



The Signal

Vol. 18, No. 2

Newsletter of the World Association for Infant Mental Health

Apr-Jun 2010

The era of using video for observation and intervention in infant mental health

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**Paper given at the Akko WAIMH
Regional Conference. Thanks
to Miri Keren and Deborah
Weatherston for editing help.**

The use of photography and cinema then video in developmental studies and in interventions began long ago, with the seminal work of Rene Spitz, then with John Bowlby's and James and Joyce Robertson's famous films, e.g. John and with several others. These have had an enormous influence on our understanding of infant mental health and in its recognition as a field. This paper presents a short history of the work of the early "cinema" pioneers, then briefly reviews how video has provided a focus on the importance of infant development and early interactions and concludes with how preventive work with infants and families has greatly benefited from the use of home videos.

A BIT OF HISTORY:

Arguably, the beginning of using movies in infant development studies can be traced with Rene Spitz's films in 1943. Spitz showed the full extent of the distress of infants who were separated from their mothers in his famous film, *Grief, a Peril in Infancy*. Young mothers had their babies when in jail and were separated from them daily when the infants, 6 to 8 months old, were moved to the prison day care facility. Some of the infants showed high distress, named 'Anaclitic Depression' by Spitz as the developing attachment relationship was observed to be at risk, even though he stated this was not depression in the full sense of the term (Spitz, 1945, 1946, 1947). The infants who experienced more extended separation from their mothers, showed a more troublesome and less reversible picture, labelled by

Spitz as 'Hospitalism'. At this point in time, most of the work on early development by psychoanalysts was retrospective and hypothetical. Spitz brought to the community the grim picture of what brisk and unprepared separation could do to the parent infant relationship. As Robert Karen points out (Karen, 1994), this was not well accepted or easily acknowledged when Spitz showed the film to the psychoanalytic community in New York. A colleague reportedly asked him, "Why did you do that to us?"

Another major step in the use of film for the purpose of observation was taken when James and Joyce Robertson followed an 18 month old boy during an 8 day separation from his parents for which the child was unprepared. In looking at the images of John at the nursery, day after day, the Robertson's and colleague, John Bowlby, were struck by the amount of distress displayed by this 18 months old boy. His distress could have been easily overlooked if he had not been filmed, day after day, at the same time. This, of course, led to a great deal of controversy. Today, this film is still hard to look at, and represents a formidable teaching tool. Other films, taken by the Robertson's for the purpose of infant observation and study, added to the evidence regarding the impact of extended separation and coping capacities of infants and young children. These films included Lucy, Thomas, Kate, and Lucy, in *A Two Year Old Goes to Hospital* (Robertson & Bowlby, 1952; Robertson & Robertson, 1969). In the fifties, some others clinicians

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used films as a demonstration of the existence of specific syndromes linked with relationship disorders. The pictures and movies from Monica, Engel & Reischman (1979) vividly illustrated the case of an 18 month old girl born with an oesophageal fistula and showing clear signs of depression/withdrawal. Of course many other contributions existed as well during this pioneer period, but let us quote only the films made by Myriam David and Genevieve Appell in orphanages and institutions in Post War France, as they had a great impact on the changes in these institutions (David & Appell, 1964; Dugravier & Guedeney, 2006 for a review). In the same vein, films in the Loczy Pikler Budapest institute in Loczy, Hungary have been very influential in designing better care for orphans (Tardos & David, 1961).

The era of discoveries of competencies and vulnerabilities of the infant: lessons from the Great Baby Watchers (T. Berry Brazelton, Beatrice Beebe, Tiffany Field, Daniel Stern and Ed Tronick)

This period starts with the seminal work of T. Berry Brazelton, describing the 'Four stages of interaction' seen at a micro-analytic level (Brazelton, Koslovski & Main, 1974). The baby takes the lead, rather than the caregiver. This becomes obvious from the frame-to-frame analysis of the video. Then the 'Still Face paradigm' (Cohn & Tronick, 1983; Field, 1984) shows how 2 month olds are trapped into the face-to-face interaction and shows their high sensitivity to violations of rhythm within the dyad. Murray & Trevarthen (1985) confirm this sensitivity, using the de-synchronization procedure, in which baby and mother interact through a video channel, in which sound and image are subtly de-synchronized. This demonstrates how sensitive the 2-month-old infant is to violations of expectations within the interaction: a single de-synchronisation of a tenth of a second has exactly the same effect as a still face procedure (See Rochat, *The Infant's World*, 2001 for a review).

WHY LOOK AT ONESELF INTERACTING WITH AN INFANT?

This situation may help us learn how interaction truly develops: Brazelton, Tronick, Beebe and Stern, looking at who does what and when, have helped us understand how the interaction truly develops, as opposed to reconstructive speculation. Looking at oneself interacting with an infant will help see the 'objective self' of the observer, seen from the outside and integrate it within the 'subjective self', seen from within (Rochat, 2001). Several manualized programs are available now, which show us how autovideo has a huge impact on helping the parents realize to which extent the infant is sensitive to relationships. It helps moving from an expert's point of view to a 'let's see together what we have here' perspective, increasing the working alliance when noticing the parents' own expertise.

The 'Attachmentists' and the video: the Strange Situation, the disorganization of attachment

Video allows the scoring and training of the Strange Situation with infants and toddlers with different attachment systems (Ainsworth, Marvin, Crittenden, Cassidy, see the *Handbook of Attachment*, 2008, for a review and references) and at different ages. Separation contextualizes the situation with a middle level of stress. Video helps identify the often subtle and brief signs of infant disorganization, as well as disorganizing behaviours in parents (Lyons-Ruth, 2005). Frightening/frightened behaviors or abdicating behaviors are some of the variations leading to an infant's disorganization of attachment. These behaviors may be subtle, occurring very quickly. One has to be particularly attentive to what happens or not when attachment is activated. The key point is that video is most interesting when the attachment system of the infant is stimulated, through fear, separation, anxiety, and distress of any kind, hunger, sleepiness or pain. Video can capture what takes place - secure base behaviour or its absence or brief events described as disorganized behaviours. The main idea here is the use of contextualized specific situations during which attachment or

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The Signal is a quarterly publication of the World Association for Infant Mental Health. Address correspondence to Miri Keren (ofkeren(at)internet-zahav.net).

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exploration behaviors are activated, be it free, cooperative play, face to face or still face, separation/reunion, nappy changes, feeding. Related projective assessment techniques such as the Mc Arthur Story Stem Battery (Bretherton & al, 1990) do use video, for the procedure as well as for training and reliability.

Some Attachment based interventions use video and the strange situation as a core tool:

The 'Circle of Security' COS: Marvin (Marvin & al, 2002) has established a system of assessment of secure base behavior that can be used in group or in individual settings., with parents' reactions to the strange situation of their child.

Slade (Slade, 2008) and Karlen Lyons-Ruth (2005): Nurse/IMH joint programs for high risk mothers, use auto video in interactional guidance, to increase self reflective function in mothers.

Juffer & Bakermans preventive use of auto video with adopted infants shows great effect size, compared to usual guidance. Juffer, Bakermans & van IJzendoorn: the Video Feedback Intervention for Promoting Positive Parenting (VIPP, 2005, 2007)

STEEP: Martha Erickson's and Egeland's program, 'Seeing is Believing,' is one of the most effective programs for prevention and intervention, using video with families. (Egeland & Erickson, 2004).

CAPDP, the first French prevention study for high-risk mothers, uses video extensively for increasing a mother's sensitivity and mentalization and reducing parental disorganizing behaviors.

All these models use auto video guidance, a major tool for intervention & prevention, since video is such a strong incentive for maternal/parental mentalization: 'What do you think the baby is feeling now? Why? What are you feeling when you are doing this?'

A major advantage of video is to help look at organizing and disorganizing behaviors in parents: AMBIANCE: is a scale for assessing parental disorganizing behaviours,

through the assessment of emotional communication (Lyons-Ruth et al, 2005), through clips of strange situation and play.

NAMES AND MODELS IN INTERVENTIONS USING VIDEO

SOME OF THE PIONEERS:

Selma Fraiberg (1980) used film to carefully assess the capacities and risks of infants and parents referred for infant mental health home visiting services, during consultation with parents and to study interactions and early relationship development during supervision and consultation to understand the risks and enhance the capacities of parents and very young children.

Susan Mc Donough (Mc Donough, 1993) has long used video with hard to reach families as a major tool for making interactive guidance effective. Susan Mc Donough was one of the first to have designed video use with hard to reach families. She gave us some major cues for this work: stick to the goals of the family, closely monitor working alliance, and keep on working on the positive aspects.

Maria Arts: Marte Meo (2008) Beatrice Beebe, in parent infant therapy (Beebe & Stern, 1977) Daniel Stern: His work with Bertrand Cramer was essential to understand ways through which parent-infant therapy works. The comparison of psychodynamic vs. CBT showed no major differences, but video was key to understanding changes in therapy (Stern, 1995).

Serge's Lebovici's use of empathy and action within the parent infant relationship was remarkable in his recorded therapeutic consultations (Lebovici, 1983).

Elisabeth Fivaz-Depursinge and Antoinette Corboz-Varnery (The Primary Triangle, 2004): based on systemic principles, their work on Triadic interactions is a major contribution to the understanding of early mental development. It is based on closely organized video clips with both parents, leading to an assessment system of the triangulation within the family.

John Byng-Hall has designed an attachment-based family therapy with the use of video to supervise and train therapists (Byng-Hall, 1995)

George Downing has worked with Ed Tronick, Beatrice Beebe and Bob Marvin. He has gathered a very large experience with video in different settings, with infants and mothers in patient unit in Germany, and in parent infant consultation in France, as well as with adolescents; he proposes his frame of analysis for videos with parents and infants, and guidelines to make videos and to watch them with families (Downing under press): Downing suggests to look carefully at these dimensions prior to watch the videos with parents:

Downing's frame of analysis of videos clips©:

Connection: contact, affect attunement, contingency

Collaboration: how is shared activity organized?

Boundaries: limit - setting

Negotiation: mostly verbal

Autonomy: how are separation autonomy and problem solving played,

Organization of time: Rhythm and temporality, frame and continuity

Organization of time: Tempo, fast or slow

Discourse; what is said and how

Finally, video has become a major tool for training/ supervision and for seeing what is going on in such a setting, with the miniaturisation of cameras and the diminution of costs.

LESSONS FROM THE GREAT BABY WATCHERS

Video has permitted us to gain insight into the way parent infant interaction develops. Through this tool we have learned from the Great Baby Watchers: Beebe, Stern, Tronick, and Brazelton, among others. To summarize:

Look at the frame by frame, micro analytic interaction

In secure dyads, even when things are 'As Good as they Get,' the rate of misattunement may reach 50% Being securely attached is working through mismatches, not avoiding mismatches

For pairs with too frequent or intense mismatches, frustration or fear of loss may lead to give up search for attunement

Video helps focusing on the baby and on the relationship and helps the parent take the baby's perspective Show the big difference between what we as parents believe we do and what we effectively do, particularly when stressed

Rhythmic coupling at 4 mo (turn taking, joining, yielding and tracking) predicts attachment classification at 12 In mild to major disturbances of relationship, defensive maneuvers in the child get built up quickly (i.e. by 9 months of age)

Attachment behavior is resistant to change, but there is always room for change
So need for focused preventive action on traumatized dyads

USING VIDEO WITH EARLY DIAGNOSIS OF AUTISM

The seminal work of Massie opened the way through analysis of family videos of autistic children. Now that video is much more easily available, we can often get family films and see them with parents. The goal is to find the early specific signs of autism, see the different modes of onset and discuss the diagnosis with parents (USA: Massie 1975, Massie & Rosenthal, 1984; Osterling & Dawson, 1994 France: Malvy, Adrien, Brauner & Wendland; Italy: Bernabei & Camaioni, 1998; Maestro 1998 (see Wendland & al for a review and references).

USING VIDEO IN ASSESSMENT

Video is now playing a key role in the clinical assessment of infants and parents. Several situations or assessment scales rely mainly on video clips of infants and parents in several settings:
Use of several clips from strange situation, play, change, clean-up in the assessment of children in foster care
The Alarm Distress Baby Scale (ADBB Guedeney & Fermanian, 2001): using a pediatric examination a 'Set Situation' to assess withdrawal behavior in infants

Feldman's Classification of Infant Behavior: using a feeding situation to assess parent infant interaction
Feldman CIB, (Feldman, 2007).
Ambiance: Lyons Ruth & al (2005): caregiver disorganizing behaviors in the strange situation
Marvin's use of the strange situation and Circle of Security© (2002).

CONCLUSION

Video has become a major tool for psychotherapeutic intervention and prevention, as it allows us to catch brief and meaningful events that can be reviewed with the parents. It helps to focus on the young child's reactions and interactions within the context of developing relationships. It is a key tool for training and supervision. Its strength is to highlight positive aspects that parents may be unaware of in the middle of difficult relationships. However, its use must be closely framed within the therapeutic relationship with the family. It should be avoided when parents are in a conflict about the care of children with legal implications.

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AFFILIATE CORNER

With the 12th Congress of the World Association for Infant Mental Health rapidly approaching, now is an opportune time to reiterate what is going to make this Congress a particularly important one in terms of the new vision WAIMH has for affiliates.

The restructuring of the WAIMH board that took place in 2009 finally gave substance to the long cited aim of WAIMH to give the affiliates a more meaningful and regular role in the governance of WAIMH. As you all know, according to the new bylaws two directors shall be elected to the WAIMH Board of Directors by the Affiliate Council (consisting of all the Presidents of WAIMH affiliates) - namely the Chair of the Affiliate Council and another Affiliate Council representative. The election for these two positions will take place during the Congress in Leipzig. In anticipation of this election, WAIMH has introduced

(for the first time) a process whereby Affiliate Presidents who are interested in becoming Chair of the Affiliate Council or the Affiliate Council representative are able to produce and distribute position papers to aid their election to the positions.

We have already had a number of position papers sent to the Central Office for people who wish to stand for election and the papers have been distributed to Affiliate Presidents. It would be fantastic if there were more position papers and there is still time. Having said this, if somebody does want to stand for election and cannot send a position prior to the Congress, or if somebody decides at the last moment to stand, this will still be possible – a position paper is not a pre-requisite. It will just mean that voting Affiliate Council members will have less information on which to judge credentials.

Earlier in the year, the central office sent out an email asking for countries (if more than one affiliate exists) to nominate a representative who would vote if the affiliate president is unable

to attend the congress in Leipzig. If there is anyone who will be attending the congress in Leipzig and knows that they are the only person attending

from their country (where there is at least one affiliate) and you know that your affiliate president is unable to attend, please ensure that you are given the right to vote on behalf of your president. This will ensure that whoever the people are that become Chair of the Presidents Council and the Affiliate Council representative have been duly elected by as many countries as possible. This will ensure proper representation of the affiliates on the WAIMH executive. Look forward to meeting the Presidents or representatives of WAIMH Affiliates in Leipzig at the following events: WAIMH Affiliate Presidents' Reception on Wednesday, June 30 and Affiliate Council Meeting on Thursday, July 1, 2010.

Mark Tomlinson
Affiliate Representative of WAIMH



Editor's Perspective

From observing babies and parents to therapists' self-observations

I remember the epoch, not a very long time ago, where what happened in the psychotherapy room was considered to be the property of the patient as well as of the therapist, "for the sake of the transference and countertransference processes". It is therefore not by chance that the very first target of video use was baby observation, mostly with the aim of showing the baby's competencies (which were disregarded by at the time by most of the theoreticians and clinicians). Then, came the idea of observing the parent and infant in interaction, again with the aim of studying the infant's relational capacities and worries about the relationship. The third phase was to use these videotaped interactions in the presence of the parent, this time, with the purpose of treating the relationship. Many models of video-based intervention have been

implemented since then, as Antoine and Nicole Guedeney have reviewed for us in this issue of *The Signal*.

Last to come, not so surprisingly, was the videorecording of a therapeutic session, where the therapist is observed as well as the patient. Different from the use of the video for intervention, its use is for observing the therapist in interaction with the patient (or parent and infant). This video technique is much less widely used. Its use is mainly in the context of supervising a trainee and in conducting intervention outcome studies. To me, it seems that senior clinicians, especially those with a psychoanalytical training, tend to agree to be videotaped during assessment interviews and much less during therapeutic sessions. This is not very surprising if we view it as a "mini revolution", as a kind of

demystification of the psychoanalytic room. Through the use of videotape, the non-verbal and unconscious therapist's movements are revealed to the observer's eyes. For some, it may be threatening their role or position as therapists.

In my clinical experience while working with a multidisciplinary team, we found that team cohesion, or positive alliance, as Elisabeth Fivaz has taught us, or trust, is the ground for mutual recognition. This, in turn, enables us to videotape our therapeutic encounters and expose ourselves to positive and negative feedback. It takes time to build trust and courage to be videotaped, but the professional gain can be considerable.

Miri Keren
Editor of the *Signal*

President's Perspective

Welcome to Leipzig!



With 1400 registrations so far, this Leipzig congress already appears as one of the major successes among all WAIMH congresses. This is the double result of the hard work of the LOC, headed by Kai von Klitzing, and of an attractive program made up by the PC headed by Neil Boris. This success is also due to the activity of the widely extended GAIMH association, established in three different German speaking countries (Germany, Austria and Switzerland). GAIMH has very wisely planned for having its annual meeting in accordance with WAIMH world congress. In addition, Leipzig is a particularly attractive site for a world congress, with its long tradition of fairs, and exceptional scientific, artistic, and political background.

This meeting will also be a turning point on the organisational level

of WAIMH, as we will elect two representative members of the Affiliates and they will join our Board. A gathering of the Affiliate presidents or their representatives will be held on the first day of the congress, so that people get to know each other better and start getting organized as a group.

On the scientific level, the DC 0-3R symposium will raise the key issue of the impact we can/should have on the DSM V. The Massachusetts IMHA has written to the DSM Task Force making suggestions and I urge all our Affiliates to take a look at this letter (enter the WAIMH site) and to discuss it with members. At the end of the road, we should have sound suggestions to offer the DSM Task Force.

Two days before the congress, the EC will meet and discuss several issues. One of the major ones is how

to establish Training Institute within WAIMH that would make use of the exceptional expertise WAIMH members all around the world have accumulated. In addition, this would be an important source of funds that would allow the organization to be less dependent on membership and congress registration fees. We definitely need to make our world association more firmly anchored financially, especially in these times of instability. The second major task of the EC meeting will be to finalize the planning for our next congress, in 2012, for the very first time in Africa.

Finally, we will all meet and catch up, share and learn, applaud to Awards, and look forward meeting again...in Cape Town, 2012.

Antoine Guedeney
President of WAIMH



Photos from the training of the Skating Amadeus Choir from Graz. Written by Marguerite Dunitz.

Information and news from the Central Office

Dear WAIMH members,

During the recent years WAIMH has aimed at strengthening the role of its Affiliates and the thousands of members of its Affiliates. This has been an important aim and now at the Leipzig Congress we are moving towards the implementation of the decisions made by the Board so far, to achieve this.

WAIMH is, however, composed of individual members - infant mental health professionals who are committed to infants' and their families' wellbeing, who are eager to learn more, who are willing to share their knowledge and who are enthusiastic to network with colleagues all over the world. You as the members of WAIMH are influential in shaping the programs and activities of WAIMH. Now, at the Leipzig Congress, you have a great opportunity to contribute to WAIMH policies by participating in the WAIMH Membership Meeting which is going to be held on Thursday, 1st of July at 17.00 – 17.45 in the Leipzig Congress Center. You will find the agenda of the Membership Meeting in this Signal (page 8).

In the Leipzig Congress besides business you can also enjoy quite unique art! For the first time ever in a WAIMH congress we will see a performance of Haydn's „Creation“, that is special on different levels. For the very first time the oratorio will be performed by children and in combination with a newly written stage-play accompanying the original composition. The plot was written by Marguerite Dunitz, who has been an active member of WAIMH for over 20 years. Her experience as paediatrician and as psychotherapist conducting a lively group of children from 4-18 years will let you share an unforgettable evening. The SKATING AMADEUS CHOIR is from Graz, a University City in the south of Austria, some 700 miles south of Leipzig. Those of you attending the Leipzig Congress, be sure not to miss this wonderful performance.

Welcome to the Membership Meeting and the activities of the WAIMH!

Pälvi and Kaija



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membership,

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office@waimh.org.

WAIMH Membership Meeting

World Association for Infant Mental Health
WAIMH 12th World Congress
Leipzig, Germany

Thursday July 1, 17.00 – 17.45
Chair Antoine Guedeney, President of WAIMH

Agenda

1. Call to order
2. President's remarks
3. Approval of Minutes of the 2008 Membership Meeting, Yokohama, Japan
4. Financial Report
5. Report on Board Activities since Yokohama, 2008
6. Central Office Report
7. Action plan for 2010 – 2012
8. WAIMH 13th World Congress, Cape Town, South Africa
9. AOB
10. Closing of the meeting

Honorary President Distinction Ceremony

Robert Emde, Honorary President of WAIMH
Antoine Guedeney, President of WAIMH

Welcome to the WAIMH Membership Meeting

Antoine Guedeney
President of WAIMH

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

By Barbara A. Danis, Carri Hill,
and Lauren S. Wakschlag
Institute for Juvenile Research,
Department of Psychiatry
University of Illinois at Chicago

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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The Disruptive Behavior Diagnostic Observation Schedule (DB-DOS) study was supported by National Institute of Mental Health Grants R01 MH68455 and MH62437 and a grant to Dr. Wakschlag through ZERO TO THREE from the Robert Wood Johnson Foundation and by the Walden & Jean Young Shaw and Children's Brain Research Foundations. The authors gratefully acknowledge their collaborators on the DB-DOS study: Kate Keenan, Bennett L. Leventhal, Alice S. Carter, Margaret J. Briggs-Gowan, Helen L. Egger, and Domenic Cicchetti.

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