

*In the Eye of the Beholder:
Critical Components of Observation When Assessing Disruptive
Behaviors in Young Children*

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Clinical observation is an essential component of a sensitive diagnostic assessment of children's development (American Academy of Child and Adolescent Psychiatry [AACAP], 1997; Benham, 2000; Cicchetti & Abner, 1998; Greenspan, Meisels, & ZERO TO THREE Work Group on Developmental Assessment, 1996). We define clinical observation as direct observation that includes experience interacting with the child. Such observations are designed to elicit a range of behaviors and other aspects of the child's functioning as he or she engages in tasks relevant to the presenting behavior problem (Wakschlag & Danis, 2004). Clinical observation provides the foundation for clinical judgment, which is the overall integrated assessment of the child's behavior. The clinician determines the importance of a child's particular behaviors on the basis of factors such as age appropriateness and the context in which they occur (Wakschlag et al., 2005).

In this article, we describe the role of clinical observation in helping practitioners make the distinction between young children's developmentally normative misbehavior and disruptive behavior requiring clinical intervention. We highlight the Disruptive Behavior Diagnostic Observation Schedule (DB-DOS) as a useful tool for this purpose.

THE ROLE OF
OBSERVATION

Clinical observation is critical for

clinical assessment of young children because of the difficulty distinguishing normal variations in behavior and development from clinical problems. Developmentally sensitive observation may be particularly vital when evaluating young children with disruptive behaviors, as there is substantial overlap between normal misbehaviors of early childhood and behaviors that are more disruptive and require intervention (Danis & Wakschlag, 2004; Wakschlag et al., 2007; Zeanah, Boris, & Scheeringa, 1997). How do clinicians make this distinction?

Without observing the behavior directly, the clinician is limited to reports from a parent or from another caregiver or teacher. Although parental and other informant reports provide critical historical context for the behaviors, reliance solely on parental report limits the clinician's ability to identify the nuanced facets of behavior that distinguish problematic patterns from normal developmental issues. Parents are better reporters about the history of behavior than about its quality (Wakschlag et al., 2005). Parent reports are further complicated by the fact that they may be influenced by a variety of factors, including a parent's knowledge of and experience with appropriate developmental expectations at a particular age, family stressors, parental psychopathology, and concern about how they will be perceived by others (Briggs-Gowan, Carter, & Schwab-Stone, 1996; Hay et al., 1999). Discrepancies between the reports from parents and those from other

informants are the rule rather than the exception (De Los Reyes, Henry, Tolan, & Wakschlag, 2008).

The opportunity to directly observe an episode of disruptive behavior (e.g., noncompliance, aggression, tantrums) during assessment allows the clinician a chance to witness what happens directly before the problem behavior as well as the quality of the behavior. Behavior quality refers to the intensity, organization (e.g., the child's ability to recover after tantrums), and flexibility of behavior to environmental input (Wakschlag et al., 2007). Direct observation also provides a chance to assess the extent to which the child's behavioral struggles vary across social partner (e.g., with a parent vs. a nonparental adult, such as a clinician or teacher). Observing the child's behavior in the context of parent-child interactions provides a unique opportunity to observe parenting behavior and parents' effectiveness in supporting a child's regulatory capacities. This information is invaluable to the clinician, both in understanding the behavior, as well as in providing treatment guidelines.

Imagine, for example, the differences between 4-year-olds Peter and Justin. Both are described by their parents as having angry tantrums at home. When they come in for an evaluation,

Clinical observation, whether conducted at home, in the therapist's office, at child care, or in the lab, is an essential component of a sensitive and accurate diagnostic assessment. In this article, the authors describe the Disruptive Behavior Diagnostic Observation Schedule (DB-DOS), a structured diagnostic tool encompassing 3 essential features of observation: (a) the use of challenging tasks to elicit behaviors of interest, (b) opportunities to observe behavior with different people, and (c) the clinician's conscious and deliberate use of self to offer various levels of support to better assess the child's capacities for self-regulation.

Peter has a tantrum in response to transitioning from playing with the toys in the waiting room to moving into the clinician's office. After being reassured that there are also toys in the office and after a firm, calm direction from his parents, he comes unwillingly into the office. Once Peter enters the clinician's office, he sees the new toys and immediately settles down, engages in play, and shares his pleasure in the new toys with his parents and the clinician. This is in contrast to Justin, who has a similar tantrum transitioning from the toys. When he enters the new office, he refuses to play with the new toys, remains angry and sullen throughout the session, and cannot settle in, despite attempts by his parents and the clinician to engage him. In a parental report, these boys would both be described as having tantrums, but once the behavior and the caretaker's response to the behavior have been observed, different conclusions and possible treatment recommendations would necessarily follow.

There is a long history of using informal, unstructured clinical observations, as well as structured observations of the parent-child interaction to evaluate children's behavior and development (Zelenko, 2004). Clinicians make observations continuously, often beginning as soon as the child enters the waiting room. A major component of clinical work is being an astute observer of behavior and assigning meaning to the behavior within the context in which it occurs. Informal, unstructured observations assist the clinician to better understand what the child's behavior may be communicating about his or her response to and fit within the environment. Observations also help to inform the clinician regarding a child's response to treatment interventions.

Although such informal observations are useful, in our experience within a specialty clinic for preschool disruptive behavior, they were not clinically informative. In particular, this style of observation did not provide the opportunity to elicit the disruptive behavior in question, except for children with extreme problems (Wakschlag & Danis, 2004), making it difficult to evaluate the behavior and provide intervention. Parents of children who seek help from our clinic typically report frequent, pervasive,

and intransigent disruptive behaviors such as destructive tantrums, aggression, and/or provocative noncompliance. These behaviors pose significant impairment to the child's ability to learn at school, make and keep friends, and get along with others. In severe cases, such children may have been expelled from preschool. The child's behavior also places a burden on the family and may severely limit the family's ability to set limits or age-appropriate expectations. Families may risk job loss and corresponding economic burdens, such as when a parent receives multiple calls from child care during work hours or must repeatedly leave early to take the child home. The family's ability to participate in the community may be constrained by a child who cannot be taken to church, to the grocery store, or the library. In addition, the extended familial or marital relationship may be affected when a parent is unable to leave the child with family members or other caretakers.

However, these same children, when observed in our clinic both informally in unstructured interactions and during semistructured parent-child interactions (Wakschlag & Keenan, 2001), did not display high rates of or variations in disruptive behavior. The discrepancy between parental report and what we observed of the child during the assessment made clinical decision making challenging. Clinicians who assess children less than 5 years old face additional challenges if the children do not participate in settings outside the home, such as school or day care, making it impossible to obtain additional reports of their behavior from other informants.

The discrepancy between parent-reported behaviors and those observed by clinicians is not uncommon and mirrors the discrepancy between parent and teacher reports of children's behavior (De Los Reyes & Kazdin, 2005). There are several reasons why a child's behavior may be better regulated in the clinical setting than at home. It is possible that a child is actively working hard to regulate his or her behavior, or the child may feel inhibited in the clinical setting and so is more reserved and quiet than is typical. Although the child is unlikely to be able to keep up this self-control, an initial assessment may not continue

for enough sessions for the clinician to observe the child's more typical behavior. Even when a child is seen over numerous sessions, a clinician may not see the behaviors that the parents report. It is informative that the child has the capacity to demonstrate adequate self-control when they have the full attention of a clinician and can play with novel toys; however, clinicians remain significantly limited in the extent to which they can make informed decisions about whether the reported symptoms are clinically significant patterns or normative misbehaviors if they have not had the opportunity to directly observe the problem behaviors.

THE DB-DOS

The DB-DOS, a standardized observational assessment tool, modeled after the Autism Diagnostic Observation Schedule (ADOS) developed by Cathy Lord and her colleagues (Lord et al, 2000), facilitates this goal with three important elements of clinical observation (Wakschlag, Briggs-Gowan, et al., 2008; Wakschlag, Hill, et al., 2008): (a) tasks designed to elicit the problem behavior, referred to as presses; (b) observation in multiple settings; and (c) the clinician's purposeful use of their own attitudes and behaviors, referred to as the use of self, during the evaluation process.

ELICITING DISRUPTIVE BEHAVIOR

The DB-DOS was organized to "test" the child's capacity for regulating behavior and modulating anger in response to a series of tasks that press for disruptive behavior, including frustration, compliance, prohibition, and social play tasks. Although such tasks may elicit mild or transient "misbehavior" (e.g. refusing to clean up) in many children, those who are having clinically significant behavior problems may demonstrate difficulty recovering from anger, intransigent defiance, provocative misbehavior, and resistance to environmental input. The presses provide invaluable clinical data about a child's capacity for self-control when faced with a challenge.

Imagine two different children, both 3 years of age, who are described as having behavior difficulties at school. Both children are well behaved during the clinical interview with the

parent, and neither parent describes difficulties at home. When seen alone with a clinician, both children are presented with a press for frustration (i.e., a bubble toy that does not work). The first child, Teresa, tries the bubble toy and, when she realizes it doesn't work, she demonstrates limited coping skills. Specifically, she puts the toy down and spends the rest of the time not making eye contact with the clinician and looking more and more withdrawn. She does not try to elicit help, nor does she try problem solving to figure out why the toy does not work. She is not responsive to prompts or suggestions by the clinician, except to try the toy again, and when it does not work, she puts it down again and withdraws.

The second child, Isabella, tries the bubble toy, and when it does not work she whines and complains to the clinician. She gets out of her seat and tries to open cabinets to see if there's something else to play with, despite directions from the clinician that she needs to wait a few minutes before they can play with something else. She sighs and pouts and uses the toy by provocatively "shooting" the clinician. She then grabs the working toy that is next to the clinician and runs around the room with it. In contrast to Teresa and Isabella, typically developing children often respond to this press by trying to fix the toy, suggesting reasons why it will not work (e.g., "maybe it needs new batteries"); asking for help from the clinician, using the toy in creative ways (e.g., as a hair dryer); or spending the time chatting with the clinician.

From these observations, we learn a great deal about the ways in which children respond to frustration, how they may try to cope or manage frustration, and in what unique and specific ways they are each unsuccessful in appropriately eliciting help from an adult. These observations lead to very different treatment goals and different suggestions about how one might structure school environment to help each child be more successful.

OBSERVATION IN DIFFERENT SETTINGS

An additional reason why clinicians may not observe disruptive behavior in the clinic is that children's

behaviors are truly context specific. Although obtaining information from multiple people who interact with the child can assist in assessing the pervasiveness of disruptive behavior, it is incomplete without direct observation by the evaluator. The DB-DOS provides a structured opportunity to directly assess the child's behavior across multiple settings and different individuals by repeating the presses within three distinct interactional contexts: one with the parent and two with the clinical examiner providing varying levels of support.

Research corroborates reports that children behave differently in different settings. In our Chicago Preschool Project sample (Wakschlag et al., 2005), in which disruptive behavior symptoms were assessed by both parent and teacher report, only 19% of children with clinically significant symptoms were identified by both parent and teacher. For example, in the Chicago Preschool Project, approximately half of the disruptive preschoolers were reported to display disruptive behavior only within the parent-child relationship and approximately one third of the disruptive preschoolers were reported to exhibit disruptive behavior only at school. These reported differences corresponded to observed differences. Children identified as disruptive by parent report but not by teacher report were more likely to be disruptive only with their parent on the DB-DOS. Likewise, children who were reported by both teacher and parent as disruptive were more likely to be disruptive with both parent and examiner on the DB-DOS (De Los Reyes, Henry, Tolan, & Wakschlag, 2008).

To illustrate, Sara was a 5-year-old girl referred to our preschool clinic because of extremely angry and aggressive behavior at home. The parents described "walking on eggshells" and feeling like this child was a tyrant in their home. However, this same child was described by her teachers as quite well behaved and successful at school. During the interactions with the examiner, during developmental testing, and with her parents during a clinical interview, Sara demonstrated age-appropriate social skills, affect regulation, and behavioral regulation. Sara's behavior was dramatically different when alone with her parents during

the observation. She refused even social bids from her parents and was bossy, inflexible, and spiteful. She provocatively tested limits, jumping up on the table and ripping up materials. She was quick to anger and slow to recover. The stark contrast between her behavior with her parents and her behavior in other interactional contexts was striking and informative.

When a child demonstrates impairing disruptive behavior only within the family context, parents may feel frustrated, incompetent, and blamed or disbelieved by the clinician. In fact, there are times when, because the clinician does not see evidence of the reported behavior problems, they may begin to doubt the veracity of the parent's report. However, research indicates that discrepancies between informants (e.g., teacher and parent) are indicative of meaningful variations in children's behavior in different contexts (Achenbach, 2006; De Los Reyes & Kazdin, 2005). In addition, direct clinical observation during the DB-DOS suggests that, although children with disruptive behavior were more likely to have mothers who exhibit problematic parenting, approximately one quarter of the mothers of disruptive preschoolers displayed responsive parenting (Hill et al., 2008). Furthermore, disruptive behavior on the DB-DOS significantly increased risk of later impairment, even with quality of parenting taken into account (Wakschlag et al., 2008). Thus, although problems in the parent-child relationship are often associated with early disruptive behavior, empirical evidence does not substantiate the notion that disruptive behavior in young children is "merely" a parenting problem.

CLINICAL USE OF THE SELF

Observing the child's response to challenging tasks within different contexts is now a standard component of our evaluations of young children. Another particularly informative feature of the DB-DOS is the process of defining or operationalizing how the evaluator uses his or her own attitudes and behaviors within a standardized direct observation. Many clinicians intuitively vary their behavior to observe the impact of changing "therapeutic bids" (Roth & Kulb, 1997) on the child's behavior. However, the extent to which this

use of self is informative is very much influenced by the particular skill and developmental knowledge of the clinician. Most clinicians have a varied and broad repertoire of skills that they use intuitively and even unconsciously to help support a child's successful social interaction. For example, clinicians may vary their tone of voice, speaking more softly to a child who seems anxious. They may sit closer to a child who is having trouble staying in her seat. They make more eye contact with a child who is distracted or less eye contact with a child who seems shy. When clinicians are trying to get a child to complete a task (e.g., during developmental testing) they often work hard to get a child's best performance, using praise and encouragement, varying the tasks to keep a child's interest, and using rewards such as playtime or snacks. During free play or play-based assessments, clinicians are typically taught to follow the child's lead during play.

The support that clinicians often provide intuitively, such as noticing early signs of the child's frustration (e.g., sighing and disengaging from a task), often enable the clinician to elicit the child's optimal capacity for functioning. We argue that, because this support is idiosyncratic to clinician and child and is based on intuitive moment-to-moment interactions, it can be difficult to systematically gauge the child's capacity for self-regulation versus the ability to make use of (often substantial) environmental support. Although the clinician may be conscious of how hard he or she has to work to help a particular child succeed, this "clinical dance" often becomes so natural that it may inadvertently mask or conceal a child's struggles.

To illustrate this point, we present the following vignette. Marcus, a 4-year-old boy, was doing well at home but having significant tantrums at school. Before we saw him, we suspected that perhaps he was experiencing separation anxiety. When he came in to the clinic, he did not appear anxious in the unfamiliar setting and, after a transition time, he separated easily from his parents. When the clinician was sitting with Marcus, he was compliant, responded to input, took pride in his accomplishments, and had good problem-solving

skills. However, when asked to work independently, Marcus displayed significant difficulty regulating his emotions and behavior. He became quickly frustrated by a challenging task and escalated, seemingly without warning, into full-blown anger. He threw puzzle pieces at the clinician. He then threw chairs and mocked and taunted the clinician when told he could not throw things.

It was clear when observing his behavior that the mere presence of an adult was organizing for this child—but why was this so? On further reflection, we realized that the clinician had been providing structure and support, without conscious awareness, which helped him to be successful. We wanted to make ourselves more conscious of these intuitive gestures. In this way, we could increase support gradually, using the child's behavior as a gauge for when support was needed. This would minimize the chance that we would unknowingly mask struggles that the child was having by rushing in and helping the child to tolerate frustration.

To this end, we developed a graded hierarchy of prompts for the clinician to use when responding to disruptive behavior (see box, Examples of Prompts in Response to Disruptive Behavior). The hierarchy builds from a minimalist response designed to gently help the child get back on track to active intervention (e.g. termination of a task when a child is too disruptive). A Level 1 response is a reminder, redirecting the child to the task at hand. A Level 2 prompt offers support by using techniques such as praise, encouragement, contingencies, or some combination of these. A Level 3 prompt is an active intervention including physical support, such as helping or physically redirecting (Wakschlag et al., 2002). The clinician utilizes clinical judgment when moving up and down this hierarchy, but there is an attempt to begin slowly so as not to immediately tamp down disruptive behavior. In this way, the clinician can learn what the child can do independently while also assessing the responsiveness of the behavior to adult support.

EXAMPLES OF PROMPTS IN RESPONSE TO DISRUPTIVE BEHAVIOR

Level 1—Reminder

Remember you have to finish before we can play with another toy.
We need to do this right now.

Level 2—Offer Support

Let's see how fast you can do it.
You're really good at this.
I can help you if you need help.

Level 3—Join In

I'll help you.
Let's do it together.
Come sit here.

Our Chicago Preschool Project included a large number of typically developing preschoolers. We quickly noticed the number of strengths and competencies that typically developing children brought to the interaction. In fact, research suggests that preschool children with clinically significant disruptive behavior also demonstrate significantly fewer competencies (Webster-Stratton & Lindsay, 1999). It became clear that the clinician's support had not only tamped down disruptive behavior but had also compensated for a lack of social skills and coping skills in the disruptive children. Typically developing children "drew in" the clinician through actively elicited positive attention and support, having multiple and flexible coping strategies, and sharing pleasure with the clinician. The social and emotional competencies of typically developing children highlighted the fallacy of the notion that the presence of clinically significant and impairing disruptive behavior is part of the normal developmental upheaval of the toddler and preschool period. For example, although typically developing children experienced frustration, they also had an internally directed coping repertoire (e.g., use of self-talk such as "I can try again tomorrow," "Maybe when I'm older I'll be able to do it," and "I have puzzles at home").

In an effort to allow the child's emotional and behavioral responses to unfold naturally, we now ask the clinician not only to gradually increase their interventions in response to disruptive behavior but also to be conscious of how much they initiate

and direct positive social interactions and positive coping as well. This gradual increase provides an opportunity to see what a child brings independently to an interaction, before the clinician provides the support that may allow the child to be a more competent social partner. However, clearly defining this use of the self has been challenging. Our goal is to make sure that we are warm and responsive to a child and to ensure that, although a child may be challenged, he or she ultimately feels supported and leaves the interaction feeling respected and understood.

One of the guidelines in trying to gradually increase the level of support offered is to limit the initiation of social interactions until it appears that the child “needs” that support; to be reactive rather than proactive (Wakschlag et al., 2002). A child may indicate a need for increased support during social interactions through negative affect or withdrawal. At these times, the clinician will begin to initiate slowly, but waiting to see what the child then does, without jumping in to scaffold too quickly. In contrast, if the child is not displaying negative affect or disruptive behavior but is also not initiating social interaction, perhaps because they are reserved or shy, the clinician is asked to mirror and reflect the child’s social interactions only. This allows us to see, when faced with the challenge of the press, if the child can elicit help from the adult when needed, through verbal or nonverbal means. In other words, the clinician is encouraged to respond to social gestures and positive behaviors as they would do typically but to keep initiations to a minimum. However, at times this feels stiff, stern, and distant. Furthermore, holding back on efforts to engage the child can feel awkward and uncomfortable to clinicians. As one clinical examiner pointed out, it feels inherently contradictory to say, “be warm and responsive” but “don’t initiate,” because much of what an adult does to be warm is initiate conversation.

In response to this inherent tension, we have recently articulated a repertoire of behaviors that attempt to convey warmth and readiness to be a social partner, to mirror the child, but without initiating the interaction. This can include, but is not limited to, making eye contact, smiling,

sitting close to the child and leaning in, nodding in response to a social referencing behavior, and reflecting back verbal statements. Despite the initial awkwardness, we have found, after seeing hundreds of young children, that we are able to easily maintain rapport with them and that they look forward to coming back to “play.” In fact, we feel that, by allowing the children to experience their own emotions and by offering the children an opportunity to regulate these emotions independently, we are able to convey to the children a sense of confidence about their ability to manage these emotions. They often feel pride when they are able to do this successfully.

For example, we recently evaluated 4-year-old Sam, who became upset during a DB-DOS compliance press (a sorting task) when interacting with the examiner. Sam began to ask for his primary caregiver and became whiny and then refused to comply. In an effort to gauge Sam’s capacity to pull himself together, the clinician gradually began to offer support, reassuring him, offering encouragement, redirecting him, and finally offering physical assistance to complete the tasks. Sam was eventually able to successfully engage with the task and to complete the remainder of the tasks. Once he was engaged, Sam was cooperative and positive, and he demonstrated good coping skills. After he completed the assessment, he went to his aunt and proudly showed her the prize he had won and told her about his experience. His aunt reported being glad that he had been able to complete the assessment, and Sam too seemed proud of his competence. Through the use of presses as a challenge, through observation of Sam within different contexts (with his aunt and with the clinical examiner offering various levels of support), and by allowing behavior to unfold before stepping in, we gained a fuller, richer appreciation for Sam’s strengths and his challenges.

LESSONS LEARNED

The development of the DB-DOS has helped us to articulate and operationalize these core principals of clinical observation: (a) using challenging tasks to elicit behaviors of interest, (b) observing behavior in multiple settings with various individuals, and (c) deliberately using

the clinician’s own attitudes and behaviors to provide various levels of support. We have come to realize that, by providing developmentally appropriate challenges and gradually increasing the support we provide, we create opportunities for a child’s strengths and challenges to unfold before us. It may be controversial to press or challenge a child without immediately providing the support that may allow her to manage her behavior and emotions more successfully. It can be uncomfortable for people to purposely place a child in a situation that may feel frustrating or disappointing. However, families who struggle with their children’s behavior consistently express relief that our observations provide a glimpse into the difficulties that they face daily. The DB-DOS observation provides families with hope for meaningful interventions that will make a real difference in their young child’s struggle with challenging and disruptive behavior problems.

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