



Socialization and Age-Appropriate Behaviors  
Learning Goal

**To understand how to interact respectfully with others, make positive choices, and demonstrate behaviors that are appropriate for your age.**

1. Greeting Others

**A good first impression begins with being polite.**

**Remember to:**

- **Say "Hello" or "Good morning."**
- **Smile when appropriate.**
- **Introduce yourself if someone doesn't know you.**
- **Use respectful language.**

**Example:**

**"Hi, my name is DD. It's nice to meet you."**

2. Good Listening Skills

**Being a good listener shows respect.**

**Good listeners:**

- **Look at the person speaking.**
- **Wait until they finish talking.**
- **Do not interrupt.**
- **Ask questions if they need clarification.**

**Remember: Listen to understand, not just to respond.**

3. Respecting Personal Space

**Everyone has a personal space bubble.**

**Always:**

- **Keep your hands to yourself.**
- **Ask before hugging or touching someone.**
- **Respect other people's belongings.**



- **Stand an appropriate distance away when talking.**

#### **4. Being Respectful**

**Respect means treating others the way you want to be treated.**

**Respect includes:**

- **Saying "Please" and "Thank you."**
- **Speaking kindly.**
- **Following rules.**
- **Helping others when appropriate.**
- **Being honest.**

#### **5. Handling Disagreements**

**Everyone disagrees sometimes.**

**Instead of:**

- **Yelling**
- **Fighting**
- **Calling names**

**Try:**

- **Speaking calmly.**
- **Listening to the other person.**
- **Using respectful words.**
- **Asking an adult for help if needed.**

#### **6. Managing Your Emotions**

**Everyone feels angry, frustrated, or upset sometimes.**

**Healthy ways to calm down:**

- **Take deep breaths.**
- **Count to ten.**
- **Ask for a break.**
- **Talk to a trusted adult.**
- **Think before reacting.**



## 7. Responsibility

**Being responsible means doing what is expected of you.**

**Examples:**

- **Completing chores.**
- **Cleaning up after yourself.**
- **Returning borrowed items.**
- **Following directions.**
- **Arriving on time.**

## 8. Making Good Choices

**Before making a decision, ask yourself:**

- **Is this safe?**
- **Is this respectful?**
- **Is this kind?**
- **Will this help or hurt someone?**
- **Would I be proud if someone saw me doing this?**

**If the answer is "No," choose a better option.**

## 9. Building Positive Friendships

**Good friends:**

- **Tell the truth.**
- **Share.**
- **Encourage each other.**
- **Respect differences.**
- **Include others.**
- **Solve problems peacefully.**

## 10. Age-Appropriate Behaviors

**As you grow older, people expect you to:**

- **Take responsibility for your actions.**
- **Control your emotions.**
- **Respect adults and peers.**



- **Follow rules.**
- **Communicate respectfully.**
- **Complete daily responsibilities.**
- **Show good judgment.**

**These behaviors help build trust at home, school, work, and in the community.**

### **Socialization:**

Developmental disability (DD) socialization involves building communication, connection, and community inclusion. Key local programs and strategies include joining specialized Meyer Foundation for Disabilities groups, utilizing [Duet](#) day services, and practicing natural peer interactions. [[1](#),[2](#),[3](#),[4](#),[5](#)]

#### **Local Omaha Programs and Support**

- Meyer Foundation for Disabilities: Partnering with the UNMC Munroe-Meyer Institute to offer adult cooking classes, dance and swim lessons, reading clubs, and group outings in the metro area. [[1](#)]
- Duet: Providing day services, community inclusion, and residential support across the Omaha metro area. [[1](#)]
- Madonna Ability Alliance: Offering a continuous span of programs from school-age integration to adult day and career services emphasizing social growth. [[1](#)]
- Autism Center of Nebraska: Delivering vocational and social skills coaching for teens and adults. [[1](#)]

#### **Effective Socialization Strategies**

- Interest-Based Groups: Joining localized crafting, art, or fitness groups tailored to specific hobbies.
- Peer Mentoring: Working alongside a mentor to introduce new settings and model positive social habits.
- Natural Practice: Engaging in low-pressure, everyday exchanges like small talk in neighborhood settings.
- For broad family training and systemic guidance, explore resources via [PTI Nebraska](#). [[1](#),[2](#),[3](#),[4](#)]

### **Age- and Developmentally-Appropriate Strategies**

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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:

- Identify milestone competencies in children.
- Implement the eco-biologic model of development in children.
- Assess social-emotional development in children.
- Communicate the developmental stages of social-emotional development and the role of the interprofessional team in educating parents on when they should expect children to achieve each milestone.

[Access free multiple choice questions on this topic.](#)

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### Introduction

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To understand human growth and development, healthcare professionals need to understand and learn about 2 areas:

1. **Knowledge of milestone competencies:** Growth in the motor, cognitive, speech-language, and social-emotional domains
2. **The eco-biological model of development:** The interaction of environment and biology and their influence on development [\[1\]](#)[\[2\]](#)



This topic reviews the developmental stages of social-emotional development. It 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, including the development of self or temperament and relationship to others or attachment. Clinicians can 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," which 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:** Fussy children do not follow routines, 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 toward new situations and new people and may withdraw or react negatively. 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 do not fit into 1 or other categories exactly. Discussing 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."[\[3\]](#)

## **Attachment**

The social-emotional development begins with parental bonding with the child. This bonding allows the mother to promptly respond to the child's needs 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. Essential trust is the first psychosocial stage described by Erickson. This allows the infant to seek parents or the caregiver during times of stress, known as attachment.[\[4\]](#)

Even before acquiring language, babies learn to communicate through emotions. One may argue that knowing emotional regulation and impulse control may determine later success in life more than IQ. There is a rapid growth in social and dynamic 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, receive, process, and interpret stimuli from the environment that produce an emotional response and build the body's dynamic and stress regulatory systems.

## **The lower limbic system**

The lower limbic system, outside the cortex, dictates most of our spontaneous, automatic emotional responses, like fear resulting in a racing heart or weak knees.

## **The upper limbic system**

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**



The amygdala is an almond-shaped structure that lies at the junction of the cortex and subcortical areas of the brain. It plays a pivotal role in sensing emotions and connects them to higher and lower limbic structures.

During the second half of infancy, emotional information from the more inadequate limbic system moves up and becomes part of the babies' consciousness. Frontal lobe activity increases, and myelination of the limbic pathways also begins 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.

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## Function

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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 essential to establish attachment and the skill set that follows.

Three distinct emotions are present from birth: anger, joy, and fear, which are 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, newborns may return a mother's gaze. Soon after, infants begin to explore their faces.

### **1 to 2 Months of Age**

The first measurable social milestone is around 1 to 2 months of age: infants begin to smile socially in response to parental high-pitched vocalizations or smiles. They recognize the smells and voices of their caregivers and respond to



gentle touch. Infants can use a distinct facial expression to express emotions in an appropriate context after 2 months of age.

### **2 to 3 Months of Age**

In the first 2 to 3 months, infants learn to regulate physiologically and need smooth routines. They progressively know how to calm themselves, give a responsive smile, and respond to gentle calming.

### **4 to 5 Months of Age**

Sensitive cooperative interaction with caregivers helps infants learn how to manage tension. Around 4 months of age, turn-taking conversations (vocalizations) begin. Infants then learn to manipulate the environment. They let their caregivers know whether taking away their toy upsets them or if they are happy when held. A sensitive but firm response from the caregiver helps infants manage emotional stress. They can recognize the primary caregiver by sight at around 5 months of age.

### **6 to 12 Months of Age**

In between 6 to 12 months effective attachment relationships establish with a responsive caregiver. Stranger anxiety emerges as infants distinguish between the familiar and the unfamiliar. Infants become mutually engaged in their interactions with caregivers and seek a caregiver for comfort, help, and play. They show distress upon separation. Around 8 months of age, joint attention skills develop. Infants look in the same direction as their caregivers and follow their gaze. Eventually, they look back at the caregiver to show that they share the experience.

### **12 to 18 Months of Age**

Between 12 to 18 months, infants learn to explore their environment with support from a caregiver. By 12 months of age, proto-imperative pointing emerges; in other words, infants request by pointing at the object of interest and integrating it



with eye contact between the object and the caregiver. Proto-declarative pointing follows at 16 months of age when children point with eye-gaze coordination to show interest. Around 18 months of age, children bring objects to show or give 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 their interests and needs. At around 15 months of age, empathy and self-conscious emotions emerge. A child reacts by looking upset when they see 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.

### **18 to 30 Months of Age**

Between 18 and 30 months, individuation (autonomy) emerges. The confidence in the child-parent relationship and continued firm parenting help 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. They 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, they learn to manipulate their subjective emotions into a more socially accepted gesture. He uses a "poker face", and exaggerates or minimizes emotions for social etiquette. For example, they 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.

### **30 to 54 Months of Age**

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 successfully establishes a child's sense of initiative and decreases 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 by 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.

## **5 and 6 Years of Age**

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.

## **7 and 8 Years of Age**

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.

## **9 and 10 Years of Age**

At 9 and 10 years of age, peer and friend groups take precedence over family. Children at this age 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 includes 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 adolescents 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.

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## Issues of Concern

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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.

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## Clinical Significance

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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 the child's interaction with the environment, including themselves. While examining the patient, they should observe age-appropriate developmental interaction. 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 and family functioning, caregiver mental health, socio-economic stress, refugee or immigrant status, safety concerns, caregiver drug addiction, etc. AAP recommends screening for autism spectrum disorder 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 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.<sup>[6]</sup> Practices that have successfully established screening are struggling with coordinating referrals and monitoring progress.<sup>[7]</sup> 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. Nursing Child Assessment Satellite Training (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 or hyperactivity disorder**

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

### **Single-dimension anxiety or 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)

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## Enhancing Healthcare Team Outcomes

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Optimal child growth and development need to orchestrate enhanced communication between the pediatrician/primary care provider and various medical specialties, including but not limited to the mother's obstetrician, nursery or neonatal intensive care unit (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, parenting classes, and education is limited due to stigmatization, cost, and availability. In 2004, the AAP 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.<sup>[8]</sup> 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.<sup>[9]</sup>



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