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Social development birth to year three: societal implications

Lee Ann Erkander

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SOCIAL DEVELOPMENT BIRTH TO YEAR THREE:
SOCIETAL IMPLICATIONS

BY
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CHAPTER I

Introduction

A child is born. The parent(s) are awed and relieved...awed at the miracle of birth...relieved that
the baby is born healthy and normal. This child will have
all of the opportunities to become a healthy, happy
contributor to the society.

A child is born. The parent(s) are young teenagers,
alcoholics, drug abusers, or have already contracted AIDS
or will in the future neglect, or physically or sexually
abuse this child. This child will not have all of the
same opportunities.

There have always been babies born, and it has been
general knowledge that each baby is different and may be
brought up differently and have different opportunities.
It is general knowledge, too, that society also impacts
on the development of the child. For example, in the
Middle Ages, Europe was struggling for survival. Many
families put their children to work as soon as possible.
Society viewed childhood as just a short waiting period
before beginning a life of work.

In the early decades of this century, emphasis was
placed on the cleanliness and hygiene of a baby. By the
1930's and 1940's, the educational and psychological needs
of the child became the issue. In the 1970's and 1980's, the issue of concern was how and why a child develops (Chase & Ruben, 1979). Yes, babies are born. Yes, society impacts the development of its children. And today's babies and young children do have an impact on today's society!

Purpose

What is normal social development from birth to year 3? How do today's societal problems affect normal social development in the young child? What can be done to help a young child who is born socially disadvantaged?

With today's problems, it is a growing concern not just to educators, but to all who participate in today's society.

It was the author's intention to describe the steps of normal social development. It was also the author's intention to describe how societal/parental problems may interrupt the young child's social development, and how once disrupted, what possible educational remediation techniques are effective.

Scope and Limitations

The author gathered data from 1970 to 1990 on the topic of normal social development birth to year three.
The most current periodicals and publications were used to describe the causes and social remediation of children (birth to 3 years) born with AIDS, fetal alcohol syndrome, drug addiction, and children born into violent or neglectful homes and to teenage parents.

Definitions

For ease of understanding the following definitions of terms used in this research paper are provided:

**Bonding** - A uniting force or influence that holds mother and child together.

**Attachment** - The affection and devoted regard between mother and child.

**Cognition** - The act of knowing or perceiving (knowledge).

**Society** - The system of community life in which individuals form an association for their mutual benefit and protection.

**Socialization** - The act of being friendly and cooperative with one or more than one being.

**Self-Esteem** - A good opinion or feeling of one's self.

**Self-Concept** - One's self image.

**Gross Motor** - Moving the large muscles in the body such as hips, knees, shoulders, etc.

**Fine Motor** - Using the small muscles of the hands and feet.
Summary

Children are born every minute of every day. These children will have to learn to be social beings in a less than perfect society. Whether the child is born normal or born deviant due to parental/societal problems, educators need to know what normal social development is in the very young child, and how to remediate when a young child is not developing vital social skills. Chapter II explores normal social development from birth to age 3 using publications from 1970 to 1990. Chapter II also explores how societal and parental deviancy may interfere with normal social development. Remediation techniques have been given when appropriate.
Babies and young children are all individuals. Like adults, children will have their own special likes and dislikes and will learn new skills at their own rate. Below the author has outlined when social skills are most likely to be attained, from birth to 36 months of age.

Because social skills encompass a variety of domains--language, gross motor, fine motor and cognition--some of those skills have been listed as part of the normal social developmental outline. Again, this outline is just a guide to be used to view normal social development; it is not to be used as any type of assessment tool.

**Birth**
- Begins to breathe air (Maxim, 1980);
- Adjusts to new temperatures (Maxim, 1980);
- Begins to take in, digest, and excrete food (Maxim, 1980);
- Communicates reactions to environment, such as hunger, pain, hot and cold (Maxim, 1980);
- Can establish eye contact (Smith, 1987);
- Tolerates being held and touched (Early Childhood: Exceptional Education Curriculum, 1988);
Social Development

- Smiles spontaneously (Caplan, 1971);
- Likes soft sounds (Caplan, 1971);
- Tries to focus in on voice and face (Caplan, 1971);
- Imitates facial movements of adults:
  - sticking out tongue (Maxim, 1980)
  - fluttering of lashes (Maxim, 1980)
  - opening and closing of mouth (Maxim, 1980)

One Month
- May quiet when picked up (Smith, 1987);
- Likes gentle touching, to be held and rocked (Smith, 1987);
- Is sensitive to others - baby may be tense if adult is tense (Smith, 1987);
- Stares at surroundings (Smith, 1987);
- May smile back at voice or face (Caplan, 1979);
- May recognize parents’ voices (Caplan, 1979);
- Watches person moving in direct line of vision (Bluma, Shearer & Frohman, 1976)

Two Months
- Shows distress, excitement and delight (Caplan, 1971);
- Can quiet self with sucking (Caplan, 1971);
- Smiles at familiar adults and siblings (Caplan, 1971);
- Enjoys bathing (Caplan, 1971);
- Vocalizes in response to attention (Bluma, Shearer & Frohman, 1976)
Social Development

-Eyes follow people and objects from side to side (Smith, 1987);
-Begins cooing and making gurgling noises, particularly when being spoken to (Smith, 1987);
-Can be distracted when getting fussy (Smith, 1987)

Three Months
- Discovers hands and feet (Caplan, 1971);
- Smiles and giggles (Caplan, 1971);
- Visually recognizes mother (Caplan, 1971);
- Vocalizes when talked to (Caplan, 1971);
- Begins to vocalize in response to another infant (Caplan, 1971);
- Vocalizes to sounds (Caplan, 1971);
- Smiles in response to facial expression of others (Bluma, Shearer & Frohman, 1976)

Four Months
- Vocalizes moods, such as enjoyment, indecision, protest, laughs during socializing, cries if play is disrupted (Caplan, 1971);
- May attempt to soothe self (Caplan, 1971);
- Is quieted by music (Caplan, 1971);
- Clasps to hands and fingers in play (Caplan, 1971);
- May smile at reflection in mirror (Caplan, 1971);
Social Development

- Vocalizes to initiate socialization (Caplan, 1971);
- Begins to show interest in playthings (Caplan, 1971);
- Begins to enjoy repetitive games (Caplan, 1971);
- Laughs and giggles out loud (Smith, 1987);
- Begins to roll over (Smith, 1987);
- May reach for a familiar person (A Preschool Curricular Sequence, 1979)

Five Months
- Shows fear, anger and distrust (Caplan, 1971);
- Discriminates mother from self in mirror (Caplan, 1971);
- Imitates facial expressions (Caplan, 1971);
- Smiles at human voices and faces (Caplan, 1971);
- Distinguishes familiar and unfamiliar people (Caplan, 1971);
- Raises arms to be picked up (Caplan, 1971);
- Clings on when held (Caplan, 1971);
- May begin teasing (Caplan, 1971);
- May vocalize to interrupt other's conversation (Caplan, 1971);
- Resists adults who try to disengage toy from play (Caplan, 1971)

Six Months
- May differentiate self from mirror (Caplan, 1971)
- Turns when name is heard (Caplan, 1971)
Social Development

- In disturbed by strangers (Caplan, 1971);
- May distinguish adults from children (Caplan, 1971);
- Smiles and reaches out to strange children (Caplan, 1971);
- Calls (indicates) need for help (Caplan, 1971);
- Enjoys repetitive games such as "peek-a-boo", "go fetch", or "come and get me" (Caplan, 1971);
- Begins to finger feed (Caplan, 1971);
- Tries to recover dropped toy (Smith, 1987);
- Indicates likes and dislikes of food (Smith, 1987);
- Transfers objects hand to hand (Smith, 1987);
- Seeks adult proximity (Early Childhood: Exceptional Education Curriculum, 1988)

Seven Months
- Desires to be included in social interactions (Caplan, 1971);
- Resists doing something that he/she doesn't want to (Caplan, 1971);
- May fear demonstrating familiar activities (Caplan, 1971);
- Wiggles in anticipation of play (Caplan, 1971);
- Plays with toys (Caplan, 1971);
- Begins crawling (Smith, 1988);
- Begins pulling to a stand (Smith, 1988);
- Imitates sounds (Smith, 1988);
- Will try to follow if adult leaves the room (Smith, 1988);
Social Development

- Enjoys other children, but is also happy to play alone (Smith, 1988);
- Will reach to be picked up (Early Childhood: Exceptional Education Curriculum, 1988)

Eight Months
- Fears strangers (Caplan, 1971);
- Fears separation from mother (Caplan, 1971);
- Shouts for attention (Caplan, 1971);
- Pushes away things that aren’t wanted (Caplan, 1971);
- Rejects confinement (Caplan, 1971);
- May use parents to get things (Caplan, 1971);
- Maintains interest in toys (Caplan, 1971)

Nine Months
- Views mother as separate person (Caplan, 1971);
- Performs for family at home (Caplan, 1971);
- Repeats performance if act is applauded (Caplan, 1971);
- May begin to protect self and objects (Caplan, 1971);
- May begin to cry if other children are crying (Caplan, 1971);
- Begins to evaluate people's motives and moods (Caplan, 1971);
- Shows interest in other's play (Caplan, 1971);
- Initiates play (Caplan, 1971);
- Plays repetitive games (Caplan, 1971);
- Chooses toy (Caplan, 1971);
- Cries when scolded (Smith, 1988);
- Uses finger/thumb opposition (Smith, 1988)

Ten Months
- Enjoys music (Caplan, 1971);
- Shows a variety of moods (Caplan, 1971);
- Shows preferences (Caplan, 1971);
- Identifies parts of the body (Caplan, 1971);
- Begins identifying with same gender; e.g., boys with males (Caplan, 1971);
- Is aware of social approval or disapproval of self (Caplan, 1971);
- May show warmth to stuffed animal or doll (Caplan, 1971);
- Understands about a dozen words (Smith, 1988);
- Says 1 word (Smith, 1988);
- Waves good-bye (Smith, 1988);
- May assist in dressing (Smith, 1988);
- Tugs on adult to get attention (A Preschool Curricular Sequence, 1979)

Eleven Months
- Asserts self among siblings (Caplan, 1971);
- Begins to alter adult's plans through protest (Caplan, 1971);
Social Development

- Obeys some commands (Caplan, 1971);
- Seeks approval (Caplan, 1971);
- Avoids disapproval (Caplan, 1971);
- Extends objects to others, but doesn't release (Caplan, 1971);
- Enjoys imitating others (Caplan, 1971);
- Knows the meaning of "NO" (Caplan, 1971);
- Shows guilt (Caplan, 1971);
- Tests parental limitations (Caplan, 1971);
- Imitates actions of adults and play of other children (Caplan, 1971);
- Parallel plays (Caplan, 1971)

Twelve Months

- Exhibits many emotions and recognizes them in others (Caplan, 1971);
- Knows self from others (Caplan, 1971);
- Fears new places and strangers (Caplan, 1971);
- May have a sense of humor (Caplan, 1971);
- Gives affection to familiar people and favorite toys (Caplan, 1971);
- May tantrum (Caplan, 1971);
- May play games with understanding (Caplan, 1971);
- Gives up toys upon request (Caplan, 1971);
Social Development

- Prefers certain people to others (Caplan, 1971);
- May insist on feeding self (Caplan, 1971);
- May use spoon and cup independently (Caplan, 1971);
- Uses 3 words (Smith, 1988);
- Has interest in pictures (Smith, 1988);
- Kisses on request (Smith, 1988);
- Rolls ball towards someone (Smith, 1988);
- Begins to show affection;
- Will use the word "NO" with other children (A Preschool Curricular Sequence, 1979);
- Gives toy to adult when requested (Sanford & Zelman, 1981)

Thirteen Months
- Enjoys an audience (Caplan & Caplan, 1977);
- Loves applause (Caplan & Caplan, 1977);
- Reaches for and pulls on familiar adults (Caplan & Caplan, 1977);
- Laughs when chased after or being found hiding (Caplan & Caplan, 1977);
- Reacts to mother and father in different way (Caplan & Caplan, 1977);
- May be aggressive towards objects (Caplan & Caplan, 1977);
Social Development

May imitate housekeeping chores (Caplan & Caplan, 1977);
- Dances to music (Caplan & Caplan, 1977);
- Is interested in playing with people (Caplan & Caplan, 1977);
- Is demanding of personal attention (Caplan & Caplan, 1977);
- Has people preferences (Caplan & Caplan, 1977);
- Will adjust to a babysitter (Caplan & Caplan, 1977)

Fourteen Months
- Establishes own basic style as a social being (Caplan & Caplan, 1977);
- Calls to be taken out of a crib upon awakening (Caplan & Caplan, 1977);
- May drop objects from high chair to get parental interaction (Caplan & Caplan, 1977);
- May offer toys to others upon request, but may want them back immediately (Caplan & Caplan, 1977);
- Solitary play (Caplan & Caplan, 1977);
- Reciprocal play with ball with adult (Caplan & Caplan, 1977);
- Babbles into telephone (Caplan & Caplan, 1977);
- Participates in chase and catch me games (Caplan & Caplan, 1977)

Fifteen Months
- Seeks adults when left alone (Caplan & Caplan, 1977);
- Enjoys going outside for rides (Caplan & Caplan, 1977);
- Can be easily diverted and entertained (Caplan & Caplan, 1977);
- Likes to dump and pour containers (Caplan & Caplan, 1977);
- Enjoys pushing cars (Caplan & Caplan, 1977);
- Enjoys music and dancing (Caplan & Caplan, 1977);
- Enjoys playing with graduated sized stack rings (Caplan & Caplan, 1977);
- Says approximately 15-25 words (Smith, 1987);
- Walks well (Smith, 1987);
- Understands the word "NO" (Smith, 1987)

Sixteen Months
- Imitates household activities (Sanford & Zelman, 1981);
- Knows layout of house in order to find parent (Caplan & Caplan, 1977);
- Follows simple commands (Caplan & Caplan, 1977);
- Behavior tends to vary according to parental reactions (Caplan & Caplan, 1977);
- Pushes and pulls various toys (Caplan & Caplan, 1977);
- Likes soft dolls or stuffed animals (Caplan & Caplan, 1977);
- May discover genitalia (Caplan & Caplan, 1977);
- Is talkative (Caplan & Caplan, 1977)
Seventeen Months

- May strike out in anger at parents (Caplan & Caplan, 1977);
- Waves and says "Bye-bye" (Caplan & Caplan, 1977);
- Responds to social interaction from strangers (Caplan & Caplan, 1977);
- Helps in simple household chores (Caplan & Caplan, 1977);
- Enjoys roughhousing with father (Caplan & Caplan, 1977);
- Relationships are based on taking, not giving (Caplan & Caplan, 1977);
- May be afraid of large animals (Caplan & Caplan, 1977);
- Cannot make choices (Caplan & Caplan, 1977);
- Tries to be independent and to control people (Caplan & Caplan, 1977);
- Is starting to undress self (Caplan & Caplan, 1977);
- Realizes importance of self (Caplan & Caplan, 1977);
- Enjoys hammering toys (Caplan & Caplan, 1977);
- Enjoys hide-and-seek (Caplan & Caplan, 1977);
- Concentrates fully when playing with toys (Caplan & Caplan, 1977)

Eighteen Months

- Will play beside another child (parallel play) (Caplan & Caplan, 1977);
Social Development

- Knows that people react differently and explores this concept (Caplan & Caplan, 1977);
- Views other children as if they were objects (Caplan & Caplan, 1977);
- Wants help when in trouble (Caplan & Caplan, 1977);
- Shows off new objects (Caplan & Caplan, 1977);
- Unzips (Caplan & Caplan, 1977);
- Defends own objects (Caplan & Caplan, 1977);
- Uses words and gestures to get wants and needs (Caplan & Caplan, 1977);
- Begins to string large beads (Caplan & Caplan, 1977);
- Has favorite toys (Caplan & Caplan, 1977);
- Creeps up and down stairs (Smith, 1988);
- Can say 50 to 75 words (Smith, 1988);
- May use personal pronouns (Smith, 1988);
- Can close doors and flush toilets (Smith, 1988);
- Indicates when finished with something (Smith, 1988);
- Will interact with peers using gestures (A Preschool Curricular Sequence, 1979)

Nineteen Months

- Enjoys a change of environment (Caplan & Caplan, 1977);
- Wants to brush own teeth (Caplan & Caplan, 1977);
- Wants to be independent, but hasn't mastered all of the fine motor skills (Caplan & Caplan, 1977);
Social Development

- Enjoys a rocking horse and swing rides (Caplan & Caplan, 1977);
- Engages in the challenge of a shape sorter box (Caplan & Caplan, 1977);
- Continues to play along side of peers (Caplan & Caplan, 1977);

Twenty Months
- Pulls adult to desired object, even when object is in different room (Caplan & Caplan, 1977);
- Likes to take off clothes and be naked (Caplan & Caplan, 1977);
- Enjoys putting groceries away (Caplan & Caplan, 1977);
- Hides toys from other children (Caplan & Caplan, 1977);
- Admires self in mirror (Caplan & Caplan, 1977);
- Completely feeds self (Caplan & Caplan, 1977);
- Will assist in putting toys away (Caplan & Caplan, 1977);
- Washes and dries hands with some assistance (Caplan & Caplan, 1977);
- Loves water and sand play (Caplan & Caplan, 1977);
- Begins imaginary play (Caplan & Caplan, 1977);
- Uses feet in push toys, example-trike, car, etc. (Caplan & Caplan, 1977);
- Loves to take toys apart (Caplan & Caplan, 1977);
- Enjoys simple interactive games like "tag" (Caplan & Caplan, 1977)

**Twenty-One Months**
- Pulls a person to show wants (Sanford & Zelman, 1981);
- Tries to relate experiences (Caplan & Caplan, 1977);
- Loves outside walks (Caplan & Caplan, 1977);
- Will give objects back to owners upon request (Caplan & Caplan, 1977);
- Names familiar people in photographs (Caplan & Caplan, 1977);
- Is apt to do just the opposite of command (Caplan & Caplan, 1977);
- May ask to do something (Caplan & Caplan, 1977);
- Hugs and kisses familiar adults (Caplan & Caplan, 1977);
- Is beginning to take other's feelings into consideration (Caplan & Caplan, 1977);
- Refers to self by name (Caplan & Caplan, 1977)

**Twenty-Two Months**
- Will share attention (Caplan & Caplan, 1977);
- Will come when called (Caplan & Caplan, 1977);
- Will cooperate most of the time (Caplan & Caplan, 1977);
- Discovers that oral language does work to get wants and needs (Caplan & Caplan, 1977);
Social Development

- Is more responsive and demanding of the mother or father (Caplan & Caplan, 1977);
- Feelings tend to get hurt easily (Caplan & Caplan, 1977);
- May constantly be testing the rules and setting limits (Caplan & Caplan, 1977);
- Knows that they are separate and unique individuals with their own set of likenesses and differences (Caplan & Caplan, 1977);
- Enjoys unwrapping candy and gifts (Caplan & Caplan, 1977);
- Puts things back when requested (Caplan & Caplan, 1977);
- Assists in dressing (Caplan & Caplan, 1977);
- Asks for food and water when hungry or thirsty (Caplan & Caplan, 1977);
- Likes new toys (Caplan & Caplan, 1977)

Twenty-Three Months

- Tries to please others (Caplan & Caplan, 1977);
- Enjoys the Mommy/baby relationship (Caplan & Caplan, 1977);
- Is still dependent upon adults for all major needs (Caplan & Caplan, 1977);
- Establishes ways of coping with separateness for parents (Caplan & Caplan, 1977);
- Recognizes own power to succeed (Caplan & Caplan, 1977);
- Can turn knobs and open doors (Caplan & Caplan)
Social Development

Twenty-Four Months

- Tries to control others and orders them around (Caplan & Caplan, 1977);
- Tells of experiences that just happened (Caplan & Caplan, 1977);
- Is able to communicate feelings, desires and interests to others by words and gestures (Caplan & Caplan, 1977);
- Trusts adults (Caplan & Caplan, 1977);
- Shows some aggressive tendencies (Caplan & Caplan, 1977);
- Rebels against bedtime (Caplan & Caplan, 1977);
- Continues parallel play (Caplan & Caplan, 1977);
- Prefers action toys (Caplan & Caplan, 1977);
- Enjoys other children (Caplan & Caplan, 1977);
- Uses two- to three-word phrases (Smith, 1988);
- Enjoys drawing (Smith, 1988);
- Likes to take things apart and put them back together (Smith, 1988);
- Will repeat words, name objects and will combine words with actions (Smith, 1988)

Twenty-Five Months to Thirty Months

- Runs, jumps, climbs (Smith, 1988);
- Asks questions (Smith, 1988);
- Can say more than 500 words (Smith, 1988);
Social Development

- Controls bowels and bladder (Smith, 1988);
- Becomes frustrated when language isn't understood by adults (Smith, 1988);
- Understands most everything said (Smith, 1988);
- Participates in repetitious poems and songs (Early Childhood: Exceptional Education Curriculum, 1988);
- Gains attention from other children in appropriate way (Early Childhood: Exceptional Education Curriculum, 1988);
- Tells full name (Sanford & Zelman, 1981)

Twenty-Six Months to Thirty-Six Months

- Uses imaginary pretend with another child (Early Childhood: Exceptional Education Curriculum, 1988);
- Begins to use dramatic play (Early Childhood: Exceptional Education Curriculum, 1988);
- Will name a friend (Early Childhood: Exceptional Education Curriculum, 1988);
- Will observe, then join other children in play (Early Childhood: Exceptional Education Curriculum, 1988);
- Shows pride in own accomplishments (Early Childhood: Exceptional Education Curriculum, 1988);
- Can separate from a parent without fussing (Early Childhood: Exceptional Education Curriculum, 1988);
- Responds to greetings (Sanford & Zelman, 1981);
- Sits in circle and joins in a group activity following a leader (Sanford & Zelman, 1981);
- Plays simple group games (Sanford & Zelman, 1981);
- Puts away toys with supervision (Sanford & Zelman, 1981);
- Shares toys (Sanford & Zelman, 1981);
- Takes turns (Sanford & Zelman, 1981);
- Listens to stories (Sanford & Zelman, 1981);
- Tells gender (Sanford & Zelman, 1981).
Factors Affecting Normal Development

Normal social development has been outlined for the very young child from birth to 36 months of age. How does society's behavior interrupt social development? Many children won't be considered "normal", due to the accepted behavior of this society.

One example of this is alcohol.

Fetal Alcohol Syndrome (FAS)

Research has shown that even small doses of alcohol consumed during pregnancy can affect the fetus in damaging ways. In a pregnant woman, the alcohol is not only carried to all her organs, but also to the placenta where it crosses the membrane separating maternal and fetal blood systems. In this way, alcohol is directly carried to the fetus and to all its developing tissues and organs (Association for Retarded Citizens, 1988).

When a pregnant woman consumes an alcoholic drink, the concentration of alcohol in her unborn baby's bloodstream is the same level as her own. Unlike the mother, though, the liver of the fetus can't process alcohol at the same rate as the adult. High concentrations of alcohol, therefore, stay in the fetus longer, often for up to 24 hours. In fact, the fetus' blood alcohol concentration is higher than the mother's during the second and third hour after a drink has
been taken (Association for Retarded Citizens, 1988).

At this time, a safe level of alcohol consumption for pregnant women has not yet been established. It is known though, that alcohol consumption at any time during a pregnancy is potentially harmful to the fetus, the duration and timing of exposure can be related to the type of damage most likely to occur. Early exposure presents the greatest risk for serious physical defects and later exposure increases the changes of neurological and growth deficiencies to the fetus (Umbreit & Ostrow, 1980).

How a baby is affected may depend on a number of factors:

1. The mother's drinking pattern;
2. The stage of fetal development at which consumption is the greatest;
3. Susceptibility of the fetus.

Not all fetuses are equally sensitive to trauma. Some experts think that the earliest days of gestation, even before the woman realizes that she is pregnant, are probably the most hazardous. Others are more concerned about the third trimester when the brain, the most sensitive to damage, has its major growth spurt (Lake, 1982).
There is no known way to reverse or reduce the effects of alcohol on the fetus once they have taken place. Post-natal growth retardation seen in children is due to their active rejection of food. Sucking and swallowing movements coupled with extrusion movements of the tongue are uncoordinated, so the food intake is less adequate and the feeding time is prolonged. Feeding problems are significant for the first year of life and may improve gradually. By the time the children are three to four years of age, they are consuming a more adequate diet, although they are highly selective of their food likes and dislikes (Ninety-Eighth Congress, First Session, 1983).

Children born with FAS have the following symptoms:

1. Low birth weight and failure throughout their lives to catch up in physical stature;
2. Head:
   - Small head size (microcephaly)
   - Small eyes (microphthalmia)
   - Flat mid-face
   - Low nasal bridge
   - Poorly developed philtrum (the groove between the nose and upper lip)
3. Central nervous system:
   - Mental retardation
   - Learning disabilities
   - Developmental delays
   - Alcohol withdrawal at birth
   - Sleeping disturbances
   - Emotional disturbances
   - Restlessness and irritability
   - Short attention span
   - Poor sucking response and eating disorders

4. Organs and body parts:
   - Muscle and joint problems
   - Bone problems
   - Heart defects
   - Kidney defects
   - Genital defects (Association for Retarded Citizens, 1988)

Infants born with FAS have short up-turned noses, thin upper lips, droopy eyelids and usually have a one-eyed squint. Often the baby's body is very hairy, especially the
facial area. The upper jaw can be underdeveloped and a cleft palate can also occur (Lemeshow, 1982).

Between 3,700 and 7,400 babies were born with FAS in 1982. Up to 36,000 newborns each year may be affected from alcohol to a lesser degree (Ninety-Ninth Congress, Second Session). The numbers have been increasing ever since.

The children born with FAS do not have the same capabilities as their peers born without FAS. The effects of alcohol are seen in the distinctive physical malformations as well as characteristic cognitive/behavioral manifestations in the form of mental retardation and learning disability; as this point, these children become the pupils of the special education program (Kavale & Karge, 1986).

The physical cognitive and behavioral difficulties that the majority of these children have are often compounded by a poor home environment; the parents often have alcohol related and other personal problems which prevent them from giving appropriate stimulation and nurturance. In some instances, the affected child is removed from the home environment. For some children, this means residing for short periods of time with several foster families rather than being raised in a single, long-term, stable environment (Schultz, 1983).
The FAS children will be in exceptional education programs and some will be in foster homes, also. Individual teachers and foster parents may make an impact on the child's life. They may be able to make the child feel like they are leading a full and rich life, but until the cycle of alcohol and pregnancy can be stopped, there will be FAS children. The saddest thing is that there is no need for any more children to be damaged. If the public were made aware of the devastating effects of alcohol on the fetus, and if programs were readily available to alcoholic women of childbearing age, the cycle would be broken.

The Non-Fetal Alcohol Child In The Alcoholic Family

Children who are born as healthy individuals, but who are born into an alcoholic family may also have problems. These problems arise because they are being raised in an unsafe, dysfunctional family system. An alcoholic family is a dysfunctional family with varying degrees of dysfunctionality. Obviously, the more dysfunctional the family, the more emotional and physical damage is done to its children (Zerrer, 1986).

Families establish rules and behaviors and roles for its family members. These rules, roles and behaviors in an alcoholic family are established as survival techniques.
The rules are to attempt to bring stability and order to an unstable situation.

There are four rules that operate in an alcoholic family. They are:

1. **The Rule of Rigidity**;
   The alcoholic family doesn't adapt to change readily. It also doesn't encourage the children to grow emotionally. In order for children to grow into being socially mature adults, the children need a safe place where there is room to experiment with different ways of behaving. The alcoholic family is too unpredictable to allow the child experimentation.

2. **The Rule of Silence**.
   The alcoholic family does not permit its children to discuss what is going on inside their family. The child who is being abused sexually or physically is unable to tell anyone about his/her feelings because that would bring about a change in the family. Rule #1, the Rule of Rigidity, would be broken. The
3. The Rule of Denial.
The alcoholic family denies that any of its members have an alcoholic problem. When children grow in this type of atmosphere, they tend to believe that the alcoholic family is just like another family. Since the children aren't permitted to discuss the family problems, they find inner conflict as to what is real and unreal.

4. The Rule of Isolation.
The alcoholic family does not encourage the children to have friends. The adult alcoholics have very few friends or other interests outside of drinking. The children as they grow, become very lonely (Kritsberg, 1988).

Alcohol does destroy children, either by the children being born damaged due to alcohol, or by the alcohol destroying the family. In either case, the child is
damaged socially.

**Acquired Immune Deficiency Syndrome (AIDS)**

The majority of infants who have AIDS are born to women who are drug users themselves, had sexual partners who were drug users or are in the high-risk groups such as bi-sexuals. It is unknown as to how many infants with AIDS there are, but it is documented that there is an increase.

Children born with AIDS experience failure to thrive. They have a special type of pneumonia. They have chronic diarrhea, swollen lymph glands, swollen liver and spleen, and most importantly, their brains are directly infected.

Some children with AIDS develop normally for several months, up to a year, and then follow a slow course of brain disease that may or may not plateau for a time. In other words, a child who may be walking may acquire an infection, leaving him/her lethargic due to the illness and drugs used to combat the infection. The infection could last for several months. During this time, the child is not developing normal milestones (Wayment, 1988). Some children die a few months after birth.

It appears that the rate of deterioration depends upon how the brain and spinal cord are being affected by
the disease.

It is sad that the children are born to families that are already fractured and have little ability to care for the child. Most of the mothers of these children are dying of AIDS themselves; but with growing medical technology, it is expected that not every child will die.

What happens to the AIDS infant and child is a problem that society will have to deal with. The children will live longer. Most of the children will need to attend schools and the state's and local school boards will have to allow them in the schools.

Another problem that society will need to address is that the children are born into families where adoption and foster care is frequently needed. Foster care is currently in short supply for normal children; it is almost impossible to find proper care for an AIDS child (Ninety-Ninth Congress, Second Session, 1986).

A child with AIDS is a socially isolated being. These children often come from parents who don't care about their offspring. The AIDS infection itself presents serious implications for cognitive, socio-emotional, and physical development in infants. Early stages of development are fundamental in that a child must master a series of
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challenges with the environment before progressing to the next phase.

The variety of illnesses associated with AIDS add to the complexity of establishing important developmental groundwork for infants in this early stage. It is difficult to explore one's environment when one is attached to I.V. tubes in a hospital. It is difficult to form personal attachments when the family isn't capable of forming them and each shift has different nurses. It is difficult to trust when one is moving from foster home to foster home or is in and out of the hospital.

It is known that social support is important for family and child functioning. Help can be given in many forms - physical assistance, encouragement, reassurance, and understanding. When a child is acutely ill and requires intensive care, unpredictable medical care, and long hospital stay, that is when support is most needed.

Programs need to be established and implemented for the AIDS infant and the family. The goals of such programs should include emotional preparation for what lies ahead, prevention of child abuse and abandonment through reducing parental isolation and stress, and increase in awareness of the community resources available. Services provided may
include hospital visits by trained volunteers, emotional support for the mothers, follow-up contacts and direct assistance to meet maternal needs (Wayment, 1988).

Presently there is little funding for infants and children with AIDS. Children receive very little of the monies allocated to AIDS work. Most of the money goes to research, little to care and treatment. As the increase of AIDS infants and children continue, federal and state money will need to be directed for their care and treatment.

Drug Abuse

Throughout history, there have been recorded documents about the effects of drug abuse. Recently, the drug crack/cocaine has made the headlines of every major media. Why is it receiving so much attention now? What are the possibilities of it's affecting the unborn children of our society?

Crack (so named because of the sound it makes when it is heated), is a highly addictive, extremely potent form of cocaine.

Since crack/cocaine is smoked rather than injected
intravenously or snorted, users who once feared the threat of AIDS from the contaminated needles have found advantages of crack to be threefold - the effects are more intense, it's "safer", and the smoke is faster acting.

Crack addition is spreading rampant in many parts of the world. It has no social barriers. Poor, rich, men and women alike have all fallen prey to its effects.

When a woman uses crack during pregnancy, it passes through the placenta, causing spasms in the fetus' blood vessels, restricting the flow of oxygen and nutrients so vitally needed. Fetal growth, including head size and brain size, may be impaired. Strokes and seizures often occur and malformations of the kidneys, genitals, intestines and spinal cord may develop. There is also the danger of the placenta tearing loose from the uterus, which kills the fetus and may prove to be fatal for the mother as well (Schneider, Griffith, Chasnoff, 1989).

Crack/cocaine babies are often born with a fragile, easily overloaded nervous system. They tend to be hypersensitive, irritable, and scream inconsolably. Some of the babies choose to escape into a deep sleep for 90 percent of the time to shut themselves off from
outside stimulation (Task Force of Pediatric AIDS, 1989).

These types of neurological problems can last for months, causing both mental and physical frustration to the mother at a time when the bonding of mother and baby is essential. The behavior on the part of the infant and the resentment of the mother towards her child often can lead to child abuse (Ninety-Ninth Congress, Second Session).

The condition of the newborns is often so critical that they may remain hospitalized for weeks or months. Sometimes depending upon the mother's addiction, the child stays at the hospital, not because of its condition, but because of the mother's attitude towards the child. If the mother is highly addicted, she may abandon the child at the hospital.

If the child is abandoned, and because of the work load of the hospital nurses, the babies may not be given the emotional support that they so vitally need. These children most often go to foster homes.

The future of these crack/cocaine babies is unsure. Their lower than normal I.Q.'s will present a problem for teachers when they become school age. The fact that
they have a difficult time making adjustments due to their easily overloaded nervous systems will make them difficult to bond with as infants. But they will be a part of society for a very long time to come.

Child Abuse And Neglect

It is well known that child abuse is a cyclical pattern; that is, parents who abuse or neglect their children were mostly likely abused or neglected themselves as children.

Every year the cases of reported child abuse and neglect increases. It is not known, however, how many cases go unreported.

Studies have shown that the majority of the reported abused children are under the age of two years (Gelardo, Sanford, 1987). It appears that the older the children get the less they are abused and neglected. What impact does child abuse or neglect have on a young developing child?

Infants who have been maltreated function more poorly in many areas of social and emotional behavior at each stage of development than children from similar backgrounds who are not mistreated (Erickson, Egeland, 1987). At 18 months of age, children who have been
abused or neglected show signs of not being attached to their primary care giver (Oates, 1989). This is due to the child's inability to trust the care giver because the infant hasn't received the sensitive care that is vital, and therefore may not feel worthy of care.

As the child matures and develops, trust should become internalized (that is, the child should be attached to the care giver, and be able to explore the environment in a safe, nonthreatening manner). When this does not occur, the child may become very passive or may show aggressiveness towards the parents, care givers or peers.

The harsh reality is that children who are abused and neglected early in life have lower I.Q.'s, poor peer relationships, low self-esteem, and lack of empathy. Research indicated that this is due to the lack of developing a strong infant/parent attachment. Clearly there is a need for more research regarding the effects of abuse on children and on what aspects of family environment are associated with various outcomes (Emery, 1989).

**Teen Pregnancy**

It has been well documented that infants born to adolescent mothers are at risk for premature motality,
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morbidity, and various types of handicapping conditions (Spencer, 1985). The infants are generally developmentally disadvantaged compared to offspring of older mothers. Consistent differences in cognitive functioning between offspring of early and later mothers appear in preschool and continue into the elementary school years. This, however, is more likely to be seen in males versus females (Clark, 1985).

Psychosocial problems may also be more common in the children of teenage mothers. For example, preschool children of teen mothers are rated as being more aggressive, active, and possess less self-control than children of older mothers (Furstenberg, Brooks-Gunn, Chase-Lansdale, 1989).

Since adolescent pregnancy has reached epidemic proportions in this country, it has become more and more accepted that the offspring of teen parents are at a greater risk. There has been much debate as to why infants born to teen parents are at risk, but research clearly indicates that the following risk factors exist for this population of infants:

- Increased incidence of lower birth weight;
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- Increased mortality and morbidity;
- Increased prematurity;
- Increased intrauterine growth retardation;
- High rate of serious health problems;
- Decrease of I.Q. scores (Spencer, 1985)

The major problems for infants born to teen parents are low birth weight and prematurity because these conditions indicate that the infant was born before all of its biological systems were fully developed (Brooks-Gunn, McCormick & Heagerty, 1988). As a result, the tiny infant who was born much too early and weighs so little has greater difficulty fighting infections found in the environment and must struggle to maintain its very existence. In some instances, this battle is more than the low birth weight, premature infant can endure. Death may be the result.

Because of the infant's medical fragility at birth and emotional status of the mother, normal bonding may not be possible. This could negatively impact the adolescent mother/infant relationship (Rindfuss, St. John & Bumpass, 1984).
It should be stated that premature babies do experience developmental delays. However, not all adolescents have pre-term infants and older mothers may have pre-term infants as well. Other factors besides the age of the mother may affect a fetus' not going full term.

It appears that the impact of adolescent childbearing may contribute to developmental and cognitive problems for the children. Teen mothers may lack knowledge and positive attitudes regarding child care. There is a close link to the socio-economic status and its impact on maternal behavior. Studies have shown that the impact of adolescent childbearing on the emotional, developmental, and cognitive growth of infants is determined by the mother's education or knowledge, parenting attitudes and behaviors, the environment, and her socio-economic backgrounds. Family structure of the teenage mother's home if she remains with her parents also influences the psychological and intellectual growth of her child. The cognitive development of the child is less likely to be impaired if a mother lives with other adults who can share in the childrearing. Whether or not a supportive network exists may be a critical determinant of the course of
teenage parents and their children (Roosa, 1983).

One of every six children is born and raised by a mother who is an adolescent. Children born to these teenage mothers, who are often unskilled, unmarried, and uneducated, have a higher incidence of physical, emotional, and intellectual handicaps. They are at-risk for low birth weight, prematurity and birth defects. Even if born healthy, the low socio-economic environment in the homes of most adolescent parents affects the achievement levels and behavior of their children, handicapping them before they enter school. Adverse effects on the children of adolescent parents occur more often as a result of the social disadvantages of the mother's environment than biological or genetic factors, and both occur more often to the children of teenagers than to the population at large (Spencer, 1985).

The children of adolescent parents are more likely to have special educational needs than children of older parents. Intervention programs have assisted some teenaged mothers in identifying and satisfying those needs. With proper training teen mothers can learn to prevent further early childbearing and to provide proper nurturing, nutrition, stimulation, and training for their
children to prevent them from suffering emotional, behavioral, and educational deficiencies.

**Recommendations For Promoting Social Skills In The Young Child**

Research has shown that the most rapid period of human development occurs during the first three years of life and that experiences during this time of growth can have profound effects (Pfannenstief & Seitzer, 1985). While some children are born "normal", and some children are born disadvantaged or handicapped, there are techniques that parents, educators and caregivers can use to promote social development for all.

The primary ingredient to help young children develop consists of loving, responsive caregivers who are tuned-in to the child's well-being. Since infants come into the world with different temperaments and adjusting styles, this commitment requires patience and flexibility on the part of the parent. Getting to know a baby takes time and interest. Adults need to be aware of differences in temperament and respond gently to the child's needs. Responding negatively can create despondency for an infant who already may have problems. Each caregiver/parent needs to recognize that the baby
is a special and unique individual. A baby who feels the security of love will grow, knowing that he/she is special (Honig, 1987).

Respect for children leads to respect for others, and it needs to begin at an early age. Showing respect and affection can be exhibited by talking to, holding, and hugging the baby. When they respond by gurgling, quieting down or smiling, smiling back and telling the child how enjoyable he/she is, gives the child a feeling of importance (Crist, 1986).

Infants enjoy watching other people. If the parent or care giver is doing chores or is busy with another child, telling them what is being done and why is an ideal way of letting the child know that he/she is appreciated and not forgotten. Babies may not understand what is being said, but they may understand the body language which is also being used.

Children's self-esteem is tied into how much control they feel that they have over their environment. Babies and children alike need opportunities to succeed in tasks and build new skills on their own. When trying a new skill, and even if the baby or child should fail, he/she should be praised for trying, and the effort encouraged.
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In the early stages of development, children learn much through the use of imitation. The child views its parent or care giver as important. This is because it is the parents and/or care givers that meet the child’s needs such as food, warmth and security (Honig, 1987). With this in mind, one should attempt to demonstrate positive actions and positive emotions. Children need to see that the world is good and will learn that it can be, through positive imitation from a positive role model.

An infant needs to be played with. Simple repetitive games such as “pat-a-cake” or “peek-a-boo” are a wonderful way to teach and practice fundamental rules of a game.

Between the ages of 12 and 18 months, children become more aware and responsive to other children. Early group experiences are valuable for children because they provide them with:

- Information on how their behavior influences others;
- Information on how their behavior is accepted and interpreted by others;
- Provides a more complex variety of sensory stimulation;
- Provides opportunities for independence;
- Adds role models for their growing sense of identity; and
- Provides input that can directly affect the development of their self-concept (Christ, 1986).

Parents and care givers should not organize children's play. They should also not have preconceived ideas of how things should turn out in children's play. Playtime should be a time for fun and creativity for all that participate.

With respect to the children born with Fetal Alcohol Syndrome, or born into alcoholic families, or born to teenage parents, or born with AIDS, or born addicted to drugs, or born into a family where they will be abused or neglected, research has not been conducted nor recommendations made as to how to improve these groups of children socially. Obviously, it would benefit the infants and young children to be in a program or day care at a young age. If the parents are unable to care for their child because they are overburdened with their own problems, finding a foster home with nurturing, warm foster parents would be to the child's advantage. If the family is able and willing, there are a variety of programs
to help the family and their respective problems by providing counselors and educators for the parents as well as the young child.
CHAPTER III
Summary and Conclusions

Functioning in today's society requires the ability to be social and to socialize. Much of this is an on-going learning process for all human beings. However, it is in the early years of life where the majority of social skills are observed, practiced and refined.

The author listed normal milestones of approximate ages of when certain social skills develop in normal children from birth to age three. The effects of child abuse, teen pregnancy, cocaine abuse, alcohol abuse and children born with AIDS were also discussed as to how it may affect an infant or young child in their most informative years. Research data used was compiled from 1970 to 1990.

Research clearly indicates that maternal cocaine abuse, maternal alcohol intake, and maternal age of pregnancy play a major role on how a fetus develops. Infants born to these mothers have lower I.Q. scores and lower birth weight. The babies may also be born with physical and neurological impairments. Obviously, these children may not develop the acquisition of new skills as readily as children born without these conditions.
The delays of these children usually include language, fine motor, gross motor, cognitive as well as socialization skills. The sooner these children are identified, the sooner they can be placed in appropriate programs to aid in acquiring all necessary skills to function in society.

Children born with AIDS have a different destiny. These children may begin to develop normally, but once the AIDS infection spreads and new infections are acquired, the development is stopped and eventually these children regress until they die. As medical knowledge and techniques become available to prolong the children's lives, it will be necessary to develop educational programs for them. Currently the only thing that can be done is for someone to care for them and to offer support to their families. It is the family who has to deal with the reality of a dying child as well as the possibilities of a dying mother.

Currently, there is little research available regarding the effects of abuse on children. What is known, however, is that parents who abuse their children were often abused themselves as children. Children who have been abused
often score lower on I.Q. tests; they exhibit a range of behaviors, from passivity to aggressiveness; they have low self-esteem; and have poor peer relationships which may be due to the lack of development of a strong infant/parent attachment.

The area of social development is an important aspect of development. However, because social development encompasses the areas of fine motor, gross motor, language and cognition, it is often overlooked. Though it may not be considered a "pure" area by educators or researchers, it is still vitally important and requires much more in the area of research and understanding by all who participate in society.

A child is born. Society needs to learn more about how and why the child develops into a social being, and how to accept and help the child who may not be developing normally.
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