Child Behavioral Assessment & Management in Primary Care

Second Edition

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Introduction

Professionals who work with children in primary care medical, psychological, and social settings are most likely to be oriented toward finding and diagnosing abnormal conditions requiring expert involvement. Yet, the great majority of concerns expressed by caregivers about their children's behavior are of mild or moderate severity, not meeting any definition of a DSM-V disorder or requiring referral to a specialist. This book, written by two clinicians who have worked for many years in primary care, rejects the notion that behavioral issues should be simply classified as normal or abnormal. Rather, the authors suggest that primary care professionals should view children's behavior on a spectrum where annoying normal variations may shade into problems and then to disordered behavior requiring specialized care. This perspective is preferable to the limited approach of simply making categorical judgments about whether or not the concerns being presented by the caregiver are severe enough to diagnose and treat as an abnormal condition or declare that there is no real problem. There are several good reasons to conceive of behavior along the broader spectrum:

1. It recognizes and considers the many levels of concern that caregivers have about their children;

2. It allows for prevention and early intervention with minor problems that are in a beginning or developing stage;

3. It educates primary caregivers and empowers them to help resolve mild to moderate behavioral conflicts with their children;

4. It encourages health care and educational professionals to feel more responsive to patients and students and be more effective in dealing with their needs; and

5. It avoids labeling children with psychiatric diagnoses when they really do not meet the criteria for them. It supports the use of environmental change rather than a reliance on medication.

Primary care providers, as defined in this book, include pediatricians, family care physicians, general nurses, pediatric nurse practitioners, community and school psychologists, physician assistants and others in general health service. They may also include social workers, teachers, other educators, and childcare providers who work directly with children in an educational or care-giving setting.

Utilizing theory, research, and clinical experience gained over the last 50 years in the child development field, the authors present a framework for dealing with normal temperament and patterns of mild to moderate reactive behavioral issues that frequently confront professionals in primary care. Suggestions are offered for direct assessment and management of child behavior as well as indications of which problems will likely require referral elsewhere for specialized services.

The perspective outlined here should prove valuable in educating new professionals in these several disciplines as well as assisting more seasoned ones to refine and improve their approaches to these important issues in infancy and childhood.

With the first edition of this book having been issued

as recently as 2012, one might wonder why a revision is being offered so soon. There is nothing to correct in the earlier version. In fact, the two book reviews in pediatric journals have been highly complimentary (Almas R, 2015; Narayan A, 2012). The difference here lies in an enhancement of the earlier text by the introduction of further helpful materials in most areas of the discussion of assessment and management. This includes in particular an expanded report of other views of temperament beside the one we have found most useful and a wider range of areas of application of temperament counseling, A new chapter deals with the problems with the confusion of terminology that has crept into this field in recent years.

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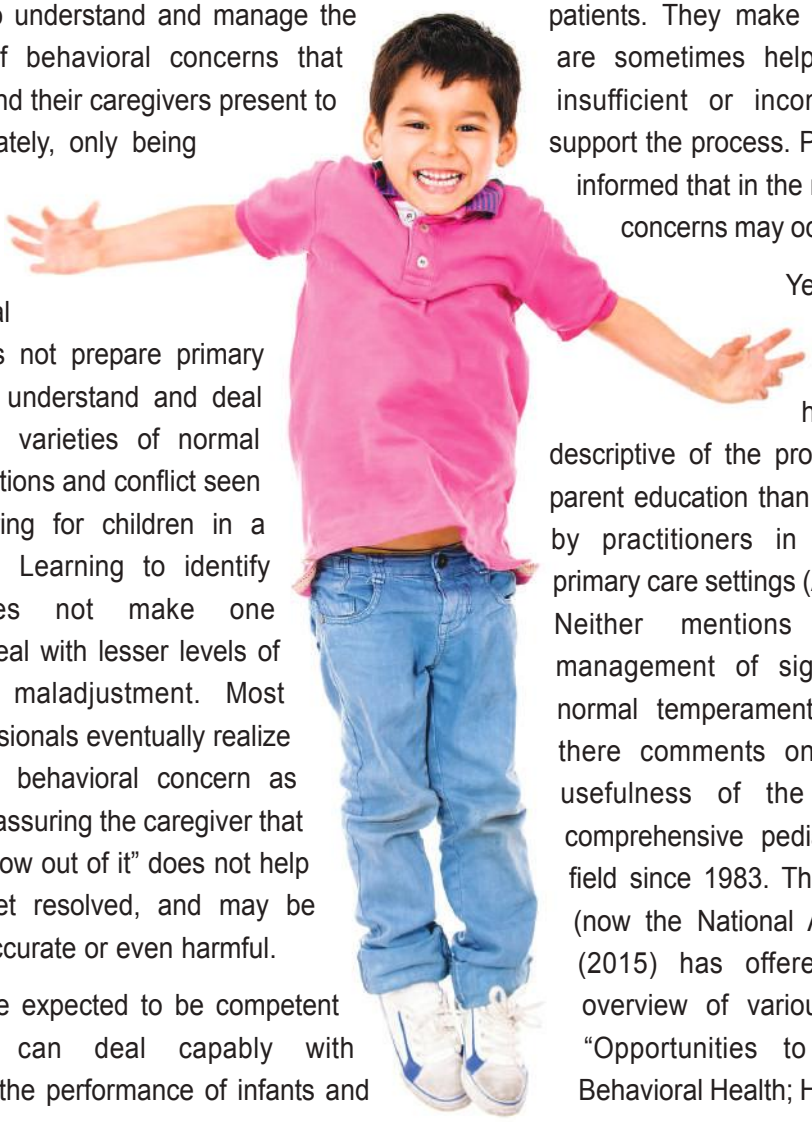
Chapter 1

The Dilemma of the Primary Care Practitioner Today

Despite enormous scientific and technological advances in many areas of healthcare in our times, most primary practitioners dealing with children's mental health today face a troubling gap in their preparation. Too often they have been given insufficient training in the science and the practical skills needed to understand and manage the wide variety of behavioral concerns that young people and their caregivers present to them. Unfortunately, only being taught about abnormal behavior requiring referral elsewhere does not prepare primary practitioners to understand and deal with the many varieties of normal behavioral variations and conflict seen daily while caring for children in a clinical setting. Learning to identify "disease" does not make one competent to deal with lesser levels of discomfort or maladjustment. Most sensitive professionals eventually realize that labeling a behavioral concern as "normal" and reassuring the caregiver that the child will "grow out of it" does not help the problem get resolved, and may be misleading, inaccurate or even harmful.



Practitioners are expected to be competent experts who can deal capably with irregularities in the performance of infants and children in their care. Sometimes clinicians are able to provide accurate and valuable counseling about behavior, but far too often what they have to offer is not sufficient or really useful. Professional groups such as the American Academy of Pediatrics urge members to provide exemplary care for their patients. They make recommendations that are sometimes helpful, but often supply insufficient or incomplete knowledge to support the process. Pediatricians have been informed that in the next decade behavioral concerns may occupy 30% of their time.

Yet, the two most recent official advice papers from the Academy have been more descriptive of the problems, screening, and parent education than promoting of solutions by practitioners in individual interactive primary care settings (AAP, 2014; AAP, 2015). Neither mentions the existence or management of significant aversive but normal temperament differences, nor are there comments on the availability and usefulness of the several established comprehensive pediatric textbooks in the field since 1983. The Institute of Medicine (now the National Academy of Medicine) (2015) has offered a similar general overview of various points of view on "Opportunities to Promote Children's Behavioral Health; Health Care Reform and

Beyond. Workshop Summary." It can be expected that professionals in other primary child care and health related areas will be similarly challenged with behavioral matters in their areas of practice.

To illustrate the plight of the primary care professional, we authors provide here some examples of this confusion of concepts, diagnosis, and management strategies:

Baby Frank (known to his mother as Frank the Crank) is two months old and cries a great deal. The average baby at this age is crying not more than three hours a day, but this little boy is fussing or yelling for at least six hours a day in spite of good health and a vigorous appetite. The doctor has suggested two formula changes without success and has finally told Frank's desperate mother not to

worry because "it is only colic" and will be gone in another month or two. The doctor has failed to understand that the solution lies in helping the mother now to understand the reaction pattern of this particular child and to respond to it more appropriately, which will lead to a reduction in the overstimulation and crying within days but will not, of course, alter his temperament.

Takesha is a healthy little girl of 18 months, but her mother is alarmed by her reduced appetite. She used to eat everything offered. Now she has to be coaxed to take in comparable amounts and variety of foods. Her clinic nurse has been advising her mother on ways to increase Takesha's intake by various strategies such as putting cereal in the bottle and urging her to keep taking another mouthful in order to gain some reward. Vegetables must be consumed no matter what. However, since Takesha is growing and developing normally and eating a sufficient variety of foods, this bribery and coercion is inappropriate and may lead to overweight. Picky eating in this period is normal.

Toddler Jill (known to her mother as Jill the Pill) is not the mild, obedient little girl her parents had expected but is highly persistent and very hard to redirect from forbidden activities. Her parents are frustrated by her opposition to them. They have been screaming at her with increasing volume and have started to spank her for her noncompliance. Not understanding about the temperamental qualities of persistence and low adaptability, the pediatrician has advised the parents to "show her who is boss" and insist on prompt cooperation. This misreading and pathologizing of her temperament has led to increased stress and greater rebellion. Jill just needs time to adjust to new situations.

Three-year-old Harry is just starting day care. He has trouble separating from his parents and is slow to join in the play activities, just sitting on the edge watching. His inexperienced teacher reports to his parents that Harry is "emotionally insecure." His competent parents are reassured by Harry's doctor of what they already know, that he is just a shy but normal child about whom there is no reason for concern.

Just turning five, Steve is finishing a preschool program and about to enter kindergarten. His daycare teacher tells his mother on the last day there that Steve has ADHD and should be taking a

stimulant such as methylphenidate. His parents are angry that such a person should make this neurological diagnosis and a recommendation for therapy. After a more professional assessment it becomes clear that Steve is not overactive, not inattentive, and not dysfunctional. He is simply a somewhat inflexible and negative child, whose temperamental traits the parents were aware of and were handling well. The teacher had noted something different about Steve but had the poor judgment of labeling an annoying normal variation as a defect in brain function.

Charlie is not doing well in first grade. He says he does not like the work. His teacher tells the parents that this bright little boy is intelligent enough but is just lazy. The school has not yet considered the possibility that he has a subtle learning difference or disability.

All of these vignettes have something in common. They all involve a concern about a child's behavior, and unfortunately in each case the physician, nurse, or teacher misunderstood the nature of the situation and provided poor advice to the child's family. An opportunity to be helpful was lost and possible harm was done.

These examples are the types of missteps that could be corrected if the professionals involved had a solid conceptual framework to use when dealing with concerns about behavior. The authors will present such an approach in the contents of this book. The framework is intended for professionals in primary care: medicine, nursing, education, child care, and psychological counseling. It is not principally for specialty referral personnel, though these professionals may recognize the extension of their main concerns into more general care. The perspective presented here includes an analysis and recommendations designed to cover concerns expressed in the three general areas of caregiver worry: truly dysfunctional behavior, aversive temperamental "fit," and caregiver misperceptions of problems. It includes all levels of behavioral, emotional, and functional performance from superior to average to perplexing normal variations to various dysfunctions and psychopathology. Thus, the approach is concerned here with strengths as well as weaknesses. This discussion does not attempt to cover physical problems or developmental issues, which are extensively discussed elsewhere (for example, Carey, Crocker, et al., 2009). By focusing directly on the elements of behavioral concerns the authors hope to define, and refine, the primary care clinician's view of the considerable ground between normal child behavior and significant psychopathology.

Chapter 2

Obstacles to the Provision of Good Care

In the previous chapter the need for improved diagnosis and management by professional persons was stressed. These providers are responsible for delivering competent mental health services to children and caregivers in primary care. Several examples illustrated the variety of missteps that occur today from the misuse of techniques now commonly available. Before proceeding to the main content of the book—that is, to suggestions for improving behavioral assessment and treatment—it would be appropriate to review in greater detail some of the current barriers to optimal professional performance. This review will specifically clarify some of the areas in which changes proposed in this book could correct many of the cited deficiencies. There are currently three main areas of weakness: 1) professional education, 2) theoretical or technical problems, and 3) logistical or practical limitations.

Professional Education

Insufficient emphasis on behavioral care during the training of many primary care professionals with regard to information now available is undeniably a problem. For example, during the three years of pediatric residency training even at the best academic centers, a disproportionately large amount of time is spent learning about the care of seriously ill children, with whom the trainees will have minimal subsequent contact, and relatively little learning about the vast majority who are physically well or those troubled with the common developmental or behavioral problems. Defining the role of the clinician as someone who only looks for diseases to diagnose and treat or refer ignores a plethora of concerns that caregivers present to their health care professionals in the normal course of a youngster's development. Furthermore, not preparing professionals to respond appropriately to caregiver concerns and limiting their view of their expected role may result in a lessened interest and level of competence in their subsequent practices. A lack of training in dealing with behavioral concerns also provides the new practitioner with a diminished source of intellectual stimulation, a lowered sense of job satisfaction, and greater overall frustration.

Clinical encounters provide an opportunity to promote wellness in addition to curing diseases. Many caregivers arrive at the office with minor physical concerns but significant behavioral issues with their child. An unresponsive clinician can actually intensify the caregiver's worries by ignoring or discounting them. Communicating to caregivers that their behavioral concerns are not important if a physical illness is not discovered may only make matters worse. Frequently the nonphysical concerns that prompt a visit to a health care professional indicate a pressing need for caregiver support. Instead primary caregivers should be able to deal with these concerns, taking the appropriate steps to assess, evaluate and intervene in an effective manner.

The topography of normal behavior has been

established by the last 50 or more years of research in child development. Some improvement in training has occurred over these years, but it is nowhere near enough to meet the challenges of today. Unfortunately this knowledge is transmitted adequately to far too few professionals during their training. A major enhancement of education is thus needed. Primary care professionals need to be taught to understand and respond to behavioral issues in the normal ranges of behavior, as well as to refer moderate to severe cases to providers who specialize in treating them clinically.

Coincident with some small improvements in education, there has also been a major shift in the prevailing beliefs about where behavior problems come from. A half century ago, human nature, both normal and abnormal, was seen as being almost entirely a reflection of the impact of the environment. In the interim the consensus has swung to the opposite extreme, that human diversity and mental status are largely determined by intrinsic brain function with only a minimal role for the environment. Somewhere along the way, awareness of the basic concept of nature-nurture interactions got lost, along with an appreciation of largely innate temperamental variations as mediators and moderators between the two. There has been a swing from an outlook of "psychobabble" to one of "neurobabble" (Carey, 2011b).

Theoretical and Technical Deficiencies

Professionals in primary care face an urgent need for an improved diagnostic system and more practical management methods in dealing with child behavior. Some specific areas for improvement are mentioned here:

1. A Clear Definition of What is "Normal"

There is little if any generally accepted definition of the nature and full range of normal behavior. Behavior is presumed to be normal if it doesn't meet the criteria for what is defined as abnormal. However, there are many children whose behavior is clearly problematic but who do not fit into any diagnostic category. Thus, teaching new professionals in their training to appreciate an unclearly defined version of normal behavior is problematic. Normal could be more accurately described in an affirmative way, not just as an absence of abnormality. Two major consequences of the normal/abnormal conundrum are: a) that ubiquitous temperament and adjustment variations seen clinically may not be recognized as normal behavior, nor appreciated by clinicians in primary care as the assets they usually are; and b) that bothersome or unusual but normal variations of adjustment are too often misunderstood and identified as abnormalities. For example, a major defect of the DSM system of the American Psychiatric Association (2013) is that it does not encompass recognition of normal variations in behavior. A child who is inattentive or overactive but who does not meet criteria for ADHD (Attention Deficit/Hyperactivity Disorder) is eligible to be given the pathological label of ADHD- NOS (Not Otherwise Specified) but not to be viewed more accurately as "disorder free"—as possibly challenging, but normal. Also, normal shyness appears to be frequently labeled as Social Anxiety Disorder if it is bothersome to the caregiver. The desire to provide help may prompt professionals to diagnose cases that do not really meet the diagnostic criteria. Professionals concerned with behavioral health need a clearer definition of the boundaries of normal so that both normal and

abnormal phenomena may be more clearly understood, and normal behavior to be treated as such.

2. Clarity on what Constitutes a Behavioral Problem

At present the official catalogues of behavioral problems, such as the DSM-V and the ICD-10 (WHO 1992) offer to professionals lists of categorical pathological disorders, the criteria for which the child either does or does not meet. However, the current definitions of behavioral disorders do not make clear the differences between annoying variants of normal, which may superficially resemble the diagnosis but which do not qualify, and levels of true dysfunction. For example, exhibiting a pattern of low adaptability is not the same as exhibiting an established, consistent pattern of opposition to the requirements of the caregivers. However, their clinical presentation can be quite similar in some instances. (Francis A, 2013)

3. Resolution of Diagnostic Complexities

The current diagnostic schemes also do little to provide allowances for frequently observed changes occurring with development and maturation with advancing age. When the diagnosis of a chronic disorder such as ADHD is made in early childhood, the youngster may have few or no signs of the disorder a few years later. So much for chronicity! Important interactions within the context of the child's environment are responsible for much of what clinicians see in child behavior, but not acknowledged in diagnostic classifications as being in any way responsible, since the "disorder" is presumed to be all in the child. Social and cultural differences in perceptions of the types of behavioral patterns considered acceptable are generally not a part of the evaluation process. They should be considered.

Thus, current thinking about behavior in childhood is based upon a rigid, categorical system for defining abnormality when what is needed is one that is developmental, adaptational, contextual and interactional.

Just published in 2011 in a leading psychiatric journal was a collection of articles about what should be done to improve the existing mental health diagnosis schemes. It was edited by the distinguished British psychiatrist, Sir Michael Rutter (2011), and included five other international experts. They reached several important conclusions about revisions. Also, there was general agreement on the "need to develop a primary care classification for causes of referral to both medical and non-medical primary care." Some of us in primary care have been working on this for a while and this book attempts to fill that need.

4. Methods for Evaluating Child Behavior

A number of clinical tools currently employed by practitioners have been developed to evaluate various dimensions of behavior. However, most appear to be much less precise and more inefficient than they ought to be, since they are based on the same classification system that generates categorical diagnoses. The process of evaluating child behavior requires: a) accurate, practical methods for collecting pertinent information; and b) a realistic conceptual framework in which to organize the data assembled for a diagnostic impression. Most available measurement techniques have substantial limitations when compared with these standards.

5. Methods for Obtaining Pertinent Information

The general methods used in obtaining the behavioral information necessary to establish a diagnosis are familiar to all clinicians: interviewing, observations, and questionnaires. However, professional training in interviewing and making observations of behavior is typically very minimal. Beyond that, obtaining sufficient information to provide assessment and guidance frequently requires the use of standardized questionnaires developed to measure behavioral status. The advantages of these behavioral scales are: 1) they gather information from the persons best acquainted with the child; 2) they include some behavior not observable in the clinical situation, such as sleep or eating; 3) they are inexpensive and quick; 4) some have norms that tentatively help identify deviations; and 5) they provide quantitative assessments concerning qualitative aspects of behavior.

Questionnaires available for use in primary care today vary widely in their value to the practitioner. Some direct response tools such as the HEADSS (Home Education/Employment Activities Drugs Sexuality Suicide) seem to work for eliciting from adolescents discussions of important areas of stress and conflict. Clinicians attempting to find out about comparable strengths and concerns in prepubertal children or their parents frequently use some sort of caregiver report instrument. Some brief screening checklists provided mainly by psychiatrists and psychologists are: The Pediatric Symptom Checklist (Jellinek et al. 1986); The Eyberg Child Behavior Inventory (Eyberg & Ross,

1978); The Conners Parent Rating Scale (Goyette et al, 1978); The Strengths and Difficulties Questionnaire (SDQ) (Goodman & Goodman, 2009); and the Parents' Evaluation of Developmental Status (PEDS) (Glascoe, 1979). These tend to be too brief and impressionistic to allow an accurate picture of the child with sufficient detail. Consequently, additional time interviewing is needed to supplement the information obtained from them.

Some of the longer instruments are: The Child Behavior Checklist (Achenbach & Edelbrock, 1983); Behavior Assessment System for Children (BASC) (Reynolds & Kamphaus, 1992); Brief Infant-Toddler Social and Emotional Scale (BITSEA) (Briggs-Gowen et al, 2004); Ages and Stages Questionnaire: Social Emotional (ASQ:SE) (Squires et al, 2002); Devereux Early Childhood Assessment Program (DECA) (LeBuffe & Naglieri, 1999); and Vineland Socio-Emotional Early Childhood Scale (Sparrow et al, 1998). Information received from these tools seems to provide more adequate data, at least about the child's side of the behavioral interaction.

Undoubtedly the completion of an informative questionnaire has the tangible value of facilitating communication between the clinician and the parent or teacher. However, there are still problems limiting their usefulness at the primary care level:

1. The data provided may suggest which youngsters need a referral to a specialist but do not assist the primary care clinician in dealing with a present problem that does not require a referral;

2. There is no evidence supporting the contention that behavioral rating scales are any more efficient than brief, well directed interviewing;

3. With rare exceptions assessment instruments

rate only abnormalities and not positive behavior;

4. Most scales utilize behavioral items that are highly impressionistic. For example, what does "often talks excessively" mean?;

5. Many do not separate out the less from the more serious problems; for example, nose picking from fire setting;

6. Questionnaires do little to reveal the extent of the issue or its impact since most rate frequency rather than the effects of issues being rated; and

7. With rare exceptions they neglect information on caregiver-child interactions, which will almost always be the focus of parent counseling. (see Carey, 2009).

And yet, use of these questionnaires is what is generally promoted in pediatric texts for behavioral screening and evaluation, rather than more sensitive, individualized interviewing. These suggested scales are usually offered by persons with little or no primary care experience.

As for the evaluation of normal temperament characteristics, a division of opinion has occurred in how to do this. Clinicians have generally found that the nine traits originally established in the 1950s by Thomas, Chess, and Birch (1968) are the best to use because of their clinical derivation and established practical usefulness. However, academic developmental psychology researchers have followed the path of submitting observed and reported data to factor analysis in order to arrive at packages of specific behaviors that serve better for the purpose of making predictions about later personality. These computer generated dimensions apparently work well for studies of behavior in normal children but have not been verified clinically or shown to have value in clinical studies or practice. We clinicians are asked to provide help with present concerns, not to make predictions.

6. A Realistic Behavioral or Mental Status Diagnostic Profile

Once data are gathered, the dilemma is how to classify the information obtained. No existing system appears to have an entirely satisfactory method for utilizing the data in primary care. The DSM-V, (2013), the most widely known one, is primarily intended for adults, uses the categorical "medical model," and does not recognize or describe normal variations.

The DSM-PC of the American Academy of Pediatrics (1996) aimed to overcome all of these limitations, but, despite its valuable offering of three levels of concern, it failed, among other shortcomings, to acknowledge physical health, temperament, developmental status, and parent-child interactions as major contributors to behavioral outcome. The ICD-10 of the World Health Organization (1992) also deals only with disorders and essentially does the same job as the DSM. The DC: 0-3 (2005)... describes itself as "a systematic, developmentally based approach to the classification of mental health and developmental disorders in the first four years of life." Its more comprehensive approach is promising but it fails to include normal temperament in any appropriate way. The International Classification of Functioning, Disability and Health for Children and Youth (ICFCY), also from the WHO (2001), is remarkably comprehensive but it is regarded as too concerned only with impairments of function. The Big Five (Eysenck, 1994) have gained in favor among colleagues in developmental psychology. However, the five adult characteristics of

extraversion, conscientiousness, agreeableness, emotional stability, and openness to experience do not fit with well with the chief clinical concerns of parents about their children like social competence, task performance, and eating and sleep problems. (For a more extensive evaluation of these scales see Carey, 2009).

7. Tools for Managing Behavioral Issues in Primary Care

For the professional person in children's primary care, recommendations for how to manage a problem that has been diagnosed usually follows the "medical model," which proposes that for each condition there is a specific preferred, evidence-based plan of treatment. Unfortunately for clinicians, particular behavioral interventions with children and caregivers do not work so conveniently. Giving standardized advice is usually effective for only a small percentage of cases and may make others worse instead of better. For example, there is generally thought to be an

established method for handling noncompliance or aggressiveness. Sometimes these methods are appropriate, but too often such remedies are generalities, such as "Don't spank. Use time out." While time out is a valuable disciplinary tool, it is not always the preferred one. (I [WBC] can recall a young pediatric trainee several years ago who advised a parent that the best way to stop a child from waking up at night was to put him in time out when he did it!) Too many clinicians fail to individualize the parent counseling to the specific situation and to deal with problems in the particular interaction apparently responsible for the trouble. Meanwhile, reliance on drugs has reached an alarming extent. (Grundmeier R, Fiks A, Liu W, et al, 2015)

To replace the common inadequate alternative strategies of Dodge, Quick Fix, or Immediate Referral, this book will encourage a framework for selecting interventions that offers an individualized and comprehensive approach that is more likely to be successful.

Logistical Problems

Besides the issues of educating trainees and the theoretical and technical barriers described above, there are some practical obstacles that should be mentioned here. One major problem is the availability of professional time to deal with caregiver concerns that do not align with a traditional medical diagnosis. In many health delivery systems there is an emphasis on delivering services that generate revenue, rather than on prevention and early intervention activities that may promote behavioral health and avoid problems in the future. Although some of the solutions to logistical issues may be beyond the scope of this book, the problem of finding enough time and sufficient compensation to deal conscientiously with matters of child behavior does deserve prompt resolution.

In brief, most of the limitations identified in this

chapter emanate from their emphasis on fitting into a system that views behavior as a categorical entity, normal or abnormal, or in assuming that the impact of intervention will be the same for all children. Professional education currently concentrates on the extremes of behavior, the diagnostic categories of DSM disorder that the vast majority of children do not have. Assessment tools may help clinicians appreciate the specific behaviors exhibited by the youngster but do not lead to a formulation of what to do about them, other than make a diagnosis. Behavioral programs usually help a certain percentage of youngsters, but may not help, or may even harm children for whom they are not suited.

Professionals in primary care operate in an environment where many different levels of behavior (situational, transitory and contextual as well as permanent) and many different techniques (specific to the child's problems and patterns of reaction) may be brought to bear to assist in dealing with caregiver concerns about behavior.

The authors' formulation of what this environment is and how it operates are delineated in the next few chapters about behavioral assessment and management.

Chapter 3

What are the Problems? A Clinician's Perspective on Behavioral Issues Presented in Primary Care

Even when bringing a child to the office for a well check or common physical problems, caregivers often present additional concerns about their children to primary care professionals. Some of these concerns are behavior- or development-related questions, which most well-trained professionals are expected to be prepared to handle as part of their daily routine. Some are more challenging ones, which can range in severity. Of course, most behavioral complaints are minor, as seen from their transient and/or situational nature, and may require only a brief investigation and suggestions or counsel to simply watch and wait. Others are much more complex and these tend to require special assessment and disposition. Based on research and clinical experience dealing with the full range of issues that caregivers present, the authors describe here a framework for conceptualizing behavioral components and outcomes spanning the normal range, up to and including the DSM disorders.

This framework suggests that there are three broad categories of issues or conditions that are presented: 1) behavioral maladjustment (including but not limited to the DSM-V disorders), 2) aversive temperament leading to a poor "fit," and 3) parental misperception or misinterpretation of normal child behavior due to parental inexperience or their own problems. The present chapter will describe in some detail these three possible situations. It should be stressed that this view can be utilized by any primary care physician, nurse, counselor, or teacher. In fact, some allied health and education practitioners are able to pursue these inquiries with equal or greater skill than many of their physician associates.

I. Behavioral Adjustment and Maladjustment

Maladjustment suggests that behavioral issues tend to be severe, obvious, and easily classified into a known category of "psychiatric illness." In primary care this is not usually the case, especially when the concerns are routine rather than urgent. The largest percentage of cases presented by parents are issues seen in children who do not meet the criteria for any psychiatric diagnosis. They represent behavioral dysfunctions that fall into the mild to moderate range of severity. Some practitioners dismiss these problems on the presumption that they need no attention if they do not represent a diagnosable "illness." Those professionals who do choose to assist caregivers with these concerns, however, recognize that dealing with these problems requires that they perform at least some assessment, and not simply dispense standard advice or refer every problem on to a mental health specialist. Some of the most common behavioral problems seen in preadolescent children include such conditions as mild to moderate aggression, anxiety,

noncompliance, sleep problems, wetting and soiling, and problems with siblings.

In considering the concept of adjustment, the focal point is the content of the child's behavior rather than its style, especially in relationships—or, simply put, what he or she actually does and why in the particular environmental circumstances. Behavioral adjustment may interact with, and be to some extent derived from, his or her physical and developmental status and temperament, but it is conceptually distinct from these other aspects of the child's functioning. A word of caution about terminology. The DSM diagnostic system (APA 2013) was primarily designed by psychiatrists who wanted to standardize mental disorder terminology for the purpose of meaningful intra-professional clinical communication. It does not include theories of causation. Many other medical, psychological, educational, and social organizations in the United States and abroad have adopted this terminology because they lack diagnostic systems of their own, even though the scheme is not developmental, contextual, or adaptational and was not designed well for children. Also, the term "psychiatric disorders" requires further definition. It implies that the behavioral status is of such a nature and severity as to require the expert services of a psychiatrist (or perhaps a skilled clinical psychologist). Therefore, although included in the DSM manual, the term should not be used to describe learning differences and disabilities, motor skills disorders, communication disorders, pervasive developmental disorders, cognitive deficits, aversive temperaments, attention deficits, enuresis, and other conditions not clearly and uniquely the province of mental health professionals. DSM categories are more appropriate for major disturbances of behavior, emotions, or function.

Before one can describe any behavior as abnormal, the clinician needs to have a clear idea of what is normal. Unfortunately such a definition is hard to find. It is usually assumed to be an absence of abnormality, but one needs a more specific positive description. One of the few clear statements of behavioral adjustment to be offered by the experts came over 25 years ago from psychiatrist Stella Chess (personal communication, 1989):

"As a working concept, keeping in mind its subjective nature, one may identify the

following broad characteristics of normal children: They get along reasonably well with parents, sibs, and friends; have few overt manifestations of behavior disturbance; use their apparent intellectual potential to appropriate capacity; are interested in accomplishing developmentally appropriate tasks; and are contented a reasonable proportion of the time. This description covers a wide range of temperamental and personality patterns. One should not arbitrarily consider certain children to be abnormal because their conduct is identified with types of behavior that do not conform to an abstraction."

Thus, she recommends thinking of positive adjustment primarily in terms of the individual's relationships with other people, with tasks, and with oneself.

The need for an adequate descriptive diagnostic scheme that is comprehensive, developmental, contextual, and adaptational led us, the authors, to devise an entirely new designation of adjustment starting with these criteria for children ages 4-14 years. The new plan recognizes strengths as well as weaknesses. And there is a useful mnemonic

that helps the user to recall the six parts: BASICS, which stands for Behavior in social relationships, Achievements, Self-relations, Internal status, Coping, and Symptoms of physical functioning. The process involved in this construction is described in a textbook chapter by Carey (2009). Inspection of the table of definitions (Table 3-1) shows the behaviors at the two poles of each of the six areas. Table 3-2 demonstrates the variations within each from outstandingly good, to better than average, to average, to less than average, to poor.

The BASICS Behavioral Adjustment Scale (BBAS) (Carey & McDevitt, 2004) was derived from this view of adjustment. This relatively new scale is comprehensive (covering all six of these areas), dimensional (positive, average or intermediate, and negative), descriptive (of actual behavior at each level), and useful for clinical practice. It was

Table 3.1: The BASICS Profile of Behavioral Adjustment

Areas of Behavioral Adjustment	Concerns: Behaviour, Emotions, Functions
Behavior competence in social relationships. Skills, success, caring, cooperation, involvement, reliance. Parents, sibs, peers, teachers, other adults.	Undersocialization- Aggression, opposition, withdrawal.
Achievements- task performance and mastery in school, home, community. High or sufficient achievement, effort, motivation, satisfaction	Poor achievement or failure. Excessive preoccupation with work or play
Self-relations - self assurance. Self esteem about academics, social worth, appearance, physical abilities. Self-care, good health and safety attitudes, practices, handling personal stress. Self-control or regulation- actions-feelings	Poor self- esteem. Poor body image. Self-neglect, risk taking. Overconcern for oneself Over-control- inhibition or under control-impulsivity.
Internal status- feeling and thinking-. Reasonable contentment. Thought clarity.	Anxiety. Depression. Thought disturbance (e.g. obsessions)
Coping or problem solving patterns: direct and appropriate engagement Identifies problems; plans solutions; works on solutions; persists at solutions; revises solutions; gets help for solutions.	Ineffective, maladaptive problem solving with excessive use of denial, avoidance or repression.
Symptoms of physical function.- Comfortable function	Moderate to severe symptoms in eating, sleep, elimination, gender, unexplained physical complaints, repetitive behaviors.

(From Carey, 2009)

standardized on a sample of more than 400 children seen in several general pediatric practices in the greater Philadelphia area. The printed questionnaire can be completed by a parent in about 15 minutes and scored by a secretarial helper in 2 to 4 minutes. An online version can be completed in the same time and scored instantly. The BBAS has good psychometric qualities of internal consistency, retest reliability, and discriminant validity. We see its main use not for primary screening but as an additional assessment of adjustment when the clinician has discovered some complex degree of parental concern about the child and desires an efficient way to obtain a broader inventory.

Its aim is to yield a description, not a score. Clinicians can use these ratings as a starting point to focus further interviewing and observations. Table 3-2 contains an approximation of the content of the BBAS. It also does not lead to a score but to a description of the child.

The BASICS model has been proposed but not extensively researched. However, it represents an initial step forward in defining the parameters of normal behavioral adjustment, suggesting gradations between happy and healthy vs. symptomatic and maladjusted. Refinement and validation of the intermediate steps is important if the gap between normal and abnormal in everyday

Table 3.2: Comprehensive Profile of Behavioral and Emotional Adjustment

Areas of Adjustment - Definations	Ratings & Comments
Behavior, social competence- Relationships with people: How well does child get along with people? • High social skills vs. deficit • Caring vs. hostile, aggressive, destructive. • Cooperation vs. opposition, defiance, manipulation. • Involvement vs. withdrawal. • Autonomy vs. dependence, overconformity	a) Highly competent, pleasant, likeable b) More pleasing, likeable than average c) Gets along moderately well. Average. d) Some significant relationship problems, not major. Conflict with parents, sibs, teachers or peers. e) Generally unpopular, often rejected. Frequent severe incidents, real or threatened exclusion from relationships. Comments:
Achievements Task performance- school, home, other. How well does child do tasks and play? • Extent of achievement • Skill development, utilization. • Motivation, effort, interest, responsibility. • Satisfaction, pride in accomplishment	a) Excellent achievement b) Good achievement. c) Average, satisfactory achievement. d) Underachievement, not failing. Excessive striving e) Poor achievement, failing. Truancy. Comments:
Self relations Self-assurance and management. How does child feel about and manage self? • Self-esteem- mental and physical abilities, appearance, social worth. • Self-care vs. neglect, abuse, risks, overconcern • Self-regulation- appropriate vs. over or under regulation	a) Excellent self-esteem, care and regulation. b) Good status in these areas. c) Variable, average status d) Below average in some of these matters. e) Poor. Problems in some or all these areas. Comments:

Table 3.2 (Continued): Comprehensive Profile of Behavioral and Emotional Adjustment

Areas of Adjustment - Definations	Ratings & Comments
Internal status- General contentment vs. disturbance in feelings or thinking. How does child feel and think? • Feelings- degree of comfort or discomfort. • Thinking- clarity and reality vs. distortion.	a) High but reasonable contentment. b) Comfortable feelings and thinking. c) Average mixture of concerns. d) Unsatisfactory. Disturbing but not crippling feelings of fear, anxiety, depression, anger, guilt; or reality distortions, phobias, obsessions, compulsions, delusions. PTSD. e) Poor- major disturbance of feelings or thinking. Comments:
Coping. Problem solving. How well does child identify and solve problems? • Identify problems vs. denial. • Plan solution vs. avoidance • Work on solution vs. passivity. • Persist at solution vs. give up • Makes needed revisions vs. perseveration. • Seek appropriate help vs. not.	a) Highly effective coping. b) Generally effective coping. c) Satisfactory. Average. Variable. d) Unsatisfactory coping. e) Poor problem solving. Excessive use of defensive strategies---denial, giving up, etc Comments:
Symptoms of body function. General comfort of body functions vs discomfort or dysfunction. • Eating • Sleeping • Elimination • Gender • Pains • Repetitive behavior	a) Comfortable in all areas. b) Generally good function. Only minimal concern. c) Some concern. Within normal range. d) Significant concern. Not severe. e) Major concern. Comments:
General assessment	
Main service needs	

(From Carey, 2009)

life is to be understood and utilized to promote behavioral and emotional well-being.

At what point can the term "psychopathology" be applied? Perhaps that is best thought of as the situation when the extent of the undesirable or unacceptable behavior is so great and internalized that it takes more than brief counseling for a restitution of healthy interactions with the environment to cause it to moderate to a more acceptable level. It is a behavioral variation that is in some way harmful. The DSM-V categories certainly define the criteria for psychopathology for specialty providers, such as psychiatrists, psychologists, therapists and others. Implicitly, all psychopathology includes significant problems in behavioral adjustment, but the reverse is not true. Many children with behavioral adjustment problems do not meet the criteria for any DSM-V disorder. Thus, the descriptive approach to adjustment difficulties can be useful in determining the type of problem and indicate the direction needed for resolution. Primary care professionals will nearly always refer most severe problems to a behavioral specialist, though a few primary care physicians do feel comfortable and competent in prescribing medications or counseling for common "psychiatric" conditions in childhood.

The authors at this time present a tentative outline for recognizing and rating behavioral adjustment for children under the age of four years, a time when "abnormal" is even harder to distinguish from acceptable, and the danger of overdiagnosis is especially great. (See Table 3-3 below).

Table 3.3: BASICS Behavioral Profile- Ages 0-4 and 4-14 Years

BEHAVIORAL ADJUSTMENT The quality of child's psychosocial functioning in BASICS areas. (not including physical status, neurological, cognitive functions or temperament.)	**Concerns: 0-11 months** (other than "difficult" temperament: especially active, unpredictable, inflexible, inhibited, intense, negative, Inattentive/inappropriate persistence, low soothability, sensitive.)	**Concerns: 12-47 months** (other than "difficult" temperament: especially active, unpredictable, inflexible, inhibited, intense, negative, inattentive/ inappropriate persistence, distractible, sensitive.)	**Adjustment Concerns- 4-14 years:** behavioral, emotional, functional.
Behavioral competence in social relationships: How well is he/she getting along with people? Skills, success, caring, cooperation, involvement, reliance. Parents, sibs, peers, teachers, other adults.	Deficient positive relations: attachment, closeness, reciprocal engagement, caring, affection, smiling, enjoyment from being held, eye contact.Excessive negative social adjustment: withdrawal, detachment; Clinging, excess crying when left alone.	Excessive negative or insufficient positive social adjustment: Noncompliance, Aggression: kicks, hits, Opposition. Tantrums. Withdrawal. Detachment. Inconsiderate of others Conduct issues- steals, lies, bullies	Undersocialization- Poor quality of interpersonal relationships. Aggression, Opposition. Withdrawal Avoidance. Detachment.
Achievements: How well is he/she performing, considering his/her abilities? Task engagement and achievement in school, home, community. High or sufficient effort, motivation, satisfaction.	Inappropriate play- solo or with others; either ignores toys, stimuli or overly occupied with repetitive activities, nonproductive use.	Insufficient achievement in tasks at home, with others and at school: clean up, helping, other chores, etc. Inappropriate solo or group play: selfish, non-cooperative, poor care of toys, destructive, etc.	Poor achievement or failure of engagement in tasks and play -in home or school despite adequate instruction. Refusal/avoidance of homework, chores, family duties, etc.

Table 3.3: (Continued): BASICS Behavioral Profile- Ages 0-4 and 4-14 Years

Self-relations-How well does he/she do viewing & managing self. **--Self–esteem**- about academics, social worth, appearance, physical abilities	(May be hard to determine this early)	Little self-confidence. Over-dependent. Clingy.	Poor self- esteem. Poor body image.
--Self-care- good health and safety attitudes, practices, handling personal stress.	Inadequate self-soothing. Excessive crying when left alone.	Careless about danger. Excessive lag in self-care- toilet, dressing, eating. Poor self-soothing.	Self-neglect, risk taking. Overly concerned about self. Preoccupied.
--Self-control or regulation- of actions, feelings; "effortful control"	Failure to achieve regulation of physical functions. Excessive crying- colic.	Inadequate self-control. Impulsive. Disruptive. Excessively inhibited or detached.	Over-control- inhibition;or under-control- impulsivity.
Internal Status: How content or troubled internally in feeling and thinking? Reasonable contentment. Thought clarity.	Little expression of contentment with care. Absence of regard/smiling. Excessive distress: negative, crying- "colic" Excess fear with non-primary caregivers.	Anxious, Fearful. Phobias. Angry. Depressed. Obsessions.	Few signs of contentment. Expression of discontent with surroundings Anxiety. Depression. Fearful. Angry.Thought disturbance- obsessions, other distortions.
Coping: Problem solving patterns. How effective is he/she at solving personal problems? Direct and appropriate engagement. Identifies problems; plans solutions; works on solutions; persists at solutions; revises solutions; gets help.	Hard to estimate in this period. Excessive avoidance, nonresponsive etc. Frequent tantrums or crying when delayed or restrained. Shuts down or disengages	Insufficient appropriate coping skills and accommodation. Excessive ineffective coping skills: avoidance or denial, shuts down, etc. Frequent (daily or more) tantrums when presented with obstacles	Ineffective, maladaptive problem solving with excessive use of ignoring, repression, avoidance. , etc.
Symptoms of physical function: How comfortable are his/ her body functions?	Little expression of contentment with body functions: eating, sleep, etc. Apparently excessive body discomfort, malfunction symptoms: night waking, food rejections.	Enuresis. Encopresis. Constipation. Sleep disorders. Self-stimulation -rocking, twirling. Gender confusion. Food fads. Pica.	Moderate to severe symptoms or disruptions in eating, sleep, elimination, gender. Unexplained pains. Repetitive behaviors

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The DC: 0-3R Manual (2005) offers suggestions for some categorical labels for use up to age four years but tends to pathologize some normal behavioral patterns. For disruptive behaviors Wakschlag et al. (2007) have proposed a still-undeveloped system focusing on noncompliance, temper loss, and aggression. To these symptoms can be added some other worrisome ones such as lack of personal feeling for people. The DSM-PC (DSM for Primary Care, Child and Adolescent Version) of the American Academy of Pediatrics (1996) was an extensive but unsuccessful attempt to adjust the DSM scheme to the primary care medical setting.

Not discussed here are screening techniques for detecting autism, ADHD, or other syndromes, which are controversial and not generally recommended. In particular, the criteria for ADHD are greatly in need of refinement (Carey, 2002) and are presently in a slow stage of reappraisal and revision (Furman, 2005; Thapar & Lewis, 2009). The problem of the overlap of ADHD symptoms with normal temperament traits has yet to be adequately resolved (Foley, McClowry, Castellanos, 2008). It seems likely that the present overdiagnosis of ADHD may in part be due to the lack of recognition by many clinicians of temperament variations which are annoying to caregivers but still inherently normal. Detecting and managing autism is not a primary concern of this book but the responsible clinician should be screening for it when it is suspected by using informed clinical observations and approved questionnaires (http://www.cdc.gov/ncbddd/autism/).

II. When No Behavioral Dysfunction Is Detected

If there is parental or other caregiver concern and the criteria for behavioral dysfunction have not been met, then evaluation of the child's status shifts to the possibility that the source of the worry could be an aversive, normal temperament or a caregiver misperception of abnormality due to either insufficient information or caregiver psychosocial problems distorting their view of the child.

Aversive Temperament

Stresses from dissonant reactions between a child's normal temperament and the values and expectations of the parents or other caregivers are a major source of caregivers' complaints to clinicians, but these situations are commonly not recognized for what they are. The extensive descriptions of temperament in clinical settings available in other sources (Carey, 2009, 2011a; Carey & McDevitt, 1995; Chess & Thomas, 1986, 1999; Thomas & Chess, 1977; Thomas, Chess, Birch Hertzig & Korn, 1968) should make necessary only a brief summary here.

The best simple definition of temperament is the behavioral style of the individual, the characteristic pattern of experiencing and reacting to the external and internal environment. It is the "how" of behavior rather than the "what" or "why." Because at least for young children we cannot know for sure what they are feeling, we rate the behavior observed by the caregivers when doing the evaluations rather than guessing what the child is feeling. At first, clinicians sometimes have a problem distinguishing between temperament and behavioral adjustment. Temperament is the normal, early-appearing, largely genetically determined, somewhat stable set of stylistic differences in reactions to the environment. Behavioral

adjustment is the normal or abnormal content or substance of the behavior, which develops later as a result of child and environment interactions. Low adaptability is temperament; chronic, pervasive noncompliance is a problem of behavioral adjustment, which may possibly be fueled by not handling low adaptability well.

History of Temperament

The modern history of definitive temperament research began in 1956 with the important pioneering work of Stella Chess and Alexander Thomas in their New York Longitudinal Study (NYLS). Interested in clarifying the role of innate "primary reaction traits" in the genesis of behavior problems, they identified nine of them (see Table 3.4 below). The NYLS group assumed that all their traits are normal through the whole range from very high to very low. However, we await clarification of at what points normal may shade off to pathological as with extremely high or low activity, regularity, approach, intensity, adaptability, or any of the other dimensions of temperament.

In academic research various developmental psychologists have developed other sets of traits largely through computer item analysis of data, but these have yet to be established as clinically useful. Some these other cited behaviors, which may or may not be truly basic temperament but rather secondary behavioral adjustment outcomes, are: impulsivity, exuberance, surgency, effortful control, and executive functions. (Further discussion in Chapter 6).

The nine NYLS temperament traits show a genetic influence of at least 50%, while the remainder is related not only to the psychosocial environment but to an increasing list of pre-, peri-, and postnatal physical influences like maternal diet, toxins, and emotions; prematurity; and childhood anemia and toxins. These traits are apparently not detectable in newborns but are by 3-4 months and display an increasing degree of stability at least until adolescence. These various etiological factors are reviewed in detail elsewhere (Carey and McDevitt, 1995. pgs. 18-24).

Table 3.4: The Nine NYLS Dimensions of Temperament

1. **Activity:** The amount of physical motion during sleep, eating, play, dressing, bathing, and so forth.
2. **Rhythmicity:** The regularity of physiologic functions, such as hunger, sleep, and elimination.
3. **Approach/withdrawal:** The nature of initial responses to new stimuli- people, situations, places, foods, toys, procedures.
4. **Adaptability:** The ease or difficulty with which reactions to stimuli can be modified in a desired way. Flexibility.
5. **Intensity:** The energy level of responses, regardless of quality or direction.
6. **Mood:** The amount of pleasant and friendly or unpleasant and unfriendly behavior in various situations. (overt behavior, not assumed internal feelings).
7. **Persistence/attention span:** The length of time particular activities are pursued by the child, with or without obstacles.
8. **Distractibility:** The effectiveness of extraneous stimuli in interfering with ongoing behaviors.
9. **Sensory threshold:** The amount of stimulation, such as sounds or light, necessary to evoke discernable responses in the child

Although none of these temperament traits is universally a source of caregiver-child friction, any of them can become risk factor for interactional stress. The commonest problems are seen in children who have low adaptability and negative mood. However, what matters for the relationship and symptom production is what Chess and Thomas referred to as the "goodness (or poorness) of fit" between the child and the preferences and expectations of the adults. Poor fit was identified early in their work as likely to produce stress in the child and often the adult as well, and the stress leads to behavioral symptoms. The nature and impact of the fit can best be elicited from the caregivers by a simple inquiry about the quality of the relationship, not just by a numerical score derived from comparing questionnaire results. Recent data have illustrated the importance of cultural preferences; for example, Chinese parents were less appreciative of approach (Chen, Chen, et al., 2009), while Italian parents were less bothered than others by negative mood (Super, Axia, et al., 2008). It is hard to find methodologically secure data in cross-cultural studies. Problems in translations and cultural differences are impediments, but the Super et al. study provides an excellent model of how to do it well.

Temperament matters a great deal. The extensive clinical significance of temperament has been reviewed in detail elsewhere (Carey & McDevitt, 1995) and need not be elaborated upon here. Its impact on the caregivers affects their sense of adequacy and their parenting responses. Possible effects on children are many: social adjustment, school performance (Keogh, 2003), physical health, development, reactions to life stressors, and a growing list of other issues such as duration of breastfeeding and ease of toilet training. A recently described area of temperamental impact on development is in slowing the acquisition of expressive language for some who are low in initial approach (Keogh, 2003; Paul & Kellogg, 1997).

As the vignette about Steve in Chapter 1 illustrated, some children with aversive temperaments but who are otherwise normal are being misdiagnosed as having Attention Deficit/Hyperactivity Disorder (ADHD). Frank the Crank is colicky because of a dissonant interaction of his temperament and his caregiver.. Jill the Pill is a persistent child of low adaptability, which is normal but not what her mother wanted.

Assessment of Temperament

Identifying where children stand with regard to temperament characteristics can be achieved by three methods. Direct observation in the clinic or office may be illustrative of the child's reaction style but, because of its brevity and the possibility of an atypical sample, it can seldom by itself provide sufficient data for a reliable diagnosis. Questionnaires like the Carey Temperament Scales (1996) are very helpful for consultations about behavioral problems or for research. Although responses to questionnaires may be influenced by caregiver subjectivity, the more precise the behavior asked about and the particular setting described, the less distortion is likely to occur.. Impressionistic items from another source like "my child is always on the go" invite distortions far more than the more precise descriptions like "the infant moves about much (kicks, grabs, squirms) during diapering and dressing." However, for initial clinical assessment one can probably gain sufficient information by interviewing. If a caregiver reports a problematic behavior that sounds like one of the temperament traits, that impression can be substantiated or rejected by following the caregiver's assertion with a series of specific illustrations (See Table 3.5). These are just suggestions as to what areas of interaction to explore, and do not lead to a formal score or diagnosis as would one of our psychometrically established scales.

The clinician must bear in mind that current caretaker psychosocial problems such as depression or anxiety in the parents may adversely influence objectivity in their reports. The detailed specific descriptions in Table 3-5 are also valuable to correct any distorted perceptions.

Table 3.5: Clinician's Impressions of Child's Temperament

Clinician's Impressions of Child's Temperament

Based on interview and office observation.

Name of child-

Age-

Date-

Professional rater-

Parental informant-

Instructions-
This checklist is designed to aid child health professionals in obtaining a rapid survey of any temperament traits causing concern. It reminds the clinician of the main areas where the trait may be described or observed. All items for each trait may not apply to all children, especially younger ones. Those appropriate for infants and toddlers come first. It produces a broad description, not a score or diagnosis.
? = Does not apply or do not know.
B = Bother- Refers to whether this specific item is a problem for the caregiver. If so, make a check mark.
For standardized questionnaires assessing temperament and/or behavioral adjustment go to www.b-di.com.

Activity: amount of physical motion	High	Medium	Low	?	Bother
During meals					
During play					
During car rides					
During dressing					
Rate of eating					
While waiting					
Going up, down stairs					
Walking with family					
Listening to music					
Watching TV					
Entering, leaving house					
Talking with parents					

Approach/withdrawal: initial reaction to novelty	Approach	Medium	Withdrawal	?	Bother
New foods					
New sitter					
New place					
New clothes					
Visitors in home					
Stranger elsewhere					
Unfamiliar children					
New toy, game					
New group activity					
Arrival at social event					
New situation					

Table 3.5 (Continued): Clinician's Impressions of Child's Temperament

Rhythmicity, predictability: physical and behavior regularity	Regular	Medium	Irregular	?	Bother
Sleeping Times					
Hunger times					
Amount eaten					
Food choices					
Response to parent					
Bowel habits					
Play schedule					
Doing chores					
Doing homework					
Care of possessions					
Order in own room					
Keeping appointments					

Adaptability: flexibility, ease of adjustment to change	High adapt.	Medium	Low adapt.	?	Bother
Change in meal time					
Change in activities					
Change in routines					
Calming if upset					
New places					
Change in familiar plans					
Settling arguments					
Accepting new rules					
Response to coaxing					
Response to mild punishment					
Response to firm punishment					
Major setbacks					

Intensity: energy of responses to:	Intense	Medium	Mild	?	Bother
Hunger					
Pain					
Happiness					
Anger					
Surprise					
Scolding					
Disappointment					
Praise					
Likes and dislikes					
Teasing					
Disapproval					
Discovery					

Distractibility: how external stimuli affect activities	Distractible	Medium	Not distract.	?	Bother
Soothability during pain or fear					
While playing alone					
Playing with friends					
Household noises					
Somebody walks by					
By TV when reading					
By conversa-tion when reading					

Table 3.5 (Continued): Clinician's Impressions of Child's Temperament

Mood: observed reactions—pleasant and friendly or negative	Positive	Medium	Negative	?	Bother
On awakening					
At bedtime					
When tired					
When hungry					
During/after meals					
Frustrated					
Sick or injured					
When corrected					
During play					
Asked to do chores					
Denied permission					
New visitors in home					

Sensory threshold: sensitivity to stimuli. Notices:	High sensitiv.	Medium	Low sensitiv.	?	Bother
Changes in taste					
Changes in lighting					
Changes in sound					
Changes in water temp.					
Changes in room temp.					
Textures of clothes					
Odors					
Soiled diapers					
Soiled clothes					
Minor injuries					
Mild parental disapproval					

Persistence/attention span: how long activities pursued	Persistent	Medium	Non-persist.	?	Bother
Practice physical activity					
Interest in new toy					
Look at, read book					
Watch TV					
Learning special skill					
Listening to parent					
Household chores					
Work on own project					
Doing homework					
Care of pet, garden					
Difficult project					
Resume task after interruption					
Resumes play after interruption					

Comments:

Concerns of caregiver:

Impressions of clinician:

Service needs and other plans:

The Carey Temperament Scales are intended for use with parents. For information from teachers one should use scales designed for the somewhat different milieu of school. See Martin and Keogh (2003) in references.

Other Views of Temperament

After the initial impetus of the NYLS advances, several academic developmental psychologists produced alternative views of temperament. Among them were Robert Plomin, John Bates, Jerome Kagan, and Mary Rothbart. This trend deserves mention here for clarification of the differences between their techniques and conclusions and ours. The focus of their interest has been on studying personality development rather than trying to understand and solve current clinical problems.

For example, a recent book by Rothbart (2011) summarizes her extensive important temperament research and her speculations about it. Some limitations of this academic approach are evident:

1. The temperament traits used for study were not those readily observable by parents and clinicians, as with the NYLS ones. They were derived from a synthetic process of factor analysis, putting all the behavioral descriptions into the computer and asking it to find more mathematically satisfying packages of them based on their wording. Among other problems it eliminated the clinically most important trait of adaptability. And it produced such traits as surgency, which collects diverse items on activity, approach, mood, etc., and is not easily recognizable clinically. Statistically derived dimensions, rather than observed ones, do not yield a clearer view of what is important in reality for parents and clinicians.

2. The range of their primary reactive temperament traits has been allowed to expand to include some behavioral adjustment areas that emerge later. Examples are effortful control (self-control?) and executive functions (coping?).

3. They have abandoned the concept of difficult temperament because it varies. But that is the point; it is the individual poor fit that makes this child's special temperament hard for these particular parents to manage. Difficulty is not a score; it is what caregivers think and tell us is bothersome. It should not be abandoned.

4. No practical use for managing current behavior problems has been demonstrated for these newer computer-generated traits.

For all these reasons we recommend using the well- established clinical traits from the NYLS. Please turn to Chapters 4, 5, and 6 for mention of other users of the 9 NYLS traits, sometimes with alterations, by various clinicians such as Cameron, Kristal, Neville, Renner, and McClowry.

Be aware that some investigators have suggested that a particular single trait is so much more important than others that it deserves almost exclusive attention: stimulus seeking, irritability, activity, "sensory integration" (environmental sensitivity and reactivity), "callous-unemotional traits" (low sensitivity to the feelings of others), intensity, dysregulation, resilience "grit" (persistence), bold/ inhibited (approach/withdrawal), Slow Cognitive Tempo, etc.

Inaccurate Perceptions of Abnormal Child Behavior

Although pediatricians and other primary care medical personnel are frequently accused of not taking parents' behavioral complaints sufficiently seriously (and too often that is correct), it is unmistakably true that parents and other caregivers do frequently complain to health care advisors about problems in their children's behavior when, in fact, there is no demonstrable abnormality. There seem to be three common instances of inaccurate perception or attribution of child behavioral issues: 1) confusing normal child temperament with a problem in behavioral adjustment, which was just mentioned above; 2) inexperience in understanding the nature and extent of normal behavior; and 3) misjudgments of the child's behavior arising from the stress or distress of psychosocial problems of the reporting caregiver.

These misperceptions are all, of course, diagnoses of exclusion, and should only be made when the normality of the child has been fully established.

1. Confusing Temperament Variations with Abnormality.

The first of these three mistakes in judgment, the misidentification of temperament traits as adjustment problems, has already been discussed above. The case of Harry at daycare in Chapter 1 is a good example: a shy child whose slow approach to preschool was labeled as due to "emotional insecurity." Caregivers may tend to infer abnormality from differences in the patterns of typical behavior exhibited by their children. If one is spirited and the other easy, the inference may be that the spirited one is abnormal, "Spirited but normal" temperament patterns are challenging but not indicative of dysfunction.

2. Parental or Teacher Inexperience

Lack of sufficient knowledge on the part of the caregiver often leads to inappropriate concern that something is wrong with the child. The inexperienced parent may believe that a normal, active and inquisitive toddler or a teenager who no longer shares all her secrets with her mother is in trouble. Takesha in Chapter 1 is eating less in her second year but this is a normal trend at that time and not a behavior problem. These issues can generally be handled at the primary care level by giving out accurate, reassuring information about normal development. (Some of this group are probably similar to those who in the adult literature are referred to as the "worried well.")

3. Psychosocial Problems in the Parents

Serious personal or family stressors can deprive caregivers of a balanced view of their children as well as of other aspects of their lives. A normal amount of activity, any slowness to adapt, or any intensity may be regarded as intolerable because of the limited coping capacity of the parent. The primary care clinician should be aware of these issues and try to restore a healthy perspective in

the caregiver. The professional may need to elicit the true source of the concerns through expression of worry about the caregiver's level of distress and then possibly refer the troubled person to another professional who is better trained to help with them.

Having described the typical outcomes of behavioral assessment, it is necessary to outline how the clinician in primary care may arrive at a determination of the specific type of problem, its severity and its disposition. The next two chapters will focus in turn on the process of assessing the nature and significance of behavioral concerns and how the problems identified can be appropriately managed by professionals in primary care.

Chapter 4

Improving Assessment of Child Behavior in Primary Care

The critical appraisal of some current techniques of diagnosis and management in the previous chapters suggested a pressing need for improvement. The discussion in this chapter proposes an outline of what the authors (two experienced clinicians and researchers, one a pediatrician and the other a psychologist) believe to be a better way to proceed. While not proposed as the last word on the subject, this framework represents a highly useful approach for the professional person in a primary care practice. The authors advocate the use of an algorithm that directs the clinician through the assessment process. It includes suggestions for determining the nature and severity of problems as well as creating a comprehensive formulation of the youngster's current state of adjustment. Finally, methods for giving caregivers feedback about the results of the assessment are covered.

Initial Steps: Listening, Observing, Making an Inquiry

The process of obtaining sufficient information about a behavioral issue begins with listening, observing, and questioning. The parent or other caregiver may spontaneously present concern about some aspect of the child's behavior, feelings, or physical functioning, or inappropriate behavior may be evident from the child's presentation in the office. Alternatively, the worry may be identified only later through the use of an interview screening process or from a written questionnaire designed for a more detailed assessment.

Observations of the child or of the parent-child interactions in the office or clinic may be quite revealing, but can also be misleading when not representative of more general behavior exhibited elsewhere. The clinician's task is to attempt to determine their significance for the general status of the child.

Although screening for physical health problems is a well-established part of the routine medical care of children, the techniques now commonly in use for investigating mental health status are not uniformly applied and in most instances could be greatly improved. For example, some clinical practitioners are trained to pose a single screening question such as "Do you have any concern about your child's behavior?" Instead of asking a single yes/ no question (or none at all), clinicians can use more revealing, open-ended initial inquiries, which will lead rapidly to greater richness of appropriate detail. For example: "What is your child like these days?", "How is your child's behavior now?", "How is your child getting on with life at present?", "How is your child treating you lately?", or "How would you describe your child's personality?" What do you like most about your child?...What do you like least?" This more open process of discovery

usually requires just a couple of minutes. It is neither difficult nor time-consuming. To provide comprehensive care, the clinician can and should make such inquiries at each well-child or health maintenance visit.

The use of an oral interview protocol or written questionnaire for screening at this point was discussed and criticized in the previous chapter. There is no evidence to suggest that such standardized, written probes are any more efficient than brief, well- constructed, individualized oral questioning by the clinician. For example, one such proposed technique, the Teen Screen, has yet to be shown to have sufficient sensitivity and specificity, and may for that reason be unsuitable and even dangerous in certain circumstances. Screening questionnaires may detect more concerns but that does not necessarily lead to improving the care given (Hacker KA, Penfold RB, Arsenault LN, et al., 2014) Therefore, it is more sensible to recommend speaking directly with the caregiver or patient. The opportunity to assess body language and tone of voice as well as the verbal response itself seems more likely to reveal the existence of concerns on the part of the caregiver than simply reviewing the results of a written source of data.

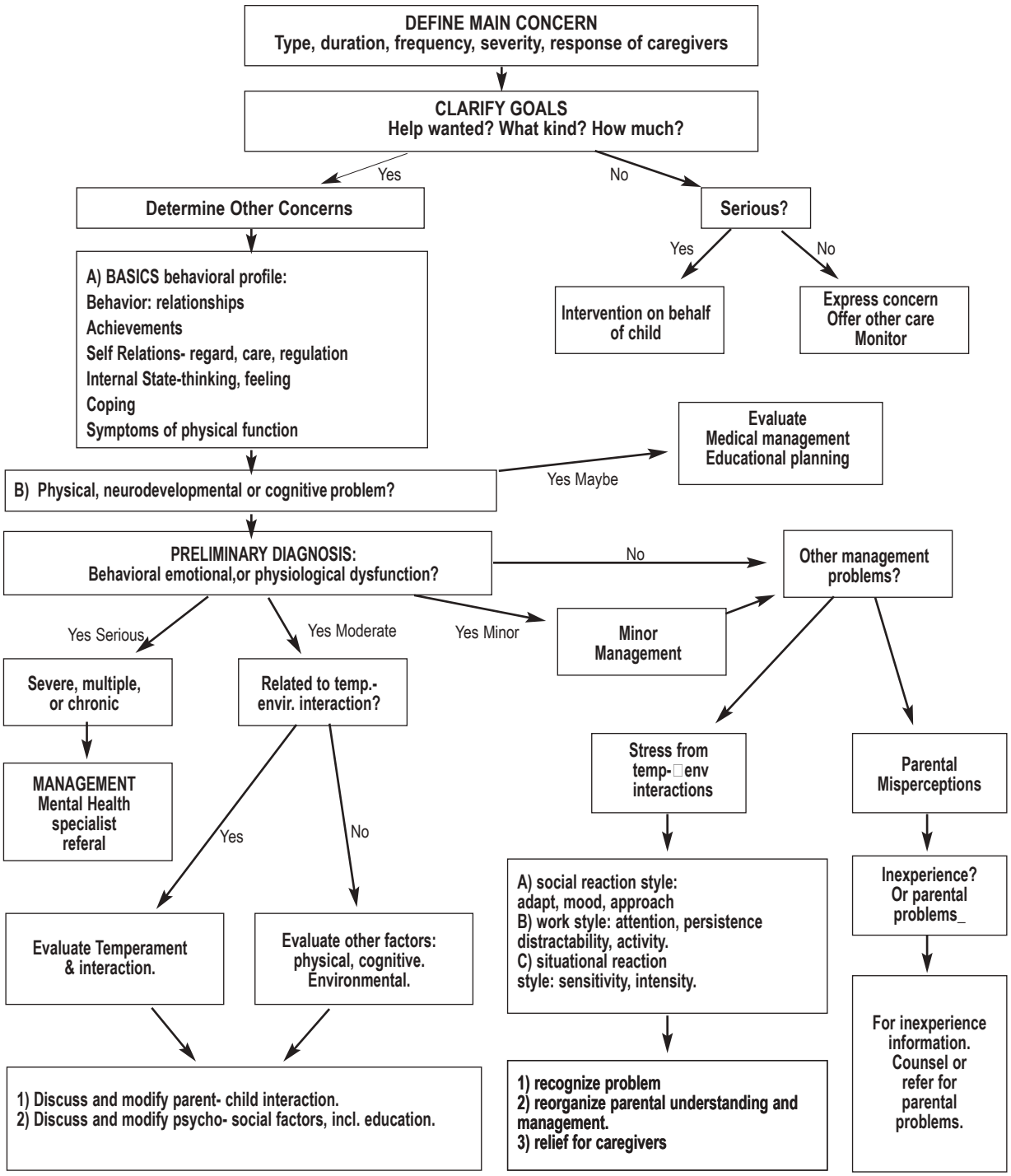
Some authors have recommended that clinicians perform a routine screening for aversive temperament traits. Since these dimensions have been implicated in many parent-child behavioral poor fits and problems, at one time it was thought to be a useful strategy to screen for possibly troublesome or "difficult" temperament. However, experience has shown that using a temperament questionnaire routinely for every patient has not been a good use of the clinician's time. As will be pointed out below, what matters for adjustment is not so much the specific temperament traits themselves as it is the "fit" of those traits with the values and expectations of the parents. It therefore has been found to be more efficient to look first for signs of interactional distress and then to assess the child's temperament if it appears to be the source of the concern or a factor in an adjustment problem.

Using an Algorithm for Assessment

Having determined that there is some cause for concern about the child's behavioral, emotional, or functional well-being, the clinician can then proceed in a systematic way to obtain the information necessary to achieve a diagnostic understanding that supports appropriate care. Unprepared clinicians often feel helpless at this point and may unnecessarily seek ways to dispose of the situation as quickly as possible, using one of the Dodge, Quick Fix, or Immediate Referral strategies. Fortunately, there is now available an algorithm, or decision tree, to guide the perplexed clinician through the steps necessary to reach an appropriate conclusion about the significance of the behavioral issue and how to manage it. Other approaches, such as various behavioral symptom-screening checklists, have been proposed, but none as organized, direct, or comprehensive as this one.

Figure 4.1

Algorithm for Management of Parental Concerns about Child's Behavior



(From Carey, 2009)

Clarify Goals

The main behavioral concerns having been identified, the first step is to clarify the goals of the child's caregivers. Are they asking for help? What kind? How much? Professionals should not automatically assume that mention of a concern in a general medical setting is the same as a request for assistance. The inadequately prepared clinician may believe that the Hippocratic Oath requires the acceptance of responsibility for diagnosis and management of any problem brought up by the caregivers. Experienced clinicians understand, however, that in many cases caregivers are simply venting their frustrations about the child or their situation and are not really requesting or needing the clinician's professional assistance with the problem at the time. Some screening questions to use to determine the caregivers intent may be:

'What help are you getting for this matter?" "How would you like me to help you with this problem?" "Would you like to spend some of our time today talking about it?" If the family is not asking for help, it would not be useful to pursue the matter, unless, of course, there is danger of physical or psychological damage to the child or surrounding children, adults or property. In that case, the clinician should express concern and attempt to enlist the caregiver's cooperation in addressing the issue together. When there are predisposing factors like temperamental difficulty in the child and considerable anger and frustration in the parent, the possibility of abuse must be contemplated. In extreme cases Child Protective Services must be called. If professional assistance is neither mandated nor requested, the process of assessment can be considered complete.

Look for Other Concerns

When there is caregiver interest in working with the clinician to achieve an understanding and a solution to the behavioral concern, the next step should be to determine other concerns. What else is going on physically, developmentally, in behavior, in relationships, etc., that might explain or contribute to the presenting complaint? This is the part of the evaluation most likely to require a significant amount of time (up to an hour), especially if the problem is complex or the child not already well known to the clinician. It may require another visit to provide sufficient time. Since most problems are not complicated and the child is often already known to the clinician, the time required here may not be long.

Developmental Screen

At some point in the diagnostic process the primary care professional should perform or obtain at least a brief screen of the child's developmental status for children under the age of 6 years. A variety of screening check lists is currently available. These allow the alert clinician to evaluate the child sufficiently and responsibly in a few minutes. Two sheets were developed by the senior author of this volume for his use in pediatric practice over 50 years ago because there was no other such checklist available at the time. Now others are available. It is not necessary to employ any particular one of the new questionnaires or electronic versions; we should just make sure that this part of the evaluation is not overlooked. The

necessary ingredients are: 1) a detailed, reliable checklist to help the clinician remember with precision the numerous milestones and 2) sufficient clinical knowledge to interpret correctly the significance of the findings. The decision for a referral to a specialist for further evaluation should rest with the primary clinician and should not be dictated by a computer.

Consider Diagnostic Possibilities

Having completed a more detailed assessment, the clinician has nearly always gathered enough information to make a judgment as to whether the child is behaviorally, emotionally, or physiologically dysfunctional. As outlined earlier, the major categories of outcomes, behavioral dysfunction, temperament problems of "fit," and misperceptions by the caregiver were discussed in the previous chapter.

Determining Severity

When a dysfunction is identified, the next step is to assess its severity. Usually issues can be placed on a continuum from minor to moderate to severe. Ultimately the clinical judgment of the practitioner guides the categorization of this part of the assessment process. However, some guidelines may be helpful to the inexperienced clinician. Severe problems are those that significantly involve health, safety or welfare of the youngster or others in the child's life. This would include severe aggression to adults, peers, or siblings; acts of self-harm; and prolonged conflicts that endanger the situation at home or at school. Great anger or frustration in the parents are warning signs. A referral to Child Protection Services may be needed. In addition, disturbances that closely conform to known major DSM-V disorders, such as depression and anxiety, should be considered to be in the severe category. Mild problems would be suggested by issues that have just appeared, those that involve only one or a few common symptoms or complaints, and those that have been partially resolved already by the caregiver. Moderate problems are longer-standing, involve some areas of adjustment difficulty, and may previously have been addressed by the primary care professional but remain unresolved.

Some other suggestions for evaluating temperament traits.

The scales for evaluating temperament traits recommended in this book came directly from the conceptualization of Stella Chess, Alexander Thomas and colleagues. However there are several other researchers and clinicians who have

proposed some other possible ways of using them as such or as similar clinical categories derived from them. Those using single traits (e.g. sensitivity) or non-clinical schemes not included here.

1. Turecki, S, with Toner L: The Difficult Child. New York. Bantam. 1985. Rev. 2000.

2. Keogh BK: Temperament in the Classroom. Baltimore. Brookes Publishing Co. 2003.

3. Cameron JR, Rice D, Hansen R, Rosen D. Developing temperament guidance programs within pediatric practice. In Carey & McDevitt (Eds.) 1994.

4. Martin RP Temperament and education. In Carey & McDevitt (Eds.) 1989)

5. Kurcinka MS: Raising Your Spirited Child. New York. HarperCollins. 1991. Reissued 1998.

6. Kristal J: The Temperament Perspective. Baltimore. Brookes Publishing Co. 2005.

7. Neville H, Johnson DC. Temperament Tools. Seattle. Parenting Press. 1998, Rev. 2015.

8. Renner R: Is That Me Yelling? Oakland CA. New Harbinger Publications. 2014.

9. Mc Clowry SG: Temperament–based Elementary Classroom Management. Lanham, MD, Rowman & Littlefield. 2014

Summarizing the Diagnostic Data and Avoiding Labels

Having obtained this information called for by the algorithm, the clinician should be ready to proceed to the management of the problem, which will be discussed in the next chapter. Some will find it helpful to summarize the pertinent information in a way that avoids premature categorization of the situation. For those who want to make a truly comprehensive summary of what is and is not known at this point, the following table may be a helpful guide. Or it can serve as a reminder of what is and is not known at any given point. It should help the clinician decide whether enough is known to begin the process of management. It is as much a reminder of important aspects to include as it an obligatory exercise in all cases. Only more complicated ones call for this full degree of detail. Most will not.

Table 4.1: Comprehensive Formulation of Assessment

Caregiver's main concern: type, duration, frequency, severity, antecedents, consequences, response of caregivers			
Other caregiver concerns:			
Caregiver's goals and expectations:			
Significant Areas	**Strengths, Assets**	**Satisfactory**	**Problems—Deficiencies, Deviations**
Adjustment—Behavior, Emotional, Functional			
Behavioral competence in relationships—parents, sibs, peers, other adults	Skills, caring, cooperation, involvement, autonomy, amiable	Average	Aggression, opposition, withdrawal, unpopular
Achievements—task performance in school, home, community	High achievement, effort, motivation, satisfaction	Average	Poor achievement or failure

Table 4.1 (Continued): Comprehensive Formulation of Assessment

Significant Areas	Strengths, Assets	Satisfactory	Problems—Deficiencies, Deviations
Self-relations—esteem, care, control of feelings and actions	Good self-esteem, care, control	Average or mixture	Poor esteem; self-neglect, abuse; overcontrol; under-impulsive
Internal status—feelings, thinking	Contentment; thought clarity	Average	Anxiety, depression, thought disturbance
Coping—identification and solution of problems	Effective coping	Average	Poor problem solving
Symptoms of body function—eating, sleeping, elimination, gender, sex, pain, tics	Comfortable function	Normal concerns	Moderate-severe symptoms
Child Factors			
Physical—nutrition, growth, maturity, illness	Excellent health	Average	Significant health or nutrition problem
Neurologic—sensory, motor, reflex, coordination	Intact; good coordination, physical skills	Average	Central nervous system problems, especially sensory and motor
Development—motor, language, personal-social	Better than average	Average	Significant delay or deficiency
General cognitive skills (e.g., memory)	Good skills; above usual range	Normal	Deficit, disability
Specific cognitive skills—reading, spelling, writing, math	High level of skills	Average	Deficit, disability
Temperament social style—approach, adaptability, mood	Flexible, pleasant	Average range	Rigid, irritable, "spirited"
Work style—persistence, distractibility, activity	High performance style; task oriented	Average range	Low performance style

Table 4.1 (Continued): Comprehensive Formulation of Assessment

Significant Areas	Strengths, Assets	Satisfactory	Problems—Deficiencies, Deviations
Situational reaction style—intensity, threshold	Appropriate level of reactions	Average range	Explosive; overreactive or underreactive
Organizational style—regular, predictable, organized	Predictable, organized	Average range	Irregular, disorganized
Pervasive, extreme inattention or activity	Not present	Not present	"Hyperkinetic"
Environmental Factors			
Caregivers' contributions—structure-general capacity, commitment, availability, involvement	Good support	Adequate	Inadequate capacity, commitment, involvement; conflict
Sociocultural influences—relatives, neighbors, school, media, affluence/poverty	Supportive, not conflicting	Mixed	Major stressors (e.g., death, divorce, violence, conflict)
Physical—neighborhood, hazards, toxins	Good; healthy	Tolerable	Inadequate or hazardous
Interactions			
Goodness of fit—caregiver and child	Excellent; good	Adequate	Troublesome or poor
Contributions of caregiver to child—content			
Physical care (protection, food, housing, medical care)	Nourishing physical care	Adequate	Poor physical care
Stimulation—developmental, cognitive	Optimal quantity, quality	Adequate	Overstimulation or understimulation, neglect

Table 4.1 (Continued): Comprehensive Formulation of Assessment

Significant Areas	Strengths, Assets	Satisfactory	Problems—Deficiencies, Deviations
Interactions			
Affection—acceptance, intimacy, warmth	Good timing, quality, amount	Adequate	Overaffection or underaffection, hostile, abuse
Guidance—approval, discipline	Attentive guidance	Acceptable	Overguidance, underguidance, or inappropriate guidance
Socialization—teaching social relations	Healthy familial and extrafamilial socialization	Average	Aberrant socialization
Effects of child on caregiver	Predominantly positive	Average, mixed	Predominantly stressful, challenging
Comments:			
Summary and Diagnosis:			
Plans—service needs:			

Using DSM and ICD-10

A variety of formal diagnostic schemes are available to the primary care clinician. We authors prefer the process of determining and describing the various areas of function and malfunction mentioned in this book, rather than immediately seeking a label that supposedly defines the entire being of the child in 2 or 3 words. The simplicity of labels is appealing but their accuracy and precision are often in question. Labels may obscure the complexity of the child's unique state of adjustment. However, there are some requirements by formal record keepers, insurance companies, and others to fit in with their thinking. Since the fall of 2015, we are asked to use the ICD-10 terminology. How can the responsible clinician put together these two somewhat different ways of regarding a child? It should be possible for the well informed clinician to think in this book's more detailed terms about what is going on, discuss them clinically, and then select a suitable label to meet the administrative needs.

Giving Feedback to the Caregiver

Feedback to the caregiver should follow a similar process of providing a descriptive summary of the issues without attaching unnecessary labels that may negatively influence the caregiver's view of the youngster or the child's view of him- or herself.

Completeness is desirable, but endless insignificant detail is seldom necessary. In instances where the caregiver has misperceived the problem, feedback should be given in a supportive way that emphasizes the caregiver's concern for the child and promotes future communication about issues with the practitioner. In any case, if there is uncertainty about the caregiver's understanding of the situation, a helpful route to clarification is to ask the caregiver to indicate what he or she comprehends as of the present. Then the clinician can modify the content where needed.

The next chapter discusses in greater detail the management of these possible common omissions and mistakes.

1. Using an unreliable, poorly qualified behavior screen as a source for case finding.

2. Failure to have caregiver (parent, teacher, etc.) define goals for contact concerning the child's behavior. What are they asking for and expecting?

3. Not distinguishing promptly between problems that require just brief counseling versus those calling for more energetic and rapid intervention.

4. Not assessing or obtaining other adequate data on the child's developmental or cognitive status.

5. Omission of consideration of physical causes or contributions to problem: inadequate sleep, poor diet, toxin exposure, infection, etc.

6. Medicalization of mental status with uncritical acceptance of poorly supported theories of CNS malfunction: assumed chemical imbalances in brain, artifacts on brain scans, etc., (Francis A: 2013; Satel S., Lilienfeld SO., 2013; Whitaker R. 2010)

7. Not recognizing normal temperament differences as possible sole cause of the caregiver concern or as a significant part in the interaction producing the adjustment problem.

8. Ignoring social factors interacting with child and causing presenting concern: intolerance of diversity, popular misinformation, overstressed or uninformed teachers, bullying, abuse, etc.

9. Oversimplified blaming a variety of problems in adjustment on a single popular trait: inhibition, lack of "grit," resilience, executive functions, stimulation seeking, etc.

10. A pattern of making variations of normal into abnormal states or traits, referred to as

"pediatric pathogenesis." (Carey WB, Sibinga MS, 1972; also Coon ER, Quinones RA, Moyer VA, & Schroeder AR, 2014)

11. Inappropriate labeling based on use of current diagnostic schemes not suited to different needs of children. DSM. ICD. vs. BASICS

Chapter 5

Better Management in Primary Care

This booklet is intended primarily as an introduction of the reader to some improved techniques for assessing behavioral concerns arising in primary care. Yet, the authors would be remiss if no suggestions were offered about how to manage the problems thus revealed. Much current teaching, at least in the medical disciplines, is clearly inadequate to meet the needs of today's parents and children. In particular, the "medical model" of seeking and trying to use a unique, specific answer for every discrete problem has notable weaknesses especially when applied to behavioral matters. Instead of attempting to apply a standardized approach, rather describing and assessing the nature of the particular interaction between child and environment appears to be a more fruitful way to approach behavioral issues in early life.

Since pediatric medicine and child psychology and psychiatry became special areas of study and care in the late nineteenth century, the focus of interest has shifted considerably. Concern continues for the more serious problems but now extends to all levels of complexity. Professional persons like those in general primary care are now also expected to be knowledgeable and helpful in a wide range of matters of development and behavior from trivial to major, although many trainees have not been adequately prepared for this important role.

Promoting Normal

The best form of management is, of course, prevention. Much has been learned about the importance in particular of a healthy prenatal and early childhood period (Leckman & Mayes, 2007) but also of a multitude of other factors in the child and the environment (see Carey, Crocker, et al, 2009). If the clinician does not identify and support normal functioning, a major opportunity for building emotional and behavioral competence is lost. Promoting prevention often means attending to issues that are minor so that they do not escalate into more serious problems. It also means finding ways to improve the "fit" between children and their environments. Supporting child and family bonds as well as assisting families earlier in the process can go a long way toward preventing the appearance of emotional and behavioral disorders. Even problems that have increased to serious levels also need to be handled appropriately by the practitioner to minimize their potential negative consequences.

Returning now to complete the algorithm presented earlier (Figure 4-1), the management

of behavioral issues involves a consideration of what to do about the three principal diagnostic outcomes: aversive temperament traits, true behavioral dysfunction, and caregiver misperceptions of behavior problems.

Let us dispose right away of the attitude that all behavioral matters are enormously time consuming and therefore impossible for the busy primary care professional. We shall stress the point that in many instances a good listener with experience and common sense can do much good in a short time.

I. Temperament–Environment Misfits

In their seminal work Thomas and Chess identified nine specific temperament dimensions which interact with the environment to produce a quality of fit that ranges from optimal to highly stressful. In their observation of "goodness of fit" they discovered that any temperament trait may prove to be aversive to a family or other caregiver. No trait is always good or bad. Our clinical experience has shown that certain ones, such as low adaptability and negative mood, are more likely to generate disharmony with parents in most settings and tend to produce stress and reactive behavioral symptoms. But not always. On the adult side of the relationship, what matters most for "goodness of fit" is not one specific kind of temperament or parenting skill, although low adaptability and negative mood can be abrasive here too, but rather the thoughts, feelings, and practices generated by the parent's values and expectations. Expressed differently, a good fit with the parents depends on: a) how well the parents understand the nature and largely innate origins of the aversive and challenging traits; b) how well they have learned to tolerate these behaviors, which they probably did not cause and probably cannot change; and c) whether they have developed management strategies that are successful enough for dealing with them so as to diminish the interactional stress. The astute clinician can help with all three of these.

In the preschool years parents have to do most of the accommodation to reduce the interactional stress for both parties. As children approach 4 or 5 years of age, they can begin to learn to suppress at least the expression of traits interfering with relationships, for instance by using strategies for controlling high activity, shyness, or low adaptability in important situations. This suppression may be important as the child enters new environments where the accommodations provided at home may not be present, such as the classroom and playground at school, with a new caregiver or babysitter or in the community at the grocery store or in other public places. Aversive temperament traits may call for the development of "fit" in these new settings. Support for these adaptations may be sought from the professional by the primary caregiver.

Temperament Counseling

The process of helping with temperament "fit" has led to an area of professional practice referred to as "temperament counseling" (see Kristal, 2005; Carey & McDevitt, 1995), which is designed to improve the quality of the fit when working with children and families. There are several types of intervention associated with this process: 1) general education about the existence and nature of temperament, 2) development of an individual temperament profile, and 3) counseling directed at changing the environment to accommodate the specific behavioral style. Each of these approaches may be utilized by primary care practitioners, depending on their background and training in the area, their receptiveness to learning, and the severity of the problem being discussed.

1. Education about Temperamental Individuality

A common issue presented in primary care is the concern that, because a younger sibling behaves differently from an older one, the caregiver must have made some important mistake or must be parenting the younger one improperly. The assumption is that if everything were all right, the younger child would be following the same path as the first. Stella Chess, a child psychiatrist, used to say that everyone believes in the dominance of the environment until they have their second child! Although the environment remains important, the biologically based temperament of each child tends to drive patterns of behavior in certain ways, and normal children with different patterns of behavior nearly always behave differently because their temperaments are not the same. Educating caregivers generally about this process can be immensely helpful, by reassuring them that they have not necessarily done anything wrong and by helping sensitize them to the individuality of their children. These discussions are generally brief but seem to have a positive, long-lasting impact. See the resources listed below concerning background reading for caregivers, which can augment understanding and strategies.

2. Developing an Individual Temperament Profile

Chapter 3 described how it is possible to approximate the results of a formal questionnaire using The Clinician's Impressions of Child's Temperament (Table 3.5). Because of its simplicity and brevity it may be a good first step in appraising the individuality of the child in question before advancing to the greater complexity of the questionnaire. Only parts of it are likely to require completion and it may be all that is needed.

In situations where the behavioral concerns are sufficiently great, simply identifying the existence of aversive temperament traits may not be enough. In these cases, developing a more detailed individual profile of temperament using a standardized questionnaire can aid in delineating the child's behavioral style areas that contribute

to the poor fit. The Carey Temperament Scales were designed for this purpose and involve parent ratings of the 9 specific temperament related behaviors, general impressions of temperament, and an overall rating of behavioral manageability (available at www.b-di.com/resources). They take about 20 minutes for the caregiver to complete and 10 minutes to score by hand or 2-3 minutes using the scoring software.

These data, combined with interviewing and direct observation of the child, allow the professional to assess accurately the temperament qualities by looking for convergence of results using all three methods. The assessment will also determine areas where the caregiver's view of the temperament is not consistent with their ratings of the child, and how much difficulty the temperament presents in managing the child. All of this information is helpful in assisting caregivers in "tuning in" to the child's individual nature and improving the accuracy of their view of the child. Also, knowing the degree of impact of the temperament qualities can guide the clinician in determining the extent and direction of intervention that will be needed to have an effect on the problem. Temperament ratings can be determined prior to a pediatric visit using ipasscode.com if the caregiver is technically aware and can use this internet based technique to complete the needed questionnaire. Or the questionnaire can be mailed out to the parent, returned, and scored prior to the consultation. Otherwise, a second visit is needed to go over the results of the questionnaire, discuss it, and give suggestions about improving

fit. Another visit or follow-up telephone call is usually needed to evaluate results of the intervention and possibly to refine or revise the procedures.

A different option for obtaining this supplementary help would be from a well- trained pediatric nurse practitioner (Kolko, Campo, Kelleher, Cheng, 2010).

Many primary care clinicians will be able to carry out this process but some will refer to a behavioral specialist familiar with temperament assessment and intervention if the time commitment needed for the intervention exceeds a couple of sessions. Such well-informed professionals are not easily found at present. The recent development of the ipasscode.com system may facilitate having results available on the second visit by using internet-based questionnaires and scoring (see www.ipasscode.com/register). Often the real benefit of developing a detailed profile of temperament is the increased awareness felt by the caregiver of the child's true nature and the enhanced feeling of closeness with the youngster. For a caregiver who was struggling with the child's behavior and feeling frustrated, guilty and powerless about it, this can be a real relief and represent the beginning of significant positive changes in their relationship.

3. Interventions to Accommodate Temperament

There are times when the clinician will be able to determine where the problems of fit with temperament are occurring and the strategy for managing the conflict will be to advise the caregivers to change their view or response to the child to improve fit. This is the essence of temperament counseling, and suggesting changes in how a conflict is handled or designing ways to accommodate the temperament can be accomplished with or without a detailed temperament profile. Temperament counseling has been shown to be effective in reducing behavioral concerns and unnecessary clinic visits in a large HMO (Neville and Cameron, 2010; Kristal, 2005).

The most important goal is helping the caregiver understand the need to work around the child's temperament rather than try to find ways to force the child to change his or her reactions. For example, frequently caregivers view gradual adjustment as noncompliance and try to punish the child for it. There is no amount of punishment that will make an inflexible child more adaptable. Rather, the focus should be on ways to prepare the child for upcoming change and to increase tolerance for the time it takes to shift to accepting the required change. This accommodation process involves avoiding unnecessary interactional stress but not does not mean giving in completely to the child. The following table offers a summary of such approaches for parents trying to cope with various normal but annoying traits.

Table 5.1: Management of Temperament Differences

HIGH ACTIVITY Help the child find ample opportunity for physical activity. Avoid unnecessary restrictions of activity. Demand restraint of motion appropriate for age when necessary.	**LOW ACTIVITY** Allow extra time to complete tasks. Set realistic limits, such as meeting the school bus on time. Do not criticize slow speed.
HIGH REGULARITY In an infant, plan feedings and other activities on a schedule. In an older child, advise of expected disruptions of the schedule.	**LOW REGULARITY** In an infant, first try to accommodate the preference for irregularity, then gradually steer her toward a more regular schedule. An older child can be expected increasingly to regularize his eating and sleeping times, even if he does not feel hungry or sleepy on schedule.
APPROACHING OR BOLD INITIAL REACTION Reinforce with praise if positive. Remember that the initial positive reaction may not last. Be aware of the child's boldness in dangerous situations.	**WITHDRAWING OR INHIBITED INITIAL REACTION** Avoid overload of new experiences. Prepare the child for new situations and introduce her to them slowly. Do not push too hard. Praise her for overcoming her fears of novelty. Encourage self-management as the child grows older.
HIGH ADAPTABILITY Look out for possible susceptibility to unfavorable influences in school and elsewhere.	**LOW ADAPTABILITY** Avoid unnecessary requirements to adapt. Reduce or spread out necessary adaptations, arranging for gradual changes in stages. Do not push too hard or too quickly. Give advance warnings about what to expect. Teach social skills to expedite adaptation. Maintain reasonable expectations for change. Support and praise effort.

Table 5.1 (Continued): Management of Temperament Differences

HIGH INTENSITY Intensity may exaggerate the apparent importance of response. Avoid reacting to the child with the same intensity; try to read the child's real need and respond calmly to that need. Do not give in just to make peace. Enjoy intense positive responses.	**LOW INTENSITY** Try to read the child's real need, and do not mistake it as trivial just because it is mildly expressed. Take complaints seriously.
POSITIVE MOOD Encourage positive and friendly responses. Look out only for those situations in which your child's outward positive behavior may mask true distress, such as with pain, and situations in which being too friendly may be troublesome, such as with strangers.	**NEGATIVE MOOD** Remember that it is just your child's style, unless there is an underlying behavioral or emotional problem. Do not let the child's mood make you feel guilty or angry; his mood is not your fault. Ignore as many of the glum, unfriendly responses as possible; however, try to spot and deal with the real distress. Advise an older child to try harder to be pleasant with people.
HIGH PERSISTENCE AND ATTENTION SPAN Redirect a persistent toddler whose persistence is annoying. In an older child, warn about the need to end or interrupt activity when continued for too long. Reassure the child that leaving some tasks unfinished is acceptable.	**LOW PERSISTENCE AND ATTENTION SPAN** The child may need help organizing tasks into shorter segments with periodic breaks; however, the responsibility for completion of the task belongs with the child. Reward the adequate completion of the task and not the speed with which it is done.
HIGH DISTRACTIBILITY If the problem involves an older child, try to eliminate or reduce competing stimuli. Gently redirect the child to the task at hand when necessary; however, encourage the child to assume his own responsibility for doing this. Praise adequately for completing the task.	**LOW DISTRACTIBILITY** If the child ignores necessary interruptions, do not assume it is deliberate disobedience.
HIGH SENSITIVITY Avoid excessive stimulation. Eliminate stimuli if disruptive. Avoid overestimating extreme responses to stimuli. Help the older child understand this trait in himself. Support and encourage the child's sensitivity to the feelings of others.	**LOW SENSITIVITY** Look out for underreporting of pain and other distress. Help the child develop an awareness of important internal and external stimuli. Help child to develop greater sensitivity to the feelings of others.

This table details the most common strategies for dealing with high and low temperament characteristics. Generally the more extreme the child's score in an area the more likely it is to be noticed, either as a risk factor for poor fit or a protective factor that maintains good fit. With experience, clinicians can learn to adapt the strategies detailed in this table to multiple situations where temperament related conflicts and stress are being experienced at a number of different ages and stages of development. When combined with practical suggestions and caregiver guidance, solutions can usually be achieved without resorting to outside referral for specialty care. Professionals frequently find that working together with parents to resolve these issues improves goodness of fit and and strengthens the child-caregiver bond in significant ways.

Readings about Temperament for Caregivers

Several books are available to provide more detailed suggestions for parents and clinicians (see end of this chapter). It is frequently supportive for the practitioner to suggest these resources when the caregiver seems unfamiliar with the notion of behavioral individuality, when the mismatch with the child seems to be pervasive rather than situational, and when the caregiver seems inclined to use such resources. In many cases caregivers mention having looked on the internet or read other books or articles while searching for answers; these individuals seem most likely to benefit from reading about temperament. An invitation by the clinician to discuss the impact of their new knowledge at a future visit can also be welcome. Having the opportunity to apply what they learn about temperament to their own child can be a motivating factor for most caregivers.

See also a more complete listing of such resources as on page 40 in the previous chapter. They have their unique features such as Kurcinka's (1998) emphasis on the positive aspects of traits commonly considered "difficult."

II. Behavior Problems without Obvious Temperament Involvement

Following the algorithm presented in the previous chapter, when there is evidence of behavioral dysfunction, the clinician determines how severe the problem seems to be. The direction management should take is based on this assessment. Minor problems like nail biting or thumb sucking can be disposed of in the course of a single routine office visit. Very serious ones like major anxiety, depression, conduct disorder, or dangerous levels of disobedience should be referred immediately to an appropriate mental health specialist. However, the great majority of parental concerns lie somewhere in between these extremes: questions of ordinary noncompliance, aggression, or physical function troubles.

This is the area of practice where the average primary care clinician often feels very inadequate as he or she mentally reviews a limited inventory of procedures for an acceptable standard solution to the question, such as time out. What practitioners may not realize is that there may be more than one suitable path to follow, and that the answer for this specific situation can usually be readily found by having the caregiver describe some illustrations of the problem and the interactions involved. With a

frequency that is astonishing to some, the problems in the interaction usually emerge within minutes and strategies for improvement become clear with unexpected speed. This process is called parent counseling because it attempts to alter the parent-child interaction. It is not psychotherapy, which tries to alter the internal organization of the parent or child. As much as possible the newly enlightened parents should be encouraged to discover for themselves some fitting answers to the situation rather than having them dictated by the clinician. In that way their self-reliance and competence can be fostered. Nearly always, brief parent counseling should be limited to the specific issue presented and focus on agreement between the professional and the caregiver as to the course of action. In some situations it becomes evident that the participation of other family members is necessary or that the problem presented represents just a small part of a larger issue with the youngster or the family. Staying within the scope of the practitioner's expertise and time resources, the clinician may choose to refer the caregiver to a specialist for these more extensive problems. In addition, situations where previous primary care interventions are not effective or only partially successful should suggest that the problem is beyond the purview of intervention in a primary care setting.

As with temperament intervention, there are a number of effective programs available to assist caregivers with behavioral dysfunction issues (Webster-Stratton, C., Hollinsworth & Kolpacoff, 1989). Frequently the caregiver may need a solution that addresses several minor issues simultaneously. These programs may depend on the use of redirection, behavioral modification, or logical consequences for behavior. When the family is receptive to this type of intervention, suggesting a well-designed program will direct the caregiver to a systematic approach which can improve behavior as well as provide valuable consistency in addressing issues in the child's environment.

The form that psychotherapy may take is likely to be unclear at the outset to the referring primary clinician. Professionals wanting to review the varying value of the several modalities can make use of comprehensive reviews such as "What Works and for Whom? A Critical Review of Treatments for Children and Adolescents" (Fonagy P., Cottrell D, Phillips J., et al. 2015.)

III. Behavior Problems in which the Child's Temperament is a Contributing Factor

In situations where the child's temperament contributes to behavior problems, the management is similar to the brief counseling approach just described above but differs in two significant ways. First, if temperament traits perceived as aversive are present in the dysfunctional interaction, this provides a partial explanation for how the troublesome reactive behavior came about. It may be helpful in explaining why this one sibling or one classmate developed problems in a specific situation while another did not. Adding the temperament factor to this discussion may clarify for the caregiver one of the sources of the friction in the relationship and increase the accuracy of their view of the situation. Second, this knowledge should affect the aims for management.

Put simply, the plan is to alter the behavior and to identify and accommodate any temperamental contribution to the inappropriate behavior. While

appropriate parent counseling should alter the interaction enough for the presenting symptoms to decrease or disappear, it is not likely to alter the temperament or its expression. For example, extensive oppositional responses may be greatly reduced but the underlying temperamental inflexibility will probably remain and require continued surveillance. Here the approach to management is twofold: 1) deal with the behavioral problem itself and 2) provide temperament counseling to identify the behavioral style in question and suggest ways to cope with the youngster's expression of temperament. Follow-up visits should include monitoring of the youngster's temperament and determine how the family is managing and whether further discussion of temperament would be helpful.

Thus, a brief summary of the use of temperament determinations in the management of children's behavioral concerns is this: If there is parental or teacher concern but no dysfunction, then it may be the normal temperament that is bothering the adult. If there is a dysfunction, or behavioral adjustment problem, and it can be determined to arise as the result of a conflict between the child's temperament and her environment, then both accommodation of the temperament and behavioral management of the reactive adjustment symptoms are indicated. The pathology in these cases is in the interaction, not the child's brain chemistry (Carey, 2009).

IV. Management of Parental Misperceptions and Misinterpretations

In Chapter 4 a category of outcomes was identified which involved problems presented by a caregiver who misinterprets some normal behavior as abnormal. It was suggested that the clinician determine whether the problem presented was a misunderstanding of normal behavior due to inexperience, or a distortion of perception due the psychosocial problems of the caregiver. The management depends on which of these two situations is present. When normal behavior, such as the well-known seeking of autonomy by toddlers, has been misread as a problem, the principal task of the clinician is to supply information about the normality of the situation. This reassurance is clearly within the primary clinician's range of competence. The clinician should always do some sort of follow-up to be sure that the assurance of normality has been accepted and utilized. If this counseling is properly done and there are no complicating issues, there should be a favorable resolution of the doubts.

In the second instance, where the caregiver is overwhelmed by other stressors and misperceives problems in normal child behavior, the clinician's role is to listen supportively and reassure the caregiver about the child's normality, while suggesting appropriate help for the psychosocial stressors responsible for the misplaced concerns. This may require the help of professionals who are better trained for this activity. If a normal child is perceived and treated as abnormal, he or she may become abnormal.

The Role of Medication for Behavior

The question of using medication for the management of behavioral problems is too vast and complex to be reviewed adequately here. There can be no question that psychotropic pharmaceuticals are being greatly overused in the United States. This

matter was mentioned earlier in Chapter 2. The fact that one American child in 10 is receiving medication to alter his or her behavior should arouse major concern among the health professions, the government, and the general public. Some of the reasons for this abuse are related to issues discussed in previous chapters:

1. Widespread ignorance among clinicians, both academic and community, about the nature and extent of normal temperament has led to frequent mistakes of overdiagnosis. The normally shy child may be misinterpreted as having a social anxiety disorder.. The normally active child (50% are by definition are more active than average) may be incorrectly seen as hyperactive. The intense child may be given the abnormal label of explosive or bipolar. Most of the two sets of nine DSM criteria for ADHD can be variations of normal, such as “Often talks excessively” or “Often has difficulty awaiting turn.” And there is no evidence that any of these “symptoms” is the result of this presumed “neurodevelopmental disorder.” These major problems have evidently been ignored by the DSM committee.

2. For lack of a sufficiently broad diagnostic system, the unwary clinician may be tempted to employ more serious categorical DSM terminology that does not truly fit the individual child in question. The BASICS system described above, which is developmental and interactional, or some similar scheme, should help with this confusion, acknowledge normal variants, minimize the overdiagnosis of psychopathology and minimize inappropriate use of drugs. (see

Carey, 2002.) We await the general acceptance of this more rational system or something like it.

3. Other nonclinical factors leading to medication overuse include the corrupting enticements of the pharmaceutical industry and various practice performance pressures that impinge on busy professionals.

In some cases medication has proven to be both effective in lowering symptom expression and reasonably safe. However, concern is mounting that the use of medication is getting out of control (Parens & Johnston, 2011). Of particular concern is the increased risky use in very young children of powerful and unproven substances (Egger, 2010). The most popular and enthusiastically supported role for medication use, methylphenidate for ADHD, has been shown to have been oversold by the experts. The eight-year follow-up of the MTA study has revealed that, while the stimulant does provide some temporary but decreasing relief from the "core symptoms" (activity, inattention, impulsivity), it does not eliminate them and does nothing by itself to solve the resulting behavioral and scholastic dysfunctions (Molina, Hinshaw, Swanson, et al., 2009).

Clinicians in primary care who prescribe medication for behavior should be alert to the limitations of this approach, and to the potential hazards from some of the more powerful substances, particularly the so-called "antipsychotic" agents. Competent, comprehensive textbook reviews of psychopharmacology are available, such as a 25-page chapter in Carey, Crocker, Coleman, et al. (2009).

Allied Services

Valuable services rendering help from psychologists, occupational therapy, speech therapy, special education, social work, and other allied professionals may be accessed by referral from primary care professionals. Descriptions of them are beyond the scope of this brief book (See Carey, Crocker, et al, 2009). Furthermore, eligibility to receive allied services may be deeply affected by state or local statutes or by insurance reimbursement policies. Nevertheless, interdisciplinary collaboration can greatly increase the effectiveness of the intervention.

Logistical Issues

Big obstacles remain for many professionals in gaining sufficient clinical time to handle behavioral matters responsibly and for a reasonable payment schedule for time spent accomplishing this end. It is hoped that policy makers will be enlightened by understanding the financial and therapeutic benefits of improving the care of children and families in the primary care setting, especially when it is effectively preventive. The American Academy of Pediatrics (www.aap.org) has developed a Current Procedural

Terminology (CPT) coding system that has identified the existence of initial visits of up to 40-60 minutes (99215, 99205) and 96127 for various emotional or behavioral assessments but their acceptance by third-party payers is uncertain. One should check with the AAP for the latest information about the status of these codes.

Many professional clinicians in primary care insist that dealing with behavioral issues invariably requires more time than is available. Of note, however, is the fact that one of us (WBC) found that in 31 years of primary care pediatrics it was possible to handle the great majority of the behavioral

concerns discussed in this book during the course of a routine office visit. Only infrequently was more time or a referral needed. Much can be achieved in well-directed, brief interventions.

Selected Books on Temperament for Professionals

1. Carey WB, McDevitt SC: Coping with Children's Temperament. A Guide for Professionals. New York. Perseus. Basic Books. 1995.

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Chapter 6

Prospects for Improvement in What We Understand and Can Do Clinically

The previous edition of this book offered a concise review of currently available objectives, diagnosis, and management of behavioral concerns as encountered in primary health care. Beside updating, another reason to write this new edition has been to take stock of how far the science and art have advanced toward optimal standards of care in recent decades and of which areas are in greatest need of improvement. This review goes back much farther than just the last four years since the first edition and also looks forward into the indefinite future. These matters should be of interest not only to practitioners but equally to educators and researchers. This chapter will deal first with the positive accomplishments achieved, particularly during our professional careers, and then list the matters that can and should be improved to enhance what we understand and can do in primary care and elsewhere.

Positive changes

In the 65 years since the first author (WBC) started his medical studies there has been much progress in what we know and can do about the behavior of children.

1) Behavioral, emotional, and functional variations and problems are much better understood now. No longer are they blamed almost entirely on the environment and particularly on mothers. For example, autism and learning disabilities are no longer somebody's fault. Greater complexity in nature and nurture causation is now generally recognized.

2) There is a greater tolerance of a wider range of normal such as gender discordance and sexual preference matters. At the same time there is now less tolerance of ignoring serious problems previously largely overlooked like child abuse and bullying.

3) A more consistent delineation of abnormal behavior is now possible with the arrival of the first version of the DSM series in 1952. However, the continuing deficiencies of even the recent fifth version of this list in 2013 are numerous, as mentioned previously and below.

4) In addition, developmental screening and assessment are now within the capacity of well-trained practitioners of primary care.

5) Some enhanced diagnostic techniques are now available such as brain imaging but they have not been developed yet to a degree of accuracy and specificity one might hope for. The history of the problem by interview, observation and standardized assessment procedures continues to be the best method.

6) More treatment options are available. The most dramatic ones are medications, which sometimes cause a remarkable improvement but too often are inappropriate, ineffective, toxic, or

too poorly studied. Evidence-based psychotherapies have been found to be useful for treatment in a number of areas. Consultation and parent training programs with caregivers have been offered by a number of professionals.

7) Some of the failures of the past like lobotomies, warehousing, facilitated communication, and patterning have apparently gone away.

Continuing controversies, confusion, and problems.

Much remains to be done to promote the efforts of those of us in primary care who want to be as helpful as possible for troubled children and their caregivers. Most of these matters have been alluded to in previous chapters but are presented here in summary.

1) Definition of normal. Professionals need to agree on what properties make behavior content and style normal. Normal temperament has been well described but definitions of normal adjustment are harder to find. Medical science apparently lacks any established comprehensive catalog of the full range of human behavioral adjustment that can be considered normal. The prominent DSM series is a list of descriptions of how adjustment can go wrong but normal is not included or acknowledged in any way. The great majority of children seen in primary care are normal or have mild or temporary behavioral issues. A model of behavioral adjustment that defines these patterns and differentiates them from the much smaller group of children with emotional or behavioral disorders is essential to provide appropriate care to all.

The authors have offered here (Chapter 3) and elsewhere the BASICS outline of significant aspects of behavior, normal or not, to be recognized but this view or anything else like it has not been accepted by the DSM committee or any others who only consider pathology. We have argued that appropriate family and interpersonal relationships, achievement within the range of capability, a realistic sense of self, freedom from internal distress, adequate coping skills, and fairly comfortable physiological function define normal adjustment. Further, most youngsters most of the time are characterized by these qualities and do not need professional help While consensus on a definition of normal may be elusive, the BASICS paradigm offers a starting point for discussion of how to define the range of adjustment from normal to optimal and contrast it with our many definitions of dysfunction and abnormality.

Behavioral style or temperament, despite its primary modern development by psychiatrists Stella Chess and Alexander Thomas, is largely ignored by the medical specialties of psychiatry and pediatrics with the unfortunate result that some normal traits like high activity or initial inhibition are frequently misdiagnosed as abnormalities of adjustment or are considered to be “subthreshold” abnormalities. While severe or long standing temperament-environment conflict has been shown to be a source of behavioral problems, the temperament is probably normal though the emotional and behavioral issues are not. Clearly distinguishing the qualitative difference between the two areas is essential; their coexistence does not make them the same.

Developmental psychology has apparently

labored under a similarly limited view of adjustment. The Big Five of adult personality psychology (Openness, Conscientiousness, Extraversion, Agreeableness, and Neuroticism or negative emotions) (Eysenck, 1994) have been embraced by many as a suitable comprehensive view also by those studying children, in spite of their failure to include common areas of clinical concern by their caregivers, such as amount of social skills, degree of performance at school and elsewhere, levels of self-esteem, self-care, and self-restraint, coping skills, anxiety and depression, and physiological disturbances like feeding and elimination problems.

Lacking a sufficient description of normal adjustment appears to explain why some academic temperament researchers are now treating areas of adjustment as aspects of temperament, for example executive functions and self-restraint. This confusion is not inconsequential. It matters to us clinicians because temperament and adjustment are different in origins, appearance, and management. Temperament traits are "primary reactive patterns" which appear earlier and are harder to change than aspects of adjustment which develop later and are more likely to respond to appropriate environmental interventions.

At the same time an increasing number of publications have described traits already reported by others, given them new names, and their importance enthusiastically proposed as if for the first time. The approach/ withdrawal trait of Thomas and Chess has been reborn as uninhibited/inhibited. Persistence is now being emphasized as "grit." Adaptability is being reintroduced as the essence of resilience. Intensity may be labelled as bipolar. A high personal sensory threshold may be seen as a callus unemotional trait. Unemotional hesitation with novelty may be misinterpreted as fear. Stress may be "toxic" but primarily for the temperamentally vulnerable. Our terminology has become excessively confused.

2. Definition of abnormal. The weaknesses of the DSM system have been mentioned already and do not need to be detailed at this point. One wonders when the authors of that prestigious volume will recognize that many here and abroad are waiting eagerly for something better. The now moribund DSM-PC (1996) (DSM for Primary Care- Children), abandoned by its parent, the American Academy of Pediatrics, should be revived and extensively remodeled. In particular, the vague definition of ADHD is greatly in need of clarification especially as the diagnosis is spreading rapidly throughout the world in part because of the looseness of that definition. (Carey, 2002).

General agreement apparently supports the definition of abnormal as including behavior that is atypical and harmful to somebody, and not just annoying. A screening test that just picks up annoying temperament traits is not a valid detector of behavioral abnormality as may be claimed. We can agree that the abnormality is more serious when it cannot be improved by altering the relationships with the environment.

3.) What causes abnormal?

The shift from "psychobabble" to "neurobabble" has been mentioned (Carey, 2011b). This change has also been referred to as going from

"brainless" to "mindless" resulting with an accompanying alteration in emphasis from blaming and treatment of the environment to managing the brain. The best answer to the question of etiology continues to be recognition of the importance of both nature and nurture and their interactions.

4) Other concerns. There are other ways in which we need to do better: the process of diagnosing problems, managing them, and finding time and space to do as well as possible. Please see the earlier chapters.

What to do?

1) We can be thankful that much progress has happened during our professional careers, but we need to push for a great deal more.

2) We at the primary care level must keep ourselves informed of new information from responsible publications and mentors.

3) We must be skeptical about opinions or rumors or preliminary reports not backed up by sufficient good science. We should remain alert for the unsupported speculations and retractions that come so frequently.

4) Let us avoid vagueness in thinking and excesses in enthusiasm for inadequately reviewed drugs or other modalities of treatment.

5) We should support appropriate research whenever possible.

6) And let us encourage and participate in the education of current and future primary care practitioners. Our occupation is a vital one.

Chapter 7

Conclusions

To provide a suitable conclusion to this slim volume, the contents should be summarized and readers urged to raise their level of clinical competence and to enrich their practice experience by utilization of the strategies presented here. Based upon years of clinical experience with children and families, the authors have questioned the utility of the normal vs. disease conceptualization as it applies to emotional and behavioral development. Practitioners are confronted with a wide range of issues that do not approach the severity of DSM disorders, and dealing with, rather than dismissing, these problems represents a useful and satisfying role in primary care. Individuals who are prepared to deal with prevention and early intervention activities are well versed in the following areas: 1) recognizing the importance of behavioral style or temperament; 2) understanding the outlines of normal behavioral adjustment, and 3) dealing with parental perceptions of problem behavior that may need to be clarified or reframed. Skill in assessing and intervening in these cases within the primary care context adds a valuable service to youngsters and their families. Unfortunately, these skills are currently uncommon in practice due to a lack of professional education and awareness.

Summary

The introduction explained the authors' aim to present a review of the best of the theoretical and practical advances in the last half century, those that would be most likely to facilitate the process of understanding and managing common behavioral concerns in children's primary care settings.

Chapter 1 described the dilemma of primary care practitioners, as presently trained, in knowing how to evaluate and manage successfully the variety of common problems presented to them, such as noncompliance, night waking, and prolonged crying. Examples that highlight the deficiencies in understanding many of these issues demonstrated the limitations of the current system and the need for a broader view of how child behavior in primary care is evaluated and interpreted.

Chapter 2 reviewed the several specific obstacles presently interfering with the provision of good care. Those identified are: 1) widespread deficiencies in professional training, such as an overemphasis on major physical illness in medical preparation, at the cost of an adequate familiarization with significant behavioral issues; 2) theoretical and technical problems—lack of clear definitions of normal and abnormal behavior and of sufficiently reliable methods of diagnosing and managing them; and 3) logistical and practical limitations, such as finding sufficient time to do the job right and getting insurance companies to recognize both the practical and economic value of these activities.

Chapter 3 described the three general kinds of caregiver concern presented in primary care: 1) true dysfunction in behavior, emotions, or physical symptoms, which include but are not limited to the DSM-V disorders; 2) normal but aversive temperament traits when they interact with their

context to produce a poor "fit" with or without resulting dysfunction; and 3) caregiver misperceptions or misinterpretations of behavioral abnormality where none can be identified, due to the caregiver's inexperience or to an inaccurate opinion distorted by their own psychosocial problems or stressors. Better methods for recognizing and assessing all three types of concerns were presented.

Chapter 4 offered a unique algorithm to guide the overall assessment process from the initial presentation of caregiver concern to the ultimate diagnostic outcome and management disposition. Also delineated was a form for a comprehensive formulation of the assessment, which could greatly improve upon the current practice of simply listing a collection of problems without mentioning assets or strengths that may lead the professional to effective strategies for resolution.

Chapter 5 described a perspective designed to improve behavioral management in primary care. Better approaches start with promoting normal behavior. The presentation outlined the major elements of temperament counseling, leading to a reasonable accommodation of the child's special needs. For dysfunctions without temperament involvement a more sophisticated approach than the currently popular prescriptive advice was proposed: exploring the conflicts in the parent–child relationship for clues as to what needs to change. When the temperament is a contributing factor in the dysfunction, both the dysfunction and the temperament require specific attention. Depending upon the source, parental misperceptions of nonexistent problems call for caregiver education about normal behavior or guidance directed toward an improved perspective and perhaps help for their own problems. The refinements proposed in this chapter should result in better diagnosis and behavioral management, which would undoubtedly reduce the currently excessive use of psychotropic medications.

Chapter 6 has been added since the earlier version of this book. It recognizes the many ways in which the science and art have become better in the last half century, but a continuing improvement of primary care efforts requires clarification of what is normal, what is abnormal, where they come from, how they are best assessed and managed. There is a pressing need to reduce the confusion in how these matters are viewed by professionals.

Prospects: A personal note

The reasons for assembling this book were both the social aim of trying to raise the level of primary care practice and the personal objective of enriching the quality of the individual professional experience of those committed to a career in primary care. The first reason requires no justification but the second one may need some clarification.

Persons involved in primary care with children (especially the pediatricians with whom I [WBC] am particularly well acquainted), are predominantly an exemplary group with a strong devotion to the welfare of the young. Most have reasonably satisfying careers. However, far too many do not for a variety of reasons. Observations formed during 60 years in pediatrics, most of the time in primary care, helped me understand who are the persons who do and do not feel that their professional time has been spent as well as possible. Those who concern themselves only with the rapid service of the "formula and shots" orientation, being involved only

with children's physical status and common illnesses like asthma and otitis media, have spoken less frequently of the gratifying life they are leading. They have in my experience had a high attrition rate to other areas of medicine, administration, or industry, and they retire as soon as they are able. By contrast those who are interested in their patients as complex developing fellow humans, whose lives can be favorably influenced by the pediatrician's broader involvement in their adjustment and relationships, give evidence of a higher degree of fulfillment in their work.

The aim of this book has been to advance primary care practice for these two reasons: better care and more satisfied clinicians. These goals are within reach but will require a major effort on the part of both the professional educators and the practitioners. But remember what Mark Twain said: "Loyalty to petrified opinion never yet broke a chain or freed a human soul." (Inscription beneath his bust in the Hall of Fame.)

NOTE: The forms published in this book are available for use by clinicians in primary care practice and by educators. To obtain a full-size paper copy of this work, go to the B-DI website and look under Books for Professionals for details about purchasing this version: http://www.b-di.com/CBAM2.html.

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Appendix: Forms for Use in Primary Care

Note: Forms may be copied from the print version of this book for professional use.

1. Comprehensive Profile of Behavioral and Emotional Adjustment

2. Clinician's Impressions of Child's Temperament

3. Comprehensive Formulation of Assessment

4. Management of Temperament Differences

Comprehensive Profile of Behavioral and Emotional Adjustment for Ages 4-14

Child name: _____ **Rating date:** _____

Areas of Adjustment—Definitions	Ratings and Comments
Behavior, social competence- Relationships with people: How well does child get along with people? • High social skills vs. deficit. • Caring vs. hostile, aggressive, destructive. • Cooperation vs. opposition, defiance, manipulation. • Involvement vs. withdrawal. • Autonomy vs. dependence, overconformity.	a) Highly competent, pleasant, likeable. b) More pleasing, likeable than average. c) Gets along moderately well. Average. d) Some significant relationship problems, not major. Conflict with parents, siblings, teachers or peers. e) Generally unpopular, often rejected. Frequent severe incidents, real or threatened exclusion from relationships. Comments
Achievements Task performance: school, home, other. How well does child do tasks and play? • Extent of achievement. • Skill development, utilization. • Motivation, effort, interest, responsibility. • Satisfaction, pride in accomplishment.	a) Excellent achievement. b) Good achievement. c) Average, satisfactory achievement. d) Underachievement, not failing. Excessive striving. e) Poor achievement, failing. Truancy. Comments:
Self relations Self-assurance and management. How does child feel about and manage self? • Self-esteem: mental and physical abilities, appearance, social worth. • Self-care vs. neglect, abuse, risks, overconcern. • Self-regulation: appropriate vs. over-or under-regulation.	a) Excellent self-esteem, care and regulation. b) Good status in these areas. c) Variable, average status. d) Below average in some of these matters. e) Poor. Problems in some or all these areas. Comments:

Areas of Adjustment—Definitions	Ratings and Comments
Internal status General contentment vs. disturbance in feelings or thinking. How does child feel and think? • Feelings: degree of comfort or discomfort. • Thinking: clarity and reality vs. distortion.	a) High but reasonable contentment. b) Comfortable feelings and thinking. c) Average mixture of concerns. d) Unsatisfactory. Disturbing but not crippling feelings of fear, anxiety, depression, anger, guilt; or reality distortions, phobias, obsessions, compulsions, delusions. PTSD. e) Poor. Major disturbance of feelings or thinking. Comments
Coping Problem solving. How well does child identify and solve problems? • Identify problems vs. denial. • Plan solution vs. avoidance. • Work on solution vs. passivity. • Persist at solution vs. give up. • Makes needed revisions vs. perseveration. • Seek appropriate help vs. not.	a) Highly effective coping. b) Generally effective coping. c) Satisfactory. Average. Variable. d) Unsatisfactory coping. e) Poor problem solving. Excessive use of defensive strategies—denial, giving up, etc. Comments:
Symptoms of body function General comfort of body functions vs. discomfort or dysfunction. • Eating. • Sleeping. • Elimination. • Gender. • Pains. • Repetitive behavior.	a) Comfortable in all areas. b) Generally good function. Only minimal concern. c) Some concern. Within normal range. d) Significant concern. Not severe. e) Major concern. Comments:
General assessment:	
Main service needs:	

Clinician's Impressions of Child's Temperament

Based on Interview and Office Observation This checklist is designed to aid child health professionals in obtaining a rapid survey of any temperament traits causing concern. It reminds the clinician of the main areas where the trait may be described or observed. All items for each trait may not apply to all children, especially younger ones. Those appropriate for infants and toddlers come first. This checklist produces a broad description, not a score or diagnosis.? = Does not apply or do not know. B stands for Bother. Check if this specific item is a problem for the caregiver. For standardized questionnaires assessing temperament and/or behavioral adjustment go to www.b-di.com

Child name: _____ **Age:** _____ **Rating date:** _____

Professional rater: _____ **Parental informant: Rhythmicity** _____

Activity: amount of physical motion	Hi	Med	Low	?	B
During sleep					
During meals					
During play					
During car rides					
During dressing					
Rate of eating					
While waiting					
Going up, down stairs					
Walking with family					
Listening to music					
Watching TV					
Entering, leaving house					
Talking with parents					
Approach/ withdrawal: initial reaction to novelty	App	Med	Wth	?	B
New foods					
New sitter					
New place					
New clothes					
Visitors in home					
Stranger elsewhere					
Unfamiliar children					
New toy, game					
New group activity					
Arrival at social event					
New situation					

Rhythmicity, predictability: physical and behavior regularity	Reg	Med	Irg	?	B
Sleeping Times					
Hunger times					
Amount eaten					
Food choices					
Response to parent					
Bowel habits					
Play schedule					
Doing chores					
Doing homework					
Care of possessions					
Order in own room					
Keeping appointments					
Adaptability: flexibility, ease of adjustment to change	Hi	Med	Low	?	B
Change in mealtime					
Change in activities					
Change in routines					
Calming if upset					
New places					
Change in familiar plans					
Settling arguments					
Accepting new rules					
Response to coaxing					
Response to mild punishment					
Response to firm punishment					
Major setbacks					

Intensity: energy of responses to:	Int	Med	Mld	?	B
Hunger					
Pain					
Happiness					
Anger					
Surprise					
Scolding					
Disappointment					
Praise					
Likes and dislikes					
Teasing					
Disapproval					
Discovery					
Distractibility: how external stimuli affect	Dist	Med	Non	?	B
Soothability during pain or fear					
While playing alone					
Playing with friends					
Household noises					
Somebody walks by					
By TV when reading					
By conversation when reading					
Mood: observed reactions—pleasant and friendly or negative	Pos	Med	Neg	?	B
On awakening					
At bedtime					
When tired					
When hungry					
During/after meals					
Frustrated					
Sick or injured					
When corrected					
During play					
Asked to do chores					
Denied permission					
New visitors in home					

Sensory threshold: sensitivity to stimuli. Notices:	Hi	Med	Low	?	B
Changes in taste					
Changes in lighting					
Changes in sound					
Changes in water temp.					
Changes in room temp.					
Textures of clothes					
Odors					
Soiled diapers					
Soiled clothes					
Minor injuries					
Mild parental disapproval					
Persistence/ attention span: how long activities pursued	Pers	Med	Non	?	B
Practice physical activity					
Interest in new toy					
Look at, read book					
Watch TV					
Learning special skill					
Listening to parent					
Household chores					
Work on own project					
Doing homework					
Care of pet, garden					
Difficult project					
Resume task after interruption					
Resume play after interruption					

Comments:

Concerns of caregiver:

Impressions of clinician:

Service needs and other plans:

Comprehensive Formulation of Assessment

Child name: _____ **Rating date:** _____

Caregiver's main concern: type, duration, frequency, severity, antecedents, consequences, response of caregivers **Other caregiver concerns:** **Caregiver's goals and expectations:**			
Significant Areas	**Strengths, Assets**	**Satisfactory**	**Problems—eficiencies, Deviations**
Adjustment—Behavior, Emotional, Functional			
Behavioral competence in relationships—parents, sibs, peers, other adults	Skills, caring, cooperation, involvement, autonomy, amiable	Average	Aggression, opposition, withdrawal, unpopular
Achievements—task performance in school, home, community	High achievement, effort, motivation, satisfaction	Average	Poor achievement or failure
Self-relations—esteem, care, control of feelings and actions	Good self-esteem, care, control	Average or mixture	Poor esteem; self-neglect, abuse; overcontrol; under-impulsive
Internal status—feelings, thinking	Contentment; thought clarity	Average	Anxiety, depression, thought disturbance
Coping—identification and solution of problems	Effective coping	Average	Poor problem solving
Symptoms of body function—eating, sleeping, elimination, gender, sex, pain, tics	Comfortable function	Normal concerns	Moderate-severe symptoms
Child Factor			
Physical—nutrition, growth, maturity, illness	Excellent health	Average	Significant health or nutrition problem
Neurologic—sensory, motor, reflex, coordination	Intact; good coordination, physical skills	Average	Central nervous system problems, especially sensory and motor
Development—motor, language, personal-social	Better than average	Average	Significant delay or deficiency
General cognitive skills (e.g., memory)	Good skills; above usual range	Normal	Deficit, disability
Specific cognitive skills—reading, spelling, writing, math	High level of skills	Average	Deficit, disability
Temperament social style—approach, adaptability, mood	Flexible, pleasant	Average range	Rigid, irritable, "spirited"

Significant Areas	Strengths, Assets	Satisfactory	Problems—eficiencies, Deviations
Work style—persistence, distractibility, activity	High performance style;	Average range	Low performance style
Situational reaction style—intensity, threshold	Appropriate level of reactions	Average range	Explosive; overreactive or underreactive
Organizational style—regular, predictable, organized	Predictable, organized	Average range	Irregular, disorganized
Pervasive, extreme inattention or activity	Not present	Not present	"Hyperkinetic"
Environmental Factor			
Caregivers' contributions—structure-general capacity, commitment, availability, involvement	Good support	Adequate	Inadequate capacity, commitment, involvement; conflict
Sociocultural influences—relatives, neighbors, school, media, affluence/poverty	Supportive, not conflicting	Mixed	Major stressors (e.g., death, divorce, violence, conflict)
Physical—neighborhood, hazards, toxins	Good; healthy	Tolerable	Inadequate or hazardous
Interactions			
Goodness of fit—caregiver and child	Excellent; good	Adequate	Troublesome or poor
Contributions of caregiver to child—content			
Physical care (protection, food, housing, medical care)	Nourishing physical care	Adequate	Poor physical care
Stimulation—developmental, cognitive	Optimal quantity, quality	Adequate	Overstimulation or understimulation, neglect
Affection—acceptance, intimacy, warmth	Good timing, quality, amount	Adequate	Overaffection or underaffection, hostile, abuse
Guidance—approval, discipline	Attentive guidance	Acceptable	Overguidance, underguidance, or inappropriate guidance
Socialization—teaching social relations	Healthy familial and extrafamilial socialization	Average	Aberrant socialization
Effects of child on caregiver	Predominantly positive	Average, mixed	Predominantly stressful, challenging
Comments:			
Summary and Diagnosis:			
Plans—service needs:			

Management of Temperament Differences

HIGH ACTIVITY Help the child find ample opportunity for physical activity. Avoid unnecessary restrictions of activity. Demand restraint of motion appropriate for age when necessary.	**LOW ACTIVITY** Allow extra time to complete tasks. Set realistic limits, such as meeting the school bus on time. Do not criticize slow speed.
HIGH REGULARITY In an infant, plan feedings and other activities on a schedule. In an older child, advise of expected disruptions of the schedule.	**LOW REGULARITY** In an infant, first try to accommodate the preference for irregularity, then gradually steer her toward a more regular schedule. An older child can be expected increasingly to regularize his eating and sleeping times, even if he does not feel hungry or sleepy on schedule.
APPROACHING OR BOLD INITIAL REACTION Reinforce with praise if positive. Remember that the initial positive reaction may not last. Be aware of the child's boldness in dangerous situations.	**WITHDRAWING OR INHIBITED INITIAL REACTION** Avoid overload of new experiences. Prepare the child for new situations and introduce her to them slowly. Do not push too hard. Praise her for overcoming her fears of novelty. Encourage self-management as the child grows older.
HIGH ADAPTABILITY Look out for possible susceptibility to unfavorable influences in school and elsewhere.	**LOW ADAPTABILITY** Avoid unnecessary requirements to adapt. Reduce or spread out necessary adaptations, arranging for gradual changes in stages. Do not push too hard or too quickly. Give advance warnings about what to expect. Teach social skills to expedite adaptation. Maintain reasonable expectations for change. Support and praise effort.

HIGH INTENSITY Intensity may exaggerate the apparent importance of response. Avoid reacting to the child with the same intensity; try to read the child's real need and respond calmly to that need. Do not give in just to make peace. Enjoy intense positive responses.	**LOW INTENSITY** Try to read the child's real need, and do not mistake it as trivial just because it is mildly expressed. Take complaints seriously.
POSITIVE MOOD Encourage positive and friendly responses. Look out only for those situations in which your child's outward positive behavior may mask true distress, such as with pain, and situations in which being too friendly may be troublesome, such as with strangers.	**NEGATIVE MOOD** Remember that it is just your child's style, unless there is an underlying behavioral or emotional problem. Do not let the child's mood make you feel guilty or angry; his mood is not your fault. Ignore as many of the glum, unfriendly responses as possible; however, try to spot and deal with the real distress. Advise an older child to try harder to be pleasant with people.
HIGH PERSISTENCE AND ATTENTION SPAN Redirect a persistent toddler whose persistence is annoying. In an older child, warn about the need to end or interrupt activity when continued for too long. Reassure the child that leaving some tasks unfinished is acceptable.	**LOW PERSISTENCE AND ATTENTION SPAN** The child may need help organizing tasks into shorter segments with periodic breaks; however, the responsibility for completion of the task belongs with the child. Reward the adequate completion of the task and not the speed with which it is done.
HIGH DISTRACTIBILITY If the problem involves an older child, try to eliminate or reduce competing stimuli. Gently redirect the child to the task at hand when necessary; however, encourage the child to assume his own responsibility for doing this. Praise adequately for completing the task.	**LOW DISTRACTIBILITY** If the child ignores necessary interruptions, do not assume it is deliberate disobedience.
HIGH SENSITIVITY Avoid excessive stimulation. Eliminate stimuli if disruptive. Avoid overestimating extreme responses to stimuli. Help the older child understand this trait in himself. Support and encourage the child's sensitivity to the feelings of others.	**LOW SENSITIVITY** Look out for underreporting of pain and other distress. Help the child develop an awareness of important internal and external stimuli. Help child to develop greater sensitivity to the feelings of others.

Child Behavioral Assessment & Management in Primary Care, Second Edition.

by William B. Carey, MD and Sean C. McDevitt, PhD

This book is intended for professionals who work directly with children in a primary care setting. This includes not only nurses and primary care physicians but also teachers, daycare workers, school psychologists, social workers, various therapists and others. Written by two clinicians who have practiced for many years in primary care, this presentation rejects the notion that behavioral status should only be classified as normal or abnormal. Rather, it suggests that primary care professionals should view children's behavior on a spectrum where annoying normal variations may shade into problems and then to disordered behavior requiring specialized care. This perspective is preferable to the limited approach of simply making categorical judgments about whether the problems are severe enough to be diagnosed and treated, or that there is no real problem. By taking into account matters of aversive temperament and atypical behavioral adjustment as well as behavioral disorders, the entire range of behavioral concerns can be considered.

The second edition of CBAM offers new content, including discussion of areas of temperament beside the one the authors have found most useful and a more detailed review of the application of temperament counseling. A new chapter deals with the confusion of terminology that has crept into the behavioral health field in recent years.

ABOUT THE AUTHORS

Dr. William Carey, a pediatrician, and Dr. Sean McDevitt, a psychologist, are long time collaborators in areas pertaining to the behavioral health of children. They have written or co-edited 4 books and numerous papers together since the 1970s. In addition, they have authored a series of temperament questionnaires, designed to identify important individual differences in infants and children, and the BASICS questionnaire, which assesses areas of behavioral adjustment in children ages 4-14. Dr. Carey is Director of Behavioral Pediatrics at the Children's Hospital of Philadelphia and Dr. McDevitt is in private practice, affiliated with AZ Behavioral Specialists, LLC in Phoenix, AZ.

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