Emotional Development

Description of phases and corresponding guidance style

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Foreword

This publication on emotional development is a revised version of the 2008 edition. In recent years, the description of the phases and the accompanying guidance style have proven to be of great interest. The publication turns out to be useful not only for people with intellectual disabilities but also for fields such as childcare, (special) education, youth and foster care, mental healthcare and (forensic) psychiatry.

In recent years, much has been developed and published at a European level in the field of emotional development. These developments are an important prompt to revise the publication. The content of the first publication was created in cooperation with Marianne Koster, then working at Amsta.
The third revised version has been adapted in its entirety by Sandra Zaal and Margriet Boerhave and published by Cordaan.

At the request of members of NEED (Network of Europeans on Emotional Development), a Special Interest Group of EAMHID and with thanks to colleague Isabella Zonneveld and NEED member Mark Hudson, this publication was translated into English in 2023. Mark Hudson, clinical psychologist at the University of Nottingham was the final editor of the English version.

We would like to thank Wilma Mathurin, Jolanda Vonk, Theo van der Aa, Anne de Waard, Ineke Teijmant and Marije Matzinger for their feedback.
And in particular, we thank Anton Došen for his permission to use the Scale of Emotional Development as the basis for this publication. Furthermore, he indicated that the publication could serve as an introduction to the extensive literature on emotional development and as a practical guide in applying the Scale of Emotional Development.

Introduction

The same human needs apply to every person, with or without intellectual disability. Besides the basic survival needs (eating, drinking, sleeping, etc.), emotional well-being is essential. People need to feel safe, connected, competent and valued, and to be able to take control of their own lives. These needs are present from birth and remain important throughout life.

We hope this publication will contribute to the quality of support for vulnerable people of all ages. It provides information and tools to recognize and understand emotional development. It remains important to note that the publication is intended to provide an impetus for targeted tailor-made individual advice. Each chapter covers the successive stages of development. General background information is provided first.

Disharmonic profile: when developmental aspects are out of balance

In practice, we find that knowledge of a client's level of emotional development is necessary in order to match the guidance style to him[1] properly. In many clients, we see a so-called disharmonious developmental profile. This means that the different aspects in the person's development are not balanced with each other. A disharmonious profile makes a person vulnerable, especially emotionally, and it is precisely from this emotional vulnerability that many clients develop psychological/psychiatric problems and/or difficult to understand (signal) behaviour.

In disharmonious profiles, cognitive aspects are found to be more developed than emotional aspects (Došen, 2014; Vandevelde et al., 2015; Došen & Vonk, 2018; Sappok, Zepperitz, & Hudson, 2021). The danger of overestimation is high when it is not clear at what emotional level a client is functioning. Coping ability plays an important role here. Besides cognitive and social ability, being able to cope emotionally is essential for balanced development. It is a case of what somebody can engage in practically, verses what they can cope with emotionally.

Emotional development rather than socio-emotional development

Thus, to address a client at the level that suits him, it is necessary to have a good picture of his emotional development. We provide a description of the different phases of emotional development in this publication.

As a starting point, we have used the phases of emotional development as described by the psychiatrist, Professor Anton Došen.

In this revised edition, we deliberately refer to emotional development instead of socio-emotional development, in order to separate the course of emotional development from that of cognitive and social development. In children with an intellectual disability, we often see that these three areas do not develop in parallel (Došen, 2014; Vandevelde et al., 2016; Došen & Vonk, 2018).

[1] for the sake of readability, 'him' has been chosen. Read: 'him/her/them'.

A new-born starts regulating basic physiological functions and activating the emotional system that is essential for adaptation and survival. Through the input and processing of external stimuli and maturation of the cerebral cortex, cognitive development is then stimulated at this very first stage of development. The integration of emotional and cognitive development creates the beginning of awareness of one's own existence, this is the first step towards formation of a personality development.

The next step is awareness of the existence of others, leading to further social development. Cognitive development leads to awareness of stimuli, memory, perception, knowledge, experience, attention and consciousness. Through social development comes awareness of the existence of oneself in interaction with other people and with their psychological world (feelings, thoughts, behaviour).

In the description above, emotional development precedes cognitive and social development. This is why emotional and social development are distinguished.

Došen's developmental-dynamic approach

Anton Došen's approach is based on the assumption that emotional development proceeds in phases. Došen combined several insights including the theories of Piaget, Luria, Mahler, Panksepp and Bowlby. Behaviour is viewed from biological, psychological, and social dimensions. Each dimension is related to the others and they influence each other. In addition to these dimensions, the developmental dimension is central to the development-dynamic approach. In other words: what has someone experienced, at what developmental level is he now functioning, and what is needed to achieve further development?

Emotional development always plays a major role in this. When it concerns a person's state of mind at the time, we talk about the emotional level of functioning. Within emotional development, attachment development is an important pillar. Central to this is the concept of basic safety (Zaal & Boerhave, 2022; Sterkenburg, et al., 2022). The degree to which the child or adult feels safe influences their emotional coping ability and the resilience needed to develop.

Emotional Development Scale

Došen has incorporated the insights from the development-dynamic approach into a questionnaire that can be used as a guide during an interview to assess emotional development. This Dutch language questionnaire 'Schaal voor Emotionele Ontwikkeling' (SEO) or Scale of Emotional Development, is divided into several domains.

In recent years, the SEO has been further developed from SEO-R to the SEO-R^2 based on scientific research (Morisse & Došen, 2017; Morisse, 2020; Morisse & Vandevelde, 2021). The SEO-R2 is used as a semi-structured interview, mainly for complex cases. The result of this scale indicates which emotional phase a client is usually in. In addition, the profile of functioning in the various domains is important. This profile provides clues and guidance for appropriate support in practice.

In recent years, in a European context (Network of Europeans on Emotional Development, NEED), the Scale of Emotional Development-Short (SED-S) was developed (Sappok et al., 2016). The SED-S (in Dutch language SEO-V) is a shortened questionnaire based on the SEO-R[2].

The SED-S aims to quickly arrive at a well-founded assessment of emotional development, to get an initial view of the profile of functioning. As such, it fulfils the role of a screening instrument. It can also be used to collect data for scientific research. In this publication, we have taken the SED-S (Sappok et al., 2016) and the Dutch-language SEO-R[2] (Morisse & Došen, 2017) as a starting point in our further description. The SEO-R[2] takes a deeper and broader look at emotional development and provides tools and advice for treatment. The SED-S can be used by English-speaking populations to arrive at a developmental understanding and treatment plan. This scale consists of fewer domains: some have been merged in terms of content.

Tools and advice for treatment

The SED-S and SEO-R[2] help to better understand behaviour and adapt the environment to the client's emotional needs. By gaining insight into needs and motivations, behaviour and psychological states can be understood and explained. Underlying needs and motivations determine the level of emotional developmental, rather than (necessarily) behaviour. It is important to read, interpret and understand emotions in order to assess and assign meaning to them.

The SEO-R[2] is administered by a professional assessor (a behavioural specialist, (child)psychologist and/or a trained diagnostician). Knowledge of the course of development and the phases of emotional development is necessary in order to arrive at a correct assessment. The scale is administered in interview form with two or more informants who know the client well. Preferably a combination of caregivers and relatives[2]. Then, based on this assessment, a translation into practice takes place.

The questions in the SEO-R[2] cover different aspects (domains) of emotional development. It looks at which developmental phase a child/client is in with regard to:

- dealing with 'emotionally significant others'
- dealing with one's own body
- perception of self in interaction with environment
- dealing with a changing environment - object-permanence
- fears
- dealing with peers
- dealing with materials
- communication
- differentiation of emotions
- aggression regulation
- leisure time fulfilment - play development
- moral development
- regulation of emotions

[2] An experimental Emotional Development Questionnaire (SED-Q, in Dutch VEO) is available that can be administered in interview form together with the person concerned (Vonk, 2021).

In explaining the different phases in this publication, we have used the aspects/domains just mentioned as a guideline. We have added the guidance style per phase and elaborated mainly in practical tools. The phases cover varying periods of time, some longer than others, see the box for an overview of the phases. Keep this in mind when using the tools provided, as it makes a difference whether you are in the beginning of a phase or at the end.

Finally, we end each chapter with a description of the characteristic issues that may occur at the described phase. This description is again based on literature by Anton Došen (Došen, 2014; Morisse & Došen, 2017; VandeVelde, et al., 2016).

The typical developmental stages in children are described first, before discussing how this knowledge can be used with adult clients as well. When describing the guidance style and the characteristic problems that can occur with inadequate guidance, the term 'client' is chosen because this section translates to guidance needs. Meeting emotional needs at each stage stimulates personality growth, this is linked to a reduction in stress and behavioural problems. Examples used in the guidance style come from the target groups of children, adolescents and adults.

In the description of emotional development, the following phases are distinguished:

1 Adaptation phase : 0 – 6 months
2 First[3] Socialization : 6 – 18 months
3 First[4] Individuation : 18 – 36 months
4 Identification phase : 3 – 7 years
5 Reality awareness : 7 – 12 years

The development of children/young people continues in a 6th and 7th phase until the age of 25, when the brain has matured into adulthood. These phases have been further developed within the European network (NEED); see the recent book by Jolanda Vonk for an introduction (Vonk, 2021).

For detailed information, please refer to the source list and reading suggestions. These can be found in the appendices, which also include a brief overview of emotional development using the SED-S.

[3] Second socialization runs from 12-17 years (Došen, 2014)
[4] Second individuation runs from 17-25 years (Došen, 2014)

1 Adaptation phase (0 - 6 months)

In this phase, the child is mainly busy physically adjusting (adaptation) to life outside the womb: breathing on one's own, getting used to food, waking/sleeping rhythm, processing sensory stimuli, e.g. sounds and touch, being moved, temperature regulation, and so on. Contact with the adult is still entirely through the proximity senses: physical sensations experienced in touch, smell and taste. The sensation of touch is already present at birth, but the baby still needs to 'learn' how to adequately process the sensation of touch and enjoy it. Crying at this stage is the main way to request closeness and attention or to achieve contact. Crying still mainly represents physical discomfort (like hunger, thirst, pain, fatigue, too many stimuli or a tense atmosphere). After two months, interaction develops through auditory (hearing) and visual (seeing) stimuli. During this phase, touch, making sounds, facial expression and eye contact between parent(s) and child ('mutual stimulation') are very important for mutual interaction.

The child shows physical tension and relaxation and shows physical arousal when feeling uncomfortable. The child shows anxiety and dissatisfaction when faced with strange or intense sensory stimuli. These feelings of anxiety and dissatisfaction are directed at himself and his environment. Furthermore, in this phase the child discovers its own body parts, which has already started in the womb. In the adaptation phase, the environment is still mainly explored through the mouth.

The child has yet to realise that something still exists when he no longer sees it ('gone = gone'). They have as yet no or only emerging interest in material, at most discovering it by chance. There is no focused contact with peers. The process of attachment starts during pregnancy but actual attachment behaviour (crying when leaving, smiling when returning, following with the eyes) is not seen until about five months of age.

1.1 Appropriate guidance style at the adaptation phase (0-6 months)

Guidance aims to contribute to psychophysiological regulation: a balance between physical and psychological condition. Ensuring rest and relaxation, and establishing regularity in activity and inactivity, are key. This means an individual approach. Physical contact and therapeutic massage are important, provided they are appropriately used in response to the client's underlying need, and (non-verbal) feedback from the client is responded to (responsiveness). Follow the other person's pace and adjust your degree of contact accordingly. Nurturing, comforting and supporting often bring peace back after signals of physical discomfort.

Body language (facial expressions, intonation, pace, and so on) is important and should be congruent with the therapeutic message being communicated. This means that if you are tense yourself, it is better to hand over the care to another trusted person.
The support at this phase is aimed at protecting against too intense or too many different stimuli. In this way, sensory stimuli can be processed. Therefore, provide appropriate and safe materials.

In addition, a clear and simple structure of space, time and people is important. The living space should be relatively small and uncluttered; within this space there should be a high degree of predictability, regularity and a fixed rhythm of rest and activity.
Support with physical care is often central: think of eating, drinking, changing, washing, and so on. These should be made into repetitive activities, in which interaction is paramount.

Depending on the developmental level, take turns moving (rocking, mirroring movements), making sounds back and forth, and changing sound rhythms and intonation (songs, rhymes). Through good care and satisfaction of basic needs, trust is built. Trust refers to basic emotional security. This is inextricably linked to secure attachment (Zaal & Boerhave, 2022; Sterkenburg, et al., 2022). Provide an emotionally sensitive approach, not one which challenges behaviour. The attitude is not corrective but empathic supportive and guiding.

Keywords adaptation phase
- sensory integration[5]
- body language, physical care and physical contact
- individual approach
- rest, relaxation
- regulate and dosage of stimuli
- constancy in environment
- responsiveness (stimulation of attachment behaviour)
- simple structure of space, time (regularity), people and activities.

1.2 Characteristic problems that may occur at this phase

The first phase is the basis of personality development on which subsequent phases are built. In unfavourable circumstances, this phase can always come to the fore again. In an adult persons, this first stage of emotional development can be found in people with (very) severe intellectual/multiple disabilities, in people with severe[6] autism spectrum disorder, in certain genetic syndromes and in crisis or severe regression in a psychiatric disorder (e.g. in a psychotic state).

Problems with (psycho)physiological regulation (psychophysiological stress) may arise in this phase, which if prolonged can lead to complete exhaustion.

Possible signal behaviour: stress and/or physical discontent manifested as restlessness, anxiety, anger outbursts, self-harm, stereotypical behaviour, withdrawal, passivity, sleep and eating problems, self- stimulation, dysregulation when environment changes, and sensory integration problems.

[5] Sensory integration is the process by which information from the body and stimuli from the outside world are received through the senses and aligned.

[6] Referenced here is the severity assessment in the DSM 5 for ASD in which the level of support required can be indicated in three levels. Level 3 is referred to here.

Aspects of treatment of characteristic problems in this phase:
Unconditional acceptance, offering closeness and safety, individual and reassuring approach, helpful limitation and guidance if necessary. No confrontation and do not expect the client to take responsibility for their own actions.

Match emotional intensity (or 'affect') according to the level of distress and disruption. Provide a supportive approach through rhythm and regularity in a predictable environment. Make contact e.g. by mirroring.

2 First socialization phase (6 - 18 months)

In this phase, the attachment relationship between the child and their significant caregivers is central. During this process the child usually still feels at one with the caregiver, who functions as a kind of extension of him. There is no differentiation yet between the child and the other. Building basic emotional safety is crucial. The child may panic when separating from the familiar figure or when they leave the caregiver's sight. The child still has little awareness that it is an independent person and 'gone' is still 'gone'. Since the child begins to learn that objects and people exist independently of themselves (person and object permanence), he experiences anxiety when the familiar figure is not present. The proximity of the familiar adult provides safety and within this environment the child dares to carry out activities. At this stage, the child is also shy and uncomfortable around strangers.

Around nine months of age, the infant calls on the parent[7] to regulate their stress by making contact through things like smiling, pointing, making noises, and crying. The 'significant other' is the buffer for the stress experienced by the child. When the child adequately 'uses' the parent for stress regulation, there is secure attachment. For a more detailed description of the attachment phase, please refer to our revised second publication: Attachment, basic safety, basic trust; guidance and treatment (Zaal & Boerhave, 2022; Sterkenburg, et al., 2022).

The child discovers that it can use its own body to grab something, touch it and so on. The child starts looking for objects that they have touched shortly before. In particular, shapes and sounds of materials are discovered. The child knows feelings of pleasure and frustration and can show love, fear and anger. Frustration is still very uncontrollably displayed by the child towards their environment. There is a budding interest in peers. The child starts pointing at objects and naming them with "that one!" or sometimes, initially, calling the object by its name.

2.1 Appropriate guidance style at the first socialisation phase (6-18 months)

The support is aimed at establishing basic emotional safety based on trust in a predictable caregiver. An individualised approach, with plenty of closeness and helpful boundaries and regulation from the environment, applies here.

Physical contact, being in sight, predictability in actions, fixed rituals and rhythms all contribute to this. In this phase, as in the previous phase, it is important that the environment offers a lot of structure and safety.

From a safe distance, there can be encouragement to explore: simple in/out materials, action/reaction play, sensory discovery. Be sure to remain visible and available during activities. Games such as peekaboo, hide-and-seek and contact games (rhymes, singing simple songs without background music) also fit well in this phase, if they suit the clients' existing developmental levels.

[7] By parent(s) we also mean other significant caregiver(s) for the child.

Communication consists of body language and short phrases (one- or two words) linked to the here and now. Making physical and eye contact before conveying the message is important. A confrontational approach towards (unwanted) behaviour is still rarely used. At this developmental age, the meaning of the word "no" is understood but cannot yet be implemented. This means that, as a caregiver, you cannot yet put responsibility on the client for their actions. Offering help is important. Put the responsibility on yourself. Getting angry does not help, getting out of the situation, interrupting the action or redirecting the client to what can be done is a better option. In order to actively change the behaviour; you have to change how you respond to the client.

Keywords first socialization phase
- physical contact
- 'significant other'
- attachment
- trust
- predictability: structure, safety and regulation
- basic safety
- beginning of one's own stress regulation
- individual approach and proximity
- therapeutic boundaries and active intervention
- imitative and exploratory behaviour
- social stimulation/play
- person and object permanence
- material handling

2.2 Characteristic problems that may occur at this phase

Basic emotional insecurity. Disruption of attachment: anxious avoidant, ambivalent or disorganised attachment.
Possible signal behaviour that, in both children and adults, may be apparent: 'clinging' behaviour, protest behaviour, contact disorder, aggressiveness towards 'significant other', restlessness, severe anxiety, fear of strangers, apathy in threatening situations, delusions, fear of change, rapid mood swings (including depression), impulsive reaction when frustrated, regressive behaviour, self-injuring behaviour when frustrated, compulsive use of material, development of rituals.

Aspects of dealing with characteristic problems in this phase:
Unconditional acceptance, offering basic safety and trust, individual approach, helpful limit setting and active intervention if necessary (guidance). No confrontation and not expecting the client to be able to take responsibility for their own actions. Doing things together is central. Sense of affectivity appropriate to needs. At the end of this phase, proximity can be maintained at a distance (though staying visible).

3 First individualisation phase (18 - 36 months)

At this phase, the child increasingly realises that he is his own little person who exists separately from the trusted adult. Autonomy and individuation are central. The child acquires a will of their own, discovers the word “no” and the word “I”, wants to do everything himself, is negative and stubborn at first and only then compliant, wants to influence his environment, but still likes to have the adult at a distance (preferably in sight). This is what the child needs in order to feel safe.
The child wants to break away from the ‘significant other’, but at the same time is afraid of losing them. This way the child is in a conflict situation, which can cause difficulties in interaction with the environment.

This phase of growing up is not easy: self-doing and self-discovery are central, even when the child is not able to carry out an activity themselves. Restriction of the child’s own will easily leads to frustration and tantrums; sometimes so violently that they scare themselves. The child is afraid of the angry words that may be spoken by others, afraid of being rejected and afraid of the intensity of their emotions.

The child can solve problems by thinking, but the way they think is not yet logical at this level. Thinking is self-centred, they can only think from within themselves. The child still has an unrealistic assessment of his skills and abilities.
It is still difficult at this phase to remember what is and is not allowed. This is learned in small steps. If something is done that is not allowed, it is often not intentional: the urge to do it themselves is stronger than the carer’s intention. There is no internal conscience yet, so there is no real feeling of guilt afterwards, at most just a realisation that they did something wrong.

The child seeks the proximity of other children but there is no interaction or playing together yet. The child cannot yet put themselves in the shoes of others. They are increasingly inquisitive about play materials.

The child has feelings of pride, fear, sadness, jealousy and love. Anger and physically expressed impotence are directed at persons, especially those who hinder them from carrying out their own will or cause frustration, but is still very unfocused. Furthermore, the child is afraid of damage to their own body at this stage.

3.1 Appropriate guidance style for the first individuation phase (18-36 months)

Guidance in this phase is aimed at increasing autonomy, but within clear boundaries, and alongside providing choice and structure. Finding a balance between the client’s self-determination and offering limits or choices is very important. In the first individuation phase, the child can function alongside others and learn in a group. However, the individual approach predominates. Proximity is needed without being perceived as unnecessarily patronising. It serves to adjust behaviour on the basis of (jointly) made rules and agreements. During moments of remote supervision and guidance, experience with more independent functioning can be gained.

The environment still offers clear boundaries, although encouraging initiatives is also important. A relationship of trust is built and maintained by a supportive approach. Such a relationship can be intentionally used in providing support. Clarity prevents confusion. The caregiver should be predictable and reliable, which makes the other person feel safe. Such clarity also includes not provoking resistance by directly asking for an action when you want it to happen. For example, “come, we are going out now” instead of “are you coming?” or “come, we are going to eat” instead of “are you coming to eat?”. Make sure the message is clear and straightforward; state what action you expect or (possibly) will do together.

The trick is to channel the client’s own will. Going into battle and standing your ground as a caregiver often backfires. This does not mean that you should just let everything happen. Every person has their own will, an important driving force in life and development. But what one person wants should not come at the expense of another. Tackle it diplomatically, distract. For example, give a choice between two alternatives, this allows the client to experience control, by choosing.

Because there is no internal conscience yet, the caregiver’s anger is only found to be annoying at that moment. So don’t expect lasting guilt or being able to remember the rules and agreements made.
The presence of the caregiver and guidance on behaviour remain necessary as an external conscience, day to day. Knowing that something is not allowed in the presence of the caregiver, slowly changes through repetition into ‘I’ve heard it before, I’ve known it’. From there, conscience develops.
Confronting the other person about undesirable behaviour requires a bond of trust and an approach that provides a support.

No independent solutions or alternative actions can be devised yet. Do that together. Help the client to get back on track by quietly resuming the activity in the desired way. Give measured responsibility. Briefly mention the possible cause of undesirable behaviour like pinching, for example: “You find it exciting”. Then possibly state the effect and the desired behaviour, for example: “That hurts, give me a hand”. Or briefly formulate the alternative: “Go and ask if you can watch” and perform the action together. Don’t confront too much with behaviour. Realise that the client is not yet able to come up with a solution or alternative action.

Separation anxiety plays an important role in this phase. This starts in the previous phase but can continue into the third year of life. While presence no longer needs to be as literally close by as in the previous phase, it is still important that signals are responded to.

When you leave, tell the client clearly where you are going, what you are going to do and that you will be back. A stuffed animal or a familiar comfort object (transitional object) can be helpful to bridge your absence. During this phase, separation anxiety may cause sleeping problems. Apart from separation anxiety, there are other fears that may come into play (see next phase).

Keywords first individuation phase
- autonomy (me - other, own will, the 'no' phase)
- separation anxiety
- trust(ing relationship)
- supportive approach
- clear messages
- adjustment on the basis of rules and shared agreements without punishment
- rewarding social behaviour
- measured responsibility
- providing more physical distance if possible
- balance self-determination - limits
- avoiding power struggles (diplomacy)

3.2 Characteristic problems that may occur at this phase

Disrupted autonomy development, involving overreacting (assertiveness) and avoiding negative feelings, can occur in this phase provided the client has a cognitive developmental level above 18 months. It can also culminate in complete surrender to the environment, showing complete dependency and passivity.

Possible signal behaviour: constantly seeking attention from significant others, unable to be alone, no or little interest in material, no interest in peers, restless, overexcited, chaotic, overly stubborn, pushing own will, negative, rebellious, defiant, disinhibited, destructive, irritable, reacting from the principle of pleasure or frustration or just passively, little individuality, imitating others, withdrawn, fearful.

Aspects of treatment for characteristic problems at this phase:
Providing space as well as offering limits, measured responsibility, if possible expanding and stimulating (doing together) activities.

Individual guidance in close proximity. Remain calm and (emotionally) available even when in conflict. Where possible, create possibility of negotiation or choice opportunities at a calmer time.

4 Identification phase (3 - 7 years)

The child becomes increasingly 'independent', adopting a more active attitude and taking initiatives towards others and activities. At the beginning of this phase, the toddler (3 to 4 years old) is still very dependent on the presence of significant others to help himself behave according to certain norms and values. Without the adult present, the temptation sometimes becomes too great to do something that is not allowed. By the end of the identification phase, the child (pre-schooler) has awareness of simple social rules and is increasingly able to obey them, even when the adult is not around. The child increasingly mirrors themselves on significant others who are role models but at the same time feels a strong sense of individual power.

Pre-schoolers may also suddenly be afraid again of being left alone or afraid of unfamiliar situations. They can cling to you when you leave or when a new situation arises. However, in familiar surroundings the child can hold his own without a trusted person.

Contact with the adult is mainly through language and play. A toddler increasingly tries to get a grip on the world around him and does so by asking lots of questions. Pre-schoolers ask why non-stop. Partly out of curiosity, partly just for the sake of chatting. The child learns to turn thoughts into questions, learns to formulate questions and learns from the answers they get. Toddlers are not yet able to see situations from another person's perspective. They see everything from their own position: egocentric (which is not the same as selfish). The same goes for sensing emotions in the other person. The immaturity in thinking means that they can hurt or injure each other. They do not yet have sufficient insight into how their actions come across to another. This (emerging) ability is only present from around the age of five/six and develops continuously. The child is often still impulsive: thinking and acting often at the same time. Consequences are not yet considered and weighed (toddlers) or at least not sufficiently (preschoolers).

In toddlerhood, children can be afraid of "the craziest things": afraid to fall, because they imagine breaking into a hundred pieces. Afraid of shower water, because they imagine being flushed down the drain. Afraid of the dark. In toddlers and pre-schoolers, fantasy and reality are easily mixed ('magical world'): fantasy is reality (think of 'the monster under the bed'). The ability to distinguish between fantasy and reality develops over the years under the influence of thought development and experience. By the end of the phase the child is increasingly able to tell apart what is real and what is just their own invention. This reality-awareness does provide a new source of anxiety, because that reality is often complicated and confusing.

Toddlers still mainly play side by side, while pre-schoolers increasingly play with each other. Pre-schoolers too, are still very focused on fulfilling their own wishes. This, together with their still insufficiently developed empathy, means that playing together does not yet take place in the way it does at the end of this phase (5-6 year olds). Games with clear rules are popular in the preschool period.

By the end of this phase, the child knows feelings of regret and (incipient) shame and can increasingly talk about his own behaviour. The child has a fear of not being accepted or appreciated by significant others and knows fear of failure. The child also has feelings like happiness. The sense of right and wrong is still very black and white. Anger and rage can be directed at the person causing it in a very controlled way. In handling materials, the child shows creativity and imagination. Imagination also becomes evident in language.

4.1 Appropriate guidance style at the identification phase (3-7 years)

At this stage, the client is dependent on significant others in terms of instilling and correcting his behaviour and thinking. He cannot yet do this sufficiently himself. Your anger will only limit undesirable behaviour in that moment. This means that your presence and guidance, giving direction to the behaviour, are needed at all times. Every single day. The impulsiveness at the beginning of this phase can often be redirected by using distraction. Explanation becomes, as the phase progresses, increasingly important. There is an emerging sense of conscience. Guidance focuses on stimulating initiative, teaching the client to take responsibility (based on experiences of success) and forming identity. Modelling desired behaviour is therefore important, as is proximity without being patronising.

Provide room for fantasy. Correct only if the fantasy stories create a sense of insecurity or fear. The why becomes increasingly important and triggers a sense of reality. By addressing the question, by saying something about the subject of the question, the client feels taken seriously and not inhibited in asking questions. Your corrections, suggestions and words trigger the forming of a sense of reality. In turn, this develops the ability to take another person into consideration. Social learning is central in this phase - watching how others do something. The client learns to take others into account by the caregiver naming what the effect is and what the possible consequence might be. Behaviour is adjusted by explanation and redirection, every time.

A group-oriented approach with social learning in mind is appropriate at this stage. An inviting (challenging), stimulating approach where group rules provide a general framework is important. In stressful or new situations, individual support is temporarily provided. Guidance on social behaviour can take place within the group, while more insight-giving or personal confrontation is done individually. Emotional closeness in the relationship is a prerequisite for the social learning process on the one hand, on the other hand it is important to handle your role in this relationship professionally.

Learning to take responsibility is a central objective (based on experiences of success). In this phase, the emphasis of the guidance shifts increasingly from doing things together to encouraging the clients to do things themselves and come up with their own solutions.

Keywords identification phase
- stimulating initiative
- social learning is paramount
- early formation of conscience
- identification figure
- impulsive ego
- individual approach during moments of stress
- empathy for emotions begins to develop
- internalisation of norms and values starts
- presence and guidance (redirecting) remain necessary
- fantasy - reality; reality awareness grows
- playing side by side - playing together

4.2 Characteristic problems that may occur at this phase

When the client repeatedly takes initiatives, and these are repeatedly met with negative consequences, it can lead to anxiety, guilt, lowered self-esteem, and various forms of compensatory behaviour: exaggeration, inauthenticity, compulsiveness, defiance and disinhibition.

Possible signal behaviour: depression, passivity or motor hyperactivity, lack of creativity, rigidity, phobias, compulsiveness, exaggerated self-confidence and enthusiasm for doing things, on the contrary, inhibition and apathy.
Dependence on the supervision of significant others, self-centredness, authority conflict, fear of failure, weak interaction with peers, lack of self-regulation, impulsivity/impulsive aggression, flight into fantasy worlds, somatic complaints with psychological stress, lack of initiative towards the environment in relationships and activities, taking away other people's things and other socially unaccepted behaviour.

Aspects of treatment for characteristic problems at this phase:
Offer support to increase self-confidence, which will allow for the possibility of taking more initiative. Provide clear, reliable boundaries, while explaining why. Provide activities that lead to experiences of success so that self-esteem is affirmed and increased.

Individual approach that offers support in stressful situations, problems and conflicts.

5 Reality awareness (7 - 12 years)

The child learns social rules, learns to be responsible, has an internalised conscience, can cooperate and develops friendships. From the sixth year of life, relationships with peers become more important and stronger. For social and emotional development, good relationships with peers are indispensable. In groups, children learn to adapt to group rules, negotiate with each other and enter into and resolve conflicts. In this age phase at school, the child is constantly presented with new material that he must then try to understand and fit in with what he already knows and has experienced. Every child is afraid of failing sometimes, of making mistakes or doing it wrong. However, some children are afraid to fail so often, that their performance is affected by this. Children who are unsure about themselves are less equipped to cope with new learning materials. They do not understand what you are asking of them and therefore become anxious and insecure. And when you are anxious and insecure, you cannot perform well and are not creative in coming up with possible solutions. This is how fear of failure arises. Primary school-aged children who are anxious generally show it through physical symptoms or through behaviour. Fearful children may also express their fear by being overly busy or by becoming very quiet. The child has fear of being unappreciated; they have social anxiety. They may also have trouble with falling asleep or with sleeping through the night, or their appetite may decrease.

If there is physically directed anger, it is controlled and sometimes even punitive, coming from black/white thinking and a strict conscience. The nuance in their thinking is often still missing. As a result, children sometimes make wrong interpretations, labelling their own experiences negatively (“I’m stupid, I can’t do it anyway”).

In dealing with materials, reality is copied; fantasy games are no longer as intense. In addition, the child is creative and focused on productivity and can become mindlessly obsessed with it. When children are in primary school, they start playing more and more in groups and more associatively, which means that they look at and adopt games and props from each other and also borrow or use play materials from each other.

As children grow older, they engage in more cooperative play, with the aim of achieving something together. When interacting with peers, the child is increasingly able to give and take, negotiate and cooperate. In addition, social competition plays an increasingly important role. Children in this phase want to measure their own physical performances. Interaction with adults is shaped into social and cognitive achievements.

The child’s world increasingly takes place outside the home. The teacher’s opinion becomes very important to the child. The language in this phase is characterised by realism, practicality and truthfulness.

5.1 Appropriate guidance style for reality awareness (7-12 years)

Cognitive abilities grow as clients are given the opportunity, peace, space and time to do so. When clients have learned enough and have had positive experiences, they are generally well prepared and can cope with the broader social world they have now entered. What is important here is that consistent, predictable, clear, structured, loving and client-centred guidance has preceded this.

In addition, it is important to identify in time when a client gets stuck in his relationships with others and to find out why; is he insecure, self-centred, not resilient, are social skills lacking or is there insufficient basic safety? If necessary, guidance adapts to the emotional phase the client is in. This may mean (temporarily) going back to the guidance style of an earlier phase.

Support in this phase is particularly aimed at encouraging independence and self-confidence. Guidance and support at a distance, offering tools and creating conditions for maximum self-responsibility, whilst not being patronising. Gaining positive learning experiences. Guidance should also help the client with their interpretations and to label situations differently or in a more nuanced way.

A caregiver plays a major supportive role: is insightful, gives positive feedback from a relationship of trust, helps with making important choices, is a role model, makes loyalty conflicts transparent. The caregiver must also be emotionally available for situations that cause stress. This can be more remote as the phase progresses, for instance through a (mobile) phone.

Keywords reality awareness

- logical thinking (cause - effect)
- world takes place more outdoors
- relationships with peers become more important and stronger
- self-confidence and self-esteem
- frustration tolerance increases
- guidance creates conditions and is no longer in close proximity, help with choices
- recognition of own achievements
- social skills
- social (performance) anxiety
- productivity and creativity in dealing with the material world
- competitiveness
- conformity to fixed rules
- moral development

5.2 Characteristic problems that may occur at this phase

If a client has experienced a lot of ambiguity, uncertainty and insecurity in earlier phases, he needs all his energy to maintain himself in an environment that is threatening to him. Not enough energy is left to learn, grow and develop. Clients who are over-thinking, anxious, insecure (lack of self-confidence), anti-social and/or lack sufficient self-respect (feelings of inferiority) and self-esteem are hampered in this growth.

Constant experiences of not being able to meet expectations create fear of failure, which again negatively affects performance. In addition, there may be an requisite need to prove oneself and live up to expectations. In cases where this fails, symptoms of exhaustion, anxiety, panic attacks, antisocial behaviour, and so on, can arise. Possible signal behaviour: negative self-image, fear of failure, feeling threatened, feeling disadvantaged, phobias, criminal behaviour, alcohol and/or drug use.

Aspects of treatment for characteristic problems at this phase:
Encourage initiative, responsibility and creativity. Guidance from a distance, with a trusted base to fall back on, including people, place and activities. Provide space for negotiation based on respect and equality. Support stress-regulation and conflict by, for example, asking focused questions (afterwards).

In conclusion

In this publication, we have tried to provide a practically useful representation of the different phases of emotional development. The SED (Scale for Emotional Development) developed by Anton Došen and subsequent editions of the scale have served as a starting point. Using these scales (SEO-R² and SED-S), an assessment of a client's emotional development can be made. It can then be assessed whether or not this development is consistent with functioning in other areas. Any behavioural and psychological problems can thus be seen as reflecting the client's underlying emotional needs.
Besides depicting the different phases, this publication offers practical guidance and treatment tools. Individual adaptation remains important here.

The main focus points from this publication at a glance:

- Emotional development concerns everyone and influences your functioning.
- Take into account someone's life story, what has someone been through.
- Map out emotional development and underlying needs in addition to cognitive development and skills
- Assume the emotional level does not exceed the cognitive.
- Is the development harmonious/disharmonious: 'being able' versus 'being able to cope emotionally'.
- Provide a guidance style that matches the emotional developmental phase and underlying needs.
- Connecting to emotional needs ensures growth and development.
- Adjust your guidance style in case of stress, keep in mind the difference in 'being able to' and 'being able to cope emotionally', this applies to every person.
- First regulate the stress, make a connection and only after that you can revisit the incident in calmness.
- Also consider your own emotional coping ability.

Overview of emotional development *(Largely based on the SED-S)*

	Relating to their own body	Relating to significant others	Dealing with change - object permanence	Differentiating emotions
PHASE 1 0-6 months adaptation	Discovering one's own body parts and processing sensory (feel, smell, taste) and autonomous stimuli (e.g. digestion).	Mainly focused on themselves, regulation by the caregiver (activity/inactivity); contact mainly through direct senses: touch, smell, taste.	No mental image of the environment. Gone is gone.	Activity and inactivity; Extreme (displeasure/ scared/anxious) responses to unusual or intense sensory stimuli. Extremes in emotions; e.g. apathetic/severely excited.
PHASE 2 6-18 months first socialisation	Discovering the instrumental function of one's own body; basic body awareness; gross motor skills.	Strong orientation towards and dependence on significant others; contact via direct senses (touch, smell, taste), and hearing, seeing, kinaesthetic experiences (based on muscular movements), physical contact and material.	Development of material object permanence; short search for disappeared/hidden objects; possibleuse of transitional objects (a stuffed animal orother important/meaningful object).	Pleasure and displeasure, fear of, or anger at separation (separation anxiety), fear of strangers (shyness), pleasure in contact with significant others.
PHASE 3 18-36 months first individuation	Discovering one's own body related to purposeful action. Perception of one's own body as the centre of the world (egocentric, omnipotent); fine motor skills.	Discovery of one's own will; fight for autonomy (self-determination): anger after longer separation; contact through language, objects and hearing and seeing.	Targeted search for hidden objects; transitional (replacement) objects; mental image of the environment.	Pride, jealousy (directed at the attention of the significant other), sadness, pleasure, anger (tantrums), fear of damage to own body or fear of loss of autonomy.
PHASE 4 3 to 7 years identification	Finding gender identity through role models. The inner feeling of being aboy, a girl, both or neither. Unambiguous use of specific gender characteristics to create a separation between the biological differences.	Incipient acceptance of social rules (from external to own conscience), incipient empathy; identification with significant others; playful and verbal contact.	Confidence in familiar environment without familiar person and in unknown environment with familiar person. Dares to distance himself from the transitional object in a familiar environment.	Pleasure (especially during contact), incipient empathy (sympathising and empathising ability), fear of not being accepted by the significant other, fear of failure, incipient feelings of shame and guilt.
PHASE 5 7 to 12 years reality awareness	Realistic self-perception and realistic assessment of one's own physical achievements compared to others (competition).	Adoption/internalisation of social rules: development of the conscience; contact via social and cognitive accomplishments.	Confidence/initiative in unfamiliar environment; internal object permanence.	Awareness of one's own worth, social anxiety (acceptance by fellow clients/peers), disappointment, own conscience, physical and social embarrassment, fun (including in competition).

Relating to peers	Engaging with the material world	Communication with others	Regulating affect
No attention to peers or perception in terms of objects.	No interest or accidental discovery, mainly through the direct senses (licking, smelling, touching).	Unfocused whole-body expression, imitative or stereotypical (sounds, facial expressions).	Regulating affect through self-stimulation/self-harm, lack of impulse control (especially with strong stimuli), stress regulation occurs through the other person.
Incipient interest; physical imitation of peers; parallel play.	Manipulation of material in the immediate environment; discovery of shape and sound, discovery of sensory play material (water, sand, clay, etc.).	Can share attention with another person; pointing, imitation, some words.	Regulating affect through contact with significant other(s); uncontrolled anger towards the environment, especially directed at the significant other (e.g. hitting, pushing).
Incipient interaction/group play; while self-focused, dominant in interaction.	Purposeful exploration/ discovery of materials and structures, focusing on the process.	Beginning of language/ wanting to tell something, use of the I form; saying 'no', challenging/ pushing boundaries, self-involved.	Incipient regulating affect through a balance between self-determination and external regulation (adjustment by the significant other). Incipient ability to compromise. Uncontrolled protest, anger, physical or verbal ("no") against causers of frustration/will restriction. 'Stubbornness phase'.
Content involved interaction; playing with others, forming friendships; pleasure during contact.	Creative and imaginative handling, focused on results.	Simple conversations (own world, why- questions, fantasy world), simple self-reflection.	Independent regulating affect is practised and is getting better. Can already do more by themselves but still has a lot of need for the other (for reassurance, stimulation, boundaries). Impulsive outbursts against the person causing the frustration.
Constructive, goal-oriented, social cooperation (playing and working in a team); close, loyal friendships; competition.	Purposeful, constructive, productive handling of materials/activities, focused on a product.	Conducts dialogue on real issues/topics (incipient discussing, arguing, concluding); ability to understand/have insights.	Self-regulation, focused on norms and values of the environment; usually control and suppression of impulsive expressions of anger.

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