

Clinical Issues

ANNOYING BEHAVIOR OR A PROBLEM?

Jenny is riding a tricycle around the preschool classroom when Jerry arrives. Jerry wants it! He watches Jenny for a few seconds as she rides around the room, then dashes over to her and tries to push her off the bike. The teacher intervenes.

Alan's mother just had a new baby, and Alan has been particularly moody and unpredictable. One minute he is clingy and tearful, the next he is wild and defiant, throwing toys and disobeying.

Sarah is a leader in the classroom and is always the one to be the "mother" in the playhouse at nursery school. When Sandra wants to take turns, Sarah protests and refuses to play with Sandra, roughly pushing her out of the way. Sandra goes off tearfully to tell the teacher.

Jeffrey has been in preschool for a week and has refused to talk to or play with the other children. In fact, the teacher has never heard him say a word to anyone but his mother. He has consistently ignored the overtures of other children and spends his time either hovering at the edge of a group of children, watching their play, or off by himself in a corner playing with trucks. When the teacher attempts to engage Jeffrey in group activities, he withdraws even more.

Jill and her mother are in the supermarket, and Jill is reluctant to stay in the shopping cart. It's no fun going shopping if you can't run around and touch things! When her mother insists that she sit in the shopping cart, Jill begins to throw groceries from the basket all over the floor of the meat department while crying and screaming. Her mother is mortified as people walk by and stare disapprovingly.

These are all familiar scenes to anyone who has had contact with young children. Most people would not consider these toy struggles, temper tantrums, or signs of sibling jealousy to be anything but typical behaviors. Indeed, studies suggest that these and a range of other behaviors that are troubling or annoying to adults are very common in the general population of preschoolers. But when do temper tantrums or fights between peers become problems worthy of concern? Is Jeffrey's social isolation just an indication of excessive shyness in a new and overwhelming situation, something he will soon overcome if left to adapt slowly? Or is it a sign of a potentially more serious difficulty in relating to others? If Jill was having frequent tantrums and was finally referred to a psychologist, would the behavior then become a symptom of a psychological disturbance? When an annoying behavior becomes something a parent cannot handle, does that make it a symptom of a child's behavior disorder or of a parent's problems setting limits? How does one distinguish among *annoying behavior*, *age-specific problems*, and *symptoms of disorder*? In an attempt to provide some conceptual clarity, the terms *worrisome* and *annoying behavior* are used throughout this chapter to refer to typical and age-appropriate behavior that may concern some parents; *age-specific problem* and *problem behavior* are used to indicate an exaggeration in the frequency and/or intensity of typical behavior to an upsetting degree, something which may or may not be a sign of a more serious difficulty to come; and *symptom* or *symptomatic behavior* are utilized to designate a problem of probable clinical significance.

These three degrees of troublesome behavior overlap considerably, and it is difficult, if not impossible, to clearly differentiate them. Furthermore, different observers may interpret a particular behavior differently, giving the same behavior a different meaning or developmental significance. For example, toy struggles in preschool are seen by some psychologists as an important developmental step in learning the rules of social exchange and sharing. Parents, on the other hand, may become upset by frequent squabbles over toys between peers or siblings and worry that their child is not learning to share. Toy struggles, in and of themselves, therefore, might be considered either annoying but healthy behaviors or age-specific problems, depending on the point of view of the observer. However, when they occur in the context of frequent aggressive encounters with other children, disobedience, and temper tantrums, toy struggles might be seen as a symptom of a more serious

problem warranting treatment. Similarly, tantrums may be the hallmark of a two-year-old's struggle to assert herself and establish some degree of independence and autonomy. Or, in the context of a variety of other problem behaviors indicative of more widespread aggression, noncompliance, and anxiety, the tantrums may be seen as symptomatic behavior. As a first step in attempting to differentiate between age-related behaviors and behavior problems in young children, a number of studies have assessed the frequency of behaviors considered annoying or problematic by adults; some of these studies have also looked at age changes and sex differences in target behaviors in an effort to clarify systematic variations in irritating or upsetting behaviors.

HOW COMMON ARE PROBLEM BEHAVIORS?

Epidemiological studies and large-scale surveys have been conducted to examine frequencies of occurrence of specific potentially problematic behaviors in representative samples of children. Thus researchers have asked parents and preschool teachers to rate large numbers of annoying and/or worrisome behaviors typically shown by children. These studies have found that most of the behaviors of interest, that is those that might be considered symptomatic of disorder in some contexts (e.g., not listening, being overactive, fighting with other children, worrying, or being shy), are very common. Thus many if not most children will exhibit these behaviors some of the time, in specific situations or at a particular period of development, although only a few children will show these behaviors at high intensities and/or frequencies. Other symptomatic behaviors are quite rare, exhibited by very few children, even at low frequencies (e.g., stealing, bizarre mannerisms), and, when they are observed, they are more obviously indicative of a problem.

Most studies of this type have been conducted on children of preschool age or older, although a few have included younger children. It is not surprising that the nature of parental concerns about young children parallels expected developmental changes. Jenkins, Bax, and Hart (1980) examined parental concerns in a representative sample of parents of children ranging in age from 6 weeks to 4½ years. In infancy, concerns were relatively rare, with worries about sleeping, feeding, and crying predominant. Between ages 1 and 2, the total number of parental concerns began to increase somewhat, with feeding and sleeping diffi-

culties still the major focus. Difficulties with bowel and bladder control emerged as parental worries at age 2. The number and intensity of parental concerns peaked at age 3, when the major complaints revolved around difficulties with management and discipline.

Other studies have likewise found that parents of young children frequently report concerns about toileting, eating habits, and sleeping problems. Relatively high proportions of parents of 3-year-olds also complain of more general problems with noncompliance, limited self-control, and poor relations with siblings and peers (Earls, 1980; Koot, 1993; Richman, Stevenson, & Graham, 1982). For example, in an epidemiological study of 705 3-year-old children in London, Richman et al. (1982) reported that 12.9% were described by their mothers as overactive and restless, 10.7% were seen as difficult to control, and 9.2% were seen as attention seeking. In a large-scale screening study of day-care attendees in rural Vermont, Crowther, Bond, and Rolf (1981) reported even higher rates of overactivity, low frustration tolerance, frequent fights with peers, and inattention in 3-year-old boys. Koot (1993) studied a representative community sample of 469 2- and 3-year-olds in Holland. Roughly 25% of parents rated their toddlers as often defiant, demanding, unable to wait, and unable to sit still. It seems unlikely that such a large proportion of young children is showing clinically significant symptoms. Rather, these studies suggest that many of the behaviors that may indicate problems are also extremely common in the general population.

Both cross-sectional and longitudinal studies also reveal that the nature of children's problem behaviors changes with age. Thus, as noted previously, management difficulties appear to peak at age 3 and to become less troublesome thereafter. According to both maternal and teacher reports, other specific behaviors, including fears and worries, tantrums, overactivity, attentional problems, and fighting with peers, seem to decrease in both frequency and severity over the preschool years in non-clinical samples (Coleman, Wolkind, & Ashley, 1977; Crowther et al., 1981; MacFarlane, Allen, & Honzik, 1954). Thus these findings from large-scale studies indicate that some problem behaviors show age-related decreases; these findings have been interpreted to suggest that problems in preschoolers generally are likely to be outgrown and often reflect age-appropriate manifestations of difficult behavior.

Sex differences in the frequency and intensity of problem behaviors have also been examined. In general, boys are more likely than girls to

be described as aggressive, overactive, inattentive, and disobedient, although findings are inconsistent about the age at which sex differences first appear. Several studies of preschoolers have found only trivial sex differences in parent reports of specific problem behaviors (Campbell & Breaux, 1983; Earls, 1980; Koot, 1993; Richman et al., 1982; Shaw et al., 1998). Crowther et al. (1981), on the other hand, reported that sex differences were apparent by age 3 on a large number of potentially symptomatic behaviors. Teachers rated boys in day care as showing more destructive behavior, disruptive behavior, noncompliance, and peer problems, and lower frustration tolerance than girls. Although sex differences in young children's behavior require further research, Crowther et al.'s (1981) findings are consistent with a large number of studies of school-age children that indicate higher rates of aggressive and overactive behaviors in boys (Achenbach, 1991; Offord, Boyle, Fleming, Munroe-Blum, & Rae-Grant, 1989).

Taken together, these studies indicate that specific behaviors that are considered indicative of psychological disturbance in some contexts are very common in the general population, that certain behaviors show age-related increases or decreases, and that sex differences are sometimes found in the frequency and severity of annoying or worrisome behavior.

DIMENSIONS OF BEHAVIOR PROBLEMS IN YOUNG CHILDREN

The foregoing discussion should make it obvious that isolated behaviors rarely reflect significant disturbance. Thus researchers have looked for clusters of behaviors that may occur together and may define a typology of disorder. Across the age span from toddlerhood to adolescence, two major classes of problem behavior have been identified in children (Achenbach, 1991, 1992): those characterized by undercontrol and those characterized by overcontrol. Behaviors characterized by *undercontrol* are typically high in annoyance value and/or the potential to hurt others. These behaviors have been termed *externalizing* because they are expressed outward against others or have an impact on the child's environment. Examples include overactivity, tantrums, fighting, destructive behavior, and disobedience. Behaviors reflecting *overcontrol* also tend to cluster together. They have been termed *internalizing* be-

cause they are reflected in social withdrawal, fearfulness, unhappiness, and anxiety and represent self-focused expressions of distress. Unfortunately, internalizing behaviors are often ignored or not recognized by adults in the child's environment because they are usually less dramatic and less irritating to others than externalizing symptoms are.

Hundreds of studies have confirmed these general clusters of behavioral symptoms, although specific behavioral manifestations may vary as a function of age and developmental level. It is not clear whether these rather global typologies of internalizing and externalizing symptomatology are sufficiently precise in their characterization of young children's problems to facilitate decisions about treatment or predictions about prognosis or whether specific subtypes of internalizing and externalizing disorders must be the focus of clinical decision making. It is likely that problems appear more global in early childhood and become more specific and differentiated with development.

A RELATIVE DEFINITION OF PROBLEM BEHAVIOR

The studies that examine the prevalence of specific behaviors do not allow us to define normality or abnormality objectively, but they do place problem behaviors in an appropriate developmental context. Knowing that 3-year-old Jamie is very aggressive in preschool and that aggression in preschool is common among 3-year-old boys may lead us to conclude that Jamie's behavior is merely typical and need not be a cause for parental concern beyond attempts to handle it in the present situation. However, such an evaluation will depend on factors in Jamie's family and peer group, on Jamie's overall pattern of behavior and its intensity in a variety of situations, and on changes in his behavior over time. Isolated behaviors are usually less of a cause for concern than those that occur together with other maladaptive behaviors or within a troubled family milieu. Similarly, even if we know that separation distress is quite rare by age 4, its presence does not permit us to conclude that a serious problem exists with long-term consequences for the child's development until other associated factors have also been examined. The presence of a disorder or an incipient disorder cannot be determined on the basis of one or two annoying or upsetting behaviors. The emphasis must be on the pattern of behavioral disturbance rather than on specific symptoms. That is, the frequency, intensity, and constellation of symp-

tomatic behavior is relevant to a determination of whether a clinically significant problem exists, as is the wider family and social context of the behavior.

Assessment of problem behavior is further complicated by differences in perceptions and interpretations of children's behavior, as well as the variability in the behaviors children display in different settings and with different people. Thus a child's toy struggles with peers, temper tantrums, or separation distress may worry one parent and be dismissed as typical behavior by another. In many families, fathers and mothers appear to perceive their children's behavior differently, as evidenced by the only modest agreement between parents on rating scales describing children's behavior (e.g., Achenbach, McConaughy, & Howell, 1987; Koot, Van Den Oord, Verhulst, & Boomsma, 1997). In addition, children behave differently with different adults and in various settings. Thus, for example, data on a community sample participating in the NICHD Study of Early Child Care (NICHD Early Child Care Research Network, 1998) indicated very low agreement between mothers and caregivers asked to rate children on the Child Behavior Checklist/2-3 at 24 and 36 months. This may reflect both different perceptions of what constitutes problem behavior and the fact that children behave differently in different settings. For instance, one child may be cooperative with new people or in preschool but noncompliant at home, whereas another is sociable at home but shy and withdrawn in preschool. Thus it is necessary to assess a child's behavior from multiple perspectives, that is, within a developmental framework and from the vantage point of several significant adults in the child's environment. A relatively comprehensive assessment is needed if an accurate picture of the child's functioning is to emerge.

As already noted, the developmental supports available to the child from within the family must also be considered in an evaluation of problem behavior. Are parental expectations unrealistic, thereby exacerbating conflict during a difficult developmental transition? For example, are parents too rigid and demanding in setting limits at a time when the toddler is attempting to establish independence and autonomy, thereby creating a "battle of wills" that leads to frequent temper tantrums and bouts of noncompliance? Conversely, are parents reluctant to set limits for fear of thwarting their child's sense of self at a time when firm, consistent, but flexible guidelines are more congruent with the child's developmental needs? Are parents who are overwhelmed with

their own problems unable to provide a stable, nurturing, and structured environment that fosters exploration and the development of self-awareness and self-control? Or is the child's behavior being misinterpreted as a problem by parents who lack an understanding of normal development? This is not to imply that parental management practices are always inappropriate. It is obvious that some extremely skilled and patient parents have children who at one time or another are extremely difficult to control. However, parental attitudes and management practices are a central aspect of the assessment process.

In summary, particular behaviors may be typical or may be indicators of a potential problem. Assessment must focus on the child in a developmental and family context. It ultimately involves a decision as to whether the behaviors in question are age appropriate, typical, and likely to be outgrown or the sign of a "clinically significant" problem. If the clinician judges the problem to be clinically significant, does it correspond to the usual patterns of aggressive or withdrawn behavior observed in young children? What meaningful clinical decisions can be made about treatment? Of course, before an assessment can be conducted, someone in the child's immediate environment, usually a parent or preschool teacher, must be sufficiently concerned about the behaviors in question to make a referral to a mental health professional.

FACTORS INFLUENCING REFERRAL

Many children with problems, especially young children who are not attending day care or preschool, probably do not reach mental health practitioners. Conversely, anyone who has worked with young children and their families has seen children with age-appropriate difficulties who were brought in for help because of parental concern. Factors influencing referral patterns are complex and have not been investigated extensively. Thus most of what follows is a distillation of clinical experience and is not based on empirical findings. However, it seems obvious that some combination of family, child, social, and cultural factors must converge to lead to referral in some cases and to work against referral in others.

At the first level, child behavior is obviously relevant. Children whose behavior is annoying to others are more likely to be referred than children whose behavior, even though equally disturbed, is quieter and

less overt. Thus children who are aggressive, disobedient, and overactive are more likely to be seen as a problem by parents or child-care workers than are quiet, withdrawn, and fearful children. Furthermore, it is likely that parents will seek help more readily if their child's exasperating behavior is apparent outside the home as well. Thus the child who throws temper tantrums at home but is well behaved and cooperative around other adults will be less likely to be referred for help. But once a parent's concern is corroborated by the preschool teacher or the pediatrician—that is, when the behavior is both sufficiently annoying to others and evident across situations (e.g., home and preschool/child care)—help seeking is more likely. Further, when the behavior problems are accompanied by cognitive and/or language delays, parents may be more motivated to seek help in order to understand the severity of the cognitive problem and to obtain remedial intervention. Clinically, it appears that cognitive and learning problems may be less threatening than behavioral ones or may be viewed by parents as more likely to require treatment.

Parents' previous experience with children, their implicit theories about the nature of development, their levels of tolerance for children's behavior, their developmental expectations, and their own definitions of "normality" will also influence their assessment of the need to seek help. Thus, for example, the parent who believes that early signs of disturbance are possible indicators of more serious, long-term problems (a continuity view) may be more likely to seek help than a parent who sees problematic behavior in preschoolers as merely a difficult phase of development (a discontinuity view). Similarly, parents with more limited tolerance for rambunctious and exuberant behavior may be more likely to seek a referral than parents who are more child centered and tolerant of high levels of noise and activity.

In my own work, I have been struck particularly with the wide variation in parents' knowledge of normal development and expectations for their children's behavior. Tolerance levels, developmental expectations, and experience with children appear to interact in complex ways. Parents with unrealistic expectations and low tolerance may make excessive maturity demands on their preschooler that may tax their child's competence or self-control, and they may seek help to "make their child behave." For example, parents with limited exposure to young children may be more likely to interpret sibling or peer squabbles as "meanness" and may have unrealistic expectations for sharing and

harmony between young children. We have found sibling and peer difficulties to be a major concern of parents of young children. On the other hand, parents who are both tolerant and aware of developmental issues concerning sibling or peer conflicts may be overly lax about setting limits and allow toy struggles or other typical child conflicts to escalate to more serious fights, thereby providing inadequate guidelines for more appropriate conflict resolution. Parents with limited knowledge of development also may become unduly upset by the finicky and faddish eating habits that often characterize preschoolers, or they may worry that problems with toilet training will develop into rebellion and other more serious problems. Forcing these issues in an insensitive and heavy-handed manner can turn eating or toileting into a battleground and lead to serious parent-child conflict that may ultimately lead parents to seek help. Whereas a discontinuity view and moderate levels of tolerance are probably adaptive for most children and parents, it is also important that parents not overlook or rationalize away a potentially serious problem.

Parental perceptions of child behavior as either typical or potentially problematic will likewise be influenced by a range of other factors, including their own history of childrearing, their family history of psychopathology, and their own experience with the mental health system and their attitudes toward it. For example, families with a severely disturbed adult member, such as an aunt or grandparent, may be more likely to seek help early on, even for relatively minor problems, as a preventive effort. Other families in which a close relative has a history of hyperactivity or learning problems may be more likely to dismiss the need for help with the comment that "Joey is just like Uncle George was." As Uncle George is now a successful businessman, they assume that Joey too will outgrow his early childhood problems. On the other hand, if Uncle George's early problems developed into more serious academic and interpersonal ones in adolescence, they may want to prevent the occurrence of problems like those they observed in their own family of origin while growing up. Similarly, parents' willingness to seek help will be influenced by their own experiences with problems and the helpfulness or lack thereof of their contacts with the mental health system.

Additional family factors that would be expected to influence referral patterns include marital status and the quality of the marital relationship, educational and occupational status, and emotional and

material resources. In a large-scale study of service utilization in the Netherlands, Verhulst and van der Ende (1997) found that most families who identified problems in their children did not seek treatment. The factors that influenced help seeking included stressful family events and the severity of child problems. Although families with a history of mental health problems were more likely than other families to see problems in their children, they were not more likely to utilize mental health services. This study, however, focused on children from age 4 to adolescence, so it is difficult to draw conclusions specifically about service utilization by families of young children. Pavuluri, Luk, and McGee (1996) studied service utilization patterns specifically in preschool children screened in New Zealand. Consistent with expectation, most parents who saw their children as having problems did not seek help, primarily because they believed that the problems would be outgrown or that they should be able to handle the problems themselves. In general, low-income, single-parent families experiencing high levels of psychosocial adversity were the least likely to seek treatment.

Similar results were reported by Lavigne and colleagues (1998a), who studied service utilization in families seeking pediatric services for their 2- to 5-year-old children. Children identified as problematic through screening assessments were more likely to have been seen by a mental health professional if their problems were more serious, if they were not members of minority groups, if problems were accompanied by family conflict, or if they were referred by their pediatricians. It is also worth noting that about one-fourth of the families seeking mental health services had not screened positive for a problem; conversely, consistent with other studies, about three-fourths of the families with a child who screened positive did not seek mental health services. These data underscore the complexities in predicting service utilization in families with young children.

From a clinical perspective, family systems issues may influence help seeking, as suggested by the Lavigne et al. (1998a) data on family conflict. For example, it is not uncommon for parents to seek help with childrearing concerns as a ticket into marital or family therapy, although neither partner is willing or able to acknowledge marital problems. On the other hand, some disturbed parents with disturbed children may postpone referral because they need to feel supported before they are able to confront and deal with their child's difficulties. Still other families may avoid seeking help because they are afraid that their

child's difficulties will reveal their own problems or because there is marked disagreement between the parents on the need for help. Thus a complex range of factors influences help seeking in parents of preschool children, and these are further compounded by issues of access to services in the United States.

Access to mental health services varies widely across countries and socioeconomic groups. It is noteworthy that both New Zealand (in the Pavuluri et al. study) and the Netherlands (in the Verhulst & van der Ende study) provide universal health care that includes mental health services; access and cost should not be major barriers to treatment and, therefore, cannot explain the low rate of service utilization reported. In contrast, in the United States, there are serious problems of access to mental health services for young children that have been exacerbated by the advent of managed care (American Academy of Pediatrics, 2000; Jellinek, 1999). Therefore, some families who may wish to seek help for their young children may be overwhelmed by the difficulties they face finding appropriate services or negotiating the bureaucracy, or they may be concerned about whether they will be able to afford services once they find them. Many health insurance policies do not provide adequate coverage for mental health services, and this is especially so for child mental health.

Once a referral is made, it is the task of the mental health professional to determine the severity of the problem—whether it is indeed serious enough to warrant intervention, or whether it reflects an age-appropriate struggle with a developmental transition that requires primarily parental understanding and support. If treatment does appear indicated, it will be necessary to decide whether the parents, the child, or the family should be the focus of intervention and what type of intervention appears most relevant (e.g., parent education, family therapy, etc.). These issues are addressed more fully in Chapter 7.

ATTEMPTS TO DEFINE CLINICALLY SIGNIFICANT PROBLEMS

Clinicians agree that a definition of disorder in young children must include a pattern of symptoms that has been troublesome for some time, that is evident in more than one situation, that is relatively severe, and that is likely to impede the child's ability to negotiate the important de-

velopmental tasks necessary for adaptive functioning in the family and the peer group. Thus it is not the presence of specific problem behaviors that differentiates “normal” from “abnormal,” but their *frequency, intensity, chronicity, constellation, and social context*. In one of the examples discussed earlier, toy struggles would not be interpreted as problematic if they occurred once in a while, were of short duration, or were apparent in a preschool-age child who had few other problems. On the other hand, toy struggles might be considered more worrisome if they occurred frequently, were intense, escalated into more serious fights, and were initiated by a child who was in other ways very difficult to control and seemed to be showing a general pattern of aggression, noncompliance, and poor regulation of negative affect. Richman et al. (1982) used a combined statistical and clinical approach in an attempt to identify children with clinically significant problems. They noted that roughly 15% of their sample was assessed as showing mild problems and another 7% as showing moderate to severe problems. Children identified as evidencing moderate to severe problems were described as exhibiting a range of symptoms of relatively marked intensity that appeared to be interfering with their developmental progress and were having a negative influence on family functioning.

These data are quite consistent with more recent epidemiological studies of diagnosed disorder in preschool children (e.g., Lavigne et al., 1996), which are discussed in more detail later in this chapter, as well as with studies examining elevated scores on checklist measures such as the Child Behavior Checklist (CBCL). For example, Koot (1993) reported that about 11% of the Dutch toddlers in his community sample were rated above the clinical cutoff on the Externalizing Problems scale of the CBCL/2–3. Lavigne et al. (1996) reported that 8.3% of a sample of preschoolers attending primary pediatric care facilities received scores above the clinical cutoff (90th percentile) on the Total Problems scale of the CBCL. Gender differences were apparent, and problems were lowest at age 2 (4.7%) and highest at age 4 (13.2%). These rates, however, are higher than those obtained in the NICHD Study of Early Child Care (NICHD Early Child Care Research Network, 1998). Moreover, in the NICHD study, when agreement between both mothers and caregivers was considered, very few children actually were seen as showing serious problems at either 24 or 36 months; only between 0.5% and 1% of children were rated above the clinical cutoffs by *both* informants on the Externalizing, Internalizing, or Total Problems scales.

Stable problems were evident in only about 3% of children, according to maternal reports obtained at ages 24 and 36 months. These data indicate that sample composition, measurement instrument, age of child, and a range of other factors influence prevalence figures. Indeed, it is likely that problems become more easily identifiable and more stable after age 3 or 4.

Even if there is moderate to good agreement among clinicians about the presence or absence of a recognizable disorder in young children (Lavigne et al., 1996), accurate prognostic predictions are quite difficult to make. The teacher, the parent, and the psychologist may all agree that Jamie's behavior is disrupting the family and impairing his ability to venture into the peer group. But does that mean that in 6 months or a year he will still be having problems? There are few guidelines to assist the professional in making such judgments in the individual case. However, contrary to the popular belief that most early problems will be outgrown, there is growing evidence that although many children do overcome early problems, a significant proportion of problem preschoolers will continue to have serious adjustment difficulties at school entry and beyond (Campbell et al., 1996; Lavigne et al., 1998a, 1998b; Pierce, Ewing, & Campbell, 1999). As noted earlier, studies that examine the persistence of troublesome or annoying behavior in non-clinical samples of young children suggest that the behaviors most often disappear with development. On the other hand, longitudinal studies of young children identified as having a constellation of problems that are impairing functioning suggest that some problems do persist (e.g., Campbell et al., 1996; Lavigne et al., 1998a, 1998b; Shaw, Owens, Vondra, Keenan, & Winslow, 1996). These studies are discussed in more detail in Chapter 8. In general, however, the evidence indicates that externalizing problems are more likely than internalizing ones to persist, particularly in boys, and that family factors appear to mediate outcome (Campbell, 1995; Campbell et al., 2000). Moreover, age at first diagnosis appears related to persistence, with children who show more clearly identifiable problems at ages 4 and 5 being more likely to show persistent problems than younger children, who might well be going through a developmental phase (Lavigne et al., 1998a). In addition, sleep disturbances, especially when they are prolonged, are often associated with behavior problems in young children (Lavigne et al., 1999; Richman et al., 1982), even with indicators of family stress controlled (Bates, Viken, Alexander, Beyers, & Stockton, 2002).

DIAGNOSTIC ISSUES

The categorization of problems in young children is particularly problematic. Although behaviors rated on checklists may cluster in relatively similar ways across the age range, the usefulness of this dimensional approach to the identification of problems in young children requires more research before we can be sure of its accuracy and predictive validity. Similarly, alternative categorical approaches to diagnosis, such as DSM-IV (American Psychiatric Association [APA], 1994), are only beginning to be examined systematically with young children (e.g., Keenan, Shaw, Walsh, Delliquadri, & Giovannelli, 1997; Lavigne et al., 1996). Moreover, if both descriptive approaches are identifying children with serious problems, they should show moderate to high convergence. It is not yet clear, however, that this is the case. Keenan et al. (1997), for example, observed similar rates of disorder when both dimensional and categorical approaches were used to classify young children, but the approaches identified different children. This raises questions about the relative predictive validity of these two diagnostic systems. Moreover, if one is to utilize the DSM approach, are the categories designed for use with school-age children and adolescents applicable to preschoolers? And finally, which approach to the description and classification of young children's problems is more clinically useful and less stigmatizing? The issue of stigmatization is often overlooked; the interested reader is referred to Hinshaw and Cicchetti (2000) for an important and poignant discussion of this complex topic.

DIAGNOSTIC CLASSIFICATION USING THE DSM AND RELATED SYSTEMS

Because the mental health professions have adopted the DSM-IV diagnostic system (APA, 1994) and are required to utilize this system for reimbursement by insurance companies, this approach to diagnosis is discussed with a focus on the disorders that appear most relevant to this age group (e.g., oppositional defiant disorder, separation anxiety disorder) but that do not reflect extreme impairment and/or developmental delay (e.g., autism, pervasive developmental disorder) or grossly inadequate care (e.g., reactive attachment disorder). These more serious disorders are beyond the scope of this book, either because they reflect a

more obvious biological etiology, as in autism (e.g., Rutter, 2000), or because they appear to result from gross and prolonged deprivation and serious deficits in parenting that are outside the normal range of experience, as in reactive attachment disorder (APA, 1994).

The changing diagnostic system over the past 20 years, from DSM-III (APA, 1980) to DSM-III-R (APA, 1987) to DSM-IV (APA, 1994), means that research has necessarily lagged behind the appearance of modified criteria. When the first edition of this book was published, however, few published studies existed that used categorical diagnoses with young children. Today, there is a small body of work utilizing these structured diagnostic systems (especially DSM-III-R) with preschool children and, to some degree, supporting their reliability and concurrent and predictive validity (e.g., Keenan et al., 1997; Lavigne et al., 1996, 1998a).

At the same time, however, both DSM-III-R and the revised DSM-IV continue to have limitations when applied to preschool children. Although the authors of DSM-IV wisely suggest that diagnoses of certain childhood disorders, such as conduct disorder, will generally not apply meaningfully to very young children, other disorders are described more ambiguously. However, the use of diagnostic criteria is based on largely unvalidated inclusion and exclusion criteria, especially when used with very young children. Further, the use of a diagnostic label implies "a dysfunction in the individual" (APA, 1994, page xxii), meaning that the disorder resides "in the child." This appears to "overmedicalize" and overpathologize less severe (i.e., nonpsychotic or nonautistic) problem behaviors in toddlers and preschoolers. There is particular concern about the overdiagnosis of disorders such as oppositional defiant disorder and attention-deficit/hyperactivity disorder. This is partly because DSM-III-R and its successor, DSM-IV, do not provide adequate guidelines for determining the developmental and clinical significance of the specific symptomatic behaviors that define these disorders, raising questions about their appropriateness for use with preschoolers.

In an effort to deal with this problem, the American Academy of Pediatrics (AAP, 1996) has published a companion to DSM-IV, called the DSM-PC, for pediatricians and others working in primary care that is meant to provide clearer developmental guidelines and to delineate distinctions among developmental variations in behaviors, problems that may be clearly evident but do not reach the level of a disorder, and

more serious problems that warrant a diagnosis (AAP, 1996). In addition, this manual provides a discussion of children in family and neighborhood context, making it clear that children's disorders do not emerge de novo, isolated from the childrearing environment and community supports. These distinctions and clarifications, along with the detailed descriptions of clinical presentation as a function of age, are an important addition to the guidelines available to clinicians working with young children. In addition, the National Center for Clinical Infant Programs (NCCIP, 1994) has published Zero to Three, a diagnostic system for infants and toddlers. This diagnostic system includes downward extensions of some DSM-IV diagnoses, as well as a new set of diagnoses. It also includes a discussion of family issues in all their complexity, especially the realization that most problems in young children reflect disturbances in relationships with primary caregivers. Thus all diagnoses are accompanied by a characterization of relationship disturbance (e.g., overinvolved, underinvolved, angry, abusive). This is an important addition to the classification of emotional and behavioral problems in young children. Despite this strength, however, this system has its own set of problems, primarily a failure to integrate these issues into the diagnoses themselves and a lack of adequate empirical support for many of the categories. The following discussion, as already noted, attends only to the DSM-IV categories that may apply to preschool children. These are discussed from the DSM-IV perspective, with additions from the DSM-PC and the Zero to Three systems where applicable.

DSM-IV Externalizing (Disruptive Behavior) Disorders

Oppositional Defiant Disorder

Only two externalizing disorders, called disruptive behavior disorders in DSM-IV, are generally considered appropriate diagnoses for children of preschool age: oppositional defiant disorder (ODD) and attention-deficit/hyperactivity disorder (ADHD). The criteria for ODD include the presence of four out of eight symptoms of uncooperative behavior and negative affect (loses temper, argues, defies or refuses to comply, deliberately annoys others, often blames others, touchy, angry, spiteful) that continue for at least 6 months and interfere with social and cognitive functioning. Moreover, to be a symptom a behavior must "occur more frequently than is typically observed" in children of "comparable age

and developmental level.” Although the developmental guidelines for this diagnosis are vague, the requirements of four instead of two symptoms (as in DSM-III) and the duration and impairment criteria make the diagnosis more exclusive and mean that it is less likely to be applied to children who are going through a short-lived developmental transition. As noted in the DSM-IV manual (APA, 1994), “Because transient oppositional behavior is very common in preschool children . . . caution should be exercised” (p. 92) in making this diagnosis in young children. Still, it is easy to imagine that parents might construe some of the typical behaviors of toddlerhood, especially in families with more than one child, as meeting symptomatic criteria (annoying others, spiteful). Thus it seems necessary for the clinician to rule out, for example, typical sibling squabbles in evaluating the clinical significance of particular symptoms in young children. Given the overlap between the typical behaviors of toddlerhood and the symptoms of oppositional defiant disorder, it may be easy to overdiagnose age-appropriate, but difficult, behavior as a disorder, with all that this concept implies. The DSM-PC (AAP, 1996) provides some perspective on this issue by including discussion of a number of issues such as the birth of a sibling, family conflict, and other stressful life events, that may lead to adjustment reactions in young children, expressed as problematic behaviors that overlap considerably with the symptoms of ODD. At the same time, parents who are dealing with a very difficult developmental transition may well benefit from structured interventions geared to handling difficult children, regardless of whether they actually meet the DSM-IV criteria for a diagnosis of ODD.

Research is beginning to address questions about the applicability of this diagnosis to young children, although, unfortunately, published studies have used the DSM-III-R criteria. Most notably, Lavigne and colleagues (1996), in one of the few studies to have examined the prevalence of the DSM-III-R diagnoses in a nonclinical sample of preschool children, found that ODD was by far the most common diagnosis. In this sample of children attending primary care pediatric practices, 16.8% met criteria for at least a probable diagnosis of oppositional defiant disorder; of these, 8.1% were considered to be showing severe symptoms. More than twice as many boys as girls were considered to have ODD, with the rate peaking at age 3 and leveling off by age 5. The only other diagnosis that occurred with any frequency was ADHD, which was observed in only 2% of children and was also more common

in boys. Almost all children who received an ADHD diagnosis also received another diagnosis, usually ODD. This is consistent with the view that ADHD and ODD may not be distinct clinical entities in very young children. In another study examining the frequency of DSM-III-R diagnoses in a relatively small sample of low-income children at age 5, Keenan et al. (1997) reported that 8% were diagnosed with ODD and 5.7% with ADHD. These two studies indicate that it is possible to diagnose these two disruptive disorders in preschool children reliably.

Moreover, follow-up data provided by Lavigne and colleagues (Lavigne et al., 1998a, 1998b) indicate that about 50% of the children with disruptive diagnoses at intake, initially seen between ages 2 and 5, were likely to continue to receive a diagnosis at subsequent follow-up assessments 1 to 3 years later. Children who were younger at the time of initial assessment were more likely to outgrow their problems, suggesting that this diagnosis becomes more valid by age 4 or 5, when real problems can be more easily differentiated from transient age-related difficulties with defiance, tantrums, and the regulation of negative affect. Recall that Lavigne et al. (1996) found the highest rates of ODD at age 3, a time at which children are often struggling with issues of autonomy and self-regulation and parents may feel frustrated as their child becomes less cooperative. This suggests that the elevated rate of ODD reported in this study at age 3 includes a large proportion of false positive cases, children who were indeed experiencing a difficult developmental transition.

Attention-Deficit/Hyperactivity Disorder

When people think about the likely problems of preschool children, they think most readily of ADHD. DSM-IV included major changes in the diagnostic criteria for this disorder, making it both more difficult and easier to receive a diagnosis. The criteria were made more stringent by the addition of the requirement that the symptoms interfere with functioning across settings (home and school or day care), thereby ruling out children who might be showing situation-specific anxiety or upset that may be misconstrued as ADHD. The 6-month duration criterion also serves to rule out children who seem impulsive and overactive because they are going through a brief adjustment reaction to stressful life events, such as entering day care or coping with the birth of a sibling. At the same time, the inclusion of subtypes means that children must

meet criteria for only six symptoms (as opposed to eight in prior versions of the DSM). Thus children showing six symptoms of hyperactivity-impulsivity (HI) or six symptoms of inattention (IA) meet criteria for ADHD-HI or ADHD-IA subtype. Children with six symptoms in each domain meet criteria for ADHD-combined type. Although younger children tend not to meet criteria for the inattentive subtype (Lahey et al., 1998), presumably because this set of symptoms is not that apparent until children must meet the demands of school, young children may easily meet criteria for the HI subtype, which include fidgeting, difficulty staying seated, difficulty taking turns, difficulty playing quietly, and talking excessively. This has raised concerns about the overdiagnosis of this disorder in younger children (e.g., Carey, as cited in Marshall, 2000, p. 1281). However, it is noteworthy that in the Lavigne et al. (1996) study, ADHD was not diagnosed excessively (using DSM-III-R criteria, requiring eight symptoms, but not necessarily across settings), and it rarely occurred in the absence of ODD. It should also be noted that in the DSM-IV manual a caveat is provided: "It is especially difficult to establish this diagnosis in children younger than 4 or 5 years" (APA, 1994, p. 81). However, the potential to overdiagnose this disorder in young children is a cause for concern, as the criteria that would differentiate between age-appropriate levels of activity, shifts in attention, and impatience are nowhere defined. It is indeed difficult to make a clear diagnostic decision when confronted with a rambunctious, curious 3- or 4-year-old whose parents cannot cope with his behavior.

Preschoolers, who are learning about the world and how to master its complexities, are expected to exhibit boundless energy, to attend readily to the new and novel, and to exhibit unrestrained enthusiasm and exuberance. When, therefore, does a shift in activity and interest signify curiosity and exploration, and when does it reflect a too-rapid change in focus and an inadequate investment of attention? When does excitable and impatient behavior indicate an age-appropriate need for external support and limit setting, and when does it suggest a failure to internalize standards necessary for the development of self-control? When do frequent toy struggles reflect a child's age-appropriate need for experiences in the peer group that facilitate sharing and turn taking, and when do they indicate excessive impulsivity and an inability to wait? Although the DSM-IV specifies that "developmentally inappropriate" inattention, impulsivity, and overactivity are required for a diagnosis of ADHD, this is a difficult decision to make in the absence of nor-

mative data defining age-appropriate behavior. However, as noted in the DSM-PC (AAP, 1996), a diagnosis is most likely to occur when there are also signs of either cognitive deficits or oppositional behavior. The rambunctious toddler or preschooler with a sunny disposition is less likely to meet criteria for a diagnosis of ADHD than is the child who is non-compliant and angry, consistent with Lavigne et al.'s (1996) observation that few children in their preschool sample received a diagnosis of ADHD in the absence of a co-occurring ODD diagnosis.

In the Zero to Three diagnostic system (NCCIP, 1994), both oppositional and hyperactive-impulsive symptoms are captured under the overall rubric of "regulatory disorders," which emphasizes the difficulties some young children have controlling negative mood, activity level, and attention. Recall that these characteristics are seen as important components of infant temperament (Rothbart & Bates, 1998) as described in Chapter 1. The Zero to Three system attempts to consider problematic behaviors from a developmental perspective, and despite the focus on the importance of relationships, there is still a sense that the problem is within the child; although early problems may be ameliorated by sensitive parenting, the problems are still described primarily as emerging from biological and maturational processes. Undoubtedly, this is accurate to some degree, and especially so for some young children who would qualify for such a diagnosis. However, substantial evidence also exists that parenting plays a role in the emergence and persistence of oppositional behavior (e.g., Campbell et al., 2000; Shaw et al., 1996; Shaw, Bell, & Gilliom, 2000), as do replicated findings indicating the importance of child-by-parenting interactions (Bates & McFadyen-Ketchum, 2000; see also Chapter 1 on temperament-by-parenting interactions).

These data raise questions about how much we gain from the addition of a diagnosis of self-regulatory deficits to the characterization of the disruptive behavior disorders. Moreover, in the absence of research on the reliability and validity of these categories and their developmental significance, it is not clear what they add to attempts to describe and explain problems in young children. Are these transient problems that might just as appropriately be considered in terms of parent-child problems or adjustment reactions? Does the proliferation of categories add to the tendency to overpathologize normative or transitional behavior? How do these categories relate developmentally to the DSM-IV categories of ODD and ADHD? That is how many toddlers with a diag-

nosis of regulatory disorder, negative–defiant subtype or motorically disorganized–impulsive subtype would ultimately receive a diagnosis of ODD or ADHD at school age? These questions obviously await further research.

Conduct Disorders in Young Children?

Although there is an alarming increase in the discussion of conduct disorder in young children, both DSM-IV and the DSM-PC indicate that this diagnosis rarely applies to children under 5 or 6. Although the rare 5- or 6-year-old may actually merit such a diagnosis, it is difficult to conceptualize the majority of symptoms of conduct disorder as applying to children younger than this. However, some attempts have been made to use this diagnosis with very aggressive and defiant preschoolers who seem more impaired than a diagnosis of ODD would suggest (Keenan & Wachsclag, 2000). The question becomes whether aggression, bullying, lying, and stealing are equivalent across developmental levels. Is hitting a child with a block the same as threatening with a knife or other weapon? As the focus of research shifts to early emerging aggressive behavior, given concerns about long-term consequences, these become serious questions with implications for prevention and treatment (Campbell et al., 2000). However, it is my view that except in very rare instances, this disorder, which entails intentional violation of the rights of others, cannot be diagnosed meaningfully in children younger than 5 or 6, and even then one can question the circumstances in which such a diagnosis is appropriate.

DSM-IV Internalizing (Emotional) Disorders

Much less is known about the internalizing disorders, reflecting anxiety, social withdrawal, fearfulness, and sad mood, in young children than about ODD and ADHD. The reason is partly that these behaviors must be more extreme than externalizing behaviors are for them to be noticed, and partly that they are often short-lived and transient. Thus, for example, many children show specific fears, such as fear of animals, the dark, or monsters (Campbell, 1986), and these are often age-related fears that do not impair functioning. Thus it is unlikely that most children with specific fears would meet diagnostic criteria for a specific phobia. Indeed, in the Lavigne et al. (1996) study, out of 510 children,

only 2 met criteria for a simple phobia. In fact, Lavigne et al. (1996) comment on the very low rate of internalizing or emotional disorders in their sample. This finding is consistent with the caveats and developmental guidelines discussed in the DSM-PC, which notes that many of the symptoms of depression (e.g., sad mood, eating or sleeping problems) and anxiety disorders (worry, avoidance of social activities, shyness) are quite common and that they may also be relatively brief reactions to specific life events or changes.

Moreover, in DSM-IV, with the exception of separation anxiety disorder, the other internalizing disorders (social phobia, generalized anxiety disorder, depression) use criteria meant to cut across the age range from childhood to adulthood; there is almost no discussion of developmental differences in clinical presentation. Discussion is provided in the DSM-PC, but it is of interest that the behaviors that may indicate fear, anxiety, or depression in young children, such as crying, tantrums, clinging to an adult, or avoiding interactions with unfamiliar people, are behaviors that may be triggered by a range of situations. Therefore, in the absence of a prolonged period of symptomatic behavior that interferes with the child's ability to progress developmentally and to interact in the peer group, it is difficult to arrive at a specific diagnosis, except possibly the diagnosis of adjustment reaction or separation anxiety disorder (see the next section). The category of adjustment disorder (NCCIP, 1994) is really meant for subsyndromal reactions that are described as short-lived responses to clearly identifiable stressful events. The absence of an obvious diagnosis need not imply that parents will not benefit from some guidance about how to handle their child's distressed behavior; but the question of whether the behavior is serious enough to warrant a diagnosis merits some thought.

Separation Anxiety

Separation anxiety is the only anxiety disorder that is specific to childhood. It is described in DSM-IV (APA, 1994) as "developmentally inappropriate and excessive anxiety concerning separation from home" (p. 113) or from "major attachment figures." Among the eight symptoms defining this disorder are "recurrent excessive distress" in anticipation of separation, worry about losing the attachment figure, school refusal, and fear of being alone or of sleeping alone. Nightmares and physical symptoms may also be present. Only three symptoms of 4

weeks' duration are required for a diagnosis, although the disturbance needs to cause significant distress and/or impairment in functioning. Developmental guidelines are not provided. However, it is suggested that separation anxiety is most likely to develop after some life stress, such as the loss of a relative or pet, a major illness, or the move to a new neighborhood. In young children, then, who do not have the cognitive capacities to understand sudden and/or dramatic life change, it is not clear when we can reasonably talk about a "disorder," as opposed to an appropriate reaction to a stressful, confusing, and/or frightening event. Because young children may not be expected to cope easily with certain kinds of stressful events or to readjust quickly to major life change but instead may need the close support of an attachment figure to help them make the necessary transitions, the expression of anxiety through nightmares, physical symptoms, or separation protest may be adaptive rather than pathological. Thus, a 3-year-old who shows a major reaction to a loss or other major life change or upsetting event, expressed as clinginess, crying, and other signs of separation distress, may be behaving in very predictable ways that clearly do not warrant a diagnosis of a psychiatric disorder. On the other hand, in the absence of any identifiable event in the life of a young child who becomes virtually panic stricken at the prospect of separation, such a diagnosis may be warranted; at the least, this fearful and incapacitating behavior may be evidence that something serious is going on in the family. It also seems reasonable that this diagnosis is less apt in 2- and 3-year-olds than in older preschool children, although in the face of a catastrophic event, such as the loss of a parent or family separation, such a reaction may not be unsurprising even in somewhat older children, who may be concerned for example, with being abandoned by the remaining parent.

It is interesting and appropriate that the Zero to Three system does not even mention separation anxiety as a disorder in its own right, because in infants and toddlers this would be an inappropriate diagnosis. Instead, the symptoms of clinginess and upset are more likely to reflect serious problems in the family and the child-caregiver relationship, if not outright deprivation or neglect. Similar comments can be made about the inclusion of mood and anxiety diagnoses in Zero to Three. Prolonged sad mood, excessive fear of strangers, excessive separation distress, and other intense fears are unlikely to occur on their own in very young children in the absence of a major loss, traumatic event, or neglectful or abusive care or in the context of a more serious disorder such as autism or reactive attachment disorder.

Parent–Child Problem

In recognition of the fact that many problems in young children reflect problems in the parent–child relationship or in parents' approaches to childrearing, the DSM also includes "parent–child relational problem" as another "condition" that may warrant clinical attention and be the focus of treatment. Surprisingly, this condition merits only a brief paragraph in the DSM, and it is not discussed explicitly in the DSM-PC despite the fact that this is a very common presenting complaint in pediatric primary care. Indeed, in the Lavigne et al. (1996) study, parent–child problem was the second most common classification (4.6%) after oppositional disorder, and it was more than twice as common as ADHD. In addition, dramatic differences appeared as a function of age. In the sample of 2-year-olds, 9.2% presented with a parent–child problem as the terrible 2's emerged, but by age 4 only 2.8% were considered parent–child problems, and by age 5, only one parent–child dyad was so classified. Because many problems of early childhood revolve around the quality of the parent–child relationship and issues of limit setting and control, and because this is by far the most widely researched area of early childhood social development, this topic clearly deserves more attention in diagnostic manuals for clinicians working with young children.

Summary

Although several diagnostic and dimensional assessment systems are now in widespread use with toddlers and preschoolers, it is difficult to make a blanket statement about which system is preferable. The dimensional approach of Achenbach (1991) that relies on the assessment of particular symptom clusters via parent and teacher rating scales has the benefit of a large empirical and cross-cultural database. On the other hand, structured interviews and the use of DSM-IV categories, especially when guided by the DSM-PC, may provide a more integrated picture of problems. At this stage of our knowledge, both are useful, although neither has adequately grappled with the developmental appropriateness versus clinical significance of behavioral clusters in very young children. Moreover, although there is accumulating data on the reliability of these measures with young children, validity issues require further work, especially in view of the large numbers of false positives that are often identified in screening and diagnostic assessments (Bennett,

Lipman, Racine, & Offord, 1998). With this in mind, I now turn to my own research on hard-to-manage preschool children to illustrate some of the issues described in prior chapters.

OVERVIEW OF LONGITUDINAL RESEARCH ON PROBLEM PRESCHOOLERS

When the first edition of this book was written more than 10 years ago, there was almost no research on problem preschoolers. The pioneering work of Naomi Richman and colleagues (1982) was my primary source of information. Over the past decade, interest in the emergence and manifestations of behavior problems in young children has grown, and I hope that my work has contributed to the concern about identifying problems early. Indeed, the work of Lavigne et al. (1996, 1998a, 1998b), Shaw et al. (1996, 1998, 2000), and Speltz et al. (1999), to name but a few, attests to the burgeoning interest in “early starters,” as well as in those with more transient adjustment reactions and difficulties with transitions.

In an effort to identify early behavioral markers for attention-deficit disorder and related externalizing behavior problems in young children and to understand more about the early developmental course of problem behavior, my students and I began a study focused on the early identification and follow-up of hard-to-manage preschool children in 1979. Two cohorts of children were followed longitudinally into middle childhood. We were initially quite concerned about the ethical implications of this work, because we worried about overpathologizing the difficult behavior of young children. For example, we were uncomfortable acknowledging that a particular child was a problem for fear of fueling a self-fulfilling cycle of negative parental perceptions, discipline problems, harsh childrearing practices, and escalating conflict. On the other hand, after years of clinical work with school-age children and their parents, we were convinced that some problems could be identified early and that parents could be given some support and guidance in dealing with hard-to-manage preschoolers who are capable of creating chaos in a family. We were also convinced that some hard-to-reach school-age youngsters developed problems partly as a result of insensitive and inappropriate childrearing, excessive stress in the family, and a generally unhealthy psychological environment that failed to support

them through difficult periods of development. Clearly, child characteristics were also important. As we got to know the families in our studies, the complexity and multiple determinants of these early-emerging problems became increasingly clear; their developmental course and outcomes also reflect complex transactions among a constellation of factors that are probably different for each child and family. This view now seems self-evident to students of developmental psychopathology and is generally accepted in the research (e.g., Cicchetti & Cohen, 1995; Cummings et al., 2000) and clinical (AAP, 1996) communities. However, when we began this work, this view was not widely accepted.

But, even today, the biological revolution in psychiatry threatens to reduce much of child psychopathology to neurotransmitter imbalances (e.g., Pliszka, McCracken, & Maas, 1996) and genetic determinism (Harris, 1998). It is certainly important to understand the underlying pathophysiology of disorder, as well as genetic contributions to child-rearing and to maladaptive patterns of behavior. Nevertheless, an overemphasis on biological determinism runs the risk of encouraging an overreliance on medication as the treatment of choice for young children (Coyle, 2000) in the absence of adequate appreciation of other factors in the child's life that require intervention if healthy development is to proceed. Therefore, although the developmental psychopathology perspective is widely accepted, the medical model perspective on children's problems is also widespread. In a sense, this perspective is reflected in the DSM approach to the diagnosis of disorders, which are conceptualized as within the individual child rather than as the outcome of a developmental and transactional process (Sroufe, 1997; Cummings et al., 2000).

Over the course of about 15 years, we have collected a huge amount of empirical data on the children and families who have participated in our studies, much of which has been reported in journal articles and book chapters (Campbell, 1991, 1994, 1997; Campbell, Breaux, Ewing, & Szumowski, 1986; Campbell & Cluss, 1982; Campbell, Breaux, Ewing, & Szumowski, 1984; Campbell, Ewing, Breaux, & Szumowski, 1986; Campbell, March, Pierce, & Ewing, 1991; Campbell et al., 1994; Campbell et al., 1996; Campbell, Szumowski, Ewing, Gluck, & Breaux, 1982; Pierce et al., 1999). This work has been conceptualized within a transactional model meant to examine changes in children and families over time in an attempt to understand the different developmental pathways followed by children who look hard to manage in the

early preschool years. I first describe the research in general terms and then present descriptions based on prototypic children that are meant to illustrate the types of problems that are apparent in early childhood. They illustrate different patterns of childhood symptoms, styles of family functioning, and strategies of childrearing that presumably set the child on a particular developmental pathway as a preschooler and ultimately also affect academic and social competence at elementary school age. They also suggest different initial causal mechanisms and different maintaining factors. Although etiological formulations remain speculative, it is generally agreed that similar clinical pictures may develop from diverse causes (Cicchetti & Rogosch, 1996).

Identification and Initial Assessment

The children in our first study did not consist of a representative sample of preschoolers who were difficult to handle. Because we were concerned about the ethics of labeling young children, we initially decided to recruit children through pediatric offices and preschools but to insist that parents initiate contact with the project. Thus our sample was composed of a self-selected group of parents who were seeking help because of problems managing their toddlers or young preschoolers. Parents with concerns about their child's activity level, defiance, poor impulse control, and difficulty playing alone were invited to participate in a study of development; parent training groups were offered as an incentive. Children with grossly delayed language development, psychotic-like symptoms, clear indications of brain damage, sensory impairments, or a Stanford-Binet IQ below 75 were excluded from the sample. Children between 25 and 47 months of age who were in good physical health made up the sample of 46 parent-referred problem youngsters and 22 controls. Details of sample recruitment may be found in Campbell et al. (1982).

Initial assessment data on each child were collected during a home visit, two visits to our laboratory playroom, and a visit to the child's preschool classroom. Assessments included a structured interview administered to the child's mother, a series of questionnaires describing child behavior that were completed by both parents and by preschool teachers, observations of the child in the laboratory during free play, structured tasks, interactive play with the mother, and a naturalistic observation of the child's interaction with peers and teachers in nursery school.

In addition, intelligence was assessed with the Stanford–Binet, and a delay task was administered as one index of impulse control. Measures of activity level, attention, compliance, and aggression were derived from the observations and questionnaires. A developmental and family history was obtained from a structured interview. Children were assessed again at ages 4 and 6 on parallel but age-appropriate measures. They were followed up again at age 9, with an emphasis on the children's behavior at home and school, as assessed by a structured interview with their mothers and questionnaires completed by mothers and teachers. At age 13, further follow-up data were obtained from interviews and questionnaires administered to mothers and to the adolescents themselves.

Initial parent reports indicated group differences on rating scales assessing hyperactive–distractible behavior and aggressive–noncompliant behavior; groups did not differ on scales assessing anxiety. Independent laboratory observations revealed that the free-play behavior of problem youngsters was less focused and directed to toys than the play of comparison children. The play of the problem children also was characterized by more shifts in activity from object to object and by more involvement with objects in the room other than toys. Parent-referred problem children also moved around more and were less attentive during structured tasks than comparison children. They were more impulsive on a laboratory task assessing delay capacity in which they were required to wait for a signal before finding and eating a cookie hidden under one of three cups (Campbell et al., 1982).

Those parent-identified hard-to-manage children who attended preschool were rated by their teachers as more hyperactive and aggressive than comparison children but, consistent with parental reports, not as more anxious. Observations in their preschool classrooms indicated that they were also more aggressive with peers; problem boys were less compliant with teacher requests than were other children in the sample. Problem and control groups did not differ in their tendency to approach peers or to play cooperatively (Campbell & Cluss, 1982). It should be noted that teachers were informed only that children were in a study of the development of preschoolers and that no mention was made of problem behavior.

Although the families of the problem children were, on average, from lower social classes and were experiencing higher levels of psychosocial stress—including parental illness, marital dysfunction or dis-

ruption, financial difficulties, or problems with extended family—there were wide individual differences on these background measures. Finally, on measures of mother-child interaction obtained during a relatively unstructured free-play period, problem children showed only a non-significant tendency to be more noncompliant or aggressive in their play. Mothers of hard-to-manage children were more likely than mothers of control children to be negative and controlling during this play observation (Campbell, Breaux, Ewing, Szumowski, & Pierce, 1986).

Age 4 Follow-Up

Parent report and laboratory measures were repeated 1 year later, when children were 4. As is often the case in longitudinal studies, differential attrition occurred. Families lost to follow-up were primarily from the problem group; even within this group, they tended to be the most distressed and dysfunctional families in the sample (Campbell et al., 1984; Campbell, Ewing, et al., 1986). This means that many of the more difficult children in the sample or those who would be expected, on theoretical and clinical grounds, to have the worst outcomes were among the children most likely to drop out of the study. Indeed, those families lost to follow-up differed significantly from those who remained in the study in both social class and level of psychosocial stress (Campbell, Ewing, et al., 1986). Despite this differential attrition, groups continued to differ at the age 4 follow-up assessment.

Children who were identified as problems at age 3 continued to be rated as significantly more hyperactive and aggressive at age 4, but not as more anxious. They also were less focused in their play, and they moved around more during structured tasks. On a laboratory task that required them to delay searching for a cookie hidden under one of three cups until they received a signal from the experimenter, problem youngsters were still more impulsive. It is also important to note that, despite these continued group differences, most children improved relative to their own initial performance, as evidenced by parallel developmental progressions in the two groups. Thus, as a group, the problem children became somewhat less active and impulsive, relative to their performance 1 year earlier, on several laboratory measures. These data indicate that children identified as hard-to-manage at age 3 continued to have more difficulties than comparison children when followed up 1 year later; thus, problems in the group as a whole did not appear to re-

flect only age-related activity or a transient developmental phenomenon. Further, within the problem group, children tended to maintain their rank order, with more active and impulsive 3-year-olds remaining more active and impulsive than their peers at age 4. For example, within the problem group, maternal ratings of aggression–hostility at age 3 and age 4 were significantly correlated, as were ratings of activity level; activity shifts during free play, observed at ages 3 and 4, were likewise related, as were impulsive responses on the cookie task.

Early predictors of maternal ratings of problem behavior at age 4 were also examined. Lower social class and more negative and controlling maternal behavior observed in the laboratory at age 3 predicted higher ratings of hyperactivity and aggression at age 4. In addition, boys who had been more noncompliant and aggressive during play with their mothers at age 3 and who had been rated by their mothers as more symptomatic at initial assessment continued to be rated as more active at age 4; negative child behavior and early aggression ratings, but not gender, also were associated with aggression ratings at age 4. These findings underline the relatively high degree of continuity in problem behavior, particularly in the context of a more negative mother–child relationship (Campbell, Breaux, Ewing, Szumowski, & Pierce, 1986).

Cohort 2

In a second longitudinal study, we focused only on boys, most recruited from local preschools and child-care centers and rated by their teachers or caregivers as overactive, impulsive, and inattentive. Boys rated high by their teachers were matched with classmates who were below our cutoffs for elevated symptom levels. A second group of parent-referred children was also included. As before, boys rated high on symptoms of ADHD (inattention, impulsivity, overactivity) were also rated high on measures of aggression and noncompliance. Moreover, most of the children rated high by teachers also received elevated ratings from parents, regardless of referral source (Campbell et al., 1991). Careful observational measures across home, school, and laboratory settings (by observers blind to group assignment or behavior in other contexts) were consistent with our data on our first cohort: problem boys ($n = 69$) were more impulsive, active, and disruptive when observed at home during a structured task, in the laboratory during free play and structured tasks, and in their preschool classrooms or child-care settings than were com-

parison boys ($n = 42$; Campbell et al., 1994). However, problem severity and its persistence over time were clearly related to indicators of family adversity (e.g., single-parent status, lower educational level, maternal depression, stressful life events) and to observations of negative maternal control in the laboratory during a toy-cleanup procedure (Campbell, 1994, 1997). To illustrate these issues more fully, four prototypic children are described next.

CHILD 1: JAMIE L.

Jamie was briefly introduced earlier. His mother called the project after seeing our descriptive poster in her pediatrician's office. Jamie was then 3½ years old. During the telephone screening, Mrs. L. stated that she was calling the project because of Jamie's problems in preschool, primarily aggression with peers and wild and uncontrollable behavior. His preschool teacher had recently asked her to consider removing him from school. Jamie's mother also complained about his frequent temper tantrums and defiance ("He doesn't take 'no' for an answer"), his overactivity ("always on the go; constantly moving"), and his tendency to get overexcited and out of control, especially when around other children.

During the home visit, Mrs. L. was interviewed about Jamie's early development and current behavior. He was born full term, weighing over 7 pounds, but with some mild delivery complications. Jamie was described as an active infant who cried a lot and was difficult to calm. He was irregular in his sleeping patterns and tended to require less sleep than his mother expected, taking short naps but not sleeping for long periods. Feeding, however, was not a problem. Jamie could be calmed somewhat in early infancy if he was held and walked, but by 6 months of age he resisted physical contact. His parents first became worried about a problem when he was just over 1 year old. Their concerns focused on his high activity level and his difficulty settling down. By age 3, their concerns also included his aggression with peers, short attention span, excitability, and discipline problems.

These middle-class, well-educated, professional parents were extremely patient with Jamie and set clear and relatively consistent limits. They avoided the use of physical punishment, which they saw as upsetting to Jamie and which could lead to even poorer control than a firm

but calm approach would. Thus they gave him a clear warning before sending him to his room to calm down. They also used a good deal of verbal reasoning with explicit rules. Mrs. L. noted that Jamie became easily upset by changes in routine and that he did best when he was well prepared ahead of time for something new.

Jamie and his 1-year-old brother lived with both parents in a quiet, residential neighborhood. Their mother had taken a break from her career to stay at home with her children. Her husband was likewise very involved with the family and spent evening and weekend time with the children; this also served to give Mrs. L. some needed time away from them. The marriage seemed stable, and the climate of the home was warm and relatively relaxed, under the circumstances. Jamie was clearly the main source of stress in the family because he needed frequent monitoring, direction, and supervision. Mr. and Mrs. L. agreed that Jamie was difficult, and they used similar methods of discipline with him. They both were feeling frustrated and defeated by the time they contacted the project.

Jamie was an appealing youngster with red hair and freckles. He greeted the home visitors enthusiastically and quickly struck up a conversation with the examiner. On the Stanford–Binet, he scored in the superior range of intelligence, and his good language and reasoning ability were especially noteworthy. Despite his cognitive strengths, the examiner noted his short attention span, fidgetiness, need for structure, and tendency to leave his seat frequently. These observations were consistent with his behavior during the laboratory assessment of free play, during which he shifted activities frequently and spent much of his time engaged with objects other than toys, such as locked cabinets. He was also more impulsive than average on the cookie task. During unstructured play with his mother, Jamie was moderately noncompliant, but Mrs. L.'s calm, warm, positive but firm approach was very effective in keeping him involved in elaborate and creative fantasy play. She was especially skilled at redirecting him to a new activity or at elaborating on his ongoing fantasy play as ways of keeping him focused. Despite Jamie's difficult behavior, Mrs. L. did not become confrontational. Jamie was eventually enrolled in a more structured preschool program, and his parents participated in a parent training group.

When Jamie was followed up at age 4, he showed some improvement in his ability to focus attention and to control himself, although he was still difficult to discipline, restless, easily bored, and aggressive

with peers. In the interim the family had moved to a new house, but otherwise the family situation was unchanged. His parents felt more comfortable about their methods of handling Jamie and were continuing to set firm and consistent limits and to support each other. Jamie was still active during free play in the lab, although he was able to control himself better on structured tasks, such as the cookie delay task.

In terms of the issues delineated earlier in this chapter, Jamie's behavior seems to be more than just annoying; he is not merely showing age-appropriate behavior that is misconstrued by intolerant parents. Indeed, his parents appear especially sensitive and supportive of him. Noteworthy are the severity and patterning of Jamie's problem behaviors, a mixture of high levels of hyperactivity, aggression with peers, and noncompliance. Further, his difficulties are apparent across situations—home, school, and lab—and persistent from ages 3 to 4.

It is difficult to arrive at a satisfactory etiological formulation of Jamie's problems, except by exclusion. Family disruption, poor child-rearing, or other environmental explanations appear inaccurate and inappropriate. Although Jamie appears to have been active, irregular, and difficult to console from early infancy, the notion of a poor match between child temperament and family environment (Thomas et al., 1968) does not seem to apply. Indeed, we were struck by the incredible patience of Jamie's parents and their ability to be firm but loving. It is hard to imagine what Jamie's behavior would have been like if, indeed, he had been born into a less stable, adaptive, and concerned family. It is hard to come up with predisposing factors except those reflected in Jamie's early problems with sleeping and consolability and the continuity noted over time in his excitability and problems with self-regulation, which may be indicative of a constitutional basis for his problems, consistent with the NCCIP diagnosis of self-regulatory difficulty. Jamie continued to have difficulties at home, at school, and with peers, despite his parents' concerted efforts to deal constructively and sensitively with his problems.

CHILD 2: ANNIE J.

Annie was also introduced at the beginning of this book. Her mother called the project when Annie was 2½ after seeing our poster in her pediatrician's office. Mrs. J. expressed concerns about Annie's high energy

level, tantrums, sleep problems, and fearfulness. She found Annie particularly difficult to discipline and seemed at a loss about how to handle her daughter's behavior. At the initial interview, Mrs. J. complained about Annie's impatience, low frustration tolerance, difficulty playing alone, lack of concentration, and fussiness. However, she also reported that Annie could amuse herself for up to 20 minutes at a stretch and enjoyed watching *Sesame Street*, suggesting that her attention span and ability to play alone were well within the typical range for a child her age. Mrs. J. was a highly anxious woman with doubts about her own competence. She questioned her own ability to manage Annie and noted that she and her husband disagreed on the best approach to childrearing. Mrs. J. had tried a number of different disciplinary approaches by the time she called the project, including reasoning, smacking, and time-out. When interviewed, her current approach was threatening to spank Annie with a wooden spoon and screaming at her when she misbehaved. Annie, in turn, was fighting back by screaming and smacking her mother and by throwing things. Despite this negative approach, Mrs. J. seemed unable to enforce limits, so that when a battle ensued between Annie and Mrs. J., Annie often won. Her tantrum behavior was clearly paying off. Annie's father appeared to be calmer, firmer, and less negative with her, as well as less easily manipulated, and, consequently, he did not elicit this explosive behavior from her. Mrs. J. also reported that she perceived Annie's difficult behavior as purposely provocative. When first seen, Annie was not yet toilet trained and was still in diapers; she was still drinking from a bottle, and she was sitting in a high chair for meals in order to keep her under control. Because she was not yet in preschool and had had only limited peer experiences, it was not possible to assess Annie's social behavior in another setting.

According to maternal report, Annie was born full term after a long and difficult delivery. Mrs. J. also reported pregnancy complications. She noted that she had been concerned about behavior problems from early infancy because Annie never slept much as an infant (although she also reported that Annie slept through the night for 6 or 7 hours from about 6 weeks on). Mrs. J. also reported feeding problems, a high activity level, and difficulty soothing Annie, who did not like to be held or cuddled. However, further inquiry did not clearly substantiate these patterns.

Annie was then the only child of college-educated parents in their

late 20s. Her father worked in a managerial position; her mother had stopped working just prior to Annie's birth and was home with her full time. The marriage was stable on the surface, with the exception of parental disagreements over Annie. No marital problems were acknowledged. However, Mrs. J.'s high anxiety level, anger and frustration with her daughter, intense concern, quite negative perceptions, and low self-esteem caused us to wonder about maternal depression and about the marital relationship as well.

Annie was an attractive little girl with blond hair and blue eyes. She was quite fussy and clingy during the home visit, demonstrating separation distress prior to the administration of the Stanford-Binet and insisting that her mother remain with her. The examiner noted that Annie was frequently out of her seat, was quite distractible, and refused to attempt several items. The test, though incomplete, revealed that she was functioning at least at the upper end of the bright normal level and probably higher. During the visit to the laboratory, Annie was frequently out of her seat and off task during structured activities; she was impulsive on a delay task; and she shifted activities frequently during free play, showing relatively limited involvement with toys and somewhat disorganized play. When asked to play with her mother, Annie was active, demanding, irritable, and noncompliant; her mother was seen as controlling and directive, as intruding inappropriately into Annie's play, as tending to nag, and as lacking in warmth. Overall, the quality of the interaction was fraught with tension and conflict over who was in control.

Mrs. J. described Annie as a difficult infant, and we did observe the overactivity and noncompliance she reported. However, the inconsistencies in Mrs. J.'s reports of Annie's behavior and her inability to set firm limits or provide opportunities to facilitate Annie's development were all indications of problems with childrearing and in the mother-child relationship. Annie probably was somewhat difficult and irritable as an infant, although it is also possible that she was a relatively easy baby with an overanxious, unsure mother who was insensitive to her signals and unable to meet her needs early on. It was quite clear from the interview material that Mrs. J. was not well informed about what to expect from a young infant; her expectations were at times unrealistically high (sleeping, attention span), at others unrealistically low (toilet training, weaning, experiences with peers). It was also apparent that

Mrs. J. was ineffective, inconsistent, and quite harsh in setting limits. Although she was intensely concerned about her daughter, she was not warm or affectionate. Indeed, project staff had the impression that Mrs. J. was extremely critical of and negative about Annie, an impression that has persisted over the years. The early history, paired with Annie's separation problems and her mother's high level of anxiety and tendency to infantilize her daughter, clearly suggest relationship difficulties, including an insecure (resistant) attachment. This impression derives from a consideration of Mrs. J.'s intense but insensitive and unresponsive behavior and Annie's apparent difficulties gaining comfort from her mother (Ainsworth et al., 1978; Carlson & Sroufe, 1995). By age 2½, Annie was locked in an ambivalent struggle with her mother over her needs for autonomy and independence, which were in conflict with her unmet needs for nurturance and support.

This troubled mother–daughter relationship probably was not helped by the fact that Mr. J. had a much easier time with Annie. He was warmer with her and less negative and controlling, and she responded by being more affectionate and agreeable. At the completion of the assessment, we recommended that Mr. and Mrs. J. attend a parent training group that focused on normal developmental expectations for toddlers and preschoolers and on setting firm, positive, and consistent limits. We also suggested that Annie be given the opportunity to play with other children. We also worked with Mr. and Mrs. J. on toilet training, as this area had become the focus of considerable parent–child conflict. Annie's parents eagerly followed our suggestions, but they had a difficult time thinking in developmental or psychological terms. They were not willing to accept a referral for additional help outside the project.

When Annie was followed up 1 year later, she had improved somewhat, according to maternal report. Similarly, observational measures suggested some improvement, although Annie was still less focused in her play than many other children in the sample. Mrs. J. also reported that Annie was toilet trained and not drinking from a bottle any longer. She also had been enrolled in a preschool program several mornings a week. There she reportedly was doing well with her peers, and she loved going. The teacher saw no problems with her. However, the interview revealed that Mrs. J. still saw Annie as requiring a good deal of structure, as defiant, and as difficult to control. Mrs. J. complained of having particular difficulty when she took Annie shopping, expecting

her to wait patiently and not to touch things, another example of inappropriate expectations. In addition, sleep problems were reported, with Annie going into her parents' bed several times a week; eating had also become an area of conflict, with Annie refusing certain foods and her mother trying to coax her to eat and at times feeding her. In addition, Mrs. J. had been briefly hospitalized during the interim for a medical problem, and Annie had begun to wet her bed in response to her mother's departure.

Thus problems with developmental tasks continued to be in evidence, fueled by the parents' difficulties conceptualizing their daughter's psychological needs or helping her to negotiate issues of separation-individuation and the establishment of autonomy and independence. It is particularly significant that Annie was able to separate successfully enough to attend a preschool program and that her teacher found her eager to play with other children and to participate in structured activities. With the appropriate emotional support provided by the preschool teacher, Annie was able to begin to reach out to others and to develop appropriately in certain areas.

Significantly, although Annie appeared to have relatively severe difficulties at age 3, and although according to maternal report, her earlier behavior had been quite problematic, she had made notable gains by age 4. Despite these gains, Mrs. J. still complained about a range of difficulties with Annie, although these difficulties appeared to be specific to her relationship with her mother and did not spill over to affect her school adjustment. Thus her problems were not cross-situational. Further, the pattern of her symptoms suggests a mixture of anxiety and high activity level rather than aggressive behavior. Her activity level may well reflect her high level of anxiety, whereas maternal reports of defiance and oppositional behavior may reflect inappropriate expectations or Annie's attempts to separate and gain control, as well as a coercive pattern of interaction between mother and daughter (Patterson, 1980). Annie's problems generally suggest a poor fit between her own developmental and emotional needs, possibly a somewhat fearful, inhibited, and irritable temperamental style (Rothbart & Bates, 1998), accompanied by poor regulatory skills, and her mother's harsh disciplinary style, unrealistic expectations, and lack of warmth and acceptance. This pattern of mother-daughter conflict and negative maternal perceptions has persisted, although Annie also continues to function well at school and with peers.

CHILD 3: ROBBIE S.

Mrs. S. called the project when Robbie was just 3, reporting that she was “at her wits’ end” and no longer knew how to deal with her son’s high activity level. She reported that he could not sit still, was up at 6 A.M. “running the halls,” that he was moving all the time, and that he had an attention span of “less than 20 seconds.” She also noted that he was unable to entertain himself, except in the bathtub.

During the intake interview, Mrs. S. reported that she had first become concerned about Robbie’s high activity level and sleep difficulties when he was 9 months old but was reassured by her pediatrician that his behavior was not that atypical and would be outgrown. She noted that he was still a restless sleeper who moved around a lot during sleep and that he slept for relatively brief periods. By age 3, he was no longer taking afternoon naps. She described Robbie as unable to relax and unable to focus on one toy for more than a few seconds, tending instead to move rapidly from one toy to another during play. He was not at all interested in stories or other sedentary activities. Mrs. S. described relatively violent temper tantrums that included throwing things, hitting and kicking, screaming, and crying, but she noted that Robbie was not aggressive around other children. Mrs. S. was firm but patient with him; she set clear guidelines for acceptable behavior and did not give in to his tantrums. She was also quick to praise his good behavior and to provide rational reasons for limits and prohibitions. Mr. S., on the other hand, was quite inconsistent, sometimes giving in to Robbie’s tantrums, sometimes becoming very angry and harsh with him.

Robbie was born full term after a long and difficult labor, but there were no indications of fetal distress. Despite sleep problems and a high activity level, he was described as a cuddly infant without feeding or other difficulties. Robbie is the younger of two children. His 6-year-old sister was reported to be developing normally. Both parents graduated from high school and were employed in managerial positions. Robbie’s mother returned to work when he was 6 weeks old, placing him in family day care. He was still in the same day care setting when he was first seen in the project.

At the time of the home visit, Robbie greeted the tester with an impish grin and proceeded to show her his trucks. Robbie was an extremely outgoing and engaging child with curly, blond hair and green eyes. He readily separated from his mother but left the test session from

time to time to “check in” with her and tell her what he was doing. His language was somewhat immature and difficult to understand, but Robbie was a bright youngster and caught on quickly to task demands, performing in the bright normal range. He was frequently out of his seat during testing, but he was relatively easy to redirect with the introduction of a new task.

During the observation of free play in the laboratory, Robbie shifted activities frequently, playing only briefly with any one toy. He was much more interested in manipulating forbidden objects (the video camera, microphone, locked cabinets) and climbing into the sink. He was at the extremes on measures of activity and inattention derived from these observations. In addition, on a delay task that required him to wait for a signal from the experimenter before finding and eating a piece of cookie, Robbie made several impulsive responses. He was frequently out of his seat and off task during structured tasks. Thus, during a laboratory assessment of activity level, attention, and impulse control, Robbie confirmed his mother's reports of problematic behavior. During the mother-child play interaction, Robbie was able to focus attention on toys for much longer and was even able to complete several tasks. His mother provided him with a good deal of structure, support, and positive feedback while firmly and consistently enforcing limits. The relationship between Robbie and his mother seemed warm and positive.

There was little doubt from Robbie's history and behavior at initial intake that he was showing early signs of problems that might well reflect attention-deficit/hyperactivity disorder. However, several issues complicate the formulation of his difficulties. First, Robbie had been in day care from 6 weeks of age until age 3 in a setting that appeared to provide adequate physical and emotional care but inadequate cognitive stimulation or organized activities with age-mates. Second, there was a significant family history of antisocial behavior and what appeared to be bipolar disorder in first-degree relatives of both parents. Third, Robbie's parents had an extremely poor marital relationship, with frequent arguments and much tension. Finally, Robbie's father was inconsistently and intermittently involved with him. Mr. S. showed brief periods of great interest and concern but would then withdraw and ignore Robbie, rebuffing his overtures.

Mrs. S. was very eager for help and support. She attended a parent training group faithfully and completed all homework assignments with incredible thoroughness. She was already utilizing most of the disciplin-

ary approaches discussed in the group but seemed to derive a good deal of satisfaction and comfort from discussing Robbie with the other parents. She also felt vindicated by the support of the group leaders. Mr. S. blamed Robbie's problems on his wife's "laxness" (i.e., her use of reasoning and time-out, rather than physical punishment), and she was clearly concerned about whether or not she might be the "cause" of his difficult behavior. Mr. S. refused to accompany his wife to any of these sessions.

Robbie changed child-care arrangements several months after entering the project. He moved from the family day-care home to a well-run day-care center with age-appropriate structured activities and a good staff-to-child ratio, where he could play with other children his own age. Robbie adjusted well to this new setting, got along well with other children, and became more manageable at home. For example, he would come home exhausted from day care and began to sleep through the night. Bedtime was no longer a struggle.

At the age 4 follow-up, Mrs. S. reported that Robbie's behavior continued to improve. His mother saw him as much more manageable and as able to entertain himself for brief periods of time. She reported that he got along well with the other children in child care and loved going. Although he still had relatively regular temper tantrums, Mrs. S. felt much more in control of the situation. She was explicit and consistent in setting limits and able to ignore tantrum behavior. Laboratory observations likewise suggested some improvement in Robbie's self-control, as reflected in more focused play and less impulsivity.

Despite these apparent improvements, there had been a number of significant changes in Robbie's life. The marital situation further deteriorated, and his parents separated just prior to his fourth birthday. Robbie was, not surprisingly, confused about the situation; unfortunately, the conflict between his parents became increasingly intense, and Robbie became the focus of their anger and resentment. This situation has steadily worsened. In particular, Mr. S. threatened Mrs. S. with a custody suit. When Robbie was 5, Mrs. S. called asking for a referral for Robbie, who was wetting his bed, having nightmares, and wanting to sleep with her. He was also having angry outbursts at home and getting into fights with his sister, as well as with other children at school. He and his sister had, unfortunately, been put into the position of message carriers between their warring parents. Robbie was seen in play therapy for a number of months in an attempt to help him deal with his

confused and intense feelings of anger and betrayal, as well as his concerns about being abandoned. Like many youngsters his age facing parental separation, his ambivalence about his absent father was intense (Wallerstein & Kelly, 1980); he longed for and worried about his father and fantasized about reunion but was often reluctant to visit and adamantly refused to leave his mother on several occasions.

It appeared that we were dealing with a youngster whose initial difficulties reflected a combination of temperamental difficultness and family tensions. His problems appeared to have been exacerbated by the continuing instability in his life. Initial problems appeared relatively severe and apparent across situations, although his good adjustment to day care and his lack of aggression with peers were noteworthy. The nature and severity of Robbie's problems appeared to wax and wane in tandem with environmental stress and instability, factors which are likely to predict later outcome. Continued follow-up has revealed persistent problems that appear to worsen when family stress intensifies; Robbie also has had a good deal of difficulty coping with the demands for conformity, achievement, and compliance required in school.

CHILD 4: TEDDY M.

When Teddy was just under 2½, Mrs. M. called the project to seek help. She was concerned particularly about Teddy's high activity level, short attention span, excitability with peers, and difficulty amusing himself. He was not, however, described as either aggressive with peers or difficult to discipline. During the interview, Mrs. M. also noted concerns about Teddy's low frustration tolerance and his lack of sustained involvement in play. Although she described him as able to play alone for as long as 30 minutes on some construction activities, she was concerned about his tendency to move quickly from one activity to another and to show little interest in many of his toys.

Teddy was described as a somewhat irritable infant who cried a lot when tired and required more than an average amount of sleep. He was not a cuddly baby, and, when upset, he was described as quite difficult to console, sometimes crying for 30 minutes at a time. When distressed, Teddy did not like to be held, and he generally resisted physical restraint. He was also quite active as an infant and walked early. Feeding

was not a problem. Teddy was a full term infant, delivered without complications. There is nothing remarkable in his developmental or family history.

Mr. and Mrs. M. were both college educated, and Mr. M. was employed at a managerial level in a local business. Mrs. M., a former nurse, remained home full time with Teddy and his 5-year-old brother. She reported that she was able to discipline Teddy effectively, relying primarily on reasoning and sitting him on a chair in time-out. The marriage appeared to be stable, and Mr. M. was quite involved with the children. There were no problems noted with their older child, who was described as much easier to care for as an infant and much less active than Teddy as a toddler and preschooler. Teddy was only 28 months old when first seen in the project, and he was not attending any organized preschool.

Teddy was a cute youngster with brown hair and brown eyes. At first he was somewhat shy with the tester, but after a few minutes of play and conversation with his mother present, he warmed up and showed interest in the “games” she had brought. Teddy was cooperative during the administration of the Stanford–Binet, and he performed at the bright normal level. The examiner did not find him particularly fidgety or inattentive, and he remained seated for the entire 30-minute testing session. During the laboratory assessment of free play, Teddy showed interest in the toys and became particularly involved with a family of dolls and a pounding toy, spending most of his time with one or the other of these. He did explore other toys and the room in general, but he was much more focused on specific toys than the other three children described previously. Although Teddy was impulsive on the cookie-delay task, he was neither fidgety nor inattentive during structured tasks. During the mother–child play interaction, Teddy was engrossed with a toy workbench, and he played relatively independently. His mother, though warm and supportive, was quite directive. Based on the laboratory assessment and our observations of Teddy during the home visit, we did not see him as more active or distractible than the average 28-month-old. Both parents attended a parent training group, where we hoped that exposure to other parents of children with more severe problems would place Teddy’s behavior in a more appropriate developmental perspective.

When seen for follow-up 1 year later, Teddy was still described by his mother as somewhat restless and inattentive on interview; she also

expressed some concern about his difficulty sharing toys and his emerging verbal defiance. However, she saw these as only mild problems. The laboratory assessment did not suggest that Teddy was particularly active, inattentive, or impulsive. Although he changed activities fairly often during free play, he was not impulsive on the cookie task and he was attentive and organized on other structured tasks.

Teddy seems to be a good example of a child who was developing normally, although he may have been somewhat more difficult than average in infancy. Alternatively, he may have been merely more active and less cuddly in infancy than his brother, something for which his parents were not prepared. In either event, it appears that Mr. and Mrs. M had high expectations and they sometimes misinterpreted Teddy's age-appropriate activity level, relatively short bouts of sustained play, and limited ability to share toys as problems. Mr. and Mrs. M. were seen as somewhat demanding, although they were also warm and loving. This type of early parent-child mismatch has the potential to lead to overly harsh discipline or to parent-child conflict that escalates and leads to more serious later problems. However, Teddy's family was a stable, caring, and concerned one and his parents were firm but not overbearing in their approach to childrearing.

The pattern of Teddy's behavior is also worth considering. Not only were his symptoms relatively mild, but parental complaints of hyperactivity and inattention were not combined with concerns about aggression toward peers or high levels of oppositional or impulsive behavior. His behavior was also not problematic in many situations, and he did not become more difficult to manage with development. Rather, parental concerns at age 4 were somewhat different from their initial complaints and focused on age-appropriate manifestations of development. Thus, from the start, Teddy looked more like a comparison youngster than a child with a clinically significant problem that was likely to persist and/or escalate in severity. Continued follow-up was consistent with this interpretation.

SUMMARY

In this chapter, several clinical issues were discussed. Differences between age-specific problems and signs of more serious, potentially per-

sistent problems were addressed. In particular, drawing on data from epidemiological studies, it was concluded that problem behaviors are very common in the general population of nonreferred children and that many troublesome behaviors also show age-related developmental change. The social and developmental context in which problem behavior occurs was seen as crucial in determining whether an annoying or worrisome behavior should be considered merely typical, an indicator of a difficult developmental transition, or a sign of a potentially significant problem. It was concluded that symptoms that clustered together and appeared to interfere with developmental progress were particularly worthy of concern. Several factors influencing referral were also noted, and patterns of behavioral disturbance in young children were described.

Diagnostic issues also were addressed. It was concluded that the developmental guidelines contained in DSM-IV are inadequate but that, when they are used in conjunction with the more elaborate descriptions of problem severity, family and social context, and developmental manifestations contained in the DSM-PC, more appropriate and more cautious diagnostic decisions can be made. Closer examination of the diagnostic criteria for attention-deficit/hyperactivity disorder, oppositional defiant disorder, and separation anxiety disorder, however, indicate that many of the behaviors that define these disorders may be age-appropriate behaviors or typical ways of reacting to stress in young children. Therefore, the need for caution in the use of these diagnostic labels was seen as important. Although some 3- and 4-year-olds may well meet criteria for these disorders, there is also the danger of overpathologizing the typical behaviors of young children; the use of a diagnostic label, with the implication that the problem is "within the child," is often misleading, unnecessarily upsetting to parents, and potentially stigmatizing. The need to consider developmental appropriateness, as well as family and social context when making a diagnosis, cannot be overemphasized.

An attempt was then made to illustrate these issues by describing our longitudinal research on hard-to-manage preschoolers. Comparisons between problem youngsters and comparison children at intake and after a 1-year interval indicated that parental concerns were likely to be confirmed by data obtained from other sources and that problems persisted in some children. Four prototypic children from the study

were then described in more detail in order to provide illustrations of the nature of early symptomatology in young children whose parents found them difficult to manage in toddlerhood and the early preschool period. In each instance, problems of one sort or another appeared quite early, at least by the child's first birthday; some relatively significant problems also were found to persist at the age 4 follow-up. In particular, the constellation of hyperactivity, impulsivity, inattention, defiance, and peer aggression was associated with continued externalizing problems. Sleep problems were also often evidenced. The relative contributions of child characteristics, parental expectations and management strategies, and ongoing family stresses to problem identification and persistence appeared to vary somewhat from one child to the next, illustrating different patterns of symptoms, as well as different pathways to early difficulties.

In one instance, child problems appeared to be rather isolated symptoms in a well-functioning family. Unrealistic parental expectations, probably paired with a child's fearfulness and negative affect, appeared to be associated with problems in a youngster whose difficulties were not clearly atypical initially. A negative mother-child relationship was associated with an uncertain outcome at age 4. With another child, high parental expectations were associated with positive parenting and a good parent-child relationship. The outlook for this child appeared to be good. In yet another, the relative contributions of endogenous child characteristics and family dysfunction were more difficult to disentangle, although severe family disruption led to the appearance of new symptoms. Symptoms of anxiety and sadness were especially apparent in association either with severe mother-child conflict or marked family disruption, although in most instances both externalizing and internalizing symptoms occurred together.

These clinical vignettes also illustrate the observation that particular symptoms appear to become salient at different stages of development, sometimes as exaggerations of normal developmental tasks. Thus sleep and feeding problems and consolability appear especially noticeable in infancy; activity level becomes particularly important as children become mobile and exploratory around the first birthday. By age 2 or so, compliance with requests and ability to play alone also become important, as parental expectations change with the child's growing cognitive and self-regulatory abilities. Peer relations, the ability to play cooperatively with other children and to share toys without eruptions of exces-

sive aggression, become noteworthy at about age 3, as children show more focused interest in peers in more formalized preschool and day-care programs. By age 4, children seem to be able to cooperate better in the peer group and to function more independently at home, although issues of noncompliance and self-regulation are still primary parental concerns.