Social and Personality Development in Childhood

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Although the series is primarily law-focused, it also embraces an interdisciplinary approach and therefore includes contributions from other academic fields.

The main areas of law covered in the series are human rights, children's rights, and the rule of law, as well as other areas of law that help ensure their effective implementation. A prominent feature of the series is its examination of the legal systems and jurisprudence of Central and Eastern European countries, though not exclusively so. As the series aims to provide useful legal knowledge to non-lawyers, it also offers general legal background necessary to understand the subject matter.

The series is divided into two distinct sub-series, each numbered separately. One sub-series is entitled 'Human Rights and Rule of Law' (HRRL) and the other 'International and Comparative Children's Rights' (ICCR). Regarding their relationship, HRRL is considered the more general sub-series, while ICCR focuses on more specific themes.

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Towards an Interdisciplinary Understanding of Childhood

Bernadett RAPOSA – Balázs Péter HÁMORNIK

1. Introductory Thoughts

This book aims to serve as a comprehensive guide for legal professionals engaged in the field of working with children. It assists them in navigating the complexities of children's social and personality development. Designed in collaboration with the Ferenc Mádl Institute of Comparative Law and the Association for Children's Rights, this guide not only provides knowledge on children's social and personality development but is also crafted meticulously to address today's nuanced challenges and evolving landscape concerning children. By equipping lawyers with deeper understanding of children's developmental milestones and psychological needs, this guide aims to enhance law professionals' effectiveness and advocacy on behalf of young clients.

In cooperation of the Ferenc Mádl Institute of Comparative Law and the Association for Children's Rights, we devoted many hours to define the goal and focus of this book's first edition.

We talked to several law professionals, inquiring their needs in the field of their work with children. We obtained insights into the enormous variety of practices and experiences encompassing the lawyers' work. Whether practicing in family law, juvenile justice, education law, or other specialised areas, lawyers often encounter unique legal and ethical considerations when representing children. This book discusses many psychological aspects that need to be considered when making a decision about a child's life. We are pleased to say that our invitation to contribute to this book was accepted by all the neighbouring countries in Central-Europe. Academics from noted universities participated in our endeavour to offer landscapes from developmental psychology.

Before we delve into the content of our book, we would like to show how profoundly psychology and law intersect in safeguarding and promoting the well-being of children. This collaboration is essential as it integrates insights from both disciplines to address the complex needs of young individuals in legal contexts, ensuring that their rights and development are prioritised. Psychology provides invaluable understanding of a child's development, behaviour, and mental health. Psychologists utilise empirical research and clinical expertise to assess the psychological and emotional well-being of children involved in legal proceedings. They provide assessments that inform decisions about custody, visitation rights, and interventions aimed at supporting the child's adjustment and resilience. Psychologists also offer therapeutic interventions to help children cope with trauma, manage emotions, and navigate the challenges associated with legal processes. Law, on the other hand, establishes the legal framework that protects children's rights and determines their best interests. Legal professionals, including judges, lawyers, and child advocates, rely on psychological assessments and expert testimony to make informed decisions in cases involving child custody, abuse, neglect, and adoption. They interpret and apply laws that ensure children are provided a safe and nurturing environment that is free from harm and conducive to their overall well-being.

In the book, we will explore various theoretical schools within developmental psychology, each offering unique perspectives on the journey from childhood to adulthood. These theories provide frameworks for understanding the complex processes involved in human development, from cognitive and emotional growth to social and moral maturation. One overarching framework that professionals often utilise is the bio-psycho-social approach. This comprehensive model is not new to the field of human studies, including psychology, but it remains fundamental in contemporary practice. The bio-psycho-social approach emphasises the interconnectedness of biological, psychological, and social factors in shaping an individual's development. Biologically, this framework considers genetic predispositions, brain development, physical health, and other physiological processes. Psychologically, it examines cognitive functions, emotional regulation, personality traits, and mental health. Socially, it considers the influence of family, peers, culture, and societal structures. The bio-psycho-social approach ensures that no facet of a child's development is overlooked. By integrating insights from various domains, professionals can provide more comprehensive and effective support. For instance, understanding how a child's anxiety might be linked to both genetic factors and stressful social environments can lead to more targeted and multifaceted interventions. Moreover, this holistic perspective is crucial because it aligns with the understanding that development is a dynamic and interactive process. Children do not grow and develop in isolation; their experiences are continuously shaped by the interplay of their biological makeup, psychological state, and social context.

In summary, the bio-psycho-social approach provides a valuable meta-framework for professionals working with children. It underscores the importance of addressing the whole child, ensuring that interventions are well-rounded and considerate of all

factors influencing development. This approach promotes a more nuanced and effective understanding of how to support children in their journey towards adulthood, acknowledging their complex and multifaceted nature as developing human beings.

In the last few years, thanks to the Ferenc Mádl Institute of Comparative Law and the Association for Children's Rights, two international conferences were held in 2022 and 2023 in Hungary devoted to the main and most urgent issues in the field of children's rights and children's well-being. We enjoyed the attendance of many law theorists, practitioners, and other child professionals who gathered and shared knowledge and experience on interdisciplinary thinking about children's life today.

One most noted child professional who participated in the Children's Rights Days in Hungary in 2023 is Dr Beáta Pászthy. She is a paediatrician, child psychiatrist, family psychotherapist, and associate professor of the 1st Department of Paediatrics, and she was awarded the Prima Prize in the Hungarian Science category in 2021. She often refers to the bio-psycho-social well-being in her statements:

A nation's development, its community mentality, its ability to unite, its present and, above all, its future, are determined by how it treats the most downtrodden, the most underserved, and among them most of all children. In welfare societies with declining populations, the HEALTH of children and the growing generation is particularly important, which does not mean the absence of disease, but physical, mental, social and spiritual well-being. I think the Hungarian language expresses this complexity in the most beautiful way. In this sense, authentic and coherent programs aimed at the health and well-being of children carry unquestionable positive content, encourage the unity of society, direct attention to the future, and even their short-term results directly improve the individual and social feeling of well-being. In the long term, they improve the health indicators of the society from child to adult, reduce the occurrence of self-destructive behaviors, the number of unproductive life years spent in illness, and significantly increase the nation's competitiveness. Society's investment in children's ENTIRE is the surest investment in the future. Children's HEALTH is therefore the most important strategic issue for the consumer societies[1].

Professionals who work with children, particularly in fields such as education, social work, and healthcare, frequently encounter the necessity of adopting this holistic view**.** They recognise that children must be seen and healed in a manner that addresses all aspects of their being. This means considering the child's physical health, mental well-being, emotional needs, and social environment. As read above, the term "*bio-psycho-social*" inherently suggests an interdisciplinary framework, a key concept central to our working group. This interdisciplinarity was a guiding principle in designing the book's structure and main messages. While the term "interdisciplinary" is often associated with academic settings, its application extends beyond universities and research institutions. In practical settings, such as healthcare, social services, and education, interdisciplinary collaboration is crucial for addressing the complex needs of individuals and communities. Professionals from different

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1 Pászthy, 2019.

backgrounds work together to develop comprehensive strategies and interventions, ensuring that all relevant aspects of a problem are considered. This holistic perspective is essential for addressing the complex and interconnected factors that influence the growth and well-being of individuals, particularly children, as they navigate their developmental pathways. Through an interdisciplinary approach integrating psychological understanding with legal protections and advocacy, professionals from both disciplines can collaborate effectively to safeguard children's rights, promote their development, and ensure they grow up in environments that nurture their potential and well-being. This can not only strengthen legal decision-making but also enhance the support systems available to children and families, fostering healthier and more resilient communities overall.

The collaboration between psychology and law is particularly crucial in cases where the child's welfare is at stake. For instance, in cases of abuse or neglect, psychologists may evaluate the impact on the child's development and recommend appropriate interventions to safeguard their welfare. Legal professionals use this psychological insight to advocate for protective measures and ensure the child's safety through legal proceedings. Furthermore, psychology and law work together to advocate for policies and practices that promote children's rights and well-being on a broader scale. This includes advocating for laws that protect children from exploitation, ensuring access to mental health services, and promoting educational opportunities that support their development.

Cases of child maltreatment, current youth mental health issues, and even children's everyday life in educational settings all need an interdisciplinary lens to fully address their complexity and provide effective solutions.

In many countries increasing focus on child abuse led to remarkable changes in recent years. child protection laws, medical guidelines provide effective means for child protection services. Sound knowledge of the clinical manifestations, the parties involved, and the legal situation are required in order to provide effective child protection interventions.[2]

In cases of child maltreatment, an interdisciplinary approach is crucial for comprehensively understanding and addressing the issue. Medical professionals, psychologists, and counsellors play a vital role in assessing the physical and emotional impacts of maltreatment, offering therapeutic support to help the child process and heal from trauma. Social workers evaluate the child's living conditions and family dynamics, ensuring that the child's environment is safe and supportive. Legal experts navigate the complexities of child protection laws, advocating for child's rights and ensuring that justice is served. This coordinated effort among various professionals ensures that all aspects of the child's well-being are addressed, leading to more effective interventions and long-term support. Current youth mental health issues also demand an interdisciplinary approach. The rising incidence of mental health challenges among young people, such as anxiety, depression, and behavioural disorders, requires the collaboration of mental health professionals, educators, parents, and policymakers. Psychologists and psychiatrists develop and implement therapeutic

interventions tailored to the individual needs of each child. These interventions may include cognitive-behavioural therapy, medication management, and other evidence-based treatments. Educators create inclusive and supportive classroom environments that promote mental well-being and accommodate students' emotional and psychological needs. Parents are integral to this process, offering support at home and working closely with schools and mental health professionals to ensure a consistent and comprehensive approach to their child's well-being. Policymakers advocate for and implement policies that increase access to mental health resources, reduce stigma, and promote mental health awareness within the community. This collective effort helps to create a robust support system for young people, addressing their mental health needs from multiple perspectives and fostering resilience and well-being. In educational settings, an interdisciplinary perspective is equally vital. Teachers, school counsellors, psychologists, and administrators must collaborate to create an environment that supports all aspects of a child's development.

In summary, developing and sustaining partnerships within and across professions that intersect in the lives of children and families are essential in various cases related to children. Interdisciplinary teams try to bridge gaps between child welfare and well-being research, policy, teaching, and service. Achieving a comprehensive understanding of a child's inner and outer circumstances is a complex and challenging task. Understanding the inner world of a child requires sensitivity and expertise to interpret their thoughts, emotions, and behaviours accurately. Psychological assessments, interviews, and observations help in unravelling the underlying issues contributing to the child's difficulties. Equally important is comprehending the outer situation—assessing family dynamics, living conditions, and social environment that may impact the child's development and well-being. Once the diagnosis is established, finding the safest and most effective intervention becomes paramount. This intervention should be tailored to meet the specific needs of the child and their family, considering their unique circumstances and challenges. This involves developing a holistic treatment plan that not only addresses the immediate concerns but also supports long-term healing and growth. Besides the work of psychologists and medical professionals, the role of legal experts is also crucial in advocating for children's best interests in legal proceedings. Ultimately, the goal is to create a supportive and nurturing environment where the child can thrive. This requires a holistic approach that considers all facets of the child's life and engages all relevant stakeholders in collaborative decision-making.

1.1. Key Concepts: Children's Well-Being and Best Interests of the Child

After establishing our initial thoughts, let us delve into the key concepts that form the foundation of this book. A central concept in discussions about children is their well-being, a term frequently used in children's law, psychology, and protection. We aim to clarify how we define this concept in our book. UNICEF's definition of children's well-being encompasses indicators across six dimensions: material well-being, health and safety, educational well-being, family and peer relationships, behaviour and risks,

and subjective well-being. In recent years, because of the efforts of international organisations and the civil sector, several developed countries have begun adopting a child well-being approach in their policies and services regarding children. This approach parallels the growing understanding of human well-being and reflects the principle, enshrined in the United Nations Convention on the Rights of the Child (UNCRC).

Well-being is not solely about avoiding child poverty. Regardless of material circumstances, children can only truly thrive if they are loved and cared for; enjoy good physical and mental health; develop their skills and abilities; live in safe and pleasant homes and environments; and benefit from opportunities for learning, play, leisure, social and cultural life, and personal development. They must also receive information; express their own identity and opinions; participate in decisions that affect their lives; and be protected from violence, neglect, exploitation, and discrimination. Additionally, they should be free from psychological problems and risky behaviour.

An important feature of child well-being is its inclusion of both objectively measurable dimensions, such as income or school performance, and subjective dimensions, such as time spent with friends or opportunities to be creative. Listening to children themselves is crucial for identifying the issues that most affect their well-being at any given time. The relative importance of the different dimensions of child well-being will undoubtedly vary from one age group to another. Moreover, enhancing the well-being of children facing the greatest obstacles will most quickly elevate the well-being of children in the society as a whole.

The multi-dimensional, dynamic nature of child well-being calls for commitment and cooperation from all those responsible for children, including parents and other caregivers, families, the community, the private sector, civil society, government, and professionals responsible for delivering social assistance, education, health, child protection, and other public services. Beyond our individual responsibilities, we can all contribute to the full spectrum of child well-being. Since child well-being is a positive concept that focusses on opportunity rather than deprivation, there is always room for improvement.[3]

In psychology, child well-being encompasses a holistic state of health and development that includes physical, emotional, social, cognitive, and spiritual dimensions. It is defined by not only the absence of illness or adversity but also the presence of positive experiences and nurturing relationships that promote growth. *Emotional well-being* involves the ability to understand, express, and manage emotions, contributing to resilience and fostering positive self-esteem. *Social well-being* refers to the establishment of healthy relationships with peers, family, and the community, which enhance social skills and create a sense of belonging. *Cognitive well-being* is achieved through opportunities for learning and intellectual growth, encouraging curiosity and active engagement with the world. Spiritual well-being in childhood refers to a child's sense of connection to themselves, others, and the larger world. It encompasses a child's ability to explore and understand existential questions, find meaning and purpose, and foster values that guide their behaviour. Finding *meaning and purpose* in life experiences and understanding one's role in the world as well as

developing personal values and beliefs that influence decisions and behaviour are core components of spiritual well-being. Additionally, children require *safety and stability* to thrive. This entails a secure environment that protects them from harm and provides a consistent context for their development.

1.2. Best Interests of the Child

The other important concept in our book is the best interests of the child. This term originates from Art. 3 of the UNCRC, which states that 'In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities, or legislative bodies, the best interests of the child shall be a primary consideration'.[2]

The UNCRC includes provisions designed to support a child's needs for safety; health; family relationships; physical, psychological, and emotional development; identity; freedom of expression; privacy; and agency to form and express their own views. Among these provisions is the well-being of the child. In essence, the best interests of the child are whatever is best for that individual child. The UNCRC explicitly recognises the role of parents and caregivers (including extended family, guardians, and others with legal responsibility) in protecting and promoting the child's best interests.[4]

Although the UNCRC does not provide a strict definition of the best interests concept, it emphasises the importance of child protection. This concept underscores the idea that children have rights but does not grant them decision-making power. Judicial or administrative authorities in states that have ratified the UNCRC are obligated to consider "the child's best interests" during all official decision-making processes pertaining to children.

The flexibility of the UNCRC makes the concept adaptable to different situations. However, this broad discretion can also enable decision-makers to impose their own interpretations of the principle, potentially at the child's expense. The role of psychology is significant in these contexts. Prioritising the best interests of the child as a "primary consideration" acknowledges that these interests must be balanced against other interests.

2. Book Content

The Social and Personality Development of the Child serves as a comprehensive guide tailored for lawyers, intended to be a definitive textbook on children's development spanning from birth through late adolescence. Each article within the book is designed to be comprehensible on its own, allowing readers to explore specific areas or topics of interest without needing to read the entire volume. However, we emphasise that reading the entire book offers a unique perspective on developmental child psychology. Its diverse content not only covers classical and modern developmental

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2 Art. 3.1 of UNCRC.

theories and key debates in developmental psychology but also encourages readers to adopt an integrative approach to contemporary issues such as children's mental health, parenting in the 21st century, and trauma-informed care in child welfare institutions.

Some readers may encounter psychological concepts for the first time. It is important to note that academic and applied child psychology employs specialised terminology, akin to other scientific disciplines. Readers may initially find it challenging to synthesise diverse psychological theories into a cohesive framework. We encourage readers to not be discouraged early on. The investment in reading the entire book is worthwhile, as overlapping discussions and repeated exposure to terms and concepts gradually bring clarity and applicability to everyday practice.

While primarily intended for lawyers, this book may also pique the interest of professionals curious about contemporary issues related to children.

In the pages that follow, we will delve into three distinct parts that structure the book:

Part one: Children in the 21st Century: This section explores the evolving contexts in which children grow up today, encompassing societal, technological, and cultural influences.

Part two: Child Development: Social and Emotional Considerations in Personality Development: This part examines key stages of child development, including insights into social and emotional growth. Topics include trauma and resilience in development, as well as methods for assessing a child's mental health.

Part three: Future Perspectives: Parenting and Societal Outlook: The final part provides a forward-looking perspective on parenting practices and societal trends that shape children's futures.

That means that the content is divided into three parts, based on thematic considerations. These sections are designed to provide comprehensive insights into the multifaceted world of child-related issues, offering valuable knowledge and perspectives for both legal professionals and other interested professionals. As mentioned above, our exploration necessarily entails some repetition and overlapping discussion.

2.1. Part One: Children in the 21st Century

The first part starts with a review chapter on children's mental health issues and psychological well-being in our days. Before the reader dives into detailed explanations on developmental stages, it is important to gain an up-to-date picture of the outer and inner contexts of children's life in Central Europe these days. Marina Merkas et al. present a broad overview on this very important area.

As the authors of this chapter note, professionals in the 21st century recognise that children face an unprecedented set of challenges that were unimaginable just a few decades ago. Every day, children encounter increased stress from social pressures, academic demands, and the omnipresent digital environment. The changing dynamics of family life, peer relationships, and cultural influences can pose significant challenges for children's well-being and mental health. Recent studies indicate a significant rise in

mental health issues among children in this era. The authors first define mental health issues; then, they explain how these issues arise and develop, identifying factors that make children vulnerable to developing mental health problems. Third, they provide a detailed overview of the prevalence of the most common mental health issues among children and adolescents. Finally, some strategies are presented that might contribute to the protection and well-being of children in the modern era.

2.2. Part Two: Social and Emotional Considerations in Personality Development

This second and longest part of the book is composed of nine chapters. These texts form the largest section of our book, focussing on social and personality development as the main aspects of human development. Let us pause for a moment and examine these two concepts from a psychological point of view. What is personality, and why do we devote so much attention to social development in childhood?

2.2.1. Social Context of Child Development

The most important aspect of a human being's development is the social context. The process of *socialisation* begins very early in a child's life[3]. It is the process by which children acquire the language and culture of their family and the community into which they are born. Within this community, children learn the language, norms, values, behaviours, expectations and social skills that are appropriate for their "world". Social interactions are an important component of nearly every aspect of our lives. The development of skills necessary to form positive and lasting social interactions begins in infancy and continues to evolve as an individual grows and develops. Skills, such as trust, empathy for others, cooperation, and channelling of emotions (e.g. joy, anger, sadness, and frustration) develop throughout childhood. For most children, the skills needed for social interaction develop naturally. That is, they are acquired through the process of natural interactions within their environment—primarily home and early education settings. They listen, observe, practice, and internalise. By the time children reach adolescence, they begin to test the values and ideas that have shaped their childhood. Friendships and peer groups gain significant importance during adolescence, and social status is related to their conformity to these groups[4].

Self-esteem is considered the most critical skill affecting friendships and other social interactions by the time children reach adolescence. Self-esteem is how we perceive our value to the world and how valuable we think we are to others. Self-esteem affects our trust in others, our relationships, our work—nearly every part of our lives. Positive self-esteem gives us the strength and flexibility to take charge of our lives and grow from our mistakes without the fear of rejection[5]. Individuals with high self-esteem are more likely to persist in the face of failure[6], while research has revealed that

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3 Martindale, Ilan and Schaffer, 2013.
4 Voss, 2020.
5 Orth and Robinson, 2022.
6 Trzesniewski et al., 2006.

low self-esteem can result in long-term poor outcomes, including depression, eating disorders, delinquency, and other adjustment problems. Low self-esteem develops if there is a gap between one's *self-concept* and what he or she believes one "should" be like. *Self-concept*—also referred to as self-identity—is the collection of beliefs one has about him or herself. Self- concept is cognitive and descriptive and reflects our perceptions of our behaviours, abilities, and unique characteristics. It answers the question, "Who am I?". Early on, this view of one's "self" is concrete and descriptive of what the children believe about themselves. Over time, the self-concept changes as children make new discoveries about who they are and what is important to them[7].

One of the most modern scientific studies on social development can be found in Sue Gerhardt's book *Why Love Matters*[8]*,* which explains how early social experiences shape our emotional and mental development. It highlights the profound impact of love and nurturing in the future well-being of a person. One of her key messages is that, from an evolutionary perspective, our brain evolves in stages, with the so-called "social brain" developing in the last stage. In everyday speech, we usually refer to "the brain", but this is not quite accurate. We actually have what neuroscientists call a "*triune brain*", or three brains in one. Each of these brains reflects a different stage in our evolution. In the third and final stage, we develop the cerebral cortex in the outer layers of the brain. This is where the *social brain*—the thing that makes humans human—is formed. The social brain is activated when we control our emotions, follow social cues, and experience empathy. It also allows us to go beyond instinctive ways of behaving. A newborn baby's brain has several systems to ensure survival. It has a functioning nervous system that makes it possible for her to breathe, a visual system that lets her track movement, and a core consciousness in the brainstem that enables her to react to sensory stimuli such as temperature. However, the social brain is missing. It only begins developing after the baby is born. After the birth, the baby is an active and interactive agent—an interactive project and not a self-powered one. Various systems in her brain are ready to go, but many more are incomplete and will develop in response to other human inputs. From baby-parent interactions patterns, attachment styles arise and evolve. This means that our earliest experiences are not simply laid down as memories or influences: they are translated into precise physiological patterns of response in the brain that then set the neurological rules for how we deal with our feelings and those of other people for the rest of our lives. It is not nature or nurture, but both. How we are treated as babies and toddlers determines the way in which what we are born with turns into what we are. According to Gerhardt, 'There is nothing automatic about it. The kind of brain that each baby develops is the brain that comes out of his or her particular experiences with people'. This also means that good parenting is not just nice for the baby; it leads to good development of the baby's prefrontal cortex, which in turn enables the growing child to develop self-control and empathy and to feel connected to others. Interaction, it turns out, is the high road from merely human to fully humane.

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7 Ibid.
8 Gerhardt, 2015.

2.2.2. Short Notes About Personality

Personality psychology is the scientific study of individual differences in people's thoughts, feelings, and behaviours. It explores the patterns and traits that make each person unique, focussing on how these characteristics develop and influence various aspects of life, including behaviour, relationships, and mental health.

Let us see one of the most common definitions of *personality*: The American Psychological Association (APA) defines personality as follows: 'Personality refers to individual differences in characteristic patterns of thinking, feeling, and behaving. The study of personality focusses on individual differences in particular personality characteristics and how the parts of a person come together as a whole'. This definition emphasises the distinct and consistent patterns in how individuals think, feel, and behave, highlighting the uniqueness of each person's personality. It also underscores the integrative nature of personality, considering how various traits and characteristics combine to form a cohesive personality structure. Based on the APA's considerations, the field of personality psychology studies the nature and definition of personality as well as its development, structure and trait constructs, dynamic processes, variations (with emphasis on enduring and stable individual differences), and maladaptive forms.

Various theories explain the structure and development of personality in different ways, but all agree that personality refers to enduring characteristics and helps determine behaviour that comprises a person's unique adjustment to life. While there is no single agreed-upon definition of personality, it is often thought of as something that arises from within the individual and remains fairly consistent throughout life.

Formation of personality components such as major traits, interests, drives, values, self-concept, abilities, and emotional patterns during childhood involves a complex interplay of genetic, environmental, and social factors. The reader can find detailed texts about these processes in our book, but let us take a glimpse at some of the components, where we can see how socialisation and personality formulation connect with each other. For example, the *emotional regulation* component shows as how children learn to regulate their emotions through their years of socialisation: interactions with caregivers act as a model and teach children coping strategies. Another very important aspect of human personality and emotional life is the *attachment style*: secure attachment to caregivers provides a foundation for healthy emotional development and resilience.

2.2.3. Measuring Personality

Psychologists measure personality using different primary methods. The main methods involve *projective tests* and *questionnaires*. Projective tests, such as the Rorschach test or the children's apperception test, involve presenting ambiguous stimuli to individuals. The idea is that people project their own thoughts, feelings, and experiences onto these stimuli, revealing underlying personality traits and conflicts. Questionnaires, such as the Minnesota Multiphasic Personality Inventory or different inventories applied to children, consist of structured items that assess specific traits

and behaviours. Participants respond to standardised questions, allowing for reliable scoring and comparison across individuals. Both methods provide valuable insights into personality, although they have different strengths and limitations. Projective tests offer depth and qualitative data, while questionnaires provide quantitative measures and ease of administration. Lawyers may encounter the psychological assessment process and its findings in their practice. Therefore, it is essential to understand what occurs during a child's assessment and how to evaluate and utilise a report to support decision-making processes related to children. The chapter presented by Dr Dominik Gołuch (Chapter 2 in Part II) discusses basic issues related to the process of psychological assessment of children and adolescents.

2.2.4. Pathological Ways of Social and Personality Development

Experts focus on not only the many influences that contribute to normal child development but also various factors that might cause psychological problems during childhood.

Research in applied psychology helps us understand how healthy personality development evolves throughout childhood and by which risk factors a pathological way of development unfolds. When talking about personality pathologies, it is important to understand that based on research, standardised processes and personality assessment methods, we can determine the subclinical and clinical categories of mental health problems. The so-called classification of mental disorders, also known as psychiatric nosology or psychiatric taxonomy, is central to the practice of psychiatry and other mental health professions. Children's classifications systems are part of these nosologies. The two most widely used psychiatric classification systems are the 11th Edition of the International Classification of Diseases (ICD-11) produced by the World Health Organization (WHO), and the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5), produced by the American Psychiatric Association.

The DSM is the handbook used by healthcare professionals in the United States and much of the world as the authoritative guide for the diagnosis of mental disorders. The DSM contains descriptions, symptoms, and other criteria for diagnosing mental disorders. It provides a common language for clinicians to communicate about their patients and establishes consistent and reliable diagnoses that can be used in research on mental disorders. It also provides a common language for researchers to study the criteria for potential future revisions and to aid in the development of medications and other interventions.

DSM-5 is the latest edition of DSM and includes changes to some key childhood disorders. For example, a diagnosis of attention-deficit/hyperactivity disorder now requires symptoms to be present prior to the age of 12 years (rather than 7 years, the age of onset in DSM-4).

The other classification system was developed by the WHO in the early 1960s. The WHO Mental Health Gap Action Programme became actively engaged in a programme aiming to improve the diagnosis and classification of mental disorders. At

that time, WHO convened a series of meetings to review knowledge, actively involving representatives of different disciplines, various schools of thought in psychiatry, and all parts of the world in the programme. It stimulated and conducted research on criteria for classification and reliability of diagnoses, and it produced and promulgated procedures for joint rating of videotaped interviews and other useful research methods. WHO released the latest version of ICD, ICD-11, which was presented at the World Health Assembly in May 2019 and implemented from 1 January 2022. The recent ICD-11 has met with great interest worldwide. As the most widely used classification system globally that is approved by the WHO, the changes will have direct implications for clinicians and researchers in the field of child psychology.

Note that child and adolescent psychiatry sometimes uses specific manuals in addition to the DSM and ICD. The *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* was first published in 1994 by Zero to Three to classify mental health and developmental disorders in the first four years of life. It has been published in nine languages. The Research Diagnostic Criteria-Preschool Age were developed between 2000 and 2002 by a task force of independent investigators for developing clearly specified diagnostic criteria to facilitate research on psychopathology in this age group. The French Classification of Child and Adolescent Mental Disorders, operational since 1983, is the classification of reference for French child psychiatrists.

2.2.5. Psychological Developmental Theories

Before reading the developmental theories in these chapters, some core supplemental notes from the editor might be useful: it is important to understand that psychological thinking does not mean one clear theory of human beings. The science of psychology experienced sequential eras, each answering the earlier era's questions and critics questioning the earlier theories of human development. Human development is a complex process, and we still do not understand it fully. Psychology has old questions: How does a personality develop? Why does one person get mentally ill while another does not under the same circumstances?

In the second chapter of this part of the book (Chapter 3) the reader can become acquainted with one of the oldest debates of developmental psychology, the so-called nature-nurture controversy. Not easy but very worth a read is the chapter by Prof. Dr. Jovan Miric, Ph.D., which discusses classical developmental theories as well as some additions about modern theories. Some of the presented theories focus on the personality as a whole, while others refer to mainly cognitive development, socialisation, etc. In the chapter, you can read about the greatest theorists in developmental psychology—Freud, Erikson, and Piaget—as well as the core concepts and evolution of attachment theories of Bowlby and Ainsworth. The chapter is specially designed for lawyers. To make this serene theoretical text easier to consume, we asked the author to add some research examples of how the nature-environment debate is reflected in concrete personality developmental patterns, such as antisocial behaviour.

The next chapter of this part of the book (Chapter 4) presents a profound description of children's development by separated areas. It discusses the stages of social, emotional, and cognitive development, which are three main areas of human development besides physical changes. According to the Author,

> "because child psychology is so vast and tries to answer so many questions, researchers and practitioners often separate development into these specific areas. Broadly, these tend to map onto children's physical, cognitive (thinking, learning, memory, etc.), and social/emotional development. Child psychologists attempt to make sense of every aspect of child development, including how children learn, think, interact, and respond emotionally to those around them; make friends; and understand emotions and their own developing personalities, temperaments, and skills".

The chapter emphasises the first two years of life as a crucial period for cognitive, emotional, and social development. Experiences during this time shape subsequent developmental stages. Positive experiences and a nurturing social environment foster the development of adaptive cognitive schemas, which support balanced social and emotional growth later in life. Conversely, negative experiences and lack of support can lead to schemas that heighten the risk of emotional and social difficulties; hinder the resolution of age-specific challenges; and may increase the likelihood of developing psychopathologies such as anxiety, depression, and personality disorders.

The longest section of our book presents a detailed exploration of the four main developmental stages in childhood (Chapters 5, 6, 7, and 8). These chapters encompass extensive and diverse knowledge on children's development, drawing from research, applied work, neuroscience, and brain mapping techniques.

Child psychology typically defines several key periods before reaching adulthood at the age of 18 years. Some frameworks refer to the four main stages, while others divide childhood into five stages. The five stages of development in child psychology are newborn, infancy, toddlerhood, preschool age, and school age. For practical purposes, we chose a simplified version of this division in our book. We designate infancy as a separate phase, combine toddlerhood and preschool years into one chapter, and divide school age into two phases: early school age and adolescence.

The stages and corresponding ages (in years) are as follows:
- Infancy (0–1);
- Toddlerhood and preschool age (1.5–6/7);
- Early school age (6/7–11/12);
- Adolescence (12–18).

2.2.6. Trauma and Resilience as Two Important Components of Human Development
This section of the book delves into two crucial topics: trauma and resilience. Both are inherently part of human development, with negative effects and protective factors playing significant roles in psychological growth. The concept of trauma, as

understood today, is thoroughly examined. Noémi Vigh (Chapter 9) presents a comprehensive overview, offering insights into the basics and relevance of the trauma framework. The focus is on developmental trauma, which has revolutionised our understanding of the symptoms, dynamics, and treatment of mental health issues in both children and adults. Additionally, the chapter explores the connections between trauma, the society, human rights, and the legal system.

Following the discussion on trauma, the next chapter (Chapter 10) provides an overview of the findings from positive psychology, particularly in relation to children's resilience. Positive psychology, which emerged in the late 1990s, aims to shift the focus of psychological research from merely repairing damage to cultivating positive qualities in people and societies. The chapter outlines the historical development of the construct of resilience and elaborates on the contributions of positive psychology to this field. It highlights protective factors and the concept of posttraumatic growth. The chapter concludes with a brief overview of interventions designed to enhance resilience in children and adolescents, along with final remarks.

One major contribution of positive psychology to the field of resilience is the identification and elaboration of protective factors. These conditions or attributes help buffer individuals against the negative effects of stress and adversity. The chapter discusses various protective factors that have been found to be particularly relevant for children, including supportive relationships with family and peers, positive self-esteem, a sense of mastery or competence, and effective coping strategies. By understanding these protective factors, researchers and practitioners can develop targeted interventions to bolster resilience in young people.

A significant portion of the chapter is dedicated to the concept of posttraumatic growth. This concept, which has its roots in positive psychology, refers to positive psychological changes that can occur because of struggling with highly challenging life circumstances. The chapter explores how children and adolescents can experience personal growth and develop new strengths in the aftermath of trauma. It discusses factors that contribute to posttraumatic growth, such as finding meaning in the experience, increasing appreciation for life, and the developing deeper relationships with others.

The chapter concludes with final remarks that underscore the importance of fostering resilience in children and adolescents. It emphasises that building resilience is about not only helping individuals cope with difficulties but also empowering them to thrive and reach their full potential. By integrating the principles of positive psychology into practice, educators, mental health professionals, and policymakers can create supportive environments that nurture the resilience and well-being of the next generation.

2.2.7. Spirituality, a Component of Resilience

The editor of the book finds it essential to add a crucial amendment to these previous chapters. Besides moral development introduced in the chapters, there is one further important field in children's development—spiritual development—which, based on bio-psycho-social and spiritual models, contributes to human wholeness and thriving.

A huge amount of psychological research reveals the role of spiritualty in human resilience and well-being. A consensus report prepared by a panel convened by the National Institute for Healthcare Research defined spirituality as behaviours, cognitions, and emotions that arise as part of an individual's search for connection with a divine being, a higher power, or an ultimate truth.[9] So, *spirituality* refers to a broad concept that encompasses a sense of connection to something greater than oneself. It often involves personal growth, meaning making, and the pursuit of inner peace. In psychology, spirituality can be seen as the way individuals seek purpose and fulfilment, which can contribute to overall well-being. It is not confined to organised beliefs and can be expressed through personal practices such as meditation, nature appreciation, or creative expression.[10]

It may be helpful to examine how this intriguing subject has been approached over centuries. Many parents and educators are nowadays are voicing their conviction that, in our turbulent society, we must provide youngsters a strong moral sensibility and deep respect for their natural environment. In the fields of counselling and psychotherapy, mechanistic approaches to personality study and treatment are giving way to the notion that human spirituality is an important and inborn characteristic. More and more practitioners are realising that unless we recognise our higher longings, self-fulfilment is likely to remain elusive.

The notion that childhood may harbour special intuitive and spiritual sensitivities has long flourished in Western European traditions. Carl Gustav Jung decisively broke with psychoanalyst Sigmund Freud's theory to forge his own systematic explanation of the human psyche. In his system of psychology, spirituality became an important, if not the most important, part of human existence. He introduced a core concept called the "self", which, according to him, is the central archetype in the collective unconscious, embodying the entirety of the psyche and serving as a guiding force towards personal wholeness and individuation. Jung viewed the self as the ultimate goal of psychological development, where an individual achieves a harmonious integration of all aspects of their personality. This process of individuation is a journey towards self-realisation, involving the acknowledgment and integration of one's inner experiences and potentials. The self is thus seen as both the totality of the psyche and the driving force behind an individual's quest for balance and completeness. Through understanding and embracing the self, individuals can achieve a deeper sense of meaning, purpose, and connectedness within their lives.

More recently, interest in spirituality during the early years has emerged from two rather different spheres of psychology. The first comes from therapeutic work with children who are terminally ill or have nearly died as a result of sickness or accident. Dr. Elisabeth Kübler-Ross has been a key pioneer in this domain. Her work led directly into the realm of transcendent experience and the field of psychological research. The second comes from investigators who have reviewed countless reports,

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9 George, et al., 2000.
10 Bridged and Moore, 2002.

some by children as young as 2 years, that consistently describe a common series of extraordinary events close to the moment of physical death, called near-death experiences. Kübler-Ross observed, 'I can only say that these (episodes) come from every corner of the world – from religious and non-religious people, believers and non-believers, from every conceivable cultural and ethnic background'.[11]

We have to make a distinction between the terms spirituality and religiousness. The latter may also involve a search for the spiritual, as it is undertaken within a collective (i.e. a church or some other type of religious community) that provides guidance, validation, and support for the methods with which that search is conducted[12]. In summary, both spirituality and religiousness are explored in psychology for their effects on mental health, coping mechanisms, and overall life satisfaction. While *spirituality* refers to a broad concept that encompasses a sense of connection to something greater than oneself, religiousness typically refers to adherence to specific organised beliefs, practices, and rituals associated with a particular faith or religion. It involves community participation, doctrine, and structured forms of worship. In psychology, religiousness is often studied in relation to community support, moral frameworks, and the impact of faith on mental health.[13]

Religious and faith development are described by some notable theorists in psychology. David Elkind's work focusses on the cognitive and emotional development of children in relation to their understanding of religion. He emphasised the role of imagination and how children use symbolic thinking in religious contexts. Elkind noted that as children grow, their capacity to understand abstract religious concepts evolves, moving from concrete representations to more abstract thinking.[14] *James W. Fowler* describes the stages of faith development, outlining a progressive framework from early childhood through adulthood:

- *Stage 1: Intuitive-projective faith* (ages 3–7 years): Children rely on intuition and imagination. Their faith is shaped by stories, images, and symbols.
- *Stage 2: Mythic-literal faith* (ages 7–12 years): Children start to understand religious stories more literally. They begin to distinguish between fantasy and reality but still think in concrete terms.
- *Stage 3: Synthetic-conventional faith* (Adolescence): Adolescents start to see the world from perspectives outside their own and begin to form a more coherent belief system influenced by their peers and authorities.[15]

These theorists collectively highlight that children's faith and religious development involve a gradual and complex process, influenced by their cognitive and emotional growth as well as their social environment. Each stage reflects a deeper and more abstract understanding of faith and religion as children mature.

11 Robinson, 1983.
12 Allport and Ross, 1967.
13 Ibid.
14 Ibid.
15 Ibid.

2.3. Part Three: Future Perspectives: Parenting and Societal Outlook

In part three of our book, readers will find two significant articles addressing current and future questions related to parenting and societal dynamics.

The first article (Chapter 11) addresses a crucial aspect of children's well-being at the societal level: development of *trauma-informed childcare institutions and educational systems.* Establishing trauma-informed environments represents a significant shift in our approach to prioritising the safety and well-being of children, thus fostering healing, growth, and resilience. The journey towards implementing trauma-informed practices in childcare and education is ongoing across the Central-European Countries. This chapter explores the concept of trauma-informed care in both childcare and education, highlighting the fundamental principles that underpin this approach. It also provides guidelines for creating systems that promote healthy developmental conditions, which are essential for children's daily lives.

The second and final article (Chapter 12) explores the question, *How can the society best support future parents in caring for their children?* Merkas et al. examine the transformations in societal expectations and living conditions over the past 50 years that have influenced perceptions of parenting. They note that the evolving role of mothers as primary caregivers, increased involvement of fathers in family duties and childcare, and impact of digital life are all contributing to a new era of parenting. Today, parents are more likely to seek advice online and look for support from family members or neighbours before consulting professionals. This shift has led to a complex environment where misinformation and public debates about parenting practices are prevalent, making it challenging to navigate the landscape of modern parenting.

3. Psychological Development in a Broader Context, And the Changing Image of the Child

The working definition of childhood in our book refers the period from birth to the age of 18 years. This is an internationally agreed definition of childhood as specified in the UNCRC. This definition encompasses enormous diversity, from small infants to young people. It is not strange to ask the question, What is a child? The answer is by no means as obvious as it may appear in modern societies in which childhood is so powerfully taken for granted. Understanding of what is a child is not fixed. It has differed over historical time and varies from society to society, culture to culture, and time to time. Children are part of families, communities, and nations.

Philippe Aries argued that European childhood is a specific, modern construction dependent on the particular social and historical factors in Europe. Sociologist Chris Jenks aptly described the complex Western discourses around childhood. He commented that ideas about children are so contradictory over time that it is possible to take one adjective to describe childhood and believe it to be true, and then take its opposite and also believe this. Some of the complex Western contemporary

ideas about children are inherited from past philosophical, artistic, and scientific discourses.

The discourse surrounding childhood has evolved significantly over time, with key contributions from philosophers such as Hobbes, Locke, and Rousseau. Each of these thinkers presented a distinct perspective on the nature of children, reflecting broader societal beliefs and shaping contemporary views. *Hobbes* portrayed children as inherently evil, emphasising a Puritan discourse that suggests the need for strict control and guidance. This perspective highlights a view of childhood as a state requiring intervention to prevent moral decay, framing children as beings in need of discipline. In contrast, *Locke* introduced the idea of the child as a *tabula rasa*, or blank slate. According to his theory, children are neither inherently good nor evil but are shaped entirely by their experiences and upbringing. This discourse emphasises the importance of education and the environment in fostering a child's development, suggesting that nurturing and positive influences can lead to moral growth. *Rousseau*, on the other hand, presented a more optimistic view, seeing children as inherently good. This Romantic discourse celebrates the innate potential of children and advocates for a naturalistic approach to upbringing, encouraging freedom and exploration as essential components of healthy development.

These foundational ideas continue to resonate in contemporary debates about childhood, influencing how children are perceived and treated today. The legacy of these discourses informs current discussions about parenting, education, and child welfare, highlighting the enduring impact of historical perspectives on modern practices. Understanding these evolving discourses is crucial for grasping the complexities surrounding childhood in today's society.

The contemporary world is often said to be going through a period of globalisation, and it clearly influences theories and policies on modern childhood. Beliefs and values about childhood are also becoming globalised. Notions of childhood inevitably become part of this process. In 1997, the World Bank published a report on early child development called *Early Child Development: Investing in the Future*. The report aimed to have worldwide significance and be applicable to all children. It divided children under 8 years into four categories: infants (0–1 years), toddlers (1–3 years), pre-schoolers (3–6 years), and young school age children (6–8 years). It then listed the expected developmental stages that every child, regardless of their whereabouts in the world, should be expected to reach. Its recommendations were meant to be universal and based on scientific facts, and the report spelled out standards that children should meet. Not only was a universal image of the child born that time, but the ideal childhood was also standardised and exported globally. If there are universal processes and standardised childhood developmental phases, it is foreseen that the construct of the "problem child" will arise.[16]

Not only has contextual thinking about childhood changed throughout the decades, but psychology itself has also made a huge journey, since child development

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16 Woodhead and Montgomery, 2002.

became a topic of interest in psychology. Our current scientific knowledge has travelled far from the beginnings of child psychology. Although we are still in search for many answers regarding human development, a lot of empirical research from the last 150 years supports our knowledge on the complex process from the moment of conception to a child reaching 18 years of age.

In the year 1799, in the rural region of Aveyron, France, a remarkable and mysterious event captured the attention of local villagers. It began with sporadic sightings of a wild, dirty, and naked boy who appeared to be living alone in the nearby dense woods. Upon his capture, it became clear that the boy had been living in the wild for a significant period. He was covered in dirt and scars, likely from his time surviving in the harsh conditions of the forest. The boy, who would later become known as Victor of Aveyron, was unable to speak and exhibited behaviours that suggested he had little to no human contact during his formative years. The case intrigued many, including Dr. Jean-Marc-Gaspard Itard, a young physician who specialised in the education of the deaf. Dr. Itard saw an opportunity to study Victor and possibly rehabilitate him, hoping to understand more about human development and the impact of social isolation on children. With permission from the authorities, Dr. Itard took Victor under his care and began a rigorous programme aimed at teaching him language, social norms, and basic human behaviours. Over the years, Victor made some progress, learning to understand basic words and perform simple tasks. However, he never fully acquired language or integrated completely into society. Despite the limited success, Victor's case provided valuable insights into child development, the effects of isolation, and the human capacity for learning and adaptation. Victor of Aveyron's story remains a poignant example of the resilience of the human spirit and the profound impact of early social experiences on development.[17]

The study of children as an empirical science was conducted as early as 1840 when Charles Darwin began to form a record of the growth and development of his child. Following Darwin, the study of human childhood became firmly established as a respected subject for scientific scrutiny, detailed description, theorisation, and experimentation.

Now, thanks to modern brain mapping techniques, we know that babies from the very beginning of life are interactive human beings. Each one comes with a genetic blueprint and a unique range of possibilities. Through the mirror neurons in our brain, we are connected to other people from the start of life, already resonating with other people from the very beginning. The active baby seeks out interactions with others. Well-managed babies come to expect a world that is responsive to them to bring intense states back to a state of comfort. This is what we call the competent baby, or the image of the competent infant.

We must note that most of the detailed descriptions of the many stages and transitions that take place in childhood are based on developmental psychology in the context of Western childhoods. On the other hand, much scientific research on

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17 Wikipedia, n.d.

childhood, especially in developmental psychology, has been criticised for presenting its conclusions as universal truths, even though that research was based on children and young people growing up in industrialised societies, especially in Europe and North America. The social constructivist approach emphasises that there is no universalist approach. We must consider that knowledge, beliefs, and understanding about childhood are culturally situated.

Beliefs and debates about how children should develop opened discussions on how to treat and educate them properly. Developmental concepts had a huge impact on how to treat children at home, in schools, or even in hospitals and childcare centres. Developmental concepts have just become a common part of everyday language. In the second half of the 20th century, parenting became an everyday topic. Current research on parent-child characteristics focusses heavily on understanding the dynamics, influences, and outcomes of the relationships between parents and their children in contemporary society. Studies explore how different parenting styles (authoritative, authoritarian, permissive, etc.) impact children's cognitive, emotional, and social development. Research often examines the balance between warmth and control in parenting and its effects on children's outcomes. Researchers emphasise the importance of considering cultural variations and socioeconomic factors in understanding parent-child relationships. This includes how cultural beliefs and practices around parenting influence child-rearing practices and child outcomes. Studies explore how digital media use by parents and children affects family dynamics, parent-child interactions, and child development outcomes, including social skills, language development, and behavioural patterns. Current studies also focus on identifying factors that contribute to parental stress, resilience, and coping mechanisms in the face of various challenges, such as economic hardships, divorce, or parenting children with special needs[18].

Overall, contemporary research on parent-child characteristics aims to provide insights into effective parenting practices, familial relationships, and factors contributing to healthy child development in diverse contexts.

3.1. Towards an Integrated Image of the Child

Although the definition of children can change across time and place, their presence does not. Childhood is part of the human experience, and children influence our world. Children are fully human, yet they are also developing beings in need of instruction and guidance. They are vulnerable orphans, yet they are also social agents with gifts and strengths that contribute to our world. They are members of the community who are nurtured by adults, and yet they also serve as models for adults.[19]

While psychology provides clear guidance on what constitutes an ideal childhood—love, attachment, and nurturing environments—the reality of addressing individual child cases can be significantly more complex. When a child is already

18 Frosch, Schoppe-Sullivan and O'Banion, 2019.
19 Woodhead and Montgomery, 2002.

facing challenges, finding the best solution becomes difficult, and the clear, idealistic concept of the child's best interest can become complicated. As discussed in the Introductory Thoughts in this chapter, since the rights of children were declared, a legal component of how we think about childhood was added and a new image of children emerged—the child with rights.

While children's rights emphasise the importance of ensuring safety, development, and well-being for every child, psychology offers insights into the emotional, cognitive, and social needs of children. The challenge lies in connecting the ideal legal concepts with the realistic circumstances each child faces. *Can we bridge the gap between ideal and realistic solutions to truly serve a child's best interests?* Can we bridge law and psychology to truly serve a child's best interests?

A key question can be raised about the status of young humanity—their needs, competences, responsibilities, and rights. Put simply, how far are children seen as innocents who need protection, nurture, and training as well as social actors who engage with and contribute to their development and have the right to be heard?[20]

Only an interdisciplinary practice can attend to children's challenges and contributions that can honour their vulnerabilities and strengths as well as emphasise adult duties and responsibilities to children. Quoting from Marina Merkas et al. in this book

> "The goal of this interdisciplinary connection is to ensure that children receive the care, support, and protection they need for their optimal development and happiness. This means that legal decisions are not made in isolation but are informed by psychological insights. It acknowledges that the well-being of children goes beyond just meeting their basic needs; it includes their emotional and psychological health, which can significantly impact their future well-being. In conclusion, when psychology and law work together to promote children's well-being, a thorough and child-centred strategy is produced, with legal choices being based on a thorough comprehension of the psychological requirements of children to support their best possible growth and well-being."

By the end of this book, we hope that readers will be well-acquainted with the major concepts in developmental child psychology presented here. Our goal was not just to present the fundamental models of psychological thinking about childhood. It is important to note that psychological thinking cannot be separated from its cultural and historical contexts. Additionally, we aim to provide insights into children's mental health issues, highlighting mainstream concepts that shape the trajectory of developmental psychology, such as the concepts of trauma and resilience. We also explore the roles of parenting and society, examining how these factors influence child development and well-being.

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20 Bunge, 2021.

At the second Children's Rights Days conference in Budapest, a new aspect of the interdisciplinary concept of childhood was briefly introduced to the public by the editor of this book. Because human beings, and especially the child, are a truly remarkable entity, they cannot be treated as being mere objects of a single science or based on one isolated social construct. Only professionals who have participated in interdisciplinary teamwork concerning a child's case can truly appreciate the numerous facets and perspectives that emerge. Each of these professionals, whether having medical, psychological, social, legal, or spiritual backgrounds, contributes their unique viewpoints, illuminating different aspects of the child's complex and integrated being. The integrated image of the child we refer to involves the concept of restoring the child to their whole existence. It is a state the child often recalls and expresses through symbols in psychotherapeutic settings. This holistic aspect is inherent in everyone, including adults, often referred to by various names such as the "inner child" or "archetypal child" within ourselves. Understanding and addressing this integrated nature is crucial in providing comprehensive care and support for the child's development and well-being.

Hans Urs von Balthasar emphasised the importance of recognising and integrating the sacred aspects of early childhood into adulthood. He believed that elements present from the very beginning of our lives hold a profound significance that should not be lost as we grow older. Balthasar's theological perspective suggests that the innocence, wonder, and inherent sacredness of childhood are crucial components that shape our spiritual and moral development throughout life. This view underscores the continuity between the sacredness of childhood and responsibilities of adult life, advocating for an ongoing integration of these early experiences within our mature selves.[21]

Therefore, it is the duty and responsibility of anyone who holds these opinions to consider how these definitions apply in children's daily lives and our work.

We hope you enjoy your journey through our book!

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21 von Balthasar, 1998.

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Part I
Children in the 21st Century

Children in the 21st Century: A Brief Overview of Children's Mental Health Issues and Psychological Well-Being in Contemporary Society

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ABSTRACT

In the 21st century, children face a unique set of challenges that were inconceivable a few decades earlier. Daily, children confront heightened stress from social pressures, academic demands, and the pervasive digital environment. The changing dynamics of family functioning, peer relationships, and cultural influences might be challenging for children's well-being and mental health. Recent studies show a significant rise in mental health issues among children in the 21st century. Before we outline how the society can help, it is important to gain some understanding of mental health issues. First, we define mental health issues, and second, we explain how mental health issues arise and develop, and which factors make children vulnerable to the development of mental health issues; third, we provide a detailed overview of the prevalence of the most common mental health issues in children and adolescents. Finally, some strategies that might contribute to the protection of children in the modern era are presented.

KEYWORDS

children, mental health issues, psychological well-being, risk and protective factors, prevention

1. Mental Health and Mental Health Issues

1.1. *What Are Mental Health and Mental Health Issues?*

Individuals' good mental health is not only important for their own functioning but also a benefit for the whole community. The World Health Organization (WHO)[1] defines mental health as 'a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community'. Mental health issues (MHIs) can be defined as difficulties in coping

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1 WHO, 2022b, pp. 9–163.

with stress, realising abilities, learning, working, or contributing to the community. The International Classification of Diseases 11ᵗʰ Revision (ICD-11)[2] defines mental disorders as

> "...a syndrome characterized by clinically significant disturbance in individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes that underline mental and behavioural functioning. These disturbances are usually associated with distress or impairment in personal, family, social, educational, occupational, or other important areas of functioning."

MHIs and mental disorders are heavily intertwined. One distinctive difference between them is that MHIs are often presented on a continuum, while mental disorders have some specific diagnostic criteria that last for a longer time period.[3,4] MHIs can vary in severity and impact a person's daily life, relationships, and ability to function effectively.

1.2. Prevalence of Mental Health Issues

In this chapter, MHIs in children and adolescents are divided into the following categories:
- Internalised problems,[5] which include anxiety and depression
- Externalised problems,[6] which include aggressive behaviour and conduct disorder
- Attention and regulation problems,[7] which include attention-deficit/hyperactivity disorder (ADHD) and specific learning difficulties
- Problems related to digital technology use, which include problematic smartphone use and internet gaming disorder

In 2022, WHO published a *World Mental Health Report* with the subtitle *Transforming Mental Health For All*. In this report, WHO takes a closer look into specific MHIs and points to the worsening of the situation in children's mental health. WHO stated that 22% of children aged 5–19 years have some MHIs.[8] WHO points out that ADHD is the

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2 WHO, 2022a, pp. 393–565.
3 WHO, 2022a, pp. 393–565.
4 WHO, 2022b, p. 13.
5 Internalised problems are problems whose effects are not apparent on the outside but rather appear in one's thoughts and emotions.
6 Externalised problems are those that have some effect on other people, such as foul language, aggressive behaviour, and destruction of property; they are focussed on behaviours towards other people, that is, their goal is to harm others.
7 These problems are part of neurodevelopmental disorders because their onset is early in development, before the start of school, and they often influence the school performance of children.
8 WHO, 2022b, pp. 9–163.

most common problem among younger children (4.6% of children); anxiety is the most common problem among adolescents of both genders (around 4.5%) and even more prominent in adolescent girls (around 5.5%), and is sometimes linked to depression.[9] In 2021, according to UNICEF, among children aged 10–14 years, 13.5% of boys and 11.2% of girls had some mental disorder, while among children aged 15–19 years, 14.1% of boys and 13.9% of girls had some mental disorder.[10] When considering both age groups, the most common mental disorders were anxiety and depression (42.9%) in both boys (31.4%) and girls (56.3%).[11]

Recent literature reviews[12,13,14,15] have shown that the COVID-19 pandemic highly influenced the mental health of children and adolescents worldwide. Especially, elevation was observed in children's and adolescent's anxiety and depression, as well as in irritability, attention problems, and problematic use of smartphones.[16,17,18] UNICEF points out that, after anxiety and depression, the most prevalent MHIs in children and adolescents are conduct disorder (20.1%) and ADHD (19.5%); both are more prevalent among boys (24.3% and 26.7%, respectively) than girls (20.1% and 19.5%, respectively).[19]

In some cases, severe anxiety and depression can lead children and adolescents to take their own lives, that is, commit suicide.[20,21] Recent data by WHO on children and adolescents worldwide show that suicide is a leading cause of death in adolescents, with UNICEF reporting that 'almost 46,000 children and adolescents between the ages of 10 and 19 end their own lives – about 1 every 11 minutes'.[22,23] Data for the whole of Europe show that suicide is the second most common cause of death in young people aged 15–19 years, right after road injuries, with 6 deaths a year for every 100,000 population.[24] Eurostat data show that in 2020, of all European countries, Estonia had the highest percentage of adolescents aged 15–19 years who committed suicide (18.86%), followed by Iceland (13.47%), while Cyprus and Malta did not report any death by suicide in this age group in 2020.[25] UNICEF reported that suicide in childhood and adolescence is more prevalent in boys (59% and 71%, respectively) than girls (41%

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9 Ibid.
10 UNICEF, 2021, pp. 29–174.
11 Ibid.
12 Meherali et al., 2021, p. 3432.
13 Mohler-Kuo et al., 2021, p. 4668.
14 Racine et al., 2021, pp. 1142–1150.
15 WHO, 2023, pp. 5–19.
16 Christner et al., 2021, p.1.
17 Irman et al., 2020, pp. 182–185.
18 Meherali et al., 2021, p.3432.
19 UNICEF, 2021, pp. 29–174.
20 WHO, 2022a, pp. 393–565.
21 American Psychiatric Association, 2014, pp. 155–235.
22 WHO, 2022b, pp. 9–163.
23 UNICEF, 2021, p. 17.
24 Ibid., pp. 29–174.
25 Eurostat, 2023.

and 29%, respectively).[26] On the other hand, conduct disorder is, as will be discussed later, more focussed on doing harm to other people and violating the rights of others; as such, it can be a risk factor for and an early sign of delinquency and some criminal behaviour. Research on this topic shows that adolescents are more prone to some delinquent behaviour (e.g. drinking alcohol or using drugs) than severe criminal behaviour.[27] Data from Europe are somewhat scarce, mainly because children aged below 14 years[28] are rarely sent to prison.[29] The most recent data on all European countries show that there are around 4,000 juvenile or minor inmates, who make up 0.1–6.9% of the total prison population in specific countries.[30,31] European countries are more focussed on the prevention and rehabilitation of child and adolescent delinquents, so most of the offenders are sent to rehabilitation centres for some form of community service.[32,33]

Research has shown that MHIs in children are related to less positive and more negative affects (i.e. daily, weekly, or monthly) and lower life satisfaction and well-being.[34] Well-being is most often defined as an affective and cognitive evaluation of one's life.[35] In this context, affective evaluation refers to the presence of positive affect and absence of negative affect,[36] while cognitive evaluation refers to life satisfaction—cognitive judgement of one's life and life experiences.[37,38] Life satisfaction and the overall well-being of children and adolescents reduced during the COVID-19 pandemic.[39,40,41,42,43,44]

These data should be considered seriously in terms of policymaking and intervention and prevention programmes. This is because childhood and adolescence are crucial life phases in which most mental health disorders begin, usually starting with milder MHIs.

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26 Ibid.
27 American Psychiatric Association, 2014, pp. 461–481.
28 In most countries, this age limit varies from 12 to 18 years.
29 Aebi and Hashimoto, 2022, p. 1.
30 Children of Prisoners Europe, 2023, p. 1.
31 Aebi et al., 2023, p. 1.
32 Aebi and Hashimoto, 2022, p. 1.
33 Aebi et al., 2023, p. 1.
34 Chen et al., 2017, p. 341.
35 Diener et al., 2002, pp. 63–73.
36 Chen et al., 2017, p. 341.
37 Ibid.
38 Diener et al., 2002, pp. 63–73.
39 Christner et al., 2021, p. 1.
40 Cowie and Myers, 2020, p. 1.
41 Meherali et al., 2021, p. 3432.
42 Mohler-Kuo et al., 2021, p. 4668.
43 Racine et al., 2021, pp. 1142–1150.
44 WHO, 2023, pp. 5–19.

2. Evolution of Mental Health Issues: Understanding Their Development

One most well-known and comprehensive theory for the development of MHIs, which is based on both biological and psychological approaches, is the biopsychosocial model (BPS). This model represents the integration of and interaction between several factors in the aetiology of MHIs: biological, psychological, and social components. The BPS model defines MHIs as emerging from a human system that includes both physiological components (biological nervous system) and psychosocial components (e.g. relationships, family, and community).[45] Biological factors encompass the genetic predisposition to certain mental disorders, neurochemical imbalances in the brain, and other biological elements that may contribute to the development of MHIs (e.g. individuals with a family history of mental health disorders may have higher risk for development of the same disorders). Psychological factors involve the emotional, cognitive, and personal characteristics of an individual, such as stress, trauma, low self-esteem, anxiety, and depression, which contribute to the development of MHIs. Social factors are all environmental factors such as social support, family dynamics, economic circumstances, and cultural factors. Within the BPS model, MHIs develop and result from a complex interplay of multiple factors.

Factors that impact the likelihood of specific MHIs are commonly known in the literature as risk and protective factors. Risk factors are characteristics, traits, or features of an individual that increase the likelihood of them developing a particular problem.[46] Biglan et al. identify fundamental risk factors for the development of multiple MHIs, including individual, family, peer, school, community, and economical factors.[47] Table 1 presents the most common risk factors for MHIs in children in the 21st century.

The mere presence and impact of risk factors do not always result in negative outcomes. Protective factors mediate and/or moderate the effects of risk factors, thereby reducing the incidence of behavioural problems.[48] While there are numerous protective factors, some of them are mentioned and emphasised more frequently in the literature, including individual, family, school, and community strengths.[49] The risk and protective factors coexist, and their dynamic interaction usually leads to the manifestation of (un)favourable patterns and experiences. Table 1 presents the most common protective factors for MHIs in children in the 21st century.

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45 Ghaemi, 2011, pp. 451–457.
46 Garmezy, 1992, p. 50.
47 Biglan et al., 2004, pp. 1–318.
48 Garmezy, 1992, p. 50.
49 Bašić, 2009, pp. 200–250.

Table 1. Some risk and protective factors for the
development of MHIs among children today[50]

	Personal characteristics	Family dynamics	School environment	Community influence
Risk factors	Genetics[51,52,53]	Insecure attachment	High academic pressure[54]	COVID-19 pandemic[55,56,57,58,59]
	Onset at a young age[60]	Low socioeconomic status[61]	Unsupportive and abusive teachers[62]	Poverty[63,64]
	Female gender[65,66]	Parental conflict[67]	Financial barriers[68]	War
	Personality traits (neurotic, irritable, depressive, and affective temperament)	Parental divorce[69]	High peer pressure[70,71,72,73]	Easily available digital technology[74,75,76]

50 Source: Author's own work.
51 Rayner et al., 2019, p. 1.
52 Zhang et al., 2021, pp. 1267–1281.
53 Yuan et al., 2021, p. 1.
54 UNICEF, 2021, pp. 15–174.
55 Ibid.
56 Gardner et al., 2019, p. 104082.
57 Gilsbach et al., 2021, p. 1.
58 Nearchou et al., 2020, pp. 8479.
59 Oliva et al., 2021, p. 1.
60 NHS England and Department of Health, 2015, pp. 13–75.
61 Reiss et al., 2019, p. e0213700.
62 UNICEF, 2021, pp. 15–174.
63 Bøe et al., 2017, pp. 1–11.
64 Adjei et al., 2022, p. 1.
65 Mendolia et al., 2022, p. 110458.
66 Giota and Gustafsson, 2016, pp. 253–266.
67 Cumming and Koss, 2010, p. 503.
68 Ibid.
69 Leturcq and Panico, 2019, pp. 921–951.
70 Ford et al., 2021, pp. 1467–1478.
71 Patalay et al., 2020, p. 106292.
72 Zhou et al., 2020, pp. 2090–2108.
73 UNICEF, 2021, pp. 15–174.
74 Kelly et al., 2019, pp. 59–68.
75 Twenge and Farley, 2021, pp. 207–217.
76 Twenge et al., 2022, p. 103512.

	Personal characteristics	Family dynamics	School environment	Community influence
Protective factors[77]	Intelligence	Positive family communication	School connectedness	Effective prevention policies
	Positive self-image	Parental support	Active participation in school activities	Clear norms and values
	Empathy			
	Problem-solving skills			

3. Overview of Mental Health Issues in Children and Adolescents

3.1. Internalised Problems

In most cases, internalised problems affect just the person with the problem and are sometimes harder to detect. The most common internalised problems in children are anxiety and depression, which are related to feelings of stress and loneliness.

3.1.1. Anxiety

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (American Psychiatric Association, 2013) defines anxiety disorders as problems 'that share features of excessive fear and anxiety and related behavioral disturbances'.[78] What defines generalised anxiety disorder in both children and adults is persistent and excessive anxiety about various life domains, with the combination of some physical symptoms, such as difficulty concentrating, sleep disturbance, and muscle tension, for at least six months.[79] The prevalence of generalised anxiety disorder in children is relatively small, as about 4–5% of children and adolescents are diagnosed with it.[80] ,[81] This is because children often have some other forms of anxiety (i.e. separation anxiety or social phobia) that are more prevalent in specific stages of childhood and adolescence and have to be distinguished from generalised anxiety disorder. The general prevalence of anxiety symptoms in children and adolescents is 15–25%, depending on the sample and country. It is also observed in research and diagnostics that girls are more prone to experiencing anxiety symptoms and being diagnosed with a disorder than boys.[82]

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77 Bašić, 2009, pp. 200–250.
78 American Psychiatric Association, 2014, p. 189.
79 Ibid.
80 Gale and Millichamp, 2016, p. 1002.
81 Steinsbekk et al., 2021, pp. 527–534.
82 CDC, 2023a, p. 1.

3.1.2. Depression

According to the American Psychiatric Association (2013), the 'presence of sad, empty or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function'[83] is a sign of some depressive disorder, such as major depressive episode or disorder.

When people suffer from some depressive disorder, they experience no pleasure in daily activities, have trouble sleeping, lose energy daily, and feel worthless or guilty. To diagnose a child or adolescent with a depressive disorder, symptoms must be present for at least one year.[84] The prevalence of depression in childhood is rather small. Research shows that around 2% of children suffer from some form of depression or experience some depressive syndromes.[85,86,87] Any type of depression symptoms, including disorders, is more prevalent in adolescence. Research has shown that during adolescence, 15–20% of boys and girls suffer from some type of depression, which is more prevalent among girls.[88,89,90] Results also confirm gender differences in the prevalence of depression in adolescents: In one sample, 29.2% of girls and 11.5% of boys had at least one major depressive episode in the previous year.[91]

3.2. Externalised Problems

In children and adolescents, the most prominent form of externalised problems is aggressive behaviour, usually in the form of bullying. However, some children can also be diagnosed with conduct disorder.

According to the American Psychiatric Association (2013), the most basic symptom of conduct disorder is a repetitive pattern of behaviour that is marked with a violation of basic rights or societal norms for at least 12 months.[92] This behaviour is described as physical cruelty to people or animals, deliberate engagement of fire, breaking into someone's house, staying out late despite parental rules, bad relationships with peers, and so on. Regarding externalised problems and conduct disorder during childhood and adolescence, boys are more likely to express this type of behaviour and be diagnosed with conduct disorder.[93,94] Generally, conduct disorder is diagnosed in 5–10% of children, mainly boys. Different research points to the fact that the ratio

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83 American Psychiatric Association, 2014, p. 155.
84 Ibid.
85 Juul et al., 2021, pp. 64–72.
86 Pataki and Carlson, 2016, pp. 10–14.
87 SAMHSA, 2022, pp. 1–72.
88 Juul et al., 2021, pp. 64–72.
89 Pataki and Carlson, 2016, pp. 10–14.
90 SAMHSA, 2022, pp. 1–72.
91 Ibid.
92 American Psychiatric Association, 2014, p. 461.
93 Dellazizzo et al., 2020, pp. 619–626.
94 Mohammadi et al., 2021, pp. 205–225.

of conduct disorder is 2:1 for boys, with around 7% of girls and 11% of boys having conduct disorder.[95,96]

3.3. Attention and Regulation Problems

ADHD is an impairment involving inattention, disorganisation, and hyperactivity-impulsivity. Children often have problems with focussing on certain tasks; have problems with listening, sitting still, and waiting; and often intrude on other people's activities. In diagnosing ADHD, it is very important for the symptoms to significantly interfere with everyday activities and normative development. Research shows that ADHD is more prevalent in boys than girls, in both childhood and adolescence. The global prevalence of ADHD is 7.2%. Different national surveys and global research show that its prevalence is around 2% in young children (i.e. aged 3–5 years), around 10% in older children (i.e. aged 6–11 years), and 5–13% in adolescents (i.e. aged 12–17 years).[97,98,99,100] It is also noticed that around 13% of boys are diagnosed with ADHD, compared to around 6% of girls, with the ratio being consistent in all age groups.

Children can also have other problems affecting their schoolwork and academic achievement, known in the literature as specific learning difficulties.[101] The most common ones are dyslexia, dysgraphia, and dyscalculia. These problems or difficulties are the result of neural development and/or brain functioning and are related to problems in reading or writing (dyslexia[102] and dysgraphia)[103] and mathematics (dyscalculia).[104] Research has shown that the general prevalence of specific learning disabilities is relatively high (around 20%).[105] Literature shows that 15–20% of children have dyslexia, 10–30% have dysgraphia, and 3–7% have dyscalculia.[106,107,108] The literature also suggests that specific learning difficulties are more prevalent in boys than girls, more during the childhood than adolescence. Moreover, specific learning difficulties are highly related to ADHD: Around 40% of children with some learning

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95 Dellazizzo et al., 2020, pp. 619–626.
96 Mohammadi et al., 2021, pp. 205–225.
97 Polanczyk et al.,2014, p. 434.
98 Bitsko et al., 2022, pp. 1–42.
99 CDC, 2023b, p. 1.
100 Salari et al., 2023, p. 1.
101 Al-Qadri et al., 2021, p. 1.
102 A syndrome wherein a person has problems with reading certain letters (e.g. b, p, and d) because their brain cannot fully distinguish similarities in the look of these letters.
103 A syndrome where a person has problems with writing certain letters because of how they look.
104 A syndrome where a person has problems with recognising and writing numbers and distinguishing between them and generally has problems with mathematics.
105 Al-Qadri et al., 2021, p. 1.
106 Ashraf and Najam, 2020, pp. 1659–1663.
107 Haberstroh and Schulte-Korne, 2019, pp. 107–114.
108 Wagner et al., 2020, pp. 354–365.

difficulty also have ADHD, and around 25% of children with ADHD will be diagnosed with some learning difficulty.[109]

3.4. Problems Related to Digital Technology Use

Recent research shows that around 25% of older children (i.e. aged 7–11 years) and nearly 90% of adolescents (i.e. aged 12–17 years) have their own smartphones and use them for long periods during the day.[110,111] These percentages were even higher during the COVID-19 pandemic, as children attended school via online platforms and spent even more time in front of screens, with some data pointing to a rise in screen time for 50% of children compared to the time before the pandemic.[112,113,114] Previous studies identify two major concerns when discussing technology use and children's mental health: problematic smartphone use and excessive online gaming.

Problematic smartphone use is defined as the use of a smartphone for longer time periods during the day, which affects daily functioning and basic needs (e.g. eating and sleeping).[115,116] The prevalence of children who can be categorised as problematic smartphone users is 10–30%. This problem is more prominent in adolescents than in younger children, as they gain more independence as they grow older and tend to disobey parental rules. Problematic smartphone use affects different aspects of functioning in children and adolescents and can trigger MHIs.

Research shows that online gaming is an upcoming problem for mental health in children and adolescents as it shows high correlation with some MHIs.[117,118] In the latest version of the *Diagnostic and Statistical Manual of Mental Disorders*, internet gaming disorder has been categorised as 'other condition that may be a focus of clinical attention',[119] but it has not yet been classified as a disorder. It is defined as 'a pattern of excessive and prolonged Internet gaming that results in a cluster of cognitive and behavioral symptoms, including progressive loss of control over gaming, tolerance, and withdrawal symptoms, analogous to the symptoms of substance use disorders'.[120] Similar to any other addiction, basic human needs, social relationships, and daily functioning are generally affected in people with an online gaming problem.[121,122,123,124]

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109 Al-Qadri et al., 2021, p. 1.
110 Auxier et al., 2020.
111 Sohn et al., 2019, p. 1.
112 Hedderson et al., 2023, p. e2256157.
113 Mokhtarinia et al., 2022, p. 681.
114 Serra et al., 2021, p. 1.
115 Park and Park, 2021, p. e0244276.
116 Sohn et al., 2019, p. 1.
117 Alrahili et al., 2023, p. 1.
118 Putra et al., 2023, pp. 196–204.
119 American Psychiatric Association, 2014, p. 783.
120 Ibid.
121 American Psychiatric Association, 2014, p. 784.
122 Alrahili et al., 2023, p. 1.
123 Putra et al., 2023, pp. 196–204.
124 Yang et al., 2023, p. 100609.

Even though gaming addiction is not yet classified as a disorder, research shows that around 3% of children and adolescents worldwide meet the criteria for gaming addiction, and this is more prevalent among boys than girls.[125,126,127]

4. What Can We Do?

4.1. Promoting Children's Well-Being and Preventing MHIs

Poor mental health has significant negative consequences on the global society and the overall economic situation because it leads to job loss, which in turn brings poverty, stigma, and discrimination. Social exclusion, violent victimisation, and human rights violations are more common among individuals with MHIs compared to the general population according to WHO.[128] A study on 30 countries in the European Union revealed that the total cost of mental, neurological, and neurodegenerative disorders in 2010 amounted to 798 billion euros.[129] A study in the United Kingdom calculated that total expenses over a person's lifetime reach 97,490 euros per child for a moderate behavioural issue and 2,981,190 euros for a severe behavioural problem.[130] Because of such consequences, it is of great importance to work on promoting mental health and well-being at an early age and on prevention, which includes timely recognition of symptoms of mental illnesses, as well as on reducing risk factors and strengthening the effects of protective factors among vulnerable groups. Mental health is a necessary precondition for the development of a sustainable society.[131,132] To protect the mental health of children and adolescents, it is necessary to invest in the promotion of mental health and prevention of MHIs.

Promotion of mental health involves all efforts to strengthen an individual's ability to respond to developmentally appropriate tasks as well as develop competencies, a sense of self-confidence, abilities, well-being, social inclusion, and the strength to cope with adversity.[133] It entails creating individual, social, and environmental conditions that are empowering and thus enable optimal health and development. Promotion that relies on a competence-enhancement model that is aimed at enhancing competencies and positive mental health should be implemented.[134] Such initiatives seek to involve individuals in processes to achieve positive mental health and improve the quality of life.

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125 Alrahili et al., 2023, p. 1.
126 Putra et al., 2023, pp. 196–204.
127 Yang et al., 2023, p. 100609.
128 WHO, 2012, pp. 1–14.
129 Gustavsson et al., 2011, pp. 718–779.
130 Parsonage et al., 2014, pp. 8–33.
131 WHO, 2013, pp. 2–27.
132 WHO, 2014, pp. 11-128.
133 WHO, 2002, pp. 7–30.
134 Barry, 2001, pp. 25–34.

Prevention is defined as the process aimed at reducing the incidence and prevalence of behavioural problems and risky behaviours in children and youth.[135] It focusses on reducing modifiable risk factors and strengthening protective factors, with the goal of such preventive interventions being risk reduction. It focusses on specific MHIs, with the aim of reducing the frequency, prevalence, and severity of problems.[136] Foxcroft (2014) outlines three functions of universal, selective, and indicated prevention, which are environmental, developmental, and informational.[137] Environmental prevention includes interventions aimed at limiting the availability of opportunities for risky behaviours through various policy programmes and legal restrictions. Developmental prevention aims to promote adaptive behaviours and prevent maladaptive ones by supporting the development of skills crucial for adequate functioning in everyday life. Informational prevention relates to education and raising of awareness, thus increasing awareness of the consequences of specific risky behaviours.

Foxcroft (2014) assumes that environmental prevention will be effective for various risky behaviours.[138] It is often equated with universal prevention, but these constructs are not synonymous, primarily because environmental prevention can take on the characteristics of selective and indicated prevention. An example of environmental prevention in the context of digital technology is the introduction of a ban, legal restrictions, or activation of social media profiles for individuals aged below 18 years (children and adolescents) to prevent the negative effects of social media on the well-being of children. In this way, environmental prevention is universal but also takes on characteristics of selective prevention as it targets a specific, vulnerable group.

4.2. How Can We Protect Children in the Modern World?

Certain subgroups are at higher risk of MHIs due to increased exposure and susceptibility to unfavourable social, economic, and environmental conditions.[139] Such disadvantages are usually persistent and accumulate throughout a person's life.

Below are some recommendations and ways in which we, as a society, can contribute to promoting children's well-being and preventing MHIs in childhood. First, it is important to emphasise the significance of early intervention for children who are at higher risk of developing MHIs. Early intervention involves identifying and addressing MHIs in children as soon as possible through regular screenings and assessments in schools and healthcare settings.[140] Schools are ideally positioned to identify and address MHIs because they provide lots of opportunities for contact with children and they have staff who are familiar with children and their families and are likely to

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135 WHO, 2002, pp. 7–30.
136 Barry, 2001, pp. 25–34.
137 Foxcroft, 2014, pp. 818–822.
138 Ibid.
139 WHO, 2002, pp. 7–30.
140 Guralnick, 1997; , pp. 391–345.

notice some changes in a child's behaviour.[141] They also have access to most children, including hard-to-reach groups and children, and children identified in schools are more likely to receive support and have better outcomes. In this context, there are two types of screening: universal and selective.[142] Universal screening involves assessing all students using questionnaires that provide an indication of a person's MHIs. These questionnaires can also be completed by their parents or teachers (using one or multiple gates). Selective screening, on the other hand, assesses only students known to school staff as being at higher risk. One recommendation regarding this question is the development and implementation of a systematic method of identifying children with mental health problems in schools or healthcare institutions. However, numerous obstacles hinder the implementation of screening in schools, including (1) inadequate financial resources, (2) inadequate training and supervision staff, (3) difficulty coordinating a full continuum of prevention and intervention services, (4) maintenance of quality and empirical support of services, and (5) limited evaluation of outcomes of services to improve programmes and contribute to policy improvement.[143]

The next recommendation is to educate and inform the public, as well as children, about factors that pose risks to mental health and those that provide protection, in addition to raising awareness about the symptoms and prevalence of MHIs. We can promote mental health literacy which is defined as knowledge and beliefs about MHIs that aid their recognition, management, and prevention.[144] A possible effective approach is the integration of mental health education into school programmes. Education increases awareness but also fosters empathy, reduces the stigma surrounding mental health, and equips children with healthy coping skills. Through such educational initiatives, individuals might become more proficient at identifying signs of distress, which may manifest as alterations in behaviour, mood swings, withdrawal from social activities, or a decline in academic performance. Moreover, creating an environment where open discussions about mental health can take place and reducing the associated stigma are essential. Moreover, such education has a pivotal role in sensitising the public to the importance of seeking professional help promptly, thus mitigating the potential development of severe MHIs. Nearchou et al. (2018) showed that young people's beliefs about other people's stigma towards MHIs were a stronger predictor of help-seeking intentions than their own stigma beliefs.[145] Furthermore, ensuring that children and parents have access to mental health services and eliminating barriers that hinder them from seeking help (e.g. lack of information about services, inflexible services, wait times, complex pathways, and cost) when needed are crucial. This ensures that appropriate support is readily available.

Another important recommendation is to consider the implementation of programmes designed to cultivate resilience in children, enabling them to effectively

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141 Weist et al., 2007, pp. 53–58.
142 Ibid.
143 Weist et al., 2008, pp. 1–363.
144 Jorm et al., 1997, p. 186.
145 Nearchou et al., 2018, pp. 83–90.

cope with challenging life circumstances. Resilience is usually defined as a positive or protective process that reduces maladaptive outcomes under conditions of risk.[146] Resilience is nurtured by providing children opportunities to confront challenges and learn from their experiences.[147]

It is important to provide parents resources and support to enhance their parenting skills and create a nurturing family environment through some evidence-based prevention programmes. Prioritising quality family time and being free from screens can strengthen familiar bonds and reduce screen dependence.[148] Promoting physical activity and a healthy family lifestyle is also paramount, as these factors are linked to improved mental health outcomes. Establishing tech-free zones or designated times during the day and modelling healthy tech habits for children foster a balanced approach to technology.

Community engagement initiatives, such as educational campaigns and support groups within the community, are needed. Encouraging children to participate in clubs, sports, volunteering, and hobbies that may facilitate social connections with local communities can significantly contribute to their mental health and overall well-being.[149] Such activities provide opportunities for social interaction, development of socio-emotional skills, and a sense of belonging, all of which may contribute to a positive mental health outcome.

Lastly, advocating for policies and legislation that prioritise children's mental health is essential. The developed systematic mental health policy refers to the future vision of the population's mental health defined by action plans, guidelines for actions and strategies, measurable objectives, and detailed areas to which activities relate.[150] Modern mental health policy should be holistic and multisectoral, consisting of five areas that encompass

- prevention and
- treatment of MHIs,
- positive mental health and promotion,
- social policies for the equality of people with MHIs, and
- the fight against stigmatisation and discrimination.[151]

The implementation of such a policy requires the collective efforts of all organisations and sectors with the responsibility for mental health such as professional associations, prevention research groups, international organisations, governments, nongovernmental organisations, the health industry (e.g. pharmacy industry), and donors (e.g. volunteers).

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146 Greenberg, 2006, pp. 139–150.
147 Southwick and Charney, 2018, pp. 1–214.
148 Roxburgh, 2006, pp. 529–553.
149 Liu et al., 2020, pp. 347–349.
150 Novak and Petek, 2015, pp. 191–221.
151 Novak and Petek, 2015, pp. 191–221; Novak and Petek, 2018, pp. 343–371.

Preventive interventions/programmes are often not comprehensive and are directed towards individual programme investments, making it challenging for them to address the existing needs of the society and achieve the desired or expected outcomes.[152] Prevention efforts are typically targeted at individuals (children), families (parents), schools (peers and teachers), or the community or neighbourhood. Such preventive activities that focus on isolated systems reflect occasional pressures and crises a community may face at a particular time, resulting in a perception of the situation's severity and the problem's prevalence. At times, issues may escalate into more significant crises that communities must subsequently grapple with. These crises, which shed light on the challenges confronting communities, serve as catalysts for the development of preventive programmes. To prevent issues from evolving into larger crises, it is crucial to proactively investigate both the risk and protective factors within the community. Efforts should be directed towards mitigating risks while enhancing protective factors. By doing so, we can not only address the immediate concerns but also work towards fostering a more resilient and mentally healthy community.

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152 Novak and Petek, 2015, pp. 191–221.

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Part II
Social and Emotional Considerations in Personality Development

| CHAPTER 2 |

Understanding the Psychological Report of a Child: What Happens During the Psychological Assessment Process?

Dominik GOŁUCH

ABSTRACT

A child psychological assessment is a comprehensive process designed to understand and assess a child's psychological, emotional, cognitive, and behavioural functioning. The aim of this chapter is to present basic information about the typical structure of psychological reports and to present important issues related to the process of diagnosing children and adolescents. This will make it easier to understand how the assessment is carried out and what to focus on when getting acquainted with the report.

The chapter discusses basic issues related to the process of psychological assessment of children and adolescents. To better understand what happens during the assessment, the standards that research tools should meet (in terms of objectivity, standardisation, validity, reliability, and normalisation) are discussed briefly. Moreover, various purposes of diagnoses and forms of diagnoses are indicated. Standards for conducting psychological diagnoses are discussed, and typical elements of the diagnostic process are described. It is indicated how children may perceive a psychological assessment situation, and, referring to the transactional model of psychological stress, the most typical factors influencing the perception of the situation are described. The roles of parents, guardians, and the psychologist-diagnostician in the entire process are indicated, along with how they can shape the process to make it more comfortable for the child. General issues related to diagnosing children at various stages of development are also discussed.

KEYWORDS

psychological diagnosis; psychometric tools; diagnosis of children and adolescents; fear of evaluation; psychological stress

1. Introduction: Diagnostic Goals, Types, and Report

A child psychological assessment is a comprehensive process designed to understand and assess a child's psychological, emotional, cognitive, and behavioural functioning.[1]

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1 Reynolds and Kamphaus, 2003, pp. 30–32.; Saklofske et al., 2013, pp. 21–22.

This process typically involves several steps and the use of various assessment tools to collect information. Depending on the area under study, the process may vary, especially when it comes to the selection of specific methods. Nevertheless, many aspects are similar, regardless of the culture, education system, or legal system. To understand what happens during the process of psychological assessment of a child, we need to not only look at the process itself, but also first discuss the standards and good practices in conducting psychological diagnoses. Only then can we look at the child's psychological situation. The child psychological assessment will differ due to the process itself and the tools used in the diagnostic process, and the broadly understanding of development and awareness of the situation will also determine the child's mental state.

Psychological diagnosis is almost always the first stage of a broadly understood intervention. Some countries conduct systematic psychological screening tests for children and adolescents.[2] Such studies may include all people in each country of a certain age to find children who deviate from the norm. Therefore, actions can be initiated to support their development. However, in many countries, the psychological evaluation process begins when either the parent, physician, teacher, or other specialist believes that something is wrong. Therefore, the purpose of the examination is to describe the child's mental, emotional, social, cognitive, and behavioural state to determine the next steps in the procedure. Having obtained information about specific undesirable symptoms or behaviours that the diagnostician identifies in an interview with caregivers or within the environment, as well obtaining the results after using appropriate research tools on the child, the diagnostician can perform the so-called differential diagnosis to check what may be the source of "abnormal" behaviour. Considering a combination of various factors, the specialist looks for the most probable cause. It is important to remember that one symptom can be an indicator of many things and not just clinical problems in the child. For example, if a child behaves aggressively, it may indicate emotional disorders or developmental problems (e.g. autism spectrum disorders);[3] it may also be related to personality traits[4] or be a reaction to the (possibly stressful) situation in which the child finds themselves.[5] When issuing an opinion in her/his report, the diagnostician should analyse all aspects comprehensively and find the most probable cause, referring to her/his experience, theory, and scientific research (evidence based diagnosis), as well as medical classifications if needed (e.g. International Classification of Diseases [ICD] or *Diagnostic and Statistical Manual of Mental Disorders* [DSM]).[6]

Having information about the condition of the examined person and the reasons for specific functioning will make it possible to undertake appropriate intervention.

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2 That is, the United Kingdom (Office for Health Improvement and Disparities, 2023) and Australia (AGDE, 2022) pp. 3–19.

3 Wrona and Józefacka, 2021, pp. 43–44.

4 Barlett and Anderson, 2012, pp. 873–874.

5 Tordjman, 2022, pp. S5–S11.

6 WHO, 2009; American Psychiatric Association, 2013, pp. 1–1120.

This intervention may be of a psychological, medical (including psychiatric), social, institutional, or legal nature. Of course, the intervention will depend on the circumstances in which the diagnostic process was initiated. It should always be borne in mind that the process very rarely starts with the child's initiative. Most often, the cause of the diagnosis is "abnormal" behaviour in the child, which is observed by specific people, and they are the ones who report to specialists. These people can be broadly divided into the following groups:

A) Parent/parents/legal guardians with whom the child lives daily: They may be concerned, for example, about changes in behaviour ('Until now, he was a calm child, but now he has attacks of aggression', 'The child has always liked to play with others, but now he prefers to play away from others', etc.) or differences between their child and other children of similar age (e.g. 'My neighbour's child is already crawling/walking/talking, but mine is not, even though mine is older', 'Other children are doing well at school, but mine is doing poorly', 'My cousin's child can recite poems very nicely, but mine has trouble remembering songs', etc.). Depending on the legal system of a given country, the consent of both[7] of the child's guardians is needed or one guardian's consent is enough[8] to start the diagnostic process.

B) Employees of the education system (nurseries, kindergartens, schools, and psychological clinics), that is, teachers, school psychologists, pedagogues, etc.: These are specialists who have knowledge in the field of child development and, at the same time, can observe the child's behaviour in a group of peers and determine whether it is within the developmental norm. The competence of these people to initiate the diagnostic process may vary depending on the legal system. Ultimately, it is the parents/guardians who must consent to the child being examined. It is a customary practice that, at the stage of enrolling the child in a facility, parents must sign an "in advance" consent for the child's participation in broadly understood psychological activities, including assessment. The reasons for this group of people starting diagnosis may include, for example, maladaptive behaviour in kindergarten/school among peers; social or emotional problems such as reacting with aggression or withdrawal inappropriate to the situation; and significant school problems, including learning and cognitive problems.

C) Health care system employees, including doctors, paediatricians, and specialists: Such employees may pay attention to certain unusual behaviours of the child during periodic examinations or if caregivers take the child to the doctor because of the child's illness. Depending on the child's condition, especially in the case of an immediate threat to life, these professionals may take appropriate actions, such as hospitalisation, beyond diagnosis, sometimes without obtaining the consent of the guardians/parents.

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7 European Judicial Network, 2023.
8 National Health Service, 2023.

D) Broadly understood group of people associated with state authority, particularly courts: This group most often has no direct contact with the child at the beginning, and the diagnosis initiated by the child appears during a specific procedure/process. The court may order a psychological examination in matters such as those related to divorce and the issue of establishing parental authority. Depending on the legal system, the court or prosecutor may order a psychological assessment in criminal cases: This involves, on the one hand, an assessment of the child as a victim (e.g. to assess the qualification of the act depending on the degree of mental health damage suffered or, on the other hand, assessment of the child as the perpetrator of a criminal act (e.g. to what extent they were aware of the threat or consequences they caused or, in the case of youth, whether they can be held responsible for a given act as an adult). Relevant, authorised authorities may order a diagnostic process in other cases, such as in the adoption procedure or when granting institutional (material and non-material) assistance to a child or family.

The result of the diagnoses in cases A, B, and C will most often be an intervention, which may be in the form of psychological assistance, additional forms of education, psychotherapy, medical therapy, or other interventions aimed at supporting the child's development and independent functioning. Such intervention may also involve parents—through education, therapy, and work with children.

In case D, the diagnosis will be aimed at facilitating the decision by the appropriate authority regarding the child's future. In particular, the authority will decide on appropriate legal solutions that will be aimed at the greatest possible good of the child. The diagnosis here is helpful for decision-makers, thanks to which they gain a better, more comprehensive insight into the child's mental functioning. Often, thanks to the diagnosis, the child's best interests (which may get lost during various legal procedures) can be considered.

Psychological diagnosis is the process of assessing and understanding a person's emotional, behavioural, and mental problems. Many diverse types of psychological diagnoses are used in psychological and psychiatric practice depending on their purpose and context.[9] Clinical diagnosis is the process by which a psychologist or psychiatrist evaluates and identifies mental disorders or emotional problems in a patient. The result of a clinical diagnosis may lead to a diagnosis such as depression, anxiety disorder, or schizophrenia. Neuropsychological diagnosis focusses on assessing the patient's brain function and cognitive skills to identify possible brain damage or cognitive disorders such as dementia or attention deficit disorders. In this form of diagnosis, it is possible to use medical devices that enable examination of the structure or functioning of the brain, such as an electroencephalogram, tomograph, or magnetic resonance imaging. For psychological diagnoses of children and

9 Groth-Marnat, 2003, pp. 37–103; Goldstein, Beers and Hersen, 2004, pp. 277–283; Lezak, 2004, pp. 3–14; Coaley, 2014, pp. 10–21.

adolescents, psychologists who specialise in working with children and adolescents diagnose developmental, behavioural, and emotional disorders in children such as attention-deficit/hyperactivity disorder, autism, and conduct disorder. For personality diagnoses, the psychologist evaluates the personality traits or dispositions of the patient to understand his style of functioning (i.e. social or emotional), behaviour (i.e. maladaptive or problematic), and thinking. In social diagnoses, psychologists analyse the impact of social and cultural factors on the patient's mental health and emotional and behavioural problems. In some cases, career counselling psychologists may perform career assessments to help individuals choose or adapt their career paths based on their skills, interests, and goals.[10]

After completing the diagnosis process, the specialist prepares a report that will be presented to the appropriate people: parents, teachers, doctors, authorities, etc. The report should contain key information that will be necessary to understand the situation of the examined child. Reports can have different structures, just as the goals and types of diagnosis can vary. Nevertheless, several elements should be included in the report. The first includes identification data of the child, parents/legal guardians, and the diagnostician. The child's date of birth and date of examination should be included. Additional demographic data may be included. The report must indicate the purpose of the study: What is the reason for the study, and who directed it? Next, the diagnostician should present basic information obtained in an interview with parents/legal guardians, in a community interview if needed, and may include important information from medical records (if it is related to the purpose of the examination). These data may include, for example, information about previous diagnoses, treatments, and therapies; child development history (physical, emotional, social, and cognitive); information about family, home, and school environments; and any significant life events affecting the child. The next element of the report is a description of the research methods used. This should be done in such a way that readers can have a general overview of the study situation. It is worth having the diagnostician justify the use of specific tools. Next, the diagnostician records the significant behaviour of the child observed during the examination (e.g. whether the child cooperates or avoids the researcher, disturbing behaviour, and whether there is any interaction). In the next part, the specialist presents the research results. They should be presented in a descriptive manner, in as much detail as required for the purpose of the study. The child's results are compared to standards appropriate for the child's age. This part may end with a profile interpretation of the results (e.g. the child's strengths and weaknesses, possible difficulties, and disorders). If the purpose of the study requires it, a diagnosis and description of the problem (if any) are provided and assigned to an appropriate classification (e.g. ICD or DSM). Moreover, if the purpose of the diagnosis justifies it, the diagnostician may provide recommendations for further proceedings (e.g. therapy, additional tests, or interventions) or tips for parents/guardians/teachers.

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10 Reynolds and Kamphaus, 2003, pp. 30–32; Saklofske et al., 2013, pp. 20–22.

Finally, the diagnostician may attach additional materials or information if they are important for the diagnosis.[11]

2. Psychometric Tools: The Concept of Norm and Health

The psychologist assesses the patient's functioning most often through observation, interview, and psychological tests.[12] While the first two methods should be considered qualitative (except for somewhat structured methods), psychological testing provides primarily quantitative information. The best tools for this purpose are those that meet psychometric standards: objectivity, standardisation, validity, reliability, and normalisation.[13] Such tools provide objective, quantitative information about the person being diagnosed. It is worth comparing the tools to a medical diagnosis: The doctor, in an interview with the patient, collects information about what is wrong with the patient. The doctor can observe certain symptoms himself and based on them, deduce the disease with which he is dealing. However, laboratory tests will play an objective and decisive role in diagnosing whether the patient is suffering from a cold, flu, cancer, or something else.

The previously mentioned psychometric criteria can be broadly and briefly developed as follows: Objectivity means that the test result and its interpretation are independent of the diagnostician. That is, two or more psychologists independently examining the same patient with the same test should reach the same conclusions. Standardisation means that all people diagnosed undergo the same testing procedure: They receive the same order or instructions on what to do, answer the same questions or perform the same tasks, and receive the same materials as other people who take such a test. Validity means that the test measures what its creators intended it to measure (in a more current approach, the test creators have data that authorise a specific interpretation of the test results). Reliability means the accuracy of measurement. Normalisation, on the other hand, means that certain thresholds have been established for test results, thanks to which we can interpret these results in low/medium/high categories by comparing the points obtained by the tested person with the average results of people in a given population (e.g. general population, children, and people with specific disorders, depending on the groups for which specific normalisation tests were carried).[14]

Let us dwell on this last criterion for a moment longer. While a diagnostician can determine how a patient behaves in an interview or observation, without relating

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11 Stemplewska-Żakowicz, 2019, pp. 45–50; Leckman and Taylor,2015, pp. 403–418.

12 Haynes, O'Brien and Kaholokula, 2019, pp. 463–469.

13 American Educational Research Association and National Council on Measurement in Education and American Psychological Association, 2014, pp. 151–163.

14 Anastasi and Urbina, 1997, pp. 8–113; American Educational Research Association and National Council on Measurement in Education and American Psychological Association, 2014, pp. 95–107.

these behaviours to norms, he cannot state that a given behaviour or symptom is, for example, normal/abnormal, healthy/pathological, or good/not good. Only thanks to knowledge about how people from a given population behave or what features they have is it possible to determine whether we are dealing with a behaviour or symptom that requires intervention. Therefore, when analysing reports from the psychological assessment process, it is necessary to know what norms or criteria the diagnostician used to determine whether the child's functioning is "normal" or "pathological". It is worth noting that according to the World Health Organization's general definition, 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.[15] In this context, the researcher will pay attention to specific behaviours or symptoms that make it difficult to achieve well-being in the areas listed in the definition. These symptoms may be described within the framework of a medical classification (e.g. ICD[16] or DSM[17]) or the psychological theory on which the tools used in the diagnostic process are based (e.g. developmental models, theories of intelligence, or personality concepts). Knowledge of the classification and theory makes it much easier to understand the report itself as well as its interpretation in terms of health or pathology.

Research tools, even those that examine similar functions, may differ from each other on many levels. The first step is defining the study area. Intelligence or social behaviour may be defined and operationalised using different methods. For example, intelligence as defined by Raymond B. Cattell[18] is one thing and intelligence as measured by the Stanford-Binet Intelligence Scale[19] is another. Second, tools can use different standard models. In psychology, these may be developmental norms or the relative position of an individual in a group (statistical model). Developmental norms assume that children have specific skills or abilities at a specific level of development or age. Many classifications are available, and they may also vary in distinct cultures. For example, if children start school at the age of 6 years in a given education system, they are expected to have the so-called school readiness, which refers to specific features and skills that enable them to function at school so they can focus on the lesson for a longer time, develop gross motor skills, etc.[20] Older children can be expected to have competence in counting, performing mathematical operations, or having knowledge of words or knowledge, in accordance with the education programme of the given country. The second type of norms determines the relative position of the child's results compared to the normalisation sample. For example, consider that a child's results in an intelligence test are higher than average, but they are much lower than average in memory tests. In this model, various scales[21] can be used, such as

15 WHO, 2020, p. 1.
16 WHO, 2009.
17 American Psychiatric Association, 2013, pp. 1–1120.
18 Kent, 2017, p. 193.
19 Roid and Pomplun, 2012, p. 249.
20 Bingham and Whitebread, 2012, p. 151.
21 Neukrug and Fawcett, 2006, pp. 127–149.

the standard, percentile, and intelligence quotient (IQ) scales. Regardless of the type of norms scale used, the diagnostician must use standards that are best suited to the patient—based on normative groups most similar to the patient. The more closely matched the norms, the more reliable the diagnosis. The diagnostician should use tools and methods that have specific standards for the population to which his patient belongs. The norms should first consider age, as what is typical for four-year-olds may be too difficult for three-year-olds. Norms should also consider intercultural[22] and intergender differences.[23]

To sum up, for the obtained diagnosis to have an objective basis and be as close to reality as possible, the researcher should use tools for which psychometric properties have been defined and tested. In his report, the researcher should list the diagnosis methods and, if possible, write something more about them, so that the reader can be sure that the diagnostic process is not based only on the diagnostician's subjective feelings. The diagnostician should also indicate to which standards the results or observations were referred, so that the reader is clear about the interpretation of the results in terms of health/norm pathology.

3. Standards in Conducting Psychological Assessment of Children

Minors should be treated in a unique way. The basic principle for a psychologist when working with minors is their well-being, which means that minors have no less rights than adult clients in contact with a psychologist. The psychologist has the right and obligation to respect the decision of the minor as a human person regarding contact with them.

The diagnostic process may vary depending on the purpose, tools used, or culture. Nevertheless, to obtain a reliable diagnosis that is as close to reality as possible, standards should be followed. They may be specified in, for example, the codes of ethics,[24] guidelines,[25] or publications.[26] Following the guidelines will help in implementing the principle of *primum non nocere*, which can be translated as "above all, do no harm". Most standards and guidelines often concern the following ethical areas related to diagnosis: informed consent to participate in the process, information obligation, right to privacy, and professional competences of the psychologist. This applies to the diagnosis of both adults and children.

All these areas are obviously interconnected: There can be no fully informed consent to participate in the study unless the patient is informed about all stages

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22 Such as: Qian et al., 2023, pp. 2290–2291.
23 Such as: Adani and Cepanec, 2019, pp. 142–146.
24 American Psychology Association, 2007.
25 Fernández-Ballesteros et al., 2001, pp. 187–200; International Test Commission, 2001 pp. 93–114.
26 American Educational Research Association and National Council on Measurement in Education and American Psychological Association, 2014, pp. 1–7.

of the process and the patient's sense of security and privacy is guaranteed. In the diagnostic process, these elements should be carefully considered at various stages by the diagnostician.

The first two areas should be discussed extensively in the first stage of the process of diagnosing children and adolescents. This can be defined as the referral of a child for examination, most often by parents, teachers, physicians, or other specialists who are concerned about the child's behaviour or development. The diagnostician tries to obtain as much information as possible from parents or guardians regarding the child's behaviour, symptoms, history, possible diseases, previously observed problems in development or functioning, etc. The scope of information will depend on not only the reasons for the diagnosis but also its purpose. Parents or guardians will be asked to consent to the assessment, which includes understanding the purpose, procedures, and potential benefits and risks of the assessment; the results that can be obtained; and how they will be shared (e.g. if the diagnosis needs to be shared with a school, care facility, court etc.). Moreover, the diagnostician presents what information will be forwarded and in what form and what will remain only in the diagnostician's confidential documentation.

In the case of children, information about the diagnostic process must be presented to the child's guardians, who consent to the tests in most legal systems. However, regardless of who ultimately makes the legally binding decision to consent to the test, the diagnostician should also present all information to the patient and obtain his/her acceptance. This has both ethical and practical dimensions. The patient's consent to conduct tests, even if it may not be required under the law, significantly facilitates the diagnostic process. The patient is then more willing to cooperate and follow instructions. However, in the case of lack of patient acceptance, the examinee may interfere with the diagnosis, not perform tasks and commands, or even mislead by giving false answers. The approach of informing the patient about the diagnostic process should be adapted based on the patient's level of development. For example, when examining a four- or five-year-old, the diagnostician may talk about what games they will play, and they will involve or say that he will ask the child to draw certain things.

After obtaining the guardians' consent and patient's acceptance, collecting information about what worries the parents, and conducting an initial conversation with the patient, the diagnostician selects the assessment tools and methods. He considers the child's age, developmental stage, and social and intellectual capabilities (e.g. even though the child may be at the appropriate age to use a given test, according to the authors' assumptions, the patient's developmental deficits may be so profound that he or she will not be able to perform any tasks). The diagnostician has a wide range of methods to choose from, such as the already mentioned standardised tests, interviews, observations, and questionnaires.

After selecting the methods, the diagnostician presents the procedure to the caregivers and patient and obtains their acceptance. He then moves on to the study session. It may involve a single session, various tests spread over time, or the same tests repeated after a certain period. Depending on the purpose, the tests most often

assess cognitive, emotional, and behavioural functioning. Cognitive assessments may include IQ, academic achievement, or cognitive processing tests. Emotional assessments may include self-report questionnaires, projective tests, or structured interviews. Behavioural assessments may include observations of a child's behaviour in various environments, such as home or school. Parents or teachers can participate in the assessment at not only the initial interview stage but also later, thanks to which the diagnostician receives information about the child's behaviour, development history, and functioning in various contexts. Several standardised methods have been developed for parents of younger children and teachers, such as the Adaptive Behaviour Assessment System-3[27] or Conners™[28] test. The psychologist may also conduct direct observations of the child in natural environments, such as at home or school, to assess how the child interacts with others, copes with everyday challenges, and exhibits specific behaviours.

Once the research phase is complete and all relevant data are collected and analysed, the psychologist typically meets with parents or guardians to discuss the results and provide feedback. This meeting is an opportunity for parents to ask questions, clarify concerns, and gain insights into the child's psychological functioning. A formal written report is usually provided. Often, there are no strict regulations on what the report should look like. However, it is recommended that it include the following elements: reasons for starting the diagnosis, description of the examined child and his/her history, main results of the research conducted, diagnosis (often also including definitions included in legal regulations), summary, and recommendations. It should summarise the results of the assessment, diagnosis (if appropriate), and recommendations for parents or guardians. If a child is referred for examination by an authorised body, the psychologist issues an opinion, certificate, or judgement in accordance with the legal order prevailing in each country. Eventually, this document may be limited to providing short, general information, in accordance with the templates adopted or issued by the relevant authorities. However, besides describing the child's functioning, the report may also include specific recommendations for intervention, therapy, or further assessment, if necessary. In this case, the final stage involves constantly monitoring progress and adapting treatment plans.

4. Psychological Situation of the Child

When trying to understand a child's psychological situation, we can consider it in terms of psychological stress. Referring to, for example, the transactional model of stress,[29] it can be assumed that stress will be stronger the more a child perceives the whole test situation as a threat or challenge. This will depend on elements such as the

27 Harrison and Oakland, 2015, pp. 3–10.
28 Conners, 2018, pp. 2–9.
29 Lazarus and Folkman, 1987, pp. 141–169.

reason for the diagnosis, attitude of the child and parents towards the examination (awareness of the situation, newness of the situation/previous experience, voluntariness/coercion, and fear of evaluation), contact with the diagnostician, and place of the examination.

Regardless of the specific reasons for the diagnosis, the common element is that virtually every time a child is subjected to a psychological assessment, the cause is some problem noticed by parents, guardians, a doctor, a teacher, etc. A psychological diagnosis is conducted because one of the above-mentioned people stated that the child does not behave as children should behave in each developmental period (e.g. 'Why doesn't my three-year-old talk yet?', 'Why doesn't my six-year-old play with other children?', 'Why does he behave aggressively when other children in a similar situation behave 'normally'?' 'Why isn't he paying attention to what I'm saying?'). In most cases, the problem and its consequences can be defined in negative terms: disorders, developmental deficits, diseases, and problems with dealing with emotions. However, sometimes, the problem may have a more positive connotation, for example, the child's intelligence level is much above average, which makes the child bored in class. However, as even such a "problem" may have negative consequences for the child, it requires appropriate treatment. Another exception may be situations in which a child is referred for mandatory psychological testing, for example, if a given country carries out psychological screening tests of the population (in most countries, these are currently recommendations rather than policies).[30] Therefore, children who are subjected to a psychological examination most often find themselves in some problematic, demanding situation. Depending on the child's level of development and knowledge as well as how the parents and the environment relate to the problem, the child may perceive the entire situation as a greater or lesser threat. They may also not perceive the entire situation based on such categories at all if their awareness or knowledge about the problem is low or they have not noticed any disturbing signals from their parents or guardians. In such a situation, the diagnostic process may be perceived as, for example, playing with an adult.

The child's attitude towards the examination is an essential element that will not only involve experiencing unpleasant emotions (e.g. fear of being judged) but also translate into motivation to cooperate with the diagnostician. People with a positive attitude towards the process will be more willing to follow instructions reliably, and they can also more easily control unpleasant emotions caused by stress. They will not treat the whole situation in the same category of stress as when they had a negative attitude. In such a situation, subjects may refuse to cooperate; follow instructions unreliably, sloppily, or randomly; and may even be misleading.

Attitude will depend on, first, the reason for the diagnosis and how other adults relate to the problem. Children who observe anxiety and fear in their parents may also approach the whole situation with fear and distance. General situational awareness is important: Does the child know why he/she is seeing a diagnostician and

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30 U.S. Preventive Services Task Force, 2022.

needs to perform certain tasks? Does the child understand what the possible consequences for him/her could be? In younger children, such awareness is lacking, but with subsequent development stages (which will be discussed later), this awareness increases. For babies and young children, the whole situation may be considered as just playing with a new person. In such a case, the stressful nature of the situation will be determined by issues such as how the child relates to newly met people? Is the child withdrawn, afraid, or rather interested and trusting? Is it time for the diagnosticians themselves to establish good contact and inspire trust or not? Is the examination taking place in a familiar or child-friendly place, or is it completely new and unfriendly? In the case of older children and adolescents, they may already be aware that they are taking part in the diagnostic process but may not fully understand that further actions, such as therapeutic or educational treatment, will depend on the diagnosis. The more awareness of the consequences is developed and the more serious the children are, the more likely it is that the study is considered a threat. At the same time, poor understanding of the research situation and procedure may lead to anxiety and a sense of stress. Situational awareness also involves knowing your own rights. Children may not know or be aware of the laws that protect them. Therefore, in situations that are uncomfortable or threatening to them, they cannot resort to the rights to cope with the demanding situation. In this respect, the knowledge of rights and their use to protect children rests with both parents and guardians as well as the diagnostician.[31]

Another issue concerns coercion and voluntariness of participation in the study. Most people do not like being forced to do anything. The feeling of coercion will make the person being assessed feel negatively towards the entire process. At the same time, in the case of children, from the legal point of view, the parents, guardians, or authorised institutions (e.g., courts) are the ones deciding to conduct a psychological examination, even if the person being examined does not want to consent. Therefore, we return to the issue of obtaining acceptance for activities conducted by the person being examined. If the psychologist has not obtained acceptance of specific methods from the person being examined, he/she should not begin the assessment. This concerns both ethical issues and the quality of the results obtained. This may also lead to incorrect conclusions and damage in the future. In the report, the diagnostician should indicate whether he/she obtained not only the consent of authorised persons but also acceptance of the examined person. If he/she did not receive it, it should be described what circumstances supported further diagnosis and how the problem was solved.

Older children who have developed sufficient self-awareness may develop the fear of being judged. Children may understand that, during the examination, they will reveal information, sometimes very intimate and sensitive information, about themselves. At the same time, they are at a stage of development in which they are just getting to know themselves and developing their competences, interests, and skills.

31 Paluchowski, 2006, pp. 182–186.

Therefore, they may feel afraid that they, as persons or certain parts of them, will be assessed as "bad", "not good enough", "sick", etc. This may arouse the fear of rejection, desire to quickly complete the research process, and even aggression ('What right does someone have to judge me?'). On the other hand, it may give rise to the desire to show oneself in the best possible light, which again leads to falsified research results. Appropriate behaviour by a psychologist and building of positive contact can largely eliminate the impact of anxiety on test results.[32]

The purpose of a psychological assessment is to provide a clear understanding of the child's strengths and weaknesses, guide appropriate interventions, and support the child's healthy development. It is important that the assessment process be carried out with sensitivity, empathy, and consideration of the child's age and developmental stage. The ultimate aim is to meet the child's best interest, through education, therapy (psychological or medical), or legal processes (the diagnosis is used as a tool that helps authorities make decisions about a child's future). Therefore, it requires appropriate professional competences on the part of the diagnostician, who will not only have substantive knowledge about the research tools used and the diagnostic process but also have an appropriate level of soft skills in building contact and managing the patient. Developing an appropriate relationship with the patient and a favourable atmosphere during the examination will result in the patient's increased motivation and a more positive attitude towards the situation. It may also help the patient cope with unpleasant emotions that may accompany the diagnostic process. The diagnostician himself should avoid becoming a source of stress through unprofessional behaviour. If there are no justified circumstances, such as safety, health, or level of development of the child, the person being examined should be alone with the diagnostician during the examination process. The researcher may not be able to obtain or observe some information about the child's development and functioning in the presence of caregivers, especially if the behaviour of parents or guardians is responsible for some of the children's disturbing behaviour. Parents may also unconsciously try to help their child perform better. Thus, absence of parents during the test may be beneficial for the research process, but it may also raise concerns or fear in the children. Therefore, it is necessary for the diagnostician to take appropriate actions to build a positive atmosphere at the meeting. This requires appropriate interpersonal skills and appropriate level of assertiveness.[33]

To sum up, the diagnostic process can be both an incredibly stressful experience and a positive challenge for the child. The behaviour of parents or guardians, as well as of the diagnostician himself, will play a significant role in how children perceive the situation. The psychologist's report should include information about the child's mental state and attitude, as well as the physical environment in which the diagnosis was made. This information will allow the report's recipient to assess both the diagnostic process, quality of the data obtained, and veracity of the conclusions.

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32 Stemplewska-Żakowicz, 2019, pp. 194–199.
33 Ibid., pp. 219–223.

5. Situations Requiring Psychological Assessment of Children

Situations in which the diagnostic process is initiated by parents or legal guardians (group A) can be called voluntary. However, in many situations, mainly during legal processes, psychological assessment of the child is mandatory. Without it, it may be impossible to determine the child's best interests. The most common situations of this type of concern are described below.

5.1. Child Custody and Visitation

Divorce or separation of parents is an extremely stressful situation for a child. This is a situation of change in the current life, which will cover most—if not all—areas of the child's functioning. If the parents cannot agree on further care of the child, it is necessary for specialists (on the court's order) to determine what will be in the child's best interest. The court will assess what situation will ensure the child's well-being and safety and provide an environment for stable development. Diagnosticians examine children, their needs, and how they develop.[34] They assess parents to consider their personality conditions to create a safe environment for the child. They also examine the relationship between the child and each parent. Their recommendations may indicate whether the child develops a stronger bond with one or the other parent, with both parents, or (less often) with neither parent. The authority may consider this information when issuing a decision on divorce or separation, considering who will continue to take custody of the child and the issue of visits and contact with the other parent.

5.2. Adoption

In the case of adoption, the child and potential adoptive parents are subject to a psychological assessment. It is important to determine the child's development needs. However, the authorities must ensure that the adoptive parents have the appropriate predisposition to create a stable and loving environment for the child. In this regard, specialists should also assess the motivation of adoptive parents and their awareness of the responsibility of raising an adopted child.

5.3. Abuse and Neglect

Too often, parents, legal guardians, or people around children neglect them or commit various abuses. To protect the child's well-being, the authority or appropriate institution must defend it. Some abuses are subject to criminal liability in various legal systems, and procedures are in place to ensure the safety of children. Psychological examination of children is necessary here to check what damage to mental health has been caused by the parents' actions and what actions (e.g. medical and psychological therapies) must be taken so that the child can continue to develop and function well in the world. Parents/guardians may also be examined to determine whether leaving the child in their care

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34 Drozd and Flens, 2014, pp. 3–4.

will not cause the child further harm. It is not difficult to find a situation in which parents neglect children, but at the same time the children are strongly attached to them. In such a case, the court must assess and make a difficult decision on whether it is more important for the child's good to maintain the bond or place the child in a safe environment.[35]

5.4. Juvenile Justice System

The legal system for minors is often distinct from that for adults. Decisions about whether a child should be tried as a juvenile or an adult, and the appropriate consequences, require a thorough assessment of the child's circumstances. In addition to assessing the harmfulness of the act itself, the court, based on the diagnosis of specialists, must determine, among other things, how aware the child was of the dangerous consequences of his actions and whether they acted consciously, whether they intentionally caused damage, whether any clinical disorders could have affected the child's performance,[36] etc.

5.5. Education and Special Needs

The Convention on the Rights of the Child[37] indicates in Art. 28 that access to education is one of the rights of the child. Many countries have included access to education as the right of every citizen. Unfortunately, due to various limitations—congenital (e.g. developmental disorders and deficits) or acquired (e.g. disability resulting from an accident and post-illness complications)—access to education may be limited. Many educational systems have introduced opportunities and systemic solutions for such children to facilitate education. The psychological diagnosis aims, on the one hand, to assess deficits, determine special needs, and indicate which programmes or activities should be addressed to this person. On the other hand, in legal terms, it assesses whether a person qualifies for such assistance at all.

5.6. Medical Decision-Making

There are situations in which it is necessary for a child to undergo treatment, but parents or guardians do not consent to it (e.g. due to their own beliefs, views, or religion). The child's psychological assessment will consider, on the one hand, his needs and the risks if treatment is not undertaken. On the other hand, it will consider the possible consequences for the child's development as a result of violating the value system of the caregivers. The court will have to assess, considering the diagnostic report and other circumstances, what will be in the child's best interests.

5.7. Guardianship Proceedings

There are various reasons why parents cannot continue caring for their children, such as incapacity or death. Therefore, the authority must determine who should have custody of the child, with whom the child will be able to develop properly, and

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35 Higgins and McCabe, 2001, pp. 547–558.
36 Teplin et al., 2002, pp. 1133–1143.
37 United Nations, 1989, Art. 28.

who will provide a stable environment for upbringing. The psychological assessment will look at the child's personality and mental state, for example, whether and to what extent the child experienced trauma after the death of the parents. Accordingly, the person taking over care will also have to make efforts to provide appropriate treatment. On the other hand, the person taking over parental authority may be subject to examination, similar to the case of adoption.

5.8. Cases of Child Immigration

Child immigrants may appear in legal proceedings as people who are (1) arriving in a new country and applying for asylum/citizenship or (2) already located and operating in a given state. The proceedings may concern issues other than permission to stay in a given territory (i.e. civil or criminal matters).[38] In the first case, authorities may assess the child's safety, well-being, and eligibility for asylum or other forms of protection. In the second case, issues arise related to, particularly, cultural differences or children's adaptation to the new environment and education system.

5.9. Child Testimony in Legal Proceedings

During various proceedings, children may appear as not only subjects of the cases but also as, for example, witnesses. The question here arises regarding the reliability and effectiveness of such testimony.[39] The court may order an assessment to determine a child's competence to testify in legal proceedings, considering their age, maturity, and ability to understand and communicate.

5.10. Child Labour and Exploitation

The Convention on the Rights of the Child[40] states in Art. 32 that children should be protected from economic exploitation and hazardous work. However, this does not mean that children are prohibited from working. Legislators in countries that have adopted the convention have passed laws protecting children from exploitation and regulating child labour. To check whether these rights are being violated, a psychological assessment will sometimes be necessary, in which specialists will assess the impact of the work undertaken for the development and health of children.

6. Conclusions

The child assessment process can take many forms. The tests may consider correctness of the child's development and the motor, cognitive, emotional, and social functions. The specific methods used will vary depending on the purpose of the study, circumstances, and available standardised tools, as well as the legal and educational

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38 Evans and Hass, 2018, pp. 69–84.
39 Westcott, Davies and Bull, 2003, pp. 99–116.
40 United Nations, 1989, Art. 32.

system in each country, the method of educating diagnosticians, and social expectations from the diagnosis itself. For the child himself, the examination situation may be something new, interesting, and intriguing. It may also be perceived as a threat and may result in fear, hostility, or aggression. This chapter omits issues related to the psychological examination of children with profound developmental deficits and certain diseases (e.g. congenital or acquired brain damage and mental disorders). In such cases, contact with children is very limited or it may be even not possible to communicate with them. The psychological assessment procedure will require the use of specific methods, or it may turn out that it will not be possible to carry it out at all. However, this issue is very extensive and goes beyond the scope of this work. In such cases, observation and interviews with parents or guardians and the environment are most often used.

When discussing a child's psychological situation, we must remember the issues discussed earlier and the task of the psychologist, who should act appropriately in each area. The process of psychological diagnosis can be a source of stress and anxiety. Children often do not understand the full situation and may fear that something is wrong with them. Therefore, it is important for the psychologist to create an atmosphere of trust and safety. Parents play a key role in the child's diagnostic process. They must provide the psychologist with relevant information about the child's behaviour and problems. However, their own emotions and expectations can influence the diagnostic process. The psychologist should support parents and help them understand that the diagnosis is intended to help the child. The child's age is important in the diagnostic process. Children of different ages understand and express their emotions differently. For a young child, the diagnosis may be difficult to understand, while older children may be more aware of their problems. Psychologists use various methods for diagnosis, such as interviews, observations, psychological tests, and therapeutic conversations. The choice of the appropriate method depends on the child's age, type of problem, and purpose of diagnosis. It is important that the methods are adapted to the individual needs of the child. Psychological diagnoses cannot be isolated from the context of the child's life. The psychologist must consider family, social, and educational factors that may influence the child's behaviour and emotions. This may require collaboration with other specialists, such as educators and psychiatrists. During a psychological diagnosis, the psychologist should ensure the child's comfort. This means creating a friendly and safe environment and adapting the pace of work to the child's needs. Children may become tired or bored, so it is important that the diagnosis is not too long or exhausting. The psychologist should communicate clearly with the child, using understandable language and avoiding medical terminology. Children should be informed about the purpose of the diagnosis and the research process. This will help reduce anxiety and build trust. Whenever possible, the psychologist should try to involve the child in the diagnostic process, allowing him/her to express his/her feelings and opinions. A psychological diagnosis may trigger various emotions in a child, such as sadness, shame, and anger. The psychologist should be ready to provide appropriate emotional support and indicate ways

of dealing with difficult feelings. It should also be remembered that psychological diagnosis is usually conducted only at the beginning of the process. A child is referred for a psychological evaluation because of a problem. The diagnosis aims to describe and explain problems in the child's functioning. The child should receive appropriate therapy or support based on the diagnosis. Parents and guardians, as well as recipients of the psychological report, should be aware that a diagnosis is a step towards helping the child.

Having a report on the child's diagnosis does not end the process of helping him. It only ensures that appropriate persons or services are included as an element in decision-making. Therefore, diagnostic specialists should create communicative reports that are understandable to the recipients—not only psychological specialists but also parents and authorities. Nevertheless, sometimes, understanding the report is not easy because it uses knowledge and terminology typical of social or medical sciences, which may differ from the methodology of legal sciences. It is in the child's best interest that those responsible for his/her future clearly understand the report. This may require not only familiarisation with its content but discussion with specialists so that there is no room for ambiguity.

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Developmental Theories: The Role of Genetic and Environmental Influences in Childhood, Classic and Modern Developmental Theories

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ABSTRACT

This text begins with an outline of the nature-nurture debate. Next, it introduces the six key theories of developmental psychology: Freud, Erikson, Piaget, Vygotsky, and Bowlby, and the social learning theory (SLT). Some of the theories presented focus on personality as a whole, while others refer mainly to cognitive development, socialisation, etc. Some take firm positions on stages (Piaget, Freud, and Erikson), others do not (Vygotsky and Bowlby), and some do not even include stages in their conceptual corpus (SLT). Erikson's theory covers the entire life course, while other theories cover stages up to maturity. Sources of the individual theories are indicated: clinical work for the theories of Freud and Erikson, the epistemological problem for Piaget's theory, Marxism for Vygotsky's theory, and a combination of two traditions (stimulus-response learning theory and psychoanalysis) for SLT. The general propositions of the key theories are presented, followed by specific issues of psychological development. The text comments on each theory's developmental factors: biological, environmental (physical, social, cultural), and individual activity. An outline of two further orientations in developmental psychology is provided at the end.

KEYWORDS

factors of development, stages of development, learning and maturation, attachment, imitation

1. Nature vs. Nurture

Developmental psychology was established as a separate discipline[1] in the last quarter of the 19th century. Since then it has added many theories to its "fund". These theories differ based on the solutions they offer to several fundamental questions about development. Is development quantitative or qualitative, continuous or discontinuous, modular or holistic, and contextual or universal? What is the role of the individual and what is the role of social interaction in development?

1 Cairns, 1998, pp. 25–105.

Is psychological development determined by heredity or the environment? This remains a question of the greatest and timeless importance. It is even older than developmental psychology itself.

In the field of development, this question often arises in terms of maturation and experience: Does novelty in the developmental course appear because of genetically programmed neurophysiological maturation or learning? In the beginnings of the developmental psychology fields, biological science was used as a model for psychological theorising about development. The theory of embryogenesis served as the basis for theories about stage-like psychological development:[2] That is, development has stages, which are invariable in order and universal, and the final stage is reached before maturity. Freud, Erikson, and Piaget incorporated such a conception. However, not one of them adhered to the principle of preformism, the idea that everything that will appear later on in life exists in prototypical form in the germ cell. Instead of preformism, these theorists accepted, in one way or another, the principle of epigenesis, according to which development is determined not only by the initial content but also moments (experiences) that appear later during interaction with the environment. Piaget attached more importance to the later experiences than Freud; Freud believed that the most important experiences occurred in the first five years, and that they permanently determined the personality (hence the saying, ''The child is the father of man'').

With the principle of epigenesis, the biology-culture, nature-nurture, and innate-acquired relationships are not set in the form of either-or, but rather inclusively, in the form of and-and. In other words, the principle of interaction between genes and the environment was adopted. Of the theorists presented below, Vygotsky and social learning theorists attributed the least significance to inheritance in that interaction.

If it is considered that genes and the environment are not independent but correlated, then there are three types of interaction[3]. *Passive interaction* occurs where parents provide the child with an environment that matches his genotype. If the parents are intelligent, they will provide the child with various books and engage in intelligent conversation. Thus, the child receives not only genes similar to the parents, but also a suitable environment. *Active interaction* occurs when a child seeks an environment that matches his genotype: if intelligent, he will spend time with intelligent peers, and if he likes sports, he will join sports groups. *Reactive-evocative interaction* occurs when a child with certain genetic tendencies influences a positive reaction from the environment that further strengthens those tendencies.

The role of individual activity is not seen only in postnatal life. For example, if the egg shell is removed and the chick is injected with an agent that immobilises its leg movements, the chick will not develop normal walking after hatching.

The extent to which genes and the environment influence behaviour is examined, among other things, through the methods of behavioural or quantitative genetics.

2 Ibid.
3 Workman and Reader, 2021, p. 152.

These studies especially egzamine monozygotic twins raised in the same and different environments. Statistical procedures determine the extent to which of the variance in the measured values of a phenotypic trait can be attributed to genetic or to environmental variability. The results show that 40–50% of the phenotypic variance can be explained by genetic variability. It is important to know that the influence of an intrauterine environment also exists (it accounting for up to 20% of the non-genetic variance). Various nutrients reach the mother's bloodstream. If they are harmful, they may cause permanent damage to the embryo. The case of the drug thalidomide is well known, as it leads to severe damage if the mother takes it 20–37 days after conception.

Table 1. Genetic and environmental influences on anticosial behaviour[4]

Behavioural genetic studies on antisocial behaviour (AB) of children and young people have been conducted on families, twins and adopted children. These studies convincingly demonstrated that approximately 50% of the phenotypic variance in AB can be explained by genetic influences; the remaining half of the variance can be attributed to both shared and non-shared environmental influences[5]. The genetic origin of variance was estimated statistically by using phenotypic similarity across individuals with different degrees of genetic and environmental sharing. We can call these studies G+E studies, because they treat the genetic and environmental components additively. However, genes and the environment can be correlated, and studies that estimates G and E interaction (GxE) are needed. Gard, Dotterer and Hyde[6] believed that research with a more complex design is needed, because AB is not homogeneous (aggression is dominant in some subtypes, and rule-breaking is dominant in others) and because aversive environmental events associated with AB occur at different ages.

Behavioural genetic studies cannot identify specific genetic markers for AB. Advances in molecular genetics have made it possible to identify individual genomic variants (candidate genes [–cG]) associated with a risk for AB. Thus, cGxE studies appeared. Of particular importance are hypothesis-free genome-wide association studies, which involved surveying the genomes of many people. They used large samples sizes (even tens and hundreds thousands of individuals), to identify genes with small but significant contribution to AB. The first cGxE studies focused, as expected, on genes involved in the regulation of dopamine, serotonin, and epinephrine hormonal systems. It can be said that this field of research is very dynamic today.

2. Psychoanalytic Theory of Sigmund Freud

Sigmund Freud (1856–1939) was a neurologist who dealt with the psychotherapy of adults who were neurotic. Based on the gained knowledge, he applied hypnosis and then the free association technique, to formulated and over time refined one of the most influential theories of personality development.[7]

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4 Author's own work.
5 Tuvblad and Beraver, 2013, pp. 273–276.
6 Gard, Dotterer and Hyde, 2019, pp. 46–55.
7 Freud, 1933, 1940.

Freud did not believe that the environment played a significant role in development, but that the role of instinctual drive forces was crucial. He distinguished two groups of drives. One group consists of self-preservation drives, including the sexual drive. Freud called those drives *Eros,* and the energy of the drives as *libido.* Freud's sexual drive is understood very broadly, far from what is directly or indirectly connected with reproduction. The second group consists of death or self-destruction drives, which were later called *Thanatos.* Drives strive for unconditional satisfaction, and the death drive, under the early influence of Eros, turns outward and manifests itself as aggressiveness.

These drives meet the demands of the social environment early in childhood, primarily in the form of parental prohibitions. Freud's work with adults showed that the origin of neurotic disorders lies in early childhood and the ways in which parents treated children's drives. Freud believed that experiences during the first five years were crucial.

Development takes place through stages. Each stage is marked by one dominant feature, the body's erogenous zone. In the first (*oral*) stage, the oral cavity becomes the dominant zone. In the beginning, libido has no object: it is free-floating, and so it relies on the function of feeding, that is, taking milk from the mothe's breasts. Thus, sucking becomes the first pleasure source in life, and the mother's breast becomes the primary object. Near the end of the first year, the libido moves to the anus, and so retention of faeces or emptying of bowels (*anal stage*) acquires libidinous value. The third stage is *phallic* (3–5 years). With the transfer of libido to the genital organ, the male child enters an Oedipal situation: sexual desire towards the mother and rivalry with the father appear (in girls, a similar situation is called the Elektra complex). The Oedipal situation is resolved around the age of five by identifying with the father (more precisely, with the father's superego) and later shifting sexual interest from the mother to other persons. By resolving the Oedipal situation, the child enters the *stage of latency*, the state of rest of the driving forces. In adolescence, the sexual drive and Oedipal conflict are reawakened, after which the fifth, *genital*, stage is reached, wgich is the most mature stage in normal psychosexual development. The young person transfers the sexual drive from the opposite-sex parent and identifies with the same-sex parent's superego.

Freud's theory is not structuralist like Piaget's, but Freud talks about the three-part structure of personality: id, ego and superego. These parts are not distinctly separated from each other but are mutually merged. Driving forces do not go to the muscular system and external objects directly: they are mediated by these structures and their interrelationships. At the beginning of development, there is only the id, made up of driving forces and desires. The id is the basic source of psychic energy. It strives for immediate and prompt satisfaction, in accordance with the pleasure principle. It contains the primary-process thought: when the object that provides satisfaction (e.g., the mother's breast) is not immediately available, hallucinatory satisfaction is resorted to. Over time, the ego develops, because the id is not always able to produce satisfaction. The ego uses energy borrowed from the

id. The ego has the secondary-process thought (perception, thinking, and problem solving) whose goal is to test reality (the reality principle). The ego also provides a delay in satisfaction and adaptation. The ego serves three masters: the id, superego, and reality. When rational processes fail to find the solution, anxiety arises, which is overcome by *defence mechanisms*: suppression, projection, reactive formation, and fixation. The superego develops last. It arises from the resolution of the Oedipal situation and identification with the same-sex parent. It has two parts. One is conscience (i.e. parental prohibitions) which is mostly negative. The other part, the ego ideal, is positive.

In the topological sense, Freud distinguished three types of processes: conscious, preconscious, and unconscious. Consciousness is what a person perceives at one moment. The preconscious is not distinctly separated from consciousness and, under certain conditions, gains access to consciousness. Unconsciousness was created in the course of individual history by mechanical suppression and can come to the consciousness by dialling down the ego, weakening the defence mechanisms or undergoing the conditions of psychotherapy.

During Freud's lifetime, there were minor or major deviations by some of his students and collaborators, such as A. Adler, S. Ferenczi, K. Horney, M. Klein, and C. G. Jung. Carl Gustav Jung went the furthest of all of them, creating his original theory called *analytical psychology*. Today, psychoanalysis has moved very far from Freud's ideas.

3. Theory of Erik Erikson

Erik H. Erikson (1902–1994) was also a psychoanalyst. He did not create a psychosexual theory but a *theory of psychosocial development*, because he gave the social relationships of the developing child the greatest importance.[8] Relationships with the caretaker, usually the mother, are especially important in early childhood. Erikson also differed from Freud as his theory encompassed the entire life, from birth to death, and not just the genital stage. In addition, Erikson did not believe that the early years are crucial or that nothing significant happens afterwards: development is influenced by what happens during the entire life course. According to Erikson, development takes place through eight stages, which cannot be skipped or changed in order. At each stage, the child encounters a new, specific developmental task. At the centre of each stage is a *normative crisis*. Each well-solved crisis leads to further development and better coping with the next crisis and the next developmental tasks. Unresolved crises can halt the development and cause major or minor problems in life. Erikson distinguised the following eight developmental stages:
  • Stage 1: Trust vs. mistrust (birth to 18 months)

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8 Erikson, 1968.

- Stage 2: Autonomy vs. shame and doubt (18 months to 3 years)
- Stage 3: Initiative vs. guilt (3 to 5 years)
- Stage 4: Industry vs. inferiority (6 to 11 years)
- Stage 5: Identity vs. confusion (12 to 18 years)
- Stage 6: Intimacy vs. isolation (18 to 40 years)
- Stage 7: Generativity vs. stagnation (40 to 65 years)
- Stage 8: Integrity vs. despair (65 years to death)

Erikson was not the first psychologist to talk about identity, but he was the one who strongly demonstrated the importance of identity.[9] His ideas about identity and identity crisis inspired numerous empirical studies on identity formation, the most significant of which are linked to the name of Gabriel Marcia.[10] Marcia singled out two basic dimensions of achieving identity in Erikson's work: exploration (crisis) and commitment. By crossing them, he obtained empirically validated four identity statuses: identity achievement, foreclosed, moratorium,[11] and identity diffusion. From his first works until today, research has spread worldwide in terms of different aspects of identity, such as sexual, professional, and religious.

4. Theory of Jean Piaget

Initially interested in biology, Jean Piaget (1896–1980) turned his attention to the epistemological issues surrounding the origin of knowledge. Disputes between rationalists and empiricists in epistemology led Piaget to conclude that the solution to this problem should be sought in human ontogenesis, not through philosophical speculation but through the scientific method (hence, his theory is also called *genetic epistemology*).[12] This led Piaget to the field of developmental psychology.

Piaget's theory is one of the best examples of the theory of stages. Each stage is a complete and qualitatively different organisation of intellectual functioning. Stages are defined by a specific structure and degree of equilibrium reached. Development involves moving from one stage to another, without skipping or detours. Piaget distinguished the following four global stages:[13]

- Sensorimotor stage, from birth to 1.5 to 2 years of life
- Preoperational stage, from 1.5 or 2 to 7 years
- Concrete operational stage, from 7 to 11–12 years
- Formal operational stage, from 11–12 to 14–15 years.

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9 Erikson, 1980.
10 Marcia, 1966, pp. 551–558.
11 A moratorium person is in a period of severe identity crisis and is not yet able to make commitments.
12 Piaget, 1971.
13 Piaget, 1967; Piaget and Inhelder, 1969.

The initial point of ontogeny for Piaget is biological. The birth of a child brings the processes of assimilation and accommodation, as well as the factor of equilibration, which is both a motivational and formative factor of development. Along with the physical and social environment and the individual's activity, equilibration acts during the entire course of development. Thus, cognitive development is in a way an extension of the biological one: equilibration continues to balance the processes of accommodation and assimilation (giving adaptation) and maturational and environmental factors. This is why Piaget's theory is labeled as interactionist; it is about the interaction between heredity and the environment.

Development in the first, sensorimotor period takes place through six phases.[14] Immediately after birth, innate reflexes start to function. Over time, *action schemes* emerge from reflexes as the first mental units. They are capable of generalication (i.e. transfer to a new stimuli) and of combining with other schemes, building the first topological structure at the end of the sensorimotor period. In this period, the whole psychic life is limited to the ''here and now''- situation and consists of the coordination of *perception and movement*. In the fourth phase, several different action schemes are coordinated into complete acts – such as when the first intelligent acts arise, and when there is a distinction between objects-means and objects-goals and *intentions*. This is also when the first *epistemic categories* emerge: scheme of object permanence, objectified causality, and continuous space and time. At the end of the sensorimotor period, semiotic means appear, especially words, and so mental development is transferred from the sensorimotor to a new, symbolic level.

In the preoperational period, the units the intellect deals with are *symbolic* (mental images, and words). Thinking in this period is guided by prominent perceptual dimensions and is called intuitive. Intuitive thought is neither reversible[15] nor composable, but it is, like the operation, interiorised, from the action plan to the mental one. The child is not sensitive to contradictions and does not distinguish between a verbal symbol and a referent.

Indicators of the concrete operations are the *concepts of conservation*: conservation of quantity, weight and volume of matter, conservation of surface, etc. The operations of classification and seriation also arise around the age of seven years, as does the operational concept of number. Reversible, interiorised and composable operations are called concrete because they are performed and depend on the content: they will be performed successfully for some contents but not for others.

14 Piaget, 1977, 1936.
15 Reversibility refers to the ability to mentally reverse or undo an action, process, or operation.

Table 2. Consevation of quantity[16]

Piaget constructed about 400 tasks to examine thinking during the child's development. One most famous is the task for testing the conservation of the quantity of matter. Two glasses of the same size and shape, A and B, are taken, and the same amount of juice is poured into each of them in front of the child. When the child confirms that there is the same amount of juice in both glasses, juice from one of those glasses, B, is poured in front of the child into the third glass, C, which is thinner and taller than the first two. The child must now compare the amounts of juice in glasses A and C. The child under the age of 7 claims that there is more juice in glass C, pointing to the level of liquid in it. The child's judgment is guided by the perceptually prominent difference. A child older than 7 years will claim that there is the same amount of juice in glasses A and C and will justify his judgement by claiming that it is the same juice or that nothing has been added or taken away or by claiming that if we pour the juice back in glass B, there will be the same amount of juice (clear evidence of mental reversibility). Weight conservation is tested with other material, but it occurs later, at the age of 8–9 years. Volume conservation occurs even later, at 10–11 years of age.[17]

Formal operations are performed with *propositions*. At this stage, understanding of the relationship between real and the possible has changed: now, the real is only a part of the possible. Numerous innovations in intellectual functioning are emerging, such as: hypothetical-deductive thinking, understanding of probability, experimental thinking, and building theories.

Piaget attempted to apply his theory to the development of moral reasoning[18] but failed to confirm the existence of stages. Instead, he found that there were two processes, heteronomy and autonomy,[19] where autonomy gradually overpowers heteronomy with age. However, the Piagetian theory of the development of moral thinking was developed by Lawrence Kohlberg, who empirically confirmed the existence of six stages defined structurally.[20] It should be noted that studies regularly confirm that moral reasoning lags behind logical-mathematical reasoning by several years.

Over time, there were certain changes in Piaget's theory. Moreover, two neo-Piagetian authors tried to combine Piaget's theory with the information-processing theory.[21]

The theories of both Piaget and Vygotsky have been applied significantly in education.[22]

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16 Author's own work.
17 Piaget and Inhelder, 1969.
18 Piaget, 1977/1932.
19 Heteronomy and autonomy for Piaget do not have the same meaning as for I. Kant. Piaget used the notion of heteronomy to include developmentally immature moral ideas: moral realism, objective responsibility, collective responsibility, immanent justice, expiatory punishment. Conversely, autonomy included more mature ideas: subjective and individual responsibility, reciprocal punishment, equity distributive justice etc.
20 Colby and Kohlberg, 1987.
21 Case, 1998, pp. 745–800: Fisher and Bidel, 2006, pp. 313–399.
22 DeVries, 2000, pp. 187–213.

5. Social Learning Theory

Social learning theory (SLT) started taking shape in the years before the World War II in the USA, through the works of Dollard, Miller, Sears, and others. Although the SLT cannot be attributed to one author, Robert Sears,[23] and Albert Bandura have played a special role in its formation. Emergence of the SLT can be understood as an effort to combine two traditions, the stimulus-response (S-R) learning theory and psychoanalysis. The first social learning theorists took the concepts and constructs from psychoanalysis (dependency, identification, aggression, conscience, and guilt), and objective methods of registering and measuring variables from the learning theory, as well as the S-R principles of learning for explanation. Experimental laboratories, as well as non-experimental research are used in the verification of hypotheses selected from the field of psychoanalysis. In addition, the SLT introduced *social reinforcers*, such as the presence of the mother, verbal praise, non-verbal signs of approval, and peers, as very important. Over time, researhes began to explore another direction of influence, from the child to the parent.[24]

Early research was driven by these autors' ambition to objectively collecting data on a large number of environmental factors, so as to explain personality entirely. Hereditary factors were given minimal importance. 'The guiding belief of social learning theorists was that personality is learned'.[25] However, researchers (e.g. Sears, Maccoby, and Levin)[26] often obtained low correlations between parental practices and children's behaviour.

Much information was gathered on environmental factors, particularly regarding parental activities, in non-experimental studies. Different writers proposed different approaches to organise the huge amount of gathered data on parental activities into more manageable units (variables). Some created *parenting styles* and some *disciplinary techniques,*[27] while others singled out special *dimensions*. Diana Baumrind[28] combined the two dimensions of parental disciplinary behaviour towards children (demanding-undemanding and warmth-cold), thus identifying four parenting styles: authoritative (demanding with warmth and accepting), authoritarian (demanding with cold and unaccepting), permissive (undemanding with warmth and accepting), and neglectful (undemanding with cold and unaccepting). Her approach inspired a research practice still relevant[29] in different cultural groups.[30]

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23 Grusec, 1992, pp. 776–786; Sears, 1951, pp. 476–483.
24 Hoffman, 2000, p. 169.
25 Miller, 2011, p. 232.
26 Sears, Maccoby, and Levin, 1957.
27 See: Hoffman, 2000, pp. 140–172.
28 Baumrind, 1971, pp. 1–103.
29 Baumrind, 2013, pp. 11–34.
30 Pinquart and Kauser, 2018, pp. 75–100.

The use of unidirectional transparent glass gave a great boost to SLT researchers, which, among other things, led to the flourishing of SLT, especially during the 1960s and 1970s. A mobile laboratory with two rooms was constructed, one in which the experimenter and child created experimental conditions and the other in which the experimenter went to observe and measure the child's behaviour without being noticed. In such investigations of children's morality, different indicators of conscience[31] were used, which were connected with experimentally manipulated finer variables, such as various parameters of punishment (intensity, timing, and delay), relationship with the child (warm-cold), and rationale (or reasoning), to determine their influence on the strength of resistance to temptation as an indicator of conscience.

SLT is not just one theory but several theories of a wider and narrower domain. SL theorists do not see development as occurring through stages: they believe that learning mechanisms are also developmental mechanisms, and development consists of modifying a behaviour and creating a new one. Socialisation, as a process of matching behaviour with the demands of the social environment and acquiring internal control over behavior, is the main subject of interest of these authors.[32] Through decades of work, these authors expanded the forms of social learning by adding observational and imitative learning.

The morality and social behaviour of children are affected by not only rewards and punishments directly assigned to them but also by indirect punishments and rewards assigned to the observed models.[33] Albert Bandura and his collaborators studied the influence of the model the most. In a classic experiment, a group of children was shown the behaviour of an adult hitting a Bobo rubber doll in a specific way, while using specific verbal statements. When the children were then left alone with the Bobo doll, it was noticed that they imitated the model's behavior, hitting the doll in the same way and saying what they heard: 'Stupid ball', 'Right in the nose' etc.[34] Bandura called this method of learning *vicarious conditioning*. In this way, children can acquire completely new forms of behavior, which cannot be done through classical or operant conditioning. In numerous experiments, various characteristics of the model were identified that increase or decrease imitation, such as: consequences to the model (reward or punishment); the model's reputation, power, competence, resemblance to the child, and attitude towards the child; and characteristics of the child (intelligence, personality traits, and self-esteem).

Over time, Bandura developed the view that developing children acquire and change behaviours in very complex ways, including through cognitive processes. Accordingly, he called his theory the *social cognitive theory*.[35] Bandura attributed a central role to observational learning, saying that children learn the most by observing different models (live and in the media), reading books, etc. Children combine

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31 Hoffman and Saltzstein, 1967, pp. 45–57.
32 Grusec, 2019, pp. 776–786.
33 A model is a person exhibiting the behaviour to be imitated by the others.
34 Bandura, Ross and Ross, 1961, pp. 575–582.
35 Bandura, 1989.

information gathered from these different sources, creating behaviours that get increasingly complex with age.

6. Socio-Cultural Theory of Vygotsky

Lev Semyonovich Vygotsky (1896–1934) was a Soviet psychologist, one of several who sought to create the Marxist psychology.

For Vygotsky, the organic evolution of the animal species occurred, until man emerged, accompanied with the evolution of behaviour.[36] Instincts, conditioned reflexes, and (practical) intelligence emerged during evolution as a form of behaviour. All these behaviours before the emergence of man are subject to the principle of signalisation (I.P. Pavlov) and the S-R scheme. With the emergence of *Homo sapiens*, the structure of behaviour changed so that a sign was inserted between the stimulus and reaction as an intermediary (principle of signification), which corresponds with the new scheme ''stimulus-sign-reaction'' or S-Sg-R.[37] Then, *history* begins, in which changes in behaviour and psychological functioning rested on historically changing sign systems and tools (*culture*). Vygotsky believed that all organic changes were completed with the emergence of *Homo sapiens*, that evolution was completely replaced by history, and that human nature as a whole is a historical product.

This is the most general framework for several particular theories on mental ontogeny. The main and most developed theory has as its subject the development of *higher psychological functions* (HPFs). In each HPFs, speech has the most important place and the greatest attention is paid to speech, as well as its relations with thinking. Besides, another mediator in man's relationship with the environment are tools, which also determine ontogenesis. Further, Vygotsky provided a periodisation of development, with an elaborate study of stable and crisis periods.[38] His theory[39] also includes detours, that is, paths that culture has introduced into the development of persons with disabilities.

Unlike evolution and history, where the transition is sudden and sharp, the transition in ontogenesis is gradual. For the first year of life, Vygotsky talks about the natural type of development. This type corresponds with evolution. Natural development comprises neurophysiological maturation, with the principle of signalisation and the S-R scheme. At the end of the first year, with the development of speech, the cultural type of development begins, involving the principle of signification and the S-Sg-R scheme. However, neurophysiological maturation continues, so Vygotsky speaks of the dual influence of 'the child's activity system'.[40] Still, cultural development is as clearly different from natural development as history is from evolution.

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36 Vygotsky, 1983, p. 26.
37 Ibid. pp. 79–83.
38 Vygotsky, 1984a, pp. 243–385.
39 Vygotsky, 1984b.
40 Vygotsky, 1983, p. 34.

The second intermediate assumption is regarding the *source* of development, which is determined differently, as the: ideal cultural form,[41] social environment,[42] learning,[43] or training.[44] The next middle-level assumption speaks of the allomorphic principle of cultural development,[45] which means that development rests on something that is external to the personality – on sign systems and tools, which are of external, socio-cultural origin. Of course, along with such statements, there is an appropriate solution to the issue of the mechanism of development: Vygotsky sees it in imitation.[46] Along with imitation as the main mechanism of development, there is also an assumption about the necessity of asymmetric interaction. Asymmetric interaction occurs between a child and someone else (adult or older child) with higher developmental achievement. Finally, this group of assumptions also includes learning that precedes and drives development. The concept of the *zone of proximal development (ZPD)* is also in line with the middle-level assumptions. ZPD is defined as the difference between what a child can do alone (e.g. in solving some type of task) and what he can do with the help of an adult. The size of the zone determines the dynamics of individual development.[47]

These propositions provided adequate reasons for many to consider Vygotsky's theory as a theory of cultural acquisition and not a theory of development.

With the main assumptions regarding *the sociogenesis of the HPF*, we move on to the field of individual functions. This assumption is understood as a kind of formula and is core statement of the Marxist Vygotsky: 'every function in the child's cultural development appears twice: first, on the social level, and later, on the individual level; first, between people (interpsychological) and then inside the child (intrapsychological)'.[48] Each HPF arises in a real social relationship and then interiorises at a certain age. Here are two examples. Thinking arises from disputes between children,[49] while will arises from commanding.[50] Therefore, the real social relationship and the speech used in that relationship are the root of every HPF. Speech is the basic content of every HPF, thanks to which a person gains awareness, willingness, and self-regulation of his psychological processes and behaviour.

Since speech is of central importance for development, it is natural that Vygotsky paid special attention, through empirical research, to the development of speech and the relationship between speech and thinking at certain ages.

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41 Vygotsky, 1984a, p.356.
42 Ibid. p. 258.
43 Vygotsky, 1982b, p. 252.
44 Ibid. p. 199.
45 Vygotsky, 1983, p. 146.
46 Vygotsky, 1982b, pp. 250–251; 1983, p. 131.
47 Ibid., p. 247.
48 Vygotsky, 1983, p. 114.
49 Vygotsky, 1984a, p. 222.
50 Vygotsky, 1982b, p. 465.

Both these functions have separate roots in the natural period,[51] and for a while, the development of these two functions takes place independently. At some point, they partially merge when a spoken thought or intellectual speech arises.

When we observe only the development of speech as HPF, we see that, at the beginning, there is *social speech* (loud speech addressed to others), after which (around the age of three) *egocentric speech* (a term taken from Piaget) appears as a private loud speech not directed to others but as speech for oneself.[52] Egocentric speech disappears around the age of seven years with 'transitions inside', and *inner speech* arises; along with it comes thinking in the true sense of the word. Private loud speech is the middle link between social and inner speech. Thus, we see how the former social relationship (interpsychic category) is transformed into an intrapsychic category through individualisation of the function (private speech).

Table 3. Empirical research on the development of concepts[53]

Vygotsky used the so-called dual stimulation test to investigate the development of concepts. The test consists of 22 figures with six different shapes, painted with five different colours. It is a perceptual stimulation. Each figure has one of four different words written on the bottom: fik, lag, sev and mur. This is another stimulation. Figures can be classified into four groups using two parameters, height and size. The child should sort all the figures into 4 groups and explain each of his decisions. In this way, syncretism (the connection between elements is random, subjective and unstable), complexes (the connection is perceptible and unstable) and concepts (the connection is stable and abstract) were discovered.[54]

The development of spontaneous and scientific concepts also attracted Vygotsky's attention.[55] Spontaneous concepts arise in everyday life through spoken interactions, they are rich in experience but are unconscious. Scientific concepts, on the other hand, are concepts of science, they are brought into children's lives at school through verbal definitions, but they lack experience and are self-conscious (i.e. the child can define them). According to this author, scientific concepts surpass the development of spontaneous concepts and make the latter develop faster than they would on their own, because they are part of the system and act within the ZPD.

Today, Vygotsky's work is considered one of the most influential in developmental psychology, and education. Together with related theoretical approaches, it belongs to the category of co-constructivist approaches in psychology.

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51 Ibid. p. 105.
52 Ibid. pp. 46–58; pp. 317–331.
53 Author's own work.
54 Vygotsky, 1982b, pp. 118–184.
55 Ibid., pp. 184–317.

7. Bowlby's Theory of Attachment

John Bowlby (1907–1990) was a British psychiatrist and psychoanalyst who did not create a broader theory like Freud or Piaget, but his narrow-scope theory had and still has a great influence on the psychology field. Bowlby has long dealt with problems arising from the child's tie to his mother. While working on them, he realised that the theoretical solutions of psychoanalysis and SLT were not adequate. Bowlby turned to the ethological theory and the theory of control systems, where he found more adequate theoretical solutions. Based on his familiarity with these theories, in 1958, Bowlby published his new opinion in the work 'The Nature of the Child's Tie to his Mother'. The following year, zoo psychologist H. Harlow published his work investigating the attachment of young rhesus monkeys, with views close to Bowlby's.[56] Bowlby presented his theory in more detail in three volumes in 1959, 1973, and 1980.

Starting from ethology, Bowlby defined attachment[57] as a *system of behaviour* whose goal is to *seek and maintain closeness with another individual*. The system was created in the evolutionary past of the human species, when its basic function was protection from predators. The strongest emotions are included in that behavior system, which consists of five main components, joined later in the development by calling. The first group of three components (smile, cry, and calling) comprise *signals*, and their role is to bring the mother (caretaker) to the child. The second group (sucking, clinging, and following) is made up of *approach behaviours* whose role is to bring the child to the mother.

Attachment is an evolving phenomenon. Newborns do not yet have a system of behaviour that establishes and maintains closeness with a particular person. Of the attachment components, they can only engage in crying, and later smiling, while the other components are not developed. In addition, the child does not yet have *perceptive discrimination* of one person. Bowlby described four stages in the development of attachment. The answer to the question of when the complete attachment system will be developed can be arbitrary, but it can be said that the system is established in most children at eight months for one or several persons. Then, one can notice the fear of strange persons, also one of the indicators of attachment. At the end of the first year, the child also develops *internal working models* as attachment representations created based on bonding experience. Internal models consist of a model of the other person (whether or not he/she is available when needed), a model of the self (whether or not I am worthy of someone's care), and a model of the relationship.

The intensity and frequency of the occurrence of attachment behaviour changes daily and depends on organismic and external factors. Organismic factors that activate this behavior system include hunger, fatigue, cold, illness, and pain. External factors are the mother's departure, refusal to approach the child, holding of another

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56 Harlow and Zimmerman, 1959, pp. 421–432.
57 Bowlby, 1969.

child in her lap, etc. The termination of this behaviour is always the same: as soon as proximity is established.

The attachment system is complementary to the mother's *caretaking*, while the antithetical behaviours are the child's play and exploration of the environment, as well as the mother's dedication to other family members and responsibilities. During play and exploration of the environment, the crawling or walking child does not move outside the mother's visual field. The mother functions as *a secure base*, and when the child is hurt or hit, the mother provides comfort as *a safe haven*.[58]

Bowlby believed that after the child's third birthday, the intensity of attachment to the mother begins to decrease, so that during the latency period, attachment to peers begins to develop. During adolescence, attachment to parents remains, and daughters are more strongly attached to their mothers than sons. That is the age when attachment to institutions (e.g. the state) appears, even more so in adults, as well as partner attachment. In old age, attachment is established to the young.

7.1. Work of Marry Ainsworth

Bowlby's theory remained incomplete, especially because a methodological procedure for assessing individual differences in attachment was not developed. That was achieved by M. Ainsworth.[59] She designed a *strange situation*, in a room with three chairs and toys in one corner. A child (about one year old) and his mother are greeted by a 'stranger' and brought into the room; the child is observed (through one-way transparent glass) in eight episodes, in which he is sometimes alone, sometimes with his mother, and sometimes with the 'stranger' and toys.

By considering patterns and not individual behaviour, it is possible to distinguish three forms or *attachment statuses*. One of them is *secure attachment (B),* and two are insecure statuses: *insecure-ambivalent attachment (C)* and *insecure-avoiding attachment (A).*

It should be said that it is not justified to assign the same attachment status to one child permanently. He/she can have one status with one parent and another with the other parent. In addition, the attachment status may change, even if a high rate of stability has been established over time.

The original research included 106 children, with 23 (21.70 %) children being in group A, 70 (66.04%) in group B and 13 (12.26%) in group C. A meta-analysis summarising the results of several studies worldwide confirmed similar proportions.[60]

7.2. Further Research on Attachment

Bowlby's theory and Ainsworth's method strongly encouraged research on attachment around the world and in relationships with numerous variables.

Observation of children in a strange situation also revealed a fourth form of attachment, *disorganised* or *disoriented* (*Status D*). A child with this status did not have

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58 Bowlby, 1988.
59 Ainsworth et al. 2015.
60 Van IJzendoorn and Bakermans-Kranenburg, 1997, pp. 135–170.

coherently organised behaviour in a strange situation (coherence was a feature of statuses A, B, and C). He/she expressed contradictory behavior at the same time: he/she was calm and occupied with the game and suddenly becomes angry or he/she had a very stiff expression, slow movements, and stereotypical body posture but often reversed roles and told the parent what to do.[61]

Numerous studies aimed to determine the antecedents and consequences of attachment, on the part of the child, the caretaker, and the environment.[62] Moreover, numerous studies were conducted in various cultural environments[63]. Research has been extended to peer and partner attachment in young people and adults,[64] stability of attachment over time.[65] transgenerational transmission of attachment,[66] etc. New methods for assessing attachment status were also created, of which Adult Attachment Interview should be mentioned. Even attachment to animals is being investigated.[67]

It is natural to expect that insecure attachment relationships in early childhood predispose person to later mental disorders. Research confirmed these expectations.[68] However, the correlations between insecure attachment styles and psychopathology are moderated by various biological, psychological, and socio-cultural factors.[69]

8. Other Orientations and Theories

8.1. Evolutionary Developmental Theories

The general principles of evolutionary developmenta psychology (EDT) in terms of psychological development are derived from evolutionary theory, which serves as a distant explanatory framework. Evolutionary developmental theorists do not deny the determinants of behaviour that come from a closer framework, made up of the immediate environment and individual history; rather, they emphasise that the existence of childhood and development has an evolutionary significance, that is for adaptation and inclusive fitness.[70] One main idea of EDT is that the mind consists of discrete modules that have specific developmental trajectories, as well as specific disorders. Modules should be understood as specific predispositions that facilitate development in special areas: language acquisition, face perception, mastery of the physical environment, and understanding of people. A special group within EDT is *ethological psychology.*[71] Ethologists are especially known for their method, the observation of

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61 Main and Solomon, 1986, pp. 95–124; Hesse and Main, 2000, pp. 95–124.
62 Sutton, 2019, pp. 1–22.
63 Van IJzendoorn and Kroonenberg, 1988, pp. 147–156.
64 Bartolomew and Horovitz, 1991, pp. 226–244; Shaver, 2016.
65 Groh et al. 2014, pp. 51–66.
66 Benoit and Parker, 1994, pp. 1444–1456.
67 Endenburg, Van Lith and Kirpensteijn, 2014, pp. 390–414.
68 See example for personality disorders: Levy et al. 2015, pp. 197–207.
69 Mikulincer and Shaver, 2013, pp. 11–15.
70 Geary and Bjorklund, 2000, pp. 57–65; Workman and Reader, 2021.
71 Bateson, 2015, pp. 208–243.

living organisms in the natural environment. Konrad Lorenz and Niko Tinbergen laid the theoretical foundations of ethological psychology before the World War II. For ethologists, the basic idea is that each living species possesses a set of inherent behavioural systems, which differ along the lines of environmentally stable/labile systems. One such system serves to establish and maintain attachment to another person. Ethologists point to the existence of sensitive periods in the development of these systems. Thes periods are the most favourable for the development of certain systems.

8.2. Bioecological Theory

Urie Bronfenbrenner is the main representative of this orientation in developmental psychology. This orientation, or model, as it is also called, has evolved over time.[72] 'Human development takes place through processes of progressively more complex reciprocal interaction between an active, evolving biopsychological human organism and the persons, objects, and symbols in its immediate external environment'. This concept emphasises that development takes place through interaction with the environment, and is not only observed within a concrete environment.[73] A developing person is active; he/she participates with his/her dispositions as well as bio-ecological resources and demands; and development takes place in proximal processes, in interaction with other persons, objects, and symbols.[74] The human environment is a system made up of special systems as layers. *A microsystem* is the closest system in which an individual participates in two-way, face-to-face interactions such as a family environment, kindergarten, and group of children at play. A *mesosystem* includes two or more connected microsystems, such as the family and school systems. *The exosystem* includes several environments, but the individual does not participate directly in at least one of them (e.g. the parent' work environment). The *macrosystem* consists of the most general cultural patterns, symbolic and value systems, and customs that influence development through lower systems. Finally, *the chronosystem* indicates the degree of stability and changeability in the environment and the individual, such as changes in the family's composition, working place of parents, and migration.

9. Concluding Remarks

Developmental theories can be evaluated and compared with each other according to several parameters: internal consistency, comprehensiveness, empirical testability, heuristic value, and practical usability. If we focus on practical usability, it is useful to first distinguish between competence and performance. Some theories (e.g. by Pieget, Freud, and Erikson) talk about development at the competence level, which means

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72 Rosa and Tudge, 2013, pp. 243–258.
73 Bronfenbrenner and Morris, 1998, p. 996.
74 Bronfenbrenner and Morris, 2007, pp. 793–828.

that development takes place at the level of basic dispositions. Other theories (e.g. SLT and Vygotsky's theory) talk about changes at the performance level. It can be said that Piaget's theory does not cover the situational variability of cognitive concepts, where SLT has the greatest strength (different models and different regimes of rewarding and punishing children's behaviour). However, Piaget provides a reliable basis for knowing at what age certain concepts *can* appear,[75] or when these concepts *can* be adopted. On the other hand, the psychoanalytic tradition (from Freud to Bowlby and beyond) can point to external factors (e.g. parental practices) that can lead to arrested development and various psychological disorders.

75 For example, the concept of rights, as normative and different from concepts of desire and need, can be understood in its true meaning only at the adolescent age.

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Main Areas of Human Development I: Emotional, Cognitive, and Social Growth From Birth to Late Adolescence

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ABSTRACT

This chapter provides an overview of human development, specifically focusing on the characteristics of cognitive, emotional, and social development from birth to late adolescence, through an overview of major foundational psychological theories. The goal of this chapter is to offer a comprehensive understanding of the diversity and relevance of emotional, cognitive, and social processes by presenting different, complementary theoretical approaches, illustrated with practical, real-life examples.

Despite presenting aspects of emotional, cognitive, and social development separately within the chapter, numerous theories and approaches, as well as research evidence, are presented that emphasise the interconnected and reciprocal nature of these processes. Proper functioning of the cognitive system is necessary for the establishment of balanced emotional states and social relationships because, as detailed within the chapter, according to certain cognitive emotion theories, emotions arise based on the cognitive evaluation of external events and internal states. Similarly, a lot of empirical evidence demonstrates that the social environment plays a primary role in a child's appropriate emotional, cognitive, and psychosocial development.

The chapter also highlights the first two years of life as a critical period in not only cognitive and emotional but also social development. Experiences acquired during this period influence later developmental stages. Positive experiences and a supportive social environment lead to the development of adaptive cognitive schemas that contribute to later balanced social and emotional development. In contrast, negative experiences and an unsupportive social environment can result in the formation of schemas that increase the likelihood of difficulties in emotional and social development; unsuccessful resolution of age-specific crises; and likelihood of the emergence of psychopathologies such as anxiety, depression, and personality disorders.

KEYWORDS

cognitive development, emotional development, social development, sociocultural context, learning

1. Cognitive Development

Cognition encompasses various intellectual abilities, activities, and processes. Cognitive development refers to changes in these abilities from birth to late adolescence. Cognitive processes include perception, attention, memory, categorisation, thinking, reasoning, and decision-making. These processes enable the acquisition, storage, manipulation, and utilisation of information in different contexts.[1,2]

The development of language is particularly remarkable, as significant differences in proficiency can be observed at various stages of life. Infants can only produce sounds, but by the age of around 1 year, they start using their first meaningful words. Language is the cognitive ability that allows us to express our thoughts and understand the thoughts of others using sounds, letters, and grammatical rules, a particularity of human cognition.[3] The most influential periods of language acquisition are infancy and early preschool years.[4] Language and thought develop side by side, with language helping us organise our internal thoughts and social interactions through communication.[5] Thinking involves manipulating all forms of information, playing a significant role in problem-solving. Reasoning pertains to logical thinking and making deductions based on the provided information. During the process of decision-making, individuals focus their thinking on selecting among different alternatives.[6,7,8]

According to the dual-process theory of decision-making, the decision-making process is realised through two parallel cognitive systems. The analytic or rational system provides logical, scientific thinking, which is associated with fewer cognitive biases, while the experiential or intuitive system enables quick, automatic thinking, utilising heuristics (shortcuts) that result in more cognitive biases. As age progresses, analytic and rational thinking becomes increasingly sophisticated. Research has shown that middle and late adolescents make more accurate and logical statistical inferences, displaying fewer cognitive biases than early adolescents. Developments in the rational system and decision-making can be explained by the maturation of metacognitive processes; this is because adolescents, with age, increasingly monitor, control, and correct their thinking processes and the strategies applied in various decision-making situations. However, concomitant with the development of the rational system, with advancing age, the experiential and intuitive system also becomes more prominent, and the application of heuristics

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1 Galotti, 2016, pp. 18–39.
2 Groome et al., 2014, pp. 2–22.
3 Ibid., pp. 302–309.
4 Galotti, 2016, pp. 178–182.
5 Owens, 2016, pp. 17–45.
6 Evans, 2020, pp. 1–25.
7 Galotti, 2016, pp. 425–427.
8 Groome et al., 2014, pp. 240–269.

becomes more frequent, especially in decision-making situations involving social contexts. [9]

1.1. Constructivist Cognitive Development Theory

Jean Piaget's theory of cognitive development emphasises the active role of children in creating new mental structures. Children assimilate their existing mental structures with environmental stimuli, thus creating new, more advanced, and complex mental structures that contribute to appropriate adaptation.[10]

Piaget developed the stage theory of development, where qualitative changes occur in different stages, each building upon the previous one. The cognitive structures developed in one stage contribute to the creation of more complex structures in the next stage. These stages are associated with specific age periods and are not interchangeable; they follow a particular sequence. According to the theory, developmental stages are universal and appear in every individual, with the environment having a less determining role.[11]

Mental structures and cognitive activities develop through the processes of assimilation and accommodation. Assimilation involves applying an existing cognitive structure to new situations. For example, seriation, a mental structure that develops in early school age, can be used for not only physically arranging objects in order of size but also mentally ordering tasks, such as scheduling homework or activities. Accommodation, on the other hand, entails changing mental structures to adapt to new environmental influences. A child's seriation ability evolves and changes each time they apply it to different tasks. Thus, both assimilation and accommodation are present in every activity, facilitating successful adaptation and development.[12]

Piaget identified four developmental stages. The first is the sensorimotor stage, which lasts from birth to 2 years. During this stage, infants are unable to mentally represent information or form conscious memories, so their development is based on sensory and motor actions. Without the presence of a perceivable object, infants lose interest because they have not formed a mental representation of the object. For example, if a hidden object is not visible to the infants, it effectively does not exist for them, a phenomenon explained by lack of the mental structure of object permanence. Infants respond to external stimuli through automatic reflexes, such as the grasping or sucking reflex. Through assimilation and accommodation, these reflexes develop into more complex schemas. For instance, infants start controlling the grasping reflex with visual cues, bringing the perceived object closer for further exploration. By the age of 2 years, they acquire the ability to mentally represent objects, including the concept of object permanence, understanding that objects and people exist even when they are not seen.[13]

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9 Albert and Steinberg, 2011, pp. 211–224.
10 Babakr, Mohamedamin and Kakamad, 2019, pp. 517–524.
11 Galotti, 2016, pp. 45–71.
12 Cohen and Waite-Stupiansky, 2013, pp. 57–72.
13 Rabindran and Madanagopal, 2020, pp. 2152–2157.

The second stage is the preoperational stage, which extends from around the age of 2 to 6. During this stage, children can use language to express their thoughts and perceive the past and future through mental representations.[14] However, reversible mental operations are lacking in this stage. Children cannot consider multiple perspectives or concentrate on multiple characteristics of an object or situation. For example, when asked to group objects of different sizes, colours, and shapes, they may shift between different criteria and fail to hold onto their initial categorisation criterion. This one-sided focus is also evident in the concept of conservation, as children in this stage cannot understand that changes in appearance do not necessarily affect quantity. In one of Piaget's conservation experiments involving plasticine, most 3- to 4-year-olds believe that a flattened piece of plasticine contains more plasticine than the original piece in ball form, simply because it appears larger. Egocentrism characterises their thinking, as they believe that others perceive the world exactly as they do. They cannot differentiate between their perspective and that of others, assuming that others know what they know, such as thinking that someone standing opposite them sees the same things they do, even when their viewpoint is different. For example, they might assume that their parents know what the toys at preschool look like or what happened at a birthday party they did not attend.

The concrete operations stage extends from around age 6 to early adolescence, up to 11–12 years old. During this period, children develop the ability to understand conservation, categorisation, and seriation. They can consider multiple perspectives, distinguish between appearance and reality, and perform mental operations with the presence of concrete objects. In the concrete operations stage, children, as opposed to those in the preoperational stage, can not only determine that two differently shaped pieces of plasticine contain the same amount but can also provide logical reasoning for it. They often use reversibility as an argument, explaining that the flattened plasticine can be reshaped into a ball. They can categorise objects based on multiple criteria and, after selecting one criterion, disregard the others. Older children can even categorise using multiple criteria simultaneously. Piaget argued that children in this stage can perform these mental operations only when concrete objects are present.[15]

The formal operations stage occurs during adolescence and is characterised by abstract and systematic theoretical thinking. Adolescents can engage in logical reasoning, conduct mental experiments to consider the consequences of their actions, and evaluate possible alternatives. Abstract thinking allows them to perform operations without the presence of concrete objects and to solve problems involving unknown variables. In the application of logical reasoning, significant differences emerge between individuals in the concrete and formal operational stages. When presented with syllogisms that contain empirically false premises, adolescents can disregard the truth value of the premises and focus solely on whether the conclusion

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14 Owens, 2016, pp. 17–45.
15 Babakr, Mohamedamin and Kakamad, 2019, pp. 517–524.

follows logically. In contrast, children in the concrete operations stage cannot separate the truth of the premises from their content. Formal operational thinkers recognise the distinction between logical and empirical reasoning. Adolescents' cognitive development enables them to understand that there are different ways to interpret the world, based on various rules and expectations. They question social norms and institutional systems.[16]

1.2. Sociocultural Cognitive Development Theory

According to Lev Vygotsky's sociocultural development theory, the cultural environment determines the cognitive abilities a child develops. In contrast to Piaget's theory, where children develop the mental structures necessary for adaptation on their own, in Vygotsky's theory, these schemas are shaped through the interaction between the child and their environment.[17] Cultural tools, available within the society, aid in the development of cognitive abilities, or their absence can result in underdeveloped abilities. The child's parents, family, and school environment contribute to the formation of mental structures by assisting the child in learning through social interactions.[18] The zone of proximal development refers to the difference between a child's current level of development (what they can do and understand independently) and their potential level of development (what they can do and understand with the help of an adult or more experienced peer).[19] Therefore, with the help of members of the social environment, a child can reach their potential level of development. The level of the zone of proximal development varies depending on the child's current level of development. For instance, a parent can assist a child in learning basic mathematical operations, such as addition, by manipulating concrete objects or presenting real-life situations that require addition, such as "Sarah eats 3 slices of apple, her brother eats 5 slices of apple, how many slices of apple do the two siblings eat together?" The process through which new skills, schemas, and mental structures become integrated into the cognitive system through social interactions is called internalisation.[20]

Culture influences which skills and mental structures a child will acquire. In Western societies, alongside basic education in math, writing, and reading, there is strong emphasis on teaching digital and practical skills that students can use in the labour market after leaving school. In contrast, other cultures focus on developing different skills and mental structures, such as fishing, hunting, agricultural skills, or craftsmanship, to ensure adaptation. Speech is one of the most important cultural tools, contributing to the formation of all mental structures and the development of cognitive abilities. Communication through speech enables assistance from the social environment, which facilitates reaching the potential level of development.

16 Galotti, 2016, pp. 45–71.
17 Hughes, 2021, pp. 41–46.
18 Swain, Kinnear and Steinman, 2015, pp. 15–48.
19 Kozulin et al., 2003, pp. 15–64.
20 Vasileva and Balyasnikova, 2019, pp. 1–15.

Internal speech also helps children, adolescents, and adults perform complex tasks and guide themselves through the tasks.[21]

1.3. Information Processing Approach

According to the information processing approach, environmental stimuli go through various processes, interact with prior knowledge in long-term memory, and are organised into existing schemas or conceptual categories. When no prior knowledge exists on a topic, new schemas or conceptual categories are formed.[22]

Information from different sensory modalities is processed and interpreted through perception in the cognitive system. Perception is the cognitive process through which information from the external world gains meaning. Attention is the cognitive ability that allows us to focus our mental resources on a specific task. It directs perception and helps differentiate between task-relevant and irrelevant information or stimuli. Complex, novel tasks require more attention and greater mental concentration, while well-practiced tasks can be performed almost automatically without significant attentional effort. Multitasking, or dividing attention between multiple tasks, is possible alongside automatic task performance.[23]

Memory is the cognitive process that enables us to store relevant information selected for attention for long-term use. The active memory unit responsible for active information processing is called the working or short-term memory, which has limited capacity. Pioneering discoveries by George Miller showed that an individual with average intellectual abilities can store and manipulate around 7±2 chunks or units of information in the working memory. Chunking, which involves grouping information based on a logical rule, allows for efficient processing of larger amounts of information compared to handling individual units. For example, when memorising a series of numbers such as a phone number, chunking allows us to create groups of two or three digits, making it much easier to remember. The process of chunking is also activated during learning when we attempt to identify relationships between pieces of information by categorising and organising the material. Working memory capacity is notably lower in preschool-aged children, at around three or four chunks, and increases with age. Through active processing, information is transferred from the working memory to long-term memory.[24]

In long-term memory, we organise our knowledge using categorisation. Significant differences exist in the amount of accumulated knowledge between younger and older children. How infants, preschoolers, young school-aged children, and adolescents organise and categorise information varies. Memory is constructive, influenced by prior experiences, knowledge, and memories. People tend to fill in missing information in their recall, often unintentionally. This phenomenon is

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21 Panhwar, Ansari and Ansari, 2016, pp. 183–188.
22 Groome, 2014, pp. 160–165.
23 Galotti, 2016, pp. 80–88.
24 Groome, 2014, pp. 137–142.

particularly evident in the memories of children, who can be highly susceptible to manipulation through suggestive questions. [24] A study conducted with 8-year-old children found that the occurrence of false memories is not only triggered by children's increased tendency to obey adults but is also influenced by the current memory traces. In the experiment, children who recalled false or partially false memories were more prone to agree with the misleading information provided by the experimenter in a deception task than did children who did not have false memories.[25] In a review from 2016, research results were summarised regarding how the interviewer's attitude can impact children's testimonies, accuracy of their memories, and their susceptibility to influence. Creating a secure, supportive environment leads to more accurate recall than neutral, unsupportive conditions. The interviewer's supportive attitude results in more accurate recall, less acquiescence, and greater resistance from the child regarding suggestive questions. For children who are less cooperative, anxious, insecurely attached, and cognitively deficient, a supportive environment and attitude during the interview are particularly important.[26] The context of encoding is also highly relevant for retrieval performance. Numerous studies have shown that retrieval is more effective when the learning context, environment, learner's emotional state, or mood at encoding matches the context during retrieval.[27]

2. Emotional and Social Development

2.1. Functions and Types of Emotions

Besides their evolutionary functions, emotions play a prominent role in the 21st century as they influence our emotional and physical well-being, learning, everyday activities, decision-making, problem-solving efficiency, adaptability to different life situations, personal successes, social relationships, and moral decisions.[28,29] Sroufe categorised the functions of emotions into three major categories.[30] From an evolutionary perspective, one primary function of emotions is to respond to emergencies, activating bodily physiological changes that trigger the fight or flight response.[31] The communicative and social function of emotions is particularly relevant since we communicate with others through our emotions and their expressions and share our emotional states, as well as through the events and experiences that led to these emotional states.[32] In infancy and childhood, the expression of emotions plays a

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25 Otgaar et al., 2012, pp. 397–403.
26 Saywitz et al., 2016, pp. 1–18.
27 Galotti, 2016, pp. 18–39.
28 LoBue, Pérez-Edgar and Buss, 2019, pp. 7–8.
29 van Kleef and Côté, 2022, pp. 629–658.
30 Wilson and Wilson, 2015, pp. 1–7.
31 Cannon, 1927, pp. 106–124.
32 Hess and Thibault, 2009, pp. 120–128.

crucial role in communication because children depend on their social environment during this period.[33] Similarly, in childhood and adulthood, the exploratory function of emotions is essential as emotions motivate individuals to learn and discover new stimuli.[34]

Emotional reactions arise from various mental processes, activities, and physiological changes. The perception, attention, motivation, thinking, learning, memory, and combined operation of these cognitive processes trigger emotional reactions. In addition to physiological reactions and the activity of the nervous and limbic systems, which ensure survival and adaptation from an evolutionary perspective,[35] emotional reactions include an automatic, powerful subjective feeling and the expression of emotion, which can be influenced by culture, context, age, and gender.[36,37,38]

Based on the interpretation of perceived events, we can distinguish between positive and negative emotions. Subjective interpretation influences whether we perceive certain emotions as positive or negative. Fear and fright are generally interpreted as negative emotions, even though feeling fear and the subsequent behaviour can have positive consequences in a dangerous situation. Similarly, love can be considered either positive or negative.[39,40] Emotions also differ in terms of their intensity and duration. Emotions are typically short-lived, intense reactions, while moods are weaker in intensity and longer-lasting states. Emotional expression also varies and is influenced by social, cultural, and gender expectations. The intensity of emotional expression does not necessarily match the intensity of the experienced emotion since individuals regulate and control the degree of emotional expression through their cognitive systems, which is a prerequisite for functioning social relationships.[41,42,43] Additionally, primary emotions and secondary emotions can be distinguished.[44,45] Discrete emotion theories emphasise the presence of culture-independent basic emotions,[46] while structural developmental theories focus on the explanation of secondary emotions.[47]

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33 Granqvist et al., 2017, pp. 534–558.
34 Sroufe, 1995, pp. 11–15.
35 Dror, 2014, pp. 13–20.
36 Poláčková Šolcová and Lačev, 2017, pp. 75–82.
37 Shuman et al., 2017, pp. 47–56.
38 Wilson and Wilson, 2015, pp. 14–21.
39 Carver and Scheier, 1990, pp. 19–35.
40 Wilson and Wilson, 2014, pp. 21–5.
41 Chaplin, 2015, pp. 14–21.
42 Hareli, Kafetsios and Hess, 2015, pp. 1–12.
43 Lim, 2016, pp. 105–109.
44 Becker-Asano and Wachsmuth, 2010, pp. 32–49.
45 Demoulin et al., 2004, pp. 71–96.
46 Hess and Thibault, 2009, pp. 120–128.
47 Sroufe, 1995, pp. 38–50.

2.2. Emotion Theories

2.2.1. Discrete Emotion Theories

Discrete emotion theories are based on Charles Darwin's evolutionary emotion theory. According to Darwin's approach, emotions served an adaptive function during evolution, ensuring survival, success, and reproduction. The correct interpretation of environmental stimuli and the behaviour and emotions of others increase the chances of the correct response. Darwin observed the emotional facial expressions of infants from different cultural backgrounds and concluded that there are universal basic emotions that are instinctive and innate.[48,49]

Similar to Darwin, Paul Ekman also examined emotional facial expressions in different cultures. He identified six basic emotions that appear in every culture: happiness, sadness, fear, anger, surprise, and disgust.[50] Carroll Ellis Izard, in addition to the six basic emotions defined by Ekman, identified four more: shame, contempt, guilt, and interest.[51] Like Izard, Silvan Tomkins suggested that emotions could originate from the interpretation of facial expressions, and that facial expressions could increase the intensity of experienced emotions, a concept known as facial feedback.[52,53]

2.2.2. Structural Developmental Theories

Emotional development is inseparable from context and environment. Emotions develop through interactions with the social environment, so emotional development is closely related to social development. Individuals with limited social networks also have basic emotions, but secondary social emotions develop during social interactions. Representatives of structural developmental theories argue that emotional development occurs through the interaction of physiological, psychological, cognitive, and social environmental systems.[54]

According to Sroufe, every secondary emotion has a preceding childhood emotion. The experience of a new emotion results from the structural transformation of a previous emotion due to the influence of the social environment. Simple early childhood emotions such as anger, joy, and fear evolve into complex emotions. Culturally and socially determined secondary social emotions include love, jealousy, anxious fear, bitterness, empathy, sympathy, and more. If early social interactions with caregivers and mothers are disrupted during infancy, the development of secondary emotions may also be negatively affected because infants learn that they cannot influence their

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48 LoBue, Pérez-Edgar and Buss, 2019, pp. 8–10.
49 Wilson and Wilson, 2015, pp. 31–35.
50 Ekman, 2003, pp. 1–13.
51 Izard, 1977, pp. 67–95.
52 Coles, Larsen and Lench, 2019, pp. 610–651.
53 McIntosh, 1996, pp. 121–147.
54 Wilson and Wilson, 2015, pp. 35–36.

social environment, which can lead to social and emotional developmental problems in the future.[55]

2.2.3. Physiological Emotion Theories

Physiological emotion theories consider the physiological component of emotions as the key factor in the formation of emotions, disregarding the study of emotional expression and facial expressions. Based on the James-Lange theory, emotions arise because of physiological and bodily reactions to an event, with emotions being triggered by the subjective perception and interpretation of these bodily reactions. According to this theory, for example, when a child is frightened by a barking dog on the street, it is not the feeling of fear that triggers the associated bodily reactions. The child begins to produce bodily reactions such as trembling, rapid heart rate, and crying as a result of perceiving the barking dog, and the perception of these bodily reactions then provokes the emotion of fear.[56,57,58]

One criticism of the James-Lange theory, as noted by Walter Cannon, is that physiological changes do not always go hand in hand with the experience of emotions. For instance, physical work or sports activities can increase heart rate and sweating, but these physiological reactions often do not generate emotions such as fear.[59] Another critique of the James-Lange theory is that emotions often appear simultaneously with the presentation of environmental stimuli, even before interpreting the bodily reactions. According to Philip Bard, emotions develop when the thalamus transmits information about the perceived environmental stimulus to the brain, which simultaneously results in physiological reactions.[60] Based on these arguments, Cannon and Bard concluded that externally triggered emotions and physiological reactions occur simultaneously, and there is no causal relationship between physiological reactions and the appearance of emotions.[61]

2.2.4. Cognitive Emotion Theories

In their theory, Schachter and Singer emphasised the role of the cognitive factor, in addition to the presence of physiological reactions, in the formation of emotions. This cognitive factor involves the interpretation and labelling of bodily reactions. According to the two-factor theory, appearance of an environmental stimulus triggers a physiological response, and the emotion is then created after the response is interpreted cognitively.[62] Therefore, if a child encounters the stimulus of a barking dog and feels fear, the perception of barking triggers increased heart rate and rapid

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55 LoBue, Pérez-Edgar and Buss, 2019, pp. 13–15.
56 Fehr and Stern, 1970, pp. 411–424.
57 LoBue, Pérez-Edgar and Buss, 2019, pp. 8–10.
58 Wilson and Wilson, 2015, pp. 31–32.
59 Cannon, 1927, pp. 106–124.
60 Bard, 1934, pp. 264–311.
61 Dror, 2014, pp. 13–20.
62 Schachter and Singer, 1962, pp. 379–399.

breathing, and the child identifies and explains these bodily reactions as fear. The theory also highlights that cognitive interpretation and context play a crucial role in the creation of emotions, as the same physiological reactions can elicit different emotions. For example, a child's rapid heartbeat and increased breathing, resulting from playing hare and hounds in the park, can evoke feelings of happiness, excitement, and joy, while the same physiological reactions during a test may result in feelings of fear.[63,64,65]

The cognitive appraisal theory, represented by Richard Lazarus and Susan Folkman, posits that cognitive appraisal is a crucial factor alongside physiological responses in the development of emotions. According to the theory, when children are confronted with the stimulus of a barking dog, they first evaluate the situation and identify the potential danger. This cognitive appraisal triggers physiological reactions and the feeling of fear simultaneously. During primary appraisal, the individual evaluates whether an event or environmental stimulus is positive, negative, or neutral. If the person evaluates the event as positive or neutral, there will be no heightened physiological reactions. However, if the event is perceived as negative or dangerous, a secondary appraisal occurs, during which the individuals assess their abilities and coping strategies that can help them deal with the negative event. The secondary appraisal can result in the person perceiving the event as harmful, dangerous, or challenging. The perception of harm or danger occurs when the person does not possess the necessary coping skills for dealing with the event or is unable to apply these skills in a given situation. The presence of coping skills or confidence in using them can lead to the event being interpreted as a challenge. Reappraisal involves continuously reinterpreting the event based on new information that may be relevant to coping with the event.[66,67]

2.2.5. Theory of Primary Emotional Systems and the Role of Play in Children's Development

In Jaak Panksepp's evolutionary theoretical approach, he distinguished between brain systems that elicit negative and positive emotions, which also influence personality traits such as agreeableness, extraversion, openness, and neuroticism (see Figure 1). Within positive emotions, he identified the brain emotional systems of seeking, lust, care, and play, while within negative emotions, he identified the brain emotional systems of fear, rage/anger, and sadness/panic. The brain's emotional systems that elicit negative emotions have an adaptive role. The fear brain system helps recognise situations indicating a threat, allowing individuals, through learning in childhood, to avoid physically or emotionally dangerous situations. The anger system can be activated in not only situations where people are under attack and must

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63 Dror, 2017, pp. 7–16.
64 Griffiths, 2017, pp. 197–203.
65 Wilson and Wilson, 2015, p. 32.
66 Folkman et al., 1986, pp. 992–1003.
67 Lazarus, 1991, pp. 819–834.

defend themselves but also situations where achieving a goal is jeopardised, leading to frustration. For example, children might get angry at a sibling if they feel they are not getting enough attention from their parents. Panic or sadness arises in situations where a person feels alone, excluded, or abandoned.

Similar to the negative emotional brain systems, positive emotional systems also play a crucial role in adaptation. The survival brain system fosters a child's curiosity and exploratory behaviour, forming the basis for survival and learning. The lust and care systems enable the satisfaction of sexual desire and offspring care needs, allowing for the experience of associated positive emotions. Despite the initiation of sexual life typically occurring in adolescence or early adulthood, activation of these emotional brain systems can be observed in children's play, such as roleplaying games where children take on roles, care for dolls, feed them, give them drinks, etc.

Figure 1: Primary emotional systems and personality[68]

Five Factor Model of Personality

Openness to Experience	Conscientious-ness	Extraversion	Agreeable-ness	Neuroticism

Primary Emotional Systems influencing the Five Factors of Personality

high SEEKING		high PLAY	high CARE	high FEAR
			low ANGER	high SADNESS
				high ANGER
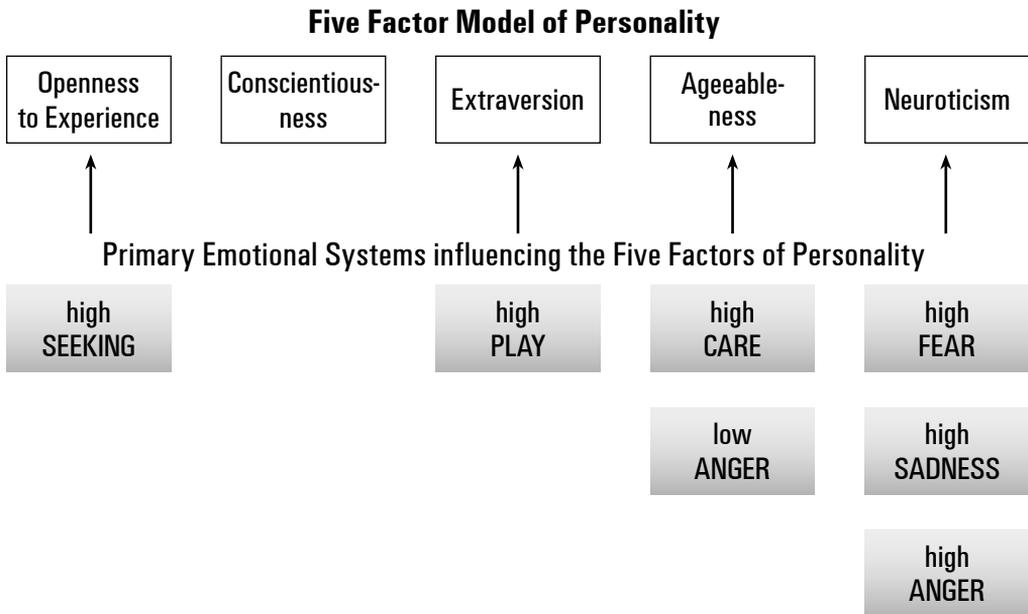
Social play is the most crucial emotional brain system in childhood, with an evolutionary role in forming and maintaining social relationships. The absence of social play in childhood and increased engagement in non-social forms of play, such as phone and computer games, can lead to reduced social skills.[69]

Play involving objects emerges in infancy, leading to exploration and learning by allowing the child to discover the properties and behaviours of objects and their

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68 Montag and Panksepp, 2017, p. 8.
69 Ibid., pp. 1–15.

functions. From the age of 1.5 to 2 years, children begin to organise objects, laying the foundation for later categorisation. By the age of 4, they start building and creating new objects using available materials. These early play activities enhance children's thinking, problem-solving strategies, language development, mathematical skills, and spatial abilities.

Another early play activity involves engaging in physical games, such as those related to movement (e.g. cycling, jumping, dancing, and climbing), fine motor games (e.g. manipulating toys, colouring, and cutting), and games with other children or parents (e.g. hare-and-hounds and hide-and-seek). Physical play activities positively impact spatial-visual skills, eye-hand coordination, math performance, social acceptance, and social competence.

Symbolic play develops through representational systems such as spoken language, writing, counting, and music. Language games, such as rhymes and tale reading, enhance children's phonological awareness. Involvement in musical games, such as singing and dancing, develops prosocial behaviour. Through drawing activities and drawing games, children can express their emotions and thoughts.

Roleplay, drama games, and fantasy games contribute to the development of children's reasoning and social skills. Imaginative play is a key learning form for language, communication skills, and storytelling. Fantasy-based imaginative play, in particular, has a positive impact on executive functions, with children possessing more vivid imagination exhibiting higher attention-switching, inhibitory control, and working memory capacity. Several studies have demonstrated that the depth of engagement in roleplaying games influences children's creativity.[70]

2.3. Attachment as a Process Influencing Emotional and Social Development

In an evolutionary approach, John Bowlby defined attachment as a genetically encoded process. This means that infants are born with the ability to form attachments, and these attachments serve an evolutionary purpose by promoting survival. Children can form attachments with multiple individuals, but one of these, primary attachment, is particularly significant and qualitatively different. Typically, primary attachment forms with the caregiver, usually the mother, during the sensitive period within the first two years of life. Infants and mothers instinctively seek proximity to each other, and the infant's inborn attachment behaviours, such as crying or smiling, cause the caregiver's attention and care.[71]

The disruption or failure to develop attachment between the primary caregiver and the child, or inadequate emotional care from the primary caregiver, is referred to as maternal deprivation. This can have long-term negative consequences on the child's social, emotional, and cognitive development. The cognitive schemas individuals form about themselves, the world, and social relationships are rooted in their early attachment experiences and determine their attachment style. Damage

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70 Whitebread et al., 2017, pp. 7–22.
71 Granqvist et al., 2021, pp. 90–113.

to primary attachment can negatively affect the establishment and maintenance of later social relationships. Children who experience maternal deprivation may have difficulty trusting others, perceive themselves as less lovable and valuable, and feel less capable of effectively managing social relationships. Early attachment representations can be altered by subsequent attachment experiences or by reinterpreting past events.

Individuals with a secure attachment style trust the person to whom they are emotionally attached. They believe they deserve love, react adaptively to relationship disruptions, and can act independently when necessary. In contrast, individuals with anxious-ambivalent attachment assume that others do not reciprocate their love and intimacy, and they are uncertain in their relationships. This attachment style often results from inconsistent or unreliable responses from the primary caregiver to the child's needs. Individuals with avoidant attachment style tend to avoid interaction with the primary caregiver and do not show signs of distress when the caregiver leaves. This style can develop when the caregiver rejects the child's attempts at closeness or exhibits impatience or aggression in response to the child's behaviour. These children learn to avoid interaction with their caregivers and believe they must rely on themselves for happiness and cannot effectively manage social relationships.[72]

In Abraham Maslow's theory regarding the hierarchy of needs, he enumerated the biological, social, emotional, and cognitive needs whose fulfilment is essential for mental well-being and ideal social and emotional development. As illustrated in Figure 2, after satisfying the basic biological needs, the next level includes the need for safety and security, the foundation of which is the presence of secure attachment. According to Maslow's theory, if the needs at the lower levels of the hierarchy are not met adequately, such as the child, adolescent, or adult not feeling safe or loved, fulfilment of needs in the higher levels of the hierarchy may also be damaged. Consequently, a child with insecure attachment may experience impaired cognitive and self-actualisation abilities and low self-esteem. According to the theory, neglecting the biological and emotional needs of a child and providing inadequate responses during critical periods by the parent, such as ignoring the child's cries, failing to comfort, or providing insufficient care for biological needs, may contribute to their school adjustment problems, low self-esteem, low academic performance, and difficulties in identifying and achieving individual potentials and goals later in life. In contrast, securely attached children, whose biological and emotional needs were adequately met during critical periods, are more effective in establishing and maintaining social relationships, have higher self-esteem and self-confidence, and are more motivated in learning, thus achieving higher academic results. They have higher intrinsic motivation, as their needs for security, autonomy, and competence are more fully satisfied, making them more effective in identifying and utilising their individual strengths during the pursuit of their individual goals.[73]

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72 Stevenson-Hinde, 2007, pp. 337–342.
73 Kenrick et al., 2010, pp. 292–314.

Figure 2: Maslow's hierarchy of needs[74]

2.4. Psychosocial Development

According to Erik Erikson's theory, individuals go through various psychosocial developmental stages from childhood to adulthood, each characterised by a psychosocial crisis. The resolution of these crises can have positive or negative effects on an individual's personality. An individual's emotional and social psychological needs interact with their social environment, which influences the satisfaction of these needs.[75]

The first psychosocial stage is trust vs. mistrust, which lasts from birth to approximately 1.5 years old. During this stage, infants completely rely on their primary caregiver for help and care. If parents respond lovingly and appropriately to the infant's needs, such as meeting their biological needs when they cry and providing emotional care by actively engaging with them, trust develops in the child. This trust extends to the world, and the children learn to count on the people around them, which positively influences their future relationships. A successful resolution of this psychosocial crisis leads to the development of hope in the child, as they learn that they can rely on others for support and safety. Conversely, if parents neglect or inadequately respond to the children's needs, the children may develop a sense of mistrust, feeling that the world is not a safe place and that they cannot rely on others when

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74 Source: www.simplypsychology.org.
75 Erikson, 1978, pp. 222–242.

needed. Mistrust leads to fear, which can have lasting effects on the child's emotional and social development.[76]

The second psychosocial stage is autonomy vs. shame and doubt, which occurs from around 1.5 to 3 years old. During this period, children begin to control basic physical actions and strive for independence from their parents. If parents encourage their children to make independent decisions (e.g. choosing their clothes or what to eat) and help them in developing new skills (e.g. dressing themselves, alimentation, learning new games, and potty training), children become more confident in their abilities and their capacity to succeed in life. The sense of autonomy contributes to self-confidence and self-control. However, if parents frequently control their children's actions, criticise their attempts at independence, or are impatient or displeased with their unsuccessful efforts, children may feel ashamed and uncertain about their abilities, leading to low self-esteem and dependence on others.[77]

The third psychosocial stage is initiative vs. guilt, which occurs when children start to control social interactions, covering the preschool period. During this time, children initiate play activities with other children, discovering their interpersonal skills. They plan and execute activities, and with supportive social environments, they can develop a sense of purpose, learn how to control their environment, and gain confidence. The initiation and execution of new activities often involves making mistakes and experiencing failures. These experiences teach children that their actions have consequences. If parents accept and are patient with their children's unsuccessful attempts to master new skills that require self-control (e.g. using cutlery and the restroom), children learn that they can control their own bodies and actions. Initiative leads to willpower and goal-oriented behaviour. However, if parents reject their children's initiatives, react impatiently to their curiosity and questions, or provide negative feedback regarding their independent actions or ideas, children may feel guilty and uncertain about pursuing their own desires and goals, inhibiting their initiative and creativity.

The fourth psychosocial stage is competence vs. inferiority, during which children begin to discover that they can accomplish tasks by developing skills. They compare themselves to their peers and draw conclusions about their abilities. This stage corresponds to the elementary school years. Support and positive feedback from parents and teachers can lead to a sense of competence and self-confidence that they possess the skills necessary to achieve their goals and perform tasks successfully (e.g. writing, reading, and performing mathematical operations). Negative feedback or the inability to develop their skills may lead to a sense of inferiority, where children may feel less capable than their peers, undervalued, and without the skills needed for self-confidence. In school, children learn to not only complete individual tasks but also work in groups, which enhances their problem-solving and time management competencies. They also learn to overcome difficulties and failure in learning through

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76 Austrian, 2008, pp. 45–50.
77 Newman and Newman, 2015, pp. 61–83.

the support of adults and peers, understanding that they can achieve their goals even in the face of obstacles.[78]

The fifth psychosocial developmental stage is identity vs. role confusion, during which an individual discovers their identity through experimenting with different roles, values, and goals, typically during adolescence. With the support of parents, teachers, friends, and peers, adolescents can freely explore various roles (e.g. in relationships, future careers, occupation-related activities) representing different interests and values. Based on the experiences gained, they develop their own identity. If the social environment restricts the process of identity exploration, or if adolescents face numerous negative experiences during this period, role confusion may develop. As a result, adolescents may struggle to find their place in the world and define their values and goals. Acceptance and positive feedback from peers can contribute to higher self-esteem and a stronger sense of identity, but feelings of exclusion can lead to role confusion and low self-esteem.[79]

James Marcia extended Erikson's theory regarding identity development by proposing that adolescents not only explore but also commit to their identities.[80] If there is no commitment or if commitment occurs without prior exploration, identity can be damaged. He termed the state of having neither exploration nor commitment as a diffuse identity. This state is typically present during early adolescence, followed by a period of exploration, usually starting in mid to late adolescence, when adolescents explore various options and roles based on activities modelled by their peers. If the state of diffuse identity persists for a long time or if adolescents fail to explore different roles, it may lead to low self-esteem, high susceptibility to influence, and lack of commitment. Foreclosure is a state characterised by commitment without exploration, often triggered by anxiety, a desire to conform to social norms, or parental pressure. Adolescents might commit to their first romantic relationship, or the career chosen by their parents, without exploring alternative options or understanding their own desires, goals, and values. Foreclosure can transit into exploration as adolescents begin to try new roles when they start thinking independently. However, this state can persist into adulthood, leading to feelings of submissiveness, inferiority, dependence on external feedback, and poor adaptability to change. In the state of moratorium, adolescents actively experiment with different roles but have not yet committed. This phase is characterised by questions, anxiety, and uncertainty, preceding the achievement of identity. Those who have explored various roles and committed to the values and goals that align with their interests have achieved identity. Achieving identity is often a lengthy process, lasting into young adulthood, as exploration continues.[81,82]

The sixth psychosocial developmental stage is intimacy vs. isolation, which is typical of young adulthood, spanning from ages 18 to 40. During this stage, the

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78 Erikson, 1978, pp. 222–242.
79 Newman and Newman, 2015, pp. 61–83.
80 Marcia, 1966, pp. 551–558.
81 Marcia et al., 1993, pp. 3–20.
82 Marcia, 2009, pp. 670–677.

primary goal is to establish loving and intimate relationships. In middle adulthood, from ages 40 to 65, the seventh stage, generativity vs. stagnation, is present. During this period, individuals focus on building their careers, starting families, or making other contributions to the society. The final, eighth, stage is ego integrity vs. despair, which occurs from age 65 until the end of life. During this stage, individuals reflect on their life satisfaction, evaluating the extent to which they have achieved their goals and desires and made good decisions.[83,84]

2.5. Empathy, Prosocial Behaviour, and Aggression

According to Jean Piaget's stage theory of development, egocentric thinking characterises a child's cognition until the end of preschool age. The children are unable to consider others' perspectives, and their behaviour is entirely motivated by the satisfaction of their own needs, disregarding the viewpoints of others. Egocentric thinking is also evident in interactions with parents and peers. At this age, a child may obey a parent, such as collecting toys, to gain a reward, such as receiving praise or avoiding punishment. Interactions with peers are also influenced by egocentric thinking, for instance, sharing a toy with another child to be able to play with that child's preferred toy or presenting good behaviour to gain approval from a kindergarten teacher.[85]

During the concrete operational stage, the child gradually develops the decentration ability, considering the perspectives of others. They begin to recognise others' emotions and understand viewpoints beyond their own behaviour. Through understanding others' perspectives and motives, empathy and the capacity for compassion towards others develop in the child. The progression of decentring and empathy replaces egocentric thinking, giving rise to social and cooperative thinking, and prosocial behaviour emerges. The children no longer collect the toys solely for self-interest but recognise and understand that it brings calmness to their mother if they clean up after themselves. Actions are motivated by a desire to make others feel good, as seen in sharing toys with a friend to bring them joy, assisting a classmate who struggles with the material to help them succeed, befriending a peer in the class who lacks friends to bring happiness to their life, and so on.[86]

According to the social learning theory, children acquire social behaviours and emotions through observation and imitation, a process known as observational learning. Significant individuals such as parents, family members, teachers, peers, or even fictional cartoon characters serve as models for children. Models can be individuals who hold high status, are rewarded for their actions, care for us, or share similarities with us. Observational learning is not limited to childhood, and people continue to learn from significant individuals throughout their lives. Regardless

83 Austrian, 2008, pp. 45–50.
84 Erikson, 1978, pp. 222–242.
85 Andreeva, 2018, pp. 26–37.
86 Masalova, 2019, pp. 380–385.

of age, individuals are more likely to imitate individuals of the same gender due to social norms and expectations.[87] According to the social learning theory, children can acquire empathy and social skills through observational learning. However, they can also learn negative forms of behaviour and emotions, such as aggression.

Based on his research regarding the imitation of aggression, Albert Bandura identified various factors that can increase the likelihood of observational learning. Similarity is one such factor that increases the probability of imitation. A preschool child is more likely to imitate the behaviour and aggression of a peer who is of the same age, shares similar interests, prefers similar play activities, and has similar external characteristics than the behaviour of older children, such as teenagers, because they can identify more with the former. Similarly, there is greater likelihood of imitation when behaviour is rewarded, meaning that it is associated with consequences that are favourable to the child. Conversely, if negative events follow a behaviour, the child is less likely to imitate it. If a child sees that classmates displaying aggressive behaviour are rewarded, such as enjoying popularity in the class or gaining some advantage (e.g. acquiring their classmates' toys), there is a higher likelihood of imitation of that behaviour. However, if teachers appropriately control aggressive behaviours, for example, if a child displaying aggressive behaviour is punished or excluded from certain extracurricular activities due to their behaviour (e.g. not allowed to go on a class trip), there is lesser chance of them adopting the role of the model. High-status and successful individuals are also more likely to become models than those with lower status or who have not achieved success. Expertise, having high-level knowledge in a specific area, is another factor that increases the likelihood of someone becoming a model.[88,89]

2.6. Moral Development

Lawrence Kohlberg defined moral development as a lifelong, dynamic process. The cognitive processes underlying moral decisions and conclusions show age-related differences, and moral decision-making can be divided into various developmental stages. The first level is the preconventional level, within which two stages can be distinguished: (1) obedience and punishment and (2) individualism and exchange. The first stage is mainly characteristic of preschool-aged children, where they perceive the purpose of following rules as avoiding punishment. For example, children collect their toys when asked by a parent to avoid punishment. In the second stage, individualism and exchange, children recognise that certain actions satisfy the needs of others or themselves. Therefore, the children can consider the perspectives of others alongside their own. However, individual interests still guide actions in this stage. The child will follow rules and exhibit behaviours that lead to some positive consequences. In school, they may listen to the teacher to receive praise, understanding

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87 Devi, Khandelwal and Das, 2017, pp. 721–724.
88 Ahn, Hu and Vega, 2019, pp. 1–12.
89 Bandura, 1977, pp. 16–55.

that adherence to societal rules and their behaviour affects how others, particularly the teacher, perceive them.[90]

Within the second, conventional level, lie the third and fourth stages of moral development: interpersonal relationships and maintenance of social order. In the third stage, children recognise that their behaviour affects their social relationships, including what others think of them. They strive to behave as good, kind, respectful, and helpful children to fit into their peer group. In the fourth stage, individuals acknowledge the existence of a social order in the world. People follow the instructions of those with higher status, obeying them while considering the laws and authority. In this stage, they do not yet consider personal values and individual rights alongside following the law.[91]

The third level of moral development is the post-conventional level, where individuals think about morality based on their own value systems and make decisions in different situations accordingly. Within the third level, the fifth stage of moral development is the social contract and individual rights. In this stage, individuals recognise that people have varying values and opinions on certain issues. They understand the importance of adhering to laws for the proper functioning of the society but also acknowledge that some people may disagree with certain laws. The sixth and final stage is universal principles, where individuals internalise certain values and ethical principles, making decisions based on them, independent of whether they align with societal expectations.[92]

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90 Gibbs, 2019, pp. 45–87.
91 Mathes, 2021, pp. 3908–3921.
92 Vozzola, 2022, pp. 27–42.

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│ CHAPTER 5 │

Prenatal Period and Infancy: Psychological Insights Into the Beginning of Life

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ABSTRACT

This chapter's focus is on the emergence and development of human psychological life and a child's bonding with the caregiver (mother) in the prenatal, postnatal and infancy periods. Developmental changes are presented from the very onset of life to familiarise non-psychologists working with children with their nature and mechanisms.

Biological transformations and the first signs of foetus's motor and sensory activity occurring in the prenatal period create a setting for the development of early mental activity, memory and various forms of learning, as well as of the neurohormonal, behavioural and psychological communication required for a child to bond with its mother.

Newborns' innate sensitivity to various forms of stimulation from people preadapts them to social contacts. In the first 12 months of life, they develop locomotor skills and an integrated perception of their environment, transition from 'thinking in acting' fed by sensory data to increasingly purposeful and intentional activities and stabilise their image of the world. As a result of interactions with the caregiver(s), they acquire the ability of pre-verbal communication, experiencing and recognising emotions and building a common space of meanings and actions.

A child's basic trust is formed based on its early experiences with caregivers. The quality of its bond with the caregiver translates into the type of attachment behaviour it will show (secure, anxious-ambivalent, anxious-avoidant and disoriented-disorganised attachment). Trust and attachment are significant for a child's readiness for exploratory activity and the onset of self-regulation.

KEYWORDS

prenatal period, newborn, infancy, child development, preadaptation, trust, attachment styles

1. Introduction

Psychology's interest in the development of a human being starts with the beginning of a new life, focusing on the complexity of multidimensional relationships between the child and the environment in which it is raised. Prenatal programming involves not only the genetic determinants of development but also the foetus's ability to adapt,

influenced by non-genetic and para-genetic factors[1]. According to research, there is close interaction between genetic programmes and epigenetic processes activated by current relational and social experiences[2].

Developmental changes taking place in the prenatal period constitute the basis from which a system enabling attachment, communication and bond with the mother develops in the foetal period; the competencies emerging afterwards are key to understanding subsequent developmental achievements.

2. The Biological Foundations of Psychological Life in the Prenatal Period

Prenatal development is a biologically determined process lasting from 38 to 42 weeks, which starts with conception and ends with birth. It is divided into three trimesters, during which the new organism grows and develops new functions. The first trimester is subdivided into the zygote stage and the embryonic stage characterised by the most rapid cell proliferation and differentiation processes, and the early foetal phase, when organs constituting the biological basis of psychological functions appearing in trimesters II and III start to bud off.

In the zygote stage, spanning the first two days after conception, the fertilised egg rapidly divides into layers of cells and travels into the uterus wall where it implants to form an embryo whose cells continue to differentiate.

The embryonic stage starts in week 3 and ends in week 8. It is the period when the main internal and external structures of the new organism begin to emerge. Cells differentiate into ectoderm, mesoderm and endoderm from which the buds of organs will develop through organogenesis. The ectoderm evolves into sensory organs such as the nervous system, the eye, ear and skin, which enable the reception of external stimuli. Their buds appear around week 3, and then the balance, touch and pain organs bud off. In weeks 5 and 6, the nervous cell precursors and neurotransmitters grow at a fast pace, and a network of synaptic connections appears, marking the beginning of sensory sensitivity (the stimulation of the foetus's mouth at around day 43 elicits whole-body movement and an EEG reading shows a reaction in the brainstem).

During the foetal stage, spanning weeks 9 to 40, precursor glial cells emerging around week 19 initiate myelination, which enables faster and more accurate transmission of nervous impulses. Following the rapid growth of neurons and the emergence of new neural connections, a motor and sensory map of the body appears in the cerebral cortex around month 5. By month 7, the early ability to recognise and learn related to the continuing expansion of the neural network and increasing density of inter-neural connections can be observed. As a result of the ongoing specialisation of all new structures, various signs of the foetus's activity appear as they begin to function.

1 Dąbrowska-Wnuk, 2019, pp. 222–227.
2 Lahousen et al., 2019.

The first signs of the foetus's activity from which psychological life will bud off become visible, and its spontaneous movements mark the onset of neuromuscular coordination. Increasingly complex motor activity (movements gradually form sequences as the foetus's control of movements and their precision improves) integrates with increasing sensitivity to intrauterine or external sensory stimuli (rhythms, sounds, tastes, or lights)[3], leading to the emergence of memory patterns related to particular modalities.

The states of consciousness resembling sleep and wakefulness appear around week 16 and gradually turn into sleep-wake cycles. The differentiating states of consciousness pave the way for the earliest mental experiences (processing, selecting and integrating of information) and the development of the budding forms of mental activity, memory, and learning (recognition, classical conditioning, habituation, associative learning and mimicking)[4]. The foetus receives and absorbs the unique traits of its caregivers' speech (such as melody, accent, rhythm, and sound intensity comprising the prosodic aspects of speech) non-auditorily. These developmental changes turn the foetus into an active entity that reacts, feels, and experiences emotions, has its individual temperamental traits and dispositions, and uses various means to communicate with the mother.

3. Prenatal Environmental Influences

Environmental factors in child development encompass both maternal internal and external influences, known as teratogens, as well as indirect factors such as social and psychological support[5].

The maternal internal environment is crucial for prenatal development. A mother's diet significantly affects the child's growth, particularly through essential nutrients like folic acid, which is vital for proper neural development. Additionally, maternal health conditions, such as diabetes, hypertension, and infections, can directly impact the baby's development. High levels of maternal stress and hormonal changes may also affect the formation of the fetal nervous system, potentially leading to developmental challenges.

External factors, or teratogens, can negatively influence fetal development. Substances like alcohol, drugs, and nicotine can lead to developmental disorders, such as Fetal Alcohol Syndrome. Moreover, exposure to chemicals, radiation and pollution can harm the fetus, while infections like rubella, toxoplasmosis, or Zika may result in congenital defects.

Social and psychological support also plays a vital role in prenatal development. Positive relationships with a partner, family, and support networks can enhance

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3 Kornas-Biela, 2004.
4 Sovilj, 2012, pp. 259–266.
5 Boyd and Bee, 2019.

the mother's mental health, which, in turn, can indirectly benefit the child's development.

By considering these factors, we can gain a comprehensive understanding of how various influences affect prenatal development.

4. The Prenatal Origin of Child Bonding With the Mother

The bond between the child and the mother is formed through their neurohormonal, behavioural and psychological exchanges. Neurohormonal communication is a biochemical dialogue where neurohormones are biochemical carriers delivering information about the mother's emotions (stress, anxiety, depression, calmness, or joy)[6]. Memorised by the foetus, the information becomes a potential determinant of the innate emotional dispositions of the child it will become[7]. Behavioural communication is based on metabolic information about the mother's behaviours (risky activities, addictions, etc.), which causes changes in the functioning of the child's organs and behaviour (for instance, it may cause hypoxia or stimulate motor activity), and during the genetically determined development of the nervous system. Psychological communication takes place when the child "reads its mother's experiences, actions and emotions (touch, speech, singing, the music she is listening to, and locomotion) while the mother learns to appropriately identify and meet its needs. This exchange shapes their bond, the course of pregnancy and delivery, and the child's health"[8]. Emotionally challenging situations surrounding mothers put the foetus at risk of experiencing "an ecological disaster in the womb"[9]. The emotions they absorb are likely to stay with them for relatively long periods, shaping their 'emotional attitude' and determining whether they will respond to events with fear or trust, thus amplifying their positive or negative impact.

The emotional states of the mother and the metabolic and physiological changes they involve cause changes in the child's brain, which are antecedent to the development of psychological functions. For instance, a mother's positive emotions have been found to support neurogenesis[10] and traumatic experiences to inhibit it and cause neural atrophy of the hippocampus and prefrontal cortex, synapse dysfunction, neural plasticity disorders and other developmental problems. Strong anxiety increases cortisol concentration in amniotic fluid, exposing a child to developmental cognitive and language problems[11]. Child-mother bonding in the

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6 Bowman, Arany and Wolfgang, 2021, pp. 1455–1486.
7 Thomason, 2020, pp. 40–50; Institute of Medicine and National Research Council, 2015; Springen, 2010, p. 15.
8 Evertz et al., 2021.
9 Kornas-Biela, 2004.
10 Emanuelle, 2011.
11 Glover et al., 2009, pp. 430–435; Laplante et al., 2008, pp. 1063–1072.

prenatal period has been studied in terms of integrating genes, brain, behaviour, and environment.[12]

5. The Newborn and Its Preadaptation to Social Contacts

The period of infancy extends between birth and the end of the first year of an infant's life. The neonatal period spanning the first 6 to 8 weeks is considered to have special importance for the child's development.

A newborn has an innately determined sensitivity to stimuli from people that preadapts it to social contacts[13]. It is most attracted to visually complex objects with distinct contours, such as the human face delineated by the hairline and the jawline, moving approximately 20 to 30 cm from its eyes, which is a typical distance between the faces of newborn and mother during feeding.

A newborn is also innately provided with behavioural patterns (crying, smiling, clinging, etc.) for interacting with the caregiver(s), distinguishes a human voice from other sounds and the voices of its caregivers from voices it did not hear prenatally, and reacts more strongly to the language(s) that it heard before its birth[14].

The newborn period is the time when an infant becomes capable of living outside of the mother's body as an individual entity. Its first activities, which are still innately determined, include states of arousal (ranging from deep sleep to active wakefulness[15]), rhythms (e.g. sleep-wake cycles, etc., representing the early temporal organisation of behaviours) and reflexes (some of which, such as seeking the mother's breast, have an adaptive purpose, while others, e.g. the swimming reflex disappearing by 6 months of age to be replaced by leg-arm coordination necessary for an infant to be able to sit up, precede the development of more advanced abilities). Of special importance are pre-organised innate behaviours, such as looking, sucking and crying that are activated at birth, as they enable a newborn to meet its various needs (for instance, sucking is a way to get food, explore the world, form bond with the mother, and self-soothe)[16].

A newborn can express basic emotions, including curiosity, disgust and anxiety, which at this stage of development are still generated by its inner states (physical discomfort, arousal, pain, or tension). The state of general arousal gradually evolves and reacts differently to positive and negative stimuli. The innate mechanisms enable first social interactions, such as interactive synchrony between infant and mother or the infant attuning its mood to the mood of other people.

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12 Esposito et al., 2017, pp. 87–89.
13 Vasta et al., 2004.
14 Ibid.
15 Wolff, 1966.
16 Vasta et al., 2004.

6. The Direction of Changes in Motor, Perceptual And Cognitive Skills in the Period of Infancy

In the first year of life, developing motor and perceptual skills and early mental processes utilising sensorimotor data[17] create a basis that will make it possible for an infant to form a bond and communicate with the caregiver(s), develop social referencing skills, and create its own image of the social and physical contexts of the world.

6.1. Motor Skills

The development of the infant's motor skills is reflected in its increasing ability to change the body's position and ways of locomotion (gross motor skills) and related improvement of manipulative skills (fine motor skills).

6.1.1. From the Foetal Position to Independent Locomotion

Muscle tension control improved in the first weeks of life enables an infant to transition from the foetal position to early motor activities. A 2-3-month old infant can raise the head and hold it lifted for some time. The ability to lift the head and arms is a precondition for an infant being able to roll over from back to side at the age of 3-4 months. The improving control of the upper torso enables a 5-6-month old infant to roll over from the back to the stomach. At the age of 6-7 months, an infant makes its first attempts at locomotion (crawling) and changing the body position (sitting up). The ability to lift the body up leads to crawling, followed by sitting up unassisted at the age of 8-9 months. At around 9 months of age, an infant can stand when held by both hands, and a 10-month old stands up on its own when gripping the crib's railing. The first attempts at locomotion are made towards the end of the first year of life.

6.1.2. The Development of Manipulative Skills

Innate reflexes, such as the 'monkey grip' and reaching out to light go away by around 3 months of age. Between months 4 and 5, reaching for an object becomes a purposeful and eye-controlled action. The increasing precision of hand movements enables various forms of gripping. Between the ages of 5-6 months and 8-9 months, simple covering of an object with the hand develops into the ability to grip small objects between the thumb and index finger (the pincer grip).

The coordination of reaching and grasping skills gradually improves: a 5-6-month old child lets go of one object in order to reach for another, passes an object from one hand to the other to reach for yet another, and opens the hand to grasp an object before it can actually do it. Around the end of the first year of life, an infant manipulates objects with the hands, using them in the same way regardless of their structure or purpose (taps, rolls, throws).

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17 Piaget, 1952.

6.2. Early Forms of Perception

New-borns are near-sighted and best see objects that are close to their eyes. At the age of 3 months, peripheral vision appears and evolves into stereoscopic in 3-4 month olds, enabling the development of depth perception.

An infant's perception of the world becomes increasingly complex and multisensory. At the age of 2 months, an infant stops seeing objects as points and contours, and starts to see them as groups of objects and discerns their organisation. For instance, a 7-week-old newborn looking at a human face is more interested in its elements, particularly the eyes, than the contours.

Along with developing motor skills (position, posture and grip changes), visual perception improves. A 4-5-month-old infant's images of people and objects stabilise, enabling it to recognise them regardless of changes in distance, lighting, shape, or colour. At the age of 7-8 months, an infant identifies objects that are moving, have been displaced, or are partly hidden, and an 8-10-month-old perceives and locates objects in space. The increasingly complex visual image of the world integrates with images generated by other senses, creating a basis for multimodal recognition of objects (intermodal transfer)[18].

6.3. Early Forms of Thinking[19]

An infant's thinking is a sensorimotor thinking, thinking in action, consisting in manipulating objects to attain some goal[20]. The first weeks of innately determined adaptation lead to an infant starting to perceive itself as physically separate from its environment at the age of 2 months and concentrating its activities on its own body at the age of 1-4 months, with the activities being more interesting than their object. This stage of development also marks the beginning of purposeful activity. Spontaneous activity is a goal in itself, and to achieve it, an infant performs sequences of movements or continues an accidental activity, such as repeating sounds (*cooing*).

At the age of 4-8 months, an infant's focus of activity moves to its surroundings. Having made a random discovery that shaking a rattle or pressing a key produces a sound or light, an infant intentionally continues to rattle and press to enjoy the effect of its activity. Only then does it realise the action-effect relationship (which introduces it to the concept of causality). Yet, an object is real for an infant as long as it plays with it, so when it disappears, an infant quickly stops looking for it.

The understanding of object permanence only appears at the age of 8 months, as an infant becomes capable of integrating its actions (reaching, grasping, manipulating) and sensory information based on visual memory and hand-eye coordination.

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18 Vasta et al., 2004.
19 Infancy spans four of the six stages of the Piaget's sensorimotor period (years 0-2): reflexive (months 0-1), primary circular reactions (months 1-4), secondary circular reactions (months 4-8), and coordination of secondary schemes (months 8-12). See: Vasta et al., 2004, pp. 270–275.
20 Piaget and Inhelder, 1962.

From this time on, an infant knows that an object exists even if it is not present and attempts to find it when it is not visible[21].

The activities of an infant start to show intentionality when it is 8-12 months old. At this age, actions become goal-oriented, and an infant can distinguish between means and ends and can coordinate both aspects. For instance, it realises that in order to get the toy it is interested in (ends), it needs to remove the obstacle on the way to it (means), and consequently, it integrates both actions.

The evolution of motor, perceptual and cognitive skills is associated with an infant developing a close bond with the mother and communication and emotional referencing skills[22]. The skills underlie its ability to build safe relationships, social learning and active exploration of the world. As research has pointed out, there is an association between brain development and the social experiences of an individual[23].

7. First Social Interactions as a Source of Personal Development: Communication, Emotional Referencing, and Interpretations

7.1. The Prelinguistic Stage of Speech Development

The first sounds produced by an infant are a test of its vocal apparatus. Crying and whining, which appear when an infant is 0-3 weeks old, represent its first attempts to communicate with the parents and turn into vocalisation, pseudocry, and cooing by the age of 4-5 months. An infant's discovery that it can make sounds leads to babbling, i.e., the intentional imitation of human speech that starts with repeating single syllables at the age of 6-7 months and turns into sequences of syllables imitating the melody of the caregiver's speech, such as 'ma-ma-ma', by the age of 8 months. A 10-month-old infant repeats the sounds it hears, and distinguishes words uttered by its caregiver. At around 1 year of age, most infants pronounce their first words and understand what is being said to them. When it comes to verbal communication, the ability to read the non-verbal components of a caregiver's messages, such as facial expressions or touch, emerges. The caregiver's and infant's shared focus on objects (e.g. a toy) precedes the development of referential communication enhanced by gestures that are gradually replaced by words.

7.2. Emotions Expressed, Experienced and Recognised by an Infant

The earliest emotions of infants are innately determined[24]: a 3-week-old newborn smiles to the mother's voice, and a 2-month old infant smiles back on seeing her smile. At month 3, it smiles spontaneously and reacts with energetic body movements to the caregiver's voice. The range of its emotions gradually increases. A 3-4-month old

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21 Ryu et al., 2017.
22 Anderson et al., 2013, pp. 1–17.
23 McCall and Singer, 2012, pp. 681–688.
24 Rosenblum, Dayton and Muzik, 2009, pp. 80–103.

infant communicates negative emotions, such as anger, sadness and anxiety, and recognises them in others without yet understanding their meaning. In the second half-year of life, the range of positive emotions expressed by an infant expands. It smiles when smiled at, provokes a smile in others, distinguishes facial expressions, and reacts differently to familiar and unfamiliar people. It can also anticipate the course of some routines (e.g. nursing), and reacts with anger, reserve and surprise to express disappointment when its anticipation proves to be wrong.

In the third quarter of the first year of life, an infant starts experiencing emotions related to its active role in social interactions. It distinguishes familiar faces from unfamiliar ones and shows interest in other people's emotions and reactions that provide guidance for it on how to behave (for instance, the mother's smile is an encouragement to proceed with an activity). Its behaviour has a regulatory effect too. Using facial expressions and verbalisation, it reveals its emotions and demands meeting its needs, e.g. such as passing a toy that is out of its reach. It also attempts to draw others' attention, to elicit reaction by repeating activities that make people smile, e.g. by mimicking their facial expressions. The way of expressing positive and negative emotions becomes increasingly different. The development of memory changes the nature of sadness or anxiety. An infant may already feel them by merely anticipating the occurrence of something unpleasant, like the caregiver leaving it alone, without such an event actually taking place.

At 8-9 months of age, an infant starts demonstrating strong interest in its permanent caregiver. New situations, especially the presence of unfamiliar people, cause it to show anxiety, reserve, and ambivalent emotions of varying intensity. At the same time, it demonstrates increasing interest in other people's emotions and interpreting them. Towards the end of the first year of life, an infant shows its first social behaviours: it tries to imitate others' emotions, comforts others, shows empathy, and understands the difference between its own and others' emotional states[25].

7.3. The Beginning of Shared Understanding of Situations and Acting Together
In order to better understand how the child and the mother build their common space of meanings and actions (intersubjectivity), the way they develop their relationship[26] needs to be considered in terms of how their activities involving people and objects integrate[27]. The transformation of their common space has been divided into four stages:

7.3.1. Encounter: From Contact to Interaction (0-1 month of age)
The pattern of child-mother interactions is established in the first month after birth based on the child's innate rhythms and the mother's reactions to their temporal organisation. It marks the beginning of a certain kind of a dialogue, where the child is

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25 Boyd and Bee, 2019.
26 Schaffer, 1995, pp. 89–123; Schaffer, 2004.
27 Trevarthen and Hubbley, 1978, pp. 183–229.

given a leading role while the mother caters for its needs, observes the sucking cycle, and tries to interpret its cues (such as turning the head away).

7.3.2. The Establishment of a Joint Field of Attention and Action (2-5 months of age).

The earliest exchanges between the child and the mother, enabling them to initiate and maintain contact, take place when their faces are close together, for instance, when the mother is leaning over the child or holding it in her arms, etc. Having intercepted her child's spontaneous attention to an object, the mother initiates an interaction, allowing her to be led and regulated by the child. In this way, a joint field of attention is created[28], which the mother expands by commenting on the object.

7.3.3. Topic Sharing (5-8 months of age)

A mother who has previously attempted to catch the infant's spontaneous gaze now intentionally chooses an object and builds their interaction around it. To engage the child in interaction and attract its attention, she first uses non-verbal methods (showing, demonstrating and pointing) and gradually replaces them with verbal methods (describing, asking questions, giving tips, naming)[29]. This leads to the emergence at around month 5 of the 'me-you' and 'you-me' roles based on complementarity and reciprocity of exchanges. Encounters are initiated and ended by an infant (for instance, by gazing at an object and looking away from it, respectively), but it is the mother who turns them into quasi-dialogues, as she knows the object of the child's interest and can anticipate its actions. By harmonising their activities, the mother and the child create a basis for building a common space of meanings together. *An early form of dialogue appears when interactions with the mother cause the child to realise that his actions cause her to react in the expected way.* The ability of a 7-month-old infant to distinguish between adults who are 'useless' and 'useful' as play partners suggests that it is able to compare current and past situations and is aware that strangers are of not much use as they will not understand its cues[30]. At the age of around 8 months, an infant communicates using gestures and signs and understands them as they are conventionally understood. Marc T. Bornstein[31] has distinguished two types of infant-parent interactions based on their purpose and manner of initiation: a) interactions intended to attract an infant's attention and engage it into an exchange through rocking, kissing, cuddling, non-verbal vocalisation, etc.; b) interactions making use of various activities to expand an infant's scope of activity, which initially aim at shifting its attention from humans to objects so that it could observe, interpret and imitate.

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28 Peacocke, 2005, 298–324.
29 Brzezińska, 2000.
30 Cole and Cole, 1989.
31 Bornstein, 2014, pp. 197–214.

7.3.4. Topic-Maintenance: Person-Object Integration (8-12 months of age)

In the last quarter of the first year of life, an infant actively coordinates its interaction with another person by referring to objects, follows the person's gaze, takes some responsibility for sharing a topic, and uses gestures to signal that it is ready to share a topic, which initiate or sustain interaction. As the asymmetry of contributions to an interaction decreases, pseudo-dialogue becomes a two-way communication relationship marking the beginning of the joint development of future interactions. Both labelling and words are used in this process. The appearance of intentionality and fluent succession of exchanges marks the onset of secondary intersubjectivity, which is understood as a shared understanding of an object of attention and common references that, as a basis of communication, link the understanding of a situation by its participants. A child learns that its reactions have a communicative value and adjusts its behaviours to others' reactions. The sequences of its actions become more and more intentional as it starts monitoring and modifying them according to anticipated goals and outcomes. By interpreting situations and their own and the child's actions, adults help a child make associations between the known and the new that create a framework for it to interpret new events and organise actions in new situations.

8. The Emergence of Attachment and Trust: The Stages of Attachment

Developing an attachment to the caregiver is an evolutionary and biologically determined need of every infant. Attachment is defined as a deep, long-lasting affective bond to an attachment figure, usually the mother, which increases the infant's odds of survival and gives it a sense of security and psychological comfort[32]. An attached child seeks closeness and contact with the caregiver when anxious, sick, or tired.

The behaviour of the attachment figure, its presence and the intimacy shown to the child have a significant effect on the child's psychological and physical development. According to Erik H. Erikson's psychosocial theory of development, the first 12 months of a child's life are the period when it can form basic trust in oneself, people, and the world or a relatively enduring sense of distrust in oneself and others[33]. Basic trust determines the ability to trust others and a feeling of being safe, translating into a sense of self-confidence, of being accepted, continuity, stability and predictability of the world seen as an interesting place to explore and offering opportunities to meet one's needs. These beliefs constitute a central element of human personality[34]. Infants start to develop trust in the first months of their life as a result of their first experiences and interactions with caregivers. Trust is the backbone of the attachment system[35], with its development being mainly shaped by the mother. The level of trust a

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32 Bowlby, 1969; Thompson, 2002, pp. 164–172.
33 Erikson, 1963.
34 Gagliardi, 2021, pp. 1–22.
35 Mikulincer and Shaver, 2003, pp. 53–152.

child will be able to attain later in life is determined by the quality of its bond with the mother, which depends not only on her ability and commitment to meeting her child's needs (both physical and psychological), but also on how she perceives the child and herself and on her vision of maternity.

There is a close relationship between the development of attachment and the child's improving motor, cognitive, emotional and social skills (for their prenatal origins, see section 4). John Bowlby has divided the evolution of child-caregiver attachment into four stages, the first three of which take place or begin during the first year of the child's life[36]. The stages illustrate how a child moves from communicating its needs through preadaptive mechanisms to closeness-building exchanges with the caregiver, intentional regulation of behaviour, and early signs of self-regulation[37].

8.1. Pre-Attachment Phase (from birth to 6-8 weeks)

An infant is preadapted to react to signals sent by people, tunes in to them, shares others' emotions, and sends its own signals without yet choosing their recipients. Its relationship with the mother (the attachment figure) is based on an innate mechanism known as interactive synchrony. The responsibility for developing the relationship rests with the mother, who 'reads' her child's signals, stabilises it physiologically and emotionally, and works out care standards and routines.

8.2. Early Attachment (from weeks 6-8 to months 6-8)

Almost from the day they are born, many infants have one caregiver or receive occasional care from few people. Initially, an infant relates similarly to other people but, as months pass, it begins to distinguish its attachment figure(s) to whom it sends cues and attaches itself to from others, probably based on signals from developing smell and vision organs. When there are several attachment figures, an infant chooses one, usually the mother (who becomes the principal attachment figure), exhibiting anxiety in the presence of strangers.

An infant takes some control of interactions, by initiating contacts and showing purposeful behaviour. The caregiver's role is to stimulate and regulate the level of its arousal so that it could learn to self-regulate its emotions.

8.3. Clear-Cut Attachment (from 6–8 months to 18–24 months)

In this period of life, an infant develops new forms of attachment behaviour, enabling it to actively maintain closeness to the mother (see the developmental characteristics of a child, section 4) and resulting in the creation of its attachment pattern. It controls the level of closeness with the mother using verbal and non-verbal communication, tries to keep as close to her as possible, and shows separation anxiety when she goes away. A mother is 'a safe haven' for a child, from which it can explore the world when it feels safe, has an appropriate level of developmental skills (locomotion skills,

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36 Bowlby, 1969; Marvin et al., 2016.
37 Czub, 2005; George, 2014, pp. 97–110.

integrated perception of the nearest environment, and the realisation of object permanence), and, importantly, believes in having an adult's support when needed[38] and self-confidence[39]. A mother has a special responsibility for regulating a child's arousal during activities and monitoring the emergence of self-regulatory processes, including adjusting to situations, controlling reactions, and expressing emotions.

Based on early experiences from interactions with the caregiver internalised by a child, internal working models are created, i.e. life-long affective and cognitive matrices guiding the formation of the child's future relationships with other people[40].

Attachment is considered as a subcategory of a wider process – the development of internal operational models[41] – within which humans interpret their experiences and construct beliefs about themselves and the world.

9. Attachment Styles

An infant's attachment is a special, deep and enduring bond connecting the infant with the mother. The first study on child-primary caregiver attachment and the role of first experiences is credited to Mary Ainsworth[42], who used the standardised *Strange Situation Procedure* to investigate the nature of the attachment of one-year old children to their mother. In their experiment, children and mothers were allowed to spend some time together in an unfamiliar environment, after which mothers were replaced by strangers to return after a time. As a result, children were exposed to the operation of three mild stressors: an unfamiliar environment, the presence of a stranger, and separation from the mother. The determination of attachment patterns was based on how children reacted to separation and reunion with their mother. The type of reaction was taken as a measure of their trust in the availability of the attachment figure, corresponding to their sense of security. The experiment led Ainsworth et al. to put forward three attachment styles: one secure (trustful) and two non-secure (anxious-ambivalent and anxious-avoidant). In 1990, Mary Main and Judith Solomon proposed a fourth attachment style that they called disorganised (fearful) attachment. The four styles provide an insight into the development of an infant-mother relationship and reliably predict the quality of relationships children will establish in the future.

9.1. Secure Attachment

Securely attached children willingly explore unfamiliar surroundings in the presence of their mother. When the mother goes away and a stranger appears, they show anxiety, cry, and stop to play. After she returns, they want to be close to her and quickly calm down, showing renewed interest in exploring their environment.

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38 Grossmann et al., 2008, pp. 857–879.
39 Cassidy, 2008, pp. 3–22; Sroufe et al., 2005.
40 Bowlby, 1969.
41 Epstein, 1991, pp. 111–137.
42 Ainsworth et al., 1978.

A securely attached child clearly and readily communicates its needs, expresses emotions, and seeks comfort and assistance, preferring the assistance of their parents. The belief that the parent is available and ready to attend to their needs increases the child's trust that it will be so in the future. Compared to insecure children, the securely attached ones are more comfortable with themselves, more easily interact with others and solve problems, and are more self-confident and independent[43]. They also tend to develop more open and flexible emotional expression, show a high level of positive emotions[44], and give positive attributions to people and events, which encourages them to explore their surroundings single-handed[45].

For a child to form secure attachment, the parent's sensitive responsiveness, including their approach to parenthood – perceiving the child as worthy of care and the ability to aptly recognise and respond to the child's needs, emotional states and cues – are crucial. Equally important are the enhancement of the child's sense of importance and belief that its needs will be met.[46]

A securely attached child has a mutually satisfying relationship with the caregiver, integrating their activities and emotions[47]. The reciprocal regulation patterns they establish have a soothing effect on the child's excessive arousal, thus helping the child to develop the ability to self-regulate and control its anxiety and negative emotions.

9.2. Anxious-Ambivalent Attachment

Anxious-ambivalent children exhibit separation anxiety when separated from their mother, and both seek and avoid contact with them when they return (an approach and avoidance reaction). This attachment pattern characterises children who perceive their mother or other attachment figures as psychologically unavailable. The unavailability should be understood as not noticing or ignoring the child's needs, reluctance to initiate and maintain contact, inadequate reactions (e.g. responding with anger to a child showing fear), or inconsistent reactions to similar situations. Anxious-ambivalent children are uncertain about whether their caregiver will be available and what can be expected of them and show contradictory behaviours and emotions when separated from the caregiver: they simultaneously seek contact (longing), reject (anger), and cling (fear) to the caregiver in fear that they might be separated again.

The parents of anxious-ambivalent children are disoriented and frustrated caregivers, full of contradictions, with a strong sense of guilt[48]. In response to the parents' unpredictable behaviours and reactions inadequate to their states and needs, children develop a tendency to react situationally and manipulate others' emotions for their own benefit.

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43 Ainsworth et al., 1978; Sroufe, Fox and Pancake, 1983, pp. 1615–1627.
44 Kochańska, 2001, pp. 474–490.
45 Cassidy, 2008, pp. 3–22; Sroufe et al., 2005.
46 George and Solomon 2008, pp. 833–856.
47 Bowlby, 1988; Grossmann et al., 2008, pp. 857–879.
48 George and Solomon 2008, pp. 833–856.

The parents of anxious-ambivalent children lack sensitivity to their emotional states and concentrate more on activities during interactions than on building intimacy. The anger and separation anxiety the children feel keep them close to the caregiver, which limits the range of their explorations and influences their *developmental characteristics*. The caregivers' tendency to dominate interactions suppresses the children's autonomy and ability to freely explore their surroundings. The inability to predict how the caregiver may react to their activities erodes anxious-ambivalent children's self-confidence[49], leads to the changeability of their moods, and makes them give contradictory attributions to events and intentions.

9.3. Anxious-Avoidant Attachment

Anxious-avoidant children seemingly do not care about the presence or absence of their mother. They do not protest when their mother goes away, continue to explore their surroundings, initiate contact with unfamiliar persons, and ask for help when they need it. They do not notice their mother's return and sometimes look away when they come up.

Anxious-avoidant attachment typifies children whose attachment figures are emotionally or physically distant (either outright reject children or punish them for trying to interact) or only pretend to be available (stay at a distance during interactions). Anxious-avoidant children, too, show some independence from their attachment figure: they avoid close contact, do not ask for help when they are in trouble, and when the caregiver becomes more distant, they focus on their activities to relieve anxiety and anger[50]. Anxious-avoidant attachment is ambiguous in that a child stays close enough to the caregiver for their needs to be met but not so close as to experience rejection. Lacking emotional contact with the caregiver, anxious-avoidant children focus on activities that they perform on their own or together with the caregiver. It is thought that they tend to see themselves as unworthy of attention, acceptance and love, and that they tend to doubt whether their caregivers will be there to support and help them in need.[51] Mothers may inadequately respond to their children's needs for various reasons. These may be their self-centeredness, unsatisfying contact with the child, indifference to its needs or to meeting them properly because of maternal immaturity, or objective causes, such as health problems or personal life difficulties. Mothers' distancing from children and avoiding closeness with them can also be a way to make children meet their high expectations. While caregivers of children with an ambivalent attachment style are inconsistent – sometimes available and sometimes too distant – caregivers of children with an avoidant attachment style often ignore the child's emotions and are distant and cold.

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49 Ainsworth et al., 1978.
50 Main and Solomon, 1990, pp. 121–160; George and Solomon 2008, pp. 833–856.
51 Ainsworth et al., 1978.

9.4. Disoriented-Disorganised Attachment

Children with this type of attachment behaviour *ambivalently react* to their mother's departure and return, seeking closeness with them and avoiding it at the same time (they run up to mothers and instantaneously pull away, or even run away). In these children, the natural need to be close to the parent conflicts with their feeling of being neglected and denied care and comfort when they needed it[52]. These children's attitude towards their attachment figure is ambivalent: they are constantly vigilant, want to control everything, and tensely wait to see how things will play out, have fits of anger, and cry. They also tend to view the mother and the surroundings as threatening and unpredictable[53].

Disoriented-disorganised children are unable to develop a strategy for communicating their needs and establishing closeness to the mother and awkwardly seek protection and care to have at least some sense of security[54]. In extreme cases, such as when the mother is emotionally unavailable, harms the child, or struggles with problems disorganising childcare[55], the childcare process becomes unpredictable. This unpredictability prevents the child from developing a consistent pattern of attachment behaviour, disturbs their image of themselves and other people, and causes them to assign to relationships fearful attributions of varying intensity, which is accompanied by a narrowed understanding of their emotional states and volatile expression of emotions[56].

Sometimes a caregiver does not meet the typical or expected behavioural patterns in their relationship with a child. An atypical caregiver may respond inappropriately or unpredictably in situations requiring emotional support, may have mental health issues and difficulties in adequately addressing the child's needs, lack experience, and be uncertain in providing adequate care. They may also use parenting methods that differ from commonly accepted social norms. Atypical caregivers may influence the development of attachment in children, potentially leading to various attachment styles, including anxious or avoidant ones.

As well as constituting an enduring, relational framework for the affective, cognitive and social development of a child, attachment patterns also influence the nature and quality of relationships it will have with the world as an adult[57].

10. Summary

New-borns are preadapted to be sensitive to various forms of stimulation from people and actively seek to be stimulated. Biological changes in the prenatal period enable a

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52 George and Solomon 2008, pp. 833–856.
53 Dozier and Bernard 2017; Main and Solomon, 1990, pp. 121–160.
54 Solomon and George 2011, pp. 3–24.
55 Ainsworth et al., 1978.
56 Czub, 2005.
57 Crittenden and Spieker, 2019, pp. 122–130.

foetus's motor and sensory activity, which marks the beginning of psychological life and bonding with the mother.

In the first year of their lives, infants gain:

- control over an increasingly wide range of motor and perceptual skills;
- the ability to think in action and stabilise their image of the world of people and objects;
- the ability to communicate pre-verbally, respond emotionally and read emotional references;
- the ability to build close relationships and interact with caregivers.

Infants' experiences from their interactions determine their level of trust and emotional attachment to the caregiver (secure attachment, anxious-ambivalent attachment, anxious-avoidant attachment, disoriented-disorganised attachment). The quality of an infant's attachment to the caregiver determines the nature of its exploratory activities and the beginning of self-regulation.

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│ CHAPTER 6 │

Toddlerhood and Preschool Age: The Dynamics of Early Childhood Development

Ewa RZECHOWSKA

ABSTRACT

With the rapid development of motor skills in early childhood, the child's perception, attention and memory improve, and preoperational thinking replaces thinking in action. The changes influence the child's logic, reasoning, and understanding of the world. Also, in early childhood, the child's theory of mind takes shape as the child tries to understand others' states of mind and feelings.

Toddlerhood and the preschool years involve the development of the child's individuality, autonomy, initiative, self-esteem and self-evaluation, as well as the formation of autobiographical memory and gender identity.

Increasing self-awareness, understanding of people's expectations and the emergence of a conscience let the child compare his or her behaviour against the established rules, prompting the birth of emotional states (shame, pride and guilt) and the ability to regulate them. The emerging awareness of norms and standards stimulates moral development. At its early stage (the pre-conventional level), the child makes judgments dictated by his or her practical interests and the need to avoid trouble, even if the child has a sense of the needs of others.

By around the age of three, children acquire the basics of their native language, leading to the development of their vocabulary, grammar and communication skills.

During the early years of life, children adopt behavioural patterns within the family (primary socialisation). These patterns are later applied outside the family and enriched through interactions with peers and teachers in kindergartens and other care settings (secondary socialisation). Peers and early friendships play a significant role in a child's socialisation, as does the evolving social organisation of play—from unoccupied play to cooperative play—and the development of prosocial behaviours.

The skills and abilities acquired during early childhood are essential for a child's successful adaptation to the school environment.

KEYWORDS

toddlerhood, preschool age, pre-operational thinking, personality development, moral judgment, emotional development, communication skills, primary and secondary socialisation

1. Introduction

Early childhood is a complex period in human life. Improving motor skills makes a child independent of the 'here and now' and enable him or her to start exploring the world and develop an early understanding of the basic rules of social functioning, communicating with others and regulating emotions. Experiences gained in early childhood underlie the formation of defining values and ideas about life, expectations of it, and rules of acting, significantly influencing what person a child will grow into. New understandings and social situations bring variety to a child's life and stimulate the creation of new strategies for the world ahead.

2. Motor Skill Development: From the Child's Exploration Of the Environment to Independence

With the development of gross motor skills in early childhood, the child's physical activity increases (the child starts to walk, run, overcome obstacles, climb the stairs, etc.). The sensory function also improves, enabling the child to start explorations into his or her environment.

The fine motor skills also become more sophisticated, introducing a child to the structure and use of objects. As a result, a child becomes capable of:
- using tools for the first time (a teaspoon, scissors) and performing self-care activities (drink from a cup, wash the hands, dress, etc.);
- playing simple 'engineering' games (building block towers, making sand cakes);
- displaying graphomotor activity (linear scribbling turns into figurative scribbling and first drawings of real objects).

As the precision and automation of movements and eye-movement coordination improve, the operations the child has learned to perform become the basis for the development of his or her cognitive (imitation), social (understanding the purpose and use of objects) and personal (the beginning of self-reliance, sense of agency, and self-confidence) skills[1].

3. Child Cognition and Mental Processing

The rapid development of motor skills in early childhood occurs in close association with changes in perception, attention and memory[2].

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1 Boyd and Bee, 2019; Brzezińska, Ziółkowska and Appelt, 2019.
2 Vasta, Haith and Miller, 2004.

3.1. Perception

With improved sensitivity of the senses, particularly sight and hearing, a child becomes capable of reacting to complex stimuli, i.e. distinguishing between and comparing shapes, colours and their shades, as well as pitch, tone and intensity of sounds. However, because 6-year-olds still perceive objects as a whole, analysing and synthesising sensory data is problematic for them.

3.2. Attention

A toddler's attention is predominantly involuntary and tends to concentrate on distinct objects and signals. It is not until the age of 6-7 years that the child's ability to control attention improves, partly due to curiosity and emotional engagement in tasks. Between the ages of 3 and 6 years, the time the child can concentrate on a task extends from 5-10 minutes to about 20 minutes, but the selectivity, sustainability, divisibility and shiftability of the child's attention are not yet fully formed, with the consequence that remembering things and contents exactly is still difficult for the child.

3.3. Memory

A toddler's memory is still essentially involuntary. A 2-3-year-old child is still incapable of indicating when exactly events happened, but the fact that they did can be stored in a child's memory for months or even years (e.g. this particularly applies to traumatic events involving strong emotions). Memories of past events are invoked by free associations with current ones and frequently blend with fairy tales and fictitious situations. Only at the age of 6 does the share of voluntary memory enabling a child to store experiences and apply them in various situations increase, and the ability to use memory strategies and metamemory (the knowledge of memory functioning) develops, following which a child becomes aware of his or her memory capabilities[3].

The pre-schooler's attention and memory are closely related to his or her cognitive and motor activity. Situations exposing the child to many diverse stimuli are remembered longer and more accurately.

4. A Child's Understanding of Physical and Social Reality

4.1. Symbolic Thinking: Pre-Operational Years (2-6/7)

Between 2 and 6-7 years of age, during the so-called pre-operational years[4], a child develops mental representations of real objects and activities, and mental processing precedes the execution of activities.

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3 Kielar-Turska, 2015, pp. 202–233; Brzezińska, Ziółkowska and Appelt, 2019.
4 Piaget, 1952.

4.1.1. From Thinking in Action to Mental Representations of Events

By the end of the first year of life, a child uses patterns of action that have proven effective in achieving goals (e.g. climbs onto a chair to reach a toy). At around the age of 18 months, it can use a trial-and-error method to modify its actions if the established solutions fail. The ability marks the appearance of the semiotic function[5], i.e. the ability to engage in activities such as deferred imitation (i.e. imitating the model's behaviour when the model is not present), pretend play (using one object for another, e.g. a candy for a pill), drawing, psychological functions based on mental images (e.g. recall memory), and language.

Mental representations enable a child to step beyond 'the here and now' and broaden his or her temporal perspective, as a result of which a child can think about the past or imagine the future. Even so, toddlers still take things at face value, and do not understand how transformations change circumstances.

In one of Piaget's classical experiments[6], a child is shown two identical containers filled with water up to the same level and asked if the levels are identical. Then, a portion of water from one container is poured into a third one. It is narrower than the two original containers, so the water level is higher. Because children under the age of 6-7 years rely on visual information, they believe that it contains more water than the other two containers. This demonstrates that children at this age tend to perceive objects one-dimensionally (in this specific case, they see the height of a container and ignore its width).

Children between the ages of 2 and 6-7 years do not remember past events and are unable to visualise the states of objects before they were transformed (i.e. reverse an operation mentally). Their thinking is called pre-operational.

4.1.2. Characteristics of Pre-Operational Thinking

The dominant characteristics of pre-operational thinking are cognitive egocentrism, centration, syncretism and transductive reasoning, which are in a child's logic and understanding of the world[7].

Cognitive egocentrism refers to children's firm belief that their own perspective – what they see, think, or feel – is the only valid one. They assume that others share the same viewpoint, making it difficult for them to accept differing opinions. This concept differs from egoism, as cognitive egocentrism stems from an inability to consider other perspectives (cognitive decentration) or understand others' feelings and needs (interpersonal decentration), both of which emerge at later stages of development.

Centration is a tendency to focus on the most obvious or conspicuous aspect of an object, situation, or phenomenon while disregarding all others, which are also important.

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5 Piaget, 1952; Vasta, Haith and Miller, 2004.
6 Piaget and Inhelder, 1962.
7 Piaget, 1952; Vasta, Haith and Miller, 2004.

Syncretism consists in interpreting successive and unrelated events as causally interlinked. For instance, a child whose mother has been in hospital and has returned home with a baby may think that she will bring another one after going to the hospital again.

Transductive reasoning is the tendency of the child to see relationships between occurrences which are logically unrelated to each other. For instance, a child who always gets cornflakes for breakfast at home may claim that he or she did not have breakfast if he or she was given a sandwich and tea elsewhere.

4.1.3. Children's Image of the World

The distinctiveness of young children's logic is reflected in their understanding about the world, which is characterised by:

- anthropomorphism – a tendency to refer to objects, phenomena and animals as if they had the same motivations and traits as humans have (*toys throw parties at night*);
- artificialism – a belief that all natural objects and phenomena have been created by and for people (*the night has been created for sleeping; someone has painted the sky blue);*
- animism – a tendency to ascribe the attributes of living beings to inanimate objects (*the sun is shining because it likes to shine; a broken twig feels pain);*
- realism – a belief that mental phenomena (thoughts, representations and dreams) are real and material *(thoughts live in the head, sleep lives under the pillow).*

Jean Piaget's theory is primarily based on the outcomes of experiments involving interactions between children and objects, like the one described below. Similar experiments with children having to solve real-life situations and drawing on their experiences (whose authors used juice instead of water and poured it into another child's glass) have shown the ability of younger children to come up with the correct answer[8].

4.2. Overcoming the Limitations of Pre-Operational Thinking: Role-Play

Children aged 3-4 years can distinguish the fictitious from the real. By the end of the preschool years, children begin to be able to reverse mental operations, which is particularly noticeable during role plays.

The ability to pretend to be someone else during a play is acquired through a several-stage process: it starts with the child pretending to perform a real activity (such as eating); then, an activity is performed on an object (feeding a doll); next, the child acts out a role (feeds a doll as if it were a daughter, in the same way as the child was fed by her mum); and, finally, the child assumes another person's identity (becomes a mother who feeds a child)[9].

8 Ibid.
9 Elkonin, 2005, pp. 11–21.

A child playing 'a mother' enters an imagined world, which requires overcoming cognitive egocentrism, adopting the mother's perspective, and integrating being a mother and a child at the same time. To be able to act out the play scenario (e.g. handle objects as if during cooking) or announce the execution of related activities (I have cooked dinner), a child has to coordinate its own and the character's perspective and smoothly switch between being a director and an actor in his or her play[10] and between reality and fiction.

4.3. Theory of Mind: Understanding Others' States of Mind and Feelings

Theory of mind (ToM), the ability to recognise the mental states, beliefs and desires of others and understand how they affect their behaviour, is crucial not only for children's cognitive but also social development[11].

Until they are 3 or 4 years old, children believe that others' thoughts, feelings and beliefs are the same as theirs. ToM is thought to start developing at the age of 4 years[12], when most children acquire the ability to attribute false beliefs to other people and begin understanding their consequences. To measure the level of ToM development, a range of picture stories have been created[13] around the 'Sally and Ann' test. In the test, two girls, Sally and Ann, are in the same room. Sally places a ball in her box and leaves the room. While she is gone, Ann removes the ball from Sally's box and places it in her own box. The tested child is asked to indicate where Sally will look for her ball after she returns to the room. A correct answer means that the child is able to attribute first-order beliefs, i.e. to deduce others' mental states from what they say or do; for this to be possible, the child must be able to separate what he or she knows is true from another person's belief[14]. The ability to attribute first-order beliefs is central to the development of other skills necessary for a child's theory of mind to expand.

After 4 years of age, the developing ToM enables children to consciously consider their thinking, which leads to understanding interpretations or others' beliefs. Marta Białecka-Pikul found this 'reflection on thinking' a new element of ToM. Over the next 2-3 years, children become capable of attributing second-order beliefs, i.e. form beliefs about others' beliefs[15]. For instance, they can predict others' intentions (know when someone is trying to cheat them) or skilfully lie (provide information that another person cannot verify)[16].

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10 Rzechowska, 2004.
11 Premack and Woodruff, 1978, pp. 515–526.
12 Understanding of other mental states begins earlier, for example, understanding desires, as shown in the early findings by Repacholi and Gopnik, 1997, pp. 12-21.
13 Unexpected Transfer Task; Wimmer and Perner, 1983, pp. 103–128.
14 Wellman, Cross and Watson, 2001, pp. 655–684.
15 Białecka-Pikul, 2012.
16 Schaffer, 2004; Kielar-Turska, 2002, pp. 83–129.

4.4. The Beginning of Social Perception

Between the ages of 7 and 12 months, children start to distinguish familiar from unfamiliar people. As their perception of other people becomes more comprehensive and objective, and their knowledge of them consolidates, their understanding of others' needs and expectations progressively improves.

4.4.1. Improving Social Perception

Very young children evaluate others situationally and inconsistently, so they may consider a person good or bad depending on the person's readiness to satisfy their wishes. Initially, they do not notice that their opinions are contradictory, but gradually, they start to understand that people have different characteristics (they are sometimes good and sometimes they are bad) but do not yet interpret them. The developing knowledge of the situational and psychological determinants of human behaviour enables a child to integrate different behaviours of the same person (*my mum is smiling at me when I keep my toys tidy, but she is frowning at me when I clutter them around*). As a result, the child can create more detailed images of individuals and form opinions about people generally based on his or her experiences (girls are quarrelsome) or interactions with others (good children obey adults).

4.4.2. Objectivisation of Social Perception

Step by step, the child's images of other persons become increasingly objective. The way younger children see other people is emotionally determined and transactional (*My aunt is nice because she reads fairy tales to me; I don't like my uncle because he won't play with me*). This 'utility-based' approach to others continues until the pre-school years, when children become more and more aware that people also have their own objective characteristics (*X is a sailor and works on a ship*).

The development of children's social perception is stimulated by their interactions with other children and attempts to interpret what they see and hear. With time, their understanding of the needs and expectations of other people and their ability to effectively influence improve, as does their awareness of conditions that make cooperation with others possible[17].

5. The Portrait of a Developing Child: Directions of Change

Older infants intentionally pursue goals they set for themselves. They also become aware that they are autonomous beings capable of acting and changing their environment. Their emerging will and a sense of independence encourage them to walk away from the mother or demand their wishes to be met. The formation of a child's identity and ***its*** social relationships is explained by Margaret Mahler's separation-individuation

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17 Włodarski and Matczak, 1998; Matczak, 2003.

theory on early childhood relationships[18]. and their role in the development of the 'structure of self' and the eight stages of Erik Erikson's psychosocial development theory[19].

The child's deepening understanding of his or her separateness and individuality, leading to the emergence of self-awareness, and increasing autonomy create the basis for the formation of self-knowledge enabling self-evaluations and the construction of self-esteem.

5.1. Discovering Self: Between Separation and Individuation

Margaret Mahler' separation-individuation theory[20] holds that a child's personality is formed in interactions with the close caregiver (e.g. the mother) and gradually evolves from symbiotic integration (separation) with the mother to a stable individual identity (individuation). Separation considered in the context of the child's development involves differentiation, increasing the distance from the mother, setting limits, and becoming less dependent on the mother. Individuation is referred to by Mahler as the child's progressing internal autonomy, accompanied by attempts to test reality and deepening physical and psychological separation from the mother.

The separation-individuation process has four subphases: hatching, practicing and rapprochement (16-24 months), when the child's awareness of his or her separateness from the mother increases, resulting in the child's ambivalent behaviours towards her (due to a conflict between autonomy and dependence), and consolidation/object constancy (24-36 months), during which the child's attachment to the mother is relatively independent of gratification or frustration due to his or her cognitive capacity to believe that the mother exists when she is out of sight and has positive attributes even when she is unsatisfying.

5.2. Erik Erikson's Crises of Toddlers and Pre-Schoolers: From Autonomy to Initiative

An attitude of trust developed during the first 12 months of life opens a child to the world, enabling the formation of autonomy and initiative at the next stages of stages of development[21].

5.2.1. Stage 2. Autonomy, Shame and Doubt (1-3 years of life)

Alongside increasing autonomy, the child acquires the ability to see him- or herself as separate from other people. Experiments with children aged 15-24 months have demonstrated that they can identify themselves in their mirror reflections[22]. The beginning of the sense of 'I' is associated with the child discovering his or /her mental individuality, leading to the birth of 'mental self'. At this stage, the child tests what can be touched, said and examined, demands his or her will to be respected, accentuates

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18 Mahler, Pine and Bergman, 1975.
19 Erikson, 1963.
20 Mahler, Pine and Bergman, 1975.
21 Erikson, 1963, 1982.
22 Lewis and Brooks-Gunn, 1979, pp. 1–20.

independence, challenges adults (negativism) by demanding respect for his or her rights, and learns to be self-reliant. The child signals his or her growing independence by appropriating things belonging to others ('an urge to possess') and 'standing ground' against alleged rivals. Using the first-person pronouns (I, me, mine), the child communicates his or her will and sets boundaries, but strong dependence on others still makes the child accept their control.

Erik Erikson promoted the creation of safe environments for young children, which they could explore on their own and learn to be independent. In Erikson's opinion, excessive parental control prevented children from becoming self-efficacious and self-reliant individuals, and caused them to experience shame and doubt when they failed in their undertakings.

5.2.2. Stage 3. Initiative and Guilt (3-6 years)

With the autonomy and initiative developed at Stage 2, the range of interesting goals that can be pursued by a pre-schooler increases significantly. The activities, games, or fantasies that the child plays out strengthen his or her sense of agency, and consistency and focus in achieving goals are rewarded with satisfaction upon completing the task.

Stage 3 also marks the rapid development of the child's conscience, which is an inner voice making judgments for the child on whether his or her actions have followed social norms and standards.

To be able to act without feeling guilt or fear and consistently pursue goals despite obstacles and failures, a pre-schooler must know which ways of acting and areas of exploration are socially acceptable and will choose those that will not end up in a conflict. Misjudgments as to which activities are safe and which are risky lead to a sense of guilt and shame, which may dampen the child's initiative.

Exploratory children are inclined to undertake activities that may end up in failure, especially when they are too ambitious, or the child feels a strong urge to be successful. Such children need a caregiver who will support them in the safe exploration of their environment without discouraging their initiative or making them feel remorseful for wishing to have or do something that might harm others or fail their expectations. Controlling the child's behaviour when necessary and allowing him or her to express feelings is central to the child developing a permanent ability to take initiative.

5.3. The Emergence of Personality: An Early Sense Of Self, Self-Esteem and Self-Evaluation

The development of the child's self-awareness (18-24 months) and a sense of agency (around the age of 3 years) initiate the formation of self and self-knowledge, which in various concepts are referred to as the core of personality.

The initial sense of self is formed in early childhood. The child's elementary self-knowledge includes information about his or her appearance, physical characteristics, skills and favourite activities and objects. The information evolves from

purely descriptive (*I am Ann, I am a girl, I have a doll, I can sing*) to pre-schoolers' value judgments derived from their experiences or adopted from other people.

Self-esteem, the value that the child attributes to him- or herself, frequently based on judgments made by the caregivers[23], consists of the child's beliefs about self (I'm loved, I'm good) and emotional states (triumph, despair, pride, shame, etc.)[24]. Children tend to evaluate themselves in terms of *specific attributes* (*I sing nicely*) until the age of around 7 years, when the attributes are integrated into a global evaluation of self, and self-esteem becomes a permanent trait of a child's personality[25].

Young children's perception of themselves is usually positive because they cannot compare themselves to others socially[26] or compare what they can do now with what they could do some time ago[27].

5.4. Autobiographical Memory and the Development of Self

Central to the development of the initial sense of self and understanding of the world and social relations is autobiographical memory, which ensures the continuity and coherence of the child's memories[28]. Until the age of around 3 years, autobiographical memory helps the child understand the world and its workings, and the memories of past events are only stored until a child becomes capable of transforming repeating experiences into a general pattern ('a script'). The development of autobiographical memory is especially stimulated by the caregiver reminiscing about past events, which helps the child to organise his or her memories and better understand the world.

In western culture, mothers start reminiscing about past events when their children are around 2 years old; during such interactions, children's participation is limited to confirming or repeating what they hear. By the age of 3-4 years, children already understand their memories and can organise them and find new associations between them[29].

The content of the child's autobiographical memory essentially depends on how the parent(s) recount past events. Elaborative parents tell detail-rich stories, and add new information each time they retell them, even if the child does not remember them well. This narrative style helps form a bond with the child, gives a wider context to past events, and explains their meaning. Repetitive parents tend to ask the same question repeatedly to refresh the child's memories about past events without giving new information or retelling the whole story. This style has been found to stimulate the development of the child's memory skills. According to research, the children of elaborative parents have a more comprehensive autobiographical memory, and their

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23 Shaffer and Kipp, 2013.
24 Hewitt, 2009, pp. 217–224.
25 Boyd and Bee, 2019.
26 Ruble et al., 1980, pp. 105–115.
27 Kemple, 1995, pp. 173–182.
28 Conway, Singer and Tagini, 2004, pp. 491–529.
29 Fivush and Reese, 1992, pp. 115–132; Fivush, Haden and Reese, 1996, pp. 341–359; Nelson and Fivush, 2000, pp. 283–296.

accounts of past events are more comprehensive and detailed, as a result of which they remember them better[30]. They also have a more differentiated and autonomous sense of self, and their memories define self and help define self in relation to others.

It has been demonstrated that parents adjust their narrative style to the child's gender. Stories told to girls are more detailed and more comprehensive, as a result of which they organise their experiences earlier than boys[31].

5.5. Basics of Gender Identity

Gender identity is the internal sense of belonging to a specific gender, identifying with it, behaving in a manner specific to it, and accepting the associated social roles[32]. Children's gender identity is usually established by the age of 3 and consists of primary identification (a child knows which children are of the same or different gender) and secondary identification (a child tries to look and behave like the model, e.g. girls put on mothers' clothes, play with their cosmetics).

5.5.1. Awareness of Own Gender

At around 1 year of life, the child can distinguish a male person from a female person, and almost all 3-year-olds know their gender (*I am a boy / I am a girl*). The awareness of gender constancy emerges in the fourth year of life, when the child understands that his or her gender will be the same in the future *(I will grow into a boy / a girl)*, and the notion of gender permanence is internalised at around the age of 5-6 years, with the child beginning to understand that changes in external appearance does not influence one's gender (*I will always be a boy / a girl*)[33].

5.5.2. Learning Gender Roles

Gender identity is formed during the child-raising process by enhancing and modelling, for instance, by having girls and boys meet different expectations and using gender-determined patterns of interactions (exercising more control over daughters than sons, teaching them to be obedient, and encouraging sons to be independent and assertive). Different toys, activities and ways of communicating with boys and girls serve the same purpose of strengthening gender-typical behaviours.

5.6. First Complex Emotions: Awareness and Emotional Regulation

Toddlers and pre-schoolers intensely express their emotions[34], which are short-lived and changeable.

Following the development of self-awareness, moral disposition and social referencing by around the age of 2-3 years, children begin to understand what others expect of them and what rules and norms apply to them. The ability to tell right from

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30 Niedźwieńska, 2003, pp. 55–60; Fivush, 2011, pp. 559–582.
31 Fivush, 1998, pp. 79–103.
32 Lips, 2018.
33 Slaby and Frey, 1975, pp. 849–856; Wojciechowska, 2003, pp. 13–27; Boyd and Bee, 2019.
34 Lewis, 2008, pp. 304–319.

wrong and an emerging conscience enable them to make judgments on their own and others' behaviour. They feel pride and satisfaction when they meet expectations and follow the rules, or guilt and shame when they fail to do so[35].

The anger caused by disconcerting situations is expressed by children through aggression. Young children's aggression is instrumental and uses hitting, pushing and kicking to force others into compliance or release tension. In older children, it is replaced by hostile aggression, intended to cause physical or mental pain by calling names, mocking, making threats and picking fights.

The preschool period involves the gradual development of the child's emotional self-awareness, encompassing emotional regulation, emotional understanding and emotional expressions[36].

Emotional regulation is the ability to recognise and name emotions and to express them in line with cultural norms. Unlike infants, whose emotional states are essentially regulated by adults, toddlers begin to acquire the skills needed to independently regulate emotions, with the process being greatly facilitated by their developing language.

Emotional understanding is the ability to share one's feelings with others; its first signs are observed around the age of 2, when children try to comfort others in the same way they have seen or experienced. The development of empathy requires the ability to read the emotional states of others, understanding that they are separate and independent beings, and share their perspective. At the age of 4 or 5 years, children begin to create their own theories about others' emotional states based on the causes and consequences of emotions and make predictions about others' experience and expression of emotions (they can assume, for instance, that a smiling child will be more willing to share his or her toys).

Emotional expression involves the ability to express emotions in a way that matches, or does not match situations, which the child starts to acquire at about the age of 4 years. As a result, a child can mask his or her true emotions (put on a smile when receiving a gift that he or she does not like, to protect the feelings of another person or avoid annoyance), pretend not to feel fear (stroke a dog to show how brave he or she is and to save face), and overcome frustration (carry on despite obstacles making them feel anger to avoid being teased by peers)[37].

Caregivers are essential in helping children learn to regulate their emotions. At the early stage of the child's development, they must control the child's emotional states and process them into a simpler form so that the child can cope with them[38]. By teaching, modelling, verbal reasoning and explaining, they can help the child to confront negative emotions and initiate transition towards autonomous regulation of emotions.

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35 Kielar-Turska, 2015, pp. 202–233; Boyd and Bee, 2019.
36 Tangney and Tracy, 2012, pp. 446–478.
37 Tracy, Robins and Tangney, 2007; Saarni, 1999.
38 See: Mahler, Pine and Bergman, 1975.

5.7. Discovery of Social Standards and the Genesis of Conscience. Kohlberg's Pre-Conventional Phase of Moral Development

Moral development is a process through which individuals' concepts of right and wrong, conscience, social standards and moral judgements are gradually formed.

The ability to obey rules expressed by gestures (e.g. hushing the child by touching the index finger to one's lips) or words (do not touch) can be already observed among 1-year-old infants[39]. Younger children (2-3 years old) understand requests and commands literally ("*do not take a doll away*" means that they must not take this specific doll) and must be repeatedly reminded not to do the same thing again. Older children can remember the rules of behaviour for extended periods and transform them into general principles (one may not take other children's toys) that they consistently follow.

Children are taught by parents to distinguish right from wrong (moral norms) from an early age. The emergence of conscience initiates moral development in the course of which children formulate internal standards of conduct and apply them consistently[40]. They begin to represent moral values and think of themselves as moral beings. By the end of the preschool years, children develop a 'moral self' that makes them want to do what is right and causes them to feel badly when they misbehave and react with uneasiness when they see others misbehave[41].

The foundation of the pre-schoolers' morality is obedience towards adults and yielding to their requests and demands. Understanding reality literally, they are unable to accept any departure from the established rules and believe that breaching them does not go without consequences (Piaget's moral realism)[42].

Lawrence Kohlberg[43] studied how people distinguish right from wrong by having his subjects make a moral judgment upon a hypothetical 'dilemma', the best known of which requires the tested person to decide whether one Heinz, a man whose wife is dying of cancer, has the right to steal an exorbitantly priced new drug that can save her life when his efforts to raise the money to buy it have proven unsuccessful.

As a result of his research, Kohlberg proposed six stages of moral reasoning that he grouped into major levels. The first level, called a pre-conventional level, is associated with a concrete, individual perspective, and involves a lack of understanding of social norms, rules, and expectations, which are treated as belonging to the external world.

Judgments made at the pre-conventional level tend to consider the physical consequences of an act for a person rather than what is right and what is wrong. As a result, a child representing the level's stage 1 (punishment and obedience orientation) formulates judgments to stay clear of trouble, e.g. yields to commands to avoid punishment. At stage 2 (naive instrumental hedonism), children are already aware of

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39 Siudak, and Bielenda-Mazur, 2020, pp. 171–186.
40 Kochanska, 2002, pp. 339–351.
41 Thompson, 2012, pp. 423–429.
42 Kielar-Turska, 2015, pp. 202–233.
43 Kohlberg 1963, pp. 277–332; Kohlberg, Levine and Hewer, 1983.

others' needs, but their judgments are still guided by practical interests (instrumental orientation). While they begin to understand that social interactions are about reciprocity and exchanges, their moral judgements on actions are still formed based on how significant they are for them (thus, a child may decide to share candy to get some ice cream in return).

5.8. Speech and Communication as Factors Organising The Child's Activities and Social Relationships

Language acquisition is a natural process accompanying the child's social interactions. Toddlerhood is the period during which children assimilate basic vocabulary and grammar of their native tongue.

5.8.1. Early Language Skills

Young children's speech, which is referred to as autonomous because it does not respect the rules of syntax, can take the following forms:

Single-word sentences represented by words used by children to describe an entire concept or idea. These can be onomatopoeia, i.e. sounds specific to things or actions, e.g. buzz, hiss, or holophrases, i.e. single words substituting simple sentences; for instance, 'ball' may mean 'this is my ball' or 'let us look for my ball'.

Two-word sentences are combinations of words that children use at the stage of acquiring basic grammar rules, e.g. 'me go' or 'more juice'.

Telegraphic speech consists of sentences made up of three or more words that convey ungrammatical messages, like those used in telegrams.

By the end of toddlerhood, children know the basics of their native tongue and all parts of speech, can distinguish among basic grammatical forms (although still have problem using them correctly), and can produce all types of sentences, including subordinate sentences. Their pronunciation becomes more intelligible, making their speech more understandable for others[44].

5.8.2. Expansion of Lexical and Grammatical Resources

Toddlers' speech is focused on objects and phenomena they have seen or imagined. Three-year-old children know about 1,000 words (approximately 3,000 by the age of 6-7 years) and the basic grammar of their native tongue.

5.8.3. Knowledge of the World and Lexical Categories

The toddler's vocabulary contains various lexical categories that describe objects (nouns) and their qualities (adjectives), represent activities and their characteristics (verbs and adverbs), and indicate relationships (conjunctions). As the child's knowledge about the world expands, the proportion of nouns and verbs decreases in relation to other parts of speech. Each lexical category undergoes diversification, resulting,

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44 Vasta, Haith and Miller, 2004; Kielar-Turska, 2015, pp. 202–233; Brzezińska et al., 2019; Boyd and Bee, 2019.

for instance, in the increasing replacement of verbs representing specific activities and movements with verbs describing activities transforming the appearance or structure of objects or mental processes and interactions.

5.8.4. Diversification of Vocabulary

In the preschool period, the child's lexical knowledge undergoes rapid development. The range of words describing objects in general terms is enriched with specific names (a rose as a type of a flower), homonyms, synonyms and metaphors.

Language acquisition by children is accompanied by various errors, such as neologisms, overextensions, underextensions and overregulations[45]. Neologisms are combinations of words that children create spontaneously to convey meanings they need (they may say, for instance, lightning catch instead of lightning rod). Overextensions and underextensions occur, respectively, when the meaning of a word is stretched beyond its established content (all animals are doggies) or when it is limited to one object only (only the family pet Fido is a doggie). Overregulations take place when grammar rules are bent to give regular forms to otherwise irregular words (resulting in 'breaked' instead of 'broken').

5.8.5. Communication Skills

Language acquisition starts with the child recognising others' intentions and interpreting them correctly. At the next stage of language development, the child becomes capable of intentionally imitating what others do and how they communicate, even when they are not involved directly in communication. The preschool years are marked by significant progress in language skills, i.e. sociolinguistic competence, interactional competence and situational competence, largely improving the child's ability to communicate. Sociolinguistic competence is the knowledge and ability to use norms, customs, phrases and non-verbal behaviours in a manner appropriate to the character of social interactions. Interactional competence comprises the ability to appropriately respond to a conversation partner and the knowledge of phrases opening and ending conversations, effectively delivering one's point, or helpful in convincing the partner. Situational competence is the ability to accommodate one's speaking style to the occasion, including the place, topic and circumstances of the conversation, including the size of the audience.

For communication to be effective, the ability to share another person's perspective, listen carefully, direct and sustain a conversation and establish a common language is necessary. The awareness of the conversation partners' mental states is also important, as it enables their needs to be predicted (see child's theories of mind).

By the age of 6-7 years, most children have good knowledge of colloquial language and easily communicate their thoughts, desires and emotions.

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45 Vasta, Haith and Miller, 2004.

6. The Child and Social Relation – Primary and Secondary Socialisation

Socialisation is the process through which individuals acquire the social skills, beliefs, values, and behaviours needed to function effectively in society or within a specific group. It occurs in two stages: primary socialisation and secondary socialisation. Primary socialisation takes place in the family environment and teaches the child to distinguish acceptable from unacceptable behaviour, values, social norms and cultural patterns prevalent in society. It also enables the child to form bonds and relationships with other people and to understand the notions of love, trust and togetherness. Secondary socialisation builds on the behavioural patterns that the child has acquired during primary socialisation. During this process, the child learns to behave in public and home situations appropriately to the circumstances, and takes in values, beliefs and attitudes that the teachers, friends and the media share with him or her, which will have an enduring effect on his or her life[46].

6.1. The Role of Parents in a Child's Socialisation

The care that children are given during early childhood and primary socialisation is of crucial importance for their development and future functioning. Its character is significantly determined by the parents' parenting style, their predominant attitude to the child and the structure of the family.

6.1.1. Primary Socialisation: Goal-Corrected Partnership and Social Learning

The fourth stage of the attachment process[47] (goal-corrected partnership) starts with the child reaching the age of about 2.5 years. Children at this age begin to take into consideration parents' behaviour, plans and intentions, and are ready to engage in setting goals with the parent. They can function consistently even when the parent, who makes them feel safe during their explorations, is absent, and they increasingly understand social rules and their complexities[48]. At this stage, the parent needs to reconcile the child's urge for autonomy and self-assertion with safety by setting limits on his or her endeavours.

The experiences gained by the child in the course of his or her first interactions with the parents provide a basis for the evolution of the child's internal working models. According to Bowlby, an internal working model is the child's mental representation of his or her relationship with the primary caregiver. It functions as a framework wherein the child will build his or her relationships in the future, and as an instrument for predicting, controlling and manipulating the environment. Most

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46 Matyjas, 2017, pp. 41–54.
47 For the first three stages of the attachment process, See: Rzechowska, 2025, pp. 137–157.
48 Bowlby, 1969; Ainsworth, Bell and Stayton, 1971, pp. 17–58.

5-year-olds are observed to have well-formed internal models of the mother, themselves and interpersonal relations[49].

The bond that young children have with the caregiver is central to their ability to learn by:
- imitating other people's behaviour;
- modelling (observing other people's actions and their consequences);
- identifying oneself with other another person (trying to look the same, sharing the person's beliefs and attitudes).

6.1.2. Parenting Styles

After studying what parents expect of their children and how they fulfil their needs, Diana Baumrind presented three main parenting styles: authoritarian, authoritative and permissive[50]. In 1983, Eleanor Maccoby and John Martin proposed a fourth parenting style: neglectful.

Authoritarian parents set rigid rules, have high expectations towards their children, and do not allow them to decide for themselves. Breaching the rules is punished swiftly and severely.

Authoritative parents also impose limitations and want to guide their children. At the same time, however, they give them some freedom to make decisions and allow them to learn from failures.

Permissive parents are relatively lax in their expectations towards their children, with whom they interact more like peers than traditional parents. They are also usually ready to respond to the children's needs and wishes.

Neglectful parents rarely interact with their children. They not only lack expectations for their behaviour, but they also neglect their needs.

Much of today's research into childhood development concerns these four parenting styles which represent a broad spectrum of parents' behaviours and explain how most parents care for their children.

The range of parenting styles has recently been extended to include respectful parenting as more and more parents show preference for this parenting style.

Parenting styles significantly influence a child's development, shaping their social, emotional, and cognitive growth. For example, authoritative parenting tends to promote independence, self-regulation and educational success in children. On the other hand, permissive parenting often leads to impulsiveness and difficulties with self-control, while authoritarian parenting can result in lower self-esteem and social competence. Additionally, neglectful parenting may hinder a child's overall development, leading to issues such as emotional insecurity and poor school performance.

However, the limitations of parenting styles lie in their generalisation. Each child is unique, and what works for one, may not work for another. Parenting styles are also influenced by cultural, socioeconomic and environmental factors, meaning they do

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49 Boyd and Bee, 2019.
50 Baumrind, 1966, pp. 887–907.

not always account for the diversity of experiences[51]. Furthermore, external influences such as peers, media, and education also play a crucial role in development, which may limit the impact of parenting alone.

6.1.3. Respectful Parenting – RIE's Basic Principles

In her *Resources for Infant Educarers* (RIE), Magda Gerber described a respectful parenting style which allows children to develop in an environment where they can feel secure, attached, independent and self-reliant[52]. For the environment to be created, the parents need:

- to accept that the child is a unique human being and deserves respect in every interaction;
- to understand that the child is authentic when he or she feels secure, autonomous, competent and connected, and that the feelings are central to the child being able to build self-esteem and develop;
- to understand that the child has natural competencies and will not engage in or perform activities for which he or she is not ready;
- to sensitively observe the child to comprehend his or her needs and true self;
- to let the child be an active participant of all care activities rather than a passive recipient;
- to create an environment that is free of physical risks, cognitively challenging, and emotionally nurturing for the child;
- to leave the child time for uninterrupted play and free exploration because play is more beneficial for the child than teaching him or her new skills;
- to be consistent: setting limits and defining expectations help children grow into disciplined persons.

Although the RIE focuses on the first three years of the child's development, its principles also apply to older children and those in institutional care[53].

6.2. Sibling Relationships

In addition to the parents' predominant attitude towards the child, the child's development is also significantly shaped by the structure of the family and relationships with the sibling(s)[54]. Siblings spend most of their time together, and their relationship is unique compared to relationships with same-age peers or adults. Interactions between younger and older siblings are crucial to the child's development. They provide younger children with an opportunity to observe and imitate older siblings and thus learn vital skills from them, while older siblings (aged over 2.5 years) learn to care about younger children and take responsibility for their well-being when the caregiver is

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51 Kuppens and Ceulemans, 2019, pp. 168–181.
52 Gerber and Johnson, 2012; Hammond, 2021, pp. 1302–1315.
53 See: Rzechowska, 2025, p. 180.: 6.4. Out-of-family care and secondary socialisation.
54 Boyd and Bee, 2019.

not present[55]. Interactions between siblings at different ages also teach them empathy, sharing and cooperation[56] and stimulate the development of skills needed to negotiate and resolve conflicts arising from rivalry for parents' attention, etc.

Occasional conflicts between siblings are unavoidable, with some of them having the advantage of stimulating the development of their social and cognitive skills. The causes of conflicts tend to vary with children's ages. Dunn and Munn have estimated that more than half of confrontations between siblings in early childhood arise from disputes over 'what is whose'[57]. In middle childhood, they are more frequently related to decisions about control over interactions (who will choose a game, etc.), disputes over facts or opinions, or rude behaviour[58]. The conflict resolution strategies employed by children also evolve with their age and are influenced by the nature of the conflict. Abuhatoum and Howe[59] have found that disputes over property rights are usually resolved through coercive strategies (e.g. involving threats), whereas older siblings' preferred solution to confrontations concerning control over social situations is based on negotiation. However, younger children may also use reasoning when in conflict with an older sibling over decision-making (*you are not the boss*). This strategy is not infrequent among younger siblings and is probably used as an adaptive strategy, enabling them to assert their autonomy.

It is important to note that friendly relationships with siblings often translate into more positive interactions with peers.

6.3. Relationships With Peers

Peers are not a source of social stimulation for young infants. The 18-month-old child still does not see a difference between inanimate objects and children[60], and consequently tests them by touching, pushing them, or pulling hair. However, the child gradually begins to realise that children are a special type of object that reacts differently to physical contact (they start crying when pushed) and that they may make good playmates. The explorative attitude to peers is still observed in 2-3-year-olds, but it is shown much less frequently than attempts to interact socially with them (by exchanging toys, imitating their behaviour, using various strategies to grasp their attention). When interacting with peers, the child imitates the behaviour of adults with whom he or she has interacted before and who are much more interesting for him or her[61].

6.3.1. The Development of Relationships With Peers

Early childhood experiences provide a framework for the child to build and foster social relationships. They enable a 24-36-month-old toddler to invite a peer to

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55 Dunn, 2004.
56 Pike et al., 2005.
57 Dunn and Munn, 1985, pp. 480–492.
58 Howe et al., 2002, pp. 1460–1473.
59 Abuhatoum and Howe, 2013, pp. 738–754.
60 Oakes and Madole, 2008, pp. 135–185.
61 Włodarski and Matczak, 1998.

interaction using a range of strategies (asking, teasing, coaxing, exchanging informa-tion, giving instructions, etc.). At the age of 36-48 months, a desire to play with other children appears and they become able to play out roles according to established rules while playing together[62]. Children increasingly often perceive peers as interesting playmates, and their interactions with them and adults undergo differentiation, with some types of interactions being undertaken more frequently or exclusively with peers[63]. Around the end of the pre-school years, in addition to adults' judgments, peers' opinions become important for children as a source of reward or punishment.

Interactions with peers are a learning experience for children, showing them how to build and foster relationships with other people. In the course of those interactions, children gradually adjust their behaviour, topics and language to the playmate's age. As a result, younger children tend to be treated with care or dominated, while older children are usually shown admiration and respect. The playmate's gender also influ-ences pre-schoolers' behaviour, as children at this age prefer to spend time with peers of the same gender.

6.3.2. The Beginning of Child Friendships

Child friendships are focused on shared activities and objects[64]. Judy Dunn found the first short-lived relationships of 2-3-year-olds to have the defining attributes of friendship: cordiality and pleasure in spending time together[65]. Pre-schoolers' rela-tionships are characterised by fondness, attachment, and care about the friend with whom children want to spend time and talk and whom they ask for favours more often than other children. Friends are treated in a special way: children avoid hurting their feelings and try to understand their point of view to the maximum extent. Compro-mise and reconciliation with a friend are more likely than with the child's siblings or other children. First interactions with peers are an opportunity for a child to learn to share feelings and thoughts with others and to understand what mental processes are reflected in their behaviour. Children interacting with friends and doing pretend play frequently function at a higher level than on other occasions.

6.3.3. The Social Organisation of Play

The child's interactions with other children evolve at a rapid pace during the first years of life, from just watching their faces and movements to trying to manipulate objects like they do and playing together. Based on how children behave when playing, several forms of play have been identified, i.e. unoccupied play (random play without a specific goal), solitary play (playing alone or differently than other children) and onlooker play (watching other children play and occasionally commenting on their activities without engaging in them) (Parten, 1932).

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62 Krauze-Sikorska et al., 2016.
63 See: Rzechowska, 2025, p. 178.: 6.3.2. The beginning of child friendships.
64 Kielar-Turska, 2000, pp. 285–332; Boyd and Bee, 2019.
65 Dunn, 2004.

The earliest form of children 'playing together' involves watching each other and doing the same things but with a different purpose in mind (parallel play). Older children may play next to each other with the same or similar objects and in the same way, but, as before, pursuing their own goals (associative play). At around 3 years of age, children start to perform the same actions to achieve a common goal (stack building blocks on a toy truck to fill it up).

In the second half of the pre-school period, a qualitative change in playmates' behaviour can be observed: each child is assigned specific tasks to perform, with the division of tasks first taking place during play and then prior to it. As the planning process becomes more detailed, the coordination of children's activities and mutual control of their performance improve (co-operative or organised supplementary play).

6.3.4. Prosocial and Antisocial Behaviour

Both prosocial behaviour and antisocial behaviour are learned by children during interactions with others, which underscores the importance of children having appropriate models of behaviour.

The first signs of prosocial behaviour, such as sharing and cooperating, looking after and helping others, kindness and tolerance, etc., are observed in children at the age of 2-3 years[66]. Their common characteristic is that they are to benefit others and address their needs. Central to the development of prosocial behaviour is empathy, without which understanding the situation of other people and sharing their perspectives and feelings is not possible.

The probability of conflicts between children increases with the number of times they interact. For younger children, understanding which behaviours may lead to confrontations is still difficult, and their skills at getting out of risky situations are not yet developed. They develop with age as the child becomes increasingly aware that his or her interests and those of another child may be in conflict, allowing him or her to find constructive solutions to conflicts, first with the adults' assistance.

Toddlers frequently display aggressive behaviour. Early on, instrumental aggression aimed at making others comply with their wishes predominates. It gradually disappears around the age of 4 years to be replaced by hostile aggression intended to inflict physical or emotional pain[67].

In children inclined to antisocial behaviours, highlighting other people's mental states stimulated their ability to decentrate, and making them aware of others' internal traits helped them understand differences between theirs and others' perspectives and, consequently, overcome their egocentrism.

Children's relationships with their peers may support or hinder their development[68]. Feeling accepted by peers is fundamental to developing self-affirmation and

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66 Boyd and Bee, 2019.
67 Kielar-Turska, 2000, pp. 285–332.
68 Rubin et al., 2011, pp. 519–570.

self-esteem, whereas a feeling of rejection, especially due to aggressive behaviour, may lead to the emergence of behaviour problems.

6.4. Out-Of-Family Care and Secondary Socialisation

In early childhood, children spend most of their time and develop in the home and family environment, sometimes also in day-care establishments and nurseries. In the case of most children, it is during the pre-school period that new environments stimulating their development appear, initiating secondary socialisation[69].

The way young pre-schoolers establish relationships with others, seek their attention, ask for help, and interpret behaviours largely builds on their experiences from the first two years of interactions with their parents, which have been transformed into internal working models[70]. It undergoes modifications as the child gains new experiences outside the family environment, with good experiences being likely to make the child feel positive about other people and exhibit friendly behaviour towards them.

The increasing awareness that his or her point of view is not the only one enables the child to create a more comprehensive and objective image of the world and realise that other people have feelings and wishes that the child needs to take into consideration. With the child's deepening understanding that one may not harm *other people in the pursuit of one's goals, the child develops the ability to decide which behaviours are socially acceptable. In the pre-school years, the child's world expands, creating multiple opportunities for meeting children* from various backgrounds, observing their behaviour, exploring and experiencing new spaces and people, and learning to deal with new situations single-handed. Not only does this help the child develop a sense of agency and self-reliance, but it also makes him or her ready to face new challenges, first outside the home environment and then at school.

7. Summary

With the rapid development of motor skills in early childhood, the child's perception, attention and memory improve, and pre-operational thinking replaces thinking in action. The change is reflected in the child's logic (egocentrism, centration, syncretism), reasoning (transductive reasoning) and understanding of the world (anthropomorphism, artificialism, animism and realism). The child's growing independence from 'here and now' and the expansion of his or her temporal perspective lead to attempts to understand others' states of mind and feelings and the emergence of the child's theories of mind.

Toddlerhood and preschool years involve the development of the child's individuality, autonomy, initiative, self-esteem and self-evaluation, as well as formation of autobiographical memory and gender identity.

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69 Matyjas, 2017, pp. 41–54; Krauze-Sikorska et al., 2016.
70 Bretherton and Munholland, 1999, pp. 89–111.

Increasing self-awareness, understanding of people's expectations and the emergence of a conscience make it possible for the child to compare his or her behaviours against the established rules, leading to the emergence of emotional states, such as shame, pride or guilt, and to the ability to regulate them. The emerging awareness of norms and standards stimulates moral development. At its early stage (the pre-conventional level), the child makes judgments dictated by his or her practical interests and the need to avoid trouble, even if the child has a sense of the needs of others.

The basics of the native tongue that the child acquires by around the age of 3 enable the development of the child's lexical and grammatical resources and communication skills. Despite errors in early word use (neologisms, overextensions, underextensions, and overregularisations), the child efficiently communicates with others and develops sociolinguistic competence, interactional competence and situational competence.

The behavioural patterns adopted by the child in the family environment during the first years of life (primary socialisation) are put into action outside the family and enriched through interactions with other children and teachers in kindergartens and other care institutions (secondary socialisation). A special role in the child's socialisation is played by peers and first friendships, the evolving social organisation of play (from unoccupied play to cooperative play) and prosocial behaviours.

The skills and abilities developed by the child in early childhood are prerequisites to the child's successful adaptation to the school environment.

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Main Developmental Changes During Middle Childhood: The Role of Peers and School

Ewa RZECHOWSKA

ABSTRACT

Middle childhood (6-11 years) is a complex period in human life in which children become pupils, having attained school maturity and readiness for reading and writing.

The younger school-age period is characterised by children's increasing awareness, control and purposefulness of attention, perception, memory and learning processes. Concrete operational thinking that children become capable of around 6 to 7 years of age makes it possible for them to reverse operations and decentrate. Both of these abilities are important for their social functioning, as they allow them to take others' perspectives and understand that their states and expectations are different from those of other people. The changes are associated with the development of children's identities and the formation and enhancement of interpersonal relations.

In middle childhood, children's sexual energy sublimates into explorations accompanied by defence mechanisms that, at this stage of development, play a positive role (Freud's latency period). They also learn to be productive and accept others' judgments on their performance (Erikson's industry vs. inferiority). By comparing their own and others' expectations, achievements, states and experiences, they start building their self-image; others' opinions become a basis for them to develop self-concept, self-esteem and self-efficacy. Their ability to take a wider perspective on things is reflected in their moral judgments, which they make considering external expectations or social norms.

In the early school years, children transition from a life focused on the family to a life concerned with peer relationships and school and develop a strong need to be part of a group. A special type of peer relationship is friendship, which can manifest itself in various forms.

School is the second developmental environment for children after the family home, in which the quality of teacher-pupil relationships, informal class structure and procedures enabling a supportive environment are important. Among the various problems faced by school children, emotional and behavioural disorders and learning disabilities are the most frequent. The creation of a safe and stimulating educational environment requires procedures protecting children from bullying and supporting talented pupils.

KEYWORDS

middle childhood, school maturity, concrete operational thinking, identity development, peers, friendship, emotional and behavioural disorders, learning disabilities, peer bullying

1. Introduction

The physical and mental development of children between the ages of 6 and 12 (middle childhood) is characterised by significant changes. Starting school is a pivotal moment, as the child takes on a new social role and becomes more open to the influences of classmates and teachers. Unstructured playtime, which once dominated the child's life, gradually gives way to school demands and rules that they must now adapt to[1]. *School responsibilities* give direction to the child's rapidly developing cognitive abilities, which become more and more voluntary and controlled as the child's ability to consciously use attention, perception, memory and learning improves.

2. On the Threshold of School: School Maturity And Readiness for Reading and Writing

School maturity, understood as an appropriate level of emotional, social, intellectual and physical development, is a prerequisite for children beginning school to be able to cope with new responsibilities, learn and develop new skills required for teaching programmes, and adjust to the social life of their schoolmates and the school. School maturity is formed by developmental processes, as well as family and out-of-family factors influencing the child[2].

The acquisition of formal literacy skills is related to children achieving three states of mental readiness:

- psychomotor readiness – enabling children to learn to read and write; it requires the skill of analysing verbal and visual information, appropriately developed kinaesthetic and motor abilities and speech apparatus, manual dexterity, vision-sensorimotor coordination, efficient short-term memory and the ability to concentrate and sustain attention;
- vocabulary and conceptual readiness – achieved as a result of children's cognitive and language experiences; to understand a written text, children must possess substantial cognitive resources (general knowledge and knowledge of their surroundings) and good language skills (rich vocabulary, the ability to communicate and verbally express their thoughts and experiences in a manner that is adapted to the situation);
- emotional-motivational readiness – allowing children to understand how literacy relates to being successful in life; children with emotional-motivational readiness have a positive cognitive attitude to knowledge, are interested in

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1 Stefańska-Klar, 2005, pp. 130–162.
2 Brzezińska et al., 2014.

books and feel motivation to explore, ask questions and overcome difficulties without asking others for help[3].

The three states of readiness are interrelated and determine the amount of time the child will need to acquire reading and writing skills and how efficiently they will be used as cognition and communication tools.

3. School-Age Children's Perception, Attention and Memory

The evolution of attention, perception, memory and learning ability represents a transition from (1) spontaneous, uncontrolled processes in these domains reflecting the child's current wishes and interests through (2) partly controlled processes in pre-school-age children to (3) increasingly conscious, voluntary and purposeful processes in younger school-age children, aligned with the caregiver's or teacher's intentions[4].

3.1. From Cursory to Intentional and Permanent Observations

The perceptions of 7-8-year-olds still tend to be inaccurate and disregard the salient aspects of things. Over time, they become capable of identifying and generalising the characteristics of objects they see and consciously directing their perception to their aspects that are of interest to them. Their improving perceptiveness is accompanied by inquisitiveness, insight, curiosity about the world and resolution to understand the world around them.

3.2. From Attention Responding to External Cues to Unstable Self-Control

Between the ages of 6 and 9, the child's ability to resist impulses, control emotions, and stay focused on a task increases rapidly. *Voluntary attention takes the place of involuntary attention, enabling the child to perform increasingly complex activities while ignoring their trivial aspects.* The scope of attention expands, and its resistance to distractors improves, but sustaining attention is still difficult for the child, making concentration on tasks that the child considers monotonous or boring difficult. In general, the attention of school-age children is focused on external objects and phenomena. However, as they approach the end of this stage, they become increasingly aware of their own mental activities and begin to direct their attention inward[5].

3.3. From Mechanical to Logical Memory – Memory Strategies, Metamemory and Constructive Memory

Along with the fast-improving cognitive abilities of younger school-age children, their memory processes undergo qualitative changes. First-formers may not remember well

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3 Brzezińska et al., 2012, pp. 7–22.
4 Vasta, Haith and Miller, 2004.
5 Flavel, 1985.

what homework they are supposed to do, but they have no problem remembering things that are interesting for them or trigger strong emotions. Gradually, logical memory replaces mechanical memory, and voluntary memory supersedes involuntary memory. First-formers requested to learn a poem or a song by heart use a passive memorisation strategy involving multiple repetitions, but older children employ active strategies appropriate for voluntary memorisation (such as organisation and repetition), where data are organised and linked together and simultaneously integrated into the child's existing knowledge[6]. The child's effort to understand and organise information reduces the number of repetitions needed to memorise it and makes it more permanent and easier to recall. The developmental improvement of memory skills is significantly associated with *the emergence of metamemory, i.e. the child's knowledge of memory, its functioning, ways of memorising things and factors influencing memorisation and the quality of information stored*. Improving ability to memorise information implies its association with the expanding general knowledge of the child[7].

General knowledge is also a resource that constructive memory uses to create more comprehensive pictures of past events or experiences. Its elements are picked to make adjustments to memories or fill in the blanks, which, in some cases, may result in memory distortions[8].

4. Cognitive Changes: The Concrete Operational Stage (years 6/7-11)

4.1. Concrete Operational Thought: Reversibility, Decentration, Conservation and Inductive Reasoning

At the age of 6-7 years, a new stage of cognitive development begins, which Piaget called the concrete operational stage *because children become capable of performing mental operations on concrete objects and events.*

Concrete operational thinking differs from preoperational thinking in that it is associated with the child's awareness of the reversibility of operations and the ability to decentrate[9].

A child who understands that operations are reversible can track his or her reasoning backwards to where it started and correct it as needed, and decentration enables a child to see the characteristics of objects, situations and realities from different perspectives, and to understand their complexity[10]. *As a result, awareness of quality conservation, i.e. the understanding that objects (and their properties) that have been stretched, cut, elongated, spread, compressed, etc. remain the same objects, emerges and develops in the following order: number, length, volume, mass, area and weight. A child who*

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6 Vasta, Haith and Miller, 2004.
7 Karably and Zabrucky, 2017, pp. 32–52.
8 Brzezińska et al., 2019.
9 See: Rzechowska, 2025, p. 161.: 4.1. Symbolic thinking: pre-operational years (2-6/7).
10 See: Rzechowska, 2025, p. 161.: 4.1. Symbolic thinking: pre-operational years (2-6/7).

is aware of quantity conservation knows that water poured from a tall and narrow container to a wide and narrow one, does not change its volume because the different heights of the containers are compensated for by their width.

One of the classic tests that Piaget developed to measure children's ability to perform operations mentally is the conservation test. In the test, children are shown *two identical objects, e.g. balls of clay, and their sameness in terms of* number, size, volume, etc. is highlighted. One ball is then rolled into a cylinder; because it is now longer and thinner than the ball, the preoperational child will say that quantity has changed, whereas the concrete operational child, capable of reversing operations and decentration, will know that it is the same because the cylinder can be made into a ball again (reversibility) and because its greater length translates into greater thinness[11].

School-age children use inductive reasoning, which assumes that their individual experiences and premises describe the world as it is. For instance, based on inductive reasoning, a child with three rude friends may conclude that friends are always rude.

4.2. Constructing the Conceptual Representation of the World: Classification

Underlying the development of the conceptual representation of the world is classification[12]. The pre-operational child, who does not yet understand the permanence of properties, determines the properties of an object empirically, and believes that they are specific to that object and the current situation. The ability to divide objects into classes develops at the concrete operations stage, as the child becomes capable of creating objective mental representations of directly experienceable properties of an object, with the term 'objective' meaning unrelated to the object and situation. Classification of objects that enables the child to organise his or her knowledge about the world requires two main operations to be formed: 1) dividing a set into subsets and 2) establishing how the set and subsets are related to each other (class inclusion). For instance, to answer the question '*Are there more girls than children in your class*?', the child has to determine the relationship between the class (children) and the subclass (girls). The preoperational child is likely to compare the sizes of the subclasses (represented by girls and boys) to determine which gender is in majority. The operational child, however, will deduce from the available information that there are more children, regardless of how many boys and girls are in the class.

As their experiences and lexical resources expand, children aged 7-11 years acquire the ability to organise objects according to different criteria, to understand classification hierarchies, and to allocate objects to general and more specific classes and subclasses simultaneously, using different types of comparison.

The hierarchical classification skills that most children acquire between the ages of 7 and 10 years have practical value for pupils who begin to understand and assimilate scientific and social concepts requiring comparisons and dividing living creatures into different groups based on whether they belong to the animal or plant world, etc.

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11 Piaget and Inhelder, 1962.
12 Inhelder and Piaget, 1958.

4.3. Operations on Relationships: Seriation and Transitive Inference

Seriation is the ability to arrange items in a specific order (series) according to a selected criterion, i.e. size, length, height, or weight. Children possessing this ability can organise sticks from the shortest to the longest or according to objects' defining characteristics. Seriation is a prerequisite to understanding concepts such as numbers, time and measures.

Transitive inference is a type of reasoning where prior knowledge is used to establish unknown relationships between objects (if A>B and B>C, then A>C). It enables children in the second half of middle childhood to conclude that John is taller than Sue because he is taller than Mary, who is taller than Sue.

4.4. From Cognitive to Interpersonal Decentration

One significant consequence of preoperational children's egocentrism affecting their social functioning is that they do not see that they are internally different from others; as a result, they have difficulty understanding others' behaviour. The comprehension of why other people behave the way they do develops around the age of 8-9 years, together with the understanding with the reversibility of operations. The ability, referred to as interpersonal decentration, enables children to understand how others perceive the world and that their own perceptions, motivations and feelings may differ from those of other people.

School-age children with interpersonal decentration perceive people more comprehensively and more objectively, which enables them to further consolidate their knowledge of them. As they understand others' needs and expectations better and better, they can make more accurate judgments about what conditions enable cooperation and what is required to act effectively[13].

With the increasing objectivity of children's perceptions of others, their judgments undergo a qualitative change. *Value judgments predominating in 7-8-year-olds are gradually superseded by objective assessments in the second half of elementary school.*

5. The Portrait of a Developing Elementary School Child: Directions of Change

In the second half of middle childhood, cognitive abilities develop rapidly due to the onset of the concrete operational stage. *As children's egocentrism, typical of preoperational thinking, is defused by their interactions with peers, their relationships with them become deeper and richer*[14]. Between the ages of 7 and 8 years, children use summation and induction to make overall assessments of their worth, which will prospectively influence their perception of self within the complex hierarchy of social relations.

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13 Włodarski and Matczak, 1998; Matczak, 2003.
14 See: Rzechowska, 2025, p. 192.: 4.4. From cognitive to interpersonal decentration.

5.1. Identity Development in Middle Childhood

5.1.1. Sigmund Freud's Latency Period

Human psychosexual development has a latency period falling in middle childhood (years 6-7), during which the child's drives and interest in sexuality are repressed or dormant. In that period, sexual energy sublimates into activities such as learning and development of social and communication skills[15]. The child develops new abilities, among which those strengthening the child's ego and protecting from frustration and the fallout of failures are the most important. Sigmund Freud called the abilities defence mechanisms[16].

Defence mechanisms are psychological reactions to unsettling or potentially dangerous situations, which are to reduce the intensity and frustration one feels and increase protection from the consequences of internal conflicts and a sense of guilt.

The defence mechanisms that children in the latency period typically use include:
- rationalisation – justification of failures;
- projection – attribution to others of one's undesirable feelings, attitudes, behaviour and characteristics;
- displacement;
- denial of reality – refusal to acknowledge painful situations;
- compensation – using substitutes for compensating unachievable things;
- regression – return to behaviours from earlier developmental stages;
- sham reaction – behaviours and emotions disguising those actually felt;
- avoidance and withdrawal.

While defence mechanisms do not solve inner conflicts, they help children in middle childhood avoid the pain they bring or make it less intense. The downside of their use is that they address the symptoms of conflicts rather than their causes, so using them repeatedly or for long periods of time can hinder the formation of adaptation mechanisms.

Sigmund Freud's latency period coincides with Erik Erikson's fourth crisis of psychosocial development[17].

5.1.2. Erik Erikson's School Age Crisis: Industry vs. Inferiority

Elementary school-age children (years 6-12) face an industry vs. inferiority crisis. One of the main challenges they face is measuring up to established standards and expectations. For the first time in their lives, they want others – classmates and teachers – to see them as competent and worthy of respect. To achieve it, they strive to develop

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15 In late childhood (stage 4), the development of the child's 'superego' is influenced by his or her strong identification with the parents. As a result, the child adopts their moral imaginations and ideals. A conflict between them and the child's ego can be source of shame and guilt.

16 Freud, 1920; Turner and Helms, 1995.

17 Erikson, 1982.

and perfect various skills, learn new knowledge, and feel pleasure and satisfaction when they can demonstrate their competence and agency. They also begin to make comparisons between themselves and their peers, feel proud and accomplished when they compare favourably to them, or inferior and inadequate when the comparison is negative, which affects their self-esteem. Also, their ability to understand and anticipate the likely outcomes and consequences of their actions and decisions is better than during the previous stage.

A resource of special significance for children is a sense of self-efficacy[18], measuring their belief in successful coping with various challenges. A sense of self-efficacy has different levels, ranging from a general one expressed as an "*I can cope with different situations*" to a specific belief in being able to achieve academically.

Frequent criticism from teachers, unfriendly peers, and excessively demanding, lax, or inconsistent parents entails the risk of the child developing an inferiority complex and having difficulty in social relations.

5.1.3. The Development of Self: Self-Understanding and the Role of Others in Self-Image
New properties of thought processes enable school-age children to see things from others' perspectives, different from their own. With that, they start to consider what other people are thinking, attach more weight to their mental states, notice the perspectives of those with whom they interact, and anticipate the potential consequences of such interactions[19]. The fact that they also become capable of seeing themselves through the eyes of others prompts the formation of their self-image and the emergence of self-concept and self-esteem based on others' opinions. Children in middle childhood view themselves more realistically than they did in early childhood and have better understanding of their strengths and weaknesses. Their self-esteem is determined by the degree to which they meet others' expectations of them (*I am good at school because my parents want me to*), their achievements (*I am not very good at school*), states and experiences (Answering the teacher's questions makes me more uneasy compared with my classmates)[20]. Because children at this age are very dependent on how others evaluate their performance in various fields, their self-esteem reacts to their successes and failures, with the strength of the reaction being related to how important a given activity is for them.

To sum up, the children's self-esteem is shaped by:
• successes and failures in various domains (as pupils, children begin to understand the relativity of their achievements);
• the importance of an activity for the child and others' evaluation of his or her performance (parents' insistence on the child being successful have a defining effect on child's aspirations);

18 Erikson, 1963.
19 Selman, 1980; see §5.2.
20 Ruble, 1983.

- opinions expressed directly (*you are gifted but lazy*) and indirectly *(we do not expect you to have all A's),* from which the child infers about the parents' expectations and their evaluation of his or her achievements.

Although the child's ability to make more independent judgments about self increases with time, they still lack objectivity and are still influenced by others' suggestions and opinions. The child's self-esteem can also be affected by a discrepancy between what the child thinks of him- or herself and the ideal self. Depending on whether such a discrepancy diminishes or boosts the child's self-esteem, the effect can be reduced activity, well-being and self-efficacy, or traumas and conflicts provoked by more realistic judgments of other people[21].

The presence or absence of self-acceptance depends on the child's system of values and whether successes and failures are associated with behaviours, personality traits, or activities that are particularly important for the child. Self-efficacy, the belief that one can accomplish a specific task or goal, is a critical resource in childhood[22]. A substantial difference between perceived self-efficacy and ability makes motivational problems more likely. A pupil believing that his or her math skills are good will probably attempt to do math homework, but one with limited trust in his or her math skills will probably procrastinate, regardless of how good they really are.

As self-efficacy is a self-constructed judgment of one's abilities, children may miscalculate or misperceive what they can really do. Albert Bandura estimated that the optimal level of self-efficacy is equal to, or slightly above, ability[23].

5.2. Acceptance of Social Norms and Rules: Lawrence Kohlberg's Conventional Phase of Moral Development

Moral development of humans involves the gradual discovery of the universal sense of good, changing one's perspective on morality and the basis for moral judgments. In the first phase of moral development (pre-conventional), judgments are guided by individuals' personal interests[24], whereas in the conventional phase (stages 3 and 4), they are made to fit social norms and expectations that one will be able to tell right from wrong, many of which are enshrined in tradition, culture, or codes of conduct.

Children at stage 3 of moral development (good interpersonal relationships) want to be perceived as good and know that praise and appreciation are for those who follow the rules. Believing that a behaviour is appropriate when accepted, liked, and helpful for others, they behave as they think others expect them to instead of pursuing their own activities.

When reaching stage 4 (law and order morality), children become more aware of the wider rules in society and make judgments to uphold them and avoid guilt.

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21 Boyd and Bee, 2019; Harter, 2012.
22 Bandura, 1977, pp. pp. 191–215.
23 Bandura, 1997.
24 See: Rzechowska, 2025, p. 180.: 6.4. Out-of-family care and secondary socialisation.

In that stage, they view a behaviour as good when it respects the law or is accepted by others. When making judgments upon others' actions, not only the motivations behind them, but also the actions' conformity with standards are important.One of Laurence Kohlberg's[25] best-known moral judgment tests[26] required subjects to decide whether Heinz, whose wife was gravely ill and desperately needed a drug he could not afford could steal as this is what a loving husband would do, or risk his wife's life not to commit an unlawful act. In either case, what other people think is right and wrong will influence the choice.

Children in the conventional phase of moral development accept norms but still have difficulty grasping their meaning and do not see how they relate to general values. As a result, they tend to obey the letter of moral rules rather than their spirit[27].

6. Social Development: From a Home Environment To School Life and Peer Relationships

Going to school involves the substantial expansion of the world in which children have lived until then[28]. They increasingly become less dependent on their parents, and display attachment behaviours and spontaneity in emotions more rarely, but parents continue to be a safe haven for them. Children at this age do not yet see their imperfections and do not directly question their decisions and authority, but this does not mean that they fully accept their parents emotionally and mentally. They frequently demonstrate their resistance through nervous or unacceptable behaviours, which turns into overt rebellion in adolescence. Their position in the family hierarchy determines the nature of their interactions with the siblings.

During middle childhood, parents' support and acceptance are still very important for children. At the same time, however, they feel an increasing need to be independent, and peers and non-family adults start playing an increasingly important role in their lives.

6.1. Relationships With Peers
The reliance of young children on adults can be seen in the early school years in their use of adults' criteria to select and evaluate their mates. As adults would, they prefer to associate with peers accepted by adults (parents, teachers), and good grades largely determine a child' popularity with the classmates. Gradually, they establish their own criteria, and their judgments become more and more independent. As well as starting to react to what another person is doing, seeing and experiencing, they also adjust

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25 Kohlberg, 1963, pp. 277–332.
26 See: Rzechowska, 2025, p. 180.: 6.4. Out-of-family care and secondary socialisation.
27 Kohlberg, 1983, pp. 277–332.
28 Rubin et al., 2013, pp. 242–275.

their behaviour to what they know about other people, their expectations, probable consequences of their activities, etc.[29]

Early school children feel a strong desire to belong to a group, which culminates in 9-year-olds. In the case of older children, peers have a stabilising and normalising influence on one another and being accepted by them becomes more important for a child than being accepted by adults. Relationships with peers are a vital source of information for children[30], help them develop social skills they need to communicate and negotiate differences, teach them how to perform various tasks and be popular, what to wear or say, and how to behave. What children learn about relationships and about themselves in relationships with others has a defining effect on their self-image.

6.2. Children's Friendship and the Role of Others

A special form of peer relationships is friendship, defined as a long-term connection between two individuals based on loyalty, intimacy and the mutual exchange of positive emotions[31].

Robert Selman has identified five partially overlapping stages of friendship based on how people at different ages perceive their friends and their relations with them, three of which occur in school-age children[32].

6.2.1. Momentary Playmates (3-7 years)

For 3-7-year-olds, a friend is someone with whom they play. Their friendships usually emerge by chance (e.g. a neighbour's child) rather than as a result of similarities. Children at this stage still have difficulty understanding others' perspectives and assume that other children think like they do, so they get very upset when they find out that it is not so and usually conclude that '*she or he doesn't want to be my friend anymore.*'

6.2.2. One-Way Assistance (4-9 years)

Children in this age group describe a friend as someone who is nice to them (shares a treat, saves a seat on the bus, gives presents, etc.). They are engaged in their friendships, but they do not think a lot about how they contribute to them. Occasionally, they are ready to tolerate someone who is not very nice simply to have a friend. Some may try to benefit from friendship, for instance, by saying things like '*I will be your friend if you do this*!'

6.2.3. Two-Way, Fair Weather Cooperation (6-12 years)

For children between the ages of 6 and 12, a friend is someone who returns favours. Fairness and reciprocity are very important for them, but they define them rigidly, so

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29 Blatchford and Baines, 2010, pp. 227–276.
30 Baley, 1958.
31 Vasta, Haith and Miller, 2004.
32 Selman, 1980.

having done something for a friend, they expect the favour to be returned at the next opportunity. They are ready to terminate friendship if the friend disappoints them. They tend to be jealous and are very concerned about fitting in and not being different from others.

6.2.4. Intimate, Mutually Shared Relationships (9-15 years)

Children in this age interval characterise a friend as someone with whom they can share thoughts and feelings that others should not know. They believe that friends should help each other with problems, seek compromise, and show mutual kindness without 'keeping score' just out of true care for the friend.

As children deepen their awareness of others' perspectives and become able to integrate these with their own viewpoints, they begin to display deeper understandings about other people, their thoughts, feelings and motivations.

6.3. School as the Child's Developmental Environment

The main environments wherein children develop and grow are the family home and school[33]. The decline in the number of informal places for peer interactions, such as yards, has caused contemporary children to have fewer opportunities to spend time together after school[34].

6.3.1. The School Class and Its Informal Hierarchy

After going to school, children soon learn their position in the class. Between the ages of 9 and 10, they start attaching more weight to others' opinions about them, which causes them to actively pursue, sustain, or strengthen a position of significance among their peers. Research on informal classroom structures[35] has shown that pupils have different but relatively stable positions in the class hierarchy. There are typically children who are more popular than others (the 'class stars'), small groups who stick together simply because they enjoy each other's company, and children who exist on the margins of the class, avoiding group activities and often isolated by their peers. Additionally, there are rejected-withdrawn children, who are easy targets for bullies due to their shyness and timidity, and rejected-aggressive children, who are avoided for being loud, intrusive and confrontational. Lastly, there are controversial children, who attract attention, and are both liked and disliked by their peers[36].

There is research evidence that children rejected by peers are more at risk of running into conflicts, experiencing low self-confidence and having adjustment problems[37].

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33 Shaffer and Kipp, 2013.
34 Juul and Oien, 2012.
35 Boulton, 1999, pp. 944–954.
36 van der Wilt et al., 2018, pp. 793–807.
37 Klima and Repetti, 2008, pp. 151–178; Schwartz, 2008, pp. 289–299.

6.3.2. Teacher-Pupil Relationship

To adjust to the school environment, the child needs to possess skills to communicate and negotiate with peers and be able to adapt to the school's rules and requirements. With the beginning of schooling, a new meaningful person appears in the child's life – the teacher – and it is the only time *when the teacher's status is so high*.

The quality of the relationship between the child and the teacher forms the child's self-assessment, self-perception and attitude towards school and school responsibilities. Younger children's perceptions of their teacher and the caregiver are very similar, and central to their relationship is emotional closeness. Children who feel safe in their attachment to the teacher are more willing to participate in school life, have better grades, and are more likely to continue education beyond mandatory levels[38].

6.4. Creating a Supportive Environment for Children: The SELF-REG Method

In addition to its educational function, school also provides an environment where children learn to live in society and self-regulate their emotions. Self-regulation is the ability to manage one's energy states, emotions, behaviours and attention in a way that is socially acceptable and helps achieve positive goals, such as good relations with others, *effective* learning and sustained wellbeing.

The Self-Reg method was created by the Canadian psychologist Stuart Shanker as a tool for parents and teachers of children at different ages[39]. The inspiration for it came from his observations that the conditions in which children develop can adversely affect their nervous systems and that adults can contribute to creating environments that enable children to build the capacity for self-regulation. The method recommends reducing the presence of stressors, creating an environment for children to feel safe again, giving them time to regenerate and helping them find a way of regeneration that is most appropriate for them (depending on the child, sitting quietly or engaging in intense physical activity will work better), teaching children how to recognise their states of arousal, and trying together to find ways to regulate them. As regards teachers, they have to make sure that the learning environment does not overwhelm pupils (has few visual and sound distractors, discourages unhealthy competition, presents errors as an opportunity to learn, and promotes mutual kindness) and organise activities bearing in mind pupils' mental and emotional states.

Stuart Shanker defined five critical domains of self-regulation and formulated recommendations addressing each of them in the school context:
- biological domain – fostering a sensory-friendly environment, taking account of pupils' sensory difficulties, making sure that their physiological needs for food, drink, physical activity, etc. are met;
- emotional domain – creating space for emotions such as curiosity, joy, peace; addressing pupil's emotions; helping them modulate negative emotions (anger, fear, frustration, etc.); addressing emotions and situations that trigger them;

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38 Hamre and Pianta, 2001, pp. 625–638.
39 Shanker, 2021.

- cognitive domain – choosing tasks of appropriate difficulty, explaining them, dividing them into parts as needed, presenting materials at the right pace, reducing distractors, ensuring that class activities are predictable and allowing pupils time to switch between activities; building on their natural sensitivity, talents and interests, helping them understand things that make learning easy or difficult and coping with stress;
- social domain – building a friendly atmosphere of mutual understanding in the class; promoting cooperation and discouraging competition (which tenses up the atmosphere); encouraging win-win solutions to conflicts and healthy inter-actions (apologetic or empathetic reactions require a certain level of self-regu-lation to be possible);
- prosocial domain – fostering good relations and friendly atmosphere in the class, creating opportunities for children to take care of one another; making them realise their strong points and uniqueness, and helping each child to feel attractive and important.

Shanker also emphasised the importance of caregivers and teachers being aware of their emotional states and how they express them because of their influence on children's capacity for self-regulation.

7. Common School-Age Problems

Among the typical problems experienced by school-age children are emotional and behavioural disorders[40] and learning difficulties[41].

7.1. Internalising and Externalising Disorders

Internalising disorders or overcontrolled behaviours include anxiety, depression, somatic conditions (occurring without any specific organic cause), withdrawal (avoidance of social interactions (social anxiety) and difficulty experienced in social situations.

Children with overcontrol can be overcautious in new or challenging situations, shy in contact with others, underperform at school, and feel that others do not appre-ciate them enough. Feeling anxious, they obey rules, which earns them the opinion of nice and controllable children. In tension-laden situations, however, these usually passive kids can explode with uncontrolled outbursts of emotion. The punishment they receive for such reactions is usually proportional to the surprise they have caused, so they withdraw even more.

Externalising disorders (undercontrolled behaviours) stem from a limited ability to control emotions and cause the outward expression of personal problems. They can

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40 See: Achenbach, 1982: internalising and externalising problems.
41 Prinstein et al., 2019.

have the form of criminalised delinquent behaviours or incompliance with the school rules (skipping lessons, swearing, lying), maladjustment behaviours (ignoring group rules, participation in informal groups) and disrespect for social norms (aggression against people and/or property, provoking conflicts).

Many children are affected by both types of disorders at the same time. Their impact is infrequently further compounded by dysfunctional relationships with peers, thought problems implying obsessive-compulsive or anxiety disorders, etc., and attention problems, with symptoms varying depending on their cause[42].

Children with Attention Deficit Hyperactivity Disorder (ADHD) are characterised by poor attention control and/or hyperactivity and impulsiveness, which impair their normal functioning[43]. It is estimated that about 5% of children have ADHD, with family and twin studies pointing to genetic changes as a significant factor in developing the condition[44].

Children with impaired control of attention have difficulty, and therefore avoid, completing activities that require sustained attention (conversations, reading, etc.), fail to follow instructions (which prevents them from completing schoolwork and other assignments, etc.), and are disorganised (have poor sense of time, problems with keeping things tidy or completing work in an orderly manner). They are also inattentive to detail, easily distractible and forgetful. Their hyperactivity manifests itself through excessive movements such as fidgeting or squirming, getting up when expected to be seated, having trouble sitting still, running around, climbing on things, replying before a question has been completed, and interrupting others.

The academic and social challenges faced by children with ADHD are enormous. Compared to non-ADHD children, they have poorer grades and score lower on tests; their expulsion and retention rates are higher; and they are more likely to drop out of school[45]. Unsurprisingly, they are also less popular with peers and usually avoided by them[46].

Among interventions developed to assist children with ADHD are social skills training, behavioural treatment, cognitive behavioural therapy, parent and teacher education, recreational programmes and lifestyle changes[47]. Depending on the severity of their condition, pharmacological treatment may also be recommended.

7.2. Learning Disabilities

Learning disabilities are developmental disorders impeding the acquisition of reading (dyslexia), writing (dysgraphia) and calculating (dyscalculia) skills by children.

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42 Wysocka and Ostafińska-Molik, 2014, pp. 131–151.
43 APA, 2013.
44 Burt, 2009, pp. 608–637; Gizer, Ficks and Waldman, 2009, pp. 51–90.
45 Loe and Feldman, 2007, pp. 643–654.
46 Hoza et al., 2005, pp. 411–423.
47 Clay, 2021.

Dyslexia is a functional impairment of the ability to read and write. Children with dyslexia have difficulty *mentally processing* printed and handwritten words, so completing written schoolwork and reading *is a challenge for them*. Dysgraphia involves physical problems in writing letters and figures, which cause handwriting to look careless and frequently make it illegible. Akin to dysgraphia is dysorthography, which hinders remembering the correct spelling of words and reproducing them in writing. The last of the learning disabilities is dyscalculia, which makes it more difficult for children to learn or comprehend arithmetic (understand and manipulate numbers, perform calculations, etc.)[48].

It is important to note that children with learning disabilities are in the normal intellectual range and do not show any symptoms of delayed mental development or lack of motivation. The causes of their problems have not yet been precisely identified, but they are usually attributed to genetic determinants, micro-injuries to the central nervous system, emotional disorders (stress, traumas and experienced aggression), poor economic conditions, the parents' child-raising model, the school environment and teachers' attitudes, inadequate teaching methods and irregular cognitive development.

8. Safe and Stimulating Educational Environment

The world in which contemporary school-age children develop is marked by the ubiquitous presence of digital technologies. Technological advancements and the evolution of family and social life models create ample opportunities for children to expand their potentials, but one has to be aware that they also involve risks for children, e.g. a risk of violence, from which they should be protected[49].

8.1. Safe Educational Environment: Schools Without Bullying

Bullying refers to a form of peer violence characterised by the repeated and prolonged exposure of an individual to harmful actions by one or more others. These negative actions are intentional and aimed at causing physical, emotional, or psychological harm. They can manifest through direct physical contact, verbal abuse, or other forms of aggressive behaviour intended to inflict discomfort or injury[50]. There are different types of bullying, including verbal bullying, which is saying or writing nasty things, teasing and name calling, taunting, threatening, or making inappropriate sexual comments. Social bullying, also referred to as relational bullying, involves spreading rumours, purposefully excluding someone from a group, or embarrassing someone on purpose. Physical bullying involves hurting a person's body or possessions. A type of bullying that deserves special attention is covert bullying, consisting of repeated

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48 Swanson, Harris and Graham, 2014.
49 Turner and Helms, 1995.
50 Olweus and Limber, 2010, pp. 124–134; Olweus, 2013, pp. 751–780.

hand gestures, weird or threatening looks, whispering, excluding people or turning back on them, or restricting where they can sit and to whom they can talk. Covert bullying is more difficult to counteract because it is less conspicuous and, therefore, harder for children to prove[51].

The development of digital technologies creates more possibilities for children to interact and communicate with their peers. Unfortunately, digital means of communication are also increasingly used by cyberbullies for distributing malicious content, creating fake profiles, posting embarrassing pictures and videos, or texting and emailing vile rumours. Cyberbullying is more 'effective' and, therefore, more harmful and dangerous than 'traditional' bullying because victims can be targeted round-the-clock without having to be physically present, and messages and images can be distributed anonymously, so they are hard to track back to the source and delete[52]. Cyberbullying increases the risk of its victims experiencing physical bullying, skipping school, and having poor grades. They are also more likely to consume alcohol and drugs to de-stress and have health issues. Physical bullying frequently turns into cyberbullying or vice versa, or both forms of harassment occur alternately or simultaneously – ridicule at school moves online[53].

Each type of bullying is incredibly hurtful and painful for the victim, which should be kept in mind especially in the context of indirect violence, which is much more difficult for adults to notice and for the child to prove. Bullying significantly lowers a child's self-esteem, destroys his or her sense of self-worth, takes away a sense of security and confidence; instils a strong sense of loneliness in the child, makes the child anxious, tense and stressed; negatively affects academic performance; can lead to school phobia, the development of depression or anxiety disorders, and in extreme cases can even lead to suicide.

Developed by Dan Olweus, the Olweus Bullying Prevention Program (OBPP) is a comprehensive, school-wide initiative designed to reduce bullying and improve peer relations among students in elementary, middle and junior high school grades. The program operates at the individual, classroom, school and community levels, offering a comprehensive approach to addressing the issue. OBPP includes the identification and support of both victims and perpetrators of bullying, the implementation of intervention strategies and the promotion of positive behaviours within the school environment. The program also introduces staff training, clear anti-bullying policies and regular monitoring of bullying incidents. Collaboration with parents and the community reinforces the actions taken within the school. Research has shown OBPP's significant effectiveness in reducing bullying, improving peer relationships and enhancing the overall school climate, making it one of the leading bullying prevention programs.

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51 van Geel, Vedder and Tanilon, 2014, pp. 435–442.
52 Pyżalski, 2012.
53 Halliday et al., 2022, pp. 110–123; Salmivalli, Sainio and Hodges, 2013, pp. 442–453.

8.2. Talent Management

Today, there is an increasing tendency to depart from the long-lived concepts of talents and educational concepts sorting children out into 'talented' and 'less talented' to ensure that each group is optimally supported[54]. One reason for this is the observation that some children have natural abilities well above average for their peers, others are gifted in any area of ability, in more than one area, or at different levels, and still others have talents as well as disabilities (e.g. autism or hearing loss).

Another reason for redefining the approach to seeking talented children is the results of neurobiological research and socio-technological changes in the environment in which they develop. Residing in the world of computers, video games, and smartphones, today's school children tend to consume or merely process contents delivered by others, rarely being active contributors or creative authors.

Contemporary education still focuses on imparting knowledge and measuring teaching effectiveness based on standard scales, tests and grade systems. The emphasis of schooling is not on developing pupils' potential, talents and interests but on fitting their activities into the framework of institutional requirements. Gerald Hüther and Uli Hauser called this approach in their *Jedes Kind ist hoch begabt[55]. Die angeborenen Talente unserer Kinder und was wir aus ihnen Machen* (2012) 'mind formatting and a waste of talents'. They proposed replacing the traditional attitude to identifying above-average children with the belief that all children are talented and gifted, and emphasised the importance of thorough examination of their talents. They also indicated that children should be provided with conditions supporting their creativity, curiosity and ingenuity and enabling them to explore the world on their terms.

9. Summary

Middle childhood is a complex period in human life in which children take on new roles and engage in new social relationships. Their good start in school is determined by school maturity and readiness for reading and writing (psychomotor, vocabulary, conceptual and emotional-motivational readiness).

In the younger school years, children's cognitive abilities develop at a fast pace. As their attention, perception, memory, and learning processes become increasingly conscious, controlled, and purposeful, they become more effective in achieving their individual or team goals set by the teacher, caregiver, or mates.

The age of around 6-7 years marks the beginning of a new stage of cognitive development called concrete operational thinking. The ability to reverse operations and decentrate that children acquire in this period allows them to grasp the concept of conservation of quantity, perform operations on classes and relationships, and

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54 Piirto, 2021.
55 Hüther and Hauser, 2012.

develop logical reasoning skills (inductive reasoning and transitive inference). These new powers are important for children's social functioning, as they allow them to take others' perspectives and thus understand that their states and those of other people are not the same, perceive motivations behind human behaviour, and integrate and objectivise their knowledge about the world and people.

These changes are associated with the development of children's identities and the formation and enhancement of their relationships with others. In middle childhood, children engage in various explorations resulting from the sublimation of their sexual energy, accompanied by defence mechanisms that play a positive role at this stage of their development (Freud's latency period). They also learn to be productive and accept others' judgments on their performance (Erikson's industry vs. inferiority). Comparisons of their own and others' expectations, achievements, states, and experiences become a basis for them to build their self-image, and their self-concept, self-esteem and self-efficacy are shaped by what others think of them. Their wider perspective on the world and people is reflected in their moral judgment-making, in which they consider social norms or external expectations (Kohlberg's conventional phase of moral development, stages 3 and 4).

In the early school years, children transition from a life focused on the family to a life concerned with peer relationships and school life, and separate more from the parents but still perceive them as their safety net. They feel a strong need to be part of a group of peers, the interactions with whom enable them to develop social skills and the capacity for self-identification. A special type of a relationship with peers is friendship, which can manifest itself in various forms (Selman's transient playmates, one-way assistance, two-way, fair weather cooperation and intimate, mutually-shared relationships).

The school follows the family home as the children's primary developmental environment. The quality of teacher-pupil relationships and the informal class structure, etc., form children's self-perception and self-evaluation as well as their attitude to school and pupil responsibilities. Caregivers and teachers can significantly contribute to the creation of an environment supportive of children's development (Shanker's SELF-REG method).

Among various problems faced by school-age children, the most frequent are those associated with emotional and behavioural disorders (internalising and externalising disorders, ADHD, etc.) and learning disabilities (dyslexia, dysgraphia, dysorthography, dyscalculia).

For a school environment to be safe and educationally stimulating for children, measures preventing or protecting them from peer harassment (bullying, cyberbullying) and effective identification and support of talented children are important.

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│ CHAPTER 8 │

Psychosocial Milestones in Adolescence: Key Developmental Tasks

Ewa RZECHOWSKA

ABSTRACT

Sexual maturation in adolescence is an intense process involving hormonal alterations, the appearance of secondary sex characteristics, and structural and functional changes in the brain.

The basis and precondition for adolescents' changing psyche is the transition from concrete to formal thinking, enabling hypothetical thinking, combinatorial thinking with deductive or inductive reasoning, abstractive thinking, and metacognition. With formal thinking, the ability to contemplate oneself and others appears, leading to the emergence of adolescent egocentrism, criticism, philosophising, making life plans, etc.

During adolescence, various aspects of identity involved in shaping both the individual and social self, become integrated. Core components of identity are established, autonomy is expanded, and the processes of identity formation and differentiation unfold. As adolescents develop their own personal systems of self-defined standards, they reorganise their self-concept, gaining a sense of integration and autonomy. Biological changes trigger the formation of gender identity, and some adolescents begin to regulate their behaviour based on abstract principles and values.

In adolescence, young people increasingly form enduring and deep relationships outside their family homes. Friendships with peers of both genders take more advanced forms, and a new type of closeness associated with romantic involvement emerges, preparing adolescents to build mature relationships.

Adolescents revise the circle of people they once considered as meaningful as new sources of role models appear. Parents and teachers lose the status of authority figures, although they frequently maintain some influence on young people's choices of role models. Adolescents increase demands on their parents to allow them more freedom and control over their lives and put them to various tests to see if they can accept and are ready to support them.

Adolescence can compound emotional and digital addictions affecting young people and increase their risk of becoming juvenile delinquents.

KEYWORDS

adolescence, puberty, formal operational thinking, identity development, status of identity, gender identity, post-conventional phase of moral development, peers, friendship, romantic relationship, parents, developmental disorders

1. Introduction

In adolescence, being the second decade of human life, young people undergo intense changes influencing their biology, cognitive abilities, identity, and social relationships. As a result, they start contemplating what kind of people they want to be and seeking their place in society.

2. Biological Changes in Development

Adolescence is a tumultuous period of life because of the multitude of developmental changes transforming the human body. One of these changes is gonadal and behavioural maturation related to the pubertal transition to adulthood.

2.1. Puberty Hormones, Secondary Sex Characteristics and Body Changes

Puberty is a biological process of sexual maturation that culminates in reproductive competence[1]. It tends to be considered as the defining event in human life, as it initiates the passage from childhood to adolescence[2].

During puberty, boys and girls experience rapid increases in both height and body mass, a phenomenon known as the pubertal growth spurt. Girls enter puberty at a younger age (8-13 years) than boys and reach their adult height between 10 and 16 years of life. In boys, a rapid body growth starts at a slightly older age, usually when they are 10-16 years old, and stops between the ages of 13 and 17. The adult height of both boys and girls is determined by their genes and external factors such as diet, medication taken, diseases, etc.

Adrenarche and gonadarche are two stages of pubertal maturation, during which the hypothalamic-pituitary-adrenal axis is activated, and the hypothalamic-pituitary-gonadal axis causing gonadal activation is reactivated, respectively. The activity of puberty hormones usually starts between ages 7 and 13 in people assigned female at birth, and between ages 9 and 15 in those assigned male at birth. The onset of puberty occurs at a slightly different time for each individual.

Puberty is initiated when the brain starts sending hormonal signals to the gonads: namely the female ovaries and male testicles. While before puberty only the external sex organs, referred to as primary sexual characteristics, distinguish boys from girls, its onset is followed by the emergence of sexual dimorphism related to the development of secondary sexual characteristics, which further differentiate the sexes. Follicle-stimulating hormone (FSH) and luteinizing hormone (LH) instruct the ovaries in females to begin producing oestrogen, one of the primary female sex hormones, and eggs. As a result of puberty hormones, girls grow taller, put on weight

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1 Sisk and Foster, 2004, pp. 1040–1047.
2 Steinberg, 2008, pp. 78–106.

and muscle mass, begin to menstruate, and develop fuller breasts and wider hips than boys. Body hair starts to grow on their legs, in the armpits and pubic areas, emotions may become more volatile and intense, and acne more prevalent. Body odour can be stronger too. In boys, puberty hormones stimulate the testicles into producing testosterone, the male sex hormone, and sperm. In addition to growing taller and putting on weight and muscle mass, boys develop larger sex organs and become capable of ejaculation (releasing sperm). They too develop body hair on their legs, in their armpits and pubic areas, suffer from acne or other skin problems, and may produce stronger body odours.

As well as contributing to significant changes in adolescents' secondary sexual characteristics, sex hormones may also have an effect on their ability to learn, their intelligence, memory, and behaviour.

2.2. Brain (Prefrontal Cortex) Changes and Their Psychological Consequences

Puberty gives rise to significant changes in brain structure and function. During this period, the developing brain increases its dimensions and mass, its cells differentiate and mature, myelinisation occurs, and new connections between various brain structures are formed. At the same time, the surplus synapses are regressively eliminated.

An important role at this developmental stage is played by the rapidly accelerating synthesis of sex hormones, such as oestrogen, progesterone and testosterone, which stimulates myelinogenesis, leading to the isolation of axons, etc[3].

The prefrontal cortex is one of the last regions of the brain to reach maturity (its full maturity is only observed at the age of around 25 years), which seems to explain why some adolescents act immaturely[4].

Covering the front part of the frontal lobe of the cerebral cortex, the prefrontal cortex determines the individual's ability to make rational judgments in challenging situations. Its responsibilities include cognitive analysis, abstract thinking, moderating behaviour appropriately to social contexts, and aligning thinking and actions with the goal to be achieved. All these operations are enabled by data received from all the senses.

MRI examinations have shown that the frontal lobes of the adolescent brain contain less white matter (myelin) than the adult brain and that its amount increases during puberty[5]. The process involves the growth of major neurocircuits, which facilitate the distribution of information among the regions of the brain. These observations have inspired the concept of frontalisation, according to which the prefrontal cortex develops to regulate behavioural reactions initiated by the limbic structures. The maturation of the prefrontal cortex and limbic structures improves self-control, facilitates communication between the brain's hemispheres, and gives access to a

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3 Arain et. al., 2013, pp. 449–461.
4 Bancroft, 2011.
5 Buyanova, Arsalidou and Cerebral, 2021.

resource of analytical and creative strategies for resolving complex dilemmas. The signs of the abnormally slow maturation of the newly emerging structures include risky and impulsive behaviour potentially leading to accidents, the use of drugs, risky sexual choices, as well as affective disorders[6].

2.3. The Psychosocial Consequences of Puberty

The changes that adolescents observe as they undergo puberty cause them to start assessing and comparing their bodies with their preconceptions of themselves and the bodies of their peers, or with the prevalent standards of beauty and behaviour. As they look more adult than they did before, their parents and other people start to treat them accordingly.

Early or delayed puberty affects the functioning of boys and girls differently. Premature puberty is less of a problem for boys, and its delayed onset has a weaker effect on girls[7].

2.3.1. Girls

Early maturing girls have to come to terms with somatic changes, including menstruation, which can make them feel embarrassed and uneasy as they are not ready for them. Remarks about their appearance, whether rude or complimentary, can also be disconcerting for them. Their misleadingly adult appearance may provoke inappropriate comments, encouraging them to engage in premature sexual activity.[8] The inconsistency between their appearance and their mental preparedness for it can cause the onset of many adverse consequences, including lower self-esteem, identity building problems, emotional disorders, greater distrust in others, diminishing popularity with peers, which sometimes leads to behavioural and eating disorders. Girls who mature early tend to be perceived by adults as mature grown-ups and, consequently, are expected to behave accordingly. On the other hand, later maturing girls rarely experience adjustment problems. Their developmental changes are less conspicuous, and their similarity to their peers makes it easier for them to adjust and function in the community.[9]

2.3.2. Boys

Premature maturation is less problematic for boys. Early-maturing boys are taller and have a stronger physique than those who mature late. They have more positive perceptions of their bodies, believe in their strength and resilience, and their parents grant them more privileges and allow them more independence. Because of the self-assertion and independence that they demonstrate, they are usually popular with peers

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6 Arnett, 1999, pp. 317–326; Forbes and Dahl, 2010, pp. 66–72; Patton and Viner, 2007, pp. 1130–1139; Paus, Keshavan and Giedd, 2008, pp. 947–957 ; Steinberg, 2008, pp. 78–106; Pfeifer and Berkman, 2018, pp. 158–164; Romer, Reyna and Satterthwaite, 2017, pp. 19–34.
7 Boyd and Bee, 2019.
8 Mendle, Turkheimer, Emery, 2007, pp. 151–171.
9 Turner and Helms, 1995.

and become leaders within their social groups. However, they are also more at risk of using psychoactive substances and starting their sexual life early[10]. Boys who mature late are unhappy about their bodies. Their peers tend to see them as children and their requests and needs are often left unaddressed. They are usually less good at sports than their peers because they are weaker than them, and they also make less attractive mates. As a result, they are frequently isolated and targeted as scapegoats[11].

3. Cognitive Changes: Piaget's Formal Operational Stage

Changes taking place in an adolescents' psyche are predetermined by and based on the development of formal operational thinking.

3.1. Characteristics of Formal Operational Thinking

Early adolescence involves the gradual development of formal operational thinking, i.e., the ability to use interiorised pictures, signs, mathematical and logical symbols, etc., unrelated to perceptions, experiences, and beliefs, with each link of the reasoning chain being examined in the context of the problem at hand[12].

At this stage of development, young people become capable of hypothetical thinking, combinatorial thinking with deductive or inductive-reasoning, abstract thinking, and metacognition.

Hypothetical thinking enables the individual to draw conclusions, not only from what can be seen but also from what is hypothetical based on interiorised data; the reasoning it involves moves from what is concrete to what is possible, probable or conditional ("if", "may be...", "assuming", "what might be"). Hypothetical thinking is more than just a thinking process for considering options; it is a logic-based system designed to construct hypotheses, make evaluations, formulate rules, and draw conclusions based on a systematic and logical examination of possibilities to produce many potential answers.

Combinatorial thinking underlies hypothetical-deductive reasoning and inductive reasoning, which combines and evaluates potential options in each situation. Hypothetical-deductive reasoning enables inferences from the general to the specific, and inductive reasoning in the opposite direction.

Abstract thinking is a type of advanced reasoning about concepts that lie beyond the physically observed, which enables a range of mental operations, such as recognising patterns, analysing ideas, synthesising information, solving problems, and creating things.

Formal operational thinking also participates in metacognition, i.e., thinking about one's thought processes, including thinking about one's self.

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10 Kaltiala-Heino et al., 2001, pp. 346–352.
11 Turner and Helms, 1995.
12 Inhelder and Piaget, 1970; Vasta, Haith and Miller, 2004.

One of the experiments developed to measure a person's level of formal operational thinking makes use of a pendulum[13], consisting of a length of string and a set of weights. The experiment requires indicating which of the three variables – the length of the string, the heaviness of the weights, and the strength of the push – determine the frequency of the pendulum's swing. To be able to answer that the length of the string is both a necessary and sufficient determinant of the swing, the person being tested must systematically examine all possibilities, which requires their reasoning to transition from what is possible to what is true.

3.2. Adolescent Egocentrism: Imagery Audience and Personal Fable

Adolescent egocentrism is the tendency of adolescents to focus on their thoughts while contemplating what others think about them. It is related to excessive self-awareness and the inability to draw a line between the perceptions of other people and one's own views, which are considered the only possibility[14].

Unlike children, adolescents understand that people differ in how they see things and think about them. According to David Elkind[15], egocentrism appears in adolescents as they start to show interest in what others think, while still being unable to separate their presumptions from others' actual concerns.

Adolescent egocentrism consists of two important aspects, namely the imaginary audience and the personal fable[16].

3.2.1. The Imaginary Audience

Adolescents believe that they are in the focus of others' attention and everything they do is assessed, judged, and scrutinised. As a result, they persistently analyse what others would think about their behaviour in various situations. Being very self-critical, they assume that other people share their critiques and worry that they know about and focus on their weaknesses as much as they do. Even the most innocent comment coming from this imaginary audience can either boost their self-respect and self-confidence or throw them into despair. With the imaginary audience in mind, adolescents concentrate on their appearance and the possession of fancy gadgets. They also behave noisily and engage in risky behaviour to be noticed by and impress others.

3.2.2. The Personal Fable

The term was coined by David Elkind to describe a state corollary to the imaginary audience. The personal fable refers to a belief typical of adolescents that they are unique (thus beyond others' comprehension), omnipotent (endowed with special authority, powers, or influence), and invulnerable (resistant to harm and injury, and even

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13 Inhelder and Piaget, 1970.
14 Galanaki, 2017; Turner and Helms, 1995.
15 Elkind, 1967, pp. 1025–1034.
16 Alberts, Elkind and Ginsberg, 2007, pp. 71–76.

immortal)[17]. The belief weakens impulse control in adolescents, frequently causing them to engage in risky behaviour, since they are undaunted by consequences.

Adolescent egocentrism appears in early adolescence (11-12 years), peaks in 14-15-year-olds, and diminishes with the development of formal thinking and the establishment of interpersonal intimacy.

3.3. Non-Cognitive Consequences of the Emergence of Formal Operational Thinking

Formal operational thinking underlies the ability to consider what is abstract, hypothetical, and goes beyond the present, and to reflect on oneself and the world in new ways[18].

The development of formal operational thinking in adolescents is headed by:
- criticism: noticing that people's behaviour and their principles may diverge (criticism, hypercriticism, and reflectiveness) and that adults have weaknesses;
- dreaming and making life plans: envisioning one's future separately from the present reality;
- creativity: writing poems, memoirs;
- philosophising: an inclination to delve into moral and social issues and worldviews;
- interest in literature: studying symbols, metaphors, and the meanings of words; examining literary techniques; the use of irony, humour, and abstract notions;
- temporal integration: an ability to integrate past, future and present events (thinking in terms of historical chronology).

4. The Portrait of a Developing Adolescent: Directions of Change

The developmental changes in adolescents primarily influence their relations with other people (due to separation and autonomy building). Adolescence is also the time when young people are building their identities, searching for the meaning of life, deepening relationships, experiencing friendship, and building their first relationships in pursuit of their own social niche.

4.1. Identity Formation: Individuation Process of Adolescence

Identity formation in adolescents is associated with the development of their internal, subjective understanding of who they are as individuals. Through the process they perceive themselves more and more as distinct and independent entities and build their own sense of agency as they gain the capacity to use increasingly complex tools to meet their needs[19]. Among the key components of identity are distinctiveness

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17 Galanaki, 2017.
18 Dolgin, 2011.
19 Brzezińska, Ziółkowska and Appelt, 2019.

(a sense of being unique and disparate from others), continuity (a sense of being the same over time), and coherence (a sense of being similar across life domains) are indicated most frequently[20].

According to Margaret Mahler's concept of separation-individuation, a child's personality is formed through the relationship with their mother (a close caregiver) during the first three years of life, which gradually evolves from a symbiotic relationship to a stable individual identity[21].

Peter Blos[22] modified Mahler's concept, suggesting that the separation-individuation stage in childhood can be a precursor to a "second individuation" in the period of maturation. According to Blos, while the primary outcome of the first separation-individuation stage is the child's ability to make a distinction between "I and not I" (the child's awareness that he or she exists as an individual), the second individuation builds a sense of identity that closely corresponds to Erikson's[23] notions of the consolidating ego identity[24].

Blos concluded that adolescence is the time when earlier developmental changes that had gone astray or ended prematurely are modified or corrected[25]. Psychological restructuring related to the second individuation has an ultimate effect on an individual's adult personality and self-awareness[26].

A child progressing from a symbiotic relationship with the mother to separation from her also develops internal regulatory abilities, which are supported by developmental changes in adolescence. The individuation of adolescents is a reflection of structural changes accompanying the child's emotional separation from their figures of attachment. Successful separation is a prerequisite for the individual to be capable of finding intimate partners in the future.

4.2. Erik Erikson's Crises of Adolescents: Identity or Role Confusion

The fifth stage of Erikson's theory of psychosocial development, falling between the ages of 12-18 years, is referred to as the identity vs. role confusion crisis[27]. The crisis initiates identity formation in adolescents and requires synthesising and integrating earlier integrations into a new identity, uniquely one's own, in order to be solved. The 12-18-year olds painstakingly review their values, beliefs, and goals in the search for a sense of self and identity. The period when they consider social roles to find one that will offer them uniqueness and "try on" different roles and groups to identify

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20 van Doeselaar et al., 2018, pp. 278–288; Meeus et al., 2012, pp. 1008–1021.
21 Mahler, Pine and Bergman, 1975.
22 Blos, 1962.
23 Erikson, 1963.
24 See: Rzechowska, 2025, pp. 218-220.: 4.2. Erik Erikson's crises of adolescents: identity or role confusion.
25 Blos, 1962.
26 Blos, 1979.
27 Erikson, 1980.

with, known as a psychosocial moratorium, enables them to form cohesive, positive identities that will allow them to contribute to society[28].

Finding a positive solution to the identity vs. role confusion crisis depends on the adolescent's readiness to accept their own past and establish a continuity with previous experiences. The search for an identity comes to an end with the adolescent finding answers to questions such as "Who am I?", "Where am 1 going?" and "Who will I become?". The adolescent must develop a commitment to religious beliefs, vocational goals, a philosophy of life and accept their own sexuality. These components of an ego-identity are essential for the emergence of sexual and affectionate love, deep friendship, and personal self-abandon without fear of losing ego-identity. They enable adolescents to progress to the next stage in the human life cycle, namely intimacy versus isolation[29].

Adolescents who fail to find their identity experience self-doubt, role diffusion, and role confusion, which may lead to a self-destructive preoccupation or activity. Some may continue to be morbidly preoccupied with what others think of them, while others may throw away others' opinions and take to drugs or alcohol in order to calm the anxiety of role diffusion, or withdraw. In its most severe form, identity diffusion may lead to suicidal ideation and suicide attempts.

Adolescents are more likely to resolve their identity crisis with a positive outcome in social contexts that provides support, guidance, and opportunities for exploration. A supportive family environment plays a key role, as families that offer emotional support, open communication, and encourage independence allow adolescents to explore their identity in a secure setting. When parents are nurturing and provide structure, adolescents are more likely to develop a strong sense of self. Positive peer relationships are also crucial, as peer groups that encourage authenticity and personal growth help adolescents share experiences, experiment with different roles, and receive feedback.

Educational settings that promote personal development, creativity, and critical thinking further aid in the identity formation process. Teachers and mentors who encourage self-discovery can help adolescents explore their interests, values, and goals. Similarly, involvement in community activities, such as clubs, sports, or volunteer work, offers adolescents the chance to engage with broader social networks, fostering a sense of belonging and purpose.

Cultural and societal values that prioritise individual expression, autonomy, and diversity create an environment where adolescents can experiment with different identities without fear of judgment. Societies that offer a variety of role models and multiple paths to success give adolescents more space for positive identity development. Lastly, having access to mentors or role models, whether within the family, school, or community, helps adolescents envision possible future selves and make informed decisions about their identity. All these social contexts work together to

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28 Erikson, 1968.
29 Erikson, 1980.

support adolescents in navigating the challenges of identity formation, leading to a more positive resolution of the crisis.

4.3. James Marcia's Identity Statuses

While Erikson laid an identity resolution on the continuum between identity and role confusion, Marcia concluded that adolescents or young adults formed four qualitatively different identity statuses, which he defined based on whether or not their formation involved the stages of exploration and commitment[30].

At the exploration stage, adolescents 'put on' different social roles, test their capacities in new situations, and experiment with themselves and their environment to determine their abilities and preferences. In this process, they deepen their self-awareness and sometimes redefine their attitudes, beliefs, values, or social relations. At the commitment stage, adolescents are ready to make decisions about themselves and their actions and take on responsibility for their consequences. The plans, goals, values and beliefs they develop give a direction and meaning to their future lives[31].

The identity theory developed by James Marcia suggests that adolescents experience various identity statuses throughout adolescence. The timing of these statuses can differ from person to person, but the general process includes the following stages:

- *diffused identity*: individuals with this status have not yet committed to developing their own standards, values, or goals. They tend to exhibit inconsistent behaviours, often imitating those around them. This status is typically observed in early adolescence (around 12-14 years old), when young people have not yet begun exploring their identity or making significant life decisions;
- *foreclosed identity*: individuals in this status adopt behavioural patterns and ideologies from role models without critically examining them. They tend to idealise these models (whether groups or individuals) and adhere rigidly to their choices. This status may emerge in early to middle adolescence (around 14-16 years old) and is characterised by adopting an identity without prior exploration, often conforming to the expectations of parents or society;
- *moratorium identity*: those in the moratorium status are actively searching for their personal life path. They test themselves, challenge reality, explore new possibilities, frequently shift interests, and sometimes fluctuate between conflicting ideologies. This stage typically appears in middle to late adolescence (around 16-19 years old) and is marked by an ongoing exploration of various options without committing to a specific set of values or goals;
- *achieved identity*: individuals with this status have undergone a period of exploration and have come to understand who they want to be, what values they prioritise, and what worldview they hold. They are committed to their life plans and pursue them with consistency. This status is usually reached in late

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30 Marcia, 1966, pp. 551–558.
31 Marcia, 1980, pp. 159–187.

adolescence or early adulthood (around 18-21 years old), when a person solidifies their identity by making long-term commitments.

These timeframes are approximate, as identity development is a personal process that progresses at different rates for different individuals.

Achieved identity enables satisfactory completion of early adulthood tasks. Only individuals who have developed a relatively stable and strong concept of their self and life can form relationships with other people without fearing for their independence and individuality. Having clear priorities and the motivation to accomplish them are a guarantee of their responsible and steadfast pursuit of life goals. This mature attitude increases their odds of having successful familial and professional lives in the future.

4.4. The Development of Self: Self-Determination and Autonomy

In contrast with children in middle childhood who tend to build their self-concept around the opinions of meaningful persons, adolescents begin to develop their own standards and assemble them into a system of references, which they use to compare their judgments with other people's opinions, whose importance steadily diminishes[32].

With the development of abstract thinking, the adolescent's self-knowledge becomes a source of information about who they are, resulting in the re-organisation of the knowledge they have accumulated thus far. External feedback, which once had the status of a final judgment, still plays a role, but rather as one out of a selection of factors to consider. It is notable that an adolescent's increasing ability to make self-judgments is not necessarily associated with their greater objectivity[33].

The perception of one's social self, i.e., the awareness of who we are for others, defining one's social relationships and position becomes important. The role of self-knowledge extends beyond its participation in behavioural self-regulation, because it is also engaged in seeking social groups or social roles worth identifying with, planning the future, or trying to control the course of events. As adolescents develop their ability to look further into the future[34], they start transforming their needs and motivations to align themselves with their long-term goals and revisit and modify their past experiences so that they correspond to their present-day self-image, sometimes with the help of defence mechanisms[35]. The vulnerability of adolescent emotions and feelings causes their self-image to be very volatile because they are uncertain about their bodies[36] and their attractiveness, as measured against prevalent standards[37].

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32 Brzezińska, Ziółkowska and Appelt, 2019; Boyd and Bee, 2019.
33 See: Rzechowska, 2025, p. 216.: 3.2. Adolescent egocentrism: imagery audience and personal fable.
34 See: Rzechowska, 2025, p. 217.: 3.3. Non-cognitive consequences of the emergence of formal operational thinking.
35 See: Rzechowska, 2025, p. 193.: 5.1.1. Sigmund Freud's latency period.
36 See: Rzechowska, 2025, pp. 222-223.: 4.5. Gender identity formation and sexual orientation.
37 Boyd and Bee, 2019.

Among the various elements of identity, self-esteem is the most fragile and vulnerable to emotions. Its changes may have a bearing on an adolescent's relationships with their parents and peers.

In the adolescent years, teenagers advance from control by adults over their activities to partly autonomous activities, and finally gain full control over them. During the process, their consolidating and integrating attitudes are formed into worldviews, compliance with the expectations of others turns into independent decision-making and taking responsibility for their consequences, and wilful criticism gives way to openness to rational arguments.

4.5. Gender Identity Formation and Sexual Orientation

Gender identity formation begins with the identification to a particular gender manifested through behaviours specific to that gender, and ends with the identification to that gender's social roles[38].

The early signs of developing gender identity are observed in two year-old boys and girls, who begin to choose different toys to play with. Older children, aged 3-7 years, start noticing behavioural differences between genders. Sexual self-awareness and related gender identity become apparent in middle childhood. In the pre-adolescent years (10-12), boys and girls associate in separate groups where they have many opportunities to learn more about their and the other gender, about masculinity and femininity, and the differences between the genders. By the end of this period, boys and girls start dating in groups and organising mixed-gender meetings, which pave the way for romantic relationships and help adolescents acquire the ability to maintain them.

Pre-adolescence is the period when young people seek models to identify with, embrace mass culture and their peers' opinions, consolidate attitudes to their own and the other gender, show interest in sexuality, the sexual organs and their functions, and consider the differences between male and female maturation. These interests are intellectual and free of emotional engagement or sexual desires[39].

The course of maturation during which young people discover and explore sexuality is different between boys and girls. In boys, sexual curiosity concentrates on sensual experiences and opportunities for sexual contacts, whereas girls usually show more interest in the emotional aspects of romantic relationships.

Until around 17 years of age, psychological and social maturation lags behind sexual maturation. An adolescent's interest in the opposite sex and mixed-sex peer groups create opportunities for first-time friendships with erotic undertones, sexual initiations, and pre-intimate relationships. Mixed-sex peer groups also provide adolescents with feedback regarding their relationships. Their behaviour in the period of sexual maturation depends on what standards of sexuality they have adopted and how integrated their self-image is.

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38 Steensma, 2013, pp. 288–297; Boyd and Bee, 2019; Oleszkowicz and Senejko, 2013.
39 Kar, Choudhury and Singh, 2015, pp. 70–74.

At around 18 years of age, the spheres of emotional character and sexual activity integrate, initiating the fast development of an adolescent's gender identity along their hierarchy of values, and influencing future sexual choices.

Insufficiently formed sexual identity may hinder the expression of one's sexuality. The stages of homosexual identity formation are well covered, *inter alia*, in the works by Vivienne Cass[40] and Susan R. McCarn and Ruth E. Fassinger[41], who conducted studies with boys and girls, respectively[42].

4.6. Abstract Principles and Values: Lawrence Kohlberg's Post-Conventional Phase of Moral Development

The second – conventional – phase of moral development involves gradually advancing acceptance and interiorisation of social norms and rules[43]. In the third, post-conventional phase[44], an individual's moral perspective is wider in the sense that judgments are made according to ethical principles of conduct, which may or may not be reflected in the law, rather than conventions or popular opinions. Morality is defined by abstract principles and universal rules guiding human behaviour.

In the fifth phase of moral development (social contract orientation), abstract reasoning is used to find moral grounds for potentially questionable decisions (stealing a drug for the sick wife is right because laws can be unjust, one has to consider all aspects of a situation, choosing life is right regardless of the law)[45]. As laws and rules are perceived in this phase as flexible tools intended to serve human purposes, it is admissible to reject them when they are inconsistent with individual rights and the interests of the majority and do not benefit people.

In the sixth phase (universal ethical principle orientation), the morality and appropriateness of decisions and actions is judged upon self-chosen ethical principles of conscience, which are abstract and universal in application. This type of judgment is formulated taking into consideration the perspectives of all individuals or groups that are likely to be affected by it (saving a human life is more important than an infringement on someone's property rights – the Heinz dilemma).

There are young people whose moral development never progresses to the post-conventional phase of moral development, just like not everyone attains the formal operational stage[46].

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40 Cass, 2015.
41 McCarn and Fassinger, 1996, pp. 508–534.
42 See: Hall, Dawes and Plocek, 2021, pp. 1–19; Bandel and Wycisk, 2021, pp. 229–250; Długołęcka, 2005; Bancroft, 2011.
43 See: Rzechowska, 2025, pp. 195-196.: 5.2. Acceptance of social norms and rules: Lawrence.
44 Kohlberg, 1963, pp. 277–332.
45 Heinz dilemma.
46 Turner and Helms, 1995.

5. Relationships With Peers, Friendships and Romantic Relationships

Children's close bonds are by and large limited to the members of their families and friends. As they reach adolescence, they begin to build more enduring and deeper relationships with people outside their family settings. Now, closeness to friends and mates is enriched with a new category: closeness in romantic relationships.

5.1. The Role of Peers and Groups

Children's early relationships with their peers are motivated by a need for social interaction and practicing interpersonal skills[47]. For adolescents, relationships with the entire peer group defining their social self are more important[48].

The development of an adolescent through membership in a peer group largely depends on the degree to which he or she is accepted by the group, the group's rules, and their interiorisation by the adolescent. Peer groups usually establish their own culture with distinctive symbols, wear, behaviours, and communication patterns that all members must adhere to. Being part of a group's culture strengthens an adolescent's identity and sense of distinctiveness[49], as well as supporting them in becoming autonomous individuals.

Contacts with peers provide adolescents with opportunities to find out about their opinions, role models, and worldviews and to choose some for themselves from those consistent with the rules and values they were taught at home. Discussions and disputes with peers are also a training ground for expressing and defending views[50]. By interacting with other members of the peer group, adolescents expand their knowledge of themselves, other people and the world, become more self-accepting, experience closeness and support, and work out patterns of functioning in future close relationships[51]. Relationships with peers are therefore critical for an adolescent's development and enable them to establish a hierarchy of values, attitudes, interests, aspirations, and life plans.

Peer group membership gives many benefits to adolescents, such as greater self-esteem, a sense of security, shared interests, the acquisition of life skills, and an understanding of group solidarity. However, some can be double-edged. For instance, a sense of solidarity with group members may turn into a dislike towards outsiders, and high self-esteem may encourage audacious behaviour.

A peer group is not the equivalent of a family, but in some circumstances it can become its substitute. Adolescents' susceptibility to peers' influences depends on their personal traits and the nature of their relations with other family members.

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47 Schaffer, 2004.
48 See: Rzechowska, 2025, pp. 221-222.: 4.4. The development of self: self-determination and autonomy.
49 Brown and Larsen, 2009, pp. 74–103; Obuchowska, 2004; Rubin, Bukowski and Laursen, 2009.
50 Obuchowska, 2006, pp. 163–201.
51 Hartup, 1992, pp. 175–205.

Their pursuit of new experiences and the readiness to follow peers contribute more strongly to their risky behaviours than each of the factors alone[52].

The norms adopted by a peer group usually override those promoted by adults when they come into conflict.

5.2. Friendship

Of the five overlapping stages in the development of friendship proposed by Robert Selman[53], two occur in adolescence[54]. These are:

5.2.1. Friendship as Intimate, Mutually Shared Relationships (9-15 years)

Friends in this age bracket exchange secrets they would not share with anyone else and help each other to solve problems. They are ready to compromise and exchange favours without "keeping a score," because they genuinely care about each other.

5.2.2. Friendship as Autonomous Interdependence (12+ years)

Adolescents aged 12 or older value trust, support and emotional closeness with friends. They are ready to accept and even appreciate differences between themselves and their friends. As they are less possessive than younger children, they tend to be less concerned over their friends' other relationships.

For adolescents who lack support and emotional closeness at home, even their first, immature friendships can help fulfil basic emotional needs and foster the development of relational skills and the ability to face challenges.

5.3. Adolescent Romantic Relationships

According to Harry S. Sullivan[55], the need for intimacy appears between the ages 9 and 12, when "a child begins to develop a real sensitivity to what matters to another person"[56]. In girls, an interest in boys and attempts to attract their attention appear when they are 12-14 old, at which age their male peers still pass time in the company of other boys and need two more years to take an interest in the opposite sex[57]. At this age, adolescents have a strong desire to be part of a popular 'gang', but the intensity of this need decreases as they grow older[58]. Same-sex peer groups, common in middle childhood, develop in adolescence into mixed-sex peer groups[59], whose members frequently become romantic partners[60]. Mixed-sex groups are friendly environments where young people learn to interact and help each other, as well as protecting them

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52 Romer, Reyna and Satterthwaite, 2017, pp. 19–34.
53 Selman, 1980.
54 See: Rzechowska, 2025, p. 197.: 6.2. Children's friendship and the role of others.
55 Sullivan, 1953.
56 Way and Silverman, 2012, pp. 91–112.
57 Żebrowska, 1980.
58 Furman and Shaffer, 2003, pp. 3–22.
59 Dolgin, 2011.
60 Connolly, Furman and Konarski, 2000, pp. 1395–1408.

from premature sexual activity. Early romantic relationships are based on companionship and doing things together, and involve enchantment or fascination with the partner, who is frequently idealised[61].

Romantic relationships teach adolescents to express their needs and recognise their partner's expectations and desires, effectively communicate with a partner, cope with difficulties, etc. These skills enable them to deepen and stabilise their relationships, experience the intimacy of emotional closeness, and take responsibility for themselves and their partners[62].

Adolescent romantic relationships tend to be short-lived and uncommitted. Yet, their significance should not be ignored. They engage a lot of an adolescent's time and give them more positive and negative feelings than friendships, family relationships, or school life[63]. They also support adolescents in identity formation, influence relations with family members and peers, and enable emotional and behavioural adjustment.

6. The Role of Parents and Community During Adolescence

Maturation can be described as the time when young people redefine their dependence and independence in relation to parents, peers, society, and institutions, etc. Adolescents start to change as they become aware of various social and cultural expectations. They begin to rethink themselves in relation to others but also re-examine how others relate to them. Their newly established personal standards make them replace their authority figures with new ones[64]. New social and educational environments, meetings with new people, the Internet, films, television, literature, the arts, social media, etc. create new role models for them (e.g., influencers). Parents and teachers lose their status as authority figures, but can still influence the adolescent's choice of a role model.

Adolescence is a transition period between childhood and adulthood, meaning that adolescents are neither. Their needs are very similar to those that adults have, but the possibilities they have of satisfying them are limited. People expect them to behave as if they were adult but control their attempts at independence, which they believe is reserved for adults[65]. Finding their relations with the parents to be out-of-date, adolescents try to renegotiate and transform them, which often leads to conflicts and tensions when both parties have different perspectives on the family hierarchy shifts.

As they believe that their feelings and emotions are beyond an adult's understanding, adolescents attach less and less value to an adult's knowledge, criticise

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61 Shulman and Kipnis, 2001, pp. 337–351.
62 Brzezińska and Piotrowski, 2010, pp. 265–274.
63 Furman and Shaffer, 2003, pp. 3–22.
64 See: Rzechowska, 2025, pp. 221-222.: 4.4. The development of self: self-determination and autonomy.
65 Bakiera, 2009.

their views, and question their authority. Quite naturally, they stop trusting adults and seek confidants among their peers. They protest when their parents interfere in their lives, restrain their emotions, reject signs of fondness, rarely ask for help and reluctantly accept it. At the same time, they test their parents in many ways to see if they accept, understand and support them and perceive parental boundaries as an expression of parents' concern[66]. An adolescent's changeable moods, attitudes, and emotional reactions are frequently perceived with ambivalence by their parents and make them feel inadequate and unnecessary. In many cases, adolescents are unaware of the causes of their behaviour.

Adolescents should be aware of what is expected of them and that their performance is consistently monitored[67]. When their goals seem to reflect wishful thinking and ignore the realities of life, parental supervision is necessary. However, it must be inconspicuous, arise from a genuine interest in the child's world, give the child as much freedom as is wise and rational given the child's needs, independence and autonomy, and communicate the strength of the parent's bond, trust, and acceptance of the child[68].

7. Difficulties and Disorders in Teenage Years

The ongoing social and cultural changes influence young peoples' experience of their daily lives. The biological, personality, and relational transformations taking place during adolescence make it a critical stage on the way to adulthood. The recent COVID-19 pandemic had even aggravated the disorders and difficulties experienced by adolescents. Emotional disorders can manifest themselves in many ways, including through:
  • irrational fear and anxiety (over one's future, a relationship, health, etc.);
  • depression impairing emotional functioning (low moods, irritability, anhedonia, a sense of guilt), cognitive functioning (attention focus problems, fatigability, pessimism, helplessness, negative perceptions of events), and behavioural functioning (withdrawal, sleepiness, having less interests, suicide attempts[69]);
  • eating disorders associated with an overconcern with the body, appearance and a distorted self-image. Girls are more likely to develop anorexia (food restriction causing physiological and psychological disorders) and bulimia (episodes of binge eating followed by compensatory behaviours, such as self-induced vomiting or the use of laxatives), while boys are more likely to develop bigorexia, an obsession with having a muscular body, leading to intense exercising and the use of anabolic steroids;

66 Fuller, 2000.
67 Blum and Rinehart, 1997, pp. 37–50; Lee and Lok, 2012.
68 Olubiński, 2002.
69 Prinstein et al., 2019.

- risky behaviours and the use of drugs (usually marihuana), alcohol, and sex[70];
- self-harm and suicide attempts, usually provoked by depressive disorders[71].

Another group of problems observed among adolescents is related to cyberbullying[72], digital addictions (video games, compulsive scrolling, activity on social media, etc.), and juvenile delinquency[73].

The motivations for juvenile delinquency can include financial gain, a desire to impress others and gain acceptance, and a sense of impunity, among other factors. They are usually associated with the inability of the adolescent's family to meet his or her basic needs (due to family breakdown, parents abusing alcohol, etc.), poor school grades, or a desire to be accepted by an informal group, usually one representing some youth subculture[74]. The age limits exempting minors from criminal liability and the catalogues of offences vary internationally. In Poland[75], minors committing offences when younger than 17 years of age are not criminally prosecuted unless, (1) the offence involves heavy bodily harm, a gang rape, an incest rape, or any other specified criminal act and the offender turned 16, and (2) the offender is aged between 17 and 18 years. In the other cases, educational, therapeutic, or corrective measures are applied in lieu of criminal penalties.

Adolescence is the time when children developing into young adults experience many problems, whose impact can be intensified by their evolving cognitive and emotional spheres. Some adolescents will not develop self-control skills, emotional stability, or the ability to make rational judgments about acts, events, and their consequences. Because of an adolescent's desire to be accepted by others and their susceptibility to inspirations coming from individuals or groups they value, their guilt for the acts they commit is frequently difficult to measure. The fair consideration of charges against juvenile delinquents should, therefore, involve an evaluation of the level of their development and the degree to which their environments may have contributed to their wrongdoing.

8. Summary

Adolescents face numerous developmental tasks, including understanding their gender's roles, developing identity, gaining personal, emotional and social independence, redefining ties with the family, taking relationships with peers of both genders to a new, more mature level, becoming ready for a relationship, learning socially

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70 Arnett, 1999, pp. 317–326.
71 Grzegorzewska, Cierpiałkowska and Borkowska, 2020.
72 See: Chapter 3, §7.1.
73 Odgers and Jensen, 2020, pp. 143–149.
74 Hołyst, 2001.
75 Kozłowska, 2011.

acceptable behaviours, and developing an attitude of responsibility[76]. All these tasks help adolescents find their place in society.

Sexual maturation in adolescence is an intense process involving hormonal alterations, the appearance of secondary sex characteristics, and structural and functional changes in the brain. Early and late maturation has different implications for boys and girls, including varying levels of parental control and expectations based on their perceived maturity.

The basis and precondition for changes in an adolescent's psyche is the development of formal operational thinking. Transitioning from concrete to formal thinking enables adolescents to think beyond the 'here and now', and abilities such as hypothetical thinking, combinatorial thinking with deductive or inductive reasoning, abstractive thinking, and metacognition appear. [77] With formal thinking, reflecting on oneself and others (analysing one's own and others' psychological states) becomes possible, paving the way for adolescent egocentrism (imaginary audience and personal fable[78]), criticism, philosophising, making life plans, etc.

During adolescence, the various aspects of identity participating in the construction of the individual and the social self integrate: the core components of identity are defined, second individuation takes place (Blos), and identity is formed (identity vs. role confusion crisis – Erikson) through different processes (there are four identity statuses: diffusion identity, foreclosed identity, moratorium identity, and achieved identity (Marcia). The emerging personal system of standards enables the reorganisation of an adolescent's self-knowledge, self-integration, and expansion of autonomy. Biological changes initiate the formation of gender identity. Some adolescents acquire the ability to regulate their behaviour using abstract principles and values (post-conventional phase of moral development[79]).

An adolescent's relationships with people other than their family members grows stronger and more enduring. A new type of closeness – romantic relationships – appears in addition to relationships with peers of both genders and advanced forms of friendship (friendship as an intimate, mutually shared relationship, and friendship as autonomous interdependence[80]).

In adolescence, young people revise their circle of authority figures to make room for new role models. Parents and teachers are less respected but can still influence an adolescent's choices of role models. As well as increasing demands on their parents to allow them more freedom and relax control over their lives, adolescents put them to various tests to see if they accept them and are ready to support them.

Adolescence can compound emotional and digital addictions affecting young people and increase their risk of becoming juvenile delinquents.

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76 See: Havighurst, 1981; Brzezińska, Ziółkowska and Appelt, 2019.
77 Piaget, 1970.
78 Elkind,1967, pp. 1025–1034.
79 Kohlberg, 1963, pp. 277–332.
80 Selman, 1980.

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Developmental Trauma: The Effects and Signs of Traumatic Events on Children, and Its Implications

Noémi VIGH

ABSTRACT

Trauma is a concept that has grown so popular in the last years that sometimes it can be considered overused and losing its weight. However, it is still popular in self-help literature, common speech and does not seem to gain its rightful place among mental health or other professionals, despite its groundbreaking neuroscientific and evolutionary background. It would be important for professionals to understand the relevance of this framework and its scientific basis, use it in contexts where it can be relevant, and even bring long awaited reforms and changes. So 'the baby should not be thrown out with the bathwater', meaning that trauma should not be neglected, just because it has become "too fashionable". In this chapter I will help to understand the basics and the relevance of this framework, focusing on developmental trauma that is revolutionary in our understanding of symptoms, dynamics and treatment of mental health issues affecting both children and adults. The whole developmental period of a human, and how it is affected by upbringing and other early age experiences has its implications for the rights and legal protection of children and childhood in general, thus it would be more than useful to obtain a common understanding among social, educational and legal professionals.

1. The Educational "Tale" of Developmental Trauma

The human brain is a magical organ that has evolved to serve our survival and reproduction in a complex and unique way. This can explain many human experiences that at first we cannot easily grasp, and this will be the perspective which will help us to understand the essential importance of developmental trauma. Also, to begin this chapter let us see a bit how our brain works. We became humans due to our constant and endless capability of learning. Our neuronal patterns can store almost unlimited amounts of information and we know that the best way to add new knowledge is to

help us picture it and connect it to already existing information bricks whilst spice it up with some emotion. Our ancestors could survive from a shared knowledge of their community which they heard in a form of emotionally presented tales. Thus, it is much easier for us to remember an event in our favourite TV series presented to us with excitement, and happening to known characters, rather than trying to remember a textbook chapter full of important facts but not much else. So, allow me to try to tell you the "tale" of developmental trauma, then give you some scientific background and legal world implications.

Once upon a time human infants came to the world as a member of a hunting, collecting tribe. This community formed a unity to cope with the challenges of life. Humans did not grow huge teeth, or camouflage in the form of fur, in order to survive. They did not stay so small that they could easily hide or learn to run the quickest to escape. Instead they developed a brain to live in a learning community that could look after each other and develop better tools for the purpose of gaining nutrition and staying alive, as well as to be able to raise their very vulnerable infants in an environment where they could ensure their survival.

As a result, the brain of a newborn, inserted into the framework of these circumstances, was wired to soak in all the information that would be needed to become an accepted and useful member of this community, so ensuring the individual's survival. All the feedback an individual received from their emotions, behaviours, and reactions were guidelines to what was safe and what could bring danger from the outside world or of being excluded from the group. The reactions of the surrounding adults taught the brain when to switch on to survival mode: ie: fight, flight or freeze. Since risk was not only present from, say a sabre-toothed tiger, but also the anger or disappointment of the caregivers could prove fatal, the brain of the child learnt to be sensitive to the signs of these reactions and switch on the appropriate reaction that seemed useful. This "guideline" would be remembered for the individual's whole life.

Automatisation is also a wonderful skill of our neurobiology, and this whole process became automatic and unconscious: ie: searching, noticing and storing information of appropriate behaviour in the group and implying it automatically and unconsciously on an emotional, and behavioural and often also on a cognitive level.

Centuries passed and in our western society the adult community around an infant is mostly a nuclear family, but the process remains the same. Babies are born and they learn from their caregivers what is safe and what is dangerous, how one is supposed to act, think and feel. The most important thing is to stay alive, so any life-threatening event has an essential message about what to learn about life: how we can avoid the reoccurrence of such situations.

What is life threatening for a child? By all means, we can imagine every possible human or natural catastrophe, and it is true that these often have a long term effect on the psyche of a child (or an adult). However, to a vulnerable and weak little creature so many more things can be terrifying. For example, if the mother is often angry, or not present, or the father is unpredictable, or the neighbourhood is

dangerous, and people are tense or aggressive. In order to survive in any environment, a keen awareness of the smallest sign of someone becoming angry or aggressive is essential, thus allowing the individual to decide whether the best form of protection would be to choose to fight, flee or if nothing else helps, to numb oneself from the expected pain. Under the circumstances where one assumes that they are fighting for their life, ancient survival instincts lead the action and the wild parts of the brain take charge. The civilised and culturally cultivated parts of the brain, that are slower because of the complexity of these thoughts, will not be involved in such a scenario.

If a child grows up in a family where aggression, ignorance or fear is constantly present, their perception will be of dangerous world where life consists of a constant fight for survival. These instinctive survival behaviours will be easily activated in school, friend groups and during adult life.

2. The Scientific Ground of the Concept of Trauma

Nowadays we think that being traumatised means that one's brain is shaped to a higher level of survival mode by a single or recurring event, and the earlier this happens the more generalised and unconscious the consequences are.[1]

Trauma and its long lasting, life changing effects received public attention mainly during the last century. The word trauma has its origins in ancient Greek, and it means wound. It already describes that we are referring to the long lasting scars that a particularly heavy experience leaves on one's soul.[2] World wars, soldiers with PTSD (Post Traumatic Stress Disorder), and catastrophic events affecting large groups of people have shown professionals a group of typical symptoms and proved that this is a mental health issue that merited research. Over many years and a lot of research, and thanks to the technology of modern neuroscience, psychiatrists and psychologists have begun to understand the neural system's background of symptoms and have realised that the reactions and changes in the body, and especially in the neural system itself can explain many phenomena that had been previously described by mental health professionals. [3]

Guiding attention towards traumatic experiences in childhood during the 1990s, Vincent Felitti and Robert Anda conducted The Adverse Childhood Experiences (ACE) study, in which they compiled data from 17,421 HMO (health maintenance organisations in the US) patients. Participants filled in a questionnaire of ten questions about whether they had experienced enumerated ACEs, including verbal and physical maltreatment, sexual contact with an adult, witnessing violence against their mothers, and having parents addicted to drugs or alcohol. Based on the

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1 Van Der Kolk, 2002, pp. 381–392.
2 Gohara, 2018, p. 13.
3 Van Der Kolk, 2020, pp. 165–189.

affirmative answers, the participants were assigned an ACE score of zero to ten. 87% of the respondents scored two or more, and the researchers also noticed that the higher a patient's score, the larger the likelihood of adult life difficulties, such as relationship and employment difficulties, substance abuse, chronic depression, and suicide attempts. [4]

Slowly mental professionals began to recognise a similar dynamic behind PTSD and the consequences of traumatic experiences among children. This perspective offered a new explanation to some well-known phenomena that psychology had previously observed. It offered a new perspective on attention disorders, issues with closeness or trust or emotional regulation and many other issues that had developed during childhood and could affect the whole life of a person. [5]

2.1. Definition

Since the 1990s the literature and scientific background on trauma has been growing rapidly, giving rise to numerous nomenclature and definitions.

Harris and Fallot [6] summarised it, in saying that trauma is an experience that occurs when an external threat overwhelms a person's internal and external positive coping resources.

According to SAMSHA (Substance Abuse and Mental Health Services Administration),[7] individual trauma results from an event, a series of events, or a set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has long lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.

I would like to use trauma here as a word referring to the consequences of a traumatic event where the person experiences an overwhelming situation to which their capacities are not enough to cope, and it elicits the emotions of fear, helplessness, hopelessness, terror and is often a subjective threat to the person's survival. It should also be added here that witnessing or becoming aware of such a seriously threatening event or series of events can be traumatic to others.[8]

The triggering events are not necessarily violent, but they do violate the person's sense of self and security. [9] It is important to note from the very beginning, that an event that is not traumatic to one individual can easily be threatening and traumatic to another who gets triggered by their own perception and experience of that specific event. This difference can be the result of different previous experiences, capacities to cope, and personal interpretations. [10]

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4 Gohara, 2018, p. 14.
5 Perry, 2019.
6 Harris and Fallot, 2001, cited in Evans and Graves, 2018, p. 2.
7 SAMSHA Trauma Definition, 2012, cited in Evans and Graves, 2018, p. 2.
8 Gohara, 2018, p. 14.
9 Randall and Haskell, 2013, p. 507.
10 Mogyoróssy- Révész, 2021, pp. 89–95.

3. Basics of Evolutionary and Neuroscientific Background

The reason why trauma scientifically seems to be a very beneficial framework is that the neurobiological and evolutionary background is well established and continuously researched. Trauma symptoms can also be described by the neurobiological consequences of the traumatic event or series of events, and the way that those influence behaviour. Our brain is an organ to serve our survival, and experiences sculpt it to try to be the best in this task. The brain "gets ready to try to avoid another threatening event". [11] In evolutionary terms it means a constant readiness to automatically fight or flight, or a numbing response to any "look alike" triggers, and it can eventually result in overreactions to perceived threats, such as anxiety, depression, emotional detachment. [12]

I would like to highlight an important theoretical alteration at this point. In traditional psychology, psychiatry professionals often considered these symptoms to be pathological. Our up-to-date understanding of these mechanisms suggests that we need to change this perspective and realise that these are in fact normal responses for abnormal events, an adaptation to cope with heavy experiences in life. We should not consider the consequences of (developmental) trauma disorders but reordering.

Neuroscientists have proved that[13] trauma changes the brain's pathways that direct cognition, impulse control, empathetic understanding, the regulation of emotions, perception of threat, the ability to differentiate the past, present and future, and the filtering of information. If this happens early on in a lifetime, it generally alters development and compromises healthy ways of growing up.[14]

Evolutionary consequences of a traumatised nervous system can be observed in two different behavioural pathways.[15]
- hypervigilance (a heightened state of awareness)
- dissociation (numbing and detachment).

In a hypervigilant state, if one perceives something threatening, their judgement will be impaired because the quicker, but evolutionary older "emotional brain" will react instead of the cognitive based executive regions. Repeated and early exposure to trauma can set this as the default stress response, and this way the "fight or flight" reaction (that is adaptive when someone is actually in danger) will govern responses to everyday situations and undermine judgement. This generates an overly alerted state which also damages impulse control, the differentiation of past and present moment, and ensures that the main focus is solely on survival.[16]

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11 Perry, 2019, pp 29–41.
12 Gohara, 2018, p. 13.
13 Van Der Kolk, 2020, pp. 189–203.
14 Perry, 2017.
15 Van Der Kolk, 2020, pp. 59–97.
16 Perry, 2019, pp 135–165.

Numbness is the final evolutionary response to an unavoidable threat; it makes a person detached from emotions and the present moment because it is too overwhelming to handle. Recurrence of such experiences can result in the chronic prevalence of this state. The phenomenon of dissociation describes a state where one is *distancing* themselves from their own physical sensations, by getting themselves into a depersonalised and numb state in order to cope. Often it creates an escape to an imaginary world, or cognitive distancing from emotions but shutting down entirely from interactions is also possible. In worse case scenarios it can cause a sort of distancing from one's own or someone else's emotions, leading to a complete lack of empathy that can create the foundation for criminal, aggressive behaviour but also an incapability to save oneself and entering a cycle of becoming a victim repeatedly. [17]

In everyday life, these symptoms can lead to a lessened capacity to cope and connect, a misunderstanding of social cues, only paying attention to possible harmful signs, ignoring friendly or positive cues and caring behaviour. Hence the world soon turns into a hostile and dangerous place, where it is not safe or smart to handle situations in a peaceful way. It can even lead to the individual's unconscious conclusion that there is no sense in trying to handle such problems at all but instead would be better to turn towards an external numbing and controlling of these states with alcohol or drugs. [18]

All these behaviours can be labelled by society as problematic and criminal. Therefore, injured people can easily get marginalised and surrounded only by similarly hurt people which strengthens the maladaptive patterns in each other.

Possibly traumatic events show a wide diversity: human and non- human causes, violence, sexual abuse, physical assault, neglect, witnessing violence, war, natural catastrophe, serious injuries, accidents, loss of loved one, medical procedures etc. However, we need to be aware that trauma is an individual experience, the same event can be traumatic to one person but not to another. Thus, we need to take individual experiences into account, and not externally judge an event to be or not to be traumatic.[19] As for the victims we can say that people from any socioeconomic background can experience trauma, but marginalised and vulnerable members of society are at greater risk to develop traumatic responses.[20]

People with different resilience levels, coping profiles, or social support can develop many different types and levels of impaired functionality. Once again, we need to bear in mind that they might seem to be a decrease in their ability to cope, but in fact these are normal responses to an abnormal event. From this perspective, even our way of looking at mental disease can be drastically changed, because very often the history of a person who is suffering from different psychological symptoms contains traumatic events that explain their way of reacting.[21]

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17 Van Der Kolk, 2020, pp. 97–117; Randall and Haskell, 2013, p. 511; Gohara, 2018, p. 21.
18 Gohara, 2018, p. 22.
19 Evans and Graves, 2018, p. 2.
20 Randall and Haskell, 2013. p. 508; Perry, 2019, pp 291–311.
21 Evans and Graves, 2018, p. 2.

3.1. PTSD and Developmental Trauma

As with any growing field, the science of trauma is getting more and more differentiated, and today we distinguish *single, chronic and complex or developmental traumas.*[22] Some of the above are already well described phenomena of psychiatry and psychology.

A well-defined point in time when trauma began to be seen as a more established phenomenon was World War I, when the conceptualisation of PTSD began. Professionals first attributed "shell shock", which described unusual psychological symptoms appearing among soldiers resulting from their exposure to the battlefield and combat experiences. Examination and descriptions continued with the medical treatment of veterans throughout the Second World War, but the real breakthrough arrived with the analysis of Vietnam veterans. The concept of PTSD entered the "civil world" by scientific and self-help literature that wrote a lot about trauma as a consequence of sexual insult, rape or domestic violence.[23]

In recent times PTSD has become a well-established diagnostic criterion in DSM V[24] (currently used diagnostic directory handbook of mental diseases)

Simple PTSD is a neurophysiological response to a traumatic event that has occurred once. It has three typical types of symptoms:

• *re-experiencing* phenomena: intrusive thoughts, rumination, flashback
• *avoiding/numbing*: avoiding anything that reminding of the traumatic events, even thoughts, emotional numbing, withdrawing from relationships:
• *hyper arousal response:* being alerted to danger, irritable, overly alert, lack of concentration[25]

ACE and other research among children has shown us that developmental or complex trauma tends to be more extensive than simple PTSD. It can affect brain development, attachment patterns, and self-capacities, such as self-regulation and coping mechanisms. Complex trauma is a result of a group of precarious and damaging events that cause traumatic shock, disruption in one's development, and the interruption of primary attachment bonds.[26] The symptoms in this case can be summarised in six core categories:

• *affect dysregulation*: modulating emotion and impulse.
• *changes in consciousness*: dissociation, attention deficit, overly alerted
• *altered self-perception*: shame, guilt, responsibility.
• *relation to others*: difficulties in establishing and maintaining intimate relationships, difficulties with trust.
• *somatisation*: stomach pain, headache or even more complex physical issues
• *alterations in system of meaning***:** hopelessness, unable to find purpose [27]

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22 Randall and Haskell, 2013. p. 507.
23 Gohara, 2018, p. 22; Van Der Kolk, 2020, pp. 13–29.
24 American Psychiatric Association, 2022.
25 Randall and Haskell, 2013. p. 511.
26 Ford, et al., 2012 cited in Evans and Graves, 2018, p. 2.
27 Randall and Haskell, 2013. p. 511.

In this chapter we will focus on complex or developmental trauma, because it is a relatively new concept that tries to define the interconnected effect of experiencing abuse, violence, and neglect repeatedly in close family relationships during childhood.[28] Additionally it has important consequences in our society, our legal and education systems, but also in our personal daily life. Childhood trauma as we see it, causes disturbances on many important levels that can determine one's happiness, or satisfaction in life, but also in one's ability to adapt to society. It can slow down the development of a child and interfere with all levels of functioning during its early years. However, it remains prevalent later in social connections, emotional regulation, and all forms of attachment and communication. [29]

The early years of a child are mostly determined by interactions with its caregivers, and later with the wider community such as siblings, friends, school teachers etc. Thus, it would be essential while raising the future generations to cooperate, and support each other as adults around children to ensure that they grow up in a stable safe environment.[30] Cooperation can be a lot better if we establish a common understanding of what is happening to a "problematic" child, and how adverse experiences can shape one's brain and behaviour

4. Bad or Misbehaving Child?

Learning about the outcomes of a trauma helps us to understand how a child with a difficult background can develop symptoms that can be considered "bad behaviours" by those who do not understand the nature of these mechanisms. For example, experiencing constant fear impairs concentration and performance, and can make them seem emotionally detached. It is important to understand that "problematic behaviour" or symptoms of children are usually signalling that something is imbalanced inside or around them. Sometimes it is just a temporary issue, for example difficulty, a bad day, not enough sleep or hunger. However, if these symptoms are prevalent for longer periods or the actual symptoms change but a healthy balance does not return, we should suspect that something more severe is affecting that child.

The symptoms that we should notice can be apparent on many levels. [31]
- *Cognitive:* memory problems, poor verbal skills, difficulty focusing or learning at school, too slow or poor skill development, development learning disabilities,
- *Behavioural* excessive temper, demanding attention through both positive and negative behaviour, regression, acting out in social situations, screaming or crying excessively, easily startled, tantrums, withdrawal, ignoring others, anxious behaviour (for example biting nails)

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28 Van Der Kolk, 2020, pp. 165–189.
29 Beyer, 2006, p.1216.
30 Perry, 2019, pp 291–311.
31 American Psychological Association, 2018 cited in Evans and Graves, 2018, p. 4.

- *Psychological/emotional*: unable to trust others, development of new fears, nightmares, fear of being separated from caregiver, withdrawn, loss of interest in normal activities, irritability, sadness, anxiety, etc.
- *Physiological symptoms*: poor appetite, overeating, weight change, digestive problems, difficulties sleeping, enuresis and/or encopresis, etc.

For an underlying dynamic that can help us understand the process of developing such difficulties we need to return to the evolutionary survival instinct. A child needs their caregivers to ensure their survival, so feeling angry or disappointed towards them can seem very dangerous. The problem is that anger is an automatic response if something feels dangerous. If this emotion arises in a human infant, but it is risky to express it and it seems to serve survival more if directed inwards, then it transforms into shame, anxiety and self-blaming. This way it makes it possible to adapt to the caregivers. The unconscious belief will thus be created, that the child or later the adult is responsible for any mistake and should blame themselves for difficulties. It leads to a strong lack of trust. This causes multiple issues and suffering in many people, in spite of the fact we know now, that it is a natural way of self-protection after being abused or not protected from violence. [32]

We can summarise that following traumatising experiences, the basics of autonomy, trust and exploratory behaviours in children are impaired. [33] The responses and typical symptoms, although individual in nature, will be different at a younger age than later in life. Toddlers and infants mostly react with increased irritability, sleep disturbances, strong emotional reactions towards separation, regression in toilet habits or speech, physical complaints, loss of appetite or food hoarding. [34]

Later the symptoms can also change in the short- or long-term, where numbing and social withdrawal can be followed by acting out or anxiety, tantrums, aggression. Both externalising and internalising behaviours can occur simultaneously.

Disturbed attachment behaviours are very common, not only among young children but also teenagers and adults, who can also be clingy, angry towards the returning caregiver or loved one, as well as ignoring, neglecting etc.[35]

5. Protective or Supporting Environment

It is important to briefly mention what constitutes a healthy and healing surrounding for a child. The basic idea of healthy development would mean ensuring the following mindset for a child: my parents/caregivers love me and accept me, they can and will protect me from harm so I can explore this world that I am curious about, and

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32 Beyer, 2006, p. 1216.
33 Beyer, 2006, p. 1217.
34 Pressley Ridge Magyarország Alapítvány and University College Leuven, 2022.
35 Beyer, 2006, p. 1218.

eventually I will get strong enough to protect myself otherwise I can always turn to my community for help. [36] In such cases where they grow up undisturbed, children reach developmental and emotional milestones and learn healthy coping and social skills. This happens naturally and automatically if their environment is safe, largely predictable, supportive and stable. If these features are established or re-established around children that are suffering or have suffered from trauma, they can gain a healthier world view, and new, more constructive coping skills. Although the scars they received will not disappear, they can learn to turn tragedy into meaning [37]

Trauma treatment is a complex work that requires the collaboration of parents or foster family with professionals. External and internal safety needs to be established, which helps to handle the fear of abandonment and issues with the subject's own and external aggression.

The goal is to grow resilience. Resilience is the ability to cope with a stressful, in some cases possibly traumatic event, and gives the possibility to learn from adverse life experiences.[38]

Resilience means the positive adaptation of a whole system after losing balance, and among young people, adaptation after negative experiences or risks can include the adaptation of the systems surrounding them such as family, school communities etc. and the system within them, such as the nervous system and immune system. [39]

A healthy childhood makes a person individually more resilient as well, through facing stress and stressful situations that they can cope with via their skills and social support. Eventually they learn the opposite from what they pick up by repeating traumatic events. The resulting knowledge of the world, the self and others will be approximately as follows: The world is a place full of challenges, many of these I am able to cope with even though it seems difficult at first. If not then I can ask for help. I am worthy of other people's love and support. We are always there for each other, and there are situations that I cannot solve but the people around me will stay beside me through the sadness that those situations cause. [40]

Developmental trauma happens in close relation to other forms of trauma and in terms of treatment, it requires close, intimate, stable relationships. Healing in this case is not an achievable static state, but a lifelong process. Disrupted attachment can heal in healthy relationships to individuals, but also this way the person gets reconnected to the wider society, or a social group can serve as a secure basis. [41]However, we need to know that isolation is a severe issue of the western society in spite of and because of its many achievements, and among these circumstances trauma is getting more dangerous since it can deeply break the connections among people.

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36 Mogyoróssy- Révész, 2021, pp. 41–59.
37 Ringel and Brandell, 2012 cited in Evans and Graves, 2018, p. 4.
38 Mogyoróssy- Révész, 2021, pp. 77–85.
39 Masten et al, 2008, p. 76.
40 Perry, 2019, pp. 291–311.
41 Perry, 2019, pp 291–311; Mogyoróssy- Révész, 2021, pp. 114–133.

6. Trauma Consciousness

In families and institutions that are the natural habitats of children, adults most often aspire to handle a child's "problematic behaviour", and not address the underlying causes of sadness and fear that leads to such behaviour. Children, and often adults do not have a conscious reflection on what inner emotion drives their or other's behaviour. The younger the child, the less they can verbally express their inner experiences, because self-reflection and mentalisation has not yet been developed, so it can only be expressed via a mood, or an act.[42]

Also based on the example of the adults surrounding them, they sometimes learn that the way for example to solve a disagreement or react to something uncomfortable is through aggression. As they do not have effective tools that they could use to soothe themselves, they get flooded by emotions that can end up as a tantrum, or deep frustration, or somatic issues. [43] In time, this can all easily lead to criminal behaviour or even substance abuse.

With these mechanisms in mind, it should be realised that children need understanding and reassurance, rather than punishment from the adults around them. This knowledge and its implications are a very important responsibility of educated professionals.

From the above-described developing scientific field of trauma, the practical phenomena of trauma consciousness has arisen. *Trauma informed or trauma conscious approach*[44] means the acknowledgment of the extent of traumatic experiences and trauma affected behaviours in our world. Following the acknowledgment actions and policies should be carried out. Thus, institutions are prepared to act in a way that takes trauma into consideration, tries to avoid retraumatisation and offers chances for rehabilitation. In a trauma informed approach, it is important that organisations create services based on these understandings but also create collaborations with other organisations handling children or families.

As professionals, who are active in the fields of children's rights or child welfare, education, politics we cannot consider trauma and its affects as a problem of the individual only. Trauma is deeply embedded in the social context, shaping choices, ideologies, and opportunities. Unresolved trauma causes widespread damages in our society. It has social, economic, legal and health related consequences. Healthcare, the education system, child welfare and even legal systems need to consider employing a trauma conscious perspective[45]

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42 Pressley Ridge Magyarország Alapítvány and University College Leuven, 2022.
43 Beyer, 2006, p. 1217.
44 Pressley Ridge Magyarország Alapítvány and University College Leuven, 2022.
45 Randall and Haskell, 2013, p. 518.

7. The Roots of Trauma in the Society

If we are looking at the bigger picture, we also need to be aware of the conditions that are constantly recreating developmental trauma in our society. The impacts of trauma are present in many people's lives; and it is much more common than one realises.

"A community-based surveys had findings indicating that somewhere between fifty-five per cent and ninety per cent of people have experienced at least one traumatic event in their lifetime, and one quarter of these people experienced it during their childhood."[46]

Trauma can be caused by severe violations of human rights and social issues, such as war, marginalisation, political conflicts, and institutional abuses. Its effects can be the lack of trust, an inability to believe in justice in the world, and insecure relationships. All these are the roots of criminal behaviour, substance abuse, and health issues. Thus, our society is shaped on many levels by developmental trauma.

On a larger scale we can take poverty into consideration as a risk factor for stressful, neglecting and thus traumatising circumstances in a child's upbringing. Nevertheless, if we look at the child welfare system, the abduction from families and then expecting children to easily adapt to foster or residential care, or school systems where children are considered lost causes because of acting out and not being able to concentrate, then we face grave institutional problems as well.

We really need the framework of trauma to improve the life that our society offers for future generations in our civilisation.

8. A Closer Look on the Legal System

If we take a closer look at the functioning of our legal system, there are various factors that we should take into consideration. Law is the guideline of our society. It can direct human behaviour but sometimes the psychological background is not thorough, or lawyers do not have enough knowledge of it.

As a systematic approach it is important to mention restorative justice which represents many values that are similar to the trauma-conscious approach. The restorative justice system aspires to create a shared narrative for everyone involved in a criminal case, which is really hard to reach but deeply healing for the individuals and the community as well. Haskell and Randall describe this approach of law followingly:

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46 Ibid., p. 503.

"Restorative justice is an approach to dealing with crimes and wrongdoing which takes seriously the need for repair of relationships harmed by these events. A restorative approach to law envisions justice in more expansive terms than is conceived of in the more traditional punitive and retributive models of criminal law. A restorative model of justice requires not only offender accountability but also victim participation and community engagement in the process of identifying and rectifying thewrongs which have been committed."[47]

A thoroughly designed restorative justice system is suitable to be a part of trauma healing processes and collaborative treatments and rehabilitation. As a result, the belief in justice and fairness can return to the lives of those affected by trauma.[48]

Consequently, we should take a look at the issues we can observe in people's lives who come from troubled or marginalised socio-economic backgrounds, and their relation to the justice system. We can probably all picture now how much confusing and traumatic events a child can bear growing up in a frustrated, stressed, and struggling family, where neglect, violence, and abuse are common experiences (probably because the parents also grew up under similar circumstances). As a result, a large number of these children, as both juveniles and adults, will deal with trauma responses which often (but not always) lead to substance abuse problems and conflicts with the law. 'Studies show that between seventy-five per cent and ninety-three per cent of those entering the juvenile justice system have experienced trauma.'[49]

Unfortunately, in many cases law enforcement only criminalises these youngsters instead of offering rehabilitation and treatment for their injuries as well. [50]

In communities where substandard housing, an ineffective education system, domestic violence and a lack of proper health care are parts of everyone's daily reality we notice a vicious circle of traumatisation. Unfortunately, in many cases our juridical system is not prepared or effective in helping to stop this, but instead makes things even worse by degrading treatment, exhibiting prejudice, and lacking empathy and understanding. [51]

Family and juvenile courts are probably the mostly affected by trauma. In cases of child protection, custody, domestic violence, minor offenders and probably most criminal cases, a knowledge of trauma would be required. Children and youngsters who get involved in such procedures often suffer from the effects of trauma, so their relationship with their family and/or any professionals (attorneys, social workers, etc.), their understanding of the court procedure, and their reactions to emotional situations where they feel vulnerable, are all impaired by their trauma responses.[52]

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47 Ibid., p. 506.
48 Ibid., 2013, pp. 517–531.
49 Ibid., 2013, p. 514.
50 Gohara, 2018, p. 50.
51 Ibid., p. 17.
52 Beyer, 2006, p. 1215.

I would like to avoid mitigating the issue of criminal behaviours, but our society needs to face its complex nature. Western law mostly considers humans rational actors who are assessing a cost-benefit when making their decisions and acting. However, we know that the fight, flight, numb responses that can be over activated by developmental trauma do not allow for rational decision-making processes with thorough evaluation, these are evolutionary automatisms. [53]

Abuse and traumatic experiences are not linear causes of criminal behaviour, but there is a complex interconnection, which should not only raise the question of who is to blame, but also how it can be prevented or treated.

If we take a closer look at the criminal justice system, trauma consciousness has implications concerning victims, witnesses and offenders.

As for the victims in a legal case, it is very important to avoid retraumatisation, victim blaming and revictimisation. This also applies to witnesses. These phrases describe different forms of further traumatisation, by repeating the traumatising story to listeners who are not understanding, or maybe even hostile, which can cause many more painful moments to the victims. In hearings and courtroom processes all the professionals involved should be aware that their sometimes inconsistent behaviour, and their lack of trust can be symptoms of trauma. Also, the nature of traumatic memories is different from non-traumatic ones, as they have less coherent narratives, and it can also be emotionally difficult to express and talk about them. [54]

Undergoing such juridical processes and being involved in the court system itself is a difficult, confusing experience for a mentally healthy adult, let alone a child with severe scars. Thus, it is the responsibility of professionals to minimise the additional stressors and be aware of consequences and dynamics of trauma and to cooperate with professionals that can support this process.

This perspective can be found in victim sensitive hearings, such as forensic interviews, which is already spreading and getting more and more common in abuse cases.

A *forensic interview* is a

"non-leading, victim sensitive, neutral, and developmentally appropriate investigative interview that helps law enforcement determine whether a crime occurred and what happened; the goals of a forensic interview are to minimize any potential trauma to the victim, maximize information obtained from the victims and witnesses, reduce contamination of the victim's memory of the alleged event(s), and maintain the integrity of the investigative process". [55]

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53 Beyer, 2006, p. 1227; Perry, 2019, p. 95.
54 Randall and Haskall 2013, p. 529; Van Der Kolk, 2020, pp. 189–203.
55 O'Donohue and Fanetti, 2016; Office of Justice Programs, n.d cited in Evans and Graves, 2018, p. 5.

A good example for this in practice is the Barnahus method, developed in Europe, in the Nordic countries, and already used in many other regions. [56]

The stress of the courtroom environment may affect the testimony of the victims or witnesses by increasing the general stress and fear levels and decreasing communication skills.[57]There are already initiatives to imply the knowledge of trauma in the courtroom and in the preparation work with the help of lawyers, for both juvenile and adult cases. For example, judges who are aware of trauma responses and dynamics could create safer courtroom settings and practices.[58]

It is possible that the court hearing would be the first time that the victim or the witness meets the abuser following the incident, and such traumatic triggers and reminders may cause the survivor to feel uneasy, anxious, or even terrified. A trauma-conscious approach could help the judges and lawyers to make this situation easier for the survivors, by offering chances to control some parts of the environment, like where to sit, who to look at, and which way to face. It can also help to prepare the survivors for what would be about to happen, discuss the processes, the timeframes, etc. Thus, the feeling of support and control can lessen the overwhelming effects. [59]

By offenders, I would like to focus on growing empathy and rehabilitation, without questioning the weight of wrongdoings and the necessity of consequences. We have already learnt that children who grow up in socially disadvantaged, aggressive, and traumatic environments can easily end up as criminals, abusers, and aggressors. Along their maturing they are often deprived of basic education and social services that could improve their circumstances, lessen traumatising effects and handle their trauma responses appropriately. If we take a look at statistics we see that the risk of abusing their partner among those boys who witnessed domestic violence is seven times widespread than in general.[60] Approximately one-third to one-half of severely traumatised people develop addictions to drugs or alcohol. Child sexual abuse is strongly associated with sexual violence in adulthood. Gang-involved youths experience PTSD at more than twice the rate of other young people. [61]

The law deems it necessary to punish them for their criminal behaviour, even though it has originated from social conditions. Society needs to take the responsibility to revisit and handle both rehabilitation and sentencing in a more complex way. This should apply, not only to juvenile offenders but also in adult cases, where a traumatic background is present.[62] Without questioning the necessity of a law system where criminal deeds are punished, maybe our perspective towards offenders could change and in some cases, we could see them as injured members of our society and

56 Johansson et al. 2017.
57 SAMSHA 2014 cited in Evans and Graves, 2018, p. 5.
58 Sickmund, 2016 cited in Evans and Graves, 2018, p. 6.
59 Katz and Haldar, 2015, p. 387.
60 Gohara, 2018, p. 19.
61 Ibid.
62 Gohara, 2018, p. 7.

not merely morally tainted and lost souls. Such a change of perspective would bring new attitudes and ways of managing such cases.

Offering these people a chance to receive treatment that considers their former injuries due to trauma could bring better results for them and for society in general, mainly concerning juveniles and minors but possibly also with adults.

On a practical level such work would aspire to maximise a safe and stable environment, where one has the chance to face one's own pain and vulnerability behind one's actions and learn to calm and soothe oneself. Experiencing an accepting, predictable, calm, safe and trustworthy surrounding is definitely healing if our inner world is shaped to always prevent danger. It can further sculpt our brain and automatisms, not by forgetting the old patterns, but by learning new ways and alternative reactions. [63]

Hopefully, in the coming years, more and more law professionals and even the whole juridical system will gain deeper knowledge of the psychology of trauma, so it could result in avoiding retraumatisation, preparing lawyers and judges to work with traumatised clients, and eventually the whole system could reach a more sensitive way of functioning, where the nature of underlying trauma is taken into consideration. By being committed to trauma informed perspectives, we can gain a closer grip on the roots of criminal activities, and violence. As a result we can create better ways of rehabilitation. Through this we can offer the whole community chances for a safer, more emotionally balanced existence, and provide real help for victims and offenders. The most essential benefit from this would be the new possibilities, and creative ways to develop transformative interventions.[64]

9. Secondary Traumatisation

There is one more issue that needs to be addressed: *vicarious trauma*. Scientific research shows that the lawyers' exposure to traumatic material can also harm their own mental health. The phenomena of vicarious trauma was first observed in social workers, police officers, and psychologists. However, lawyers or judges can also be exposed and affected by the traumas of their clients. [65] Secondary traumatic stress is an expansion of PTSD in DSM V. [66] The symptoms can be: higher general level of stress; PTSD like flashbacks; rumination, and a feeling of hopelessness. It can easily lead to burn out, emotional exhaustion, but other non- adaptive copings such as a detachment from emotions, substance abuse, and overworking.

Psychological distress that is created by traumatic content or handling the trauma responses of clients is increasing and causing more problems among lawyers. Studies

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63 Perry, 2019, pp. 85–113.
64 Katz and Haldar, 2016, p. 370.
65 Weir, 2022, p. 22.
66 Brady et al, date; Pearlman, date cited in Weir, 2023, p. 24.

show that depression, anxiety and alcohol abuse are more common among lawyers than in the general population[67]

The exposure to indirect trauma, particularly for those who work in criminal law, child protection, or even those who take on family cases is capable of touching everyone involved. In the absence of adequate coping mechanisms or professional support, this does leave marks for life.

It is common that lawyers working with traumatic cases report emotions such as sadness, disgust, and frustration from these experiences. However, their usual coping mechanism tends to be denial, distraction, and distancing.[68] This extensive use of avoidance-based coping mechanisms and suppression can often be detect in them taking on heavy workloads which unconsciously prevent such unbearable emotions from coming to the surface. However, this is only temporary solution. These ways of "surviving" can easily lead to severe mental health issues.

The role played by legal professionals of the detached professional role is quite common in this subgroup culture. It builds a barrier for the whole community that prevents them facing this problem. [69] The change that would universally beneficial would require the legal world to address and be aware of vicarious trauma and offer solutions for those affected. It might begin by facing any vulnerabilities, and removing the taboo of mental health issues, as well as raising awareness about these "professional hazards" at university during the education process.

Another smaller scale solution could be strong organisational support emanating directly from the place of employment, where mental health issues are not considered to be a stigma or a taboo, and trauma is a known concept, so that lawyers can receive professional help and collegial support in their close work circles. [70]

Traumatic experiences that get handled and treated can increase resilience and lead to post-traumatic growth, in the case of vicarious trauma as well. With professional support these experiences can help people to reach a more sensitive complex level of understanding and working within society. [71]

10. Conclusions

In bringing this chapter to a close, I would like to highlight the importance of deeper understandings of old phenomena. In the field of mental health sciences it was observed many years ago that many pathologies have their roots in a person's childhood. Thanks to the framework of developmental trauma and its neuroscientific background, we are beginning to understand its dynamics, which gives us an opportunity to develop better treatments and prevent many subsequent issues. The

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67 Weir, 2022, p. 101.
68 Ibid.
69 Weir, 2022, p. 103.
70 Ibid., 105.
71 Mogyoróssy- Révész, 2021, pp. 77–85.

crucial change might be also the angle we take to look at this phenomenon. PTSD and developmental trauma cause a lifelong alteration in one's brain. Such changes used to be necessary in evolution to save the individual from the possible reoccurrence of a similar situation. Therefore, some behaviours considered maladaptive in our current culture were essential for survival in ancient times and might still be essential in modern day violent surroundings. This is a given natural reaction of humans. This perception can promote implications in organisational levels, policies, laws and change in attitudes of our society towards childhood, mental health issues, marginalisation, criminal behaviour and many other aspects of life.

Bessel Van der Kolk [72] an important researcher of the field of developmental trauma summarised the consequences of such experiences on individuals in the following words

> "the complex disruption of affect regulation; the disturbed attachment patterns; the rapid behavioural regressions and shifts in emotional states; the loss of autonomous strivings; the aggressive behavior against self and others; the failure to achieve developmental competencies; the loss of bodily regulation in the areas of sleep, food, and self-care; the altered schemas of the world; the anticipatory behavior and traumatic expectations; the multiple somatic problems, from gastrointestinal distress to headaches; the apparent lack of awareness of danger and resulting self endangering behaviors; the self-hatred and self-blame; and chronic feelings of ineffectiveness".

These words again underline the complexity of the consequences and remind us how severe are the problems that those affected will need to face.

Beyond the individual outcomes of a traumatising childhood, we discussed in this chapter the levels at which society as a whole, policies, institutions, health care, and the legal system are affected.

As for the legal system, it can be crucial to imply the essential knowledge of trauma, since it is responsible for protecting society (especially children and their development), and preventing criminal acts while simultaneously supporting the rehabilitation of law-breakers. Completing this mission can be more effective by acting in a trauma-informed manner and implementing methods that handle all targeted groups with sensitivity.[73] Furthermore, collaborating with other systems, and creating interdisciplinary platforms will be crucial in the anticipation of necessary changes in areas such as the child welfare system, mental health support, addiction treatments, and the law enforcement of social services.

This could all begin with the education of professionals. They would not only be taught about trauma and its nature, but also about cooperation and collaboration. They could then be trained to be dedicated to systematic changes and improvement.

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72 Van der Kolk, 2005, p. 5.
73 Evans and Graves, 2018, p. 6.

As trauma-informed systems begin to develop partnerships within their communities, trauma-informed communities will begin to emerge. Trauma-informed communities would make collaborative efforts among multidisciplinary practices, providing trauma-focused interventions that would minimise re-traumatisation

After opening this chapter with a story, let me finish it with a hopefully not too far-fetched vision of the future. Let us imagine a courtroom where a trial will soon be under way. A group of teenagers had had a street fight a few days before, and the police had also found some illegal substances on them. In the courtroom the parents of these boys would be present. They would have been contacted, not only by the police, but also social services before the trial, visited by social workers and would have agreed to attend regular meetings in the subsequent period in order to help family support and create a safe background for the rehabilitation of the teenagers. The social workers would have offered counselling and help to the families, asked the parents to check what resources they had access to, and what help would be needed in order to be active participants in the rehabilitation of the youngsters.

The social workers and the police would have also had a meeting before the trial with the state issued lawyers of the teenagers about what had happened, what they had seen within the families, what information the social workers would have gathered from the school, as well as what the possible outcomes of the trial would be, and what the rehabilitation process would look like. These lawyers and also the judge would have completed education courses on trauma and its implication on a juvenile court. They would have planned beforehand the process of the hearings of the offenders, and also of the victims and witnesses. Some victims who had previously been bullied by the offenders, would be offered help from psychologists and the preparation for their hearings which by their request did not take place before the offenders.

The trial in our tale would take place in a safe and calm way, where professionals would be responsible for creating this atmosphere, and would be aware that frustration, anger, shyness, and the non-communication of the victims, the witnesses or even the offenders could be a manifestation of their trauma response. So a lot of effort would be put into creating a stable, predictable, safe, trustworthy, and calm environment.

The rehabilitation process after sentencing would involve cooperation of social workers, teachers, and mental health professionals. It would offer treatments that take trauma dynamics and responses into account, and also ways in which these youngsters could develop coping mechanisms and new ways of handling situations, instead of maladaptive automatisms that would only result in violence, aggression and ultimately substance abuse.

If we read this story, we can realise it is actually not so far- fetched; many legal and social systems do contain the seeds of such processes. Children's rights, forensic interviews, and interdisciplinary collaborations are indeed gaining more and more

strength and attention in recent years. I do believe that we all have to work hard to keep pushing these trends.

It is essential that sensitive, well-educated trauma informed professionals participate in the creation of laws and policies, in developing and sustaining social, educational and health systems, and last but not least that such professionals work with children, families and vulnerable members of our society in everyday situations.

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| CHAPTER 10 |

A Brief Overview of the Relevant Findings From Positive Psychology on Childhood Development: The Concept of Protective Factors and Resilience in Childhood

Majda RIJAVEC – Barbara BALAŽ

ABSTRACT

This chapter focuses on an overview of the contribution of positive psychology's findings to the body of knowledge about children's resilience. Firstly, different definitions of resilience are presented, which conclude that resilience is a process consisting of two mutually related conditions - the experience of severe adversity and positive adaptation despite it. Along with adversity, researchers refer to risk factors which are related to higher rates of undesirable developmental outcomes, and could include individual, family and environmental factors. Another inseparable dimension of resilience is positive adaptation which refers to better-than-expected outcomes despite the exposure to the risk factors. It could be assessed as the absence of psychopathological symptoms or as positive behaviors. Besides this, it could be examined as internal or external adaptation or both. Research on positive adaptation revealed that resilience and positive adaptation are context specific. Alongside positive adaptation, there are protective factors which refer to variables that are related to better-than-expected. Secondly, there is presented the contribution of the field of positive psychology to the research on children's resilience. Positive psychology moved away from the psychopathology perspective to an approach that focusses on strengths and resources which significantly contributed to development in the field of resilience. From this perspective resilience is not merely the absence of symptoms but also includes positive changes. Positive psychology contributed to the research on these positive changes in various areas, including protective factors in resilience and post-traumatic growth. Thirdly, there are presented positive psychology interventions aimed at fostering resilience. The chapter concludes with final remarks about the relationship between children's resilience and positive psychology.

KEYWORDS

adversity, positive adaptation, positive psychology, protective and risk factors, resilience

1. Introduction

If someone mentions psychology or a psychologist, the first thing one might think about is dealing with personal problems. Rarely would one associate it with building personal strengths or empowering individuals and societies. This negative perception of psychology as focussed on only helping people get through tough times when they encounter problems also worried the pioneers of positive psychology, such as Martin Seligman and Mihaly Csikszentmihalyi. In 1998, when Seligman became the president of the American Psychological Association, he stated that the mission of psychology should be to not only cure mental illness but also achieve two other neglected goals—find ways to make people's lives more productive and fulfilling and learn how to discover and further nurture high talent[1]. That was the moment in time when positive psychology was officially established with one specific aim—to shift the focus of psychological research from resolving the problems to cultivating positive qualities among people and societies[2]. Accordingly, positive psychology is broadly defined as follows:

> "The field of positive psychology at the subjective level is about valued subjective experiences: well-being, contentment, and satisfaction (in the past); hope and optimism (for the future); and flow and happiness (in the present). At the individual level, it is about positive individual traits: the capacity for love and vocation, courage, interpersonal skill, aesthetic sensibility, perseverance, forgiveness, originality, future mindedness, spirituality, high talent, and wisdom. At the group level, it is about the civic virtues and the institutions that move individuals toward better citizenship: responsibility, nurturance, altruism, civility, moderation, tolerance, and work ethic."[3]

Positive psychology moved from a reactive intervention approach involving the repair of the problems to a more preventive approach that builds and cultivates people's existing strengths, and which could help them survive hard times in life[4]. However, many constructs the field deals with were already familiar to researchers. One of them is the research on resilience, which began in the 1970s with a similar mission—to learn more about what helps children and adolescents go through tough times in life without severe consequences and how to use that knowledge to promote resilience[5,6]. One main concern of the research on resilience was to find out why some children, despite experiencing traumatic events, grow into healthy individuals and

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1 Seligman, 2002, p. 4.
2 Seligman and Csikszentmihalyi, 2000, p. 5.
3 Ibid.
4 Seligman, 2002, p. 5.
5 Luthar, Cicchetti and Becker, 2000, pp. 543–544.
6 Masten, 2011, p. 494.

why others do not. Despite many similarities as well as differences between the fields of positive psychology and resilience research, positive psychology has contributed substantially to what we know about resilience today.

This chapter focusses on an overview of the findings on positive psychology that are relevant for children's resilience. First, the construct of resilience and its essential elements are defined. Then, the contribution of positive psychology to the field of resilience in children and adolescents is elaborated on, along with the protective factors and posttraumatic growth (PTG). The chapter ends with a brief overview of interventions to enhance resilience among children and adolescents and concluding remarks.

1.1. Definition of Resilience

As with many constructs in psychology, throughout the years, it has been difficult to find a unique definition of resilience. Definitions changed based on new insights about the construct, as well as based on the authors or research teams who examined it. An analysis of the history of studies on resilience distinguishes four research waves[7,8]. Pioneering work on resilience started in the 1960s and 1970s[9] in the context of children at high risk for developing serious mental disorders; surprisingly, these children developed successfully. This first wave of research was mainly descriptive and identified a list of characteristics, that is, protective factors (e.g. child's self-esteem and autonomy, family cohesion, and caring teacher) that were related to children's resilience. In the second wave, researchers realised that the identification of protective factors was not enough and stressed the need to find underlying processes that lead to resilience, for which it was necessary to conduct longitudinal research. The search for underlying processes should answer questions such as why some individuals keep their levels of self-esteem and self-efficacy in times of adversity, in contrast with others who give up and lose hope[10]. The third wave mainly focussed on interventions that were designed to promote resilience among children growing in high-risk environments. The last, fourth wave of studies aimed to integrate contributions and knowledge from earlier studies of resilience across different levels of analysis (e.g. gene-environment interaction and social networks), species, and disciplines, which offers opportunities for much deeper understanding of the process that leads to resilience in children[11,12].

Despite the different aims throughout the history of research on resilience and changes in its definition, the term resilience is typically used to describe three different outcomes: (1) a person with high-risk status shows good outcomes, (2) a person

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7 Masten, 2007, pp. 922–923.
8 Masten and Obradović, 2006, p. 14.
9 Luthar, 2015, p. 740.
10 Rutter, 1987, p. 317.
11 Masten, 2007, p. 924.
12 Masten and Obradović, 2006, p. 23.

has sustained competence while the threat is under way, and (3) a person experiences recovery after trauma[13,14].

Therefore, Luthar[15] in her summary of 50 years of research on resilience defines it as 'a phenomenon or process reflecting relatively positive adaptation despite experiences of significant adversity or trauma'. This version of the definition encompasses all necessary parts of the construct that are broadly accepted and implies that resilience is a superordinate construct that necessarily includes two different dimensions: significant adversity and positive adaptation[16]. Based on this definition, it is crucial that resilience is a *process* or *phenomenon* but not a personality characteristic[17]. The misinterpretation of resilience as a personal trait can suggest that if a person does not have that specific trait or behaviour, he or she cannot resist adversities[18] and could be blamed for not functioning well under threat[19]. Therefore, when someone is talking about resilience, he or she is not talking about some specific characteristic that one child has and the other does not, but about the process that includes two coexisting conditions—the experience of severe adversity and the presence of positive adaptation despite it[20].

1.1.1. Adversity and Risk Factors

One cannot claim that a child showed resilience if there is no demonstrable significant adversity or threat to his or her development, which can be present in the moment or can have happened in the past and has the potential to disrupt a normative child's development[21]. In this context, researchers often refer to *risk factors*. Risk factors are statistically associated with higher rates of undesirable developmental outcomes; that is, their presence can indicate a higher probability of developing a disorder[22]. It should be noted that one factor can be assumed as a risk factor for one outcome, but it can be an asset for another outcome at the same time[23]. For example, a young mother's biological age can represent a risk for higher levels of behavioural and emotional problems, but at the same time, it is associated with lower risk for the trisomy 21 syndrome. On the other hand, *adversity* indicates that a person has experienced or been exposed to negative life experiences. In contrast to risk factors, adversity is not defined in relation to specific outcomes, and, in some way, it can be considered as a type of risk factor[24].

Throughout the years, numerous risk factors were identified, ranging from individual factors (e.g. sex, social and intellectual skills, potential biological, and

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13 Masten, Best and Garmezy, 1990, p. 426.
14 Masten, 2007, p. 923.
15 Luthar, 2015, p. 742.
16 Masten et al., 1999, p. 144.
17 Luthar, Lyman and Crossman, 2014, p. 128.
18 Luthar and Cicchetti, 2000, p. 6.
19 Masten, 1994, cited in Luthar and Cicchetti, 2000, p. 6.
20 Luthar, Cicchetti and Becker, 2000, p. 546.
21 Masten, 2001, p. 228.
22 Masten and Garmezy, 1985, p. 3.
23 Obradović, Shaffer and Masten, 2012, p. 36.
24 Ibid.

psychological indicators), family factors (e.g. maltreatment), and children's environmental factors (e.g. residential area)[25]. Risk factors can also be distinguished by the degree of direct influence on a child[26]. Namely, there are distal risk factors, such as poverty, that do not affect children directly but indirectly. On the other hand, proximal risk factors, such as the mother's irritability due to work overload, directly affect children's development.

It is important to note that, in reality, only one risk factor is rarely present; often, multiple risk factors are present. Rutter[27] showed that when more risk factors are present at the same time, their effects combine, and children's developmental outcomes tend to be far more negative in contrast with the situation when only one risk factor is present. This notion led to cumulative risk assessment using two methods: risk indices and stressful life experience scores[28]. The risk index considers an array of environmental and sociodemographic risk factors that might be present in the life of a child, and the common strategy to calculate it involves summing risk factors that are proven to have negative consequences for one or more specific developmental outcomes[29]. The other strategy involves focussing on the specific negative life events a child has encountered during a longer period of life, and they are typically assessed using self-report instruments that list adverse events someone could experience[30].

Although it seems easy to detect risk factors among children, there are some important challenges. One of them is the scarcity of data on what defines mild, moderate, and severe levels of risk exposure, which would enable comparing them across different populations and contexts[31]. Therefore, those criteria are commonly defined based on data collected from participants who were involved in the study, which makes it harder to compare the results of different studies. Another important challenge is that many risk factors vary across time and are rarely static[32]. For example, the socioeconomic status of the family or the number of siblings can change over time. Consequently, it is very important to collect data from children repeatedly over time to capture the processes and changes in different developmental periods. Further, an important notion is that the same risk factor can have different effects depending on the developmental periods, especially during transitions such as adolescence[33]. For example, parents' exposure to alcohol has different effects on a foetus, preschooler, adolescent, or young adult[34]. Lastly, cumulative risk indices, although representing a more realistic picture of a child's life, can make it difficult to discover the unique contribution of a specific risk factor, since its role can change in the context of other

25 Masten and Garmezy, 1985, p. 3.
26 Baldwin, Baldwin and Cole, 1990, pp. 257–258.
27 Rutter, 1979, cited in Luthar, 2015, p. 742.
28 Masten and Reed, 2002, p. 71.
29 Obradović, Shaffer and Masten, 2012, p. 37.
30 Ibid., p. 41.
31 Ibid., p. 44.
32 Ibid.
33 Masten and Gewirtz, 2006, pp. 25–26.
34 Obradović, Shaffer and Masten, 2012, p. 45.

risk factors[35],[36]. As will be evident in the next paragraph, some of these challenges are not reserved exclusively for determining risk factors but can also make it hard to detect and measure positive adaptation.

1.1.2. Positive Adaptation and Protective Factors

Second, *positive adaptation* is an inseparable dimension of resilience that follows after a child experiences or witnesses significant adversity. Positive adaptation refers to better-than-expected functioning despite the exposure to observed risk factors[37]. More specifically, the criteria for the quality of a child's adaptation must be evaluated as *good* or *OK*[38].

The estimation of children's positive adaptation (e.g. adaptation after parents' divorce, children's positive development despite their genetic vulnerability for different psychopathology states, maltreatment, loss of one parent, or living in poverty) is never an easy job, primarily because such adaptation is not constant but changes as children encounter new vulnerabilities and strengths due to changed life circumstances[39]. Moreover, a child can leave the impression of good functioning in terms of behavioural indicators but, at the same time, experience inner distress, such as depression and anxiety[40]. Consequently, this inner stress, if not treated, could undermine resilience[41]. These findings led to the conclusion that resilience is context specific[42], which implies that a person can be resilient regarding some environmental threat, in some outcomes, and/or in one period but not in another[43]. This is also typical for children who did not experience significant adversity: They usually do not show uniformly positive or negative adaptation in different developmental areas[44]. Therefore, there is no reason to expect that positive adaptation among children who showed resilient behaviour should be an across-the-board phenomenon[45], since they can have strengths in some areas but concurrently have significant deficits in others. Luthar, Cicchetti, and Becker[46] suggested that positive adaptation domains should be theoretically similar; for example, if academic grades are examined, data from peers about a child's adjustment in the classroom could also be collected. For that reason, researchers must be specific about positive adaptation depending on the concrete areas in which it was examined[47] and clearly state that in their conclusions.

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35 Ibid., p. 46.
36 Masten and Schaeffer, 2006, p. 14.
37 Luthar, 2015, p. 742.
38 Masten, 2001, p. 228.
39 Garmezy and Masten, 1986, pp. 508–509.
40 Luthar, 2015, p. 741.
41 Luthar and Cicchetti, 2000, p. 22.
42 Masten, Best and Garmezy, 1990, p. 439.
43 Rutter, 2006, p. 4.
44 Luthar, Doernberger and Zigler, 1993, p. 10.
45 Luthar, 2015, p. 741.
46 Luthar, Cicchetti, and Becker, 2000, p. 548.
47 Luthar, 1993, p. 2.

After considering the aforementioned facts, the answer to the question of how positive adaptation can be measured is still missing. Some researchers define positive adaptation as the absence of psychopathology symptoms, while others do so in terms of positive behaviour. Some focussed on external adaptation (i.e. how a child is doing), some focussed on internal adaptation (i.e. how a child is feeling), and others considered both dimensions[48]. Positive adaptation is mostly defined as a behaviourally manifested social competence (e.g. judgements about a child's competence are made based on external standards observed by others, such as school achievement and absence of delinquency, and not based on their inner state, such as the child's feeling of depression or anxiety) or as meeting of developmentally appropriate tasks depending on the child's age[49]. Developmental tasks are defined as standards for judgements about how well the child has adjusted according to culturally expected norms for behaviour at a specific time point and moment in history for certain groups of children[50,51]. Those tasks are primarily oriented on external adaptation and not the child's internal well-being, such as happiness[52]. When the child's behaviour is characterised as resilient, it indicates that the child is successful at meeting developmental tasks despite the experience of significant adversity[53]. Some of the most common indicators of positive adaptation among children and youth are different measures of academic achievement, conduct, peer acceptance, good mental health, and participation in different activities[54]. Positive adaptation is therefore multidimensional, since there is an array of developmental tasks children need to perform in specific age periods and specific cultural contexts[55].

Furthermore, when considering positive adaptation, it is important to measure adaptation related to the risk domain due to its context-specificity, as discussed above, and to consider the stringency of the chosen criteria [56]. The stringent of criteria must depend on the observed seriousness of the risk[57], which will determine if the criteria will be defined as having average instead of excellent levels of competence[58,59]. If the major traumas are examined, then the appropriate adaptation criteria could be the absence of psychopathology instead of highly positive functioning in everyday life[60]. To avoid a too narrow definition of positive adaptation, it is necessary that indicators of adaptation include different domains so that we can have a more realistic picture

48 Masten and Gewirtz, 2006, p. 27.
49 Masten, 2001, p. 229.
50 Masten and Gewirtz, 2006, p. 27.
51 Masten et al., 1995, p. 1636.
52 Masten and Obradović, 2006, p. 15.
53 Masten and Reed, 2002, p. 76.
54 Ibid.
55 Masten and Curtis, 2000, p. 533.
56 Luthar, 1993, pp. 2–4.
57 Luthar, 2015, p. 743.
58 Luthar, Cicchetti and Becker, 2000, p. 549.
59 Rutter, 2012, p. 342.
60 Masten and Powell, 2003, p. 7.

of children's adaptation across domains. This helps us understand in which area children are doing well, and in which one they perform poorly[61].

Closely related to positive adaptation are *protective factors*, defined as variables related to better-than-expected outcomes[62]. They can be determined in several ways based on whether they are related to (1) more positive outcomes, especially in the presence of negative environmental factors; (2) positive outcomes among average children who experienced severe adversity with apparently high diversity in adaptation; and (3) lower incidence of psychopathology among children who are high risk[63]. Protective factors are assumed to counteract or counterbalance the effects of adversity due to negative life circumstances[64].

Adversity, protective factors, and positive adaptation are mutually related in several ways that are examined within the following models: *compensatory* or *main effect models* [65], *moderator* or *interaction models*[66,67], and *mediator models*[68], which are described in Table 1.

Table 1. Types of relationships between adversity,
protective factors, and positive adaptation[69]

Compensatory (main effect) models	The protective factor is assumed to counterbalance the negative effects of risk factors. *A child who has better parental support and nutrition and lives in a safe neighbourhood will have better outcomes.*
Moderator (interaction) models	1. a. Some stable characteristics of the child (e.g. *personality*) or environment have the potential to increase or decrease the effects of the threat on a child. 2. b. Protective factors are activated upon the occurrence of adversity (e.g. *airbags in cars*) and have the function of ameliorating the effect of that threat on the children's developmental outcomes.
Mediator models	The effect of adversity on a child's outcomes can be mediated by protective factors to reduce the impact of adversity on the child. *Use of interventions to help parents deal better with stressful situations (moderating the mediator) has implications for better outcomes among children.*

The compensatory models answer the question about what differentiates children who are doing well from those who are doing poorly among the sample of high-risk

61 Luthar and Burack, 2000, pp. 41–43.
62 Masten and Garmezy, 1986, p. 14.
63 Masten and Garmezy, 1985, pp. 14–15.
64 Masten and Gewirtz, 2006, p. 30.
65 Ibid., p. 33.
66 Ibid.
67 Masten and Reed, 2002, p. 79.
68 Masten and Gewirtz, 2006, p. 34.
69 Masten and Gewirtz, 2006, p. 33; Masten and Reed, 2002, p. 79; Masten and Gewirtz, 2006, p. 34.

children, while the interaction models answer the question about which characteristics of the child show differential positive outcomes at high but not necessarily low levels of risk[70]. Depending on the data obtained from different models, there are differences between the type of proposed implications for policy and practice aimed at developing resilience among children and adolescents.

Based on everything written above about the definition of resilience, it can be concluded that resilience stems from some extraordinary processes that are reserved for only lucky individuals. However, that would be a wrong conclusion, since research showed that resilience often arises from well-functioning common human adaptation systems[71,72,73]. These include attachment, mastery motivation, self-regulation, and cognitive development and learning. They are products of biological and cultural evolution that has equipped people with tools for adaptive functioning in both favourable and unfavourable conditions.

The problem occurs when these systems are damaged due to some adversity (e.g. deprivation of parenting). In that case, it is essential to restore conditions necessary for cognitive and social development to promote resilience among high-risk children. Therefore, policy and practice should first focus on protecting, restoring, and facilitating human adaptation systems if they are affected by risk factors to sustain resilience among the children and youth.

2. Positive Psychology and Resilience

As already mentioned, positive psychology moved away from the psychopathology perspective to an approach that focusses on strengths and resources that allow individuals to survive and grow despite extreme challenges and adversities. This paradigm shifts significantly contributed to development in the field of resilience. From this perspective, resilience is not simply recovery from adversity but rather a process that results in growth, knowledge, self-understanding, and increased resilience[74]. Thus, resilience is not merely the absence of symptoms but also positive changes. Positive psychology contributed to the research on these positive changes in various areas, including protective factors in resilience and PTG.

2.1. Protective Factors Among Children

Many children face various, sometimes extremely challenging and high-risk, situations. As elaborated above, some of them may become overwhelmed by these events, but many manage to cope extremely well, with no apparent disruption in their functioning. Why do some children do better than others when faced with adversity? What

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70 Luthar, 1993, p. 8.
71 Masten and Coatsworth, 1998, p. 212.
72 Masten and Powell, 2003, pp. 14–15.
73 Masten, 2001, p. 227.
74 Richardson, 2002, p. 7.

qualities of children and their environments might explain this difference? A vast number of studies on resilience in children and youth identified various protective factors that can be categorised into those within the child, family and other relationships, school, and community. We briefly summarise these findings as well as the contemporary research in positive psychology contributing to the understanding of protective factors.

2.1.1. Protective Factors Within the Child

Several large-scale longitudinal studies[75] showed that children with certain individual attributes cope successfully with adversity. The protective potential of various child characteristics includes high intelligence, self-mastery, planning skills, internal locus of control, good coping skills, and easy-going temperament. These are children's inner strengths that promote resilience. Positive psychology contributed to the research on protective factors within the child, mainly in the area of character strengths and positive emotions. Both character strengths and positive emotions have been found to promote children's resilience and help them cope with adversity.

2.1.1.1. Character Strengths

The field of positive psychology contributed further to the research on resilient children's individual characteristics by exploring the role of human strengths in adapting to difficult life events[76]. Peterson and Seligman[77] defined character strengths as positive, morally valued traits of personality and proposed a classification of 24-character strengths that are assigned to one of six universal virtues. Table 2 presents the Values in Action (VIA) classification of character strengths modified for children[78].

Table 2. Values in Action (VIA) classification of character strengths for children[79]

Intellectual Strengths	Interpersonal Strengths	Temperance Strengths	Transcendence Strengths
• curiosity • love of learning • creativity • appreciation of beauty	• social intelligence • teamwork • leadership • kindness • perspective • love • bravery • fairness	• forgiveness • modesty • self-regulation • authenticity • prudence • persistence • open-mindedness	• spirituality • gratitude • hope • zest • humour

75 Werner, 2005, p. 95.
76 Peterson et al., 2008, p. 216.
77 Peterson and Seligman, 2004, p. 8.
78 Shoshani and Shwartz, 2018, p. 7.
79 Ibid.

Character strengths in children and adolescents are related to desirable outcomes such as subjective well-being, social adjustment, and school adjustment, as well as fewer symptoms of depression; less suicidal tendencies; and less social problems such as substance use, alcohol abuse, and violence[80,81]. It has been documented that in children with life-threatening diseases, the strength of hope helps reframe difficult situations by encouraging expectations of a better future[82]. Gratitude can alleviate symptoms of post-traumatic stress disorder by stimulating a greater appreciation of life and reducing negative emotions[83]. However, it should be noted that having strengths is not enough to promote resilience. In childhood and across the lifespan, individuals can possess strengths without using them[84]. Therefore, the environment (including family, school, and community) is critical in enabling and maximising their use.

2.1.1.2. Positive Emotions

Besides character strengths, the positive affect, intensively studied within positive psychology, has been found to play an important role in resilience, as documented by several studies. Positive emotions, such as joy, hope, contentment, and interest, are more common among individuals with high-level resilience[85]. Moreover, the experience of positive emotions contributes to the selection and usage of more adaptive strategies to cope with adversity. Resilient individuals use positive emotions to recover from stressful situations and find a positive meaning in such events. The adaptive benefits of positive emotions are greater when individuals are under stress[86].

The role of positive emotions in developing resilience can be explained by the broaden-and-build theory[87]. According to this theory, the experience of positive emotions expands awareness, cognition, and behavioural repertoires and builds enduring and better physical, intellectual, and social resources. These resources in turn support the ability to recover better from adverse situations and are crucial for achieving resilience[88]. For example, a study on children of alcoholics found that behavioural resilience is associated with decreased internalising problems and increased positive affect[89].

2.1.2. Family-Related Protective Factors: Strength-Based Parenting

Nurturant, responsive parenting is strongly related to positive outcomes in children, including fewer externalising and internalising behaviours[90] and higher peer social

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80 Park, 2004, p. 12.
81 Shoshani and Aviv, 2012, p. 8.
82 Shoshani, Mifano and Czamanski-Cohen, 2016, p. 2014.
83 Israel-Cohen et al., 2015, p. 7.
84 Kashdan and Stager, 2011, p. 13.
85 Tugade and Fredrickson, 2004, p. 323.
86 Ibid., p. 325.
87 Fredrickson, 2001.
88 Tugade and Fredrickson, 2004, pp. 9–11.
89 Carle and Chassin, 2004, pp. 11–13.
90 Masten et al. 1999, p. 159.

competence[91]. While the importance of providing love and emotional support to children has long been recognised widely, the importance of deliberately identifying and building strengths in children is now beginning to gain more attention. As already mentioned, children's use of their strengths have various benefits when they are confronted with adverse situations. These studies have prompted interest in identifying factors that may cultivate the use of strengths in children and adolescents, including factors related to family.

Strength-based parenting (SBP) reflects the tendency of parents to recognise their children's strengths and encourage them to use these strengths. This style of parenting seeks to 'identify and cultivate positive states, positive processes, and positive qualities in children' [92]. The emphasis is on building a child's assets (e.g. curiosity, persistence, optimism, or bravery) to create positive experiences that can be called upon during adversities[93].

SBP has been shown to be positively related to well-being, life satisfaction, positive emotions, and self-esteem in children. Children of parents who use SPB have higher-level achievement as well as reduced risk of depression and anxiety. They also show higher-level mental toughness, persistence, and self-efficacy and cope better with stress and adversity such as friendship problems and homework challenges[94,95,96]. One reason why SBP reduces stress in children is that it encourages them to take strength-based coping approaches when faced with adversity. SBP thus increases the internal resources (i.e. personal strengths) children can draw upon in challenging situations.

2.1.3. School-Related Protective Factors

Sometimes, the family is unable to provide enough support to the child facing adversity. In such circumstances, the community can be an important source of alternative support and care. At an early age, high-quality childcare with emotionally supportive caregivers with positive characteristics is particularly helpful for children in the most at-risk families[97]. Later, protective factors include the presence of secure relationships with adults outside the family, including teachers[98]. The school plays a very important role in fostering resilience in children and adolescents.

The application of a positive psychology perspective in education is known as *positive education*. It is not a single approach but generally aims at building strengths, abilities, well-being, and resilience in educational communities[99]. One currently dominant theory within the field of positive education is the PERMA model, which includes the

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91 Wyman et al. 1999, p. 653.
92 Waters, 2015, p. 690.
93 Sağkal and Özdemir, 2019, p. 8.
94 Jach et al., 2018, p. 575.
95 Loton and Waters, 2017, p. 8.
96 Waters et al., 2019, pp. 13–14.
97 Maggi et al., 2011, p. 1084.
98 Ebersöhn and Ferreira, 2011, p. 504.
99 Slemp at al., 2017, p. 103.

five elements of well-being—positive emotions (P), engagement/motivation (E), meaning and purpose of life (M), positive relationships with others (R), and achievement (A)—and it is used widely in schools[100]. It also encompasses a large variety of character strengths that have been associated positively with each element of PERMA in varying degrees[101]. Table 3 presents the application of the PERMA model for children.

Table 3. PERMA model for children[102]

Dimensions of PERMA	Description
P – positive emotions	What makes the child feel good, happy, or grateful?
E – engagement/motivation	What strengths help the child get immersed and lose track of time?
R – positive relationships	Who brings the child joy, peace, and support?
M – meaning and purpose	What things are meaningful and worthwhile for the child?
A – achievement	What does the child want to achieve and when? What gives her/him a sense of accomplishment and helps manage setbacks?

A scoping review that included 190 studies showed that all PERMA aspects were associated with greater well-being and resilience as well as fewer symptoms of mental illness in primary school-aged children[103].

2.2. Posttraumatic Growth and Resilience

Resilience studies emphasised the importance of strengths in individuals, families, and communities for good adjustment under various extremely challenging life situations. However, they were not as explicitly concerned with positive outcomes as opposed to the absence of negative outcomes, as positive psychology has espoused.

One line of research that focussed explicitly on the development of positive functioning in relation to stress and trauma is the topic of PTG. PTG involves positive personality and life changes that enhance functioning and result from the emotional and cognitive processing of trauma exposure[104]. Such conception implies that it is not the event itself but rather the struggle in the wake of trauma that leads to PTG.

Although both resilience and PTG are characterised by some positive post-adversity manifestations, they are distinct constructs. Resilience is the ability to overcome adversity, relatively quickly return to previous levels of functioning, and maintain usual functioning despite adversity. PTG refers to positive changes in the person beyond their previous developmental process and reflects positive adaptation despite significant life adversity. It refers to a transformative process by which one

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100 Seligman, 2018, pp. 1–3.
101 Wagner et al., 2019, pp. 8–10.
102 Source: Author's own work.
103 Turner et al., 2023, p. 32.
104 Tedeschi and Calhoun, 1995, p. 1.

experiences positive changes (i.e. extending beyond mere adjustment) because of his or her struggle after trauma[105].

Traumatic events threaten individuals' physical and mental integrity. The negative effects of trauma and adversity in adolescents are well documented. Around 80% of adolescents experience at least one negative life event (not necessarily traumatic), and 20% develop moderate levels of posttraumatic stress[106]. However, negative outcomes are not inevitable. Traumatic experience can be restructured successfully and lead to the beginning of positive psychological changes or PTG.

Until recently, the research on PTG mainly focussed on adults, and studies among children and adolescents are scarce. These studies reported growth in children following an accident, disaster, illness, or other trauma[107,108].

Example of posttraumatic growth in adolescents

In a study by Altinsoy[109], five adolescents aged 15 years from the Marmara region of Turkey who had serious health problems and chronic diseases (brain, heart, blood, or endocrine) were interviewed. In a semi-structured interview lasting 45–60 min, three questions were posed: (1) *How did you feel after you learned about your disease?* (2) *After this event, what have you experienced in a positive sense in your relationships with other individuals? Can you give an example?* (3) *After this event, what have you experienced or discovered in a positive sense about your perspective on life? Can you give an example?*

The results yielded the following five sub-themes:

• Relationship with others: *I have learned to be able to accept to listen to other people and accept them as they are and have become a more understanding human model.*

• Appreciation of life: *I thought that difficulties and diseases could happen to anyone, and I did not have to be bothered (too much) by them, so I moved on with my life, I understood better that the family is the most important thing in the world.*

• Personal strength: *I was able to go on with my life and realized that I was strong.*

• Spiritual and existential change: *In this sense, I have learned to be always understanding to everyone, I have learned to be always thankful, and I express my gratitude not to go through these events again.*

• Life opportunities: *I saw that life was short and I had to live; life takes (only) three days (very short), so I have to achieve my dreams, I have come to understand that very well.*

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3. Positive Psychology Interventions in Fostering Resilience

There is evidence that protective factors such as positive affect, self-efficacy, self-esteem, optimism, social support, and life satisfaction have a stronger relationship with resilience than risk factors and sociodemographic variables in both children

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105 Kilmer et al., 2014, p. 508.
106 Joseph et al., 2000, p. 479.
107 Joseph, Knibbs and Hobbs, 2007, p. 152.
108 Milam, Ritt-Olson and Unger, 2004, pp. 198–199.
109 Altinsoy, 2021, pp. 15, 17, 18–19.

and adults[110]. Therefore, to develop resilience, it might be more effective to enhance protective factors than to reduce the risk factors. Moreover, it may be difficult or sometimes even impossible to change some risk factors in children's life, but it should be possible to enhance various protective factors at both the individual and environmental levels. Within positive psychology, a vast number of *positive psychology interventions* were developed. They are defined as 'intentional activities specifically addressed to cultivate positive feelings, cognition, and behaviours'[111], which can serve as protective factors in fostering resilience.

Studies examining the effects of positive psychology interventions on the well-being of preschool children are scarce and produced inconsistent results. However, several studies demonstrated the importance of positive psychology interventions to promote positive aspects of development, such as positive emotions, engagement, accomplishment, and positive relationships[112]. Studies on character strengths interventions in schools found increases in well-being, life satisfaction, positive affect, classroom engagement, class cohesion, relatedness and autonomy need satisfaction, strength use, social skills, academic performance, and improved problem behaviour[113].

Positive psychology intervention in kindergarten

Positive emotions
Children are encouraged to identify their personal causes of happiness; participate in activities for expressing gratitude; practice the expression of various feelings through movement, art, speech, and facial expressions; and write about memories of happy experiences.
Engagement
There are opportunities for children to bring personally meaningful toys from home to kindergarten, choose a personally enjoyable topic or activity for the morning group meeting, and identify and use their personal character strengths in daily activities.
Positive relationships
Children participate in games that demand peer cooperation, play with friends in different situations, practice offering positive responses to other children, participate in conflict resolution situations, and are encouraged to care for their friends' feelings.
Achievement
Children participate in games that require persistence in challenging situations and provide a sense of efficacy. They are encouraged to continue trying despite failure and select and work on personal projects such as producing a book of drawings or exploring an interesting topic[114].

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110 Lee et al., 2013, pp. 273–274.
111 Sin and Lyubomirsky, 2009, p. 468.
112 Benoit and Gabola, 2021, pp. 12–14.
113 Shoshani and Shwartz, 2018, p. 8.
114 Shosani and Slone, 2017, p. 3.

Character strengths-based intervention

The *Strengths Gym* positive psychology intervention programme for adolescents[115] is based on the Values in Action classification of character strengths. During the programme, students complete strengths-based exercises through in-class activities, open discussion, and real-world home-work activities where they can apply the concepts and skills in their own lives. Here are examples of developing the strength of *love of beauty and excellence*.

Love of beauty and excellence – Description: You notice and love beautiful things, in nature, art, music, or people. During this week, you should engage with this strength. The following are some examples:

- Strength in action story: Can you remember a time when you or someone you know well showed love for beauty and excellence? Write, draw, or tell a story about love for beauty and excellence.
- Animal beauty contest: Which animals do you find beautiful? Why? (group work): Which animals do your classmates think are beautiful? Make a top list of the most beautiful animals. Compare your leaderboard with the list of other groups in the department.
- Look for beauty on the way to school. Tell someone from your family or a friend what you noticed on the way to school.

It should be noted that positive psychology interventions focus on all children and youth and not just on those with problems. Thus, they can be implemented in schools as primary prevention tools to promote resilience; individual growth; and positive interactions among all students, not just those at risk.[116]

4. Conclusion

The aim of this chapter was to define resilience and present an overview of positive psychology contributions to resilience among children. It can be concluded that although the research streams of resilience and positive psychology have similar missions and significantly overlap in their aims to foster resilience among children and adolescents, there are some differences that should be noted[117]. One of the first differences is that positive psychology focusses on all individuals and not only those who have faced adversity, as is the case with research on resilience. Moreover, resilience research focusses on individuals' resilience throughout the life span, while positive psychology is primarily oriented towards adults. Regarding indicators of positive adaptation, positive psychology typically considers only positive aspects of people's functioning, primarily through self-report measures, while resilience research examines both positive and negative outcomes, mostly by using reports of others about a child's adjustment. Despite these differences, much has been done in the past few years to overcome some limitations of each area of research and to

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115 Proctor et al., 2011, p. 383.
116 McCabe et al., 2011, p. 179.
117 Luthar, Lyman and Crossman, 2014, pp. 132–133.

unite their findings to obtain a comprehensive view of resilience. Although many open questions remain about which processes lead to resilience, progress is evident. Moreover, this chapter reviewed contemporary findings, specifically from the positive psychology field, as a starting point for studying resilience among children and adolescents.

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Part III
Future Perspectives:
Parenting and Societal Outlook

| CHAPTER 11 |

Trauma-Conscious Childcare Institutions and Education System: How Can We Create a System for Both Childcare and Education That Recognises and Handles Developmental Trauma?

Ana HARAMINA

ABSTRACT

Development of trauma-conscious childcare institutions and education systems represents a pivotal shift in how we approach the well-being and development of children who have experienced trauma. By recognising the effects of developmental trauma and implementing strategies that prioritise safety, empathy, and individualised support, we can create environments that foster healing, growth, and resilience. The journey towards trauma-conscious childcare and education is an ongoing process that requires collaboration, dedication, and a shared commitment to the well-being of every child.

Introduction

Childhood experiences significantly shape an individual's physical, emotional, and cognitive development. Unfortunately, many children worldwide encounter adverse

events[1,2] that can lead to developmental trauma. These experiences, which range from neglect and abuse to witnessing violence and enduring loss, can have long-lasting effects on a child's mental health, behaviour, and ability to learn. As our understanding of trauma deepens, it becomes imperative to create childcare institutions and an education system that not only recognises but also effectively addresses developmental trauma.

This chapter delves into the concept of trauma-conscious childcare and education and the essential principles underlying this approach, exploring guidelines to create a system that fosters healing, resilience, and healthy development. By examining such guidelines of trauma-informed practices, especially related to childcare institutions and the education system, we aim to equip the reader with the basic and available current information that must be accounted for when attempting to create safe and supportive environments for children who have experienced trauma. However, it must be considered that practice and scientific research are continuously, vividly, and actively interwoven in this area, which constantly results in better and more adequate ways of acting.

By the end of this chapter, we hope that readers will gain a profound appreciation of the importance of trauma-informed practices in childcare and education. We believe that armed with this knowledge, individuals and institutions can play a vital role in nurturing resilience and empowering young minds to overcome adversity and reach for a brighter future.

2. Benefits of Trauma-Informed Practices

In the ever-evolving landscape of mental healthcare, education, and social services, the principles of trauma-informed practices have emerged as a promising approach to better understand, support, and empower individuals who have experienced trauma. There are various advantages of implementing the trauma-informed approach in systems, but they can be summarised as follows.[3,4]

Trauma-informed practices prioritise the emotional and psychological well-being of individuals who have experienced trauma. By creating safe and supportive

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1 Tanyu et al., 2020, p. 8.
2 Adverse events can occur at the interpersonal, community, or larger society level. Moreover, acute events can include natural catastrophes, disease, accidents, violent incidents in the household or society, parental divorce, or death of a loved one. Chronic adverse life events include historical trauma; poverty; marginalisation; institutional racism; and lack of safety in the community, at home, at school, or due to parental neglect or mental illness. They can also include forced labour, homelessness, displacement, or separation from loved ones. Trauma occurs when a traumatic event is exceedingly terrifying, dangerous, or detrimental to one's bodily or mental health: Tanyu et al., 2020, pp. 11–14.
3 Redd, et al., 2017, pp. 170–180.
4 Bunting et al., 2019, pp. 1–22.

environments, these practices can lead to improved mental health outcomes, including reduced symptoms of anxiety, depression, and post-traumatic stress disorder.

Trauma-informed care aims to help individuals build resilience, which is the ability to bounce back from adversity. By fostering a sense of empowerment, choice, and control, trauma-informed practices can enable survivors to develop the coping skills needed to navigate future challenges.

Trauma-informed practices emphasise the importance of avoiding retraumatisation. This means that caregivers and organisations are more attuned to potential triggers and stressors that may exacerbate trauma symptoms, thereby reducing the risk of further harm.

Trauma-informed care prioritises empowering survivors to make decisions about their own recovery and well-being. This sense of agency can be transformative, as it allows individuals to regain a sense of control over their lives.

A trauma-informed approach fosters trusting and empathetic relationships between caregivers, educators, and survivors. These relationships are built upon mutual respect and understanding, which can facilitate healing and create a supportive network for individuals.

Organisations that adopt trauma-informed practices often observe improved staff morale and reduced burnout rates. Employees in such organisations tend to feel more valued and supported, which can lead to better job satisfaction and retention.

These practices are founded on a profound recognition of the prevalence and impact of trauma in our society, emphasising the creation of safe and empathetic environments that prioritise healing and resilience.

Accordingly, the following sub-chapters consider the relationship between the child and his/her environment in the context of developmental trauma and then considers aspects of the trauma-informed system.

3. Development of the Child and His/Her Social Environment in the Context of Developmental Trauma

As already explained in more detail in a previous chapter, developmental trauma refers to complex and pervasive exposure to life-threatening events that takes place during critical stages of infant and child development; interferes with interpersonal bonds; jeopardises a person's safety and security; alters basic capacities for cognitive, behavioural, and emotional control; and frequently contributes to the emergence of complex post-traumatic stress disorder in adults.[5,6,7,8,9] Adversity and/or trauma in children can stem from a wide range of sources such as abuse, neglect, loss of a

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5 Cooke, et al., 2019, pp. 27–37.
6 Cruz, et al., 2022, pp. 1–14.
7 Jowett, et al., 2022, pp. 52–67.
8 Karatzias et al., 2022, pp. 1-6.
9 Lewis et al., 2021, pp. 448–455.

caregiver, witnessing of violence, experience of a natural disaster, poverty, and war. Poverty, caregiver neglect or absence, and risks to bodily and psychological safety are the most common causes.[10] Poverty negatively impacts children's developing brains, bodies, and emotional and behavioural health.[11,12] When adults who are supposed to take care of children do not or cannot do so, the children end up in adverse situations.[13,14] Millions of children globally face physical risks to their safety because of natural disasters or political issues such as war and conflict.[15,16] Numerous children also face various interpersonal risks that jeopardise their physical and psychological well-being.[17,18]

Healthy development involves a regulated balance between the child and the social environment, so the latter is well-equipped to support the child, as you have already learned in-depth in previous chapters and other child development literature. Impaired emotional and behavioural control and failure to preserve the natural systemic balance between the developing child and his/her social environment (e.g. family, school, peer group, and neighbourhood) are two important features of developmental trauma.[19] This regulatory balance then encompasses the care system once children enter the service system.

Considering the topic of interest of this manual (social and personality development in childhood) and the topic of this chapter (trauma-conscious childcare institutions and education system), the first two sub-chapters largely introduce some key

10 Tanyu et al., 2020, pp. 11–14.
11 cfr. Murphy and Redd, 2014.
12 Children who live in poverty are more likely to live in neighbourhoods with concentrated community poverty, which increases their risk of exposure to crime, violence, and environmental toxins. Poverty also increases the psychosocial stress parents and other caregivers experience, making it more difficult for many of them to provide a safe and nurturing environment for their children. It is also more difficult for parents and other caregivers to provide for the material requirements of their children when they are poor; cfr. Murphy and Redd, 2014.
13 Tanyu et al., 2020, p. 12.
14 Parental substance misuse, inadequate coping mechanisms, feeling of being overburdened by parental responsibilities, and other factors such as parental physical or mental health issues can all lead to child neglect. When parents neglect to take their children to school regularly or fail to offer proper supervision, it can interfere with the children's healthy development. Certain forms of neglect are related to the physical needs of the child; these include inadequate medical attention, inadequate nutrition (if the caregiver can afford to feed the child enough), insufficient material resources (e.g. clothing and school supplies), or an unhygienic or unsafe environment; Tanyu et al., 2020, p. 12.
15 Tanyu et al., 2020, p. 12, p. 25.
16 Over 13 million school-aged children were refugees or internally displaced as of 2019, with 7.9 million of them aged between 5 and 11 years and 5.2 million aged between 12 and 17 years; Tanyu et al., 2020, p. 25.
17 Tanyu et al., 2020, p. 12.
18 Besides coming from the community, school, or larger society, these threats—which include peer aggression, physical abuse, psychological abuse, and sexual abuse—often start in the child's household; Tanyu et al., 2020, p. 13.
19 Saxe, Ellis and Kaplow, 2007, p. 6.

ideas that present the trauma systems therapy approach[20] in an interesting, practical, clear, and evidence-based[21,22] manner. Presenting the entire approach, which involves a comprehensive treatment, exceeds the goal of this chapter and topic. Nevertheless, we consider the basic starting ideas to be concrete and applicable (without diminishing the complexity of the dynamics) and therefore significantly useful in understanding the mentality required for creating trauma-conscious childcare institutions and education system.

3.1. Considering the Fundamentals of Child Development

The fundamentals of child development must be considered when intervening with a child who has suffered developmental trauma. Understanding that the appropriate interventions for infants and adolescents are different is important, as is the fact that a treatment plan for a child with developmental delays would differ from one for a child without such delays. At different ages, we must think about how to handle issues such as attachment, emotional control, identity, and cognition in interventions. These concepts are crucial for a child who has suffered developmental trauma.

The fundamental cause of traumatic stress is survival. The brain interprets potentially lethal events and converts this information into actions that keep the body alive. This mechanism is known as survival circuits.[23] When faced with life-threatening circumstances, our brain processes information emotionally and takes over our awareness. Such processing is typically fast, fragmented, decontextualised, stimulated, moment-to-moment concentrated, and accompanied by survival behaviour. One characteristic that makes child traumatic stress distinct is dysregulation of emotional states.[24] Emotional states are characterised by unique patterns of thinking, feeling, and behaviour that are comparatively stable and strongly associated with an individual's self-concept and interpersonal relationships. Even though awareness

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20 In addition to individual-based methods, trauma systems therapy is a complete strategy for treating traumatic stress in children and adolescents that directly addresses the children's social context and/or system of care. Trauma systems therapy was created to offer a comprehensive and well-coordinated system of services, all of which are based on in-depth knowledge of the characteristics of child traumatic stress. By improving the children's ability to regulate emotions and reducing continuing stresses and threats in the social environment, trauma systems therapy aims to assist the children learn control over their emotions and conduct. Trauma systems therapy was created to increase the ability of important people in a child's surroundings to support him/her in managing his/her emotional and behavioural responses. In addition to providing a unique and innovative clinical model trauma systems therapy offers a framework for setting up trauma-informed services. The four main intervention modules that make up the phase-based treatment approach for trauma systems therapy are (1) home and community-based care, (2) services advocacy, (3) emotion regulation skills training, and (4) psychopharmacology. Depending on the child's level of emotional dysregulation and stability of his/her social environment, different modules may be therapeutically necessary; Saxe, Ellis and Kaplow, 2007.

21 Redd, Malm, Moore, Murphy and Beltz, 2017, pp. 170–180.

22 Murphy, Moore, Redd and Malm, 2017, pp. 23–34.

23 cfr. Sullivan and Opendak, 2018, pp. 50–55.

24 cfr. Andrewes and Jenkins, 2019, pp. 220–243.

operates moment by moment, the brain blends moments together to create a continuous sense of self. This basic neural ability to combine events is essential to our ability to develop a consistent identity or sense of self across time.[25] Early interpersonal relationships children experience shape their brain's survival circuits, which in turn affects their ability to control their emotions under pressure.[26] It is crucial to remember that correct experiences (safe relationships) have the power to modify the survival circuits of children who have undergone traumatic stress as well as their social surroundings.[27] When approaching this with a developmental mindset, we might think about many questions to ask for establishing safe and supportive surroundings, such as the following:[28] What type of attachment bonds might a child who has a depressed mother and a very aggressive father form? What impact does his father beating him up have on his sense of self, self-worth, and sense of control? How do these experiences impact a child's capacity for emotion regulation, and how do they affect attachments and identity formation? What kinds of peer groups does he typically join? How do cognitive growth and academic achievement differ for children who experience terror?

3.2. Considering the Social Ecology and Adopting a Systemic Mindset

The social environment's responsibility after a trauma (in the context of the previously highlighted dynamics of traumatic stress) is to help the child regulate abilities so that he/she may successfully control the resulting emotions. Members of the child's social environment must recreate a sense of stability, control, and order, which requires engagement of a lot of people: parents, guardians, relatives, friends, teachers, social service workers, therapists, psychopharmacologists, and advocates.

In shaping a child's development, larger organisations, and cultural surroundings play critical roles, according to Bronfenbrenner.[29] Each level of social ecology is crucial to some part of a child's healthy development and, as a result, may be crucial to the child's recovery after experiencing traumatic stress. The Bronfenbrenner model[30] gives us a means to comprehend how children affect and are influenced by their environment as they grow. These interactions, or mutual impacts, show how healthy development can either be aided or hindered.

The *individual* level includes all that a person contributes to any circumstance, including their biology and the knowledge and abilities they have acquired up to that point in their development.[31] The emotional, cognitive, and behavioural resources (i.e. strengths and weaknesses) children have available to them as they engage with the world around them are determined by their experiences, and these experiences

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25 cfr. Music, 2018, pp. 71–93.
26 cfr. Schore, 2001, pp. 201–269.
27 Saxe, Ellis and Kaplow, 2007, pp. 23–45.; Shonkoff, Phillips, 2000.
28 Saxe, Ellis and Kaplow, 2007, pp. 60–61.
29 Bronfenbrenner, 1979, pp. 109–295.
30 Bronfenbrenner, 1999, pp. 3–28.
31 Ibid.

are crucial in deciding how they will react to traumatic situations. Children who have established good adaptive resources will be fairly resilient in the face of trauma, whereas children who do not have such resources may not be able to adapt well to stressful situations and even end up with psychopathology. The child's capacity for emotional control "houses" itself at this specific level of social ecology.[32]

The *microsystem*, which includes the family environment and factors such as parenting styles, family dynamics, developmental histories, psychological resources of every family member (e.g. their strengths and weaknesses), financial strains, and family members' own experiences with and reactions to traumatic events, is the next level of the social ecology.[33] It includes the family environment. These elements affect not only how the family functions but also how parents teach their kids to control their emotions and behaviour. A child's ability to adjust to stressful events will be greatly influenced by how his/her family handles them. The degree of the child's discomfort will also impact how the family copes.[34]

The *exosystem* is the next level, and it consists of both formal and informal social structures, including schools, peer groups, social networks, churches, presence of structured support systems and services, and career opportunities that impact the children's immediate surroundings.[35] The risk and resilience characteristics of these environmental components have significant effects on development. Children's development will be impacted very differently by an exosystem that offers them a suitable educational setting, a secure neighbourhood with opportunities for prosocial peer and support network interactions, and long-term employment opportunities for caregivers, compared with an exosystem wherein children do not receive proper education or support in school, neighbourhood conditions are violent and residents feel unsafe, peer and social support networks are weak, and so on.[36] These environments, as one might expect, will also have diverse effects on how children heal from traumatic experiences.

The *macrosystem*, which is the final component, includes cultural beliefs and values that influence how the society functions in general and how families work in particular.[37] In essence, this level of culture shapes how individuals and families interact with other levels of the social ecosphere, and it surrounds and imbues every other level of the child's reality with meaning. The members' understanding of trauma, proper and inappropriate responses to it, and the therapies required to address it are all influenced by these cultural factors.[38]

The topic of our chapter focusses, in accordance with the previous description, on the last two levels.

32 Saxe, Ellis and Kaplow, 2007, pp. 70–71.
33 Bronfenbrenner, 1999, pp. 3–28.
34 Saxe, Ellis and Kaplow, 2007, p. 71; p. 76.
35 Bronfenbrenner, 1999, pp. 3–28.
36 Saxe, Ellis and Kaplow, 2007, p. 71; pp. 77–80.
37 Bronfenbrenner, 1999, pp. 3–28.
38 Saxe, Ellis and Kaplow, 2007, p. 72; pp. 80–82.

3.3. Importance of Early Childhood Experiences

Relationship quality determines the success or failure of care interventions. The traumatised child usually becomes the focus of professional interest because of some sort of relationship issue, and the strength of the relationship the professionals build with the child (and family) offers the only chance for rehabilitation.[39] Therefore, as professionals, we shall either carry out our task knowing or ignoring this basic fact.

Relationships act as a bridge between a child's capacity for emotional regulation and the social environment's ability to support that capacity. The level of quality of interpersonal relationships impacts how emotions are controlled. In very early stages of development, regulatory responsibilities are understood as interactions between the infant and caregiver rather than as capacities of the individual infant. Regulating the infant's distress is the main focus of the caregiver's response. As the infant grows older and gains the ability to control his/her own distress, these developments are continually improved through interactions with caregivers. These concepts are heavily influenced by the attachment theory,[40,41] and the nature of these connections can be characterised as signals of caring within care systems. This critical mass of care signals from people within the system must serve as the foundation upon which systems of care are constructed.[42] The child (or any human) will feel uneasy, uncomfortable, and unsafe if enough care signals are not present. The literature and research distinguish between developmental and interpersonal trauma and consider their combined effects. The many manifestations of affective, behavioural, cognitive, relational, somatic, and self/identity dysregulation are combined to form developmental trauma disorder. Interpersonal or complex trauma—intentional acts by other people that endanger children's life or physical integrity, as well as their primary support systems and caregivers—have particularly severe and pervasive negative effects on children's psychosocial functioning and neurodevelopment.[43] The

39 Central to the relational dynamic approach is the acknowledgement that transformation of the self and others occurs within relationships and can potentially continue throughout one's life. For theoretical and research-based accounts of infant-caregiver intersubjectivity underpinning the relational dynamic approach, and for understanding how the practices of therapy, supervision, and education provide a potential matrix for transformation, one can consult works such as Macaskie, Meekums and Nolan, 2013, pp. 351 -362.

40 Schore and Schore, 2008, pp. 9–20.

41 Attachment theories postulate that the physical bond between a parent (typically the mother) and child fosters a sense of both physical and psychological security. Nonresponsive or rejecting interactions with caregivers can induce feelings of anxiety, insecurity, and low self-esteem in the child. These psychological insecurities can impede the child's ability to form fulfilling relationships with others, including, ultimately, their own offspring. Therefore, attachment theorists posit that neglectful and abusive behaviours are transmitted across generations. However, the attachment theory has been critiqued for its limited conceptualisation of family dynamics beyond the mother-child dyad and for its failure to incorporate social and cultural factors such as poverty and unemployment. Nonetheless, the theory's emphasis on psychological security and interpersonal relationships constitutes a significant contribution to the understanding of the psychodynamics of abuse; Anderson, 2008, p. 243.

42 Saxe, Ellis and Kaplow, 2007, pp. 84–86.

43 Spinazzola, Van der Kolk and Ford, 2018, pp. 631–642.

formation of attachment bonds between young children and their primary caregivers can also be affected or disrupted when children and their caregivers experience interpersonal trauma. Interpersonal trauma and primary attachment disruption have been demonstrated to impede children's ability to master critical life skills such as emotion regulation, autonomy, and age-appropriate prosocial skills.[44] These skills are essential for learning and thriving in relationships and activities that are essential to psychosocial development. However, as discussed in subsection 1.1, emotional processing and, consequently, the survival circuits, can be regulated by strong, safe, and caring relationships. Such relationships are restorative and healing in all areas of life, but they become even more important when considering the possibility of retraumatisation.[45]

To summarise, as a multifactorial neurobehavioral disturbance, developmental trauma significantly alters children's cognitive, emotional, physiological, and relational capacities.[46] Nevertheless, various factors, all of which can lessen the long-term effects of developmental trauma, related psychiatric comorbidities, and functional impairments, mediate and/or attenuate the mental health issues linked to the development of trauma. The Bronfenbrenner socio-ecological model[47] supports this idea by arguing that multiple levels of influence[48]—individual, interpersonal, organisational, community, and public policies—are required to comprehend the wide range of adaptations associated with interpersonal trauma, because they can either confer additive risks or, conversely, potentiate positive and resilient transformations in response to adverse childhood experiences.

4. Systems of Care

Children, families, and several levels of the social ecology can all suffer from the effects of traumatic experiences. Trauma can also reduce children's ability to receive support from their environment. Individual-level interventions are insufficient to address all these problems. Comprehensive interventions are needed to assist

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44 Ibid.

45 Retraumatisation is defined as one's reaction to traumatic exposure that is amplified or shaped by one's reactions and style of adaptation to previous traumatic experiences. Retraumatisation generally refers to the resurgence of symptoms that were previously experienced because of trauma, even though the exposure may not be intrinsically traumatic and may only contain reminders of the initial traumatic event or relationship. This idea is given additional depth by the attachment theory, which places trauma and trauma adaptation in the context of intimate relationships; Alexander, 2012, pp. 191- 220.

46 Recurring traumas become transformative developmental experiences that change the global evaluation of children with traumatic histories and their subsequent reactions to stress (VanMeter, Handley and Cicchetti, 2020, pp. 1–11.

47 Kelley, Curtis and Wieling, 2022, pp. 476–489.

48 Systemic factors such as the state and federal policies, distribution of resources for prevention and intervention, discrimination, and stigma impact how people respond to trauma and how quickly they recover; Cruz, et al., 2022, p. 8.

children, enhance the capacity of the many levels of their social ecology, and aid them in the process of recovering from traumatic events.

4.1. Education System

The setting in which children spend the most of their time is the school environment, which is comparable to the home environment. The school gives children the chance to interact socially; receive career training; participate in sports; and, in certain schools, learn about religion. Additionally, children must attend school. Therefore, schools play a crucial role in every child's social ecology and are crucial to interventions in the lives of traumatised children. Sadly, the same elements that make schools such a significant part of a child's life—being in charge of many aspects of child development for so many children—can make it challenging for teachers or school staff to attend to specific trauma-related needs of individual kids.[49]

Working with the school as part of the child's social environment involves, among other things, assisting teachers in comprehending the central and additional characteristics of traumatic reactions, such as understanding the distinctions between inattention and dissociation, between hyperactivity and the potential for increased arousal and watchfulness (hypervigilance), and between inattention and dissociation.[50] Teachers could also use assistance that acknowledges the obstacles they encounter when managing the demands of working with traumatised children in the context of their other professional obligations.

Depending on the circumstance, either the classroom needs to be modified or the teachers need additional training to help them deal with traumatised students in the classroom. Through the use of behavioural modification plans, curriculum adaptations, coordinated counselling services, transportation, social skills instruction, assistance with activities of daily living, attendance at summer school, use of in-school respite workers, supportive tutoring, tracking and investigation of the causes of school absence, and other strategies, individualised education plans can be developed for children to specifically address problems of traumatic stress.[51]

4.2. Childcare Institutions

Social service agencies are often involved in the lives of traumatised children with the overarching goal of protecting the child. However, underneath that shared goal can be a lot of different opinions about how to best provide that protection and different assessments of what is urgent or important to do for any given child.[52] The essential elements of trauma-informed child welfare practices to guide caseworkers include the following:[53]

• maximise the child's sense of safety;

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49 Ko et al., 2008, p. 398.
50 Saxe, Ellis and Kaplow, 2007, p. 78.
51 Ko et al., 2008, p. 398.
52 Saxe, Ellis and Kaplow, 2007, p. 80.
53 Ko et al., 2008, pp. 397–398.

- assist children in reducing their overwhelming emotions;
- help children create new meaning of their trauma history and current experiences;
- address the impact of trauma and subsequent changes in the child's behaviour, development, and relationships;
- coordinate services with other agencies;
- utilise comprehensive assessment of the child's trauma experiences and their impact on the child's development and behaviour to guide services;
- support and promote positive and stable relationships in the life of the child;
- provide support and guidance to the child's family and caregivers; and
- manage professional and personal stress.

Some examples of how children's traumatic experiences can result in the involvement of legal or court systems include an investigation into a child's abuse for the purpose of the perpetrator's prosecution, a refugee family's petition for political asylum, or a child's behavioural dysregulation.[54] To be the most beneficial and least harmful for a child, the legal services system may require support and advice from a trauma-trained clinician, just like any other layer of the social ecology.[55]

In the framework of the quality improvement and quality assurance systems already utilised for integrating and assessing promising new practices, healthcare organisations are well-positioned to adopt evidence-based traumatic stress therapies. Through inclusion into the current quality improvement-assurance activities, trauma stress screening and therapies may gain further traction in healthcare systems.[56]

Numerous families and children have spiritual and cultural ties that influence how they view themselves. Given the significant role these systems can play in the recovery of a child and family from traumatic events, it is crucial to consider how these layers of the social ecology can be incorporated into the child's treatment.[57]

According to Bronfenbrenner's theoretical framework, additional coordinated efforts among leaders and stakeholders in the fields of education, law, medicine, and politics would be feasible if they were aware of the prevalence and range of opportunities for reversing the detrimental effects of developmental trauma disorder. This requires considerable alteration for those who have been diagnosed with it, which necessitates this kind of knowledge. Systems must support formal policies that, at the organisational level, acknowledge, value, and de-stigmatise developmental trauma disorder.[58] System-wide policies and procedures are advocated, such as enhanced and coordinated evaluation protocols, formal response training, long-term care

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54 Saxe, Ellis and Kaplow, 2007, p. 81.
55 Ko et al., 2008, pp. 400–401.
56 Ibid.
57 Saxe, Ellis and Kaplow, 2007, p. 82.
58 Matlin et al., 2019, pp. 451–466.

programmes, and community participation, to identify, support, and treat persons with developmental trauma disorder.[59]

5. Trauma-Informed Approach

A trauma-informed approach is a comprehensive framework that acknowledges the prevalence of trauma in the society and seeks to create a culture of understanding, empathy, and support for individuals who have experienced trauma. Its fundamental principles guide organisations, institutions, and individuals in recognising, responding to, and preventing the effects of trauma. The framework for the trauma-informed approach, along with its key assumptions, principles, and guidance for its implementation, is a product of the work of the Substance Abuse and Mental Health Services Administration (SAMHSA). The SAMHSA document guides worldwide systems that want to implement a trauma-informed approach in their operations. Therefore, the following two sub-chapters are largely guided by these guidelines and data from research that monitored the processes and effects of the implementation of trauma-informed practices.

5.1. Key Assumptions in a Trauma-Informed Approach

Services, programmes, organisations, and systems that include trauma-informed approaches consider what SAMHSA has dubbed the "4 Rs": the realisation that trauma has a significant impact on the person, but there are multiple pathways to recovery; the recognition that trauma may result in signs and symptoms of significant disruption; a comprehensive and integrative response to the person exposed to trauma; and a reduction in the risk of retraumatisation.[60]

In a trauma-informed approach, everyone in the organisation or system, regardless of level, has a fundamental understanding of trauma and is aware of how it can affect families, groups, organisations, and communities in addition to individuals. People's experiences and behaviours are interpreted in the context of coping mechanisms intended to help people deal with difficult situations.[61]

Individuals within the system or organisation can also identify the symptoms of trauma.[62] These symptoms may be specific to gender, age, or environment and may be displayed by people who are receiving or giving services in these environments. The

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59 Cruz, et al., 2022, pp. 1–14.
60 Tebes, et al., 2019, pp. 494–508.
61 SAMHSA, 2014, p. 13.
62 Some examples of possible symptoms of trauma in childhood are as follows: Preschoolers may experience nightmares, excessive crying or screaming, poor eating and weight loss, anxiety, or fear of being separated from parents or caregivers. Elementary school students may experience anxiety, fear, guilt, difficulty concentrating, difficulty sleeping, or feelings of depression or isolation. Middle and high school students may experience eating disorders and self-harming behaviours, start abusing alcohol or drugs, or start engaging in sexual activity.

identification of trauma is aided by strategies for workforce development, employee assistance, and supervision as well as trauma screening and assessment.[63] It is crucial to emphasise that trauma manifests differently for every child because early development is unique. This is especially true for children.

The language, behaviours, and policies used by staff in every area of the organisation—from the person who welcomes clients at the door to the executives and governance board—have been altered to account for the trauma experienced by both children and adults who use the services as well as by the staff who provide them. This is achieved through leadership that recognises the impact of trauma on the lives of their staff and the clients they serve, staff training in evidence-based trauma procedures, and a budget that supports ongoing training. Organisational policies such as mission statements, staff handbooks, and manuals encourage a culture based on ideas of resilience, healing from trauma, and recovery from trauma. The organisation is dedicated to offering a setting that is both physically and emotionally secure.[64]

A trauma-informed approach aims to prevent staff members and clients from experiencing new trauma. Employees who work in a trauma-informed setting are trained to notice how organisational procedures may bring back unpleasant memories and retraumatise clients who have experienced trauma in the past.[65]

5.2. Implementation Domains of Trauma-Informed Approach

SAMHSA's (2014) *Concept of Trauma and Guidance for a Trauma-Informed Approach* also provides a list of domains through which trauma-conscious care is implemented in different organisations. In the following, we provide a brief description of areas for which the concepts were adapted from the work of different authors.[66,67] Moreover, we are guided by SAMHSA's manual.[68] It is precisely through the following areas of application of trauma-conscious care that we can observe the progress of the adaptation process as well as spot areas that need improvement.

Regarding leadership and governance of the organisation, it should be considered how, for example, the agency leadership communicates and demonstrates its support and guidance for implementing a trauma-informed approach.[69]

Within the domain of policy, it should be considered how, for example, the agency's written policies and procedures recognise the pervasiveness of trauma in the lives of people using services, express a commitment to reducing retraumatisation and promoting well-being and recovery, and demonstrate a commitment to staff

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63 SAMHSA, 2014, p. 13.
64 Ibid.
65 Ibid.
66 Fallot and Harris, 2006, pp. 1–25.
67 Henry, et al., 2010.
68 SAMHSA, 2014, pp. 1–27.
69 Ibid.

training on provision of services and supports that are culturally relevant and trauma-informed as part of staff orientation and in-service training.[70]

The physical environment must be welcoming, safe, and not a threat to the physical or psychological safety of the organisation's employees and those receiving services.[71]

At all levels and in all functional areas of the organisation, those in recovery, trauma survivors, those in need of assistance, and members of their families in need of services should have a significant voice and meaningful choice.[72]

Within the domain of cross-sector collaboration, it should be considered, for example, if a system of communication is in place with other partner agencies working with the individual receiving services to make trauma-informed decisions, and what mechanisms are in place to promote cross-sector training on trauma and trauma-informed approaches.[73]

Evidence-based, trauma-specific screening, assessments, and therapy should be used effectively, while trauma-informed principles need to be continuously evaluated, tracked, and monitored. This is important regarding trauma education for members of organisational staff and for individuals and families seeking services so that they can choose from a variety of appropriate, efficient, and available trauma-specific interventions.[74]

There are also peer support and procedures in place to support staff who have experienced trauma in the past and/or who are suffering from severe secondary traumatic stress disorder or vicarious trauma from being exposed to and working with people who have experienced complex trauma.[75]

The financing structures should support a trauma-informed approach, including resources for staff training on trauma; creation of suitable and safe facilities; development of peer support networks; provision of supports for screening, assessment, treatment, and recovery from trauma; and creation of trauma-informed cross-agency collaboration.[76]

Finally, it should be considered, for example, how the agency conducts a trauma-informed organisational assessment or what measures or indicators show their level of trauma-informed approach?[77]

Considering the areas of implementation of the trauma-informed approach, below, we take a closer look at some aspects of this application in the field of the education system, child welfare, and legal system, which have been pointed out by research collected in some systemic reviews.

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70 Ibid.
71 Ibid.
72 Ibid.
73 Ibid.
74 Ibid.
75 Ibid.
76 Ibid.
77 Ibid.

6. Implementing a Trauma-Informed Approach

When implemented effectively, trauma-informed care has the potential to transform lives, organisations, and communities. It can break the cycle of trauma, promote healing, and empower survivors to regain control of their futures. Additionally, organisations that adopt trauma-informed practices often see improved staff morale, reduced burnout, and better outcomes for the individuals they serve.[78] Implementing trauma-informed care requires a systemic approach. This means integrating trauma-informed principles into every aspect of care, from policy development and organisational culture to individual interactions. Trauma-informed care should not be viewed as a one-size-fits-all approach but as a flexible framework that can be adapted to various settings, including healthcare, education, and social services.

The main goal of treatment strategies is to lessen the signs and symptoms of psychological, behavioural, social, and spiritual disruption following a traumatic incident for an individual, family, or society. It is the goal of prevention or promotion strategies to lessen the possibility of disruption following trauma. Although evidence-based treatments have been demonstrated to be successful in fostering recovery,[79,80] their widespread application is constrained since their performance and maintenance necessitate substantial professional training. Contrarily, preventative or promotion strategies provide a larger range of interventions for promoting wellbeing that can be used before experiencing trauma and in various settings.[81] Considering the developmental context in working with children, we want to promote the development of trauma-informed service collaborations that include both treatment/healing and prevention/promotion approaches.

6.1. Some Key Principles of a Trauma-Informed Approach

Instead of following a predetermined set of techniques or processes, a trauma-informed approach demonstrates adherence to fundamental principles. Although terminology and application may be sector- or setting-specific, these ideas may be applicable in various circumstances. Below, we briefly describe the key principles of a trauma-informed approach.

Creating a safe and supportive environment is paramount in trauma-informed care. This involves physical safety, emotional safety, and the assurance that individuals will not be retraumatised or harmed while receiving care. Understanding safety as defined by those served is a high priority.[82]

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78 cfr. Azeem et al., 2017, pp. 170–174; Huckshorn, 2014, pp. 40–47.
79 Branson, et al., 2017, pp. 635–646.
80 Hanson and Lang, 2016, pp. 95–100.
81 Herrenkohl, Leeb and Higgins, 2016, pp. 363–365.
82 SAMHSA, 2014, pp. 14-16.

Building trust is the cornerstone of trauma-informed care. Caregivers and organisations must be transparent, honest, and reliable in their interactions with survivors of trauma, fostering trust and reducing the potential for revictimisation.[83]

Trauma-informed care recognises the value of peer support and collaboration. Survivors often benefit from connecting with others who have had similar experiences, providing validation, empathy, and shared coping strategies. Healing happens in relationships and in the meaningful sharing of power and decision-making. The organisation recognises that everyone plays a role in a trauma-informed approach.[84]

Strengths and experiences of individuals are acknowledged within the organisation and among the clients it serves, and they are built upon. The organisation promotes the idea that the people it serves come first; that people are resilient; and that people, groups, and communities are capable of promoting healing and recovery from trauma. Giving survivors of trauma a sense of agency and control over their life is important. Trauma-informed care must include empowerment and choice so that victims can decide how they will heal and recover.[85]

The organisation is actively responsive to the racial, ethnic, and cultural needs of those served and rejects cultural stereotypes and biases.[86]

6.2. Trauma-Informed Childcare Institutions

A system-wide awareness of how to recognise and address the effects of traumatic stress, child screening and assessment, data systems, workforce development, and evidence-based and evidence-informed treatments are characteristics of trauma-informed child welfare systems.[87] However, no particular specified activities or programmes exist because this approach tries to generate a tailored reaction to each child's specific trauma history.[88] Nonetheless, there is mounting proof that relationally focussed interventions and integrative treatment modalities are successful in treating developmental trauma disorder. The adaptable, component-based intervention known as attachment, regulation, and competency (ARC)[89] was created for children and adolescents who have undergone complex trauma as well as for their caregiving systems. The four main research domains forming the basis of ARC are risk and resilience, attachment, traumatic stress, and normative childhood development. ARC is intended to be used as not only an organisational framework to support trauma-informed care in service systems but also an individual level clinical intervention in youth and family treatment settings. ARC-identified concepts have been applied successfully to the youth with a wide range of symptom presentations and developmental and cognitive functioning levels, from infancy to young adulthood.

83 Ibid.
84 Ibid.
85 Ibid.
86 Ibid.
87 Child Welfare Information Gateway, 2015.
88 Berliner and Kolko, 2016, pp. 168–172.
89 You can find a comprehensive description in Blaustein and Kinniburgh, 2018.

Considering the people working with children in childcare institutions, we can mention trauma systems therapy. A research-based strategy called the trauma systems therapy was created to help children and young people who have suffered trauma function better emotionally, socially, and behaviourally. According to trauma systems therapy, trauma must be addressed as a barrier to children's self-regulation before they can identify and cope with it through cognitive behavioural therapy and other therapies. It is predicated on the idea that to give children a sense of safety and empower them to identify and process their trauma, the "triggers" in their surroundings that set off "fight, flight, or freeze" reactions must be lessened or eliminated.[90] When trauma systems therapy was incorporated into child welfare systems, improvements were observed among not only care team members who had the closest contact with children but also those who had a more distant relationship. This suggests that the knowledge, expertise, and coherence of the child's care team as a whole may be more responsible for producing better results than specific individuals.[91]

Based on the proposed guidelines and available research, we briefly summarise several guidelines for trauma-informed care in the welfare system:

- Children who have experienced trauma often have heightened sensitivity to their environment. Trauma-conscious institutions should prioritise physical and emotional safety, providing predictable routines and clear boundaries that help children feel secure.
- Staff in trauma-conscious childcare institutions should be trained in recognising signs of trauma and responding with empathy. Teaching children healthy emotional regulation strategies empowers them to manage their feelings in a constructive manner.
- Building secure attachments is vital for children who have experienced trauma. Caregivers should employ attachment-focussed techniques that facilitate trust and emotional connections between children and caregivers.
- Trauma-informed practices involve understanding the effects of trauma and integrating this understanding into all aspects of care. This might include avoiding triggering language or situations and providing sensory tools to help children self-regulate.
- Collaboration with mental health professionals and families is essential. Trauma-conscious childcare institutions should establish partnerships that offer comprehensive support for children's emotional well-being.

6.3. Trauma-Informed Education System

The goal of trauma-informed school approaches is to lessen the effects of trauma and support healing, growth, and change by utilising all facets of the educational system, including policies and procedures that collectively create safe and supportive

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90 Redd et al., 2017, pp. 173–180.
91 Bunting et al., 2019, pp. 17–19.

learning environments.[92] This helps support all students' wellbeing and development and enables them to control their emotions, pay attention, and succeed in school and in their social and academic environments.

Studies identified professional development as a key change agent, essential to developing trauma literacy and enhancing motivation to modify practices. Staff training helped staff members reframe difficult student behaviours to reduce their own potential reactive responses and the risk of punitive measures, which may have prevented future student escalation.[93]

Adoption of trauma-informed rules and procedures, particularly regarding disciplinary processes, were viewed as important organisational reforms that would help minimise incidents and maximise learning time. Discipline reforms supported "time-in" rather than "time-out" in classes by focussing on developing self-regulation skills, improving empathy, and sustaining relational connection. The literature on evidence-based therapies for trauma provides significant support for swapping out punitive, reactive measures with restorative, strength-based, and skill-building approaches.[94]

Various elements of trauma-informed schools, such as social and emotional well-being and strength-based relational practices, have strong evidence linking them to improved learning outcomes.[95]

Approaches including restorative practices, mindfulness, social emotional learning, positive behavioural interventions and supports, and a focus on the school environment and culture have all seen notable increases in popularity and use. Many of these strategies offer learning, healing, support, and connections—all of which are beneficial for students who have experienced trauma.[96] An evidence-based, tiered framework called positive behavioural interventions and supports is used to support students' academic, behavioural, social, emotional, and mental health. When applied faithfully, this framework enhances academic performance, school atmosphere, and social emotional competency. It also enhances the health and happiness of teachers.[97] It is a means of establishing learning settings that are encouraging, dependable, fair, and secure so that everyone can succeed.

Based on the proposed guidelines and available research, we briefly summarise several guidelines for trauma-informed care in the education system:

• Educators should receive training in recognising signs of trauma and understanding its effects on learning and behaviour. This could empower teachers to create an inclusive and supportive classroom environment.

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92 Bateman, Henderson and Kezelman, 2013, pp. 3–6.
93 Avery et al., 2021, pp. 381–397.
94 Ibid.
95 Ibid.
96 Thomas, Crosby and Vanderhaar, 2019, pp. 422–452.
97 Eber, et al., 2020, pp. 1–17.

- Trauma-informed classrooms should prioritise emotional and physical safety. This involves establishing clear behaviour expectations and fostering a sense of belonging for all students.
- Teaching children self-regulation skills can aid their ability to manage emotions and stress.
- Children who have experienced trauma might have unique learning needs. Trauma-conscious education systems should develop individualised plans to accommodate these needs and provide necessary support.
- Social and emotional learning programmes could be integral to trauma-informed education. They equip students with skills for recognising and managing emotions, building positive relationships, and making responsible decisions.
- Recognising that trauma can be experienced differently across cultures, trauma-conscious education systems should embrace culturally responsive practices that honour students' diverse backgrounds and experiences.
- Adequate training for caregivers and educators is crucial. This requires resources and commitment from institutions and governing bodies.
- Creating trauma-conscious environments may require additional resources, including staffing, materials for sensory tools, and mental health support.
- Effective collaboration between childcare, education, and mental health professionals is essential but can be complex to establish and maintain.
- Limitations in the research and overall lack of studies indicate that more rigorous collaborative research is needed to determine which approaches contribute to what positive outcomes, for which students and under what conditions.

6.4. Trauma-Informed Justice Systems

The juvenile justice system is a complex network of interconnected institutions, including police departments, courts, jails, detention facilities, or "training schools" (along with the educational programmes and medical care provided therein), probation and parole officers, residential facilities such as group homes and residential centres, and community rehabilitation programmes. The juvenile justice system has a widespread understanding that trauma plays a crucial role in the development and rehabilitation of juvenile offenders.[98]

Numerous trauma-informed treatment programmes have been created to lessen the impact of trauma as juvenile justice systems have become more sensitive to the needs of traumatised adolescents. Studies on trauma-informed care show that the symptoms associated with trauma can be lessened with its use. Additionally, earlier studies have shown that trauma-informed therapy can lower behavioural transgressions and institutional violence.[99]

While the fundamental aspects of trauma-informed practice were generally consistent, individual practices and policies showed a great deal of variance. More

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98 Ko et al., 2008, pp. 400–401.
99 Zettler, 2021, pp. 113–134.

research is required to evaluate the variety of trauma-informed interventions at each step of the juvenile justice system.[100]

Juvenile justice agencies should conduct trauma screening and thorough assessments of trauma-related symptoms for all young people who come into contact with the system to offer tailored therapy to adolescents with traumatic histories. Additionally, juvenile justice personnel should receive training on how to determine what type of therapy would be most advantageous for a certain child based on the outcomes of screening and assessment procedures.[101]

Additionally, it is crucial that care providers apply evidence-based strategies that have been shown to be successful in treating trauma-related symptoms. While cognitive behavioural and skills-based programmes have been shown to be helpful in lowering trauma-related and other mental health symptoms, little is known about how well they work in preventing other outcomes, such as future violence and recidivism.[102]

In light of the previous general guidelines, guidelines on the school and welfare system, and a few remarks regarding the trauma-informed justice system, we would like to conclude the story with a few ideas about the ways in which professionals in the legal system can contribute in different segments for the implementation of trauma-informed care:

- Professionals in the legal system are instrumental in ensuring that trauma survivors have access to justice. They can help survivors navigate the legal system, providing legal representation, information, and support throughout the process.
- Professionals in the legal system should advocate for the protection of the rights of trauma survivors, including the right to safety, privacy, and dignity. They can challenge systems or institutions that perpetuate retraumatisation or violate survivors' rights.
- Professionals in the legal system could engage in policy advocacy to create and change laws and regulations that impact trauma survivors. This includes advocating for policies that support trauma-informed practices in various sectors, from healthcare to education.
- Professionals in the legal system can play a crucial role in raising awareness about the prevalence and impact of trauma. They can mobilise public opinion, engage with policymakers, and promote trauma-informed approaches in communities and organisations.
- Professionals in the legal system often work in collaboration with other professionals, including lawyers, healthcare providers, educators, and social workers, to promote trauma-informed practices. This collaboration ensures a holistic approach to supporting survivors.

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100 Ibid.
101 Ibid.
102 Ibid.

- Professionals in the legal system could facilitate training and education programmes to help communities understand trauma and its effects. They can promote empathy, reduce stigma, and encourage community members to become allies in supporting survivors.
- Professionals in the legal system work to influence policy at the local, state, and national levels. They could lobby for changes that prioritise trauma-informed practices in various systems, including criminal justice, healthcare, and education.
- Professionals in the legal system can incorporate trauma-informed principles into their own legal practice. This involves recognising the trauma history of clients, adapting communication styles, and creating supportive legal environments.

7. Challenges of Trauma-Informed Practices

While the benefits of trauma-informed practices are substantial and promising, it is also essential to acknowledge their inherent limits and complexities. By comprehending both aspects, we can forge a more nuanced and informed path towards supporting and healing individuals who have experienced trauma, ultimately striving for a more compassionate and resilient society. Challenges in implementing the trauma-informed approach in systems can be summarised as follows.[103,104]

Implementing trauma-informed practices can be resource intensive in terms of time, training, and financial investment. Many organisations may struggle to allocate the necessary resources to fully embrace these principles.

Trauma-informed practices are not universally applicable in the same way across all contexts. What works in one setting may not work in another. This necessitates flexibility and adaptability, which can be challenging to achieve consistently.

While trauma-informed practices are widely recognised as beneficial, the empirical evidence supporting their effectiveness is still evolving. More research is needed to establish clear guidelines and best practices.[105]

Without proper training and understanding, there is a risk of misapplying trauma-informed practices, which can inadvertently cause harm. For instance, making assumptions about individuals based on their trauma history can be counterproductive.

Addressing trauma is complex, and the road to recovery can be long and challenging. Trauma-informed practices cannot provide quick fixes and require a long-term commitment to support survivors on their journey to healing.

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103 Redd et al., 2017, pp. 170–180.
104 Bunting et al., 2019, pp. 1–22.
105 Berring et al., 2024, pp. 1–26.

Some organisations and individuals may resist the shift towards trauma-informed practices, viewing it as a departure from established norms or practices. Overcoming this resistance can be a significant barrier to implementation.

8. Conclusion

In conclusion, trauma-informed practices offer numerous benefits in terms of improved mental health, resilience, and empowerment, as well as the reduction of retraumatisation. However, their implementation can be resource-intensive, context-specific, and complex. To maximise the benefits and minimise the limits, organisations and individuals must prioritise ongoing education, training, and a commitment to creating environments that prioritise the well-being of trauma survivors. Developing trauma-conscious childcare institutions and education systems represents a pivotal shift in how we approach the well-being and development of children who have experienced trauma. By recognising the effects of developmental trauma and implementing strategies that prioritise safety, empathy, and individualised support, we can create environments that foster healing, growth, and resilience. The journey towards trauma-conscious childcare and education is an ongoing process that requires collaboration, dedication, and a shared commitment to the well-being of every child.

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| CHAPTER 12 |

What Can We Do for the Parents?
How Can a Society Help Future Parents Support
and Care for Their Children in the Best Possible Way?

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ABSTRACT

Becoming a parent is one of the most life-changing experiences that has long-lasting consequences for not only the individual who has taken on this new role but also the child and, consequently, the whole society. There is no formal education for being a parent, and some people naturally have more skills and feel more confident. For some people, it could be intimidating to imagine how they will handle parenting. Before outlining how we can help parents, we must gain some understanding of the complex dynamics of parenting. First, contemporary changes in parenting are described; second, parental responsibility, parental competence, and positive parenting are defined, and we briefly describe what determines parenting and parental behaviour. Then, a list of possible ways to support parents as individuals and their living conditions is provided.

KEYWORDS

parental responsibility, parental competence, positive parenting, support, parenting programmes

1. Introduction

1.1. Contemporary Changes in Parenting and Parental Behaviour

Changes in the society and living conditions during the last half of the century[1] triggered changes in expectations and experiences of what parenting should look like.[2] Over the past few decades, the maternal role as a primary carer has also changed

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1 Examples include decades of decreased rates of fertility and marriage, increased rates of divorce and number of single-parent households, increase in unmarried or divorced families, increase in single and same-sex parents, decrease in family stability and family living arrangements, increase in working mothers, increase in the number of children by family, and older age of childbearing.
2 Ulferts, 2020, pp. 8–9.

due to women's increased economic roles, declining fertility rates, implementation of paternity leaves in many countries, and more paternal involvement in family duties and childcare.[3] However, mothering is still different from fathering despite the shift in gender and parental roles over time,[4] and mothers continue to predominantly assume caregiving within the household.[5] More recently, the COVID-19 pandemic has had a deep impact on family dynamics, relationships, and routine.[6] As of writing this chapter, the war in Ukraine and migration trends bring new challenges for parents, and the policies and services of different countries since war and migration have also had a significant effect on parenting.[7,8] In the digital age, rapid development of technology contributed to changes in family life and modified the way parents and children communicate and interact more than ever.[9] Parents today seek advice and are more inclined to look for support and help online before visiting a professional office or asking for help from family members or neighbours. Media content can include misinformation and be misleading because a mass of information is shared by people who are not parenting experts. It seems impossible to escape this fast information contamination and public disputes about how parenting should look like. To counterbalance such media and public debates, evidence-based information on parenting should be provided.

All previously noted changes are likely related to the trend of intensive or over-involved parenting,[10] especially among (upper) middle class parents. The evolution of intensive parenting is almost certainly a parental attempt to manage today's uncertainty.[11] Modern society has evolved into a risk-averse society because of the uncertainty of everyday living.[12] This impression of children's safety and vulnerability is influenced by the media, which made parents more vigilant about potential threats and fuelled their ongoing need to evaluate and manage risks in all facets of their children's lives.[13] Moreover, because of the stronger individualism of parental responsibility due to the feeling of disconnection from extended family and community, parents are left with growing concerns about their ability and power to ensure their children's well-being and success.[14] This intensive parenting approach is usually well intended but generally hinders children's development of autonomy and self-reliance.

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3 Ibid.
4 Endendijk et al., 2016, pp. 3–4.
5 García Román and Cortina, 2016, p. 921.
6 Weeland, Keijsers and Branje, 2021.
7 Eltanamly et al., 2021, p. 153.
8 Bornstein, Bohr and Hamel, 2020.
9 Livingstone and Blum-Ross, 2020, pp. 29–58.
10 LeMoyne and Buchanan, 2011, pp. 399–418.
11 Ulferts, 2020.
12 Ibid.
13 Ibid.
14 Ibid.

The literature has several variations and modern terms for such parenting, such as "concerted-cultivating parenting",[15,16] "helicopter parenting",[17,18,19,20] "tiger parenting",[21,22,23,24] "bulldozer parenting",[25] "lawnmower parenting",[26,27] and "snowplough parenting".[28,29] Research using the dimensional approach to parenting describes, for example, intrusive,[30] overprotective,[31] and overinvolved[32] parenting. All these terms describe parenting that involves excessive intervention in and control of a child's life; although there are slight differences, all these variations can be summed up as overparenting.[33,34] Overparenting is intrusive, overcontrolling, and overly assertive, and it involves developmentally inappropriate parental involvement or behaviour towards children to promote children's achievement; remove obstacles or difficulties; and ensure happiness, success, and well-being.[35,36]

Although parenting behaviours have evolved, classic parenting styles and dimensions remain relevant.[37] Diane Baumrind,[38] the pioneer of parenting styles, emphasised control as a crucial parental feature, identifying three models: authoritarian

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15 Carolan and Wasserman, 2015, pp. 168–169.

16 These parents take an active role in their children's education and development by involving them in various extracurricular activities; having extensive conversations with their children, usually about school; and being overly involved in school, asking for extra attention from teachers.

17 Padilla-Walker and Nelson, 2012, pp. 1177–1178.

18 İlgar, 2021, pp. 143–145.

19 Somers and Settle, 2010, pp. 18–20.

20 These parents are extremely overprotective and hovering towards children, constantly monitor their children's activities, are overinvolved in children's interactions and activities, and are overprotective and controlling regarding decision-making; thus, the children usually lack independence and responsibility for their own choices.

21 These parents are strict and demanding and push their children to achieve high levels of academic success and excellence in extracurricular activities, often at the expense of other aspects of life, such as play and socialisation; they practice strict discipline, have high expectations, focus on academic excellence, limit free time, and practice high parental control.

22 Chua, 2011, pp. 3–4.

23 Juang, Qin and Park, 2013, p. 1.

24 Kim et al., 2013, pp. 7–8.

25 Sharma and Sarna, 2018, p. 13.

26 Locke, Campbell and Kavanagh, 2012, p. 250.

27 Bristow, 2023, pp. 267–290.

28 Malley-Morrison, 2009.

29 This refers to an overprotective and overly involved style of parenting where parents attempt to clear all obstacles and challenges from their child's life.

30 Taylor et al., 2013, pp. 1145–1146.

31 Thomasgard and Metz, 1993, pp. 67–68.

32 Ulferts, 2020, pp. 17.

33 Locke, Campbell and Kavanagh, 2012, pp. 25–261.

34 Munich and Munich, 2009.

35 Segrin et al., 2012, pp. 237–252.

36 Segrin et al., 2013, pp. 569–595.

37 Ulferts, 2020, pp. 24–26.

38 Baumrind, 1967, pp. 43–88.

(rigid and strict), authoritative (democratically consistent), and permissive. Eleanor Emmons Maccoby and John Martin[39] introduced the term demandingness instead of control and added parental warmth. Combining these dimensions resulted in today's four parenting styles: authoritarian, authoritative, permissive, and neglecting.[40] Research consistently supports the positive impact of authoritative parenting on child development.[41]

1.2. Raising Children in the Digital Age

In the digital age, parents feel the need to monitor and manage children's device and media use. Parental mediation refers to the involvement of parents or caregivers in managing and guiding their children's use of media and technology.[42] The primary goal of parental mediation is to ensure that children have a safe and beneficial media experience while also promoting their media literacy and critical thinking skills. Parents use different strategies of mediation.[43,44,45] Parental restrictions, prohibitions, or insistence on close parental supervision are examples of restrictive mediation.[46] Enabling mediation involves parents engaging in proactive strategies such as talking to their children about their online activities and encouraging them while also providing safety advice. It also includes actions that may appear restrictive (e.g. the use of technical controls and parental monitoring) but are better understood as creating a safe environment to encourage children's positive use of the internet.[47] Parental mediation can vary depending on the age and maturity of the child.

Research showed how technology can disrupt parenting, namely by phubbing and sharenting.[48] Parental phubbing specifically pertains to parents' acts of paying more attention to their smartphones or other electronic devices than to their children, particularly during face-to-face social interactions. Parental phubbing is associated with "technoference", which, in the context of parenting, refers to everyday intrusions and interruptions of parent-child face-to-face interactions due to parents' technology devices, most often cell phones or smartphones.[49] Research shows that this act negatively affects parenting and child development. "Sharenting"[50] refers to the practice of parents sharing information, pictures, and updates about their children

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39 Maccoby and Martin, 1983, pp. 1–101.
40 The authoritarian style is characterised by low warmth and high demandingness, authoritative style with high warmth and high demandingness, permissive style with low demandingness and high warmth, and neglecting style with low warmth and low demandingness.
41 Darling and Steinberg, 1993, p. 487; Berk, 2018, p. 283.
42 Livingstone and Helsper, 2008.
43 Kotrla Topić, Perić Pavišić and Merkaš, 2023, pp. 1–19.
44 Livingstone and Byrne, 2018, pp. 19–30.
45 Valkenburg et al., 2013, pp. 445-469.
46 Livingstone and Byrne, 2018, pp. 19–30.
47 Ibid.
48 Burns and Gottschalk, 2019, pp. 82–85, pp. 103–113.
49 McDaniel and Coyne, 2016, pp. 85–98.
50 Cataldo et al., 2022, pp. 1–12.

on social media platforms and other online spaces. While sharenting can be a way for parents to connect with friends and family, seek advice, and celebrate their children's achievements, it also raises privacy and ethical concerns.

2. Who Is a Parent, and What Is Parental Responsibility?

A parent is responsible for children's upbringing, education, and property and, in European Union (EU) countries, has the right to represent children legally.[51] A married father and a mother both have automatic parental responsibility in all EU countries.[52] Depending on the country, different laws govern which obligations and rights an unmarried father is entitled to.[53] In most countries, parents have an 18-year obligation to take care of a child.[54]

According to Art. 18 of the Convention on the Rights of the Child,[55] three components make up a parent's obligation to raise a child.[56] First, the obligation must be shared equally and agreed upon by both parents. Second, parents or other carers are largely held accountable. Third, the obligation must be given with the child's best interests as the primary consideration. The convention[57] postulates that parents are the primary persons responsible for the development of children, that they have parental responsibility for children, and that they must behave in the best interest of the child. Legal guardians, or other individuals legally responsible for a child, have parental responsibility similar to parents. Parental responsibility can be described as the legal right to participate in decisions that affect a child's life, such as those involving his or her education, health, and any medical care he or she may get. The focus is on the parents' duties towards their children; that is, parents must behave dutifully towards their children, and childcare belongs to parents.[58] In sum, parents, legal guardians, or other individuals legally responsible for a child have legal and moral obligations and duties towards children, which are called responsibilities. In this context, parents may be described as authorities, providers, caregivers, protectors, and socialisers.[59] The specific definition and general scope of parental responsibility include providing for and ensuring the child's needs, physical and emotional safety,

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51 European Union, 2023.
52 Ibid.
53 Ibid.
54 UNICEF, 2023.
55 United Nations, 1989, p. 5. States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern.
56 Ruggiero, 2022, pp. 153–163.
57 UNICEF, 2023.
58 Eekelaar, 1991, pp. 37–50.
59 Pagliocca et al., 1995, pp. 437–457.

education, healthcare, emotional support and nurturing, financial support, stability, and consistency, as well as making legal decisions for the child and guiding the child's cultural and religious upbringing.[60]

However, "responsibility" refers to a function that should be carried out by the parent rather than by another entity[61] and not to how the parent really acts towards his child. Ultimately, parental responsibility is grounded in the principle that parents have a duty to act in the best interests of their child and ensuring their safety, well-being, and development into responsible and well-adjusted individuals. This exact principle also guides lawyers in the domain of child protection who aspire to have parents take on their responsibilities to meet the needs and uphold the rights of children and eventually ensure positive child development and well-being. Since the outcomes of child protection cases have a significant impact on the life of children and their families, lawyers often must put additional effort to ensure that the legal process takes place and necessary decisions are made with due caution and sensitivity.[62] This effort of lawyers can be seen in actions such as participating in open and democratic discussions with children, assisting in their legal education, establishing a mutual understanding with all participants in the legal process of child protection involvement, and making sure there are adaptable chances for involvement.[63] Hence, there are ample opportunities for interdisciplinary collaboration between psychologists and lawyers.

The explicit connection between law and psychology in the context of children's well-being can be depicted as follows. The law establishes rules and regulations that define parental responsibilities and rights. It sets the guidelines for custody, visitation, child support, and various legal aspects of parenting. This legal framework ensures that parents have specific obligations and that children have certain rights under the law. Psychology, on the other hand, plays a critical role in understanding the psychological needs of children. It delves into the emotional, cognitive, and social aspects of a child's development. Psychologists can assess and address issues such as emotional well-being, trauma, behaviour, and overall mental health. They provide insights into how different parenting approaches can impact a child's well-being. When we combine these two disciplines, an interdisciplinary approach emerges. It means that legal decisions related to child custody, support, and visitation are made with a deep understanding of the psychological needs and well-being of the children involved. By considering psychological factors alongside legal considerations, we can create more holistic and child-centred solutions. The goal of this interdisciplinary connection is to ensure that children receive the care, support, and protection they need for their optimal development and happiness. This means that legal decisions are not made in isolation but are informed by psychological insights. This also

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60 European Union, 2023.
61 Eekelaar, 1991, pp. 37–50.
62 Walsh and Douglas, 2012, pp. 181–211.
63 Horsfall, 2013, pp. 429–444.

acknowledges that the well-being of children goes beyond just meeting their basic needs; it includes their emotional and psychological health, which can significantly impact their future well-being. In conclusion, when psychology and law work together to promote children's well-being, a thorough and child-centred strategy is produced, with legal choices being based on a thorough comprehension of the psychological requirements of children to support their best possible growth and well-being.

In this context, it can be useful for lawyers to gain specific knowledge about parenting, which will be discussed further.

3. What Are Parental Competence and Positive Parenting?

Just because someone has parental responsibility legally and is authorised as a "parent" does not imply that they are a loving and caring parent, or that he or she acts in this way or behaves in the best interest of the child. Being a loving and caring parent means to practice positive parenting. According to the Council of Europe, *positive parenting* involves parental behaviour based on the best interests of the child that is nurturing, empowering, non-violent, and provides recognition and guidance, which involves setting of boundaries to enable the full development of the child.[64] Parents should give their children the following: "nurture" by meeting the children's need for affection, warmth, and security; "structure and guidance" by giving the children a sense of security, predictable routine, and necessary boundaries; "recognition" by paying attention to the children and valuing them as persons; "empowerment" by boosting the children's sense of competence and personal control; and "a non-violent upbringing" by excluding all corporal or psychological punishment because of children's rights to respect for their bodily integrity and human dignity.[65] These parental behaviours sum up the authoritative parenting style.

To be able to practice positive parenting, one must have parental competencies. *Parental competence* is defined by its impacts, and although it has been studied from several angles, all of them converge on at least three key criteria.[66] The first is that, regardless of the developmental stage of the child, warmth, acceptance, and sensitivity to children's basic needs; social cues; and what is adequately expected for a given child's developmental level appear to be universal components of successful parenting. However, the ability to be sensitive does not define or guarantee parental competence because it must be put into practise for the care to be regarded as competent. Parenting that is sensitively attuned to children's capabilities and their developmental tasks promotes developmental outcomes that are thought to be important: emotional security, behavioural independence, social competence, and intellectual

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64 Council of Europe, 2006, Recommendation of the Committee of Ministers to member states on policy to support positive parenting (Rec(2006)19), sec 1.
65 Ibid.
66 Teti and Candelaria, 2002, pp. 149–180.

achievement.[67] The second criterion is that strict, harsh, critical, and coercive parenting is universally recognised as being bad for children. Third, although parental participation is not a good indicator of parenting ability on its own, it is probably better than not being involved at all. Therefore, the level and consistency of parental participation in a child's life and upbringing matters.

We can highlight the intersection of law and psychology when it comes to the well-being of children, specifically in the context of fulfilling parental responsibilities and addressing psychological needs. This intersection can be seen as an interdisciplinary connection where legal and psychological aspects come together to promote the overall well-being of children. In this interdisciplinary connection, the law provides a framework for defining and enforcing parental responsibilities and rights, while psychology plays a crucial role in understanding and addressing the psychological needs and well-being of children. By integrating these two disciplines, we can better ensure that children receive the necessary care, support, and protection they need for their optimal development and well-being.

4. What Determines Parenting and Parental Behaviour?

Belsky's comprehensive process model,[68] which considers various factors such as developmental history, personality, marital relations, work, social network, and child characteristics, sheds light on parenting dynamics. For instance, one's developmental history, including experiences such as divorce[69] or parental conflicts[70] during upbringing, has a lasting impact on one's adult intimate relationships and own families. People mainly learn to form close bonds in their families of origin, and based on their early experiences with parents, they develop an inner working model of their self and of others.[71,72] Parental divorce can affect the nature of the parent-child relationship, disrupting the attachment between the child and parents, which then negatively affects intimate relationships.[73] Secure attachment to parents in childhood tends to translate into more sensitive and emotionally warm parenting in adulthood.[74]

Personality traits also play a crucial role. Parents with high extraversion, agreeableness, conscientiousness, and openness tend to provide warmer and more organised parenting.[75] Conversely, those with elevated levels of neuroticism may adopt an

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67 Belsky, Robins and Gamble, 1984, p. 254.
68 Belsky, 1984, pp. 83–96.
69 Amato and Cheadle, 2005, pp. 191–195.
70 Amato, Loomis and Booth, 1995, pp. 895–896.
71 Bartholomew and Horowitz, 1991, pp. 226–263.
72 Secure, preoccupied, dismissive, and fearful attachment styles emerge from the model of self, which can be positive or negative, and the model of others (positive or negative).
73 Crowell, Treboux, and Brockmeyer, 2009, cited in Mustonen et al., 2011, p. 616.
74 van IJzendoorn, 1995, pp. 387–389.
75 Prinzie et al., 2009, pp. 351–362.

authoritarian style and become overly protective.[76] Furthermore, studies indicate that higher parental self-efficacy[77,78] is linked to a nurturing and supportive child-rearing environment.[79]

The transition to parenthood[80] can be challenging for a partner relationship as parents must adjust to their new roles and responsibilities, which can affect the quality of their relationship.[81] Concerning work, schedules that do not align well with family life, such as evening or weekend work (especially working Sundays),[82] shift work, and excessive overtime, are linked to stress related to balancing work and family.[83] This conflict can arise from time constraints, constant tension, fatigue, or ineffective time management,[84] with accumulated overtime hours adding strain to marital relationships.[85] Furthermore, absence or inadequacy of social support can jeopardise parents' well-being and lead to potentially inappropriate parenting practices.[86]

Before providing recommendations for supporting parents, it is essential to emphasise the pivotal role of children in the dynamics of parenting. Research, influenced by Bell's[87] ground-breaking work on socialisation effects, has revealed that children significantly impact their parents and parenting behaviours. Factors such as the child's age, gender, and temperament[88] have a profound influence on how parents interact with them.[89] Parenting differs when dealing with a challenging versus an easy-going child or when caring for a toddler compared to an adolescent. Furthermore, children themselves interpret and respond to parenting behaviours, and their perceptions change as they age and develop. They actively participate in the parenting process; for instance, adolescents' willingness to disclose information to their parents can affect parental knowledge and subsequently reduce problem behaviours over time.[90,91] In essence, every child is unique and interprets parental actions in their own way. This relationship is reciprocal and evolves as both the parents and child grow older. It is crucial to bear in mind that not all parents, children, and families will respond favourably to a one-size-fits-all approach to support.

76 Kendler, Shami and MacLean, 1997, pp. 549–562.
77 This refers to the caregiver's or parent's confidence in their ability to raise children effectively and successfully.
78 Jones and Prinz, 2005, pp. 341–363.
79 Wittkowski et al., 2017, p. 2961.
80 Doss and Rhoades, 2017, pp. 25–28.
81 Kluwer, 2010, p. 106.
82 Batinić, 2014, pp. 55–78.
83 Barnett, 1998, cited in Alexander and Baxter, 2005, p. 19.
84 Čudina-Obradović and Obradović, 2006, p. 172.
85 Fursman, 2009, pp. 55–67.
86 Belsky and Jafee, 2015, cited in Nunes et al., 2009, p. 3.
87 Bell, 1968, p. 81.
88 Bornstein, 2002, pp. 3–43.
89 Rodrigo, Byrne and Rodríguez, 2014, pp. 2173–2196.
90 Stattin and Kerr, 2000, pp. 1072–1085.
91 Willoughby and Hamza, 2011, pp. 463–477.

Parenting exists within a complex ecological framework.[92] To support parents in becoming responsible, positive, and competent caregivers, Bronfenbrenner's ecological model[93] places parents at the centre, primarily engaging with the family microsystem. This microsystem includes factors within the family, such as the marital relationship, child characteristics and behaviours, and parental mental health. In today's digital age, we also recognise virtual microsystems as significant contexts for parental engagement,[94] according to the neo-ecological theory.[95] Moving outward, mesosystemic influences involve interactions between parents and other microsystems, such as the child's school, parents' workplace, and healthcare systems. Beyond this, the exosystem encompasses more distant influences on parenting, including economic and political systems, government policies, and mass media. For example, a healthy economy with ample job opportunities and decent wages benefits parents and parenting, while economic hardship, including poverty and financial struggles, poses risks to positive parenting.[96] The macrosystem, the largest layer, represents cultural ideologies and values. While there are cultural variations in parenting practices related to parental ethnotheories,[97,98] there are also shared global parenting goals.[99] Parents universally desire their children to survive, thrive, respect adults, socialise effectively, succeed in adulthood, and receive education. They generally believe in the negative consequences of overly harsh parenting. However, cultural differences exist in how these goals are pursued.[100] Lastly, the chronosystem acknowledges that diverse environmental and historical influences on parenting may occur at various time points.

5. Support for Parents

The challenge today is not that the evidence is insufficient to show the effects of parenting, but rather that evidence has revealed a reality that is far more complex than critics expected or that writers can convey in most popular media outlets.[101] The same level of education and guidance does not need to be provided to all parents.[102] Public service announcements, one-time community seminars, and printed or online resources such as newsletters and parenting articles that teach fundamental knowledge about child development and parenting techniques are a few examples of ways to

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92 Bronfenbrenner and Morris, 2007, pp. 793–828.
93 Ibid.
94 Navarro and Tudge, 2023, pp. 19338–19354.
95 Ibid.
96 Batinić, Bošnjaković and Merkaš, 2018, pp. 245–265.
97 The ethnotheories represent shared beliefs regarding the objectives of child development and the methods of socialisation that can achieve these objectives defined by the cultural setting.
98 Greenfield and Keller, 2004, p. 546.
99 Teti et al., 2017.
100 Ibid.
101 Collins et al., 2022, pp. 89–116.
102 Teti et al., 2017, pp. 1–34.

provide support. The literature advocates that parenting approaches and their impact vary because parenting is embedded in history, modernisation, and the wider social context; parents depend on social and economic resources in their functioning and their family's functioning; parenting is a "family-centred process",[103] bidirectional in nature between a child and a parent; and the parent's and child's characteristics impact parenting. 'Given the systematic nature of parenting' ecology, a single problem or policy has the potential to benefit parents, even if it is a distal factor'.[104] However, additional elements may quickly outweigh the advantages of a single constructive improvement. Therefore, it makes sense to approach the topic of parenting support from a comprehensive and systematic perspective. This also involves respecting the notion that social support encompasses various types of assistance, such as instrumental (e.g. financial help or support with everyday chores), informational (e.g. advice and feedback on personal and family matters), and emotional (e.g. empathy and expressions of care).[105] Drawing on the recent literature about supporting parenting,[106,107] implications for policies and support are discussed next, considering an evidence-based and culturally sensitive framework of parenting when applied in real life.

5.1. Individual-Level Factors: Helping Parents Thrive as Individuals

Clear and strong evidence from the literature confirms that *parents' psychological distress* and *parents' relationship problems with their partner or spouse* are two proximal determinants that seem to have the strongest link to and pose risk factors for positive and competent parenting.[108] "Distress" refers to the triad of depression, anxiety, and stress that negatively affects positive and competent parenting. When parents are distressed and have marital problems, parenting worsens. Thus, the aim of support for parents should be to strengthen them as individuals so they can face the challenges of parenting and practice positive parenting.

Here is a list of different specific and general ways to support current and future parents, with the aim of strengthening them as individuals who will have better well-being, better parental competencies, and ability to practice positive parenting.

- Develop and implement high-quality, easily accessible parenting education programmes: Offer accessible and affordable parenting education programmes by experts covering child development, discipline, communication, parental mediation, overparenting, co-parenting, and stress management. These programmes can be conducted in schools, community centres, and online, and they should be easily accessible to parents. Regulate these high-quality

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103 Ulferts, 2020, pp. 7–40.
104 Teti et al., 2017, p. 5.
105 Ulferts, 2020, pp. 7–40.
106 Teti et al., 2017, pp. 1–34.
107 Ulferts, 2020, pp. 7–40.
108 Teti et al., 2017, pp. 1–34.

programmes for practical, guided training and knowledge transfer, involving teachers, kindergartens, and schools. Incorporate evidence-based parental education into high school and college curricula for both genders. Develop and implement parenting interventions that enhance parenting skills and relationships, benefiting children's emotional, cognitive, behavioural, and health outcomes.[109] These interventions are essential for EU member states to support families.[110] Effective parent-training programmes include increasing positive parent-child interactions and emotional communication skills, teaching parents to use time out and the importance of parenting consistency, and requiring parents to practice new skills with their children during parent training sessions.[111] It is also important to emphasise the co-parenting skills and relationship.

- Support the creation of parent support groups, parental support networks, and parenting hotlines: Facilitate support groups where parents can connect with others who face similar challenges. These groups can provide a sense of community, share experiences, and offer emotional support. Encourage the formation of parental support networks, such as parent-teacher associations and neighbourhood groups that facilitate peer support and community engagement. Establish helplines or hotlines staffed by trained professionals who can provide advice, guidance, and emotional support to parents facing challenges or seeking information.
- Develop and install high-quality and easily accessible mental health services, counselling services, and online mental health support: Offer counselling services to parents who may be dealing with issues such as substance abuse, domestic violence, or mental health issues.
- Develop and implement prenatal and postnatal support: Ensure expectant parents receive comprehensive prenatal care, including healthcare access, childbirth education, and postnatal resources, as well as breastfeeding support. Encourage fathers to participate in obstetric and paediatric visits. Implement home visiting programmes for guidance and support, especially for families with young children.
- Enable access to educational resources and technology: Ensure parents can access parenting resources, including books, articles, online materials, and community services. Promote digital literacy and technological access for parenting information. Establish programmes to support high school completion, college enrolment, and job training, particularly for parents facing social inequalities.

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109 Gardner and Leijten, 2017, pp. 99–104.
110 European Commission, 2019, Positive Parenting Interventions, p. 2.
111 Kaminski et al., 2008, pp. 567–588.

5.2. Contextual and Social-Level Factors: Policies, Services, and Programmes

Designing approaches and policies that are strength- and community-based and family-centred as well as permit individualised support for all families[112] should be our goal in the future. Provide a continuum of parenting services across all communities, starting with preventative strategies and incorporating strategies that have been tailored for parents who are at risk from proximal or distal influences.[113,114,115]

Here is a list of different specific and general ways to support current and future parents, with the aim of making their living environment supportive and nurturing.

- *Develop and implement child and family services*: Enhance child protective services and family support agencies to aid families facing challenges such as substance abuse and domestic violence. Establish community centres for resource access, workshops, and family activities. Provide respite care for parents of children with special needs or those having high stress levels. Promote community resources such as family support centres and gardens for education, social support, and recreation. Strengthen local support in childcare, schools, family centres, parks, and organised activities, especially in disadvantaged areas. Ensure services are accessible in frequently visited places such as hospitals, schools, churches, and community centres.

- *Develop and implement parent and family friendly policies*: Develop policies and programmes that are inclusive and culturally sensitive, recognising the diverse needs of families from various backgrounds and communities. Encourage flexible work policies and parental leave options that allow parents to better balance their career and family responsibilities (e.g. regular work schedule, standardised flexible work hours, telecommuting options, and parental leave for both parents). Develop and implement labour market and welfare policies that mitigate family stress and enhance family bonding (e.g. paid leave). Ensure that insurance policies cover two-generation integrated services and permit the participation of additional carers, such grandparents, in the support network through legislation.

- *Launch public awareness campaigns*: Launch public awareness campaigns about support for parents, investment in child well-being, and available resources. Reduce stigma and encourage participation in evidence-based parent training with campaigns highlighting parenting's value for all. Promote nurturing, communicative, and non-violent discipline methods in media. Advocate for family-supportive policies. Disseminate parenting information through campaigns, printed materials, and school/community events. Implement policies for distributing parenting resources at obstetrics/gynaecology and paediatric offices. Support efforts to expand proven parent-training programmes for parents facing depression or relationship and marital problems.

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112 Ulferts, 2020, pp. 7–40.
113 Freymond and Cameron, 2006, 3–318.
114 Teti et al., 2017, pp. 1–34.
115 Cameron, Coady and Adams, 2007, pp. 1–368.

- *Develop and implement high-quality education and healthcare services for children*: Ensure equitable access to quality education for all children, regardless of socioeconomic status. Provide affordable, safe, and high-quality childcare to support working parents and their children. Offer subsidised childcare services for families facing work-family balance challenges. Enhance school-family relationships and manage parental involvement. Expand access to affordable, high-quality childcare for babies and young children, and summer programmes for school-aged children, including those with special needs and during non-traditional hours.
- *Provide professional training*: Train educators, healthcare providers, and social workers to identify parental stress and challenges, offering referrals and assistance. Provide cultural sensitivity training for professionals working with diverse families. Implement parenting knowledge, risk, and psychopathology screenings at obstetrics/gynaecology and paediatric offices, schools, and kindergartens. Educate paediatric staff and teachers on interpreting and prioritising screening results for appropriate community service referrals.
- *Provide financial support*: Ensure parental access to financial assistance programmes (e.g. child support, food, housing) to reduce financial stress, but condition it on the attendance of parenting programmes. Increase economic support through cash transfers to low-income families and improve employment opportunities by raising the minimum wage. Expand tax credit for low-income families and offer paid family and sick leave. Enhance paid parental leave for childbirth and provide state-wide support for unemployed worker retraining and affordable job training. Ensure affordable healthcare for preventive and timely medical care. Expand day-care tax credits and simplify the application process to help families afford high-quality childcare.
- *Collect data*: Invest in research and data collection to better understand the needs of parents and children and to inform evidence-based policies and programmes.

5.3. How Can Lawyers Support Parents?

Lawyers can assist parents in various legal matters and situations, ensuring that their rights are protected and that they are able to fulfil their responsibilities as parents. Here are some ways in which lawyers can help parents:[116,117,118,119,120]

- *Legal advice and consultation*: Lawyers can offer legal advice to parents on various family law issues, including divorce,[121] child custody, child support, and property division. Lawyers can educate parents about their legal rights and responsibilities, helping them make informed decisions regarding their family and

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116 Gottlieb and Pitchal, 2007, pp. 17–35.
117 Gottlieb, 2005, pp. 1263–1276.
118 Bala, Hebert and Birnbaum, 2017, pp. 557–589.
119 Kelly and Kisthardt, 2009, pp. 1401–1420.
120 Spinak, 2007, pp. 393–411.
121 Pruett and Jackson, 1999, pp. 283–310.

children.[122] Lawyers can navigate various legal processes, ensuring that parents meet deadlines, file the necessary paperwork, and adhere to legal requirements.

- *Drafting of legal documents*: Lawyers can draft legal documents, such as parenting plans, custody agreements, guardianship designations to ensure that their children are cared for in the event of their death or incapacitation, prenuptial agreements, and wills, to ensure that the legal aspects of parenting and family matters are properly addressed.
- *Legal representation*: Lawyers assist parents in various legal proceedings such as divorce, child custody, adoption, and child support cases. They advocate for their clients' rights and represent them in court. In custody disputes, lawyers provide guidance, negotiate agreements, and prioritise children's best interests. During divorce or separation, lawyers handle property division, spousal support, child support, and parenting plans for custody and visitation arrangements.
- *Enforcement of court orders*: Lawyers help parents enforce court orders for child support, visitation, and custody. They take legal action against non-compliant parents. When circumstances change, lawyers assist in modifying existing orders due to changes in income, living, or child needs. In cases of domestic violence or child abuse, lawyers aid in obtaining protection orders for parent and child safety.
- *Adoption*: Lawyers aid parents in adoption, handling of paperwork, compliance with adoption laws, and court representation when needed. They assist with guardianship and foster care, helping parents establish legal guardianship or navigate the foster care system. For surrogacy and assisted reproduction, lawyers offer guidance on parental rights and responsibilities in complex legal matters.
- *Paternity issues*: Lawyers can handle paternity cases, representing parents in legal matters concerning paternity, child custody, and child support. They also protect and assert parental rights, particularly in cases involving disputes or challenges.
- *Mediation and alternative dispute resolution*: Lawyers[123,124] assist parents in resolving conflicts cooperatively outside of court. They focus on co-parenting, communication, and decision-making to create a healthier family environment for the child.
- *Child advocacy*:[125,126] In cases prioritising the child's well-being, lawyers advocate for their rights and needs. For child support matters, family law specialists assist in determining support amounts and enforcing orders. In education, lawyers help parents advocate for their child's educational rights, especially if the child has special needs or faces school-related challenges.

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122 Masson, 2012, pp. 202–211.
123 Cooper and Brandon, 2007, pp. 288–308.
124 Maclean and Eekelaar, 2016, pp. 1–23.
125 Gottlieb and Pitchal, 2007, pp. 17–35.
126 Kisthardt, 2006, pp. 1–77.

6. Concluding Remarks

When it comes to the well-being of children, specifically in the context of fulfilling parental responsibilities and addressing children's needs, the intersection of law and psychology can be seen as an interdisciplinary connection where the legal and psychological aspects come together to promote the overall well-being of children. In this interdisciplinary connection, the law provides a framework for defining and enforcing parental responsibilities and rights, while psychology plays a crucial role in understanding and addressing the psychological needs and well-being of children. By integrating these two disciplines, we can better ensure that children receive the necessary care, support, and protection they need for their optimal development and well-being.

Supportive communities, access to resources, and a strong social network can contribute to parental competence and positive parenting, which are continuous and evolving processes. It is important to note that there is no one-size-fits-all approach to parenting, as each child is unique, and parenting styles and practices may need to be adjusted to suit children's individual needs and personalities. One-parent and immigrant families depend on a smaller support network, particularly in terms of family members, and need more support compared to other family types. Investment in promoting the father's involvement, negative effects of overparenting, negative impact of media and technology use on parenting, and education and the promotion of parental mediation of children's digital technology use are needed.

Programmes and policies aimed at parenting must recognise the cultural similarities and differences across a country's communities. There is neither a universal answer to parenting nor a justification for treating all parents from a certain culture uniformly. Instead, parenting programmes must be designed with an awareness of the situations in which they will be used and adapted to be as effective as possible in those contexts.

Parents have a legal right and obligation to decide for their children, considering the best interests of the child. Support must be provided to them not only as individuals but also in the context of their childcare and living. Support should be given to parents to develop their parental competence and skills in positive parenting before legally taking their parental responsibility from them. Support for parents should be a joint activity of different stakeholders and stem from the collaboration efforts of the government and non-governmental sectors that need to be educated about the importance of parenting and support to parents.

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