Clinical applications of temperament
What I did, when, and why. What you can do.

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1. Initiated clinical pediatric temperament research 1968. Showed that it could be done in practice and is important. About 10 temperament researchers in world. Previously beside Thomas & Chess only Pavlov, Gesell, but not well known. No specific training in psychology or test design, Inspiration of Thomas & Chess. Exciting adventure but little interest generated among pediatric colleagues.
2. Constructed ITQ in 1968 by self, first of its kind, Then with Sean McDevitt et al- RITQ, BSQ, TTS, MCTQ, and EITQ. All while in solo pediatrics practice. Achieved greater age range and psychometric sophistication. Scales widely translated and used (and misused) around the world.
   Early battles with establishment over value of "maternal perceptions of temperament" vs. brief observations by professionals.
3. Studies by me and others of participation of temperament in clinical problems: colic, weight gain, injuries, sleep problems, toilet training, coping ("executive functions"), school underachievement, some developmental milestones, etc. Clinical value of temperament in understanding and present management of these and other issues. However, no clinical help evident from making predictions of possible later behavioral issues.
   An algorithm to demonstrate when and where temperament determinations are useful in diagnosis process and management: a) as component of adjustment problem or b) as source of misperception of abnormality when no dysfunction.
4. Demonstrated after 20 years that routine temperament screening in practice is not a good use of the clinician's time. Temperament is not pathology. Better to limit determinations of it to times when there is concern about the child's behavior or functioning, which must also be evaluated appropriately.
5. Developed BBAS (www.b-di.com) with McDevitt to have available a more suitable conceptualization of and scale for evaluating behavioral outcome, both positive and negative. DSM too pathology oriented, not sufficiently developmental or contextual, and not cognizant of normal variation.
6. Pointed out repeatedly problem of pathologizing of temperament by DSM. Aversive temperament is seldom a sign of CNS malfunction. Recently clinical temperament research has languished amid a wave of theories about neurotransmitters and chemical imbalances. Especially the vague diagnostic criteria for ADHD have led to too much pathologizing of normal temperament and failure to recognize contributory role of other factors like sleep deprivation and adjustment problems. The ADHD epidemic a serious diagnostic and social problem, which has provoked too little concern.
7. Education of health professionals in many places here and abroad about nature, importance, and management of temperament concerns. My present particular attention to pediatricians in training at the Children's Hospital of Philadelphia.
8. McDevitt and I started biennial OTC meetings in 1978. Let us continue.