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StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-.

## Developmental Stages of Social Emotional Development in Children

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Last Update: September 18, 2022.

## Continuing Education Activity

To apply knowledge regarding human growth and development, healthcare professionals need to be aware of 2 areas: (1) milestone competencies, for example, growth in the motor, cognitive, speech-language, and social-emotional domains, and (2) the eco-biological model of development, specifically, the interaction of environment and biology and their influence on development. This activity reviews the developmental stages of social-emotional development and discusses the role of the interprofessional team in educating parents on when they should expect children to achieve each milestone.

### Objectives:

- Describe milestone competencies in children.
- Summarize the eco-biologic model of development in children.
- Review social-emotional development in children.
- Outline the developmental stages of social-emotional development and cover the role of the interprofessional team in educating parents on when they should expect children to achieve each milestone.

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## Introduction

To understand human growth and development, healthcare professionals need to understand and learn about 2 areas: (1) knowledge of milestone competencies, for example, growth in the motor, cognitive, speech-language, and social-emotional domains, and (2) the eco-biological model of development, specifically, the interaction of environment and biology and their influence on development.[1][2] This article reviews the developmental stages of social-emotional development and also discusses the role of the interprofessional team in identifying the cause of social-emotional problems and therefore, intervening effectively.

Social-emotional development covers 2 important concepts of development including the development of self or temperament and relationship to others or attachment. Clinicians will be able to identify and intervene to resolve social-emotional problems in early childhood if they have a better understanding of these concepts

### Temperament

Temperament is an innate attribute that defines the child's approach to the world and his interaction with the environment across 9 dimensions which are activity level, distractibility, the intensity of emotions, regularity, sensory threshold, and the tendency to approach versus withdrawing, adaptability, persistence, and mood quality. We can

define temperament as the child's "style" or "personality," and it is intrinsic to a child. It influences child behavior and interaction with others. Based on the above attributes that define temperament, researchers have categorized young children's temperament into 3 broad temperamental categories:

1. *Easy or flexible*: This category includes children who are friendly and easygoing, comply with routines such as sleep and mealtimes, adapt to changes, and have a calm disposition.
2. *Active or feisty*: Children who are fussy, do not follow routines and have irregular feeding and sleeping schedules, are apprehensive of a new environment and new people, have intense reactions, and get easily upset.
3. *Slow to warm up or cautious*: Children who may be less engaged or active, have a shy disposition to a new situation and new people, may withdraw or have a negative reaction. They become more comfortable and warm up with repeated exposure to a new environment or person.

This classification is for ease of discussion, and all temperaments will not fit into one or other categories exactly. Discussion about temperament with parents and caregivers can better identify the child's strengths and needs. Based on this, caregivers can adapt their management and caregiving styles to match the child's temperament. This can mold a child's behavior and facilitate the child's successful interaction with the environment, defined as "goodness of fit."<sup>[3]</sup>

## Attachment

The social-emotional development begins with parental bonding with the child. This bonding allows the mother to respond to the child's needs timely and soothe their newborn. The consistent availability of the caregiver results in the development of "basic trust" and confidence in the infant for the caregiver during the first year of life. Basic trust is the first psychosocial stage described by Erickson. This allows the infant to seek for parents or the caregiver during times of stress, known as attachment.<sup>[4]</sup>

Even before acquiring language, babies learn to communicate through emotions. One may argue that learning emotional regulation and impulse control may determine later success in life more than IQ. There is a rapid growth in social and emotional areas of the brain during the first 18 months of life. The nonverbal parts of the right brain, including the amygdala and the limbic system, receives, processes and interprets stimulus from the environment that produce an emotional response and build emotional and stress regulatory systems of the body. The lower limbic system, outside the cortex, dictates most of our spontaneous, instinctive emotional responses, like fear resulting in a racing heart or weak knees. The upper limbic system part of the cerebral cortex, known as the limbic cortex, controls conscious awareness of emotions and refines the responses according to the environmental culture of the individual. The amygdala is an almond-shaped structure that lies at the junction of the cortex and subcortical areas of the brain and plays a pivotal role in sensing emotions and connects them both to higher and lower limbic structures. During the second half of infancy, emotional information from the lower limbic system moves up and becomes part of the babies' consciousness. Frontal lobe activity increases and myelination of the limbic pathways also begin during this time. With this gain in the limbic system, a caregiver's soothing and consistent response to the child's emotions develops into the child's attachment to the caregiver, usually the mother. Attachment is regarded as a pivotal event in a person's emotional development. It lays the foundation of a child's security, harbors self-esteem, and builds emotional regulation and self-control skills.

## Function

In healthy children, social-emotional stages develop on an expected trajectory, and monitoring these milestones is an imperative part of preventative health supervision visits. The caregiver's sensitive and available supportive role is imperative to establish attachment and the skill set that follows.

Three distinct emotions are present from birth; anger, joy, and fear, revealed by universal facial expressions. Cognitive input is not required for emotional response at this stage. During the brief periods of alertness in the newborn period, the newborn may return a mother's gaze. Soon the infant explores her face. The first measurable social milestone is around one to two months of age, and it is the infant's social smile in response to parental high-pitched vocalizations or smiles. She recognizes the caregiver's smell and voice and responds to gentle touch. Infants can use a distinct facial expression to express emotions in an appropriate context after 2 months of age. In the first 2 to 3 months infant learns to regulate physiologically and needs smooth routines. She progressively learns to calm herself, gives a responsive smile, and responds to gentle calming.

Sensitive cooperative interaction with the caregiver helps the infant to learn how to manage tension. Around 4 months of age turn-taking conversation (vocalizations) begin. The infant learns to manipulate his environment. They let their caregiver know whether taking away his toy upsets them or if they are happy when held. A sensitive but firm response from the caregiver helps infants manage emotional stress. She can recognize the primary caregiver by sight at around 5 months of age. In between 6 to 12 months effective attachment relationships establish with a responsive caregiver. Stranger anxiety emerges as an infant distinguishes between the familiar and unfamiliar. The infant becomes mutually engaged in her interactions with the caregiver. The infant seeks a caregiver for comfort, help, and play. He shows distress upon separation.

Around 8 months of age, joint attention skills develop. An infant will look in the same direction as the caregiver and follow his gaze. Eventually, they will look back at the caregiver to show that they share the experience.

Between 12 to 18 months, the infant learns to explore his environment with support from a caregiver. By 12 months of age, proto-imperative pointing emerges, in other words, the infant requests by pointing at the object of interest and integrates it with eye contact between the object and the caregiver. Proto-declarative pointing follows at 16 months of age when the child points with eye gaze coordination to show interest. Around 18 months of age, the child brings the object to show or give it to the caregiver.

Around 12 months of age, the child takes part in interactive play like peek-a-boo and pat-a-cake. They use gestures to wave bye-bye and communicate his interests and needs. At around 15 months of age empathy and self-conscious emotions emerge. A child will react by looking upset when he sees someone cry or feel pride when applauded for doing a task. The child imitates his environment, helps with simple household tasks, and explores the environment more independently.

Between 18 and 30 months, individuation (autonomy) emerges. The confidence in the child-parent relationship and continued firm parenting helps the child face environmental challenges on his own more persistently and enthusiastically. The child's temperament manifests itself more, and they are aggressive and reserved or friendly and cooperating. Around 18 to 24 months they learn to pretend-play such as talking on a toy phone or feeding a doll and playing next to or in parallel with another child. He may imitate other child's play and look at him but he cannot play in a cooperative, imaginative way with another child yet. During preschool years he learns to manipulate his subjective emotions into a more socially accepted gesture. He uses a "poker face", and exaggerates or minimizes emotions for social etiquette. For example, he will say thank you for a present he didn't like. The child refers to himself as "I" or "me" and possessiveness "mine" and negativism "no" emerge.

Between 30 and 54 months, impulse control, gender roles, and peer relationship issues emerge. A caregiver plays a major role in helping preschoolers define values and learn flexible self-control. Testing limits on what behaviors are acceptable and how much autonomy they can exert is an expected phenomenon. Thoughtful parenting with a balance between setting limits and giving choices will successfully establish a child's sense of initiative and decrease anxiety from guilt or loss of control. At 30 months pretend play skills emerge and the child shows evidence of symbolic play, using an object as something different like pretending a block to be a telephone or a bottle to feed a doll. The play scenarios become more complex with themes and storylines. By 3 years of age, the child engages more in interactive play, masters his aggression and learns cooperation and sharing skills. They can play with 1 or 2 peers, with turn-

taking play and joint goals. Imaginative and fantasy play begin like pretending to be a cat and role-play skills develop. The child, however, cannot yet distinguish between reality and imagination and it is common to be afraid of imaginary things. They master this skill to differentiate between real and imaginary around 4 years of age. They enjoy playing tricks on others and are worried about being tricked themselves. Imaginary scenarios and play skills are developing and becoming more complex. They can play with 3 to 4 peers, with more complex themes and pretend skills.

At 5 and 6 years of age, the child can follow simple rules and directions. They learn adult social skills like giving praise and apologizing for unintentional mistakes. They like to spend more time in peer groups and relate to a group of friends. Imaginative play gets more complex, and he likes to play dress, and act out his fantasies.

At 7 and 8 years of age, the child fully understands rules and regulations. They show a deeper understanding of relationships and responsibilities and can take charge of simple chores. Moral development furthers, and he learns more complex coping skills. At this age, a child explores new ideas and activities and peers may test his beliefs. Children identify more with other children of similar gender and find a best friend in common.

At 9 and 10 years of age, peer and friend groups take precedence over family. Children at this age will show increasing independent decision-making and a growing need for independence from family. Parents can use responsibilities and chores to earn time with friends. A positive nurturing relationship with a caregiver with praise and affection and setting up a reasonable balance between independence and house rules builds self-confidence and self-assurance. Promoting supportive adult relationships and increasing opportunities to take part in positive community activities increases resilience.

Greater independence and commitment to peer groups drive the transition to adolescence. This will include indulging in risky behavior to explore uncertain emotions and impress peer groups. Social interactions include complex relationships, disagreements, breakups, new friendships, and long-lasting relations. Normally the adolescent will learn to cope with these stresses with healthy adult relationships and guidance to make independent decisions. As young adulthood approaches, school success and work-related activities become important. For a healthy transition to adulthood positive and supportive adult guidance and opportunities to take part constructively in the community play a pivotal role.

## Issues of Concern

The inability to reach age-appropriate milestones can be a manifestation of psychosocial disturbance and needs further exploration. Examples of early childhood social-emotional disturbance include autism, reactive attachment disorder, social anxiety disorder, generalized anxiety disorder, attention-deficit hyperactive disorder, bullying, oppositional defiant disorder, conduct disorder, and post-traumatic stress disorder, among others.

## Clinical Significance

A failure to follow the expected trajectory of social-emotional development can lead to undetected mental and emotional health problems. Adverse childhood experiences can alter development significantly. Thus, alongside screening for child development, actively screening for family dysfunction and supporting families in establishing a healthy nurturing environment is vital. By having a thorough knowledge of developmental pathways and adverse childhood experiences, and having a close follow-up established with families in the medical home, pediatricians and medical professionals are in a prime position to identify risk factors and developmental delays timely.

Medical professionals taking care of children should begin with identifying and addressing the family's concerns, asking open-ended questions regarding social-emotional milestones, and intentionally observing parent-child interaction and child's interaction with the environment including themselves. While examining the patient, they should observe age-appropriate developmental interaction. They should give teenagers the opportunity to engage in

health visits in a private and safe environment without a caregiver. Also, should be able to address questions about parenting advice. These include advice on temper tantrums and defiant behaviors, child care and preschool guidance, referring to parent training management when appropriate, and counseling on temperament differences and "goodness of fit" models.

The American Academy of Pediatrics (AAP) and Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents emphasize active screening for developmental delays and environmental risk factors on top of clinical surveillance. This includes the use of standardized screening tools for social-emotional development and for environmental risks appropriate to the risk level of the population you serve. Environmental risk factors should include caregiver/family functioning, caregiver mental health, socio-economic stress, refugee/immigrant status, safety concerns, caregiver drug addiction, etc. AAP recommends screening for autism spectrum disorder (ASD) at both the 18- and 24-month health supervision visits, and whenever concerns are raised. When using screening tests, one should be cognizant of some potential limitations including the inability to administer and score the screening tool correctly, using it as a diagnostic tool, failure to incorporate other available clinical data, and using a linguistic or culturally inappropriate tool.[5]

If screening identifies any risk factor or delays, it should always follow with further assessment and evidence-based interventions. Screening for maternal depression especially during the first year of childbirth is important. Identifying and intervening for maternal depression early on can avoid attachment and social-emotional problems in the child later. With clear delays in social and language development, it is important to initiate services even before a confirmed diagnosis as early intervention is the key. If the child is younger than 3 years should be referred to local Early Intervention EI services. A child 3 years of age or older should be referred to their school district. Anticipatory guidelines should include evidence-based strategies for age-appropriate behavioral interventions such as the management of temper tantrums for toddlers. Implementing the use of developmental screening tools in clinical practice has shown an encouraging trend though still, a wide gap in practice remains.[6] Practices that have successfully established screening are struggling with coordinating referrals and monitoring progress.[7] We need further research to identify barriers to the use of standardized tools and the coordination of services and interventions.

## **Standardized Screening Instruments**

### **Caregiver Functioning**

1. Adverse Childhood Experience Score
2. Parenting Stress Index-Short Form
3. Depression, Anxiety, and Stress Scale
4. Patient Health Questionnaire-2
5. Edinburgh Postnatal Depression Screening
6. Center for Epidemiologic Studies Depression Scale

### **Temperament**

#### Carey Temperament Scales

### **Infancy to Early Childhood**

1. Ages and Stages Questionnaire: Social-Emotional
2. Survey of Well Being of Young Children
3. Communication and Symbolic-Behavior Scale

4. Developmental Profile, Infant Toddler Checklist
5. Brief Infant-Social Emotional Assessment

### **Early Childhood to Adolescence**

1. Eyberg Child Behavior Inventory
2. Pediatric Symptom Checklist
3. Pictorial Pediatric Symptom Checklist

### **Multidimensional**

1. Infant-Toddler Social Emotional Assessment
2. NCAST Parent-Child Interaction Feeding and Teaching Scale
3. Achenbach System of Empirically Based Assessment
4. Behavior Assessment Scale for Children Second Edition
5. Connors Comprehensive Behavior Rating Scales
6. Child Symptom Inventories-4
7. Vanderbilt Parent and Teacher Assessment Scales

### **Single Dimension Attention-Deficit/Hyperactivity Disorder**

1. Conners Third Edition
2. Attention Deficit Disorders Scale
3. Brown Attention Deficit Disorder Scales

### **Single Dimension Anxiety/Depression**

Beck Youth Inventories

(Adapted from Duby JC, Social and Emotional Development. In: Voigt RG, Macias MM, Myers SM, eds. Developmental and Behavioral Pediatrics. Elk Grove Village, IL: American Academy of Pediatrics; 2011:241–248)

### **Enhancing Healthcare Team Outcomes**

Optimal child growth and development need orchestrating enhanced communication between the pediatrician/primary care provider and various medical specialties including but not limited to the mother's obstetrician, nursery/NICU teams, nursing staff, psychology, psychiatry, child life, and social work. Twenty percent to 25% of children seen in primary care clinics experience social-emotional problems that are clinically significant. Access to mental health services and parenting classes and education is limited due to stigmatization, cost, and availability. In 2004, the American Academy of Pediatrics organized a Task Force on Mental Health to enhance identification and intervention for social-emotional problems in primary care pediatric practice. One of the key findings in its report was having integrated models of care with collaboration with psychologists, social workers, psychiatrists, and others in the community to formulate a comprehensive care plan. With help from other professionals, primary care practice should be able to put together a list of clinical and family concerns, coach the family on self-management techniques, and create a resource list including professionals involved in care, community partners available to the family and child,

and treatment goals and strategies.[8] Building a comprehensive system of care with a focus on prevention and early intervention can address the unmet needs of social-emotional development and behavioral problems in children. To achieve such a system, it is imperative to establish training models with an integrated system of care. Such a model will encourage and train professionals to collaborate mutually to prevent, identify, consult, educate and plan treatment for patients.[9]

## Review Questions

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**Disclosure:** Fatima Malik declares no relevant financial relationships with ineligible companies.

**Disclosure:** Raman Marwaha declares no relevant financial relationships with ineligible companies.

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