Is This a Behavior Problem or Normal Temperament?*

CASE

Harry’s parents report concern about him to their pediatrician because the child care worker has told them that he seems “insecure.” In the first 3 weeks of the new day care program, this 2-year-old boy separated reluctantly (with much crying and clinging) from his parent in the morning and then remained on the periphery of the activities. He watched quietly but observantly from the sidelines while most of the other children talked and played. He repeatedly resisted invitations from the staff and other children to join in the activities. Yet, he seems interested and does not appear to be unhappy. At home he has 2 playmates in the neighborhood. The child care worker advised professional evaluation for his “emotional insecurity.”

The parents of 7-month-old Jimmy come to you in great dismay, saying that he has been “basically screaming since birth.” At present he is crying or fussing for well over 3 hours a day. The management strategies that had worked well for their 2 older children seem to be quite inadequate for Jimmy. He is sensitive, irritable, and hard to soothe. The parents are spending much of the day and night carrying him around the house. The previous pediatrician said at 2 months that it was “just colic” and would either get better soon with a special formula or that it would take another month or so to go away by itself. Yet, 5 months later, the fussing and crying are only a little better, although Jimmy does have periods when he smiles and laughs. The parents consulted a psychologist who only told them that Jimmy was developmentally normal. One of the grandmothers recommended marital counseling for the parents because they are arguing over how best to handle their baby. The parents think that they should reject that suggestion because they believe that they have a good marriage and they have had few problems with their 2 older children. There is no vomiting or diarrhea and no unusual family stressors, and the physical examination and developmental screen are negative.

Carla is a bright 14-year-old girl whose parents ask you what they should do about her school underachievement. Throughout elementary school and now in middle school, she has made high scores on aptitude tests but only average results on achievement tests and grades. She could be getting A’s, but she generally receives only B’s or C’s. From discussions with the parents, you recognize that Carla is somewhat disorganized, timid, inattentive, and distractible, but she has no learning disabilities and no evidence of behavioral or emotional problems at home or at school. When confronted by a crisis such as writing a long-neglected term paper in the next 24 hours, she concentrates very well and usually gets an A. The school is more than adequate. The school counselor is mildly concerned and called for a parent conference but is not recommending any further evaluation because Carla is not failing. However, her highly achieving parents are somewhat disappointed. An aunt has suggested that she should be “tested for ADHD [attention-deficit/hyperactivity disorder].” The parents want to know your opinion.

INDEX TERM. temperament.

Dr Martin T. Stein

Over 40 years ago, Stella Chess and Alexander Thomas¹ expanded our view of the range of individual behaviors in children. Trained as a child psychiatrist and an adult psychoanalyst, they made use of their astute clinical observations to reframe the way we now look at many behaviors among children. They formulated the concept of “temperament” (initially termed “primary reaction patterns”) as an alternative to what they saw as the limitations of behavioral theory (behavior as a function of environmental contingencies) and psychoanalytic theory (behavior motivated by a desire to obtain pleasure and to avoid pain).¹³ Carey and McDevitt² observed that temperament reflects patterns of behavior that are “…stylistic and unmotivated, [and] provide a new path for the study of aspects of behavior that [are] mediators of the influence of environmental factors. Furthermore, these fundamental elements of personality seemed to insulate the child or, alternatively, make him or her more vulnerable to stress.”² Pediatricians understand temperament as those individual differences in emotional reactivity, activity level, attention, and self-regulation that may be predictors of adaptive skills, resiliency, and behavior problems. Perhaps most importantly, the temperament model reframes many behaviors in the context of a child’s individuality. In this way we can often help parents to see their child’s unique needs and develop effective strategies for behavior management. Four major areas define the scope of temperament³:

1. Temperament is the stable pattern of reactivity and responsiveness. It is the foundation of personality.
2. Temperamental characteristics influence all aspects of development and behavior.
3. Certain clusters of temperamental characteristics are associated with an increased likelihood of behavioral concerns, discipline problems, and adjustment difficulties at particular points in development.

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4. Lack of fit or a mismatch of temperamental characteristics is often the source of difficulties for a parent or other child care provider.

The challenge for pediatricians has been the development of practice models that effectively make use of our current understanding of temperament. How can it be assessed readily in clinical practice? When is it most useful as a diagnostic or therapeutic tool? When is a problematic behavior a reflection of temperament, and when is it a behavior problem?

The 3 brief case scenarios in this Challenging Case each describe a common behavioral presentation at different stages of development. In each situation, either a behavioral diagnosis or a specific temperament pattern may be applied by different clinicians. Two pediatricians were invited to comment. Dr William Carey, Professor of Pediatrics at the University of Pennsylvania School of Medicine, has championed the utility of temperament as an effective tool in behavioral pediatrics. While in general pediatric practice for several decades, Dr Carey carried out numerous studies that demonstrated the adaptability of the temperament model to pediatric practice. Dr David Snyder is a developmental-behavioral pediatrician in Fresno, California, and Associate Clinical Professor of Pediatrics at the University of California School of Medicine in San Francisco. He has extensive experience as a teacher and pediatric practitioner working with children with developmental and behavioral problems and their parents.

**REFERENCES**


**Dr William Carey**

Although much has been written about temperament variations and even more about behavior problems, too little has been offered to help clinicians distinguish their differences. A person’s temperament is his or her behavioral style, the way that individual experiences and responds to the environment. The best-known and most practical conceptualization is by Stella Chess and Alexander Thomas. They found 9 clinically pertinent dimensions: activity, regularity or predictability, initial approach/withdrawal (bold versus shy), adaptability, intensity, prevailing mood, persistence/attention span, distractibility, and sensory threshold. Chess and Thomas demonstrated 2 clinically significant clusters: the “difficult” traits of low adaptability, negative mood, intensity, initial withdrawal, and irregularity and the “slow-to-warm-up” traits, which are similar but without the intensity. From studies of normal elementary school students, Barbara Keogh established the “low-task orientation” cluster of low persistence/attention span, high distractibility, and high activity. All 9 variables, whether individually or in clusters, are considered normal even at the extremes, but they can predispose to behavioral, emotional, or functional problems when there is a “poor fit” between them and the values and expectations of the caregivers. By themselves, they can also cause parental distress without generating secondary disorders.

By contrast, behavioral problems involve dysfunction in 1 or more of the 5 BASIC areas of adjustment: Behavior or interpersonal relationships; Achievements, including school performance, other tasks, and play; Self-relations: self-esteem, self-care, and self-regulation; Internal status: feelings, thoughts, and body function in eating, elimination, sleep, etc; and Coping. Discriminating between behavior problems and normal temperament is necessary because the management is different. Behavioral dysfunction can generally be lessened or eliminated by appropriate management, but parents have to learn to live with their children’s temperaments because we do not know how to alter them. With adverse temperaments, the steps are (a) recognition of the temperament by the clinician, (b) reorganizing of the parental understanding and strategies, (c) relief for the caregivers, and (d) referral to a mental health specialist, which should seldom be necessary.

These principles must also be remembered when behavioral dysfunction has resulted from a poor fit.

As the codeveloper of 5 different temperament scales for parental ratings between the ages of 1 month and 12 years, I almost always use the appropriate one to gather this valuable information before a consultation visit. However, it is possible for routine pediatric care and sometimes for consultations to rely on just a few minutes of interviewing to obtain an adequate picture of the child’s contributions to the problems in the interaction.

**Harry:** Before my office consultation with Harry’s parents, I asked the parents to complete the Toddler Temperament Scale, which revealed a typical slow-to-warm-up pattern including initial withdrawal and slow adaptability. A developmental and behavioral history from the parents was consistent with what they had reported. A review of the 5 areas of behavioral adjustment produced no evidence of significant problems in relationships, play, self-assurance, or contentment. His physical and developmental status were normal. There were no grounds for calling him “emotionally insecure.” He was just a rather shy but otherwise normal child whose temperament had been misperceived as a behavior problem by the inexperienced child care worker. Management of the situation involved making sure that the parents understood that Harry was really normal and offering help with handling such behavior. I suggested to the parents that they have a conference with the teacher.
and her supervisor at the child care center to acquant them with his temperament to urge that they patiently bear with him for a little longer until he made the expected adjustment and to suggest that the supervisor help the new teacher understand the variations of normal. By the end of another 3 weeks, Harry was still shy and never first in line but was separating readily from his parents in the morning and happily joining in the play.

**Jimmy:** An Infant Temperament Questionnaire completed before the visit demonstrated a “difficult” pattern that would be hard for any parent to manage: sensitive, irritable, hard to soothe, unpredictable, and intolerant of change. The parents were concerned that something was wrong with him, and they felt that they should be immediately responsive to any fussing to reduce his distress. Jimmy was clearly being misread and overstimulated by his worried parents. Successful pediatric management consisted of refraining the parents’ view of him as a normal but temporarily “spirited” or “challenging” infant, whose behavioral style was not due to illness and was nobody’s fault. The plan was for them to try to figure out when the fussing was an expression of true need and when it was simply fussing. Learning not to overreact was essential. Relief for the parents was strongly advised, including evenings out together and more care by grandmother so that the mother could get out during the day for shopping or recreation. Two follow-up telephone calls in the next 2 weeks announced that Jimmy was crying less and when he did cry the parents were better able to understand and tolerate it without fear that there was something wrong with him. The parents were confident, happy, and well rested and were starting to enjoy their “spirited” child.

**Carla:** She had a low-task orientation temperament of low persistence/attention span, high distractibility, and high activity, but she was also adaptable and free of learning difficulties. Even at the extremes of these temperament traits, children are not necessarily dysfunctional. Carla’s behavioral adjustment profile was normal, and no significant psychosocial problems were evident in the family or environment. Nor were there any physical problems. Carla was underachieving because of her temperament, but she was not in trouble for her achievement or her social behavior. The vague diagnostic criteria for ADHD could not responsibly be stretched to fit her. Medication was definitely not indicated. With moderate success, the parents and teachers tried by various means to induce her to apply her considerable abilities to a greater involvement in her studies. Finally, in college her intellectual curiosity was aroused, and she became motivated to overcome her dilatory work habits. She graduated with a Phi Beta Kappa key.

In common cases such as these 3, a primary reliance on the history of the child, including a description of the child’s temperament, is likely to lead to the correct diagnosis and an effective intervention more quickly, more accurately, and with less physi-

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**REFERENCES**

with desperate crying would raise the question of an “anxious attachment,” which would warrant further psychological assessment.

If Harry’s behavioral history suggests a slow-to-warm-up pattern since infancy, the parents should be counseled regarding his essential normality and provided guidance regarding preparing him for new experiences that can be anticipated, eg, a family vacation or starting school. If Harry seems to be experiencing developmentally appropriate separation anxiety, the parents should be reassured, and the day care provider should also be counseled about techniques to reassure the child. An anxious attachment or continuing concerns regarding other emotional disorders warrant further psychological assessment.

Jimmy’s parents are frustrated by his excessive crying, which responds poorly to consoling interventions. This crying pattern has been present since birth and is only a little better at 7 months. Jimmy’s parents have demonstrated competence with their other children, and there are no acute stresses. Although Jimmy shows no physical signs of disease and no developmental delays, his behavior and social responsiveness are not described. Can we assume he is socially responsive? Can we assume there are no indications of an autistic spectrum disorder? Jimmy is 7 months old. Eight months is a watershed for socially significant behaviors such as stranger anxiety, imitation of speech sounds, and imitation of gestures. Normal emergence of these behaviors would certainly be reassuring.

Jimmy is described as “sensitive, irritable, and hard to soothe,” and this suggests the possibility of a temperamental pattern of a low sensory threshold. I would ask whether minimization of stimulation is associated with decreased crying. I would also try to assess the amount of stimulation he encounters in the home, especially with his 2 older siblings. I would determine whether his hypersensitivity is sensory modality-specific, ie, is he tactiley defensive, noise-intolerant, etc, or is it the total amount of stimulation that upsets him? A therapeutic trial of decreasing stimulation would be worthwhile. If Jimmy does seem to be primarily hypersensitive to stimulation, whether to a single modality or globally, enlisting the assistance of an occupational therapist experienced in working with infants might be most helpful.

I have seen a number of infants (mostly infants born prematurely) who have presented with inconsolable crying, normal physical examinations, and normal development, who have eventually been diagnosed with gastroesophageal reflux and esophagitis. Generally, they had been referred to a pediatric gastroenterologist, and the diagnosis was made following endoscopy. I frankly don’t have a sense that there was a clear relationship between feedings and crying episodes or other clinical clues from history that support this association.

Carla is a bright 14-year-old girl whose parents ask what they should do about her school underachievement. This presentation is certainly one of the typical stories for a child with ADHD, inattentive type. I see nothing in the case description inconsistent with that diagnosis. However, before settling on the diagnosis, I would want to assure myself that there are good data supporting the assertions that she is indeed “bright” and that “she has no learning disabilities.” I would want to elicit behavioral descriptions from both home and classroom environments that met the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, criteria for hyperactivity disorder. A positive family history would add support to diagnosis.

I find that an interview with the child, separate from parents, to be an invaluable part of the diagnostic process. Although some children do deny or minimize their attentional difficulties, most will candidly describe their problems with concentration, staying focused, or paying attention. They will describe for you just what factors make it easier or harder for them to concentrate in class. The child’s own story is too often neglected to the detriment of diagnostic accuracy. This is particularly true for children with the inattentive type of ADHD, because their behavioral symptoms are subtler than those of more hyperactive children.

Straightforward but nonjudgmental questions are usually most productive. For example: “Is it hard for you to pay attention to the teacher or to your work in class? What makes it hard?” Examples of more specific questions are: “Do you find yourself daydreaming or thinking of other stuff when you are supposed to be working or listening to the teacher? Does this make it hard for you to get the assignment or finish your work on time? Some kids get distracted when their friends are talking in class. Does this happen to you? Is this a big problem for you or a little one?”

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REFERENCES

Web Site Discussion
The case summary for the Challenging Case was posted on the Developmental and Behavioral Pediatrics web site (www.dbpeds.org list) and the Journal’s web site (www.lww.com/DBP). Comments were solicited.

‡ A bimonthly discussion of an upcoming Challenging Case takes place at the Developmental and Behavioral Pediatrics Web site. This Web site is sponsored by the Maternal and Child Health Bureau and the American Academy of Pediatrics section on Developmental and Behavioral Pediatrics. Henry L. Shapiro, MD, is the editor of the Web site. Martin Stein, MD, the Challenging Case editor, incorporates comments from the Web discussion into the published Challenging Case. To become part of the discussion at the Developmental and Behavioral Pediatrics home page, go to www.dbpeds.org.
Commentary on Harry (2 Years Old)

Meg Zweiback, RN, CPNP, of Oakland, California, writes: This is a tough situation, not because Harry is abnormal, but because the presenting problem is so common. A child who does not meet the expectations of the child care staff is described in a way that places responsibility on the parents for the child’s behavior in child care.

Further history is important. If his parents report that he has always taken time to adjust to new situations, tended to observe for a while before he interacts with new people or places, and shown sensitivity at first to noise or lots of activity but eventually gets comfortable, then it is likely that his current behavior is due to his temperament and he will eventually adjust.

However, it may be that Harry has had limited experience separating from his parents. He may have had unpleasant experiences in child care that cause him to be cautious in this new situation. He may feel alone and not ready to trust the adults who care for him, even if they attempt to engage him. Most 2½-year-old children who begin child care will adapt best to the new situation when a parent stays during the first few days (or a week or two in some cases), gradually decreasing time in child care, with support from staff at the time of separation.

Group size and age range may be a factor. In some states, it is legal for child care centers to have a ratio of 12:1, children/adults, so children get very little individualized attention. If group size is large and there is no primary teacher for small groups, a 2-year-old may be asked to relate to 4 different caregivers as well as 23 new children. Harry may feel much safer on the periphery rather than plunging into a large group of 2-year-olds with few social skills or 2- to 4-year-olds where he is the smallest and least able to communicate.

The red flag in this case is the child care provider’s description of Harry as being “emotionally insecure.” If Harry’s reluctance to engage is dismissed with such a simple explanation, it is an indication that the child care staff is inexperienced with a wide range of children’s behavior and is also unable to communicate with parents in a way that is likely to be helpful. I would help Harry’s parents understand and interpret his behavior in a way that could help him adjust to this challenging situation. Alternatively, I would give the parents support and skills for finding a child care setting that was a better fit for their child.

Children like Harry are seen frequently in my practice, which is located in an area with many working parents and a number of large child care centers that don’t work well for all children.

Linda Nathanson-Lippitt, MD, of Atlanta, Georgia, writes: I certainly endorse what Meg Zweiback had to say. I think it is important to recognize temperaments as valid profiles of a child’s make-up. This child has friends and plays well at home. He is calm and interested in school. He probably falls into the slow-to-warm-up type of personality. It seems that some inservice for the day care workers is in order and reassurance to the family. At this point, where the parents have established a routine of dropping him off, I would be reluctant to backtrack to having them stay with him. Perhaps a special bracelet or pin and a “transition object” could help ease the parting. One should also counsel the parents to be sure that they are not inadvertently reinforcing the leave-taking trauma.

Morris Wessel, MD, of New Haven, Connecticut, writes: I think that Harry’s adjustment to day care is well within normal limits. I would have used the term “sensitive” to new experiences to describe Harry’s response to day care. I would suggest that the mother leave a scarf or some other item at the school so her child can be reminded that she will be back. I would have suggested that they visit the school a few times before the program began. I think that a pediatrician or nurse practitioner could easily see this family through this experience. I would compliment the parents for having done a good job in that the child at this tender age appreciates and needs them but that in all probability he will warm up and join in the program.

Commentary on Jimmy (7 Months Old)

Meg Zweiback, RN, CPNP, writes: I think that it would be helpful to find out what is helping Jimmy to not cry for the rest of his waking hours. What is he like when he is happy and how do they engage him in ways that feel successful? In order to take their concerns seriously and to collect useful data, I’d ask the parents to keep a log for a few days. Record Jimmy’s periods of sleep as well as wakeful, cheerful, fussy, and screaming episodes. The record may reveal underlying patterns that will help them to understand his behavior. I’d try to have them bring this to the first visit if I knew in advance the nature of the problem. Sometimes fatigue and/or overstimulation are underlying causes and the most difficult times are when the baby really needs to go to sleep or withdraw. No matter what the cause, I agree that the parents should have some relief!

Neil Stalker, MD, of Peru, Indiana, writes: Jimmy, an active 7-month-old infant, is a challenge to what sounds like good parents. Although he may have qualified for the diagnosis of colic earlier, he has certainly progressed past the age that most infants outgrow those symptoms. Food and formula intolerances/allergies are frequently a consideration with these children and are probably overdiagnosed. It is useful to ask about a temporal relationship to the symptoms and the suspected food or formula. Central nervous system structural malformations can usually be ruled out by a normal developmental history, an assessment of the rate of head circumference growth, and a normal neurodevelopmental examination.

A fussy, irritable infant can be a severe stress on the emotional well-being of any parent, especially one who prides himself/herself on competent parenting skills. Self-blame and defensiveness can impair a parent’s ability to monitor and modify reactions to an infant’s behavior as well as interact with other family members. The circumstances of the
pregnancy (both physical [any health threats to mother or fetus] and emotional [planned, wanted, impact of new baby, infidelity, etc]), delivery, and postpartum period (depression, bonding, marital conflict, etc) need to be explored.

The history does suggest that this is a temperamentally difficult baby. I would help the parent’s discover a physical sensation that soothes many fussy babies, eg, sound, light, motion, touch, or warmth. Is the behavior seen in different environments (eg, with a grandmother, a babysitter, etc)? If temperament is a reasonable explanation for the baby’s behaviors, the parents need to understand that concept, partly to remove guilt as well as to reassure them that there is nothing seriously wrong with their baby. Knowing that the temperament is the source, parents may be able to discover ways of soothing the baby as they look at his problem from an entirely new perspective.

Morris Wessel, MD, writes: Jimmy’s “screaming” may well be normal for him. I would suggest that the mother try to find a high school girl or any other “sitter” who could come in for a few hours, develop a relationship with the child, and in due time take him for a walk. He may be “just a sensitive child” and the mother needs some ongoing help and support. This child is obviously somewhat different from the others. Many “colicky” babies are highly reactive to all kinds of external and internal stimuli and thus deserve to be called “highly perceptive.”

REFERENCE

Linda Nathanson-Lippitt, MD, writes: I am concerned about Jimmy. It is unusual for “colic” to last into the 7th month. I would look for some medical problems, specifically otitis media, gastroesophageal reflux, and milk sensitivity, before ascribing this to behavior, particularly since you say he does have periods when he is happy and interactive.

Dr Martin T. Stein

New ideas that inform a student often come in bursts of insight. A lecture, a small group discussion, an article, a book (for some, the morning shower)—there are many potential moments when a student is introduced to an important concept. I recall one of those moments in 1969 when, at a dinner in the home of Dr Louis Fraad who directed my pediatric residency program, I met Herbert Birch. Dr Birch was a research psychologist at the Albert Einstein College of Medicine. He spoke about his productive collaboration with Stella Chess and Alexander Thomas in which he contributed his methodological and analytic skills to the early studies of temperament. At the time, although excited by the ideas he spoke about, I had a limited appreciation for the value of temperament as an important tool in the practice of pediatrics. Time and clinical experience taught me about the significance of the conversation with Dr Birch.

The 3 cases presented here, an infant, a toddler, and an adolescent, demonstrate the clinical value derived from a recognition of an individual child’s temperament at various developmental stages. Some pediatricians use the standard questionnaires to which Dr Carey referred in his commentary. Most clinicians rely on focused questions and behavioral observations in the office to determine a temperament profile. Dr Snyder provided several examples of questions tailored to assess temperament in each case study. His discussion of Harry and Jimmy are especially instructive.

A practice-based model for the assessment of temperament-related behavioral issues has been in development by the Northern California Kaiser Permanente Group, a large health maintenance organization. Parents are given a health education manual in the third trimester. The manual explains the importance of differences in temperament, describes the behavioral manifestations of temperament at each stage in early development, and guides parents in their own assessment of temperament-specific behaviors. The manual also includes a 4-month temperament questionnaire. Between 5 and 16 months of age, anticipatory guidance during health-supervision visits focuses on letting the parents know what temperament-related behavioral issues are likely to occur for their infants based on the 4-month questionnaire. Evaluation studies demonstrate predictive validity, with improved parent management of more challenging temperament-related behaviors when parents were prospectively informed of their infant’s behavior compared with a control group. Consumer and clinician satisfaction with the program was seen. Anecdotal case reports of cost savings from expensive diagnostic evaluations was documented among some infants with difficult temperaments whose parents were able to accept a behavioral diagnosis and not insist on further medical evaluation.2

All of the discussants pointed out the value of understanding temperament when faced with a variety of behaviors. “Slow-to-warm-up” Harry, “difficult” Jimmy, and “low-task orientation” Carla describe temperament profiles that may be used to help parents begin the process of understanding their child’s behavioral endowment. The clinician can then correlate clusters of temperament-related behaviors with a probability that certain problem behaviors (eg, discipline problems, disruptive behaviors, and sleep problems) might occur either at a particular developmental stage or at a time of change and transition. As Dr Carey emphasized, a lack of fit or a mismatch of temperament among a child and parent is often the source of behavioral problems in a family. Recognition of a lack of fit (also known as “goodness of fit”) emphasizes the need to consider the individuality of a person and the demands of the social environment. In each case summary, we were not informed about the parents’ temperament, a critical component to most behavioral evaluations in pediatric practice.

An additional value to a consideration of temperament when evaluating behavioral problems in children is the opportunity it brings to build on and strengthen the therapeutic alliance with the parents.
Recognition and discussion of temperament often initiate a positive response in a parent. To reframe a cluster of difficult behaviors as a biological foundation of the child’s individual maturation and development is an epiphany for many parents. I often discover that it uncovers the parents’ intuitive understanding of their child’s behaviors that they were not able to express or understand before learning about temperament. It is during these teachable moments that pediatricians have an opportunity to “connect” with parents and strengthen the therapeutic alliance to be used in the service of the best possible care for children and families.

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