INTRODUCTION

Until recently, the assessment of very young children's psychiatric problems has been constrained by a lack of age-appropriate instruments. Clinical observations and empirical studies of at-risk children have documented the presence of serious and persistent social–emotional problems in infants and toddlers ***(Sameroff & Emde, 1989; Radke-Yarrow et al., 1992; Zero to Three, 1994; Zeanah, 2000).*** Moreover, many of these early problems have shown remarkable stability into the school-age years ***(Fischer et al., 1984; Campbell & Ewing, 1990; Prior et al., 1992; Shaw et al., 1994).*** Normative data for problem behaviors are available for children as young as 18 months of age ***(Achenbach & Rescorla, 2000; Mathiesen & Sanson, 2000).***

The standardized measures that were available to assess young children were parent-report checklists, such as the commonly used Child Behavior Checklist 1.5–5 years (CBCL) ***(Achenbach et al., 2001)*** and Infant-Toddler Social and Emotional Assessment ***(Carter et al., 1999).*** These parent and teacher report questionnaires have many advantages for certain research questions, but they do not include coverage of all symptoms that are needed to make the Diagnostic and Statistical Manual, Fifth Edition (DSM-V) diagnoses that are needed for clinical service and clinical research. In addition, they lack linkage for disorder-specific functional impairment, which also is required for making diagnoses. The checklist format precludes interviewing in which problems can be probed, challenged, and expanded upon to determine if respondents truly understand the items and are giving accurate information.

Despite the advances represented by the preschool age psychiatric assessment (PAPA), there are encumbrances to its use in clinical service or research settings, and the Diagnostic Infant and Preschool Assessment (DIPA) was created with several features to fill this gap. The PAPA is quite long to administer. Questions about five anxiety disorders are intermixed in one module without disorder headings; a clinician cannot tell from the interview if a child has a particular anxiety disorder without creating an algorithm for items that are dispersed throughout the module ***(Egger et al., 2006).*** Symptoms of conduct disorder (CD) and oppositional defiant disorder (ODD) are also intermixed. Symptoms of sleep difficulty, appetite disturbance, and fatigue are separated from the major depressive disorder (MDD) module. Also, two of the symptoms needed for post-traumatic stress disorder PTSD (sense of a foreshortened future and diminished interests) are in the MDD module ***(Egger et al., 2006).*** In contrast, each disorder in the DIPA is in self-contained modules.

Beyond these practical issues of organization, two theoretical differences distinguish the instruments. The PAPA was limited to children 2 through 5 years of age, and the stem questions and coding rules are not applicable for infants or one-year old children ***(Egger et al., 2006).*** The DIPA was worded so that it could be applied to younger children if desired and was not based on an a priori assumption that disorders could not be detected in younger children in the absence of data.

Rational

Assessment of a child in a manner that is accurate and appropriate is the crucial first step for both research and clinical practice. Accuracy is determined by the conceptual validity and reliability of measures used to determine the child's status. Assessment of behavior requires a good description of the behavior, antecedents and consequences, appropriate or inappropriate in terms of age, severity of response, frequency, and duration of the behavior ***(Nikapota, 2009).***

There is lack of Arabic tool to diagnose Psychiatric disorders in preschoolers and Diagnostic Infant Preschool Assessment (DIPA) ***(Scheeringa and Haslett, 2010)*** has fulfilled all these advantages so we chose to translate it and test its validity and reliability to use it in the research and clinical practice in our country.

Hypotheses

The hypothesis of this study is that the Arabic Diagnostic Infant Preschool Assessment (DIPA) is a reliable valid tool.

Aim of the Work

1) Translation and cultural adaptation of Diagnostic Infant Preschool Assessment (DIPA) from English to Arabic.

2) The test-retest reliability

3) Validity of DIPA subscales on categorical variables against the CBCL.

Chapter (1): Challenges in diagnosis and management in child psychiatry: Scope on preschoolers

To diagnose disorders in childhood we face many challenges. Child psychiatry requires a "first principles" approach to a much greater degree than almost any other field of clinical work. Diagnostic categories rarely provide a key to understanding mechanisms of disease or causation. The conditions are common, the factors contributing are a lot and blend imperceptibly into "way of life" and "human condition" issues ***(Lask et al., 2003).***

Diagnosis of child psychiatric disorders is full of challenges especially in the preschoolers. Families may spend years feeling shame, anxiety and depression about their difficulties with their child symptoms, dealing with them as naughtiness. In primary care, physicians may misdiagnose some disorders due to its different presentations e.g. loss of appetite or somatizations maybe treated as medical problems rather than symptoms of depression. Sometimes, there is over-diagnosis for other disorders as ADHD ***(Lask et al., 2003).*** Even after referral to psychiatrists, there are many difficulties in diagnosis also due to different stressors, presentations of disorders and lack of psychometrics especially in the preschoolers. According to treatment, there are many challenges relating to lacking of psychotherapists and fears about psychopharmacology in young children.

Interview with preschoolers

Psychiatric evaluations of children are rarely initiated by the child. Clinicians must obtain information from the family and the school to understand the reasons for the evaluation. Preschoolers can be excellent informants about symptoms related to mood and inner experiences, such as psychotic phenomena, sadness, fears, and anxiety, but they often have difficulty with the chronology of symptoms and are sometimes reticent about reporting behaviors that have gotten them into trouble ***(Lask et al., 2003).***

Interviewing with ADHD children may be very difficult due to their hyperactivity in the clinic and easily distractibility. Children with aggressive conduct disorders are typically uncooperative, hostile, and provocative ***(Lask, et al., 2003).***

Identification of stressors and predisposing factors

In child psychiatric disorders, usually many factors are likely to contribute but the relative significance will vary from one disorder to another. For example in attention deficit disorder, biological factors such as neurotransmitter imbalance are likely to have a major influence, but psychological factors such as the child's temperament, and social factors such as styles of parenting, are also likely to contribute. In school refusal psychological factors such as poor self-esteem, and social factors such as peer group teasing or bullying, may be predominant, but biological factors such as a genetic predisposition toward anxiety may be a necessary prerequisite ***(Lask, 1992; Angold, 1995; Lask et al., 2003).***

Another important point for psychiatrist to assess is parenting style. It plays an important role in the child disorders. Overprotection is particularly common in the emotional disorders such as depression and anxiety, parental dissatisfaction and criticism have been shown to be key factors in the emergence of both emotional and disruptive behavioural disorders. In the case of parental personality difficulties or psychiatric disorder, it may at first seem obvious that children, who are exposed to the symptoms of their disturbed parents, may themselves become ill. However, the situation is not always straightforward. Some parents may take steps to protect children from their symptoms. Other parents are so obviously ill that their children can identify when they are sick and when they are well, and respond to them appropriately. Surprisingly, those parents who are most likely to have a negative impact on their children are neither the psychotic nor the profoundly depressed, but those with longstanding personality difficulties and problems in interpersonal relationships. Children may find it difficult to identify their parents as ill when their parents have lifelong personality problems. Another explanation relates to the coping style of many parents with personality difficulties which may cause children to believe that they are the cause of their parent's problems ***(Lask, 1992; Angold, 1995; Lask et al., 2003).*** Another important factor is marital discord. It has consistently been shown to be associated with increased rates of psychiatric disorder in children. Children frequently attribute to themselves responsibility for parental fighting and the breakdown of marital relationships.

The society or environment in which the child live may precipitate to various psychiatric disorders; these include peer group difficulties, school-based problems, and adverse life events.

Presentation of disorders during preschool age group

Although diagnostic criteria for disorders are sometimes the same for children and adults, the manner in which these symptoms present may be different. Adolescents with depression are more likely to experience anhedonia, boredom, hopelessness, hypersomnia, weight change (including failure to reach appropriate weight milestones), alcohol or drug use, and suicide attempts. Younger children are more likely to have somatic symptoms, restlessness, separation anxiety, phobias, and hallucinations ***(Williams et al., 2009).*** The child's cognitive level should be considered too; for example, younger children may appear sad but have difficulty verbalizing their mood ***(Klein et al., 2005).***

Bipolar I disorder is being diagnosed with increasing frequency in prepubertal children. The “classic” manic episodes are uncommon in this age group, even when depressive symptoms have already appeared. Features of the mood and behavior disturbances among prepubertal children include extreme mood variability, intermittent aggressive behavior, high levels of distractibility, and poor attention span. This constellation of mood and behavior

disturbance is often not clearly episodic but is fluctuating and appears to be less responsive to mood-stabilizing agents than classic episodes of depression or mania in older adolescents and adults. Children with atypical hypomanic episodes often have past histories of severe attention-deficit/ hyperactivity disorder (ADHD), making the diagnosis of bipolar disorder even more complicated ***(Lask et al., 2003).***

Presentation of psychiatric disorders in children differs according to the age and development too. For example, the fear of strangers and separation anxiety peaks at about 18 months and then becomes less intense with occasional peaks with the commencement of preschool and school, illness, or family adversity. In early childhood, between 3 and 5 years old, fears also appear in response to animals, darkness, the toilet, and imagined creatures and situations. From 6 to 11 years fears of illness, parental death, personal embarrassment, failing at a task, and losing control are common. Fear of being teased at school and disapproved of by the teacher may be prominent. Adolescence heralds other interpersonal issues with a deep awareness of others of the same age group. Continual comparisons of bodies, clothing, relationships, etc. Age related changes in circumstances that can provoke anxiety are paralleled by the onset of pathological anxieties. For example, separation anxiety begins in the preschool years, animal phobias begin in early childhood, performance anxiety in late childhood, and social anxiety in adolescence.

Anxieties are experienced in ways similar to adults with both mental and physical components. However, they are often more diffuse in their effects than in adults, more bound up in a non-articulated distress and therefore more often expressed with physical symptoms ***(Last et al., 1995).***

Obsessive compulsive disorder affects between 0·5% and 1% of the younger population but the disorder frequently goes unrecognized, as children tend to be secretive about their difficulties. It is unclear at what age obsessions might commence, but they are rarely evident in prepubertal children. Common obsessional themes include contamination, aggression, sex, and religion, and the urge to carry out certain activities in a repetitive, specific and ritualized manner. Common compulsions include repetition, washing, checking, touching, counting, and ordering ***(Kaplan and Sadock, 2009).***

Psychosis is a frightening term and usually a terrifying experience for child and family. The nihilism and despair of previous eras carries over to the present day, even when the prognosis is better or, at worst, uncertain. Childhood-onset schizophrenia (COS) is a rare and severe form of schizophrenia. Children diagnosed with COS have high rates of premorbid developmental abnormalities that appear to be nonspecific markers of severe early impaired neurodevelopment. Schizophrenia with childhood onset has the same core phenomenologic features as schizophrenia in adolescence and adulthood; however, extremely high rates are seen of comorbid psychiatric disorders, including

attention-deficit/hyperactivity disorder (ADHD), depressive disorders, and separation anxiety disorder in children and adolescents with COS ***(Kaplan and Sadock, 2009).***

Disorders specific for childhood period

ADHD and Disruptive behaviour disorders

Some children trouble others but do not seem, and may not be, troubled themselves. These children were once referred to as having conduct disorders and more recently externalising disorders. The dominant feature of their presentation is disruption to others and to the course of their own lives rather than distress. Refusal to cooperate, defiance and stubbornness can lead to a battle of wills between parent and child, teacher and child, or child with child. ADHD, Oppositional defiant disorder (ODD) and conduct disorder (CD) are very stressful and need special considerations when dealing with the child and the families ***(Lask et al., 2003).*** Diagnosis of these disorders in preschoolers.

Autism spectrum disorder

The newest edition of the Diagnostic and Statistical Manual of Mental Disorders (5^{th} ed., DSM-5) introduced substantial changes to the diagnostic criteria for autism spectrum disorder, including new severity level ratings for social communication and restricted and repetitive behavior domains. The complex nature of ASD, coupled with the inadequacy of medical or biological markers for diagnosis,

as well as changes in clinical definitions over time, has increased challenges in diagnosing and monitoring the prevalence of ASD. Therefore, the diagnosis has depended on the abilities of experienced clinicians to identify ASD through detailed history taking, direct behavioral observation, and use of assessment instruments designed to identify this disorder. Current 'gold standard' diagnostic practice involves a best estimate clinical consensus (BEC) based a detailed developmental history from caregivers; multidisciplinary professionals' opinions; results of standardized assessments; observation of the individual in multiple settings; and diagnostic criteria as described in the DSM-5 ***(Filipek et al, 2000; Baird et al, 2000, 2011).*** At present, there are a number of standardized tools and questionnaires designed to assess for autism that are routinely used in the clinical setting, e.g.; Childhood Autism Rating Scale (CARS), Modified Checklist for Autism in Toddlers (M-CHAT), Gilliam Autism Rating Scale (GARS) ***(Schopler et al, 1980; Robins et al, 2001; South et al, 2002; Ozonoff et al, 2005; Gilliam, 2008).***

Reactive attachment disorder (RAD)

Diagnosis of RAD is based on the presumption that the etiology is directly linked to environmental deprivation experienced by the child.

The disorder has two subtypes: the *inhibited* type, in which the disturbance takes the form of constantly failing to initiate and respond to most social interactions in a

developmentally normal way; and the *disinhibited* type, in which the disturbance takes the form of undifferentiated, unselective social relatedness.

These developmentally inappropriate behaviors are presumed to be caused mostly by pathogenic caregiving, but less severe disturbances in parenting may also be associated with infants who exhibit the disorder so identifying this is really difficult ***(Lask et al., 2003).***

Comorbidty in preschoolers

Comorbidity in the childhood is a rule rather than exception, Doctors have to be aware of comorbidity wherever possible. Anxiety, depression, posttraumatic stress disorder, ADHD and any other comorbid conditions should be considered ***(Kaplan and Sadock, 2009).***

Medical comorbidity must also be considered. Repeated studies have shown an increase in psychiatric morbidity associated with chronic medical illness in childhood. Children with systemic disease not involving the central nervous system usually have two to three times the rate of psychiatric disorder. Children with chronic disease of the central nervous system will have five to six times the rate of psychiatric disorder. Children with both expressive and receptive language disorders are more likely to have psychiatric difficulties. Those with receptive disorders are more likely to have associated social impairment than those with expressive disorders. Children with specific reading, mathematics or other learning disorders have an increased rate of emotional and behavioural disturbance ***(Lask et al., 2003).***

Treatment of psychiatric disorders in preschoolers

Treatment should start with attempts to relieve the immediate distress rather than searching for deeper underlying meaning. In time there will be a need to move from a medical formulation of disease to an understanding of possible psychological contributors. This may lead to a focus on family and particularly parenting issues, and even to an acknowledgement that all is not well with the marriage. Almost all negotiations about children involve working with their parents unless it is clear that harm may be done ***(Lask et al., 2003).***

Psychotherapy

Theories and techniques

Psychodynamic approaches are generally mixed with supportive components and behavioral management techniques to build a comprehensive treatment plan for a child. Individual psychotherapy with a child frequently takes place in conjunction with family therapy, group therapy, and, when indicated, psychopharmacology. Several theoretical systems underlie psychotherapeutic approaches with children, including psychoanalytic theories, behavioral theories, family systems theories, and developmental theories.

Common types of psychotherapy

Family therapy

Working with various combinations of the family to explore and resolve precipitating and perpetuating factors. As with other therapies there are many models of family therapy, and yet more are emerging. No one approach is likely to be superior to any other and most skilled therapists draw upon different styles and techniques, rather than being bound to one. It is now most commonly used when children are presented by parents for help with mental health problems and indications include:

Advice, reassurance, if the nature of the problem is less significant than the way the family is handling the problem or where parents and children are having difficulty working together on the problems that face them. Also when the behavioural and emotional problems in the child requiring a clear, combined parental strategy as school refusal, separation anxiety, phobias, soiling and disruptive disorders, the spectrum of child abuse and neglect ***(Lask, 1998; Carr, 2000; Hoffman, 2001).***

Cognitive behavioural Therapy

CBT offers a simple, practical and solution-focused approach to many problems. It is of most value for those children with problems such as depression, anxiety disorders and obsessive compulsive disorder. Attention deficit hyperactivity disorder and problems with anger