

# Child Development in Integrative Psychotherapy: Erik Erikson's First Three Stages

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## **Abstract:**

Child development concepts and research provide the basis for therapeutic inquiry in a developmentally based, relationally focused integrative psychotherapy. This article focuses on the developmental ideas of Erik Erikson and relates them to the concepts of Bowlby, Fraiberg, Piaget, and Winnicott. The various developmental concepts provide the basis for developmental attunement, forming developmental images, phenomenological inquiry, and therapeutic inference that allow implicit and procedural memory to be expressed in a therapeutic narrative.

**Keywords:** Attunement, unconscious relational patterns, developmental attunement, developmental image, implicit memory, procedural memory, subsymbolic memory, child development, developmental psychotherapy, therapeutic inference, integrative psychotherapy, relational psychotherapy, Erik Erikson

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My client arrives late for our therapy session with his shoe laces untied, his hair uncombed, and his shirt stained with food. He is nervous as he shuffles into the office and plops down on the sofa. I ask him what he is feeling and he shrugs his shoulders. I have learned from past sessions that he quickly agrees with my  
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feedback when I suggest what he may be feeling based on his facial expressions and body gestures. But I am concerned by his compliant answers. This is a pattern I have seen before whenever he is not talking about current difficulties such as his mother's advancing cancer, his financial worries, or his wish for a more interesting job. He reports that he is "used by others" at work and also by his large family. He tells me that he never says "no," certainly not to family members. He describes his boldest form of protest as silently slipping out of an uncomfortable family dinner. It seems to me as though he has no sense of will, agency, or direction in his life.

I notice during our early sessions that he frequently tears pieces of tissue into small fragments and then rolls them into little balls. At first I wonder if he is distracting himself from feeling. I observe his intense facial expressions and body posture and how he plays with the tissue like a toy. In our moments of silence, he seems to be pleased with pulling the tissue into little pieces. I ask what he is experiencing and he says, "I don't know." He immediately puts the tissue down as though being obedient to some unspoken command. A few moments later, he takes another tissue and begins to tear it into fragments.

I wonder what unconscious experience is embodied in his gestures and enacted in the behavior I am observing. At what age would I expect a typical child to retreat into such activity? To engage in repetitive play alone? And to have no words to describe what he or she is sensing? I am raising questions to myself from a developmental perspective. I think about the importance of repetitive and solitary play, the absence of self-reflective words, and the age at which saying "no" is a necessary expression of self-definition. Who is my actual client? Is it this 38-year-old man or a 2-year-old boy? Or is it both?

### **Developmentally Based Psychotherapy**

Child development theories and various research reports on the social and emotional maturation of children provide the foundations for my therapeutic interventions when I am engaging in psychotherapy with clients. The primary purpose of this article is to describe some of these foundations of a relationally focused integrative psychotherapy (Erskine, 2008, 2009, 2015a) in order to provide a guide for therapists providing in-depth psychotherapy. I will articulate some of the ideas and theories that influence the work I do, particularly Erik Erikson's first three stages of child development, which range from birth to about age 6. Erikson delineated these first three of his eight stages as basic trust versus mistrust, autonomy versus shame and doubt, and initiative versus guilt.

Foremost in my understanding of the physical and relational needs and developmental tasks of infants and young children are the observations and hypotheses of many people who have written about child development. They include (but are not limited to) Ainsworth (Ainsworth, Blehar, Waters, & Wall, 1978); Beebe (2005); Bowlby (1969, 1973, 1979, 1980, 1988a, 1988b); Fraiberg (1959); Kagan (1971); Mahler (1968), Mahler, Pine, and Bergman (1975); Main (1995); Piaget (1936/1952, 1954, 1960); Piaget and Inhelder (1969, 1973); Stern (1977, 1985, 1995); and Winnicott (1965, 1971). In addition, the research of several neuropsychologists have validated the way I organize my psychotherapy, including the work of Cozolino (2006), Damasio (1999), LeDoux (1994), Porges (1995, 2009), Schore (2002), and Siegel (1999, 2007). However, it is Erikson's (1959, 1963, 1968) concepts that have been a constant guide in forming my hypotheses about clients' developmental conflicts, what was missing during their early formative years, and how to be in relationship with them.

A developmentally based, relationally focused integrative psychotherapy, in theory and methods, emphasizes the therapeutic importance of *developmental attunement*. This presupposes both knowledge of children's emotional and cognitive development and a sensitivity to each client's unique childhood history of relationships. This includes attunement to our clients' various affects, their rhythms and attachment patterns, how they organize experiences, and their variety of needs (Erskine, Moursund, & Trautmann, 1999).

Developmental attunement necessitates the therapist's sensitivity and responsiveness to the brief expressions of age regression and the transference expressions of unresolved relational disruptions that emerge in the process of psychotherapy. Such therapeutic sensitivity requires that we understand the personal and relational crises that young children live, the relational needs that emerge at each developmental stage, the physiological survival reactions and experiential conclusions they may come to, and what constitutes reparative therapeutic involvement.

*Sara: Lost and Empty.* Sara came to therapy complaining that she was depressed, slept a lot, and would often find herself just staring into space. She entered the office for the first time with a toothpick in her mouth. In the next several sessions, she constantly rubbed her lips with her fingers and often looked at the wall when she talked. Once we had established a comfortable working relationship, I began to make a series of inquiries, first with a variety of questions about her adolescence and middle childhood years and then specifically about her first year of life.

She eventually told me about her mother's breast infection, which occurred at the end of Sara's first month of life. Her mother had been hospitalized for several days, Sara was abruptly placed on bottle feeding, and her mother became depressed. This story helped me to understand Sara's sense of being "lost in space" and her own struggle with depression. I was forming a *developmental image* of a baby longing to nurse and craving her mother's vitality. I wondered if Sara's depression was a reliving of the emotional experience of a depressed baby or if Sara was bearing her mother's depression, or both.

Over the next 2 years, these hypotheses shaped my interventions. I frequently talked to Sara about what she may have needed as a baby, what well-cared-for babies may experience, and how she may have managed when her mother was depressed during her first year of life. Early in our work, she could not tolerate my looking at her; she was afraid. We spent many sessions with her experimenting with looking at my face and then hiding her face in her hands. Often she would cry with deep sobs. Later, when I inquired about her crying, she said that she had "no thoughts or words."

As our emotional connection deepened, Sara said that she feared I would disappear. She required reassurance that I was healthy. She suffered when we had a break in our weekly, and sometimes twice weekly, appointments. Eventually, she insisted on holding my hand "just to know you are real." She asked me to sit near her on the couch so that she could feel my presence. On several occasions, she reached out to touch the contours of my face, to rub her fingers over the shape of my nose, forehead, ears, and mouth. Her touching my face was just like a baby exploring its mother's face. She would then close her eyes and touch her own face, back and forth, touching my face and then her own. She repeated this infantile form of exploration several times before she could look into my eyes.

Although our sessions had long periods during which Sara did not speak, when she did talk, she described the deep sense of "emptiness in my stomach," "an emptiness that is never satisfied." Eventually, Sara realized that she was longing for a mother who was alive and happy to be with her. As the therapy continued, I sought occasions for us to share moments of liveliness and exuberance together.

## **Developmental Image**

In the story of Sara, I describe having a developmental image that helped me to remain aware of the relational neglect she experienced as a baby and to respond sensitively to her need for authentic presence. A developmental image is based on a combination of intuition and empathic imagination of what it is like to be in a particular child's experience and to have the quality of relationships that he or she had at a specific age (Erskine, 2008). Creating a developmental image allows us to constantly keep the distressed child in mind, to stay attuned to his or her relational experiences and unrequited needs, and to guide us in forming a reparative relationship.

However, developmental images are formed not only on the basis of empathic imagination and intuition. To be therapeutically effective, developmental images also require a thorough understanding of children's physical, emotional, cognitive, and social development—an understanding based on both informal and professional observations, the findings from child development research, and the theoretical concepts derived from such research. Developmental images remind the therapist to focus on the client's early life, his or her unrequited needs, and the relational crises that may have occurred at various ages. This is especially important in sessions during which the client becomes immersed in current events in his or her life.

## **Erik Erikson's Developmental Observations**

Josef Breuer and Sigmund Freud, in *Studies in Hysteria* (1893-1895/1955), were among the first to report on how early emotionally disruptive childhood experiences shape adult life. Freud (1894/1962, 1915/1957) went on to describe how childhood traumas are defensively "repressed" and thus unconsciously influence an adult's behaviors, attitudes, and emotions. In reflecting the social pressures of Vienna prior to 1900, he defined five psychosexual stages of development: oral, anal, phallic, latent, and genital (Freud, 1905/1953). Although not dominant in my treatment planning, I periodically consider aspects of Freud's psychosexual stages as a broad guide in assessing the psychological age of my clients and in seeking age-appropriate interventions.

Erikson theorized that human development progresses through a life cycle composed of eight developmental stages, ranging from infancy to old age, in which each stage marks a new dimension of personal and social integration. These describe a new dimension in an individual's phenomenological sense of himself or

herself as well as how he or she interacts in relationship with others (Erikson, 1959, 1964). This ever-evolving and integrating sense of self is the result of resolving specific personal and relational crises that an individual faces at various developmental ages.

Erikson (1958, 1969) referred to this process of psychological maturation as the *quest for identity*, a term that indicates a process that extends over several developmental stages. Progression toward a healthy personality depends on the successful mastery of personal and relational tasks at each stage of development (Erskine, 1971). Erikson (1968) called each of these personal and relational tasks a *developmental crisis*, a “turning point, a crucial period of increased vulnerability and heightened potential” (p. 96) and, therefore, either a source of internal strength and growth or a source of confusion, maladjustment, and interpersonal conflict.

In infancy, identity is not a mental construct. Rather, it is physiological in that the baby’s nervous system may crave, tolerate, or be repulsed by the caretaker’s touch. This is reflected in Bowlby’s (1969, 1973) descriptions of young children’s physical bonding and relational disruptions. The early infancy physiological sense of self, together with the presymbolic experiences of the preschool years and the experiential conclusions and explicit decisions of the school years, are all foundations on which later adolescent identity is formed.

Erikson (1968) said that successful passage through each stage is not an achievement secured once and for all, but rather a sense of accomplishing the developmental task of that age. This sense of accomplishment is not a cognitive or linguistic experience but rather a physically felt experience of security, agency, and/or self-esteem that is consistent with that age. In describing the eight epigenetic developmental stages, Erikson purposefully prefaced each stage’s descriptive title with the phrase “a sense of.” It is this phenomenological sensation of having achieved or of having been frustrated in accomplishing the stage’s task that is important in determining successful development in succeeding stages.

Erikson’s (1959) theory is relational in that at each stage the child’s mastery of a specific developmental crisis depends on the quality of the parents’ presence and involvement; it is epigenetic in that each stage involves both antecedents of previous developmental experiences and the precursors of future stages. For example, trust and mistrust issues will arise repeatedly throughout every stage of development, not just in the first year of life. And, although the formation of identity is at its peak in late adolescence, an aspect of identity begins in infancy when the task of basic trust is predominant. By combining his own insights on child

development with Freud's psychosexual stages, Erikson (1946, 1959, 1963, 1968) was able to conceptualize developmental progression as an interaction of biological, psychological, and relational variables that continue throughout the life span, which differed from Freud's static concept of child development. Each of Erikson's stages presents a new form of personal expression and relational engagement that lays the foundation for successive stages. At the same time, future developmental stages have a rudimentary influence on the current developmental stage (Erskine, 1971).

Significant in a child's development are the reciprocal relationships between parents and children (Erskine, 1971). For example, as the infant struggles with issues of trust and mistrust, his or her parents are grappling with issues of generativity, that is, caring for children, negotiating marriage, managing finances, and engaging in employment. The earlier description of Sara's psychotherapy illustrates Erikson's concept of child-parent reciprocity and the effects of the parents' affect and behavior on the child as well as Freud's concept that orality is the essential quality of infancy.

Erikson's (1953, 1959, 1963, 1968, 1971) writings also provide an understanding of the long-term negative effects of childhood relational disruptions and serve as a guide in forming psychotherapy inquiry and shaping a reparative therapeutic relationship. For instance, when an adult client has difficulty with creativity or finishing projects, I often think about the 4- or 5-year-old child's relational need for an adult companion who shares in the child's industrious activity. I may make several historical and phenomenological inquiries about the nature of the child's play time, the creative projects in which he or she engaged, who shared his or her interests, and whether the significant adults were supportive and enthusiastic about the child's play activities or if the child was criticized for or prohibited in exuberant play. Such information allows me to be instrumental in helping the client express appreciation for the need-fulfilling relationships that he or she may have had as a kindergarten-age child—or, alternatively, to therapeutically grieve and/or express anger at the lack of relationship with significant others. A developmentally attuned understanding may then lead me to demonstrate an active interest in the client's projects, hopes, and plans and thereby to create a reparative therapeutic relationship (Erskine & Moursund, 1988/2011; Moursund & Erskine, 2003).

## **Trust Versus Mistrust**

Erikson (1963) placed the foundation for all later development on the first year of life and the corresponding crisis of basic trust versus mistrust. He wrote that even prior to the infant's birth, the mother's attitudes toward her child throughout pregnancy and delivery have an effect on the newborn's responses. Once the child is born, symbiosis with the mother's body is replaced by a mutual activation between mother and infant. Fairbairn (1952), Winnicott (1965, 1971), and Stern (1985) described how an infant is capable of experiencing relationship from the very beginning of life and that the quality of the infant's experiences depends on interpersonal contact with significant others.

The interpersonal contact and reciprocity of giving and receiving permits the mother to respond to the needs and demands of the baby's body and mind. When the infant's needs for nurturing touch, comfort, and security are largely satisfied under this reciprocal relationship, the child learns to trust the mother, himself or herself, and the world. Erikson (1963) emphasized this point by saying that the parents "must be able to represent to the child a deep, almost somatic conviction that there is a meaning to what they are doing" (p. 249). The parents' consistency, reliability, and dependability communicate to the child that he or she is safe and that his or her basic and vital needs will be met, at least most of the time. This intermix of trust and mistrust is echoed by Winnicott's (1965) often quoted idea of the "good-enough mother" (p. 117).

Because the infant still lacks body image and object permanence, his or her sense of trust or distrust is nonspecific. It applies to all persons, including the self that is still undifferentiated from the maternal world. A mother who is consistently stabilizing and who regulates the infant's affect and physical needs is experienced as a sense of trust in both self and the external world. An emerging sense of trust leads to the establishment of hope. A mother who is inconsistent or neglectful is experienced by the child with a sense of distrust in himself or herself and in relationships. Distrust of an unreliable mother becomes self-distrust because the infant does not sense his or her mother as separate from himself or herself.

Developmental psychologist Jean Piaget said that during this early "sensory-motor" stage the infant is not aware of cause and effect; self-focused sensations are all that exist (Maier, 1969). Therefore, "the failure of the parent to provide the basis of trust is the infant's failure since he is not 'cognitively' able to perceive his existence as separate from his parents" (Erskine, 1971, p. 39). In my experience, the absence of a secure and trusting relational foundation may result

in clients having a physiologically based, indescribable sense of hopelessness. When adult clients talk about a sense of hopelessness—an internal sense of despair that exists even when their life is going well—I am inclined to focus on their first year of life. I begin by inquiring how they receive another person's touch and physical closeness, and I am interested to know if they have a sense of comfort and emotional stabilization through physical closeness or if they feel agitated by such intimacy. I may then inquire about the quality of the infant-mother relationship in significant aspects of baby care: feeding, diaper changing, bathing, play, and sleep time.

If a young child's sense of attachment is infused with a greater degree of mistrust than trust, later in life he or she may react disagreeably to even minor inconsistencies in someone else's behavior and use those inconsistencies as evidence that the person should not be trusted (Erskine, 2015b). If, on the other hand, the child has gained a sense of trust and it has been reinforced over several developmental ages, then in adult life he or she may see such inconsistencies as insignificant and a normal part of life.

I am particularly interested when clients perceive inconsistencies in my behavior or affect that lead them to mistrust me. I want to know how their perception stimulated and influenced this sense of mistrust and devote time to exploring how my behavior may have been an impetus for their lack of trust in our relationship. It is important for me to take responsibility for my inconsistencies and/or therapeutic errors before we investigate any possible early childhood sense of mistrust. It is essential that we work within our current person-to-person relationship to establish (as much as possible) a secure interpersonal connection before investigating the qualities of their early mother-infant relationship.

During the same era that Erikson was working, Bowlby (1969, 1973, 1980) also wrote about early child development. He described the biological imperative of prolonged physical and affective bonding in the creation of a visceral core from which all experiences of self and others emerge. Both Bowlby's and Erikson's writings delineate the unconscious relational patterns that are generalized from experiences in infancy and early childhood (Erskine, 2009). Bowlby proposed that healthy development emerges from the mutuality of a child's and a caretaker's reciprocal enjoyment in their physical connection and affective relationship. Mothers who are attuned to their baby's affect and rhythm, who are sensitive to misattunements and quick to correct their errors of attunement, establish for their infant a *secure base* (Bowlby, 1988b). It is these qualities of interpersonal contact, communication of affect, and reparation that are of utmost importance in forming

secure relationships, a sense of mastery, and resilience in later life (Ainsworth et al., 1978).

Bowlby's comments provide an outline of what a relationally focused integrative psychotherapist actually does with clients, that is, we create a secure base. Just as with involved, responsive parents, we attune to our clients' affects and rhythms, are sensitive to and take responsibility for our misattunements, correct our errors, strive to establish and maintain emotional and physical stability, create relational safety, and enjoy who they are (Tronick, 1989).

Bowlby (1973) articulated how the quality of a young child's relationship with his or her parents provides "a sense of how acceptable or unacceptable he himself is in the eyes of attachment figures" (p. 203). These repeated experiences establish *internal working models* that unconsciously determine anticipation, emotional and behavioral responses to others, the nature of fantasy, and the quality of interpersonal transactions. Stern (1995) referred to these same phenomena with the term *schemes of ways of being-with-another*. Both Bowlby and Stern were describing subsymbolic procedural forms of memory—memory that is not available to conscious thought although it is expressed in physiological sensations, affect, and relationships.

Bowlby went on to describe insecure attachments as the psychological result of disruptions in bonding within dependent relationships. Repeated experiences of security or lack of security in the first few months of life are what Erikson (1963) was referring to when he described this period of development as a time of trust versus mistrust.

Although Eric Berne provided no indication that he was aware of Bowlby's early research findings and theoretical ideas, he was well aware of Erikson's emphasis on the formation of trust or mistrust in the first 2 years of life. Berne (1961) described the relational disruptions in infancy as the "primal dramas of childhood" (p. 116), which resulted in an "extensive unconscious life plan" (p. 123). Berne used the terms *protocol* and *palimpsests* to describe the infant and early childhood interactions between a child and his or her caretakers that are imprinted as presymbolic, subsymbolic, and procedural forms of memory that form "unconscious relational patterns" (Erskine, 2015a) that later in life interfere with health maintenance, problem solving, and relationships with people—the early basis of a life script.

Winnicott referred to this early period in a child's life as a time when body memories are formed even though the infant is nonconscious and does not have a fully formed sense of "me." The infant is only aware of sensation, but body sensations are the neurological substructure of the child's emerging sense of trust and mistrust (Porges, 2009). Winnicott (1965) wrote that the baby is always struggling with the contrast between spontaneously expressing needs and having them fulfilled versus reacting to the demands from outside that interrupt the baby's "continuity of being. ... [W]hen reacting, an infant is not 'being' " (p. 185).

Incidents of relational disruption will undoubtedly occur between children and caretakers. Such reactions denote moments of disruption in the baby's sense of relying on the caretaker. The impediments to trust happen through recurring relational disruptions, wherein the child has an ongoing sense of a lack of security. Such a lack of security, mistrust, and the sense of needs not satisfied is not thought about or cognitive. Such body senses are subsymbolic, procedural forms of memory that are established when the child is preverbal. But these physiological sensations may last a lifetime and are influential in shaping relationships later in life.

Fraiberg's (1982/1983) research showed that behavioral signs of infant and parent relational disruptions are evident in the first few months of life. To paraphrase Fraiberg, these self-stabilizing survival reactions include infants freezing their body movements, flailing in agitation with their arms and legs, turning away from face-to-face contact, and transforming their affect. We may see subtle versions of these same self-stabilizing dynamics in adult clients when they tighten their bodies, agitate, avoid eye contact, or deflect from their feelings. Such behaviors may signal unresolved relational disruptions in early childhood.

### ***Applying Developmental Concepts in Practice***

In the first couple of months of psychotherapy, Sheila sat in my office biting her fingernails and constantly shaking her foot. Not only was she physically agitated, she also had great difficulty talking about her internal experience. She could freely tell me about her social interactions with other people during the previous week but usually without any eye contact. If I made more than one or two phenomenological inquiries, she would tighten the muscles in her face, shoulders, and chest and become silent.

Often in the first few months, I thought about Sheila's repetitive body gestures, her tense muscles, and how these behaviors might be an adult's

manifestation of an infant's gestures of agitated flailing, physical freezing, and turning away from contact—desperate attempts at self-stabilization when a significant caretaker fails to provide the physical and emotional stabilization necessary for the infant to develop a basic sense of trust (Fraiberg, 1982/1983).

Pacing my developmental investigation with only a few historical questions in each session, we began to slowly construct, over the next 9 months, the story of her first 2 years of life with a mother whom she described (with information provided by her two aunts) as “often high-strung, upset, and distressed.” Gradually, Sheila was able to tolerate my inquiries about her body sensations, variety of affects, fantasies, and how she coped, even as a toddler, with what she described as an “uptight mother” who had constant fights with her alcoholic father. She described family stories about how her mother would leave her in a playpen all day until her father came home to change her diaper and eventually feed her. She had a recurring image of being strapped into a high chair, crying to be let out, and “then just giving up.”

Sheila said that she did not remember the fights between her parents when she was 2, but she had a number of explicit memories of the verbal fights between them in her preschool and school years. She said, “I know in my body that I lived with constant tension” and “I could not trust anyone.” “Even now it seems impossible for me to rely on anyone.”

With some clients, I ask what they know about their conception, how their mother felt during pregnancy, and the quality of their parents' relationship with each other both during pregnancy and in the first few months after the birth. The client's rudimentary knowledge is usually based on family stories and fragments of information that he or she has put together over the years. Also, I may ask the client to “imagine” being fed by his or her mother during the first few months of life. I inquire about the client's “internal sense” of mother's touch, the rhythm of the feeding, the mother's sensitivity to the infant's need to be nurtured, and the presence or absence of eye contact. Did mother sing or talk when feeding or was it done in silence? I am curious to know if mother was relaxed or stressed and how my client physically responded to mother's body.

Based on what the person knows of his or her mother's personality, I ask the client to imagine those affectively charged and relationally significant interpersonal interactions (Stern, 1998; Tronick, 1989). Although most clients say that they do not have explicit memories of this period in their life, I am interested in their impressions because those are configured from physiological and

emotional experiences that are recorded as subsymbolic memory. Although not based on explicit memory, such prelinguistic, procedural memories are the foundation for unconscious relational patterns that may influence the client's affect, behavior, and relationships later in life (Bowlby, 1969, 1973, 1980; Erskine, 2009). These forms of memory are not conscious in that they are not transposed into thought, concept, language, or narrative, but they are phenomenologically communicated through physiological tensions, undifferentiated affects, longings and repulsions, tone of voice, and interpersonal interactions (Bucci, 2001; Kihlstrom, 1984; Lyons-Ruth, 2000; Schacter & Buckner, 1998).

In helping our clients construct a comprehensive narrative of their life, we are working with *therapeutic inference*, which is made from assembling bits and pieces of information, emotional and body reactions, internal images, family stories, and fantasies (Erskine, 2008, p. 136). These inferences are constructed through intersubjective dialogue between client and psychotherapist about the client's early life and may not be based on verifiable information. They are composed of internal sensations, impressions, physical reactions, and emotions that determine the client's internal processes and perceptions and may shape their behaviors in adult life.

Metaphorically, I think that in a developmentally focused psychotherapy we are constructing the client's narrative in a way that is similar to doing number-to-number drawings where a picture is formed by connecting various dots. For example, just as a child drawing a line between the dots numbered one, two, ... nine, and ten reveals the image of a cat or horse, we help clients construct a narrative that gives meaning to their experience through:

- Affective, rhythmic, and developmental attunement
- Consistent phenomenological and historical inquiry
- Fragments of information
- Developmental images
- Family stories
- Judicious use of child development theory, observation, and research

### **Autonomy Versus Shame and Doubt**

Erikson's (1963, 1968) theory states that the second developmental conflict—autonomy versus shame and doubt—occurs between 18 months and 3 years of age. This period corresponds with Freud's anal stage and is built on the foundations of trust or mistrust established during the oral stage. As the child nears

his or her second birthday, a qualitatively new kind of intellectual functioning occurs that Piaget (1951; Piaget & Inhelder, 1969) termed *preoperational*. The child has become more physically developed (walks and climbs), better coordinated (self-feeds), perceptually aware (observes family interactions), and determined to express his or her own wants (the need for self-definition and to make an impact on another person). This struggle for autonomy starts at age 2 and lasts until about 3-and-a-half years of age, although Piaget describes it as lasting until about age 7.

If the child does not have a basic sense of trust when entering the second stage, Erikson (1959, 1963) theorized that “the child will turn against himself all the urges to discriminate and to manipulate” (p. 70) and will over-manipulate himself or herself, develop a precocious conscience, become obsessive, and, in adult life, subscribe to more authoritarian attitudes.

The dominant behavior of this second stage is manifested in the child’s ability to both tightly hold on to items and to willfully throw them away. At the same time, the child is developing physically with “the arrival of a better formed stool and the general coordination of the muscle system which permits the development of voluntary release as well as of physical retention” (Erikson, 1968, p. 107). In writing about this stage, Erikson expanded Freud’s concept of the anal period and framed it in terms of the relationship between child and caretakers—a struggle for the child to exercise choice and a growing sense of autonomy. At this age, children are actively exploring, doing what they want, doing things their own way and at their own pace. With ongoing support and a protective environment, they form a sense of autonomy. If a child at this age is repeatedly criticized, if caretakers are demanding, controlling, or impatient, the child may be left with a sense of self-doubt.

Erikson’s (1959) discussion of autonomy largely focused on toilet training. But he emphasized that the quality of the relationship between the child and his or her parents at this time is a primary factor in whether or not the child will leave this stage with a sense of self-worth and competency or will feel powerless, ashamed, and inhibited. Erikson (1963) emphasized that it is important that the child not feel that his or her will is being broken. The quality of autonomy that children develop depends on their parents’ ability to grant autonomy with dignity and a sense of personal independence.

In addition to the rapid gains in muscular maturation, during this stage, the child learns to coordinate a number of highly conflicting action patterns and

vocalizations that delineate the world as “I” and “you,” “me” and “mine,” “no” and “I want.” The development of language is a tremendous tool in helping children to expand their world beyond the primary mother-child relationship. Although language at this point is poorly formed and more expressive than communicative, it allows distance between mother and child. Mother can now direct the child verbally without physically having to touch him or her. The child can refuse to obey by saying “no” or ignoring her, thus declaring his or her will, an expression of the emerging sense of autonomy.

Erikson wrote that a child’s “sense of self-control, without loss of self-esteem,” is the basis for a “lasting sense of autonomy and pride”; it is the ontogenetic source of a sense of free will.” He went on to say that “from ... a loss of self-control, and of parental over control, comes a lasting sense of doubt and shame” (Erikson, 1959, p. 109). A sense of doubt and shame results from the parents’ belittling, teasing, and overcontrol, which robs the child of the sense that he or she is capable of self-control and is able to direct his or her own life successfully.

*David: No Will.* David came to psychotherapy to resolve his career difficulties as a jazz musician and to address the lack of a permanent partner in his life. In the many months that I worked with him, it was increasingly clear that he became distant each time I was empathetic, such as when I validated his feelings or when we were saying good-bye. David’s distancing was subtle, but I could feel the emotional space between us, a vague disquieting sense within me, a desire to emotionally reach out to him and, at the same time, a contradictory sense of respecting the physical space between us. Most likely I was responding to David’s recurring patterns of managing emotional closeness and/or to what he may have needed as a boy.

I thought about Erikson’s descriptions of how a young child grapples with trust and mistrust. Although David attended his sessions weekly, I wondered if, at some primal level, he did not trust me. In several sessions I asked how he perceived our relationship. He hesitantly talked about how he imagined that I would eventually control him: “I know you won’t control me. I’ve watched you all these times, but I keep waiting for you to manipulate or criticize me.” Those transference transactions prompted me to ask David several questions, first about our current relationship and then about his life as a little boy.

Although he did not have specific memories of his early life, he described his mother as being “strict” and “always in control.” I asked him to imagine being 2

or 3 years old and wanting to climb on the furniture. He tightened his shoulder and back muscles and immediately said, "She would hit me if I did that. She would curse at me. She would destroy me." Although David did not have an explicit memory of being hit, he said "I know it to be true." He then went into detail about how he, both as a boy and as a man, feared his mother.

David described several times in his early life when his mother reprimanded, criticized, or hit him for being "willful." He did not want to be physically close to her and never told her what he was feeling or thinking. He realized that with me he was not only enacting an early pattern of mistrust but also that he was afraid of expressing his opinions and aspirations in his intimate relationships and his professional life as a musician. David's sense of will had been stymied. My therapeutic task included creating an emotionally and physically secure interpersonal space, supporting his aspirations, validating his self-definitions, and allowing myself to be impacted by him.

### **Initiative Versus Guilt**

Erikson's (1963) third stage is initiative versus guilt, which begins to develop at approximately 3-and-a-half years and continues until about age 6. However, the time frame may vary for some children. For Piaget, children in this same age range organize cognitive experiences preoperationally, with intuitive thought. They engage in symbolic play and manipulate symbols and toys, but they do not yet use concrete logic or transform, combine, or separate ideas (Piaget, 1951, 1952). This is the beginning of what Fraiberg (1959) called the "magic years," a time of fantasy, egocentrism, and parallel play. What children of this age do not understand in reality they create in fantasy.

This stage encompasses the genital and oedipal stages in Freud's theory. In the previous period of autonomy versus shame and doubt, the driving force behind the child's behaviors was the establishment of self-will and making an impact. The third stage is characterized by the child's capacity to plan and execute playful projects for the pleasure of being active, to self-define, and to satisfy the imagination. It is a time of purpose, direction, and repetitive manipulation of toys. Although children in this stage are full of play, exaggeration, and fantasy, they yearn for companionship, someone to play alongside them, someone who will be used as a toy and will respond to their initiative.

Successful building of children's' sense of initiative is based on their increased awareness of their own autonomy, which leads to more self-direction in their behaviors. In the preschool years, children develop a clear notion of goals

and how they want to achieve them. If they cannot succeed in reaching their goals, they are able to either modify them or change the method by which they intend to reach those goals.

Erikson (1953) wrote that the dominating behavior of the initiative stage is a variety of repetitive activities and fantasies into which the child intrudes, including into people's ears and minds with loud noises, space by vigorous actions, other people's bodies by jumping and climbing on them, and the unknown with consuming curiosity (Erikson, 1968, p. 116).

At this age, children have developed greater freedom of movement that allows them to move vigorously and to have a wider radius of goals. Language development has progressed so that they can ask about and understand many concrete events, although they may not comprehend diverse human relationships. Their understandings are concrete and egocentric (Maier, 1969).

At the same time, children are expanding their imagination by playing out the roles they imagine are available in life. They model their play on those adults they see as strong and beautiful. It is this imagination of the young child that provides the groundwork for the development of initiative. The selection of goals and the perseverance in accomplishing them have their origin in the child's fantasies about being almost as good as grown-ups.

Because children in this stage may not distinguish clearly between actuality and fantasy, overzealous parents can easily squelch their developing sense of initiative. If many of the child's vigorous and intrusive activities, play projects, or fantasies are forbidden, he or she begins to think of his or her ideas as wrong or bad. A sense of guilt may overshadow the child's playful imagination and resourcefulness (Erikson, 1968, p. 122). The developmental task at this stage is a sense of conviction, without guilt, that "I can be what I imagine myself to be." In my therapeutic experience with adult clients who were repeatedly hindered in their childhood play, expressions of fantasy and a self-defining sense of purpose tend to be inhibited, and they retreat to a passive internal world.

Erikson (1963) agreed with Piaget (1951) that in this stage, between 3-and-a-half and 6 years, play is necessary for a child's development. Play facilitates children's natural progression toward new mastery and new developmental stages; it is their way of reasoning about their world. Erikson (1963) wrote, "The child's play is the infantile form of the human ability to deal with experience by creating model situations and to master reality by experiment and planning" (p. 22). He went

on to say that he agreed with Freud that play provides the fantasy needed to rectify anxiety experienced by the young child. It allows the child to free himself or herself of the boundaries of time, space, and reality and provides an acceptable avenue for self-expression. However, a reality orientation is maintained because he or she and others know that it is “just play.”

*Timothy: Longing for Companionship.* After Timothy had been in therapy for 2 years, he embarrassingly described how he frequently masturbated, often more than once a day, from the time he was in kindergarten until today. He said that it was the most pleasurable thing in his life. This stimulated me to think of five developmental dynamics:

- Freud’s descriptions of the phallic stage that occurs about 5 years of age
- Erikson’s descriptions of the child’s budding sense of initiative and play
- The importance of play in Piaget’s theory of child development
- Fraiberg’s description of how fantasy is a dominant form of mental activity for a kindergarten-age child
- My own observations regarding the 5-year-old child’s increased need for a shared experience (Erskine et al., 1999)

These five concepts guided me to inquire about Timothy’s family relationships when he was in kindergarten. He described how his mother was always busy, “too busy to be with me.” His father was traveling for work. Timothy always played alone because he was not allowed to play outside the house or to invite friends over. His most vivid memory was of being reprimanded for making too much noise. He was prohibited from playing with his toys except in his bedroom. In his telling me this history, I could sense his loneliness and longing for a shared experience, and, at the same time, he was ashamed to tell me about what he was feeling and doing.

As I wove a series of historical and phenomenological inquiries into our sessions over the next several weeks, Timothy became aware of a great sense of emptiness and sadness, a longing for companionship. He recalled at age 5 hiding under the stairs, playing with his penis in order to not feel his loneliness. It dawned on him that as an adult he was still comforting himself with masturbation rather than engaging with people. He remembered how he felt restricted and could not reach out to either parent for comfort. He said, “By age five I was already a loner.” This led me to inquire about the earlier years of his life. A year later he joined a men’s group that met weekly. After the men’s group spent several sessions talking about various aspects of shame in their lives, Timothy told the group about the

harsh, cold family in which he had lived and his constant sense of loneliness. He wept in response to compassion and understanding voiced by the other men in the group.

## **Conclusion**

The writings of Erikson and other developmental psychologists mentioned earlier serve as a beacon to guide my phenomenological inquiry and understanding about the relational dynamics of my clients' early lives. Of course, our clients will not have explicit memories of early relational interactions. The symbolic, cognitive, and linguistic areas of the brain are not sufficiently formed during the first few years to allow for explicit memory, but memory consists of so much more. Early childhood memory may be embodied in physiological sensations, entrenched in affect, or unconsciously enacted in relationships (Erskine, 2008). These memories are not available to conscious thought because they are prelinguistic, presymbolic, procedural, and implicit. However, these neurological imprints give rise to "unconscious relational patterns," what Bowlby called internal working models of self-in-representation (Erskine, 2009, 2015a). When I am with a client, I frequently imagine myself as a curious detective searching for nonobvious clues as to what happened in that person's early life. These clues are encoded in the person's stories, fantasies, hopes, and dreams. Hence, a major psychotherapeutic task includes decoding the clues that may reveal the early childhood ruptures in relationship and thereby help provide a therapeutic relationship that repairs those relational ruptures.

Although sensitively attending to the current crisis and central events in a client's life is essential in a relationally focused psychotherapy, prolonged attention to current events may lessen the time devoted to a developmentally based, in-depth psychotherapy. However, as we know, the client's past relational disruptions are often being relived through current crises. To minimize the amount of time spent on current events in therapy, I make use of consistent phenomenological inquiry. My questions focus on bodily experience and related affect to bring the client's attention to what is occurring internally. I ask about early family dynamics, even though the usual answer early in therapy is, "I have no memories before elementary school."

Nevertheless, I often ask clients to imagine being a specific age, such as a nursing baby, a toddler learning to self-feed, a preschooler having a bath, or a kindergarten-age child playing with toys. I explore with them their feelings and associations when I inquire about bedtime at various ages, what they felt when

they observed interactions between their parents, and other emotionally charged happenings in their life. I ask about who was present or absent, what interpersonal involvement happened between the child and grown-ups, and what relational needs were satisfied or ignored (Erskine et al., 1999). I encourage them to interview family members who were either adults or older children when they were between infancy and kindergarten age to gather information that may confirm or disconfirm their own stories.

In much of this work, my clients and I are using therapeutic inference, that is, constructing a story based on clients' internal sensations, impressions, and fragments of information. We are working with early childhood implicit and procedural forms of knowing rather than only with explicit memories. Such phenomenological and historical inquiry stimulates implicit and procedural memory and provides an opportunity to put that memory into thought and language, often for the first time. These are the foundations of a developmentally based, relationally focused integrative psychotherapy.

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