors can cause a change in a person's behavior. If health care workers are aware that physiological needs are not being met, they can provide understanding and support to the patient and make every effort to help the patient satisfy the needs.

Safety

Safety becomes important when physiological needs have been met. Safety needs include the need to be free from anxiety and fear, and the need to feel secure in the environment. The need for order and routine is another example of an individual's effort to remain safe and secure. Individuals often prefer the familiar over the unknown. New environments, a change in routine, marital problems, job loss, injury, disease, and other similar events can threaten an individual's safety.

Illness is a major threat to an individual's security and well-being. Health care workers are familiar with laboratory tests, surgeries, medications, and therapeutic treatments. Patients are usually frightened when they are exposed to them and their sense of security is threatened. If health care workers explain the reason for the tests or treatments and the expected outcomes to the patient, this can frequently alleviate the patient's anxieties. Patients admitted to a health care facility or long-term care facility must adapt to a strange and new environment. They frequently experience anxiety or depression. Patients may also experience depression over the loss of health or loss of a body function. Health care workers must be aware of the threats to safety and security that patients are experiencing, and make every effort to explain procedures, provide support and understanding, and help patients adapt to the situation.

Love and Affection

The need for love and **affection,** a warm and tender feeling for another person, occupies the third level of Maslow's Hierarchy of Needs. When an individual feels safe and secure, and after all physiological needs have been met, the individual next strives for social acceptance, friendship, and to be loved. The need to belong, to relate to others, and to win approval of others motivates an individual's actions at this point. The individual may now attend a social function that was avoided when safety was more of a priority. Individuals who feel safe and secure are more willing to accept and adapt to change and are more willing to face unknown situations. The need for love and affection is satisfied when friends are made, social contacts are established, acceptance by

others is received, and the individual is able to both give and receive affection and love (figure 8-16).

Maslow states that sexuality is both a part of the need for love and affection, as well as a physiological need. **Sexuality** in this context is defined by people's feelings concerning their masculine/feminine natures, their abilities to give and receive love and affection, and finally, their roles in reproduction of the species. It is important to note that in all three of these areas, sexuality involves a person's feelings and attitudes, not just the person's sexual relationships.

It is equally important to note that a person's sexuality extends throughout the life cycle. At conception, a person's sexual organs are determined. Following birth, a person is given a name, at least generally associated with the person's sex. Studies have shown that children receive treatment according to gender from early childhood and frequently are rewarded for behavior that is deemed "gender appropriate." With the onset of puberty, adolescents become more aware of their emerging sexuality and of the standards that society places on them. During both childhood and adolescence, much of what is learned about sexuality comes from observing adult role models. As the adolescent grows into young adulthood, society encourages a reexamination of sexuality and the role it plays in helping to fulfill the need for love and affection. In adulthood, sexuality develops new meanings according to the roles that the adult takes on. Sexuality needs do not

FIGURE 8-16 Individuals of all ages need love and affection. *(Courtesy of Sandy Clark)*

cease in late adulthood. Long-term care facilities are recognizing this fact by allowing married couples to share a room, instead of separating people according to sex. Even after the death of a spouse, an individual may develop new relationships. Determining what role sexuality will play in a person's life is a dynamic process that allows people to meet their need for love and affection throughout their life.

Sexuality, in addition to being related to the satisfaction of needs, is also directly related to an individual's moral values. Issues such as the appropriateness of sex before marriage, the use of birth control, how to deal with pregnancy, and how to deal with sexually transmitted diseases all require individuals to evaluate their moral beliefs. These beliefs then serve as guidelines to help people reach decisions on their behaviors.

Some individuals use sexual relationships as substitutes for love and affection. Individuals who seek to meet their needs only in this fashion cannot successfully complete Maslow's third level.

Esteem

Maslow's fourth level includes the need for **esteem.** Esteem includes feeling important and worthwhile. When others show respect, approval, and appreciation, an individual begins to feel esteem and gains self-respect. The self-concept, or beliefs, values, and feelings people have about themselves, becomes positive. Individuals will engage in activities that bring achievement, success, and recognition in an effort to maintain their need for esteem. Failure in an activity can cause a loss of confidence and lack of esteem. When esteem needs are met, individuals gain confidence in themselves and begin to direct their actions toward becoming what they want to be.

Illness can have a major effect on esteem. When self-reliant individuals, competent at making decisions, find themselves in a health care facility and dependent on others for basic care such as bathing, eating, and elimination, they can experience a severe loss of esteem. They may also worry about a lack of income, possible job loss, the well-being of their family, and/or the possibility of permanent disability or death. Patients may become angry and frustrated or quiet and withdrawn. Health care workers must recognize this loss of esteem and make every

attempt to listen to the patient, encourage as much independence as possible, provide supportive care, and allow the person to express anger or fear.

Self-Actualization

Self-actualization, frequently called *self-realization,* is the final need in Maslow's hierarchy. All other needs must be met, at least in part, before self-actualization can occur. **Self-actualization** means that people have obtained their full potentials, or that they are what they want to be. People at this level are confident and willing to express their beliefs and stick to them. They feel so strongly about themselves that they are willing to reach out to others to provide assistance and support.

MEETING NEEDS

When needs are felt, individuals are **motivated** (stimulated) to act. If the action is successful and the need is met, **satisfaction,** or a feeling of pleasure or fulfillment, occurs. If the need is not met, **tension,** or frustration, an uncomfortable inner sensation or feeling, occurs. Several needs can be felt at the same time, so individuals must decide which needs are stronger. For example, if individuals need both food and sleep, they must decide which need is most important, because an individual cannot eat and sleep at the same time.

Individuals feel needs at different levels of intensity. The more intense a need, the greater the desire to meet or reduce the need. Also, when an individual first experiences a need, the individual may deal with it by trying different actions in a trial-and-error manner, a type of behavior frequently seen in very young children. As they grow older, children learn more effective means of meeting the need and are able to satisfy the need easily.

METHODS OF SATISFYING HUMAN NEEDS

Needs can be satisfied by direct or indirect methods. Direct methods work at meeting the need and obtaining satisfaction. Indirect methods work at reducing the need or relieving the tension and frustration created by the unmet need.

Direct Methods

Direct methods include:

♦ hard work
♦ realistic goals
♦ situation evaluation
♦ cooperation with others

All these methods are directed toward meeting the need. Students who constantly fail tests but who want to pass a course have a need for success. They can work harder by listening more in class, asking questions on points they do not understand, and studying longer for the tests. They can set realistic goals that will allow them to find success. By working on one aspect of the course at a time, by concentrating on new material for the next test, by planning to study a little each night rather than studying only the night before a test, and by working on other things that will enable them to pass, they can establish goals they can achieve. They can evaluate the situation to determine why they are failing and to try to find other ways to pass the course. They may determine that they are always tired in class and that by getting more sleep, they will be able to learn the material. They can cooperate with others. By asking the teacher to provide extra assistance, by having parents or friends question them on the material, by asking a counselor to help them learn better study habits, or by having a tutor provide extra help, they may learn the material, pass the tests, and achieve satisfaction by meeting their need.

Indirect Methods

Indirect methods of dealing with needs usually reduce the need and help relieve the tension created by the unmet need. The need is still present, but its intensity decreases. **Defense mechanisms,** unconscious acts that help a person deal with an unpleasant situation or socially unacceptable behavior, are the main indirect methods used. Everyone uses defense mechanisms to some degree. Defense mechanisms provide methods for maintaining self-esteem and relieving discomfort. Some use of defense mechanisms

is helpful because it allows individuals to cope with certain situations. However, defense mechanisms can be unhealthy if they are used all the time and individuals substitute them for more effective ways of dealing with situations. Being aware of the use of defense mechanisms and the reason for using them is a healthy use. This allows the individual to relieve tension while modifying habits, learning to accept reality, and striving to find more efficient ways to meet needs.

Examples of defense mechanisms include:

♦ **Rationalization:** This involves using a reasonable excuse or acceptable explanation for behavior to avoid the real reason or true motivation. For example, a patient who fears having laboratory tests performed may tell the health worker, "I can't take time off from my job," rather than admit fear.

♦ **Projection:** This involves placing the blame for one's own actions or inadequacies on someone else or on circumstances rather than accepting responsibility for the actions. Examples include, "The teacher failed me because she doesn't like me," rather than "I failed because I didn't do the work"; and "I'm late because the alarm clock didn't go off," rather than "I forgot to set the alarm clock, and I overslept." When people use projection to blame others, they avoid having to admit that they have made mistakes.

♦ **Displacement:** This involves transferring feelings about one person to someone else. Displacement usually occurs because individuals cannot direct the feelings toward the person who is responsible. Many people fear directing hostile or negative feelings toward their bosses or supervisors because they fear job loss. They then direct this anger toward coworkers and/or family members. The classic example is the man who is mad at his boss. When the man gets home, he yells at his wife or children. In such a case, a constructive talk with the boss may solve the problem. If not, or if this is not possible, physical activity can help work off hostile or negative feelings.

♦ **Compensation:** This involves the substitution of one goal for another goal to achieve success. If a substitute goal meets needs, this can be a healthy defense mechanism. For example, Joan wanted to be a doctor, but she did not have enough money for a medical education. So she changed her educational plans and became a physician's assistant. Compensation was an efficient defense mechanism because she enjoyed her work and found satisfaction.

♦ **Daydreaming:** This is a dreamlike thought process that occurs when a person is awake. Daydreaming provides a means of escape when a person is not satisfied with reality. If it allows a person to establish goals for the future and leads to a course of action to accomplish those goals, it is a good defense mechanism. However, if daydreaming is a substitute for reality, and the dreams become more satisfying than actual life experiences, it can contribute to a poor adjustment to life. For example, if a person dreams about becoming a dental hygienist and takes courses and works toward this goal, daydreaming is effective. If the person dreams about the goal but is satisfied by the thoughts and takes no action, the person will not achieve the goal and is simply escaping from reality.

♦ **Repression:** This involves the transfer of unacceptable or painful ideas, feelings, and thoughts into the unconscious mind. An individual is not aware that this is occurring. When feelings or emotions become too painful or frightening for the mind to deal with, repression allows the individual to continue functioning and to "forget" the fear or feeling. Repressed feelings do not vanish, however. They can resurface in dreams or affect behavior. For example, a person is terrified of heights but does not know why. It is possible that a frightening experience regarding heights happened in early childhood and that the experience was repressed.

♦ **Suppression:** This is similar to repression, but the individual is aware of the unacceptable feelings or thoughts and refuses to deal with them. The individual may substitute work, a hobby, or a project to avoid the situation. For example, a woman ignores a lump in her breast and refuses to go to a doctor. She avoids thinking about the lump by working overtime and joining a health club to exercise during her spare time. This type of behavior creates excessive stress, and eventually the individual will be forced to deal with the situation.

♦ **Denial:** This involves disbelief of an event or idea that is too frightening or shocking for a

TODAY'S RESEARCH: TOMORROW'S HEALTH CARE

An artificial bone that grows?

Bone cancer is rare, but when it occurs, it usually happens in children and young adults. Common sites are the knee or leg bones. Amputation of the leg was once the only hope for a cure. Then surgeons began to cut out the tumors and use metal rods to replace the damaged bones. The only problem with this treatment was that the bones did not grow with the child. Every few years, additional surgery was required to replace the metal rods with longer rods.

Now researchers in France have invented Repiphysis, a "growable" metal rod. Repiphysis contains a spring that is held together by a polymer sleeve hooked to an antenna. Harmless electromagnetic rays are beamed at the leg. These rays cause the antenna to create heat. The heat softens the polymer sleeve and the spring loosens. This allows the ends of the metal rod to extend slowly. When the rod has "grown" to the correct length, and the leg matches the growth of the child's other leg, the electromagnetic beam is turned off. In seconds, the polymer sleeve hardens and the metal rod is frozen at its new length. The best feature of the procedure is that it is painless and can be done in a physician's office.

person to cope with. Often, an individual is not aware that denial is occurring. Denial frequently occurs when a terminal illness is diagnosed. The individual will say that the doctor is wrong and seek another opinion. When the individual is ready to deal with the event or idea, denial becomes acceptance.

♦ **Withdrawal:** There are two main ways withdrawal can occur: individuals can either cease to communicate or remove themselves physically from a situation (figure 8-17). Withdrawal is sometimes a satisfactory means of avoiding conflict or an unhappy situation. For example, if you are forced to work with an individual you dislike and who is constantly criticizing your work, you can withdraw by avoiding any and all communication with this individual, quitting your job, or asking for a transfer to another area. At times, interpersonal conflict cannot be avoided, however. In these cases, an open and honest communication with the individual may lead to improved understanding in the relationship.

FIGURE 8-17 Refusing to communicate is a sign of withdrawal.

It is important for health care workers to be aware of both their own and patients' needs. By recognizing needs and understanding the actions individuals take to meet needs, more efficient and higher quality care can be provided. Health care workers will be better able to understand their own behavior and the behavior of others.

STUDENT: *Go to the workbook and complete the assignment sheet for 8:3, Human Needs.*

CHAPTER 8 SUMMARY

Human growth and development is a process that begins at birth and does not end until death. Each individual passes through certain stages of growth and development, frequently called *life stages*. Each stage has its own characteristics and has specific developmental tasks that an individual must master. Each stage also establishes the foundation for the next stage.

Death is often called "the final stage of growth." Dr. Elizabeth Kübler-Ross has identified five stages that dying patients and their families may experience before death. These stages are denial, anger, bargaining, depression, and acceptance. The health care worker must be aware of these stages to provide supportive care to the dying patient. In addition, the health care worker must understand the concepts represented by hospice care and the right to die.

Each life stage creates needs that must be met by the individual. Abraham Maslow, a noted psychologist, developed a hierarchy of needs that is frequently used to classify and define the needs experienced by human beings. The needs are classified into five levels, and according to Maslow, the lower needs must be met before an individual can strive to meet the higher needs. The needs, beginning at the lowest level and progressing to the highest, are physiological, or physical, needs; safety and security; love and affection; esteem; and self-actualization.

Needs are met or satisfied by direct and indirect methods. Direct methods meet and eliminate a need. Indirect methods, usually the use of defense mechanisms, reduce the need and help relieve the tension created by the unmet need.

Mastering these concepts will allow health care workers to develop good interpersonal relationships and provide more effective health care.

INTERNET SEARCHES

Use the suggested search engines in Chapter 12:4 of this textbook to search the Internet for additional information on the following topics:

1. *Erikson's stages of psychosocial development*: search for more details and examples of the stages of development

2. *Stages of human growth and development*: search words such as infancy, childhood, adolescence, puberty, and adulthood to obtain information on each stage

3. *Eating disorders*: search for statistics; signs and symptoms; and treatment of anorexia nervosa, bulimia, and bulimarexia

4. *Chemical or drug abuse*: search for statistics, signs/symptoms, and treatment of chemical and drug abuse (*Hint*: use words such as alcoholism and cocaine.)

5. *Suicide*: search for statistics, signs/symptoms, and ways to prevent suicide

6. *Death and dying*: search for information on Dr. Kübler-Ross, hospice care, palliative treatment, advance directives, and the right to die

7. *Maslow's hierarchy of needs*: search for additional information on each of the five levels of needs

8. *Defense mechanisms*: search for specific information on rationalization, projection, displacement, compensation, daydreaming, repression, suppression, denial, and withdrawal

REVIEW QUESTIONS

1. Differentiate between growth and development.

2. List the seven (7) life stages and at least two (2) physical, mental, emotional, and social developments that occur in each stage.

3. Create an example for what a patient and/or family member might say or do during each of the five (5) stages of death and dying.

4. Explain what is meant by the "right to die." Do you believe in this right? Why or why not?

5. Identify each level of Maslow's Hierarchy of Needs and give examples of specific needs at each level.

6. Create a specific example for each of the following defense mechanisms: rationalization, projection, displacement, compensation, daydreaming, repression, suppression, denial, and withdrawal.