

Psychiatric and Behavioral Problems of Non Referred Preschoolers (aged 3-6) in Nurseries in Ismailia

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This study was designed to identify the presence of psychiatric and behavioral problems in preschool children (aged 3-6 years) attending daycare nurseries in Ismailia city. Initially 900 preschoolers were screened by the use of Conners Rating Scale (both parent and teacher reports), each child was behaviorally assessed by the Child Behavior Checklist (CBCL) (both parent and teacher forms) and by the use of the Boyd Developmental Progress Scale.

Results showed that 19.9% (n= 146) of preschoolers studied (n= 734) were reported by their parents and 15.7% (n= 115) by their teachers to be problematic. Teachers identified significantly more boys (60.9%) than girls (39.1%) to be problematic. Problematic boys were reported by their parents to be more aggressive than non problematic boys, while problematic girls were described by their parents to be more schizoid, depressed, uncommunicative, socially withdrawn, hyperactive, aggressive, and delinquent.

On the other hand, problematic boys were reported by their teachers to have more self destructive, obsessive compulsive, inattentive and nervous overactive behavioral problems than girls. In addition, 75% of problematic boys were found to have motor skill deficits on neurodevelopmental evaluation than problematic girls (20%).

The implication of these results suggests that preschool screening for behavior, psychiatric and neurodevelopmental skills and difficulties would help in early recognition and intervention.

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Introduction

Little is known about the psychiatric and behavioral problems in preschool population in our society. Most of the available studies about normative data are limited and restricted to psychiatrically referred preschoolers or only to one or few disorders (Abdel Baki et al, 1992).

In North America, Godberg et al

(1979) reported that 5-15% of preschoolers have specific psychiatric disorders, while Larson et al, (1988) showed that the prevalence of one or more of the deviant behavioral symptoms identified by Child Behavior Checklist was 11.1%. Recent follow up and cross - sectional studies of preschool and young children have demonstrated adverse outcome for those with observable behavioral patterns (Morrison et al, 1989). On the other hand, Hooks et al, (1988) pointed out that in a sample of psychiatrically referred preschoolers 58.5% presented with behavioral problems and 58.5% with developmental delays. The association between behavioral problems and developmental deviation has been recently established (Satterfield et al, 1994 and Beitchman et al 1994, Biederman et al, 1993).

The rates of child psychopathology in developing countries appear to be comparable to rates in developed countries, which range from 14 to 20% (Bradenburg et al, 1990 and Costello, 1989). Giel et al. (1981) found rates ranging from 12% to 29% in the Sudan, the Philippines, India, and Columbia on the 10 - item Reporting Questionnaire for Children (RQC) developed by World Health Organization (WHO) experts. Similarly high rates of identification were found using the RQC in Nigeria, where 15% of 5- to 15 - year old children had some form of psychopathology (Abiodun, 1993). In Africa, studies in Sudanese village have placed the rate between 8% and 20% (Cederbald, 1968) and research on Ugandan school children found an overall rate of 18% with a high of 24% in urban settings (Minde, 1975).

Child psychopathology has become a major concern among health professionals and educators in the developed world, yet has remained relatively unrecognized in developing countries. For example, in

Ethiopia, where children younger than 15 years constitute 50% of the population, yet only 10% of the people seen in psychiatric outpatient clinics (from 1980 to 1990) were children (Araya and Aboud, 1993). Because of poor mental health training and large work loads, health personnel and teachers in developing countries are rarely able to identify children with problems. In one study, only 15% of cases were correctly identified by health workers (Giel et al., 1981). To identify and treat child psychopathology, culturally valid measures of prevalence need to be examined at the community level.

However, for establishing and extending psychiatric services to the preschool children, and for early recognition and intervention there must be enough knowledge about the size of psychiatric and behavioral problems in our society. The Faculty of Medicine, Suez Canal University (FOMSCU) has took the lead to carry out a series of research work investigating the behavioral and psychiatric problems of different age groups in the community. The present study is the first one to target preschool children of nurseries in the Suez Canal area and was originally designed to identify the prevalence of psychiatric behavioral and neurodevelopmental problems of preschool children attending daycare nurseries in Ismailia. Also, this study describes the use and application of different measures of psychopathology in Egypt to determine the prevalence rates of different clinically and culturally relevant problems. It also examines the common neurodevelopmental correlates in preschool children attending nurseries in Ismailia.

Subjects and Method

Data were collected during the period of the first of February, 1994 to the end of June 1994. Initially 900 preschool children were randomly selected by a two

stage procedure and systematic random sampling from 15 randomly selected nurseries under the authority of the ministry of social welfare (n= 7) and the ministry of education (n= 8) in Ismailia city. Complete informed consents and permissions were taken from local departments of education and social welfare, from nursery authorities and supervisors, and from parents of randomly selected children.

Inclusion criteria were: regular enrollment in the nursery, age between 2 years, 11 months and 5 years, 11 months. Teachers and parents were asked to fill out the Conners Rating Scale (El-Defrawi et al, 1992 Daradkeh, 1993, and Conners, 1973), and the Child Behavior Checklist (CBCL) (Achenbach and Edelbrock, 1986) for each child separately. The Conners parent and teacher rating scale is a 10-item scale used heavily for quick and rapid screening of behavioral problems, for follow up and drug studies. The scale was translated to Arabic and its reliability and validity had been established and used on a large scale in studies in Suez Canal area (Zeitoun and Sahrhan, 1992).

The Achenbach Child Behavioral Checklist (Achenbach et al 1987a, 1987 b, Achenbach and Edelbrock, 1983) consists of 20 competence items and 118 items describing behavioral and emotional problems. The competence items included physical, social, and academic activities performed at home or in school with comparison of the child's performance to other children at his age. The other part of the CBCL, the behavioral problems scales comprises 118 behavioral problem items which are analysed into 9 behavioral factors (schizoid, depressed, uncommunicative, obsessive compulsive, somatic complaints, social withdrawal, hyperactive, aggressive and delinquent)

and 2 second order factors, internalizing and externalizing. The internalizing and externalizing factors represent a distinction between fearful, inhibited overcontrolled behavior (internalizing) and aggressive antisocial uncontrolled behavior (externalizing) (Ross et al, 1990).

In addition, preschool children were evaluated for their neurodevelopmental milestones by the use of the Boyd Neurodevelopmental Progress Scale (Lezak, 1983 and Boyd 1974). This is an easy administered scale that tests behavior in three areas of motor, communication and self - sufficiency skills from birth to the seventh year. The scale focuses on the adaptive aspects of behavior in each of the three test areas. The Boyd Developmental Progress Scale had been used in a study by Khatab et al (1994) and El-Defrawi et al (1993) in Suez Canal area.

The preschooler was considered to have a developmental delay if the parents reported delays in 2 or more skills in each of the three areas of the scale at and / or below the child's chronological age and verified by the investigators.

Medical history, physical examination, socioeconomic assessment of the family as well as the presence of any chronic illnesses or seizures of the studied preschool children were obtained.

Results

Of the 900 preschoolers screened, only 734 preschool children (81.5%) were included in the study because of the failure of the return of the parental responses and / or report forms (18.5%) and non compliance with the research procedures or refusal to consent.

Table (1) shows the sample distribution according to age. Table (2) shows that according to the Conners reports, parents identified about 20% of their preschool children to be problematic, more

boys (24.45%) than girls (15.8%).

Table (3) shows that teachers identified 15.7% of the preschool children to be problematic, significantly more boys (20.1%) than girls (11.7%) ($p < 0.05$).

Table (4) shows that when the Conners threshold for identifying behavioral problems was raised from a cut off point of 15 to 19, as suggested by El-Defrawi et al (1992), rates of behavioral problems dropped to 8% as reported by parents and more in boys (10.3%) than in girls (6%). On the other hand the rate identified by teachers dropped to 6.7% (Table 5).

Table (6A) shows that 5.2% of children were reported and agreed upon by both parents and teachers to be problematic behaviorally. Table (6B) shows correlation between teachers and parents' ratings which appear to be highly significant at the level of $p = 0.0001$.

Table (7) shows that problematic children on the Conners were described by their parents to be only more aggressive than non problematic boys ($p < 0.03$), while problematic girls have statistically significant multiple behavioral problems than non problematic girls

(shiziod, $p < 0.008$, depressed, $p < 0.04$, uncommunicative, $p < 0.002$ social withdrawal, $p < 0.03$, hyperactive, $p < 0.001$, aggressive, $p < 0.002$, and delinquent, $p < 0.0004$).

Table (8) shows that problematic boys were reported by their teachers to be significantly more self destructive ($p < 0.007$), obsessive compulsive ($p < 0.02$), inattentive ($p < 0.02$), nervous ($p < 0.02$), and aggressive ($p < 0.01$) than non problematic boys. On the other hand, problematic girls showed significantly more schizoid, social withdrawal, inattention, self destructive, obsessive compulsive, nervous and aggressive behaviors than non - problematic girls.

Table (9) shows that there were no statistically significant differences between problematic preschool boys and girls as reported by parents CBCL and teachers CBCL (Table 10).

Table (11) showed the neurodevelopmental status of preschool children as reported by their parents and as objectively assessed. Problematic boys and girls exhibited significantly more motor delays on the Boyd, Scale than non problematic preschoolers ($p < 0.05$).

Table 1
Distribution of the Studied Preschoolers
According to Age Group and Sex

Sex Age Group	Boys		Girls		Total	
	No.	%	No.	%	No.	%
2.11-3.10	39	11.21	20	5.18	59	8.04
3.11-4.10	116	33.33	137	35.49	253	34.47
4.11-5.10	174	50.00	213	55.18	387	52.73
5.11	19	5.46	16	4.15	35	4.77
Total	378	47.4	386	52.6	734	100

* Mean of age = 4.75 ± 0.71 years
 $P > 0.05$

Table 2
Distribution of the Studied Preschoolers According to Their Score &
Sex as Reported by Their Parents Using the Arabic version of Conners
Scale (Cut Off Point 15 and / or more)

Sex Score in Conners Scale	Boys		Girls		Total	
	No.	%	No.	%	No.	%
Less than 15	263	75.6	325	84.2	588	80.1
* 15 and more	58	24.4	61	15.8	146	19.9
Total	348	100	386	100	734	100

* Mean score Boys = 18.85 Girls = 18.13 Total = 18.55

Psychiatric and Behavioral Problems in Preschoolers

Table 3

Distribution of the Studied Preschoolers According to Their Score & Sex as Reported by Their Teachers Using the Arabic version of Conners Scale (Cut Off Point 15 and / or more)

Sex Score in Conners Scale						
	Boys		Girls		Total	
	No.	%	No.	%	No.	%
Less than 15	278	79.9	341	88.3	619	84.3
* 15 and more	70	20.1	45	11.7	115	15.7
Total	348	100	386	100	734	100

* Mean score Boys= 19.2 Girls= 18.62 Total= 18.97
P value < 0.05 (Significant)

Table 4

Distribution of the Studied Preschoolers According to Their Score & Sex as Reported by Their Parents Using the Arabic version of Conners Scale (Cut Off Point 19 and / or more)

Sex Score in Conners Scale						
	Boys		Girls		Total	
	No.	%	No.	%	No.	%
Less than 19	312	89.7	363	94.0	675	92.0
* 19 and more	36	10.3	23	6.0	59	8.0
Total	348	47.4	386	52.6	734	100

* Mean score Boys= 22.17 Girls= 21.65 Total= 21.97
P value < 0.05 (Significant)

Table 5

Distribution of the Studied Preschoolers According to Their Score & Sex as Reported by Their Teachers Using the Arabic version of Conners Scale (Cut Off Point 19 and / or more)

Sex Score in Conners Scale						
	Boys		Girls		Total	
	No.	%	No.	%	No.	%
Less than 19	315	90.5	370	95.9	685	93.3
* 19 and more	33	9.6	16	4.1	49	6.7
Total	348	47.4	386	52.6	734	100

* Mean score Boys= 22.55 Girls= 22.69 Total= 22.59
P value < 0.05 (Significant)

Table 6 A

Prevalence of Psychiatric Problems in Preschoolers as Reported by Both Parents and Teachers Using the Arabic Version of Conners Scale ≥ 15

< 15		> 15		Total	
No.	%	No.	%	No.	%
694	94.0	40	5.2	734	100

Table 6 B

Mean and Standard Deviation of Score of the Studied Preschoolers as Reported by Their Parents and Teachers Using the Arabic Version of the Conner's Scale

Parents		Teachers	
Mean*	$\pm$ S.D.	Mean*	$\pm$ S.D.
8.627	$\pm$ 6.482	8.387	$\pm$ 6.326

Correlation Between Parents and Teachers Score

$r = 0.37$ $P = 0.0001$

* P Value < 0.05 (Statistically significant)

Discussion

This is the first study, to our knowledge, that attempts to report on the psychiatric and behavioral problems among preschool children attending daycare nurseries in Ismailia. The study design and the large number of preschoolers evaluated give confidence in the results and to certain extent, some generalization to be reported. However, we are aware that only less than 10% of the preschoolers under the age of 6 years attend daycare centers in Egypt.

Despite the present study's strength as one of the first to investigate the psychiatric and behavioral problems in preschool children within a representative community sample, a few limitations should be noted.

Our results suggest that obtaining information on children from different

Table 7
Mean and Standard Deviation of Internalizing Factors in Boys and Girls Scored Less Than 15 and Those Scored 15 or more as Reported by Their Parents Using the Arabic Version of CBCL

Sex Problem Area	Boys				P Value	Girls				P Value
	< than 15		15 & more			< than 15		15 & more		
	Mean	±S.D.	Mean	±S.D.		Mean	±S.D.	Mean	±S.D.	
I- Schizoid	4.6	±3.007	5.06	±3.26	> 0.05	2.77	±2.38	5.17	±2.92	0.008*
II- Depressed	6.93	±4.92	8.87	±6.41	> 0.05	6.05	±4.30	9.85	±6.31	0.04*
III- Uncommunicative	4.4	±2.43	6.40	±5.66	> 0.05	3.16	±2.21	7.36	±6.86	0.002*
IV- Obsessive Compulsive	5.57	±4.66	7.03	±5.36	> 0.05	4.63	±5.12	7.09	±5.31	>0.05
V- Somatic Complaint	3.5	±3.26	3.75	±2.54	> 0.05	4.66	±3.88	4.60	±4.31	>0.05
VI- Social withdrawal	3.51	±3.11	4.16	±3.49	> 0.05	2.7	±1.63	4.24	±3.32	0.03*
VII- Hyperactive	5.33	±3.37	6.59	±3.46	> 0.05	3.36	±2.01	6.41	±3.90	0.001*
VIII- Aggressive	10.96	±7.29	15.96	±7.41	0.03*	8.0	±4.95	14.26	±7.86	0.002*
IX- Delinquent	5.5	±4.89	6.45	±4.09	> 0.05	1.57	±0.79	6.42	±6.80	0.0004*
Internalizing	21.96	±14.45	25.46	±19.03	> 0.05	17.5	±14.19	30.23	±18.85	0.02*
Externalizing	21.76	±13.62	31.72	±17.03	0.03*	14.25	±7.96	30.58	±17.66	0.0001*
Total Scores	44.37	±25.22	58.63	±34.61	> 0.05	31.75	±20.69	60.82	±35.13	0.001*

* P value < 0.05 is Statistically Significant.

Table 8
Mean and Standard Deviation of Internalizing and Externalizing Factors in Boys and Girls Scored Less Than 15 and Those Scored 15 or more as Reported by Their Teachers Using the Arabic Version of CBCL

Sex Problem Area	Boys				P Value	Girls				P Value
	< than 15		15 & more			< than 15		15 & more		
	Mean	±S.D.	Mean	±S.D.		Mean	±S.D.	Mean	±S.D.	
I- Schizoid	6.88	±4.26	6.85	±5.63	> 0.05	6.45	±4.43	8.21	±5.28	0.05
II- Social withdrawal	3.4	±3.14	4.46	±4.50	> 0.05	3.77	±3.56	6.58	±4.28	0.02*
III- Unpopular	4.0	±3.47	4.72	±4.34	> 0.05	5.2	±4.02	6.19	±3.66	>0.05
IV- Self Destructive	3.2	±2.85	5.96	±5.44	> 0.007*	3.6	±3.21	6.86	±4.23	0.008*
V- Obsessive Compulsive	2.73	±2.92	4.56	±3.73	0.02*	3.0	±1.41	4.84	±3.17	0.009*
VI- Intensive	6.36	±5.63	9.94	±7.55	0.02*	5.22	±4.17	11.18	±6.57	0.0007*
VII- Nervous	2.8	±2.85	4.42	±3.04	0.02*	2.14	±1.34	4.25	±2.32	0.0005*
VIII- Aggressive	10.08	±10.44	17.78	±15.31	0.01*	8.71	±7.71	18.5	±13.09	0.002*
Internalizing	14.38	±14.12	22.13	±22.19	> 0.05	12.66	±12.6	27.78	±18.58	0.003*
Externalizing	17.18	±16.74	31.02	±26.04	0.007*	12.8	±12.22	32.96	±21.56	0.0004*
Total Scores	27.76	±27.29	55.21	±47.67	0.003*	27.19	±23.07	60.0	±39.28	0.001*

* P value < 0.05 is Statistically Significant.

Psychiatric and Behavioral Problems in Preschoolers

Table 9
Comparison Between Boys and Girls Scored 15 and more as Reported
by Their Parents Using the Arabic Version of CBCL

Sex Problem Area	Boys		Girls		P Value
	15 & more		15 & more		
	Mean	±S.D.	Mean	±S.D.	
I- Schizoid	5.06	±3.26	5.17	±2.92	> 0.05
II- Depressed	8.87	±6.41	9.85	±6.31	> 0.05
III- Uncommunicative	6.40	±5.66	7.36	±6.86	> 0.05
IV- Obsessive Compulsive	7.03	±5.36	7.09	±5.31	> 0.05
V- Somatic Complaint	3.75	±2.54	4.60	±4.31	> 0.05
VI- Social Withdrawal	4.16	±3.49	4.24	±3.32	> 0.05
VII- Hyperactive	6.59	±3.46	6.41	±3.90	> 0.05
VIII- Aggressive	15.96	±7.41	14.26	±7.86	> 0.05
Delinquen	6.45	±4.09	6.42	±6.80	> 0.05
Internalizing	25.47	±19.03	30.23	±18.85	> 0.05
Externalizing	31.72	±17.03	30.58	±17.66	> 0.05
Total Scores	58.63	±34.61	60.82	±35.13	> 0.05

* P value < 0.05 is Statistically Significant.

Table 10
Comparison Between Boys and Girls Scored 15 and more as Reported by Their
Teachers Using the Arabic Version of CBCL

Sex Problem Area	Boys		Girls		P Value
	15 & more		15 & more		
	Mean	±S.D.	Mean	±S.D.	
I- Schizoid	6.85	±5.63	8.21	±5.28	> 0.05
II- Social withdrawal	4.46	±4.50	6.58	±4.28	> 0.05
III- Unpopular	4.72	±4.34	6.19	±3.66	> 0.05
IV- Self Destructive	5.96	±5.44	6.86	±4.23	> 0.05
V- Obsessive Compulsive	4.56	±3.73	4.84	±3.17	> 0.05
VI- Inattentive	9.94	±7.55	11.18	±6.57	> 0.05
VII- Nervous	4.42	±3.04	4.25	±2.32	> 0.05
VIII- Aggressive	17.78	±15.31	18.5	±13.09	> 0.05
Internalizing	22.13	±22.19	27.78	±18.58	> 0.05
Externalizing	31.02	±26.04	32.96	±21.56	> 0.05
Total Scores	55.21	±47.67	60.0	±39.28	> 0.05

* P value < 0.05 is Statistically Significant.

Table 11
Neurodevelopmental Assessment of Preschoolers by the use of Boyd
Developmental Progress Scale According to their Problematic Status

	Skill	Boys		Girls	
		Less than 15	More than 15	Less than 15	More than 15
Parental reports of developmental milestones	Motor	15.9%	17.6%	19.6%	19.6%
	Communication and Language	12.9%	11.7%	9.2%	9.8%
	Self - Sufficiency	1.5%	2.3%	1.8%	1.6%
Neurodevelopmental assessment	Motor *	15.8%	* 75%	6.3%	20%
	Communication and Language	3.1%	9.8%	1.5%	8%

N.B. The preschooler was considered delayed if he showed two or more delays in the sectors covering the motor, communication and language, and self sufficiency skills.

* P value < 0.05 (Statistically significant).

sources is useful, and the differences in teachers (15%) and parents rating of behavior (19.9%) is partly situational where children are more disciplined (DuPaul and Rapport, 1994) and that parents tend to overestimate the problems of their preschoolers (El-Defrawi et al 1992 and Verhulst et al 1985). Parents are likely to have less tolerance for children who are very aggressive at home (Zimet et al., 1994). The findings that problematic boys were reported to be more aggressive than non problematic boys suggest that the main concern for teachers in daycare is the aggressive behavior (Verhulst et al, 1985). Problematic boys were one and half times more than girls this is similar to other findings. (Zimet et al, 1994). The customary child psychiatry practice of using both child, he / his teacher., and his or her parent (S) together information about the

child's symptoms has been shown to be helpful (Gershon et al, 1985, Verhulst et al., 1985). On the other hand, while problematic boys were described as significantly more aggressive than their peers, problematic girls were reported to have multiple behavioral problems than non problematic girls. This is in accordance with similar studies that showed that although girls are less likely to have behavioral problems (almost 1:2) than boys, however, problematic girls are usually multihandicapped with their behavioral problems (August and Garfinckel, 1994). Most of the behavioral problems described in our sample could be attributed to hyperactivity and disruptive difficulties. Attention - deficit hyperactivity disorder (ADHD) is a very frequent and severe problem affecting about 3-10% of preschool and elementary school children in the United States (Biederman

et al, 1991). Difficulty with attention impairs learning while problems of restlessness and irritability affect behavior. Associated problems of oppositionality, argumentativeness, and low frustration tolerance often add to the developmental burden of these children. Learning disabilities and aggressive conduct disorder are significantly increased in this population, leading to disruption at home and at school. Depression and anxiety, irritability and explosiveness, also occur with increased frequency (Faraone et al., 1991) in approximately half of the cases when the problem continues into middle childhood, adolescence and adulthood (Biederman et al., 1993). Our rates of behavioral problems are not different from rates reported in other culture, and studies. However, as the concept of cultural competence is more widely accepted within child psychiatry and child mental health, investigators are reexamining the influence of culture on the diagnostic process. Both the cultural factors affecting the expression of psychopathology as well as biases on the part of clinicians have come into question (Cross et al., 1989). For example a number of studies support the presence of cultural and racial differences in diagnostic assessment between African - American especially toward the diagnosis of conduct disorder, (Fabrega et al., 1993), ethnic, racial background toward a significant differences in the total symptomatology and internalizing symptomatology (Pumariega et al., 1991), and rural /urban differences in psychopathology with higher levels of emotional disturbances in urban child psychiatry population (Zahner et al., 1993). Egypt as a developing country has many risk factors for psychiatric, behavioral and developmental disorders, in preschool children, including consanguineous marriage, malnutrition, and low socioeconomic families.

Genetic factors play a determining role for certain developmental and psychiatric disorders (Lombroso et al, 1994) El-Defrawi and El-Sayed (1992) have reported that children with nutritional disadvantages have high rates of behavioral problems in Egypt. Raadal et al (1994) suggested that poverty is a risk factor for mental distress in children leading to increase levels of behavioral psychopathology. In our sample, problematic children were described to have more somatic symptoms. Recurrent medically unexplained physical symptoms are common in the pediatric age group, are often associated with other psychiatric symptoms, and may represent a common presentation of psychiatric disorder in the primary care setting (Campo and Fritsch, 1994). In Egypt as in many developing countries, people often describe psychological difficulties in terms of physical symptoms such as headaches and sleep disturbances may be expressed by children and reported by mothers in diffuse clusters of physical (somatic) and behavioral problems. The results of the neurodevelopmental assessment that showed that problematic children were more delayed than non problematic suggest that preschoolers with behavioral disturbances could be additionally handicapped by developmental delays. This is supported by what Cowen et al (1994) had reported that delayed mastery of early developmental milestones may be a risk factor associated with poor behavioral adjustment and academic underachievement in later childhood. Screening at age 5 may be useful, as most serious speech/ language/ behavior impairment problems that emerged by middle childhood could be identified at age 5. (Beitchman et al., 1994).

In conclusion, our results showed that behavioral problems and developmental delays are found in the preschool children in rates not different from other

studies or cultures. Future research should include a replication of these findings with a demographically similar sample as well as expanding the study to samples who are not attending nurseries yet not so highly advantaged.

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Les Troubles psychiatriques et du comportement chez des enfants d'âge préscolaire (3-6 ans) fréquentant des garderies à Ismailia

900 enfants d'âge préscolaire (3-6 ans) ont passé un bilan psychologique utilisant différentes batteries d'évaluations. Les résultats montrent que 19,9% des enfants étaient décrit par leurs parents et 15,6% par leur maîtresse comme étant problématiques. Des différences significatives entre filles et garçons étaient notées. Les implications de cette étude souligne l'importance d'un bilan comportemental, psychiatrique, et développemental afin de dépister et d'intervenir assez tôt.

المشاكل الطبينية والسلوكية فى الأطفال

فى سن ما قبل فى المدرسة فى الحضانات فى مدينة الاسماعيلية

قام الباحثون فى هذه الدراسة بإجراء مسح طبينى وسلوكى ونمائى باستخدام مقياس كورنر ومقياس وصف سلوك الطفل ومقياس بويد للنمو العصبى وذلك لعدد تسعمائة طفلاً وطفلة (من سن ٣ - ٦ سنوات) فى حضانات مدينة الاسماعيلية، وقد أظهرت النتائج أن الوالدان قررا وجود مشاكل سلوكية فى ١٩,٩٪ من الأطفال أما مدرساتهم فقد أشاروا إلى أن ١٥,٦٪ من الأطفال لديهم مشاكل سلوكية، وكانت نسبة الصبيان فيهم (٩,٦٠٪) أكثر من البنات (٣,٩١٪)، كما قرر الوالدان أن الصبيان الذين لديهم مشاكل سلوكية كانوا أكثر عدوانية من البنات اللاتي لديهن مشاكل سلوكية وطبينية، وكما أظهرت النتائج بالنسبة لتقرير المدرسات أن الصبيان نوى المشاكل السلوكية قد أظهروا إيذاء للنفس وسلوك وسواسى وعدم تركيز وعصبية زائدة أكثر من البنات، بالإضافة إلى أن ٧٥٪ من الصبيان الذين إتصفوا بوجود المشاكل السلوكية كانوا أقل أداءً من ناحية النمو العصبى الحركى بالمقارنة بـ ٢٠٪ فى البنات المتصفات بوجود مشاكل سلوكية باستخدام مقياس بويد لتقدم النمو العصبى.

وتناقش الدراسة ضرورة عمل تقييم ومسح ميدنى للمشاكل الطبينية للنمو السلوكى

والعصبى فى أطفال ما قبل المدرسة لإكتشافها المبكر وعلاجها.