

Psychiatric Disorders in a Sample of Egyptian Preschool Children

M. H. El-Defrawi

Studies of childhood psychiatric disorders have been primarily based on school-age children. This study reports on a series of 100 preschool children (aged 4-6 years) presented for consultation, evaluation and treatment to a child psychiatry clinic. Diagnoses were assigned according to DSM-III-R. The Arabic version of the Child Behavior Checklist (CBCL) was used to describe the behavioral problems, in addition to a clinical interview. Results showed that Attention Deficit Hyperactivity Disorder (54%) was the most common psychiatric diagnosis followed by Functional Enuresis (29%), Undifferentiated Attention Deficit Disorder (16%), and Disruptive Behavior Disorder (10) on Axis I. Specific Developmental Disorders (84%) and Mental Retardation (27%) represented the most common Axis-II diagnoses.

While, comparison of behavioral profiles according to gender (boys vs. girls) revealed no statistically significant differences, mother - father discrepancy suggests that mothers reported significantly more obsessive compulsive symptoms, ($P < 0.03$), somatic complaints ($P < 0.05$) and other problems ($P < 0.05$) and other problems ($P < 0.05$) than fathers. Our results suggest that psychiatric problems of preschool children are multiple, loaded with developmental problems and need multiple sources of information.

(Egypt. J. Psychiat., 1997, 20: 271-282).

INTRODUCTION

Preschool years of life are universally accepted to be of profound importance to human emotional development. Yet less psychiatric intervention occurs in this period than any other (Kirz, 1980).

Little is known about how to identify young children who will develop future psychiatric disorders and who might, therefore, benefit from early evaluation or treatment.

There are few published studies of psychiatric clinic population of preschool children. Wolf (1961) reported on 43 children under age 5 years attending a child guidance clinic. He excluded

from his sample children with distinct pathological entities including brain damage, mental defect, epilepsy, and childhood psychoses. Hooks et al., (1998) reported, in a sample of 193 preschool children, that 58.5% with developmental delay. In their sample, 41% presented with a single problem, 35% with two problems, and 24% three or more problems. They found that the most common grouping of problems was a developmental delay (usually language) with aggression or oppositionality. 61% of their sample were delayed, 31%, in language 28%, and in motor development 2%.

Detecting and studying psychiatric problems of preschool children is important because there is evidence that behavioral symptoms, poor academic performance, cognitive impairment, low

Mohamed Hassib El-Defrawi, M.D., Assistant Professor, Suez Canal University.

selfsame, and difficulty with peer relationship may continue into adolescence and adulthood (Weiss et al., 1978, August et al., 1983). Follow-up studies of preschool hyperactive children also indicate continuity of hyperactive behavior (Campbell et al., 1977a,b). McGee et al., (1991) in a twelve-year follow-up study of preschool hyperactive children reported that preschoolers continued to show poor cognitive skills, lower levels of reading ability, disruptive and inattentive behavior at home and at school, and higher rates of DSM-III disorders in pre-adolescence and adolescence.

Recent follow-up and cross-sectional studies of preschool and young children have demonstrated adverse outcomes for those with certain observable behavior patterns (Morrison et al. 1989). Aggressive preschoolers maintained a persistent pattern of aggressive behavior (Kohn, 1977) and functioned more poorly than classmates when they entered elementary school (Chamberlin and Nader, 1971). Children with higher ratings of overall behavior disturbance were found to have increased risk for developing future psychiatric disorders (Lerner et al., 1985). Conduct disorder and hyperactivity were more common in boys than in girls regardless of informant (Offord et al., 1989).

Aggressive preschool girls showed significant decrements in intellectual achievement by second grade (Kohn and Rosman, 1972). Compared to normal controls, hyperactive children had lower IQs after 2 years (Halverson and Waldrop, 1976), lower self-esteem and more disruptive school behavior after 3 years (Campbell et al., 1977), higher academic failure rate after 5 years (Minde et al., 1971), and persistent learning disabilities after 7 years (Huesy and Kohn, 1976).

Moreover children with speech and language problems had higher rates of psychiatric disorders than the general population (Cantwell and Baker, 1980, Cantwell et al., 1979, 1980). Children with language delay had a higher prevalence of behavioral disturbance (Jenkins et al., 1980, Stevenson and Richman, 1978).

Furthermore, Jensen et al. (1988) reported that mothers rated sons and daughters significantly higher in symptoms than did fathers. According to Achenbach et al. (1987) the sex differences found in four countries (the American - Dutch and the French - Canadian Studies) were remarkably consistent in that girls obtained a mean score that was slightly below that for boys, a difference averaging 2.3 points across the four countries.

While boys presenting with problematic behaviors (temper tantrum, overactive, aggressive) were nearly double as much as girls in Lee's (1987) sample, these differences development and enuresis.

This study examines the psychiatric presentations of a sample of referred Egyptian preschool children and their behavioral profiles at a child psychiatry clinic over a 4-year period using DSM-III-R criteria and a reliable, valid assessment tool (Child Behavior Checklist) (CBCL). Moreover, gender differences compared to investigate areas of agreement and disagreement. Implications for mental health service, planning and research are discussed

SUBJECTS AND METHODS

A series of 100 preschool children (62 boys and 38 girls) referred to a child psychiatry clinic were assessed through:

A- Interview

Preschool children were diagnosed via a semistructured interview using DSM - III - R diagnostic criteria for Axis I and II problems. Developmental scales (Denver Developmental Scale) and intelligence for children) were used to assess each child's self - help, social, and communication skills as well as I.Q. speech and language were evaluated by Zimmerman's preschool Language scale. The evaluation begins with a history - taking interview with one or both parents. After the initial interview the parents were given the CBCL to fill. The evaluation included observation of the child and the child - parent interaction and the separation process. The usual evaluation procedure typically entailed a minimum of 4 hours of direct contact with the child and parents or care - giver.

The mean age of the children was 4.9 years (± 1). There were more boys (62%) than girls (38%). 25% of the children seen were attending a nursery or kindergarten at the time of evaluation.

B- Instrument (CBCL)

Research on child psychopathology has long been handicapped by a lack of uniformity in the assessment procedures used in different studies and different settings. Because standardized assessment procedures are essential for advancing the study of child psychopathology, obtaining the parents reports of the children's behavioral and emotional problems by a reliable and valid instrument becomes a must. Such procedures make it possible to compare results of studies across time and places as well as to build upon the findings of previous studies.

The child behavior checklist (CBCL), is designed to obtain standardized parent's report of children's prob-

lems and completeness. It is for ages 4 to 16 years and can be completed in 15 to 17 minutes. Rigorous cross - cultural comparisons of CBCL data have been reported on children from U.S.A., Holland, Thailand and Australia. (Achenbach et al., 1987, 1989, Weisz et al., 1987). Data from a Chilean translation of CBCL problem items have also been reported for general population and clinical samples from metropolitan Santiago, Chile. (Bird et al., 1991).

The test - retest reliability of the English language CBCL has been amply demonstrated as has validity with respect to discriminations between referred and non-referred children (Achenbach and Edelbrock, 1983, 1986, 1987).

Good internal consistency and validity with respect to psychiatrist's judgment of maladjustment with significant association with DSM - III diagnoses have also been demonstrated (Costello et al., 1984, Edelbrock et al., 1984, Edelbrock et al., 1989, Costello, 1989).

The CBCL includes 20 competence items and 118 behavior, emotional problem items that have been detailed also where (Achenbach and Edelbrock, 1981, 1983). Besides the 118 items that refer to specific problems, there is an open-ended item that request the parent to describe any additional physical problems without known medical cause and an item for describing any other problems.

The parent scores each problem item by circling a of 282 if the items is not true of the child, 1 if it is somewhat or sometimes true, and 2 if it is very true or of ten true, the CBCL is designed to be self - administered by parents who have at least fifth grade reading skills, but it can also be administered by an interviewer. The instrument was initially translated into Arabic for use with Egyptian parents, the translation was re-

viewed by child psychiatrists and clinical psychologists who were all fully bilingual. After being modified in the course of this review, the instrument was back-translated by a professional translator from the university, the bilingual mental health professionals reviewed the back translation to ensure that the connotations of the original CBCL items were accurately captured. Vernacular expressions were added where necessary to facilitate understanding.

Parents were asked to fill the questionnaires independently. Those who cannot read were helped by the author. The questionnaires were analyzed to obtain factor scores, internalizing, externalizing factor scores, internalizing, externalizing, externalizing and total scores according to Achenbach and Edelbrock (1983). Maternal reports were compared with paternal reports and the means of both were used to contrast differences between boys and girls using the one way analysis of variance (ANOVA).

RESULTS

The major presenting Axes I and II diagnoses are listed in table (1). These diagnoses are not unlike those found by Beitchman et al., (1981) in a preschool outpatient population and in hospitalized preschool psychiatric inpatients (Dalton et al., 1987).

Specific developmental disorders (84%) include: mixed specific developmental disorders 26% (17 boys and 9 girls), developmental language disorder, expressive type 21% (14 boys and 7 girls), developmental language disorder, receptive type 21% (14 boys and 7 girls), developmental articulation disorder 9% (5 boys and 4 girls), and developmental motor disorder 7% (3 boys and 4 girls).

Table (2) shows the gender difference (boys vs. girls) in the problem behavioral profile. There are no statistically significant differences.

Table 1
DSM-III-R Diagnoses of the Whole Sample (N= 100)

Diagnosis	Sex	Boys	Girls	N	%
Axis I					
Attention Deficit Hyperactivity Disorder		38	16	54	54
Functional Enuresis		19	10	29	29
Undifferentiated Attention Deficit Disorder		6	10	16	16
Disruptive Behavior Disorder		7	3	10	10
Separation Anxiety Disorder		4	4	8	8
Overanxious Disorder		3	4	7	7
Stuttering		6	2	8	8
Functional Encopresis		3	2	5	5
No Diagnosis or Condition on Axis I		1	3	4	4
Avoidant Disorder of Childhood		1	2	3	3
Simple Phobia		2	0	2	2
Oppositional Defiant Disorder		1	3	4	4
Gender Identity Disorder of Childhood		1	0	1	1
Axis II					
Specific Developmental Disorders		53	31	84	84
Mental Retardation		16	11	27	27
Pervasive Developmental Disorder		9	3	12	12

*Diagnoses are not mutually exclusive.

Table (3) shows the father / mother reports discrepancy of problem behavioral profile. Mothers reported significantly more problems of obsessive compulsive ($P < 0.03$), somatic complaints ($P < 0.05$),

and other problems ($P < 0.05$), than fathers internalizing factors tended to be reported more by mother ($P < 0.06$) but this did not reach a statistical significance.

Table 2
Comparison Between Girls and Boys as Reported by Mothers Using (CBCL)

Problem Area		Sex	Girls Means ($\pm$ SD)	Boys Means ($\pm$ SD)	P* Value
Internalizing Factors	I- Schizoid or Anxious		5.4 ($\pm$ 2.8)	4.2 ($\pm$ 3.2)	0.2
	II- Depressed		10.4 ($\pm$ 4.7)	8.7 ($\pm$ 5.2)	0.2
	III- Immature		4.6 ($\pm$ 3)	4.9 ($\pm$ 3.3)	0.7
	IV- Obsessive Compulsive		7.4 ($\pm$ 4.1)	7.4 ($\pm$ 4.6)	0.9
	V- Somatic Complaints		2.5 ($\pm$ 1.9)	2.6 ($\pm$ 2.6)	0.9
Externalizing Factors	VI- Social Withdrawal		4.7 ($\pm$ 2.5)	4.7 ($\pm$ 2.5)	0.9
	VII- Aggressive		8.3 ($\pm$ 4.8)	9.7 ($\pm$ 4.2)	0.3
	VIII- Aggressive		15.9 ($\pm$ 7.7)	17.0 ($\pm$ 8.9)	0.6
	IX- Other Problems.		3.6 ($\pm$ 3.5)	4.1 ($\pm$ 3.0)	0.6
	X- Other Problems.		10.7 ($\pm$ 5.3)	10.7 ($\pm$ 5.4)	0.9
	Internalizing Factors		30.2 ($\pm$ 12.3)	27.7 ($\pm$ 15.2)	0.5
	Externalizing Factors		27.8 ($\pm$ 13.4)	30.8 ($\pm$ 14.0)	0.6
Total Score.			73.4 ($\pm$ 236.9)	74.5 ($\pm$ 30.3)	0.9

* All statistical analyses are insignificant.

Table 3
Behavioral Problems as Reported by Parents Using the CBCL

Problem Area		Parent	Girls Means ($\pm$ SD)	Boys Means ($\pm$ SD)
Internalizing Factors	I- Schizoid or Anxious		3.6 ($\pm$ 2.8)	4.6 ($\pm$ 3.1)
	II- Depressed		7.6 ($\pm$ 5)	9.3 ($\pm$ 5)
	III- Immature		4.9 ($\pm$ 9)	4.8 ($\pm$ 3.1)
	IV- Obsessive Compulsive		5.5 ($\pm$ 4)	7.4 ($\pm$ 4.4)
	V- Somatic Complaints		1.7 ($\pm$ 2)	2.6 ($\pm$ 2.4)
Externalizing Factors	VI- Social Withdrawal		4.3 ($\pm$ 3)	4.7 ($\pm$ 2.6)
	VII- Aggressive		9.2 ($\pm$ 3.9)	9.2 ($\pm$ 4.4)
	VIII- Aggressive		14.9 ($\pm$ 8.6)	16.6 ($\pm$ 8.4)
	IX- Other Problems*		3.7 ($\pm$ 3.3)	3.9 ($\pm$ 3.2)
	X- Other Problems.		8.7 ($\pm$ 5)	10.7 ($\pm$ 5)
	Internalizing Factors		23.4 ($\pm$ 13.7)	28.6 ($\pm$ 14.2)
	Externalizing Factors		27.7 ($\pm$ 14)	29.7 ($\pm$ 13.7)
Total Score.			64.1 ($\pm$ 31.8)	74.1 ($\pm$ 28.6)

* Statistically significant

DISCUSSION

The limitation of the present study should be emphasized. The sample consisted of consecutive referrals and was not epidemiological in nature. In addition, various factors may have affected differential patterns of case detection and referral, e.g., the mental retardation, the developmental disorders and the pervasive developmental disorders may represent the most difficult, uncontrollable preschoolers that deserve to be evaluated and treated by child psychiatry. Such cases are undoubtedly overrepresented in this sample. At the same time the data are of interest, as they provide important information, as they provide important information about preschool children who present for clinical services.

This population (N= 100) represents the preschool children who were psychiatrically evaluated and diagnosed evermore than four - year period. The data reflect the fact that most of the preschoolers were the source of concern and worry of their parents because their problems could not be neither contained, successfully treated nor resolved without psychiatric help.

Our results are closely similar in many ways to those of lee (1987) where behavioral problems reported by parents were difficult to manage/control 42.6%, temper tantrum 23.3% overactive/ hyperactive 18.6% on the other hand disruptive behavior disorder in that study was 25%, disorder of elimination 15%, and specific developmental disorder 18%, global developmental delay 13%, and pervasive developmental disorder 10% in addition, 84% of the children with developmental disorders have received Axis I diagnoses.

The prevalence and general pattern of behavior problems of this clinical

sample are comparable to estimates based on earlier work of beitchman, et al., (1981) and closely approximate projected distribution suggested by hooks et al., (1988). Hooks et al. (1988) reported that 41% presented with single problem, 35% with two problems and 24% with three or more problems. In their study, the most common grouping of problems was developmental delay (usually language) with aggression or oppositionality and boys were more likely to be referred for a behavioral problem than girls.

The findings that there were no statistically significant differences between boys and girls problem behavioral profiles as reported by mother raise many questions that it answers. Garison and early (1985) suggested that across the various behavior scales on child behavior scales were especially high on externalizing factors such as aggression, delinquency and hyperactivity. On the other hand, girls, behavior scales were especially high on the depressed and somatic complaints.

In contrast to the very low frequency of attention deficit disorder (4.1%) in hooks et al. Sample, our results showed that this category predominates axis I presentation in psychiatrically disturbed preschool Egyptian children (54% ADHO and 16% undifferentiated ADD). There are few reasons for this discrepancy. The first is that hyperactivity with short attention span is an expression of C.N.S. immaturity, thus it is expression of to predominate in a sample with multiple psychiatric and developmental disorders. Second, attention deficit disorder as a syndrome was expanded in DSM - III - R to allow description of different forms including mild, moderate and severe, thus it is possible that this expansion has resulted in inclusion of milder forms that would have not been included

according to be previous DSM - III.

Third, the use of parent's reports, in addition to observation and psychiatric assessment of the child, has allowed accurate detection of many of the problems that could be either the result or the accompaniments of ADHD, thus increasing the incidence of these disorders in the present sample.

Two consistent findings emerged from the present study. The first is that attention deficit hyperactivity problems (54%) ranks first in diagnostic presentations of psychiatrically disturbed preschoolers. It is possible that preschool children with mental retardation and developmental disorders have increased problems. Between one - third and two thirds of children with mental retardation in epidemiological samples exhibited a significant degree of psychopathology, a rate several times higher than that found among non mentally retarded comparison groups (Bregman, 1991) although recent follow up studies suggest that these disorders continue to school - age, adolescence and adulthood (Boyle et al., 1991), however, evidence suggest that early identification, treatment and follow - up ameliorate and reduce much of the adverse outcome of this disorder

The second major finding is that axis - II diagnoses of specific developmental disorders reached 84%. There are few significant reasons for this apparently high estimate. The first, is that DSM - III-R encourages multiple developmental diagnoses along with axis I disorders. Thus, a child could be hyperactive with language delay and possibly has articulation problem, the second, is that because most of the specific developmental disorders were essentially language development problems, and that DSM - III - R separated developmental language disorders into two separate diagnoses mainly, developmental expressive and develop-

mental receptive language disorders. Most of the children with language problems have a combination of both diagnoses. Thirdly, evidence suggests that those preschool children presenting with both developmental and behavioral problems are multihandicapped children with increased incidence of psychiatric diagnoses (Hooks et al., 1988). With this background in mind, it is not surprising that there is an increasing recognition of the relationship between many forms of psychiatric disorders including learning disability later on and difficulty with language in preschool years.

Children with language disorders consistently are shown to be at risk for psychiatric disorders (Cantwell and Backer, 1985, Beitchman et al. 1986). Approximately half of language disordered. Conversely, children who present with psychiatric disorders also commonly have a language disorder among the presenting complaints (Chess and Rosenberg, 1974). Gualtieri et al. (1983) suggested that a large proportion of psychiatrically disturbed children have language disorders that may go undetected unless language skills are routinely and systematically examined. Their study found that half (50%) of 40 children treated as inpatient had moderate to severe language disorders that had not been identified previously. Cohen et al. (1989) reported that of children referred solely for a psychiatric problem, 28% had a moderate or severe language disorder that previously had not been suspected or diagnosed. These children differed from a comparison group of children with both psychiatric and language disorders in that they were younger and more likely to have an externalizing behavioral problem. These findings indicate that there is a sizable proportions of children whose language disorders are overlooked possibly because of their disruptive behavior this suggests

the need for routine screening of language in child psychiatric populations.

This association of developmental and language delay with psychiatric problems deserves explanation.

One explanation is a neurodevelopmental immaturity is the underlying deficit among linguistically impaired children. This deficit may be general and severe, leading to global impairment or specific, leading to milder deficits.

Another explanation for the association between psychiatric disorders and developmental disorders in preschool children is the psychosocial model. Underlying this model are associated variables commonly linked to psychiatric disturbance such as socioeconomic status, family environment, I.Q. and others.

Egypt is a developing country with many social, economic and health problems that could affect the development of preschool children.

Beitchman et al. (1989 a, b) in their studies of the relationship between speech, language impairment and their relationship to psychiatric disorders in preschool children suggested that specific developmental disorders place children at an increased high risk of behavioral disturbance, particularly hyperactivity or attention deficit disorder with hyperactivity. Their assumption strongly supports the biological neurodevelopment vulnerability.

Furthermore, results suggest that fathers and mothers differ significantly in their ratings of their children's behavioral problems on three factors, namely, obsessive compulsive symptoms, somatic complaints and other problems. These findings parallel the reports by Achenbach and Edelbrock (1983) about clinical samples. Although significant differences between boys and girls, when the

means of parents' ratings were used, were not found in this study, mothers did tend to rate daughters higher (as in Achenbach and Edelbrock's findings). Thus, interparent reliability appears to be related to the gender of the rating parent but not the gender of the rated child. This may indicate a higher threshold in fathers mothers in perceiving their children's behavioral problems particularly in the three factors detected. It also suggests that mothers tend to be unduly sensitive and overreport behaviors that are repetitive, somatic and physical, probably because mothers contact these children longer than fathers.

Mothers reported more physical symptoms and complaints about their children than fathers. Goldberg et al. (1979) reported that children with mental health problems complain to the pediatrician of diseases of the digestive tract more frequently than any other symptom complex. Moreover, psychosomatic problems have been reported in 8 to 10% of children in primary care facilities (Starfield et al., 1980).

Although parents were asked to independently complete the questionnaires no means were available to assess actual interpret collaboration. Given the likelihood that some collaboration between the parents did take place in the home settings, actual interpret differences may be somewhat higher than reported in this study. However, overall impression is that mother-father agreement on certain behaviors predominate and was generally moderate. Evens and Rehm (1988) have reported similar results.

One of the most important implications for the present study is that programs for early identification of psychiatric problems of preschoolers should consider age-appropriate language development milestones as a major criteria for detection of high risk children by the use

of standardized preschool language checklists, scales and tests. Perhaps in the near future language readiness skills will be part of screening admission procedures for nurseries and kindergartens. Also, parental educational programs and child-care training courses should emphasize the significance of language assessment and remediation in the care of preschool children.

Curriculum development for post graduate psychiatric programs and training in child psychiatry should stress the significance of developmental disorders in relation to psychiatric presentation of preschool children.

Moreover, psychiatric assessment of preschool children should be comprehensive and includes multiple sources of information as well as standardized assessment tools.

In conclusion, further research is needed in this area of behavioral and language dysfunctions of psychiatrically disturbed preschool children.

REFERENCES

- Achenbach, T.M. and Edelbrock, C. (1983) *Manual for the Child Behavior Checklist and Revised Child Behavior Profile*. Burlington, VT: University associates in Psychiatry.
- (1986) *Manual for the Teacher's report Form and Teacher Version of the child Behavior Profile*. Burlington, VT. University Associates in Psychiatry.
- Verhulst, R.C., Baron, G.D., and Akkerhuis, G.W. (1987) Epidemiological comparison of American and Dutch children: I. Behavioral/ emotional problems and competencies reported by parents for ages 4 to 16. *J. Amer. Acad. Child Adolesc. Psychiat.*, **26**: 317-325.
- and Edelbrock, C.S. (1987) Manual for the Routh Self-report and Profile. Burlington, VT: University of Vermont. Department of psychiatry.
- and ----- (1981) Behavioral problems and competencies reported by parents of normal and disturbed children aged four through sixteen. Monographs of the Society for Research in Child Development. 46, serial no 188.
- Conners, C.K., Qudry, H.C., Verhulst, F.C. and howell, C.T. (1989) Replication of empirically derived syndrome as a basis for taxonomy of child/adolescent psychopathology. *J. Abnorm. Child Psychology* **17**: 299-323.
- August, G., Stewart, M., and Halmes C. (1983) A four-year follow-up of hyperactive boys with and without conduct disorder. *Brit. J. Psychiat.*, **143**:192-198.
- Beitchman, J.H., Nair, R., Clegg, M., Ferguson, B., and Patel, P.G (1986) Prevalence of psychiatric disorders in children with speech and language disorders. *J. Amer. Acad. Child Adolesc. Psychiat.*, **25**: 528-535.
- (1985) Speech and language impairment and psychiatric risk, *Psychiat. Clin. North Amer.* **8**: 721-735.
- Hood, J., Rochon, J Peterson, M., Mantini, T., and Majumdar, S. (1989a) Empirical classification of speech/ language impairment in children. I. Identification of speech/ language categories. *J. Amer. Acad. Child Adolesc. Psychiat.*, **28**: 112-117
- (1989b) Empirical classification of speech/ language impairment in children. II. Behavioral characteristics. *J. Amer. Acad. Child Adolesc. Psychiat.*, **28**: 118-123.
- Murray, C., and Minty, G. (1981) A survey of referral problems to a psychiatric preschool program: patient characteristics and therapeutic considerations. *Cnad. J. Psychiat.*, **26**: 323-328

- Bird, H. R., Gould, M.S., and Canino, G. (1991) Screening for childhood psychopathology in the community using the child behavior checklist. *J. Amer. Acad. Child Adolesc. Psychiat.*, **30**: 116-123.
- Boyle, M.H., Offord, D.R., Racine, Y.A., and Catlin, G. (1991) Ontario child health study follow-up: Evaluation of Sample loss. *J. Amer. Acad. Child Adolesc. Psychiat.*, **30**: 449-456.
- Bregman, J.D. (1991) Current development in the understanding of mental retardation. Part II: Psychopathology. *J. Amer. Acad. Child Adolesc. Psychiat.*, **30**: 861-872.
- Campbell, S.B., Endman, M.W. and Bernfield, G. (1977) A three year follow-up of hyperactive preschoolers into mentary school.
- and Bernfled G. (1977a) A three -year follow-up of hyperactive preschoolers into elementary school. *J. Child Psychol. Psychiat.*, **18**: 239-249
- Cantwell, D.P. and Baker, L (1980) psychiatric, and behavioral characteristics of children with communication disorders. *J. Pediat. Psychol.*, **5**: 161-178.
- and Baker, L. (1985) Speech and language In: *Child and Adolescent Psychiatry: Modern Approaches*, ed. M. Rutter and L. Hersov. London: Balckwell, PP. 526-544.
- Baker, L. and Mattison, R. (1979) the prevalence of psychiatric disorder in children with speech and language disorder: An epidemiological stydy. *J. Amer. Acad. Child adolesc psychiat.*, **18**: 450-451.
- Baker, L., and Mattisan, S. (1980) psychiatric disorders in children with speech and language retardation. *Arch. Gen. Psychiat.*, **37**: 423-426.
- Chamberlin, R.W. and Nader, P.R. (1971) Relationship between nursery school behavior patterns and later school functioning. *Amer. J. Ortho Psychiat.*, **41**: 597-601
- Chess, S. and Rosenberg, M. (1974) Clinical differentiation among children with initial language complaints. *J. Aut. Child Schiz-oph.*, **4**: 99-109
- Cohen, N.J., Davine, M., and MelocheKelly, M. (1989) Prevalence of unsuspected language disorders in a child psychiatric population. *J. Amer. Acad. Child Adolesc. Psychiat.*, **28**: 107-111
- Costello, A.J., Edelbrock, C.S., Dulcan, M.K., and Kalds, R. (1984) Testing of the NI MH Diagnostic Interview schedule for children (DISC) in a clinical population: Final reprot Rockville, MD: Center for Epidemiological studies, National Institute for Mental Health.
- (1989) Developments in child psychiatric epidemiology. *J. Amer. Acad. Child Adolesc. Psychiat.*, **28**: 836-841.
- Dalton, R., Forman, M., Daul, G., and Bolding, D. (1987) Psychiatric hositalization of preschool children: admission factors and discharge implications. *J. Amer. Acad. Child Adolesc Psychiat.*, **26**: 308-312
- Edelbrock, c., Costello, A., and kessler, M.D. (1984) Empirical corroboration of attention aficit disorder. *J. Amer. Acad, child adolesc. Psychiat.*, **23**: 285-290
- Dulcan, M.K., kalas, R., and conover, N.C. (1985) Age differences in the reliability of the psychiatric interview of the child. *Child Developm.*, **56**: 265-275.
- Garrison, W.T. and Earls, F. (1985) The child behavior checklist as a screening instrument for young children. *J. Amer. Acad. Child Psychiat.*, **24**: 76-80
- Godberg, I.D., Regier, D.A., McInerny T.K., Pless, I.B., and Roghmann, K.J. (1979) The role of the pediatrician in the delivery of mental health services to Children. *Pediatrics*, **63**: 898-909.
- Schleifer, M., Wess, g., and Perlan T., (1977b) A two-year follow-up of hyperactive preschools. *Amer. J. Orthopsychiat.*, **47**: 149-162

- Gualtieri, C.T., Koriath, U., Van Bourgondien, M. and Saleeby, N. (1983) Language disorder in children referred for psychiatric services. *J. Amer. Acad. Child Adolesc. Psychiat.*, **22**: 162-171
- Halverson, C.F. and Waldrop, M.F. (1976) Relations between preschool activity and aspect of intellectual and social behavior at age 7.5. *Developm. Psychol.* **17**: 107-112
- Hooks, M.Y., Mayes, L.C., and Volkmar, F.R. (1988) Psychiatric disorders among preschool children. *J. Amer. Acad. Child Adolesc. Psychiat.*, **27**: 623-627
- Huessy, H.R. and Cohen, A.H. (1976) Hyperkinetic behaviors and learning disabilities followed over seven years. *Pediatrics*, **57**: 4-10.
- Jenkins, S. B., Bay, M., and Hart, H (1980) Behavioral problems in preschool children. *J. Child Psychol Psychiat.*, **21**: 5-17.
- Jensen, P.S., Traylor, J., Xenakis, S.N., and Davis, H. (1988) Child psychopathology rating scales and interrater agreement: I. Parents' gender and psychiatric symptoms. *J. Amer. Acad. Child Adolesc. Psychiat.*, **27**: 442-450
- Kirz, R.H. (1980) The preschool child. *Psychiat. Clin. North, Amer.* **3**: 548-561.
- Kohn, M (1977) The Kohn social competence scale and Kohn symptom checklist for the preschool child: a follow-up report. *J. Abnorm. Child Psychol.*, **5**: 249-263
- and Rosman, B.L. (1972) Relationship of preschool social - emotional functioning to later intellectual achievement. *Developm. Psychol.*, **6**: 445-452.
- Lerner J.A., Inui, T.S., Trupin, E. W., and Douglas, E. (1985) Preschool-behavior can predict future psychiatric disorders *J. Amer. Acad. Child Psychiat.*, **24**: 42-48.
- Lee, B. (1987) Multidisciplinary evaluation of preschool children and its demography in a military psychiatric clinic. *J. Amer. Acad. Child Adolesc. Psychiat.*, **26**: 313-316
- McGee, R., Partridge, F., Williams, S., and Silva, P. (1991) A twelve-year follow-up of preschool hyperactive children. *J. Amer. Acad. Child Adolesc. Psychiat.*, **30**: 224-223.
- Morrison, D., Mantzicopoulos, P., and Carte, E. (1989) Preacademic. Screening for learning and behavioral problems. *J. Amer. Acad. Child Adolesc. Psychiat.*, **28**: 101-106.
- Minde, K. Lewin, D., Weiss, G., Lavigne, H., Douglas, V., and Sykes, E. (1971) The hyperactive child in elementary school: A 5 years controlled follow-up except. *Child*, **38**: 215-221.
- Offord, D.R. Boyle, M.H., and Racine, Y. (1989) Ontario child health study: Correlates of disorder. *J. Amer. Acad. Child Adolesc. Psychiat.*, **28**: 856-860.
- Starfield, B., Gross, E. and Wood, M. (1980) Psychosocial and Psychosomatic diagnoses in primary care of children. *Pediatrics*, **66**: 159-167.
- Stevenson, J and Richman, N (1987) Behavior, language, and development in 3 year old children. *J. Aut. Childh Schizo.*, **8**: 299-313.
- Vens, C., and Rehm, L.P. (1988) Assessment of childhood depression: Correspondence between report by child, mother, and father. *J. Amer. Acad. Child Adolesc. Psychiat.*, **27**: 738-741.
- Weiss, G., Hechtman, L., Perlman, T., Hopkins, J. and Wener, A. (1979) Hyperactives as young adults. *Arch. Gen. Psychiat.*, **36**: 675-681.
- Weisz, J., R., Suwanlert, S., Chaiyasit, W., Weiss, B., Adchenbach T.M. and Walther, B. R. (1987). Epidemiology of behavioral and emotional problems among Thai and American children: Parent reports for ages 6 to 11. *J. Amer. Acad Child Adolesc Psychiat.*, **26**: 890-897.
- Wolf, S (1961) Symptomatology and outcome of preschool children with behavior disorders attending a child guidance clinic. *J. Child Psychol. Psychiat.*, **2**: 269-276.

Troubles Psychiatriques Chez Un Echantillon D'enfant D'age Préscolaire

Les études concernant les troubles psychiatriques de l'enfant ont été principalement faites sur des enfants d'âge scolaire. cette étude porte sur 100 enfants d'âge préscolaire ayant fréquenté la consultation pédopsychiatrique. Nous avons utilisé le DSM III-R comme manuel diagnostique. Nos résultats montrent que sur l'axe I le trouble hyperkinétique avec perturbation de l'attention était le diagnostique le plus courant (54%), suivi par l'énurésie non organique (29%), les troubles indifférenciés de l'attention (16%) et les troubles de conduite (10%). Les troubles spécifiques du développement (84%) et le retard mental (27%) étaient les plus courants sur l'axe II.

Nous n'avons pas noté de différences statistiquement significatives entre les problèmes de comportement posés par les garçons ou les filles, par contre nous avons noté des divergences significatives entre le récit du père et celui de la mère. di lère et celui de la mère.

Nos résultats indiquent que les problèmes psychiatriques des enfants d'âge préscolaire sont multiples, chargés de manifestations liées au développement et nécessitent des informations de diverses sources.

الاضطرابات النفسية في عينة من الأطفال المصريين في سن ما قبل المدرسة

يستعرض هذا البحث التشخيصات الطبية النفسية لعينة من الأطفال (٦٢ طفلاً و ٣٨ طفلة) في سن ما قبل المدرسة من المترددين على عيادة طبية نفسية للأطفال، وقد تم تقييم سلوك هؤلاء الأطفال وتشخيص اضطراباتهم من خلال المقابلة الكلينيكية وباستخدام أدوات اختبار مقننة ومقاييس للذكاء بالإضافة إلى قائمة وصف سلوك الطفل التي ملأها الوالدان والتي تصف الاداء الاجتماعي والمشاكل السلوكية العاطفية للأطفال.

وقد أظهرت النتائج أن اضطراب فرط النشاط وقصور الانتباه هو أكثر الاضطرابات تواتراً يليه البوال الليلي اللاإرادي (٢٩٪) ثم اضطراب قصور الإنتباه غير المميز (١٦٪)، ثم الاضطراب السلوكي (١٠٪) وذلك على المحاور التشخيصية الأولى، وعلى المحاور التشخيصية الثانية كانت الاضطرابات النمائية النوعية هي الأكثر تواتراً (٨٤٪) يليها التأخر العقلي (٢٧٪)، ثم اضطراب الذاتية الطفولية (١٢٪) وأشارت مقارنة المشاكل السلوكية (حسب قائمة وصف سلوك الطفل) بين البنات والأولاد إلى عدم وجود اختلافات ذات دلالة إحصائية، وذلك بعكس المقارنة التي تمت بين السلوكيات الموصوفة من الأمهات والآباء حيث أظهرت فروقاً ذات دلالة إحصائية عندما سجلت الأمهات تقييماً أعلى من الآباء بالنسبة لسلوكيات الوسواس القهري والشكاوى الجسمية والمشاكل الأخرى وقد ناقش البحث أهمية هذه النتائج بالنسبة لمشاكل الرعاية الطبية النفسية للأطفال في سن ما قبل المدرسة.