Ain Shams University
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Studies

CONDUCT DISORDERS IN DEAF CHILDREN

Thesis submitted for fulfillment of ph. D. Degree
Childhood studies (medical department)

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AIN SHAMS UNIVERSITY
1997

APPENDIX

ACKNOWLEDGMENT

I would like to express my sincere gratitude to my ***Professor Doctor Hamed El-Khayat,*** Professor of Pediatrics, Faculty of Medicine, Ain-Shams University, for his precious help, sincere guidance and valuable suggestions.

Special thanks to ***Professor Doctor Mostafa El-Nashar,*** Assistant Professor of E.N.T, Post-graduate Institute of Childhood Studies, Ain-Shams University, for his faithful help and sound advices throughout the whole work.

My deep appreciation and gratefulness to ***Professor Doctor Olweya Abd-El-Baky,*** Assistant Professor of Childhood Medical Studies Post-graduate Institute of Childhood Studies, Ain-Shams University, for her great efforts and constructive help throughout the whole work.

Special thanks to director, teachers, psychologists and social workers of El-Amal Primary School for Deaf Children Shoubra, Cairo and doctors, nurses and technicians of School Health Centre, El-Mazallat for their great help.

Special thanks to ***Professor Doctor; Nilly Hassan,*** Assistant Professor of Public Helath and Statistics, Cairo University, for her great help and assistance in statistic of this work.

I am deeply indebted to ***Doctor Sayed Abd El-Maksoud*** Director of Naser General Hospital and Consultant of Obstet. and Gynecol. for his great help and encouragement thrtoughout the whole work.

Special thanks to ***Mr. Tadros Gaballa, Miss. Houda Gamal and Eng. Gamal; the Manager of Angel Computer Centre,*** Khalfawi Who helped me a lot in finishing this work.

Finally, I find no adequate words to express my deep feelings of love, precious gratitude and cordial considerations and gratefulness to my wife, ***Dr. Faten Gamal***, and my sons ***Mena and Mickel*** and ***my parents*** to whom I owe all my life.

This work is dedicated to Mena & Mickel

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ABBREVIATION LIST

• A.D.D.	:	Attention Deficit Disorder.
• AGG.	:	Aggressive.
• C.M.	:	Classmates.
• C.S.O.M.	:	Chronic suppurative otitis media.
• d.B.	:	deci-Bell.
• D.M.P.	:	Diagnostic Manual of Psychiaric Disorder.
• D. S. M I	:	Diagnostic and Statistical Manual of Psychatric Disorder I (1952).
• D. S. M II	:	Diagnostic and Statistical Manual of Psychatric Disorder I (1969).
• D. S. M III	:	Diagnostic and Statistical Manual of Psychatric Disorder I (1980).
• D. S. M IIIR	:	Diagnostic and Statistical Manual of Psychatric Disorder I (1978).
• D. S. M IV	:	Diagnostic and Statistical Manual of Psychatric Disorder I (1992).
• H.L.	:	Hearing loss.
• I.C.D.	:	International Classification of Psychiatric Disorder.
• I.Q.	:	Intelligence Quotient.
• NON-AGG.	:	Non-aggressive.
• NON-SOC.	:	Non-socialized.
• SOC.	:	Socialized.

CONDUCT DISORDER

IN

CHILDREN

REVIEW OF LITERATURE

INTRODUCTION AND AIM OF THE WORK

Hearing loss is considered one of the most common and important forms of sensory deprivation *(Mc Entee, 1995)*. It has a profound effect on child's developmtnet. The more profound the loss and the earlier the onset the greater the effect *(Hindley and Brown, 1994)*.

Approximately 3% of primary school children in Egypt have hearing impairments *(Wassila and Mahasen 1994)*.

Severe hearing loss presents a major handicap for normal psychological development and has a major implication for the child functioning in his physical, psychological and social terms *(Northern and Downs, 1984)*.

Hearing disabilities; due to their interactie nature, strongly affect intimate relationship that lead to social isolation and emotional impact *(Hetu, 1994)*.

Al-Gendi (1993) in his study found that psychiatric disoders were commoner in the hard of hearing group of children.

The deaf child is subjected to all the frustrations of the hearing child. But to these, it is added the further frustration of his inability to communicate with his family and friends by quickest method possble: speech *(Silverman, 1970)*.

Conduct-disordered children constitute a major problem to their families and community. The essential features of this group are repetitive and persistent patterns of antisocial behavior that violates the rights of others. *(DSM IV, 1992)*.

Deaf children with conduct disorders seem to have the worst prognosis among psychiatric disorders with perhaps the exception of childhood psychosis. *(Shaheen, 1990)*.

This work is an attempt to study:

1- The prevalence of conduct disorders among deaf children.

2- The subgroups of conduct disorders among them.

3- The different forms of conduct of the cases in school and home.

4- The possible etiological factors that may contribute to development of conduct disorders such as:
   - Demographic data: age, sex, birth order, ...
   - Personal data: I.Q. religious attitude, scholastic achievement,
   - Familial factors: work of parents, attitude of parents, reactin of parents to child' misconduct, religious attitudes, drug abuse, family history of psychiatric diseases or criminal records .....

5- Mapping a preventive program, depending on the data obtained in order to help in:
   - early detection of vulnerable group who are at risk of development of conduct disorder
   - treatment of this group on a scientific base.
   - early detection of deafness in childhood before being implicated by psychiatric disorders mainly conduct disorder.
   - taking care of families which are more liable to have conduct disordered children.

CONDUCT DISORDER

Conduct disorder is a distressing problem in both industrialized and developing countries. If forms a large single group of psychiatric disorders in childhood and adolescence, in which the main feature is persistent socially-disapproved behavior. This behavior may be limited to the child's home and family but it may extend to affect the wider community which may or may not be delinquent by itself.

Conduct disorder is a term used in childhood to describe a disorder in social relationships where the antisocial behavior is the main presenting feature (*Werry et al., 1987*). This child has a lack of concern for rules and regulations even when they are for his own safety (*Hassibi & Chess, 1978*).

Definition:

Conduct disordered youngster is the one who have already committed a number of delinquent acts but may have escaped prosecution. Those delinquent acts may range from minor misdemeanors to major felonies. They may range from the most serious crimes such as burglary or robbery to irritating but trivial acts such as playing ball in the street. There is always the fear on the part of the adults that the trivial acts if continued, may somehow lead to long lasting or serious misconduct. They may involve a behavior that is considered illegal only by virtue of the youngster's age such as truancy or runaway (*Weiner, 1979*).

Prior to the twentieth century, the conduct disordered-child was regarded as a wilfully criminal and his misbehavior was seen as a result of a conscious choice to be bad. Punishment was of course the proper response to such deliberate mischief and it tended to be harsh (*Meek, 1984*).

Now, conduct disorder is considered a form of disturbed social relationships where the antisocial behavior occurs within the context of a variety of styles of interpersonal relations (*Werry et al., 1987; Kay and Kay, 1986*).

According to DMPI (1979): conduct disorder was defined under the category character trait disorder where there is exaggeration of a traits including kleptomania, pyromania, explosive personality, and dyssocial character. It was also included under the behavior disorder of childhood and adolescence. It includes runaway reaction, unsocialized aggressive reaction and group delinquent reaction.

According to the ICD-9 (1979), it was defined as aggressive and destructive behavior and disorders involving delinquency. It was either socialized, unsocialized or compulsive conduct disorder.

According to the DSM III (1980) the essential feature of conduct disorder is a repetitive and persistent pattern of conduct in which the basic rights of others, or, major age-appropriate societal norms or rules are violated.

According to the DSM III R. (1987) the essential feature of conduct disorder was the same as in the DSM III but they added that this pattern of behavior is present at home, in the school with peers, and in the community. Physical aggression is common. The severity of the disorder was also mentioned.

In the proposal draft of ICD-10 (1987) the main feature of conduct disorder was a repetitive and persistent pattern of antisocial, aggressive or defiant conduct. Such behavior when at its most extreme form the individual should amount to major violations; and is therefore more severe than ordinary childish mischief or adolescent rebelliousness.

A comparative study was done between conduct disordered children and normal children. Many characteristic differences were concerning; personality level, activity, interpersonal, neurodevelopmental, academic, and cognitive variables. It was noted that conduct disordered-children were characterized by difficult temperament, poor moral judgment, increased impulsivity and restlessness. Conduct disorder seems to be an early presenting disorder marked by egocentricity, aggressiveness, a defect of empathic interpersonal relations and adverse child rearing environment (Werry et al., 1987).

Robins (1979) study of youngsters evaluated on a St. Louis Child Guidance Clinic revealed that those with severe behavior problems were less likely to receive extensive treatment despite that they are at high risk to develop psychiatric disorders in later life. It is more difficult to engage these children and their families in meaningful therapeutic work. They often respond to therapists in a way that are not calculated to enhance the professionals sense of degnified competence. The bad behavior characterizing those youngster stire strong uncomfortable feeling in every one professional and nonprofessional alike.

DIFFERENT NOSOLOGIES OF CONDUCT DISORDER

Introduction:

The diagnosis of psychiatric disorders of childhood and adolescence has been derived from adult nomenclature. Some behavioral deviations specific to the childhood period have been unrecognized in current classification lists. Actual detailed observations of children are relatively recent psychiatric histories. Here in this chapter we are going to present the term of conduct disorder in some of the different nosological schemata.

A- The Diagnostic And Statistical Manuals Of The American Psychiatric Association (DSM):

[1] DSM I (1952):

This classification demonstrated a lack of any special consideration of children except for mental deficiency.

[2] DSM II (1969):

The DSM II by including adolescence in section (308), allowed for a separation of behavior disorders of adolescence.

The classification is derived almost entirely on the basis of behavior with little emphasis on the internal forces which are at work within the child.

The category of behavior disorder of childhood and adolescence (308) included 3 main forms of conduct behavior; (308.3) runing away reaction (308.4) unsocialized aggressive reaction, and (308.5) group delinquent reaction.

According to the DMS II, symptomatic behaviors such as stealing, runing away, vandalism, cruelty to animals, sexual assault, lying, fire-setting, out bursts of rage and violence provocative behavior, defiance and disobedience as well as manipulative behavior, may be important manifestations of a variety of diagnostic categories. They may appear as a relatively normal behavior in response to transient situational disturbances. They may became manifest in the course of illness as in the case of psychoses (May, 1984).

DSM II behavior disorders are defined in rather narrow terms. They provide very little flexibility for the diagnosis of the disturbance which seem to be primarily a symbolic manifestation of a neurotic conflict, or, for classifying syndromes which arise from a state of neurotic family homeostasis. *(Meek, 1984).*

[3] DSM III (1980):
This system allowed a separate section for the diagnosis of different psychiatric disorders of childhood and adolescence among which is the conduct syndrome.

The conduct disorders are divided into two groups; the unsocialized and the socialized; each includes aggressive and non-aggressive types.

The undersocialized aggressive type of disorder is fairly self-explanatory.

Antisocial in the DSM III emplies lack of concern for the feeling of others and poor relationship with all but few peers.

The undersocialized non-aggressive type implies the same antisocial relationship, without open aggressive behavior although there may be stealing, lying, disobedience etc. *(May, 1984)*.

The "socialized conduct disorders" is of special interest. It requires antisocial behavior in the company of others i.e. it includes gang and group antisocial activity. It also implies some meaningful relationships with a few selected people, usually peers. (May, 1984).

Accordingly, the DSM III conduct disorder includes 4 specific subtypes mentioned earlier in addition to 5th "atypical form"- These subtypes are classified according to the presence or absence of adequate social bonds and the presence or absence of aggressive behavior.

Diagnostic Criteria:

According to the DSM III:

(a) **Aggressive:** is defined by a repetitive conduct in which the basic rights of others are violated. It is manifested by physical violence against persons or property. (not to defend someone else or oneself) e.g vandalism, rape, breaking and entering, fire setting, mugging and assault. It also includes acts outside the home involve confrontation with the victim e.g extortion, purse-snatching and armed robbery.

(b) **Non-Aggressive:** is a form of persistent and repetitive pattern of behavior in which either the basic rights of others or major age-appropriate societal norms or rules are violated. It is manifested by chronic violation of important rules of home or at school e.g truancy, substance abuse, repeated runing away from home overnight, persistent serious lying in and out of the home, and stealing not involving conformation with the victim.

(c) **Undersocialized:** it means failure to establish normal degree of affection, empathy or bond with others. It is evidenced by no more than one of the following indication of social attachments:

(1) Has one or more peer group friendships that have lasted over six months.
(2) Extends himself or herself for others even when no immediate advantage is likely.
(3) Apparently feels guilt or remorse when such a reaction is appropriate (not just when caught or in difficulty).
(4) Avoids blaming or informing on companions.
(5) Shares concern for the welfare of friends or companions.

(d) **Socialized:** Evidence of social attachment to others as indicated by at least two of the items mentioned before in unsocialized type.

In addition to the previous criteria, the duration of pattern of conduct whether the aggressive or non-aggressive form should lasts for at least 6 months. The age of onset is usually prepubertal for the undersocialized type and pubertal or postpubertal for the socialized type.

For the typical conduct disorder it represents a residual category for illnesses in which the predominant disturbances involve a pattern of conduct in which there is violation of either the basic rights of others or major age-appropriate societal norms or rules, but which cannot be classified as one of the specified subtypes of conduct disorder.

[4] DSM III R. (1987):

Conduct disorder is included as a main subtype of distruptive behavior disorder together with attention deficit hyperactivity disorder (314.01) and oppositional defiant disorder (313.91). Conduct disorder is subdivided into three main subgroups (312.20) conduct disorder group type (312.00), solitary aggressive type and (312.90) undifferentiated type.

The essential feature of this disorder is a persistent pattern of conduct in which the basic rights of others and major age-appropriate societal norms or rules are violated.

The behavior pattern is present in the home, at school with peers and in the community. Physical aggression is common.

Types of conduct disorder (according to D.S.M. III. R) are:

(1) **312.20 group type:** The essential feature is the predominance of conduct problems occurring mainly as a group activity with peers. Aggressive physical behavior, may or may not be present. It corresponds to socialized non-aggressive type of DSM III.

(2) **312.00 solitary aggressive type:** The essential feature is the predominance of aggressive physical behavior usually toward both adults and peers, initiated by the persons (not as a group activity). This type corresponds roughly to type DSM III concept of under-socialized aggressive type.

(3) **312.90 undifferentiated type:** This subtype for children or adolescents with conduct disorder with a mixture of clinical features that cannot be classified as either solitary aggressive type or group type. It may be far more common than the other two groups.

Severity of Conduct Disorder:

(1) **Mild:** Conduct problems cause only minor harm to others, few if any conduct problem in excess of those required to make the diagnosis.

(2) **Moderate:** Number of conduct problems and effect on others intermediate between mild and severe.

(3) **Severe:** Many conduct problems in excess of those required to make the diagnosis conduct problems cause considerable harm to others e.g serious physical injury to victims, extensive vandalism or theft prolonged absence from home.

[5] **D S M - IV (1992):**

312.8 Conduct Disorder:

A. A repetitive and persistent pattern of behavior in which the basic right of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:

Aggression to people and animals:

(1) often bullies, threatens, or intimidates
(2) often initiates physical fights.
(3) has used a weapon that can cause serious physical harm to others (e.g, a bat, brick, broken bottle, knife, gun ....)
(4) has been physically cruel to people.
(5) has been physically cruel to animals.
(6) has stolen while confronting a victim (e.g. mugging, purse snatching, extortion, armed robbery).
(7) has forced someone into sexual activity.

Destruction of property:

(8) has deliberately engaged in fire setting with the intention of causing serious damage.
(9) has deliberately destroyed others' property (other than by fire setting).

Deceitfulness or theft:

(10) has broken into someone else's house, building, or car.
(11) often lies to obtain goods or favours to avoid obligations (i.e "cons", others).
(12) has stolen items of nontrivial value without confronting a victum (e.g, shoplifting, but without breaking & entering; forgery).

Serious violations of rules:
(13) often stays out at night despite parental prohibition, beginning before age 13 years.
(14) has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period).
(15) often truant from school, beginning before age 13 years.

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. If the individual age is 18 years or older, criteria are not met for antisocial personality disorder.

Specify type based on age onset:
Childhood - Onset Type: onset of at least one criterion characteristic of conduct disorder prior to age 10 years.
Adolescent - Onset Type: absence of any criteria characteristic of conduct disorder prior to age 10 years.
Specify Severity:
Mild: few if any conduct problems in excess of those required to make the diagnosis and conduct problems cause only minor harm to others (e.g, lying, truancy, staying out after dark without permission).
Moderate: number of conduct problems and effect on others intermediate between "mild" and "severe" (e.g. stealing without confronting a victim, vandalism).
Severe: many conduct problems in excess of those required to make the diagnosis or conduct problems cause considerable harm to others.

B. Diagnostic Criteria of Different Categories:
(1) I.C.D - 9 (1979):
The following types were described:
(a) Unsocialized Disturbance of Conduct (312.0):
Diagnostic Criteria:
1- behavior such as defiance, disobedience, quarrelsomness, aggression, tantrums, destructive behavior, solitary stealing, lying, teasing, bullying and disturbed relations with others.
2- Sexual misconduct.
(b) Socialized Disturbance of Conduct (312.1):
Diagnostic Criteria:
Acquired norms and values of a delinquent peer i.e. group delinquency.
(c) Compulsive Conduct Disorder (312.,2):
Diagnostic Criteria:
- Disorder of conduct
- Compulsive in origin.

(d) Mixed Disturbance of Conduct and Emotions (312.3):
Diagnostic criteria:
(1) Disorder of conduct unsocialized or socialized.
(2) Considerable emotional disturbance such as anxiety, misery, or obsessive manifestations.

(e) Other (312.8)

(f) Unspecified (312.9):
The criteria are not defined for these two categories.

(2) The Proposed Draft of ICD-10 (1987):
Conduct disorder is classified under the (F 9); behavioral and emotional disorders with onset usually occurring in childhood and adolescence. Conduct disorders have the code No. (F 91).

It is characterized by repetitive and persistent pattern of antisocial, aggressive or defiant conduct. Such behavior, when at its most extreme for the individual should amount to major violations of age-appropriate social expectations; ordinary childish mischief or adolescent rebelliousness. The duration of the behavior is 6 months or more.

Examples of behavior on which the diagnosis was based include; excessive levels of fighting or bullying; cruelty to other people or animals; severe destructiveness to property; fire setting, stealing; repeated lying, truancy from school and runing away from home, that are usually frequent, severe temper tantrum and disobedience.

F 91-0 Conduct Disorder Confined to The Family Context:
This category comprises conduct disorders in which the abnormal behavior is entirely, or almost entirely confined to home and/or interactions with members of the nuclear family or immediate household. The disorder requires that the overall criteria for F 91 be met.

The diagnosis requires that there should be no significant disturbance outside that family setting and that the child's social relationships outside the family be within the normal range.

F 91-1 Unsocialized Conduct Disorder:
This type of conduct disorder is characterized by the combination of persistent antisocial behavior (meeting the overall criteria of F 91) with a significant pervasive impairment in the individuals relationships with other children. This is evidenced by isolation from and/or rejection by or unpopularity with other children, and by a lack of close friends or of lasting empathic, reciprocal relationships with others in the same age group. Relationship with others tends to be marked by discord, hostility and resentment but good relationships with adults can occur. Frequently there is some emotional disturbances.

Usually the disorder is pervasive across situations but, it may be most evident at school. Specificity to situation other than the home is

compatible with the diagnosis.

F 91-2 Socialized Conduct Disorder:
This category implies to conduct disorder occurring in individual who are generally well integrated into their peer group. The child may form part of non delinquent peer group with his/her own antisocial behavior taking place outside this context. Relationship with adults in authority tend to be poor. There may be good relationships with adults. Emotional disturbance are usually minimal.

F 91-9 Conduct Disorder not Otherwise Specified:
This is a non recommended residual category for disorders that meet the general criteria for (F 91) but which have not been specified as a subtype.

F 91 Mixed Disorders of Conduct and Emotions:
This group of disorders is characterized by the combination of persistently aggressive, antisocial or defiant behavior with overt and marked symptoms of depression, anxiety or other emotional upsets.

F 92-0 Depressive Conduct Disorder

F 92-1 Other Mixed Disorders of Conduct and Emotions:
There is still another category of conduct disorder which was considered by I.C.D. 10 under the broad category of hyperkinetic conduct F 90., hyperkinetic conduct disorder F 90-1. This diagnosis should be made when the overall criteria for both hyperkinetic disorder and conduct disorder are both met with.

C- **DMP I (Diagnostic Manual of Psychiatric Disorder) 1979:**
The conduct disorders are mentioned under two broad categories:

(1) 11.00 Personality and character trait disorder
11.1 Character trait disorder
11.10 The explosive personality is characterized by:
1- Outbursts of rage or of verbal, physical aggression.
2- Inability to control it.
3- Patients may be regretful and repenlant for them.
4- Over reponsive to environmental pressures.
5- Cases considered as aggressive personality are classified here.
11.11 Kleptomanic characters
11.12 Pyromanic character
11.13 Dyssocial character

(2) 13.0 behavior disorders of childhood and adolescence.

(3) Other variants of conduct disorder were grouped under:
13.3 Runaway reaction of childhood (or adolescence)
13.4 Unsocialized aggressive reaction of childhood (or adolescence).
13.5 Group delinquent reaction of childhood (or adolescence).

EPIDEMIOLOGY

In the last twenty years, a number of important epidemiologic studies have contributed to the understanding of the prevalence of conduct disorder. However, the studies of different symptoms and traits of conduct disorder have used different methods of assessment and categorization. Since many deliqnuent acts do not come to the attention of authorities concerning with crimes authorities and therefore are not reported in official records, the charting of non-delinquent conduct disorder, as a single and distinct category is incomplete.

Delinquency was reported in every country and culture. In western Europe and United States of America, the statistics of delinquency fluctuates in various years and locations. The urban areas of industrialized societies have shown a higher rate of reported delinquency than the rural communities. However, those and other statistical facts may always proove to be the artifact of identifying and reporting the delinquent person (*Chess and Hassibi, 1978*).

Werner et al. (1968) examined after 10 years, the 1955 birth Cohort of the boys and girls on the Island of Kanal, Hawaii, and found that approximately 7% demonstrated persistent overt aggressive behavior including conduct disorder symptoms i.e. acting out of the problems, lying, overtly contrary and subborn behavior, violent temper and destructiveness.

The Isle of Wight study (*Rutter et al., 1970*) is the only one to provide clear cut information on the prevalence of conduct disordered children. Among 10 and 11 years old children, conduct disorders occurred in 4%. The aggressive conduct disorders accounted for 1.1% and non-socialized conduct disorders accounted for 1.5%. The study also found that 2/3 of those with other psychiatric disorders had conduct behavior. *Rutter (1973)*, conducted a similar examination of the same aged-children residing in an inner London bourough. He revealed conduct disorder rates to be twice as high as that on the Isle of Wight.

The prevalence of the total sum of the individual antisocial symptoms among primary school children in a study conducted by *El-Sherbini et al. (1981)*, in the City of Tanta, Egypt, proved to be 5.3%.

Hamouda (1984), in his epidemiological study on primary school children, of 3 schools, one in Kafr El-Sheikh (as a representative of a rural area), and two schools in Cairo, (as a representative of an urban area), found that the prevalence of conduct disorders were 6.35%. It was mostly of the socialized type. The ratio of socialized type versus undersocialized type was 5 to 1. The prevalence in the urban was 7.46% VS 3.93% in the rural area. However, there was a special emphasis on age, sex, birth order and family size and socioeconomic level as deciding the quality of conduct disorder.

[1] Age Incidence:

Antisocial behavior often appears to be strongly related to age. Many researchers tend to associate antisocial behavior with adolescent period. The peak incidence of crimes against property as an example is at age 17 in USA and 14 in UK. With increasing age there may be an increase in the occurrance of some unacceptable behavior such as runaway (*Minuchin, 1967*).

Rutter et al. (1970) in Isle of Wight study found that the prevalence of conduct disorder among 10-11 years old were of the nonsocialized conduct disorder.

Wolfgangs' longitudinal study of nearly 10,000 Philadelphia boys, born in 1945 demonstrated that 35% of the boys were arrested for at least one delinquent act prior to 18 years of age. Approximately 1/5 of those arrested, moreover, were recidivists and were responsible for more than 3/4 of the total reported antisocial acts (*Wolfgang et al., 1972*).

Strachan (1981) studied the records of 79 delinquent fire-setters. Their mean age was 12 years and 5 months and only five of them were solitary offenders.

Steward and Culver (1982) found that older children admitted to psychiatric unit set fires with others away from home while those under the age of 10 set fires on their own at home.

According to *Lewis (1984)*, children under the age of 15 accounted for almost 5% of those arrested for violent crimes. Those 18 years and younger accounted for 18.4% of arrests in this category. Of all the arrests for property crimes in 1981, nearly 40% were of those 18 years or younger.

Hamouda (1984), found that the mean age of conduct disorder was 9.9 years of age. It was 9.6 years for boys and 10.3 years for girls.

Jacobson (1984), found 104 child with definite fire setting among 4200 referrals to psychiatric unit over 8 years period. There were two age peaks of incidence 8 and 13 years.

Wolf (1985), noted that several forms of aggressive behavior are commoner under 8 years of age while, specific antisocial symptoms such as lying, stealing and wandering are common to occur in youngsters over 8 years of age. The antisocial symptoms are more common to occur at elder age. The rates for elder age group were significantly higher than the rates for young age group. The rates were 7.3% VS 4.2% respectively. This may be related to the fact that older children have a wider area of activity than the younger children. This may give the chance to their unacceptable behavior to be detected and opposed by the society. Exposure of the youngster to peer reinforcement

of aggression at school or neighborhood evokes more aggressive and antisocial impulse within the youngster even if initially non-aggressive.

Jennings (1988), constructed a study on children referred for psychiatric evaluation and not recommended for special education. It was found that 17% of the cases were conduct disordered children with mean age 9.6.

[2] Sex Differences:

From the different studies, constructed by *Rutter et al., (1970); Strachan, (1981); Jacobson, (1984); Hamouda, (1984)* and others, concerning the prevalance of conduct disordered children in the different cultures, it was found that it is more common in boys than in girls.

Patterson et al, (1972), studied the prevalance of aggressive and antisocial behavior in a school nursery. They found that the nursery school boys reinforce each others'aggressive behavior especially when adults do not intervene. The activity level of the children plays an important role in this sex differences.

Rutter et al., (1970), showed that symptoms of conducts disorder such as restlessness, destructiveness, fighting, disobedience, bulying and temper tantrum were commoner in boys than in girls.

According to the DSM III (1980), both the aggressive undersocialized and the non-aggressive socialized types were more prevalent in boys than in girls; the ratio ranges between 4 : 1 up to 12 : 1. The non-aggressive undersocialized type is found to be equal in both sexes.

Stainback and Stainback, (1980), in their study on the prevalance of conduct disorder found that boys to girls ratio ranging from 3 to 1 up to 7 to 1.

Strachan, (1981), studied the records of delinquent fire setters and found that of the 79 youngsters, there was only one girl.

Jacobson (1984), also in his work on 104 children who set fires noticed that 84% of the sample was boys and the rest was girls who tended to be older in age.

Hamouda, (1984), reported in his study, cited earlier, that in the rural general school, the prevalance in boys was 6.78% while in girls it was 1.47% i.e ratio of nearly 6 : 1. As regards the schools in the urban rea, for the general school, the prevalance in the boys was 13.16% while in the girls it was 4.55% (i.e the ratio was nearly 2.8 : 1). For the private school, the prevalance among the boys was 7.5% versus 3.92% in the girls (i.e the ratio was 1.91 : 1). In general the prevalance was 9.3 for boys versus 3.33 in girls (i.e the ratio was nearly 3 : 1).

Werry et al., (1984), noted that the male/female difference concerning the prevalance of conduct disorder was statistically significant. It was proved to be 8.1% VS 2.7%.

Offord et al., (1987), agreed with the previous authors. The prevalance of males and females in their studies ranged from 6.5% to 10.4% and 1.8% to 4.1% respectively. He added that there is a relative increase in conduct disorder with age for girls more than for boys. This gives the false impression of decreased number of conduct disordered boys in older age. *Boyle et al., (1987)*, agreed with this view that for conduct disorder male preponderance decreases with adolescence because of the onset of conduct disorder in the girls at that age group.

However, different authors tried to explain the prevalance of conduct disorder among male youngsters. Differential reactions of parents and teachers to boys and girls and children' initiation of such reactions are likely to contribute to the increased male/female ratio among conduct disordered children. *Eme (1979)*, suggested that it may be easier to facilitate aggression in boys because of their higher activity level which is due to mesomorphic body built and due to male hormone pattern.

Yeudall (1980), added that neurohormonally controlled gender differences in brain development render males more susceptible to brain damage and hence more liable to develop all forms of conduct disorders. He further suggested that this may be the result of dominant hemisphere dysfunction; the male being regarded as having a general superior but also generally more vulnerable dominant hemisphere.

Cultural factors explain the imbalance in the sex distribution of delinquent, with a heavy preponderance of males. Those factors favour a bold, aggressive innovative stance among boys and more submissive attitude among girls (*West, 1985*). The permissiveness of aggressive behavior between male sibs at home was a necessary contributing factor for reinforcement of this behavior among males. It tends to cause boys to be more active overlty aggressive and combative than girls and even it tends to be more preponderant in boys regardless of age (*Wolf, 1985*).

[3] Child Birth Order:

As regards the birth order of the conduct-disordered children; *Koller (1971)* observed that there is a lower incidence of conduct disorder in the first order child with increased incidence in the second, third and fourth position. There is observed lower incidence in the even later position as compared with the expected frequencies.

Hamouda (1984), found that conduct disorder is more common in the first ordered child in 31.01% of the cases, the elder brother in 11.11% of the cases and was the only child in 18.51% of the cases. He claimed that this may be due to the fact that the elder child is always a precious

child especially if he is the only child, thus he is more spoilt and always forgiven for his misconduct. On the other hand being the elder sib, the family overloads him with great expectations concerning unusual success and this causes him to misconduct to compensate and overcome his feeling of inadequacy.

Fahmy (1987), on her study on 100 antisocial personality-disordered adolescents, found that the majority of the patients (61%), were in the middle group according to their ordinal position. She mentioned that this may be due to lack of care and supervision that usually exist concerning the middle child, thus if exposed to a delinquent neighbourhood he adopts the delinquent behavior easily,

[4] Family Size and Socio-Economic Level:

The prevalance of conduct disorder or antisocial behavior seems to have important linkage to the condition of poverty. Poor families may have insufficient time or energy to provide appropriate parenting during childhood. This results in a higher rate of recorded delinquency. Emotional deprivation, lack of community cohesion, despair and anger towards the larger society tends to explain the higher incidence of antisocial behavior in some low socio-economic population (*Minuchin, 1967*).

Aggressive children especially of lower class parents, when become more aggressive in response to poor relationship outside the home, evoke punitive reactions from their parents (*Patterrson, 1974*).

Rutter et al. (1970), showed that antisocial symptoms such as restlessness, destructiveness, fighting, disobedience, bullying and temper tantrum were more common to occur in boys coming from large families, than those coming from small families.

Delinquent youngsters coming from large families are mostly victims of their economic circumstances. The families are mostly dependent on one inadequate source of income. The rate of parental physical and mental illness is higher in these families reflecting the imposed strain for caring for large number of children (*Koller; 1971*).

Rutter et al, (1976), described large families of 4 or 5 children to be twice as likely to develop conduct disorder just as they are more liable to become delinquent.

West (1979), added that in the large number of sibship that favours delinquency, the main cause of this damage is the competition among siblings for limited parental resources of care and attention.

Sadek (1981), in his study on juvenile delinquents in Egyptian children, found no statistically significant difference concerning the prevalance of delinquency in both upper and lower socio-economic standard. The same result was obtained by *Hamouda, (1984)*; in his

study on primary school children in both public and private schools. The prevalance of conduct disorder was proved to be nearly the same. It was 5.77% for middle class children and 6.54% for lower class children that are represented by both the private and public schools respectively.

ETIOLOGY AND PSYCHOPATHOLOGY OF CONDUCT DISORDER

Conduct disorder as any psychiatric disorder depends on the interaction between the characteristics of a person and his environment. The psychological and sociological factors are of great importance. Psychic traumatization at early stages of development is a crucial factor in the development of psychopathic personality. *Becker (1962)* stressed the effect of inconsistent discipline in the development, and the increased tendency for conduct problems and agonistic behavior in children. In addition *Minuchin (1967)* added that any event that cause disorganization of the community as a whole or the family pattern in particular results in an increased incidence of behavior disorders including conduct problems.

Anna Freud (1973) pointed that aggression can be due to a variety of underlying disorders. As a result of such factors can lead to gross deficits in the development of the ego i.e. the competent self; and the superego i.e. the conscience and ideal self.

Hughes and Barad (1983), added that both sexual and physical abuse in children were identified to have a great influence on the occurence of behavioral problems including antisocial behavior in preschool children. *Jaffe et al., (1986)* in their social studies have pointed to family violence as a major social problem that lead to children who are considered to be unintentional victims of this violence.

Lewis (1984) found that in addition to the above mentioned factors both organic and constitutional factors may serve to make a youngster more difficult to socialize which increases the tendencies towards antisocial behavior.

Le Blanc et al. (1988) stressed the importance of criminology as a serious expectation of conduct disorder to be the field of inquiry where both the psychological and sociological factors meet in seeking to explain delinquency.

[A] Social Factors:

There is an inherent assumption in the theories of delinquency that abarrent behavior is more indication of attempted adaptation to a hostile environment than a confirmation of psychopathology.

Ohlin and Cloward (1960) emphasized the very limited opportunities provided in social order for lower class youngster to satisfy their needs. Under these conditions the stream of failure results in alientation and the use of illegitimate alternatives as possible routes to the successful fulfillment of goals. They identified three different types of delinquent subcultures with which lower class urban males

affiliate in an attempt to adapt to the pressure created by the limited accessibility of middle class channels to satisfy their aspirations. One is called the criminal subculture, in which there is strong tie to adult criminal behavior through a sort of apprenticeship program. They added that a second group is referred to as the conflict subculture in which there is no direct connection with adult criminals but where the gang aggress against others and uses physical violence to acquire status for himself and for his members. The third group is the retreatist subculture in which members have reservations and committing criminal acts against property or person and instead engage in the use of drug, sexual promiscuity, or other self indulgent pleasurable experiences.

West and Farrington (1973) also referred to those influences contributed by the family, community and peer environment. They mentioned that erratic, inadequate, permissive or punitive parental supervision and disciplinary styles have been linked with the development of both child and adult psychosocial mal-adjustment.

Farrington (1978) in his study of 400 youngsters (boys) from eight years age to adulthood, determined that those youngsters who went on to commit violent acts were twice as likely to have been the recipient of harsh punishment from their parents as the group of nonviolent youth.

Offer et al. (1979) found that while parents of conduct disordered or delinquent youngsters may see that their children are less well adjusted, they appear to be less in touch with their children's self-image and exhibit less understanding of their children than do parents of model adolescents. The difficulties of the lower class youngsters is in successfully achieving highly valued middle class goals. The boys are poorly prepared to cope with such demands of middle class institutions as delay of gratification and pressures for achievement and success. Failure brings frustration, loss of status and deep resentment over rejection by middle class society. Affliation with a gang subculture provides an important sense of belonging as well as performance and status criteria that those youngsters can meet. It bolsters and enhances self-esteem by group membership.

Moore and Arthur (1983) favoured the development of social learning perspectives in which primary and secondary social variables are seen as interactive and mutually influential to the development of conduct disorder. The primary variables are those eminating directly from the parent-child relationship and address such parameters as; style and consistency of supervision and discipline, the affective and affiliative characteristics of the relationship, and quality of parental socialization of the child. They have examined the role of peer influence, with the common findings that antisocial acts are commonly committed in groups and that antisocial acts-youngsters have antisocial friends. The studies do not elucidate, however, the question of peer influence on behavior versus individually-motivated peer choice.

(a) Familial Factors

[1] Family Influence on Conduct Disorders:

No one deny that the proper social conduct begins at home, representing the major role of the family on society.

Quay (1965) found that conduct disordered children usually come from slum areas of the city, with overcrowded dirty homes. Their families are of low socioeconomic class. *Cloward and Ohlin (1960)* noticed that delinquency in such children, though unwanted becomes the logical by-product of the social organization in which delinquency becomes a means of achievement.

Kayser (1968), found that poor parent-child relations are related to increased tendency for aggressive and antisocial behavior among children which is more manifest in boys than girls.

Rutter et al. (1970) added that large family is associated with conduct disturbance rather than with emotional disorder..

Knight and West (1975) and Rutter & Gerald (1985) in their studies, found that low social status has rather inconsistent association with psychiatric disorder. It tends to be more often linked with persistent conduct disorder. *Frringtton et al. (1975)* noted that persistent social difficulties e.g. excessive drinking, frequent unemployment, and abnormalities of the personalities of either parents are also associated with anti-social behavior in children. Also, *Giraham (1979)* agreed with the previous authors that the families of conduct disorderd-children are mainly large size families with low income and poor housing. *Rutter and Gerald (1985)* also agreed that low social status tends to be more often associated or linked with persistent conduct disorder than with either transient delinquency or emotional disorder.

Robins et al. (1975) mentioned that the presence of delinquent sibs in the family yet further increases the risk of delinquency. *Offord et al. (1978)* added that it appears that part of the association between large family size and delinquency may be a result of the children's exposure to delinquent brothers and sisters.

Chess and Hassibi (1978) said that the mothers of children with antisocial behavior tend to be always neglectful or unavailable. The mother may have been delinquent during her childhood. The discipline she applied is more dependent on her mood rather than on the child's activities. While *Richman et al. (1982)* noticed that the working mothers are more irritable and are unable to meet their children's emotional needs and this contributes to the genesis of childhood aggression.

As regards the fathers of such conduct disordered-children, *Chess & Hassibi (1978)* found that they have diserted the the family, are unemployed or have served time in the jail. They are in contineous conflict with the mothers with a history of drug abuse. *Richman et al.*

(1982) suggested that the father may simply be too immature or emotionally disturbed to function in the parenting role. Other family members are actively colluding to exclude the father from a position of influence. The mother may also be intrusive and excessively dominating especially in socialization of the daughter.

Meeks (1984) added that parental hostility and uninvolvement in child rearing is strongly related to the development of antisocial behavior. He found that scapegoating is a pattern of family structure which encountered with conduct disordered children. The problem child is utilized to demonstrate the inadequacies of each parent.

Horsove & Rutter (1985) mentioned that another family pattern commonly encountered in families of conduct disordered-youngsters is that utilizing the child as a substitute spouse to compensate for inadequacies in the marital relationship e.g. a severely antisocial girl of 14 years always become the confidant and protector of her mother whenever the father entered one of his episodic rages.

[2] Effect of the Mothers on Developing Conduct Disorders:

Mothers and fathers are the major sources of stimulation and the primary models of socially-approved behavior *(Parke and O'Leary, 1976)* and to *Schaffer (1971)* what matters is the intensity of interaction rather than the length of time of this interaction. Any pleasurable interaction that gratifies the child's needs increases the likelihood of attachment.

The mothers of conduct disorder or antisocial children are always neglectful or unavailable. The mother may have been delinquent herself during her childhood. Maternal deprivation has been said to lead to conduct disorder. Distortion of bond formation may be more determental factors than disruption of the affective bond in children's future emotional health, self worth and confidence. A child's aggressive reaction in a depriving environment is essentially a counter aggression, since the child views that the failure of the environment to provide his needs is equivalent to hostile and aggressive acts directed against him *(Chess & Hassibi, 1978)*.

Patterson (1982), established that socialized aggressive children are exposed to higher levels of coercive response especially from mothers and siblings, than normals.

Absence of adequate nurturing in early infancy where the mother is not available for her child may interfere with positive parenting is a pre-requisit for adequate socialization *(Meeks, 1984)*.

[3] The Effect of the Father on the Development of Conduct Disorder:

Griffit (1970), noted that the paternal absence or loss, at or under 4 years of age may lead to aggressive behavior, both, as a reaction formation and as a response to mother dominated household.

Singer (1974), noticed that if the father is consciously asocial, he provides a pathological model for the youngster. The father establishes a family atmosphere which requires the youngster to adopt an antisocial pose for the sake of survival within the same family. But if the paternal antisocial impulse is unconscious it leads to father-child interaction in which antisocial behviour is overtly condemned while it is covertly promoted.

A body whose father is absent early in his life is more likely to be psychologically maladjusted, to adopt gender in appropriate sex role and performs poorly at school (*Lamb, 1982*).

The absence of the involvement of the father in so many post divorce families, coupled with the overburdened state of many single mothers, seem at least partly responsible for the prevalence of externalizing, aggressive behavior problems among children of divorce (*Furstenberg, 1983*). Divorce rather than death as a cause of loss of father is associated with aggressive conduct especially in boys (*Wolf, 1985*).

(b) Psycho-social Stressors:

Psychic traumatization at early stages of development is a crucial factor in the development of psychopathic tendencies. *Minuchin, (1967)*, noted that any event that cause disorganization of the community as a whole, or the family pattern in particular, results in an increased incidence of behavioral disorder including antisocial behavior.

Jernkins (1969), found that unwanted illegitimate children and only children are common in the runaway reaction. The family background; economic status, family structure and neighborhood of children with disordered behavior are found to fit and affect the various diagnostic categories of behavioral disorders including antisocial behavior.

Meyer & Linderthal (1972) found that life events such as birth of a sibling, hospitalization of the child or parent, divorce, change of school and move to new neighborhood have preceeded manifestations of behavioral disorder in children including antisocial behavior.

Anna Freud (1973) pointed that aggression can be due to a variety of underlying disorders. It can arise from poor impulse control in children with organic brain dysfunction. Adverse circumstances such as neglect, unstable object relation (i.e. intimate ties to parental figures), traumata, undue parental pressure and absence of adequate parental models and identification. These factors can lead to gross deficits in the development of the ego (i.e. the component self) and the superego (i.e. the concience and ideal self).

Cohler et al. (1975) mentioned that the psychological reaction to such life events in children may be in the form of aggressive behavior.

Douglas (1975), Quinto & Rutter (1976) and *Dunn et al. (1981)* found that three event have been shown to be associated with subsequent antisocial behavior in children; parental divorce, birth of a sibling and hospitalization of the child.

Dunn et al. (1981) noticed that conduct disordered-children are known to experience marked psychological and social disadvantages.

Melvins (1984), found that most of the traumata which have considered important in the etiology of antisocial behavior have been ascribed to deprivation in parenting. Statistical studies of delinquent behavior noted the high incidence of broken homes in the delinquent's background. Maternal deprivation with absence of adequate maternal care in early infancy interferes with the capacity for the development of affectionate bonds to other human socialization process and aids in the development of antisocial behavior. Unwanted births may be an important factor that cause young children to be at high risk for psychosocial problems which play an important role in the production of conduct disorder.

Both physical and sexual abuse in preschool children were identified by *Hughes and Barad (1983)* to have a great influence on the occurence of behavioral problems including conduct disorder children.

Jaffe et al., (1986), have pointed to family violence that leads to children who are unintentionally violent.

[1] The Effect of Marital Discord on the Development of Conduct Disorder:

Marital unhappiness and conflicts are related to the development of behavioral problems including aggressive and antisocial behavior (*Emery & O'Leary, 1982*).

Rutter & Giller (1983) pointed the association of family discord i.e. quarreling, marital discord hostility ..... etc. and family disruption with conduct disorder and later on delinquency.

Jaffe et al. (1986) noted that children witnessed their father's violent or assaultive behavior towards their mother may be unintentionally victims of this violence. This is supported by intergenerational transmission of abuse and violence in husbands who witnessed this behavior or attitude as children.

Maltison et al. (1986) noticed that the families of conduct disordered-children have higher rates of marital disturbances, child abuse and history of psychiatric illness.

Singer (1974) added that the parents of antisocial youngsters utilize discipline which is characterized by rigid and exacting policies.

Olweus (1980) found that, the presence of step parents and a mother both inconsistently shielding and punishing, with maternal negativism and rejection in early childhood, is responsible for aggression present in adolescent boys. While *Werry et al. (1987)* noticed that in families of conduct disordered-children there is explosive expression of anger with unhappy marital relations, and increased interpersonal conflicts. There are also increased inconsistent, punitive or lax discipline together with inadequate parental supervision.

Brodly et al. (1987) stressed the point that the inconsistent discipline in families of conduct disorder, together with marital disharmony contributes indirectly to likelihood of sibling conflicts by influencing individual child functioning. It provides the child with models of aloof, distant or verbally aggressive behavior.

Jenkins (1970) showed that the development of unsocialized aggressive child usually exist with the presence of broken homes, family hostility, maternal rejection while the socialized aggressive child is associated with social disadvantages, parental neglect and delinquent associates. Also he found that unsocialized aggression occurs typically as a reaction to frustration within the family. The parent's marriage is often unstable.

Hetherington et al. (1971) noticed that the unsocialized aggressive boys were associated with variable pattern of parental dominance but poor participation of the boys in decision-making process.

Olweus (1980) found parental dominance and permissiveness in the socialized group but conflictual, maternal dominance and restrictiveness in the undersocialized group.

Rutter & Giller (1983) noted that the socialized aggressive group was associated with dominance by fathers, parental neglect and emotional disturbance with physical illness, maternal anxiety and parental overcontrol.

This behavior is more in younger children for they are more liable to be influenced by high levels of marital disharmony and discord than older sibs. Older sibs spend more time in other social setting and thus have more opportunities to find outside support systems that might buffer the deleterious effects of a discord home. (*Mash & Johnson, 1983*).

[2] The Effect of Divorce on the Development of Conduct Disorder:

Bowlby (1973) mentioned that children exposed to prolonged and multiple separations or to repeated threats of abodoment on the part of angry parents, develop hate for their parents with abnormal expression

of anger in the form of irrational acts of aggression and antisocial behavior.

In general, *Mc Dermott (1970); Kalter (1984); Schoettle & Cantwell (1980)* and *Pianta et al. (1986)* agreed that there exists a higher rate of delinquency and antisocial behavior among children of divorce than among children from intact households.

Negative short-term effects of divorce on children have been reported by *Guidubaldi & Perry (1984)* in the domain of social adjustment, academic performance and emotional well being which are yard-sticks in the development of conduct disorder.

Helharington et al. (1985) and *Guidubaldi & Perry (1985)* observed that aggressive and antisocial problems are prominent among the short term effects of divorce on children, that represent externalizing problems.

Helherington et al. (1985) found that the preschool children of divorced families are more dependent, disobedient, aggressive, demanding and unaffectionate, more in boys than in girls.

A surprising finding of a study presented by *Brady et al. (1986)*, was that children from remarried families, compared with children from divorced and separated families, demonstrated consistently more conduct problems and hyperactive behaviors with poor sibling relationship.

[3] Parental Illness as an Influencing Factor in The Development of Conduct Disorders:

There is some tendency for parents with criminality or a personality disorder to have children who show disturbances of conduct or hyperkinesia (*Cantwell; 1975*).

In a study conducted by *Fine (1979)* on eleven juvenile delinquents, he found that six had parents with severe psychopathology including suicide, homicide, psychosis and alcoholism.

Also, *Conner et al. (1979)*, noted that the offsprings of affectively ill parents have a higher than average rate of aggressive antisocial behavior, impulsivity, hyperactivity and anxiety. While to *Stewart et al. (1980)* conduct disorder in sons is related to personality disorder of parents, and to *Torgensen (1983)*, it is related to parental mental disorder.

In a study conducted by *Weissman et al. (1987)*, on parents of major depression; they found that the children of such parents are more liable to develop psychiatric problems in the form of major depression, conduct disorder, poor social functioning, substance abuse and poor social adjustment than children of normal parents. The

reason for this is that depressed parents perceive themselves as insufficient and ineffectual parents. They perceive their children as poorly adjusted. This reflects an increased strain imposed by caring for the children leading to vague parental commands which might increase the rate of child misbehavior and deviancy.

[4] Effect of Punishment on the Development of Conduct Disorder:

Parents who punish frequently or severely tend to have children who are more aggressive or disruptive (*Rutter & Cox, 1985*). There are several reasons for this which are:

- high frequency of punishment is often associated with great inconsistency and so with very indifferent reinforcement.
- highly punitive parents are often also cold and rejecting and the adverse parent-child relationship is likely to increase aggression.
- experimental studies indicate that punishment is really successful only when the child has other more ways of coping and responding. But, parents who punish frequently often fail to provide adequate alternatives for the child and fail to reward non-aggressive responses.
- what seems like punishment may actually be rewarding. Thus the child whose father bellows and shouts at him may be reinforced by the satisfaction of getting his father angry and making him loose control.
- punishment may be disruptive in the effects by causing anxiety and resentment.
- corporal punishment or angry shouting not only serves as a response to the child's aggression but also as a model of how to behave. The model of aggression provided by the parent may make it more likely that the child will behave similarly.

Punishment should take place within the context of a warm relationship and that the punishment should not be of a kind that provides a model of aggression or loss of control (*Rutter & Cox, 1985*).

[5] Parental Criminality or Violence:

It appears that the rate of conduct disorder or delinquency in children increases two or three folds, when a parent is a criminal, even more so if both parents are criminals (*Rutter and Gould, 1985*), and (*Rutter et al., 1975*). The association is strongest when the parental crime record is both recidivist and extends into the period of child rearing. Criminal parents tend to exercise poor supervision over their children. Modeling of deviant behavior may be another mechanism. This is suggested by the association of delinquency in older sibs (*Robins et al., 1975*).

It should be noted that excessive drinking by the parent with abnormalities in personality are also associated with antisocial behavior in children (*Farringtton et al., 1975*).

However, there is slight tendency for parents with criminality or a

personality disorder to have children who show disturbances of conduct or hyperkinesia (*Canlwell, 1975*).

There is a tendency for personality disorders in the parents to be linked with conduct disturbances in sons (*Stewart et al., 1980*).

The youngster's symptomatology is clearly shaped by the specific behavioral problem of important adults in his life. The presence of a socially deviant parent model have a great influence in the development of conduct disorder in the children (*Meeks, 1984*).

Females who have been exposed to violence at home are more likely to show more internalizing problems such as depression and anxiety as well as lower level of social competence than those coming from non-violent families. Males from violent families show both internalizing and externalizing behavior problems, in addition to having a lower level of social competence as defined by their activities, social achievement and peer-relationships. It should be noted that children in violent families have suffered other stressors apart from witnessing assaultive behavior. They have experienced crises of parental separation. They also find their primary care taken in poor physical and emotional health and had to cope with a number of financial and social hardships family violence as a major social problem leading to the development of behavioral disorder in children (*Jaffe et al., 1966*).

[B] Organic Factors.

Backwin & Backwin (1972) noted that a history of premature labour, toxaemia of pregnancy or bleeding during pregnancy were found to be of high statistical significance among conduct-disordered-children compared to non-conduct-disordered children.

Lewis et al. (1979) pointed that perinatal complications resulting in brain damage have been held to contribute to childhood behavioral disorder and subsequent delinquency.

The link between gross brain damage and behavioral disorders including conduct disorder are obvious. There is no readily predictable connection between the site and nature of cerebral pathology, and the extent or quality of psychological sequelae. A great deal depends upon the interaction between the child's constitutional or acquired vulnerability and the environmental circumstances to which he is exposed to at home and elsewhere (*Rutter, 1981*).

Maternal disease during pregnancy, neonatal trauma or infection to the central nervous system and the presence of temporal lobe epileptic focus may predispose to the occurrence of conduct disorder in children (*Hamouda, 1984*).

Head injury is associated with increased risk of emotional and

behavioral problems including conduct disorder (*Offord, 1987*).

E.E.G. abnormality in the form of high frequency E.E.G. dysrhythmia may play a role in producing behavioral symptoms including aggressive and antisocial behavior (*Thomas, Chess & Birch, 1968*). The epriodic dyscontrol and other phenomena attributable to temporal lobe epileptic disturbances has relevance to a small number of cases (*Mark & Errin, 1970*).

[a] Child Temperament:

behavioral disorders in general, develop in situations where there is a poor fit between the child's temperament and the environmental demands. His temperamental characteristics prevent him from meeting family expectations. The parents fail to recognize the youngster's need for special training or assistance (*Thomas et al., 1968*). A child with difficult temperament with slow adaptation, high intensity of mood expressiveness and withdrawal from new situation is specially vulnerable to develop antisocial behavior (*Chess & Korn, 1970*).

[b] Genetic Factors:

A statistically significant correlation was found between adopted delinquent children and their biologically antisocial parents and relatives: *West (1979)* and *Hutching & Mednick (1975)* looked at the incidence of criminality among male adoptees related earlier recorded criminality in their biological and adoptive fathers. Over 1/3 of men with criminal biological fathers alone had criminal records. For those adoptees with no history of criminal biological fathers, the incidence of criminality was 10% regardless of whether the adoptive fathers were criminal or not.

Mednick and Hutching (1978) in comparing the criminality concordance rates in monozygotic and dizygotic twins, found it to be higher in monozygotic than dizygotic twin at a rate of 36% and 12.5% respectively while Okasha (1988) mentioned that the monozygotic dizygotic concordance rates are equal in juvenile delinquents but show higher monozygotic rate for adult delinquents.

Schenifeld (1972) studied monozygotic twin concerning the tendency for delinquency if one of the twinship is a delinquent. It was found that the tendency is 1 to 4 times more in monozygotic twin if compared with dizgygostic twin. This may be due to the sameness of the method of upbringing and the influence of each sib on the other.

Neilson and Henriksen (1972) in their study implies the possibility of transmission of a genetic predisposition in young criminals with longer chromosomes, who had a significantly higher proportion of fathers with criminal records or psychiatric disorder, than those youths who had shorter Y. chromosomes.

Zellweger & Simpson (1977) stressed the importance of

chromosomal abnormalities notably an enlarged or double Y chromosomes in those with delinquent behavior.

Tennes et al. (1977) denoted that there are increased incidence of aggression and impulsivity in male children with XYY configuration.

Dorus (1980) referred to the association of number and length of the Y chromosomes with impulsive, aggressive and violent behavior. There is a ten fold increase in the incidence of abnormal sex chromosome configuration among male criminals.

[c] Biochemical Aspects of Conduct Disorder:

Chronic psychotic, aggressive and neurotic children have been shown to have a high red blood cell catechol-O-methyl transferase (COMT). (*Walker, Daniclson and Levitt; 1976*).

Another study showed no difference in whole blood 5-hydroxytryptamine (5HT) in children with conduct disorders compared to controls. This study also reported decrease in plasma dopamine beta hydroxylase (DBH) in an undersocialized group and increase in a socialized group (without differentiation of nonaggressive VS. aggressive in either group) compared to normal controls. Compared to normal controls, red-blood cell, catechol-O-methyl transferase (COMT), was similar in the undersocialized group but high in the socialized group. No difference as regards to platelet monamine oxidase (MAO) was reported (*Rogeness et al., 1982*).

Within the animal literature and the evolving human literature, the most consistent relationship between neurotransmission and aggression has been those neurotransmitters that are centrally predominantly inhibitory, 5-hydroxytryptamine (5HT) and gamma aminobutyric acid (GABA), are associated with decreased aggressive behavior. Those that are centrally predominently excitatory i.e. nor-epinephrin (N.E.), dopamine (D.A.) and acetylcholine (A.Ch.), are associated with aggressive behavior (*Valzelli, 1981*).

Psychopathology

Human beings have a variety of needs that appear early in life and are refined and augmented as time goes on. Satisfaction of the needs brings contentment. Denial of the needs leads to discontent and unhappiness which may be expressed either in the form of overt behavior such as temper tentrum, fighting and aggression or it may be retained internally through repression, resignation or withdrawal. Needs to be recognized and admired or needs to achieve status may lead a youngster who feels unnoticed and unappreciated to resort to delinquent acts (*Cavan, 1962*).

The youngster may be experiencing a need for help in a distressing problem and delinquent act is the way to get this massage across. His behavior is mostly accompanied with depression

(Hetherington et al., 1971).

A child's aggressive reaction in a depriving environment is essentially a counteragression, since the child views the failure of the environment to satisfy his needs as the equivalent of hostile and aggressive acts directed against him *(Chess and Hassibi, 1978).*

The deviant behavior of an unsocialized child is not merely a reflection of his failure to incorporate with forms of society but also a series of maladaptive mechanisms by which he is trying to gain entrance to group membership and toward off isolation. Lacking a workable guide lines, he continues to use his own wishes as the yard-stick for his actions; to the extent that these are unappropriate and unacceptable, they further eliminate him from his group. The child may find companionship alongside other children of the same bent. He may be hardened in his attitude towards the suffering of others and not feel any guilt over his transgression. However, the sense of loneliness and futility never leaves him. Self destructiveness in a direct or indirect manner is always present in such a picture *(Szurek and Berline, 1969).*

Severely disturbed unsocialized aggressive child has impaired or deficit ego function. The ego is highly skilled to assess opportunities for successful delinquency. The ego has the capacity to defend against any sense of guilt. His skills include a schrewed understanding of the motives of others which allow artful manipulation of people. They are skilled at provoking anger and mistreatment by others. So that, they can justify their misbehavior and avoid guilt. Among the faulty ego functions are low tolerance for frustration, inability to cope with inner feeling of anxiety and fear, poor control and disorganization when guilt is aroused, low responsivity to normal challenges of life such as; peers, school and athletics, high responsivity to inner impulses; and inability to perceive external reality. This is manifested by blaming others and not themselves for their actions, expecting not to be caught or engaging in infantile fantasies or aggrandizement *(Aichorn, 1961).*

From the adaptive point of view the ego of the antisocial youngster is seriously impaired. Youngster erruption of an impulse is considered to be an effort to compensate for other ego deficiencies. Their care impairment in the adaptive skills, enables one to master the environment and to maintain secondary narcissism and a sense of adequate selfhood. In his relationship with his parent he commonly uses them as ancillary ego agents. All the time he is trying to deny that their interventions are desired or helpfull. At the same time in his interactions with the environment he uses or elicit an unusual degree of parental support directions and even intervention. (Meeks, 1984). The presence of a cold, critical and rejecting parents produces feeling state of frustration within the youngster. This feeling enhances or causes arousal of anger and produces a motive to inflict injury. Aggressive behavior is always a consequence *(Rutter & Cox, 1985).*

Rutter (1970) noted that the youngster may show many indirect evidences of operative and even harsh superego. The basically self destructive quality of their behaviors, the frequent tendency to invite external punishment and the vulnerability to periods of self hatered and depression, strongly suggest that the youngster expends considerable energy attempting to avoid powerful feeling of guilt. Also, the presence of faulty superego function in children with psychopathic and antisocial behavior. He referred to the deficiency as superego lacunae. It denotes an absence of the superego rather than its weakness or ineffectiveness. Specific lacunae in certain areas of behavior in the child are similarly found in the parent's superego Although unconscious and subtle, parental lacunae serve to sanction the child's behavior, since the parents experience vicarious pleasure when the behavior occurs.

Whereas *Chandler, (1973)* mentioned that in the presence of a harsh superego the youngster will admit in the substract that many of his behaviors are wrong and make plans to avoid these in the future. He often show limited adaptive skills in the form of stereotyped repetitive patterns or attitude towards reality. He is preoccupied with a hedonistic search for pleasure. He preferes to be viewed as defiant, or even bad rather than overwhelmed. The acting out behavior serves the dual purpose of gratifying forbidden parental wishes and of expressing hostility to the child for doing what he or she should not have done.

Meeks, (1984) referred to the superego defects as demonstrated by the lack of remorse or conscious guilt ever actions that are clearly harmful and unfaire to other people. They show a lower capacity for self critical guilt. This non-challange regarding the rights of others and the importance of social norms is organized into verbalized philosophy of life which is selfish, callous and amoral.

Kay & Kay, (1986), added that Aichorn advanced the premis that a defective ego ideal (superego) accounted for conflicts being acted out by the delinquent child rather than the child's repressing and dealing with these conflicts in fantasy, dreams and play, this occurs with a normal or neurotic child. The underlying defect in the superego was described as being of three possible groups. In the first group (neurotic group) are Freud's criminals from a sense of guilt, in whom overtly harsh superegos created intolerable guilt which these adolescents attempted to relieve with punishment provoking behavior. In a second group, non social superego resulted from identification with different parental values. In the third primitive delinquent group, the defect was a lack of superego identification. They also added that other psychanalytic searchers have seen delinquent and, or aggressive behavior as the manifestation of a defense against anxiety, in an attempt to recapture the early mother - enfant relationship, as a result of maternal deprivation, or failure of internalization of necessary controls.

However, the psychopathology is generally discussed under different symptoms of conduct disorder which will be dealt with in the following chapter. These symptoms includes, aggression, stealing, runaway reaction, truancy, fire - setting, sexual assaults and cruelty towards animals.

Aggression:

Aggression represents a main feature or trait in the subcategories of conduct disorder as was presented before.

According to *Robert et al. (1984)*, it is a form of behavior directed towards the goal of harming or injuring another living being who is motivated to avoid such treatment.

Baron (1980) added that accidental failure to harm should be included. The hostile wish to harm even when it is not acted is also sometimes considered a form of aggression. Aggression may take the form of physical or verbal, aggression towards persons, animals or property.

Aggression is not always mal-adaptive. It may often be developmentally desired and normative. It springs from an innate tendency to grow and master life which seems to be characteristic of all living matter (*Elliott, 1979*).

Determinants of Human Aggression:

Aggression is influenced by either external factors including social and environmental or by internal factors including genetic, constitutional and organic factors.

[A] External Factors:

(1) Social Factors:

Harris (1974) and Gerkowitz (1978) mentioned that frustration leads to hightened aggression. *Kimble et al. (1977)* and *Degerink et al. (1978)* proved that persons exposed to physical provocation tends to aggress more. *Baron (1978)* added that exposure to aggressive models can serve to trigger similar actions on the part of others on the scene.

Banadura (1977) in studying the effect of televised violence found that underlying mechanisms include acquiring new aggressive responses through the process of observational learning. The willingness to aggress against others may be greatly enhanced through the reduction in the strength of internal restraints against overt aggression.

Thomas et al. (1977) added that regular exposure to filmed violence seems to produce gradual desensitization to aggression and to signs of pain or suffering. This may together with other factors may contribute to the occurrence of overt aggression.

(2) Hightened Psychological Arousal:

Hightened psychological arousal as participation in repetitive activities and hightened sexual arousal may facilitate overt aggressive attacks (*Jaffe et al., 1986*) while milder stimuli of these types may actually inhibits such a behavior leading to quite pleasant feeling that counter the effects of past provocation leading to reduction of aggression (*Donnerstein et al., 1978 and Baron, 1978*).

(3) Environmental Factors:

Donnerstein and Wilson (1976) found that loud and unpleasant noise may facilitate or initiate the occurrence of interpersonal aggression. *Friedman (1975)* added that crowding may have the same effect. *Baron and Bell (1976)* observed the same as regarding exposure to excessive heat for it may cause person to feel uncomfortable and unpleasant and have shortened temper and so set the outbreak of collective violence. It may on the other hand reduce the tendency to aggression against others. Some biologically active agents such as large quantities of alcohol may well influence the occurrence of overt aggression.

Rutter and Harsove (1985) mentioned that films and television may have some impact on attitudes and behaviors and hence may play some part in the predisposition to violent acts. It may increase the acceptance to violent solution to personal frustration or problems that seems both permissible and normal.

[B] Internal Factors

Berman (1984) mentioned that, the aggressive drive as a component of the Id is consiptuelized as instinctual in nature and is unconscious. Aggressiveness is the manifestation of the drive in thoughts, acts, emotions and symptoms; As the ego gradually emerges it utilizes the aggressive drive to obtain various basic needs through its internal capacities and external support to achieve gratification of those needs. The ego's regulation of these drives is facilitated by the development of the superego by the age of 5 to 6 years. The superego strengthen the internal control over aggressive behavior and postpone gratification of a need of pleasure in facing with the dictates of parents.

When children are neglected, abused psychologically and or physically, when their essential needs are not met, then they intereject. Such an experience as bad and ultimately it is projected onto the society, which is viewed as being indifferent to their nurturing needs. Denial complements projection to protect the child from some painful aspects of reality. *Keith (1984)* added that being raised by controlled, rejecting, frustrating, neglecting, helpless or violent parents may lead to internalization of the dis-sociability and criminality of such parents from the side of the child, by defensively identifying with the aggressors, doing to others as had been done to him.

INDIVIDUAL SYMPTOMS

[1] STEALING

Stealing, is the commonest antisocial behavior or disorder. It occurs in about 5% of primary school children (*Wolff, 1967*).

In all social groups, however, there appear to be some developmental and age-related patterns which are important in encouraging or preventing stealing (*Wolff, 1971 & Lewis, 1984*).

Very young children appropriate any object which excites their interest and which is available to them. This can't be considered as stealing until the youngsters is old enough to understand, first of all the concept of separateness of others and eventually the idea of property right. This occurs during the period of separation individuation as the recognition and awareness of himself and his mother as separate being occurs (*Meek, 1984*).

Concerning the stealing as a symptom represents an unsatisfactory parent-child relationship. It may be a form of non compliance to unskilled parents, but specially to parents who are themselves delinquent and inadequately attached to the child (*Patterson, 1982*).

Stealing may appear in response to transient family stresses in an otherwise basically functional family unit. Illness in a sibling may transiently result in a relative neglect of other youngster who feels deprived and may respond by stealing. If other siblings are clearly favoured with affection and gifts, the deprived youngster may devise his own system for equalizing the distribution of wealth. Emotionally cold parents are usually the target where the youngster utilizes the stolen objects from cold parents as symbiotic substitute for the withheld affection. Thus stealing may begin as an effort to cope with a threat to a dependency relationship; "since you refuse to give me what I need, I will have to take it". If the frustration within the relationship becomes chronic, the stealing becomes more ingrained (*Meek, 1984*).

The youngster who had often storted in very early childhood, tended to be unhappy solitary thief. He has an underlying feeling of being unloved and rejected by parents, because of the history of early maternal separation and rejection. Once he steals, he also lies and both behaviors elicit the very response of anger and disapproval from parents and teachers. The youngster anger and consequent fear, of expressing his hostility will lead to further rejection when he steals. This reinforces the child's craving for affection which lead to persistence of both the symptoms and the anger (*Wolff, 1971*).

The youngster tends to project his own hostility onto others. He views people in general as exploitative, unreliable and corrupt. This

defence protects the youngster from internal guilt and also insure a safe distance from other people. Any sense of guilt is suppressed or repressed. Denial is mobilized to avoid the acknowledgment of potential reality consequences, and to defend against recognition of the needs for affection and respect. Displacement is widely used and all adults are viewed as though they were the original frustrating parental figures. Underlying depression and emptiness drive the youngster to increase theft which increases the need for further defensive operation to maintain a faltering homeostasis. Neurotic stealing occurs in youngsters whose parents actively suggest antisocial conduct to their child by means of repeated warning. The child's exploites provide vicarious satisfaction for the parents who then assuage their own conscience by punishing the child. By inconsistent child rearing parents, such parents pass onto their children their own superego lacunae (*Johnson & Szurek, 1962*).

Repeated stealing is often a sign of poor impulse control in children with poor parental models who are deprived or who live in a subculture where stealing has other meaning (*Wolff, 1971*).

Stealing represents a poor development of the ego and superego with no parental sanctions against stealing and the child rarely experiences guilt (*Lewis, 1976*).

If stealing is accompanied with guilt, it is considered as way to search for punishment, that is to say, it is the expression of a harsh superego. The form of stealing is such that, there is a strong likelihood of being caught or punished. It was suggested a relationship between stealing and homosexuality and transvistism in some disturbed boys. In these cases the stealing represents an identification with the depriving phalic mother and gratifying unconscious homosexual impulse towards the father. Stealing also represents an autoerotic solution to conflict at the sexual level (*Lewis, 1984*).

Compulsive strealing of a single specific item or a special group of objects which share similar qualities may represent an attempt to solve infantile sexual deficits. For example, the theft of phalic objects by latency age girls may represent a symbolic effort to obtain a penis. However, even in these instances, an underlying oral tendency towards passive or active susceptiveness may play a role in shaping the symptomatology. In a similar way, stealing by a boy often appear to be motivated partially by an unconscious drive through their claring and boastfulness their superiority to the father or father figure. Thus, it is inevitably accompanied by a growing alientation from real objects. The result is an increase in sel-abasement narcissism and impoverishment of the reality ego. A progression beings towards greater narcissism and greater recourse to infantile omnipotent fantasies. Gradually the alientation from others tends to increase. The only friends that can have are other thieves. Often he does not even pretend that there is honor between him and his comrades. They may admire each other,

but they often recognize that given the opportunity, their friends may well steal from them or use them shamelessly (*Meeks, 1984*).

There is a group of families where the youngsters encouraged to steal in order to meet pathological parental emotional needs. There is a basic disturbance in the communicative process, where the youngster behavior is encouraged by one parent either to discomfort the other parent or to proove the spause's inadequacy in child rearing and upbringing. In families where the youngster's right to privacy and possession is not recognized, protected and defended from the intrusions of both parents and sibling, the concept of morality "finders keepers and loosers weepers", is slowly internalized. The youngster continues to steal because of a simple adaptation to a social system, where the property rights are not defined and mutually respected (*Wolff, 1985*).

[2] FIRE SETTING:

Although fire setting is not a frequent presenting symptom for children referred to a psychiatrist, yet it can cause great economic loss as well as morbidity and mortality (*Kauffman, 1961*).

In a preschooler, fire setting may simply be an act of exploration by a poorly supervised child even though it can lead to tragic consequences. The extent of damage or loss of life can't be equated with the degree of disturbance in the child. Among school age children, fire setting may be a distinctive aggressive act among a myriad of unacceptable behaviors such as stealing and using incene language. For those children, fire does not have a symbolic meaning nor is there a preoccupation or fascination with it. However, once those children discover the destructive force of fire without personally suffering from it, they may deliberately choose fire setting as a mean of revenge on people who have deeply injured them. It was also found that children who often set fire and who are assessed by psychiatrist, show evidence of great deal of psychopathology, that other members of their families are often also disturbed. Fire setting is seldom the only presenting complaint (*Vandersall and Wiener, 1970*).

Stuart, Fine and Don Louie (1979), examined the records of all reported cases of fire setter aged 5 - 16 years from 1971 - 1973. They found 78 cases; 26 of them had been referred to juvenile court. The reason for referral was seldom the fire setting alone, but complaints such as running away from home and uncorrigibility. Also, *Strachan (1981)*, studied the records of 79 delinquent fire setters. All but one were boys. Mean age was 12 years and 5 months. All fires were outside the family home. Only five were solitary attenders. Most of the children had other serious conduct disorders; stealing in 55%, breaking and entering in 38% and truancy in 24%. Only 35 lived with their both parents. Many of the fathers were unemployed.

Steward and Cluver (1982) found that, for elder children who set fire and referred to a psychiatric unit, usually set fire with others away from home. Children under the age of 10 years tend to light fires on their own at home. All had criminal or alcoholic fathers. Small number of those children started fire lighting at 4 years and seemed intent to injure members of their families. While *Jacobson (1984)* mentioned that mothers may be alcoholic, drug addict or psychotic. Homes are mostly violent. Children often lack basic physical care, and, may have witnessed both violence and adult sexual behavior. There appear to be a clear destructive symbiotic bond between the child and his mother. Fire setting represents an obvious unconscious and/or conscious collusion in his destructive behavior.

Macht and Mack (1960) described four adolescent fire setters whose fathers were closely associated with fire through their work or avocations. The fathers were absent from home. The searchers suggested that the youngster may have started to set fire from an unconscious desire to be reunited with the absent father. Also, fire setting may represent a way of release of extreme tension and a full expression of intense frustration and anger by the youngster.

Some youngsters may use fire and their ability to set fire to compensate for their feelings of impotent rage against their environment. They feel isolated and unable to relate to others. Their unrelieved rage and chronic depression find spectacular expression in starting a fire. They want to watch the fire, but they run away for safety, more, out of fear of retaliation than a desire to save themselves. Persistent fire setting is only one of the several indication that these children are in serious emotional difficulty. The families of fire setters are usually rejecting and frustrating in their relationships with the patient and the youngster may be subjected to unusual physical mistreatment within the family (*Meeks, 1984*).

Jacobson (1984), in a comparative psychiatric case-note study on fire setters reported two age peaks of incidence: 8 years and 13 years. Girls tended to be older. 80% of the fires were set at home. In comparison with other conduct disordered children, fire setters were younger, more destructive, more antisocial and aggressive and had greater relationship disorders.

Kazdin and Kolko (1986), said that; parents of fire setters showed significantly greater dysfunction in terms of psychiatric symptoms, and higher level of depression, and reported lower levels of affectional expression, consensus, and overall adjustment in their dyadic relationships.

In 1989, Kazdin and Kolko added that some fire setters showed greater curiosity about fire, involvement in and exposure to fire-related-activities and knowledge about first safety things from burn than did non-fire-setters.

[3] RUNAWAY REACTION:

Runaway has its roots in very early levels of psychosocial development. Eighteen months old have been known to toddler off and disappear. Three and four-year olds tend to stay beyond the geographical boundaries established by their mothers. This is a part of separation - individuation. Sometimes, these children hide from their mothers and ignore frontic calls to return, which may be a response to maternal over protection. Most youngsters especially those with outgoing and active tempremental styles are simply unable to resist the call of the unknown, the sense of freedom and excitement which accompany it (*Meeks, 1984*). Therefore, many of the youngsters who runaway from home for days or weeks are seeking an opportunity to proove their self-sufficiency and capacity to survive in the large world (*Howell et al., 1973*).

Runaway behavior is more likely to occur in presence of family conflict. The late Oedipal or early latency, child may decide to leave his home because of a strong feeling that he is unloved, mistreated, or unappreciated. Often the child fantasizes finding a new home where his position will be more favourable. The runaway behavior reflects the young child's effort to negotiate conflicts between attachment to the parent and simultaneous fears of being shamed, engulfed, abondened, or otherwise damaged by this dependency. Developmental pressures towards autonomy play a role in the child's periodic wish to leave home. However, the parent may suffer from unresolved oral conflicts which cause him to reject the youngster's dependant approaches or to force unwanted closeness on the child in order to gratify personal neurotic needs. The youngster vacillates between clinging behavior and aggressive rejection to any bond.

Old children who are exposed to incest by their fathers may not be able to take direct action in response to the incest. The may act out by engaging in delinquent behavior or running away (*Brant and Trisza, 1977*). Also *Kempe, (1978)* estimated that about half of the females in juvenile detection for running away are incest victims. While *Rimsza et al. (1988)*, reported that for sexually abused children at follow-up there is a great tendency for the development of emotional and behavioral problems. The most common are runaway behavior, sleep disorders and suicide.

Usually runaway from home is associated with many other symptoms of a developing behavior. Runaway from home may suggest severe disturbance in the youngster resulting form mental retardation, brain damage or extremely deviant constitutional pattern. It may indicate a pronounced impairment in parent-child relationship (*Morrison et al., 1975*).

Stierlin (1973), conceptualized that; there are three types of runaway youngster's according to the pattern of psychopathology in the

family. These include:

[1] The Loner:

Here the youngster's capacity to relate to peers and external world is extremely deficient. If he runaway, the absence is usually brief. His loneliness forces him to return to the family with a wish to run again because of his unsatisfactory adjustment within or outside the family.

[2] The Hood:

This child is rejected and neglected by the family. He is forced to meet his needs in any way that does not require the parent's time and attention. He does not trust emotional ties of any kind. He is well prepared to maintain himself and succeed among the criminal elements.

[3] The Emissary:

This child acts out impulses which are present within the parents but which the parents' superego forbid them to express directly. He is encouraged to leave the home and engage in activities which indirectly benefits one or both parents.

Youngsters escape from threatening situation by running away from home for a day or more without permission, typically they are immature and timid and feel rejected at home, inadequate, and friendless. They often steal furtively (*Egyptian Psychiatric Association, 1979*).

In 1988, Rimsoza et al., conceptualized that follow up studies of sexually-abused children cleared that the most common emotional and behavioral problems among them are the runaway behavior and suicide.

[4] TRUANCY:

Blagg, (1979) and *Health, (1983)*, enquiring into the causes of truancy, found significant association with excessive parental control particularly by corporal punishment. Also, dirty home, uninterested parents and keeping the child at home in the past without good cause represent other factors that cause the child to feel unhappy, unsociable and cause him to be a truant.

Truancy occurs frequently in association with poor school attainment in children from families where marital discord, criminality and adverse social circumstances are common (*Farrington, 1980*). In a study conducted by *Hersove (1960)*, on 50 children referred for truancy from moudsly hospital, he found that children came from large families where home discipline was inconsistent. They experienced parental absence both in infancy and in later childhood. They changed school frequently. Their standard of work was poor. Their truancy was an indication of a conduct disorder that often involved other antisocial or delinquent behavior.

Tennets' (1969), study on 65 truant boys found that they have some neurotic features coexisting with the conduct disorder such as marked anxiety about going to school, anxiety about events at home when at school, psychiatric symptoms of an affective type and returning home when truanting from school rather than roaming alone or in company.

Berg et al. (1978), noted that a small number of truants will show anxiety symptoms and social isolation and they may show more often other symptoms of conduct disorder rather than emotional disorder.

Blagg (1970), found significant association with excessive parental control particularly by excessive punishment, uninterested parents and keeping the child at home, represent the factors that cause the child to feel unhappy, unsociable and cause him to be traunt.

Barker (1981), said that truancy often accompanies other antisocial behavior. It is different from school refusal, in which neurotic anxiety prevents the child getting to school. The truant is not prevented by anxiety but by a stronger desire to do something else for example, play in the park or just sit at home playing or watching television. In one common form the child leaves home, and returns there, at the appropriate times, but without having attended school. The parents think he is at school, and the school staff often conclude he is sick. It is surprising how long this can sometimes continue. If both parents work during the day, the child may sit at home unknown to them, ignoring anyone from school who comes to the house, and even destroying letters from the school. Some parents show little interest in ensuring that the child attends school, and do not regard school and its benefits as important. Sometimes parents actively encourage the truancy, perhaps to have help with housework or shopping, or with feeding the baby. Most truants are poor pupils at school (unlike school refusers who usually have good academic records), and their consequent failure to get satisfaction from school work in an additional factor in discouraging attendance.

[5] SEXUAL ASSAULT:

Sexual assault is extremely rare prior to adolescence. However, precocious sexual activity, which may be quite aggressive is common in the history of many antisocial children. A study conducted by ***Haughaard and Tilly (1988)*** to predict children' response to sexual encounters with other children: Approximately 42% of the subjects reported a child sexual encounter with another child. Most encounters involved sexual kissing, and exposing genitalia and they generally occurred with a friend. Subjects who experienced a high level of coercion from another child reached to their sexual encounter with an adult. In another study, 47 boys between ages of 4 and 13 with a mean age of 8 years and 9 months who have solested children younger than themselves (with mean age 4 years and 9 months) were described by *Johnson (1988)*: 49% of those boys have been sexually abused and 19%

have been physically abused. In 47% of the cases the sexual abuse was of sibling. There was a history of sexual, physical and substance abuse in the majority of the families of those children. While the sexually-abused children tend to have a higher frequency of inappropriate sexual behavior than the physically abused children. Sexual activities appears to be related to an extremely distorted mother-child relationship which is at once erotized and inhibiting. The mothers are viewed with extreme ambivalence; they serve at once as strong and powerful sources of emotion and as serious threats to the boys musculinity. The mother is likely to be prudish and yet fascinated with her son's sexual thoughts and behavior. She may be somewhat seductive, at least to the extent that she prefers her son's companionship to that of her inadequate marital partner (*Gale et al., 1988*). The father is typically both emotionally cold and relatively ineffective. The effect of this family structure on the boy is to produce intense preoccupation with sexuality and marked inhibition regarding the appropriate channels of socialization and dating. The boys are naive and show a marked tendency towards a polarized view of life and relationships. He also considered that positive ties are seen in a very idealized light. The smallest frustration at the hands of a friend is perceived as a vicious betrrayal of trust. This makes the youngster preoccupied with his image status and methods of forcing other to respect and admire him which makes a reliable source of narcissistic support. The result is an increasingly narcissistic adjustment which is highly precarious. The extreme variance between the youngster's image of himself and his actual functioning leads to repeated and severe narcissistic injury in the course of daily living. If these are occasioned by a real or imagined rejection at the hands of a desirable girl, this girl is all too likely to be the object of sexual assault. The act expresses the patient's rage towards women and his intense need for sexual acceptance (*Mreeks, 1984*).

[6] VANDALISM:

Vandalism as any other antisocial action has its origin in the innocent anarchy of early childhood. The young child crayons the mother's walls because they are attractive and available receptacles for his creative urge. The mother's response to this early behavior may be crucial in determining the youngster's later attitude toward property destruction (*Freidman, 1975*).

In homes where there is pride of possession and children are not taught to value this social expectation, the youngster can not internalize respect for possessiones of adults. On the other hand, in household, where material possessions are prized more highly than children, the child may come to despise valued property and develop a procivity for attacking it as a symbolic extension of unloving adults (*Meek, 1984*).

The rapid escalation of vandalism in public schools may well represent a vindictive reaction to the impersonal and even hostile atmosphere which the youngster subjectively experience in those institution. The drawing of graffitic on school desks or walls example, may serve of possessing it and at the same time to retaliate for real or imaginated neglect. The individual is expressing aggressive and destructive wishes to befoul and simultaneously posses the involved structure at the owner's expense. The destruction may be an impulsive expression of frustration such as kicking a door, breaking a window or smashing a lamp. Hostility is displaced from the frustrating human object and expressed indirectly by destroying property (*Lomas, 1973*).

Vandalism may result from an individual's failure to achieve a sense of personal belongingness and value within the community, or from a generalized lack of cohesion and shared concern. Other acts of vandalism serve more as defiant expressions of power and fearlessness of youngster who run through the streets breaking off car antennae and destroying other property primarily to prove courage and daring (*Golomeier, 1974*).

The individual psychodynamics of vandalism are those of the unsocialized aggressive behavior disorder in general. It represents an intense largely unmodified aggressive urges expressed against the environment. It represents a failure in ego control. Still in other cases there is a need to deal with unrecognized guilt requires youngsters of this kind to project hostility onto the environment. They read their own destructiveness as the fault of others, and often feel victimized, and potentially vulnerable. Their fears generate and justify even more vandalism and a vicious cycle ensues. In some cases the youngster feels a sense of superiority and personal victory. Unconsciously however somewhere within him he knows is doing wrong. (*Lamphear, 1985*).

Vandalism may be due to the following causes:

1- Impulsive expression from frustration. Hostility is displaced from frustrating human object and expressed indirectly by destroying property (*Lomas, 1973*).
2- The hostile atmosphere of some institution especially at school may generate and justify destructive wishes which personalize the institution, to gain some sense of possessing it and at the same time to retaliate for real or imaginated neglect (*Lomas, 1974*).
3- Failure of the youngster to achieve a sense of personal belongeness and value within the community, or from generalized lack of the cohesion and shared concern (*Gloomeier, 1974*).
4- Failure of the youngster to internalize respect for possession of others.
5- Failure in ego control (unmodified aggressive urges expressed against the environment) or feeling of superiority mastery and personal victory. (*Lamphear, 1985*).

[7] CRUELTY (AGGRESSION TO ANIMALS):

The infant and young toddler often handle animals in a way that from an adult point of view would be described as cruel. This mistreatment is simply the outcome of the child's desire to manipulate, tug, twist and pound a variety of objects in the environment. It is based on a lack of full awareness that the pet experiences pain (*Noshpitz, 1984*). Later, the child mistreatment seems related to the youngster sense of object possession and his belief that the object exists entirely for meeting his personal needs. If he is in a kind and loving mood, his dog is petted, but, if he is angry or frustrated, the animal is Licked, ignored or otherwise abused (*Meek, 1984*).

Boys at the latency age engage in rather random acts of cruelty towards animals to proof their toughness. The symptom may reflect a strong fixation at the pregenital phase, or a severely disturbed role in the family system. They may be forced into a scapegoat role within the family group. They then turn their hostility towards family pets because the animals are the only family members below them in a hostile pecking order. Many youngsters who are cruel to animals have in fact been treated quite cruelly themselves. Much of their behavior represents a protective identification with the aggressor and is primarily defensive in its origin (*Anna Freud, 1965*).

While youngster may have been subjected to considerable frustration with the result that their anger and aggressiveness are increased. Extreme aggressiveness may originate either from defensive need to deny fear and vulnerability or as a direct expression of sadistic impulses (*Anna Freud, 1973*).

[8] LYING:

Anna Freud (1965) has suggested that falsification by youngsters can be divided into three types:

(1) Innocent Lying:

Refers to the young child's inability to separate inner and outer reality and his failure to distinguish between primary and secondary process thinking.

(2) Fantasy Lying:

Is a later development which arises because of reality frustrations and disappointment for which the child compensates by elaborating regressive wishfulfilling versions of life events are more satisfying.

(3) Delinquent Lying:

Refers to deliberate distortion of fact in order to gain a direct advantage over reality issues, that is, to avoid punishment or to achieve some material or interpersonal gain.

It is obvious that these three forms of lying overlap to some extent e.g. in anti-social youngster, delinquent lying may be so strongly coloured by wishful thinking that the youngster himself comes to

believe his fabrication.

Lying must be evaluated within the social norms extant in the child's family and social group. In many families, lies are utilized to avoid not only unpleasant confrontations but even necessary and difficult problem solving. *Meek (1984)* considered that parents of lying youngsters often utilize deceiful and corupt parenting practices and personal behavior.

Pseudologia phantastica is the severest form of lying where the lier seems to retain the capacity to recognize the unreality of his statements. He seems to go to considerable trouble to make his stories plausible including obtaining facts and information which lend to surface variety to his productions. Lying is a cognitive movement from pure action to thought and words which are generally regarded as a higher level of mental activity. Lying is less narcissistic than stealing for it requires an avoidance and thereby involves another human being. The primary motive in lying is to deceive the self. The listener is utilized only as a support to that internal operation. This is corroborated by the extent to which the liers come to believe their own fabrication. (*Noshpitz, 1984*).

[9] DISOBEDIENCE AND RESISTANCE TO DISCIPLINE:

This general dimension of behavior includes not following direction, paying no attention to requests or doing the opposite, disregarding house-hold rules and being defiant or disrespectful. (*Rutter et al., 1970*).

The overall complaint of parents is that they are tried every system of discipline from harsh punishment to letting the child to do what he or she wants, and "it has not worked". The clinician should accept these symptoms as a significant problem only if they have persisted for at least a year, if they're so obvious that relatives and friends as well as the parents have noticed them, and if they have disrupted the family in specific ways. Both parents should think that the child's behavior is different from behavior of the children of the same age (*Grahama, 1973*).

Most children who are describred by their parents as seriously disobedient and resistant to discipline will be describred by their teachers as presenting the same problems in classroom. These behavior problems generally go together with aggressiveness and they also tend to be associated with antisocial behavior such as lying and stealing. Most antisocial children or adolescents disregard rules, have no respect for adults, and have generally defiant attitude towards authority. On the other hand, many children who are thoroughly disobedient are not involved in antisocial behavior (*Gresten et al., 1976*).

[10] NON-COMPLIANCE:

Another defining behavior of the conduct disordered child is non compliance or oppositional behavior. Simply defined, non compliance is "not doing what is requested" (*Patterson et al., 1975*).

The range of behaviors related non compliance can encompass merely ignoring the request to protesting and actively resisting each request. An extreme form of non compliance is negativism which is "an exaggerated form of resistance, occurring when a child becomes stubborn or contrary, often doing quite the opposite of what the parents wish." (*Herbert, 1978*).

Like aggression, non compliance is found in all normal children. The difference, however, with conduct disordered children is that the intensity and frequency of the non compliance is much higher. *Patterson et al. (1969)*, using observers in the home of conduct disordered boys, found that on the average, one non-compliant behavior occurred every ten minutes. This is one of the most common behavior problems of childhood (*Herbert, 1978*). In their normative study, *Johnson et al. (1978)* reported that it comprises one third of children's deviant behavior.

The effect of severe non-compliance and oppositional behavior are not difficult to understand, they leave parents with feelings of helplessness. The expression "under controlled" has frequently been used to describe the conduct disordered child, and its usage stems directly from non-compliant behavior. The lack of conscience and moral concern for others may be explained partially by the effects of non compliance in early development. *Herbert (1978)* speculates that the development of compliance in young children is critical to socialization and moral development. Learning to comply may be an essential core of morality in that a child learns to regulate his interpersonal behavior by a set of external rules and values and not be what happens to please him at the moment.

[11] DELINQUENCY:

Many of aggressive and immoral acts are characteristic of children considered to be delinquent. However, juvenile delinquents are often defined as children who have been apprehended by legal authorities because they are accused or suspected of committing illegal acts. Of course many juveniles break the law and are not apprehended or even suspected (*Griffin and Griffin, 1978*).

Too, many juveniles are taken into custody or referred to a juvenile court with little or no evidence of their criminal offences. The differences in the laws, law enforcement practices, and juvenile court procedures from one state and locality to another make reliable and meaningful statistics regarding juvenile delinquency difficult to obtain or to interpret. However, it is clear that serious crimes committed by persons under the age of 18 have increased at a tremendous rate within

the past several decades, that girls are becoming involved in more serious and more aggressive crimes at an increasing rate, that juvenile crime is more frequent in inner city and poverty areas than in other types of communities, and that in a given approximately 3% of all American children are adjudicated (*Kirk, 1976*).

Delinquency is increasing quantitatively and is becoming qualitatively more violent and destructive (*Cohen, 1973*).

Davids and Flak (1975), found evidence that over a period of 15 years, delinquents appear to become more jaded and less well adjusted psychologically and socially. In comparing the responses of delinquents in 1959 to those in 1974, they found that, the more recent sample was more present oriented, less willing to delay gratification, and less concerned for others. In 1959, non of the delinquent mentioned drugs as something of interest, where as in 1974 delinquents frequently mentioned wanting to buy drugs. *Cohen (1973)* said that, the nature of the problem is not just the law-violating behavior of children but also the responses of adult authority to it punishment have been miserable failures in controlling delinquency. In short, the problem is one of a rising wave of criminality in children coupled with responses by adult authorities that tend to exacerbate rather than reduce the problem.

The risk of delinquency is increased within broken disorganized homes in which the parents themselves have an arrest record and are lax in discipline (permissive, indifferent, or neglecting) but are also hostile, rejecting, capricious and cruel in punishing their children (*Hetherington & Martin 1979*).

Most studies of delinquency have involved boys rather than girls or have not separately analyzed the data for females. *Offord, Abrams, Allen, and Prushinsky (1979)* studied Canadian families with delinquent daughters and found that delinquent girls tended to come from broken homes have mothers who were considered mentally ill, they have father with records of criminal behavior, and have parents with a history of being on welfare. The factor most clearly distinguishing delinquent from non delinquent girls was the frequency of broken homes. These findings do not indicate that parental separation causes female delinquency, but that parental discord and separation are part of the family characteristics correlated with low violation by girls.

Warren (1987) suggested an increase in female delinquency along with a shift in the nature of the offences committed, with more girls being convicted of violent offences and more boys being considered in need of protection by the courts.

DIFFERENTIAL DIAGNOSIS OF CONDUCT DISORDERS

Children and adolescents are referred to a psychiatrist for a variety of emotional and or deviant behavior. Deviancies are the direct or indirect consequences of developmental disorders, organic, environmental or psychiatric with or without complex emotional reactions. Also features of conduct disorder can be symptoms of other psychiatric conditions. For example oppositional disorder, mental retardations, psychomotor epilepsy, attention deficit disorder and isolated acts of antisocial behavior. Yet the essential features of conduct disorder can not be fulfilled.

[1] Mental Retardation:

Richard et al. (1979) in their study on the mildly retarded group, found that the rates of anti-social as well as emotional and developmental disorders were all appreciably higher than in the general population. This agreed with *Douglas (1975)* who found that low I.Q. generally antedates the psychiatric disorder so that, the retardation or the factors associated with it must lead to psychiatric disorder rather than the other way round. They added that the low I.Q. in early childhood is associated with both emotional symptomatology and delinquency in adolescence.

Although aggression may be a behavioral manifestation resulting in, or associated with mental retardation, the essential features of mental retardation was suggested by the DSM III as a significantly subaverage intellectual functioning resulting in or associated with deficits or impairment in adaptive behavior, with the onset before the age of 18. The diagnosis is made regardless of whether or not there is a coexisting mental or physical disorder. The degree of impairment is correlated with the level of general intellectual functioning. The presence of associated features such as behavioral features other than those reflecting the mental retardation itself e.g. symptoms of other mental disorders as attention deficit disorder, irritability, aggressivity, stereotyped movement disorder or infantile autism. Often there are multiple neurological deficits.

Reid (1980), noted that the symptoms of behavior disturbances associated with mental retardation were related to the child's age, level of I.Q. and language disability. Thus, while truancy from school and stealing from outside home may be features of conduct disorder in children with normal intelligence, few severely retarded children have the opportunity to display the symptoms, but may exhibit persistent wandering from home or stealing from within the home in response to family stress. They still can not be diagnosed as conduct disorder as the essential features of conduct disorder are not yet present.

In the mildly retarded child, educational retardation may contribute to maladjustment by impairing school learning. Educational failure may then lead the child to react against school values. He may rebel and seek satisfaction in activities contrary to school rules and so become involved in disruptive behavior. This is particularly seen in both mild and severely retarded children, when unrealistic expectations lead to a child being maintained in a school situation in which he can't cope. There may be considerable improvement when he receives special educational help more appropriate to his needs. Features of conduct disorder may be a presentation of cases of mental retardation especially of the mild and severe forms. Severely retarded group may present with high frequency of primitive disorganized behavior which may resemble conduct disorder behavior but with impulsivity and hyperactivity. Mildly retarded may present with emotional problems in the form of low frustration tolerance and depression with secondary aggressive and hostile behavior directed towards playmates. Scholastic difficulties may present with aggressive behavior, truancy or involvement in antisocial acts that might be appreciated by other peers with conduct problems (*Corbett, 1977*).

The mentally retarded child does not have the same opportunities for socialization as his normal peers. His tolerance for anxiety and frustration is lower than would be expected of his chronological age. He is exposed to hazards in achieving emotional growth because of factors related to slow rate of development, difficulties associated with possible central nervous system damage and parental rejection or over-protection. These factors if not taken into consideration in rearing a mentally retarded child may result in various behavioral disorders. Social relationships can represent sources of emotional conflicts leading to disturbed social relationships, aggressive behavior and school problems.

[2] Attention Deficit Disorder:

Features of conduct disorder may exist in cases of attention deficit disorder to the extent that distinction of either of the two disorders is difficult. Attention deficit disorder may predispose to conduct disorder due to the presence of poor academic achievement together with the development of unsatisfactory peer relationship. This may favour the development of aggressive antisocial behavior in children. According to the DSM III, a child with this disorder displays for his or her mental and chronological age, signs of developmentally inappropriate inattention, impulsivity, and hyperactivity. The symptoms of inattention and impulsivity result in some impairment in social and occupational functioning. Associated features vary, as a function of age and include, obstinacy, stubberness, negativism, bossiness, bullying, increased mood lability, low frustration tolerance, temper outbursts and lack of response to discipline. However, the criteria labelled for conduct disorders are not fulfilled.

Okasha (1977), defined the syndrome of Attention Deficit Disorder as a general motor hyperactivity with violent motor unrest. A generally-agreed learning difficulties are usually present with marked aggressiveness towards brothers and sisters. According to *Winde (1971)* the behavior of the attention deficit disordered children is quite variable. Typically symptoms fluctuate from time to time and from situation to situation. Thus, a child's behavior may be well organized and appropriate on a one to one basis or in specific tasks or activities, but disorganized when in a group or at school. They are more likely than others to run off in several directions at once rather than to plan and organize their actions with fore-sight and judgement. Excitability is manifest by temper tantrums, low frustration tolerance and a tendency to become overexcited, and more active in stimulating situations especially in large groups of other children. Also, antisocial behavior is more frequent in older hyperkinetic children. Thus, it may develop as a secondary reaction. Children who are unable to succeed in an academic setting, who are unable to develop satisfactory peer relationships, who find rejection at home and at school are likely to become aggressive and rebel against the values of society.

Taylor (1986), distinguished hyperactivity as a syndrome from conduct disorder and findings with regards to its origin in brain dysfunction and neurophysiological unresponsiveness. Those factors were found to be more prevalent in the hyperkinetic syndrome. *Taylor et al. (1986)*, explored the distinction between hyperactivity and conduct disorder in 64 boys, aged 6-10 years, referred for psychiatric assessment because of antisocial or disruptive behavior. The hyperactivity was associated with greater activity, younger age, poorer cognitive performance and abnormalities on a developmental neurological examination. While conduct disorders were associated with impairment of family relationships and adverse social factors. *Werry et al. (1987)* agreed in his study on attention deficit disorder with *Taylor et al. (1986)* that attention deficit disorder may be a cognitive disorder possibly of neurodevelopmental origin and that conduct disorder is one of social relationship of psychosocial origin. The coexistence of attention deficit and conduct disorder is probably common and increases the degree of disability.

[3] Oppositional Disorder:

There are some of the features that are present in conduct disorder such as disobedience and opposition to authority figures. However the basic rights of others and major age appropriate societal norms or rules are not violated as they are in conduct disorder (DSM III, 1980). The essential feature is a pattern of disobedient, negativistic and provocative opposition to authority figures. Oppositional attitude is toward the family members, particularly the parents and teachers. There is no violation of the basic rights of others or other age appropriate societal norms or rules (as in conduct disorder) and the disturbance is not due to other mental disorder. The course is usually

chronic and lasts for several years. It can interfere with all social relations. In some cases there may be continuity with passive aggressive personality disorder. School failure is common and it may cause serious academic problems if it includes refusal to learn. In some instances what first appear to be oppositional disorder may alter turn out to be an early manifestation of conduct disorder. Oppositional disorder may begin as early as 18 - 36 months and is considered a part of normal developmental phase.

[4] Epilepsy:

In children with psychomotor epileptic symptoms the disorder may be frequently associated with aggressive behavior and offenses against persons. Some papers have called attention to the association of violent or antisocial behavior with psychomotor epilepsy and suggested that psychomotor epilepsy is probably more common among delinquents. Psychomotor epilepsy is known to be preceeded by feelings of fear and anxiety together with fluctuation of awareness. This may provoke the development of paranoid ideation and subsequently the hostile or aggressive antisocial behavior of those individuals (*Lewis, 1976*).

An abnormal EEG in an otherwise healthy subject is a strong evidence of an inborn constitutional abnormality involving the central nervous system. The abnormality appears to be non specific and may manifest itself in the subject or his off-springs as a behavioral disturbance which may be psychoneurotic, psychopathic or epileptic in type. *Ounsted, Lindsay, and Norman (1966)* reported outbursts of catastrophic rage in approximately one third of their children with temporal lobe epilepsy. *Lindsay (1972)* regarded the outbursts as a form of fail-safe device i.e. the rage occurred when the child had been overloaded with emotional stimuli of one sort or another. Children with temporal lobe epilepsy may manifest rage outbursts at any age. This can lead to complications in older patients and may take the form of murderous assaults and infliction of bodily injury on others. Careful history taking should make it possible to recognize the repeated stereotyped epileptic events and distinguish them from the more continuous disturbance associated with a personality disorder. Also, O'Donohoe (1979) mentioned that outbursts of catastrophic rage may be seen in children and adolescents with temporal lobe epilepsy, which is interesting in view of the suggested relationship between limbic dysfunction and aggression.

Lewis & Ball (1973) stressed that the absence of any memory for violent acts should raise the possibility of some form of seizure disorder including psychomotor epilepsy. A history of birth difficulty, cerebral infection or head injury may be important forerunners of an organic conditions resulting in poor impulse control or seizure disorder.

Difficulties in diagnosis of psychomotor epilepsy arise where only sensory phenomena or automatism occur, since these may be difficult to distinguish from behavioral aberrations of one sort or another. In this respect it should be remembered that psychomotor seizures are generally paroxysmal episodes of relatively short duration usually without any precipitating factors and they start and end abruptly while the reverse is characteristic of psychiatric disturbance. The latter is usually provoked by some disturbing situation. However, the distinction between the two can be blurred by the fact that temporal lobe epileptic attacks are more likely to happen when the subject is emotionally disturbed (*O'Donohoe, 1979*). *Okasha (1988)* added that psychological difficulties are manifest in about 50% of temporal lobe epileptic seizures. Many epileptics, before the onset of fits may show particularly episodes of aggressiveness, impulsiveness and moodiness which may be regarded as mild psychomotor equivalents. The present evidence suggests that temporal lobe EEG abnormality carries with it an increased risk of personality disorder though the character and the degree of deviation depend on what pathways are involved in the paroxismal activity. However, psychosocial rather than organic factors may link the epilepsy and the subsequent development of the nucleus for later personality disorder. Paroxismal activity is precipitated by emotional stress more readily in temporal lobe epilepsy than in other types of epilepsy. This would seem to predispose the patient to psychopathological developments especially that many of the studies reported a high incidence of disturbed environment in these patients.

[5] Emotional Disorder:

Children and adolescents with emotional disorder are referred to a psychiatrist for a variety of deviant behaviors. These deviancies are the direct or indirect consequences of developmental disorders with or without complex emotional reactions. More often, the deviant behavior is the outcome of distorted, faulty interactions with other people. Depression, anxiety and aggression are not well differentiated and separate entities within the spectrum of mental anguish; rather there is always a mixture of these emotions in which only the relative proportion may change. An anxious child is depressed by his awareness of his inability to cope with his environment and angered by his plight. An aggressive child who for example set fire may present this aggression and destructive act as the last resort or the last disperate attempt of a deprived, abused child to bring attention to himself even though the risks, being destroyed in the process (*Rutter & Cox, 1985*).

Observation of children's responses to the death of parent have shown that in younger children, death is totally denied; they fail to show any prolonged reaction to the event. In older children, affective changes are not very obvious; instead there are behavioral changes such as hyperactivity, restlessness, aggressive behavior, temper tantrum and delinquency. These behaviors have thus been designated

as possible equivalents of the depressive mood in children (*Chess & Hassibi, 1978*).

In reporting 14 cases of overt depression in children, *Pozanski and Zrull, (1970)*; found that in 12 out of these 14 children, there were episodes of directed aggressive behavior, though self-destructive ideation could also be elicited. The children who have been overtly rejected are the children of families with a high incidence of depression. The children's symptomatology developed slowly and insideously over one or more years. They tend to be highly irritable and try to deny their unhappiness by engaging in provocating behavior.

Cytryn and Mckneu, (1979), described behavioral manifestation as a part of childhood depression. It includes disturbed sleep, loss of appetite, psychomotor retardation, or conversely hyperactivity, aggressiveness and delinquent acts. Depression, fantasy, dreams, and thoughts represent the earliest manifestation or indication of childhood depression and are the last to disappear with improvement of child's mood.

[6] Schizophrenia:

Lewis and Ball (1973) mentioned that history of interpersonal difficulties and behavior problems at school may be important harbingers of later psychotic symptomatology associated with conduct disorder and delinquency.

Lewis (1984), found schizophrenia to be the most common discharge diagnosis in hospitalized adolescents previously diagnosed as having conduct disorder and demonstrated that a major factor leading to the diagnosis of conduct disorder was violence with no other symptomatic differences from psychiatrically hospitalized adolescents. She asserts that due to the emphasis on manifest behaviors and lack of exclusionary criteria, the conduct disorder diagnosis obfuscates other potentially treatable neuropsychiatric disorders and discourages clinicians from conducting comprehensive diagnostic assessment. She advocated that the diagnosis be limited to the patients showing no signs of neurological dysfunction or mental retardation, and having no history of drug induced psychotic symptoms. She recommended that violent behavior should be eliminated from criteria of conduct because it is seen in so many other disorders.

[7] Isolated Acts of Antisocial Behavior:

Isolated acts of antisocial behavior may qualify for a diagnosis of conduct disorder if the antisocial behavior is persistent and repetitive. In such a case there will be obvious impairement in social and school functioning that frequently will not be present when the antisocial behavior represents an isolated act (DSM III, 1980).

TREATMENT

Treatment of Conduct Disordered Children:

During the late 1960s and early 1970s behavior therapists established that training parents in the use of behavioral principles and methods could be effective in altering the behavior of children with conduct problems. Children who present with aggressive problems such as noncompliance and tantrums, and come from relatively stable well - adjusted families, respond rapidly to behavior modification. Those who fail, tend to present with delinquent problems and come from socially deprived multiproblem families. Delinquent children respond less well to behavior therapy than aggressive children for the families of the former were found to have lower rates of social exchange than other group. Such families are often of low socioeconomic status, have poor educational attainments, tend to have frequent contacts with police and they are relatively isolated within the community (*Mc Auley, 1982*).

Treatment Techniques:

(1) Behavior Therapy:

Patterns (1974) described a sophisticated programme of group training for 27 out of 35 referred families of boys with conduct disorders. Parents were trained to follow a programmed text and to use social reinforcements, time out and token systems. At the end of treatment two thirds had a 30% reduction of symptoms. Booster shots were given to children who relapsed. While *Mc Auley (1982)*, pointed that; families of children who steal are as a group less open and socially responsive, and much harder to engage in treatment than are families of aggressive children. But, for children with seriously disturbed parents, therapeutic approaches in the school may be more fruitful (*Wolff, 1985*).

Treatment of antisocial children, presenting with fire setting; in the community seems to be particularly unsuccessful. Removal of the child from the home environment for a short period of time seems to be necessary to stop the maladaptive behavior. Inpatient evaluation, subsequent foster home placement or residential treatment should be considered. Months later further improvement took place, at a total average cost of 31.5 hours of professional time. Generalization effects occurred to non-target behavior and to the behavior of siblings. Methods of training parents have consisted of modeling sessions in the clinic, group training, home visits and the training of new parents by parents experts. Also, filmed modeling procedures may be e used to train parents in the use of behavioral techniques (*Wolff, 1988*).

For the past 15 years; Patterson and his colleagues in Oregon have been developing both a social learning theory of aggression and a treatment approach for parents of aggressive children to apply in their

own programme (*Patterson, 1982*). The key to the programme has been the development of a complex, reliable and valid system of observing and coding interactions between the aggressive children and family members within the home setting (*Patterson et al., 1969*). Parents are taught to define, pinpoint and measure the deviant and prosocial behavior they wish to alter in their own children. They are helped to construct and excute appropriate modification programms in their own homes. The results are evaluated through the direct observation procedures, as well as through the data the parents collect and through changes in parent-rating scales. Following 8 weeks of treatment of 27 referrals from community agents there was an average reduction of 60% in the rates of occurrence of target behavior. Three quarters of children showed significant drops in the frequency of undesirable behavior. As a by-product of this research programme, it has emerged that children who steal in addition to being aggressive are more difficult to treat. It was found that the stealers exhibit less overall deviant behavior, and that they came from families that exhibit much lower rates of friendly behaviors.

Patterson and Fleischman (1979), reported the outcome of 114 families treated over a 10 years-period; 17% had dropped out during baseline sessions. 50 families provided full data at 4, 8, and 12 months after termination of treatment. It was found that gains made during treatment. It was found that gain made during treatment persisted. Recidivism rates varied significantly according to the style of treatment. The author concluded that a focus on families persé was not sufficient to modify family interaction patterns or to reduce rate of delinquency. Behavioral method offer something more than psychodynamic, client centered, but it has not been clearly identified.

(2) Family-Style Small Group Home:

Another model for helping young delinquent was Family-Style Small Group Home for up to 10 boys aged 12 - 16 years. In addition to their delinquency, most of the youths are 3 - 4 years behind academically. The home is run in a sophisticated token economy where points are earned for appropriate prosocial behavior and lost for antisocial behavior. The house is run by a couple who are professional "teaching - parents", well versed in behavioral approaches. While at achievement place, the boys continue to attend the same school as they did before conviction. They continue contact with their natural families, and as they improve so they spend a longer time at home with the token economy gradually faded-out. It aims to teach young delinquent the rules of everyday living and to train them in any skills in which they are not proficient. They can be taught simple ingotiating skills as a means to more positive family interaction (*Rappaport & Holden, 1981*).

Foster Home Placement:

Foster home placement may be indicated when the family is clearly unable to deal with the child's needs. Treatment of conduct-

disordered children must be directed at integration within the school stem and provision of role models, preferably within the community to aid identification. When the family is willing or able to cooperate, they can be helped to provide close supervision and a more predictable and supportive environment for the child (*Chess & Hassibi, 1978*).

(3) Group Therapy:

The group therapy is often important in the therapy of antisocial youngster. Two types of group therapy have been used in the treatment of youngsters with behavior disorders:

(a) Older youngsters may be included in groups treated by means of dynamically-oriented, exploratory group psychotherapy. The presence of the behavior problems in the group must be balanced by the inclusion of other youngsters with stronger egos and a more reflective approach to problem solving. However, the action oriented impulsive youngster can be a valuable addition. His eagerness to challenge authority and his readiness to verbalize forbidden impulses may enliven and catalyze a group interactive process, (*Kraft, 1965 and Meek, 1973*).

(b) Younger children with behavior problems seem to respond better to groups which are more actively oriented. This activity group therapy engages the youngster in structured group play situation in which verbalization play a secondary role. Ego growth is accomplished through the promotion of positive identification with group leader (usually of the same sex as the single sex group); the modeling of appropriate resolution of interpersonal disagreements between group members, and through success experiences in mastering group tasks. Properly conducted groups of this kind often provide the behaviorally-disordered youngster with his first experience of positive peer interaction and, may result in considerable strengthening of ego. (*Meeks, 1973*).

Group psychotherapy has also proved of value to severely antisocial older youngsters. These groups work on altering the symptomatic antisocial behavior through an inspirational, and educational approach (*Franklin & Nollage, 1969*). Vocational training may be a primary focus. Groups of this kind are quite effective. During the early phases of the youngster's membership, they may depend on some external authority to enforce attendance. One of the primary group tasks is to assimilate and rehabilitate new members successfully. The therapist can create a nucleus of youngsters who discover that there are more pleasant and productive ways to live than the constant batteling and hollow victories for delinquency (*Massino & Shore, 1963*). The old members in the group build a strong group ethic of honesty, self-direction and interpersonal fairness. With the therapist's help they are able to confront the new member with himself

destructiveness and his deceptive style of relating to other human beings. Often they do this with considerable accuracy and empathy, because they recognize their own previous style in the resistances, defenses and evasions of the new antisocial member (Noshpitz, 1984).

(4) Family Therapy:

Family therapy may be valuable as an adjunct to individual or group psychotherapy, as a useful modification of approach during specific periods in the treatment process, or as the primary therapeutic approach with antisocial youngster. In cases of antisocial youngsters, the problem is often with the parents. Many of these families utilize external and mutual blaming as primary defenses (*Offer & Vanderstoop, 1975*). Scapegoating parents are threatened by the recommendation of a family approach, since the decision to utilize this method clearly implies that they have a role in the youngsters problem (*Rabiner et al., 1962*). From a therapeutic point of view, the family approach is particularly indicated in those cases where the child's current symptomatology seems to be deeply imbeded in a state of neurotic family hemeostasis. This includes youngsters who are severely scapegoated, those superego lacunae patients (described by Johnson and Szurek), and some cases where the antisocial behavior appears to represent an attempt at separation from a binding or symbiotic family entanglement. In spite of the technical difficulties in beginning and conducting family therapy with this diagnostic group, the technique does have important advantages, both diagnostically and therapeutically. Observation of the entire family often permits recognition of the important pathological deviations in family structure which were described above. These aspects of the problem are not always evident from individual interviews with the family members. Even clinicians who not interested in the family interview as a therapeutic technique might seriously consider including at least one interview with the entire family in the diagnostic evaluation (*Noshpitz, 1984*).

Family therapy for loosely linked families may be difficult and individual therapy seems to be of limited value (*Fine & Louie, 1979*).

(5) Individual Psychotherapy:

It may be useful when the child has internalized a poor self-image and his delinquent behavior can be traced to his feeling of hopelessness and futility. In older delinquents, external control may be best provided in a structured setting in which the youngster is protected from further risks of involvement in antisocial activities while every attempt is made to help with his deficiencies. When the adolescent's delinquency is traceable to intrapsychic and neurotic conflicts, individual psychotherapy and parental supervision will help him to control his acting-out behavior. For pre-delinquent child, treatment must be directed at integration within the school system and provision of role

models, preferably within the community, to aid identification. When the family is willing or able to cooperate, they can be helped to provide close supervision and a more predictable and supportive environment for the child. Foster home placement may be indicated when the family is clearly unable to deal with the child's needs. Social programms aimed at removing poverty, creating jobs, cleaning slums etc. are commendable goals and may in the long run be effective in combating juvenile delinquency (*Chess & Hassibi, 19178*).

PROGNOSIS AND OUTCOME OF CONDUCT DISORDER

In a follow up study of the adult status of 524 white children who were referred to the St. Louis Child Guidance Clinic for antisocial behavior. *Robin, (1966)*, found that there is no clear connection between the form of deviancy in childhood and the deviant behavior exhibited in adult life. Of her sample, 28% were diagnosed as sociopathic in adulthood with chronic inability to function as parents, spause, worker, or member of the armed forces. They were isolated form their relatives, did not have any friends, and did not belong to any organization. They had divorced more often and their children had been frequently involved in antisocial behavior. Another significant percentage of the original group had been diagnosed as chronically alcoholic or schizophrenic during their adult life (no figures are mentioned). On the other hand, about 50% of the children with antisocial behavior had grown up to be functioning members of society. Children who had engaged in more varieties of antisocial activities and over a longer period of time were more likely to become antisocial adults. When mothers and fathers were antisocial , the antisocial behavior of their children had higher likelihood of continuing into adult life. Also she observed that children with severe behavior problems were less likely to receive extensive treatment despite the fact that they are at high risk to develop psychiatric disorders in later life.

It is now known that many individuals with chromosomal defects notably an enlarged or double Y anomaly live normal social lives and that their vulnerability to behavioral problems is much less than originally supposed (*Zelluweger & Simpson, 1977*).

Hassibi & Chess (1978) suggested that the manifestation of failure in socialization in conduct-disordered children depends on the child's stage of development and the environmental circumstances. The prognosis for each child with a deviant behavior can be conceptualized as the degree of flexibility in environmental circumstances and the individual's responsiveness to these changes. A good percentage of juvenile delinquents becomes stable functioning members of society in their adult life when correction of their behavior is directed at the millieu as well as to themselves. To *Henn et al. (1980)* the outcome of conduct disorder varies according to certain factors such as age of onset (worse with earlier onset), abnormal personality features, and family circumstances. The under-socialized subcategories of conduct disorder tend to have a worse prognosis. *Staterfied et al. (1982)* mentioned that delinquent and criminal behavior usually originates in early childhood and that antisocial behavior once firmly established is notoriously resistant to treatment. On the other hand, *Meek (1984)*, also noted that Aichorn and the group of pioneering psychoanalysts, who followed his

lead, through their work and studies on delinquent youngsters failed to produce positive results and even suggested that this group of problems may be outside the legitimate area of psychiatric investigation.

Rutter and Gould (1985), found that the youngsters with disturbances of conduct, if they show problems in adult life (as a high proportion do), tend to exhibit personality disorders with accompanying social difficulties as well as psychiatric impairment. While *Stewart and Keslo (1987)* did a 2-years follow up study on 53 aggressive conduct disordered boys; 55% of them showed persistence of their symptoms. This persistance of the symptoms were predicted by the presence of hyperactivity and inattention in early childhood.

According to the *D.S.M.III-R (1987)*, the outcome of conduct disordered child may be in the form of drug abuse, sexual disorder, personality disorder or character trait disorder that is callous, tough, with low self-esteem, poor frustration tolerance and irritability. Conduct disordered child may later on develops symptoms of anxiety and depression that rustify additional diagnosis. He may have specific developmental disorder.

Farrington et al., (1988), in the Cambridge study on delinquent development , a prospective longitudinal survey of 411 males. A vulnerable group of 63 boys from criminogenic background was defined on the basis of the best non behavioral predictors of delinquency at age 8 - 10. These predictors include: low family income, large family size, convicted parents, low IQ, and poor parental child rearing behavior. Those males were followed up to the age of 32 and the more successful men were defined to have satisfactory social adjustment. Those successful men at the age of 8 - 10 were already better behaved and less daring than those later judged as unsuccessful men. They were those who had been neurotic at age 10, had few friends at age 8, without convicted parents or behavior problem siblings and with mothers who had high opinion in their sons. *Farrington et al.* added that shyness acts as a protective factor against delinquency for non-aggressive boys but, as an aggravating factor for aggressive boys. Whereas men who had been reared in aggressive families tended to be expressive as well as liable to commit crimes. Men reared by punitive parents showed a tendency to be egocentric.

Juvenile Delinquency:

Delinquents from the psychological point of view are a markedly heterogenous group. Their behavior may occur infrequently or repeatedly and consists of acts that violate the law.

Types of Juvenile Delinquents:

Offer et al., (1977) in their in-depth study of 55 juvenile delinquents; formulated 4 clinical types: the impulsive, the narcissistic, the depressed borderline and the empty borderline.

(a) The impulsive delinquent: is characterized by few internalized controls, immediate discharge of experience, little constructive fantasy or planning and the greatest propensity for both violent and nonviolent antisocial behavior.

(b) The narcissistic delinquent central problem is the regulation of self-esteem, which is maintained largely through acting-out behavior. The youngster perceives himself to be well adjusted, although others view as manipulative and superficial. He has a tendency to be grandiose and to use other people to solidify temporarily a faulty sense of self.

(c) The depressed borderline type is often well liked, shows initiative at school. He has a considerable guilty feeling and depression. His acting out behavior is mainly to relieve depression.

(d) The empty borderline is extremely passive, often not liked, and emotionally depleted. *Offer et al., (1979)* mentioned that for these delinquents, acting out behavior is in the service of warding off psychotic disintegration or fragmentation and help to reduce the intense inner emptiness.

In terms of their psychological make up, some of the youngsters are sociological delinquents with few psychological problems and are well integrated members of delinquent subculture. Others display a variety of psychological problems associated with their deviant behavior; some are chatacterological in nature, others expressing neurotic concerns (*Hetherington et al., 1971*),

Chess and Hassbi (1978), viewed a delinquent child as an older child, 13 - 15 years of age. He has been arrested several times. He may have appeared in court on one or more occasions, charged with robbery, assault, or possession of stolen goods. He may have engaged in a variety of sexual misbehavior, such as rape and sodomy. He now uses his home only as an occasional place to sleep. Either not seeing or totally disregarding his father. He may show more concern for his mother, although she can no longer count on his obedience. His attendance in school is irregular and only for the purpose of meeting with his companions. He shows contempt for those who spend their time in pursuit of academic studies. His social relations are limited to association with others like himself. A delinquent girl is more likely to have been engaged in sexual misbehavior. Pregnancy, prostitution, use of drugs and alcohol, and shoplifting may be the presenting complaints. Her relationship with her parent is usually unsatisfactory. She may complain of depressed mood and nervousness or various somatic complaints (*Chess & Hassibi, 1978*).

(1) Sociological Delinquency:

It is considered a form of delinquency that consists of a motivated goal oriented behavior learned from experience. It tends to represent adaptive rather than maladaptive behavior, and to comprise social rather than solitary delinquent acts. The sociological delinquent engages in playful, easily understandable behavior to satisfy his desires. His success in satisfying these desires through illegal means, earns his praise and prestige among his immediate social group. The behavior is essentially socialized even if illegal. It consists of group behavior and is referred to as gang delinquency. The child appears to have good capacity for interpersonal relations and to feel himself satisfied, secure and accepted member of a social group (*Jenkin, 1969*). Inadequate parental supervision and low socioeconomic standard attribute much to the occurrence of sociological delinquency. The parents are usually found to have experienced fairly close and supportive family relationships in their early years with lack of supervision later. They are unlikely to develop any neurotic symptom formation or to display any basic disorder in his personality functioning (*Weiner; 1975*).

(2) Characterological Delinquency:

Characterological delinquency has generally aggressive, asocial attitude with lack of concern for the welfare of others. He is unable and unwilling to control his behavior. He does what he wants when he wants. His acquisitive and pleasure seeking drives are expressed through the most direct routes he can conceive, without regard for how others suffer in the process (*Robin, 1966*). He has experienced parental rejection in early years of life. Early family disruption, either, because one or both parents are not at home or they paid little attention to him. Mothers have given them little love and affection during the preschool period. Neither parents has provided consistent well intended discipline or supervision (*Weiner, 1975*). Those patients have usually been exposed in their early lives to antisocial parental models including such behavior as criminality, desertion and chronic unemployment particularly the father. He used to have a long record of fighting unruly behavior in school of bullying younger and smaller children. He used to steal whenever the opportunity presented itself. He has a history of few warm feelings towards other people and caring little about their feelings towards him of being subject to temper tantrums in the face of even mild frustrations of his wishes and demands. All these factors aid in the development of the characteristic, lovelessness and guiltlessness of the youngster. It is a maladaptive form of delinquent behavior. It represents frustration-induced rather than positively-motivated behavior. It consists of acts that are found in youngster' social circle. It constitutes unsocialized behavior that tends to represent solitary delinquent acts with a social personality orientation. Characterological delinquent is a loner trusting no one, and loyal to no one although he

may pretend trust and loyality when it serves his purpose to do so (*Friedman, 1975*).

(3) Neurotic Delinquency:

This young person commits illegal acts as an individualized and very personal attempt to communicate needs that he is unable to impress on his environment in other ways. The onset can be traced to the emergence or excerbation of some personal sources of concern, and its remission usually follows closely on the needs of some resolution of these concerns (*Weiner, 1975*).

Bruks & Harrison, (1962) mentioned that the needs usually to contribute to neurotic delinquency are:

(1) Needs to be recognized and admired or to achieve status may lead a youngster who feels unnoticed and unappreciated to resort to delinquent acts.

(2) A need for help for he is experiencing distressing problem that he is afraid of, or embrassed to communicate to anyone directly, or whose effort to communicate have fallen on deaf or disinterested ears. So he may resort to delinquent acts to get his message across. They added that carelessness about being caught and identified or found, is a support for the diagnosis. His acts are apparently motiveless. His life history or previous life pattern has been controlled and conforming presence of a precipitating event. It tends to exist in the context of a close family relationship and mutual concern among family members for each others welfare. The psychological problem that is usually associated with this pattern of behavior is depression.

Frankis and Nottage (1969) designed a scale for predicting future delinquency based on information and observation collected at 6 years of age. The three areas studied were family background, character traits and personality traits. Character traits were isolated from responses on Rorschach tests, and personality traits were observed in clinical interviews. The children with a higher risk of future delinquency had hostile, overstrict fathers and indifferent or hostile rejective mothers. They showed suspiciousness, destructiveness and aggressiveness on their Rorschach responses; and they were adventurous, stubborn, and emotionally labile. The scale was reported to be 87% predictive of delinquency. This device has been shown to be reasonably effective in distinguishing boys with a high delinquency potential from those with a relatively low risk.

DEAFNESS IN CHILDHOOD

DEAFNESS IN CHILDHOOD

Deafness in children is a serious handicap that tends to isolate the children from normal life. A deaf child is cut off from many of the experiences and opportunities for learning that ordinary children enjoy, and has to make constant and considerable efforts to achieve things that come relatively easily to ordinary children. (*Bowley & Gardner, 1975*).

To the degree that a child's auditory abilities are affected, he may have a problem in communication, the underpinning for many of the developmental tasks of childhood. This is particularly true in our society which places heavy emphasis on the verbal aspects of communication (*Cox & Edelin, 1978*).

Mykebust, (1960) stressed the role of hearing in the verbal communication system and pointed out from an evolutionary standpoint that man's primary sensory avenue involved in language acquisition has been hearing. Any hearing loss, then, may critically alter the child's acquisition of the crucial auditory skills (e.g. inner language and receptive language) and may alter his expressive speech and language. Consequently the child's communication patterns, which are intimately tied to his ability to learn and grow emotionally, may be affected.

Definition:

It is important to define the most frequently used terms related to hearing loss. *Schein and Delk, (1974)*, noted that definition has been made on the basis of the degree of hearing loss, age of onset, speaking ability and cause of hearing loss. They used hearing impairment as an umbrella term, specifically for all significant deviation from normal, including deafness. They defined deafness as the inability to hear and understand speech.

Cox and Edlin (1974), used the term hearing impairment to denote all degrees of hearing loss and the term deaf refers to those persons who, even with amplification cannot hear or understand well enough to achieve minimal communication.

The term congenital deafness denotes deafness since birth, however from the functional standpoint, there is no substantial difference between the child whose deafness was indeed present at birth and one who suffered a significant loss of hearing in the prespeech period. In fact, in many children it is not possible to determine whether the hearing loss was present at birth or somewhat of later onset (Bergstrom, 1976).

Incidence:

In Egypt the incidence of complete hearing loss is 0.24 in 1000 school children (Gabre, 1980). Hearing impairment constituted 36.96% of cases of delayed language development in Egypt in 1974, and this percentage decreased gradually and reached 20.97% in 1978 (*Kotby, 1979*).

Deafness is the most prevalent chronic physical disability in the United States surpassing the number of persons with visual impairment, heart diseases or other chronic disabilities. The average of hearing disabilities is 1 in 1000 to 1 : 200 live births and 16 in 1000 of school population in United States (*Schein and Delk, 1974*).

For every child identified as deaf, there are probably six or seven children who are hard of hearing and who may need certain special education services (*Moores, 1987*).

Types of Hearing Impairment:

The two main types of hearing impairments are conductive and sensorineural:

Conductive hearing loss results from abnormalities or complications of the outer or middle ear. A buildup of excessive was in the auditory canal can cause a conductive hearing loss, as can a disease that leaves fluid or debris. Some children are born with incomplete or malformed auditory canals. A hearing loss can also be caused if the eardum or ossicles do not move properly. As its name implies, a conductive hearing impairment involves a problem with conducting, or transmitting, sound vibrations to the inner ear. Because the rest of the auditory system is generally intact, conductive hearing losses can often be corrected through surgical or medical treatment. Hearing aids are usually beneficial to persons with conductive impairments. (*William and Michael, 1992*).

Sensorineural hearing loss refers to damage to the auditory nerve fibers or other sensitive mechanisms in the inner ear. The cochlea converts the physical characteristics of sound into corresponding neural information that the brain can process and interpret (*Berg, 1986*), impairment of the cochlea may mean that sound is delivered to the brain in a distorted fashion or is not delivered at all. Amplification - making the source of sound louder - may or may not help the person with a sensorineural hearing impairment. Unfortunately, most sensorineural hearing impairments cannot be corrected by surgery or medication.

Mixed hearing loss is the combination of both conductive and sensorineural impairments.

ETIOLOGY

Broadly, hearing disability could be classified into hereditary (genetic) and non hereditary (nongenetic) causes. Genetic deafness runs in families and can be traced in subsequent generations expressing the different modes of Mandelian inheritance i.e. dominant, recessive and sex-lined inheritances. Non genetic deafness is that which results from environmental influences. (*Black et al., 1971*).

Among prenatal and perinatal causes, one major study (*Gentile and Rambin, 1973*) has shown the following incidence rates, expressed in percentage rate per 1000 students of total specified causes: maternal rubella 38%; hereditary 19%; prematurity 14%; Rh incompatibility 8.7%; other complication of pregnancy 6.2%; trauma during delivery 5.7%; medication during pregnancy 1.7%; trauma to mother during pregnancy 1.4%; and other causes 5.3%. Maternal rubella is still one of the main cause of hearing impairment even in non-epidemic periods.

Among the postnatal causes of hearing loss, the previously cited study (*Gentile and Rambin, 1973*) reported the following incidence rates expressed in percentage rate per 1,000 students with specified causes: meningitis 27%; measles 15%; otitis media 12%; fever 8.4%; trauma 5.6%; mumps 4.7%; and other causes 27.3%.

The etiology of the given child's hearing impairment is useful information to the practitioner as an indicator of the severity of the problem. Etiology is also an important factor to consider because of the relationship between it and the progressiveness of the hearing loss, as an examples are the many forms of hereditary hearing impairment that have an onset delayed until sometime during the child's first year of life or, perhaps, during later childhood or adolescence (*Cox and Edelin, 1978*).

Although several hundred causes of hearing impairment have been identified, for bout 30% of hearing impaired children, the exact cause is listed as "unknown" (*Moores, 1987*).

According to *Brown (1986)*, four prevalent causes of deafness and severe hearing impairment in children warrant special attention:

1) Maternal rubella: Although rubella has relatively mild symptoms, it has been shown to cause deafness, visual impairment, heart disorders, and a variety of other serious disabilities in the developing foetus when it affects a pregnant woman, particularly during the first trimester. A major epidemic of rubella that took place in the United States and Canada between 1963 and 1965 accounted for more than 50% of the hearing impaired students in special education programms in the 1970s and 1980s.

Rubella deafness is characterized by sensorineural hearing loss with a flat audiometric pattern. The severity of hearing loss may differ substantially between the two ears (*Barr & Lundsrom, 1961*). Severe to profound deafness has been found in 4 - 8% of children with histories of maternal rubella, and it has also been recognized following asymptomatic maternal infections (*Schuknecht, 1974*).

Subclinical rubella may develop following immunization, but viraemia and fetal infection generally do not ensue. However, the attenuated virus vaccine itself can produce fetal damage. Therefore, it must never be given to pregnant women or those who may become pregnant within 2 months following immunization (*Wintrobe & Thorn, 1974*).

Because of the high incidence of birth defects, abortion should be considered seriously in any case of rubella found during the first 3-4 months of pregnancy, when infection is most likely to result in congenital anomalies (*Sataloff and Sataloff, 1992*).

2) Heredity: Hereditary factors can be implicated in about one-third of hard-of-hearing patients. However, only a very small number of these people develop hearing loss before the age of 19; even fewer have it at birth. Nevertheless, it is important to consider genetic or hereditary hearing loss in the differential diagnosis of all cases of hearing impairment (*Sataloff and Sataloff, 1992*).

With the exception of periods of rubella epidemics, the leading cause of deafness is genetic factors (*Vernon, 1987*). There is strong evidence that congenital hearing impairment runs in some families. A tendency toward certain types of adventitious hearing loss may also be inherited. Even though 90% of deaf children are born to hearing parents, various surveys have found that a high percentage of deaf students have relatives who are also hearing impaired (*Moores 1987*).

More than 200 types of hereditary or genetic deafness have been identified. The common syndromes are:

- Alport's Syndrome:

This partially sex-linked, autosomally transmitted syndrome may be detected during the first week of life by the presence of haematuria and albuminuria. Hypertension, renal failure, and death usually occur before the age of 30 in males. Females demonstrate a much less severe form of the disease (*Proctor, 1978*).

The hearing loss is progressive, bilateral, and cochlear. It generally is first detected when the patient is about 10 years old. This syndrome is estimated to account for about 1% of hereditary deafness. Treatment consists primarily of controlling urinary tract infections and renal failure. Frequently, the need for ototoxic drugs for urinary tract infection complicates the hearing loss (*Proctor, 1975*).

Approximately 10 other recognized syndromes combine hearing loss with renal disease. This frequent association warrants a routine urine analysis in the evaluation of sensorineural hearing loss, particularly in children and young adults (*Sataloff and Sataloff, 1992*).

• Waardenburg's Syndrome:

This dominant syndrome includes partial albinism classically seen as a white forelock of hair, laterally positioned medial canthi, different colored irises, and congenital non-progressive sensorineural hearing loss (*Waardenburg, 1951*).

Vestibular abnormalities and temporal bone radiological abnormalities may occur (*Proctor, 1978*).

The deafness may be total with only slightly residual hearing in the lower frequencies; moderate, with near - normal hearing in the higher frequencies and severe loss in the low frequencies; or unilateral with near - normal hearing on one side (*Schuknecht, 1974*).

Only 20% of patients with Waardenburg's syndrome demonstrate hearing loss; however, Waardenburg's syndrome accounts for about 1% of all hereditary deafness. At present, no treatment exists other than sound amplification when applicable. Genetic counseling is relevant in these cases (*Proctor, 1975*).

Pendred's Syndrome:

Nearly 10% of hereditary sensorineural loss is associated with the recessive syndrome of non-endemic goitre and deafness (*Proctor, 1975*).

The disease involves abnormal iodine metabolism and appears to be caused by absence of the enzyme iodine peroxidase. The thyroid enlargement usually appears around 8 years of age, but in some cases it may be present at birth. The hearing loss is usually congenital, bilateral, sensorineural, and moderate to profound, and it is usually worse in the high frequencies. There may be slow progression during childhood. More than 50% of these patients have a severe hearing deficit (*Kongismark and Gorlin, 1976*).

Vestibular function frequently is abnormal, although vertigo is uncommon. Inheritance is autosomal recessive. Several laboratory tests, including the perchloride test and the fluorescent thyroid-image test, aid in establishing the diagnosis of this syndrome. Therapy should include thyroid replacement, and the hearing loss must be treated symptomatically (*Anderson, 1974*).

The disease must be differentiated from endemic cretinism with deafness, which may be found in areas where iodine is missing from the diet. However, cretinoid features are absent in Pendred's syndrome (*Lindsay, 1973*).

Familial Streptomycin Ototoxicity:

In several families, even low doses of streptomycin have produced severe ototoxicity with impairment of vestibular functions. Inheritance appears to be autosomal dominant but may be multifactorial. Before prescribing any ototoxic drugs especially streptomycin, a careful history of prior exposure to ototoxic drugs, as well as familial sensitivity to such drugs, is required (*Kongismark and Gorlin, 1976*).

No Associated Anomalies:

Recessive sensorineural hearing loss without associated defects is the most common form of hereditary hearing loss (*Schuknecht, 1974*). It is usually not progressive and generally is congenital, bilateral, and may vary from mild to severe. Certain audiometric patterns, are characteristic of hereditary hearing loss. Vestibular function is normal. X-linked inheritance may also occur (*Kongismark and Gorlin, 1976*).

Dominant sensorineural hearing loss first occurs between the ages of 6 and 12 years. The hearing loss is most commonly bilateral, progressive, and high frequency (*Proctor, 1978*).

Hereditary progressive sensorineural hearing loss is also quite common and may be dominant or recessive. Colloquially, this condition is often referred to as genetic deafness. This condition is characterized by sensorineural hearing loss that gets gradually worse over time. It is most commonly worse in the higher frequencies (*Sataloff and Sataloff, 1992*).

Reviews of the literature on causal factors in childhood deafness, in fact, indicate that somewhere between 25 and 50 percent of all childhood deafness is due to heredity (*Hoemann and Brigaa, 1981*).

3) Prematurity and Complications of Pregnancy:

These factors appear to increase the risk of deafness and other disabling conditions. It is difficult to precisely evaluate the effects of prematurity on hearing impairment, but early delivery and lower birth weight have been found to be more common among deaf children than among the general population (*William and Michael, 1992*).

Complications of pregnancy arise from a variety of causes:

Rh Incompatibility:

The hearing loss in Rh-incompatibility is usually bilateral and more severe in the high frequencies. Genetically, the infant born of a woman's first pregnancy is not affected because the mixing of fetal and maternal blood that initiates the immunologic process usually occurs at the time of delivery of the first child. Subsequent Rh-positive children may then suffer severe haemolysis during fetal development, because of the persistence of maternal antibodies to the Rh factor which recognize antigenic fetal red blood cells.

Modern developments have made this type of hearing loss preventable in most patients. Rh screening should be done routinely before parenthood. When Rh incompatibility exists, the mother should be treated in the immediate post-partum period with the drug "anti D". This immunoglobulin effectively suppresses the formation of maternal antibodies to the Rh factor. The drug also should be given following miscarriage, abortion, or ectopic, because these events may initiate the immunologic mechanism by introducing a small number of Rh positive red blood cells into the maternal circulation.

Hypoxia:
Oxygen deprivation in the neonatal period may produce sensorineural hearing loss. This connection may explain the increased incidence of deafness associated with traumatic, cyanotic, or premature birth, although the causal relationship has not been proven. Children who have suffered a complicated delivery should be screened (*Schuknecht, 1974*).

Neonatal Jaundice:
Kernicterus (encephalopathy associated with severe unconjugated hyerbilirubinemia) has long been known to cause sensorineural hearing loss. It is unclear whether the primary site of damage is peripheral, central or both (*Schuknecht, 1974*).

Rh or ABO blood group incompatibility between mother and child is one of the most common causes, although several others, such as hepatic and biliary dysfunction, can be responsible. Acute bilirubin encephalopathy is most likely to cause damage between the third and seventh days of life. Regardless of the cause, hyperbilirubinemia should arouse suspicion of hearing loss. Hearing screening is recommended (*Barnett and Einhorn, 1972*).

A.I.D.S.:
The A.I.D.S. clinical syndrome is characterized by immunodeficiency, frequently complicated by opportunistic infection and neoplasia. AIDS-related diseases may affect every body system, including the head and neck. Patients with AIDS are particularly susceptible to infectious agents including viruses, bacteria, and fungi. Pneumocystic carinii infection has been found in the external and middle ear. These infections are associated with mixed conductive and sensorineural hearing loss (*Sandler, 1990*).

Viral infections of the head and neck are common in AIDS patients, particularly those caused by cytomegalovirus (CMV), Epstein-Barr virus (EBV), human papilloma virus, and the herpes virus, both simplex and zoster. All cranial nerves may be affected. Herpes zoster is particularly likely to involve the eighth cranial nerve, causing hearing

loss, vertige and often severe pain and facial paresis or paralysis. HIV - associated syphilis may also be responsible for sensorineural hearing loss.

Hearing loss may be caused not by the great number of opportunistic otologic infections associated with AIDS, but also with drug-induced ototoxicity, central nervous system toxoplasmosis, and meningitis. The HIV virus itself is known to be neurotropic and may be itself capable of causing eighth nerve dysfunction including hearing loss. (*Coleman, Creen and Archibold, 1987*).

4) Meningitis and Other Infections:

Meningitis :

The leading cause of adventitious hearing impairment is meningitis. It is bacterial or viral infection that can, among its other effects, destroy the sensitive acoustic apparatus of the inner ear. Difficulties in balance may also be present. *Brown (1986)* reports that children whose deafness is caused by meningitis generally have profound hearing losses but are not likely to have additional handicapping conditions.

The hearing loss is bilateral in approximately 80% of cases and partial in about 70%. Many patients suffering partial hearing loss recover to some extent. However, any patient with meningitis, especially a child, should have a hearing evaluation upon recovery (*Nadol, 1978*).

Otitis Media:

Probably the most common problem of the middle ear is otitis media, which occurs in about 5 percent of all children before the age of 10 (*Martin, 1975*). Otitis media is usually caused by infection, which may spread from the Eustachian tube to the middle ear, with which it is connected.

If untreated, otitis media can result in a buildup of pus and ruptured eardrum, causing permanent conductive hearing impairment (*William and Michael, 1992*).

Mumps:

Mumps appears to be the most common cause for total unilateral loss in the United States. Interestingly, the vestibular system is affected rarely. Because the disease often occurs in childhood and because children are so adaptable, deafness may not be recognized for many years if hearing in the unaffected ear is normal. The deafness is almost always total and unilateral. So when these patients are tested, the ear that has normal hearing must be masked carefully to avoid crossover and false impression that patients have residual hearing (*Staloff, 1966*).

Mumps is probably the most common cause of unilateral severe cochlear hearing loss in children. In effect, mumps ear is usually a non-functioning ear and cannot be used for hearing-aid amplification.

Rubeola and Other Infections:

Measles (rubeola), cytomegalic inclusion disease, herpes, roseola, infectious mononucleosis, varicella, mycoplasma pneumonia, typhoid fever, scarlet fever, influenza, and other infections have also been associated with sensorineural hearing losses (*Paprella, 1973*). The hearing loss may be severe or profound and may be sudden or gradually progressive. So far, only symptomatic and preventive therapy is available. These diseases may occur in adults, in children, and in utero. Particular effort should be made to protect pregnant mothers from exposure to these infectious agents. Measles and scarlet fever also are notorious for their destruction of the eardrum and middle ear.

Flu:

The "Common Cold" often has an associated earache which may result from referred pain caused by pharyngeal inflammation or from otitis media. When the illness is bacterial, otalgia may be due to otitis media secondary to pneumoccus, Haemophilus, streptoccus, or staphyloccus. In newborns, gram-negative organisms such as Escherichia coli are common pathogens. When the illness is viral, viruses often can be cultured from the middle ear fluid, although, this is rarely necessary (*Neu, 1977*).

DIAGNOSIS OF DEAFNESS IN CHILDREN

History:

The earlier a hearing impairment is identified, the better a child's chances are for receiving treatment and thus developing good communication ability, which is essential for learning both academic and social skills. If a child's hearing impairment goes unnoticed until the age of 5 or 6, when children usually enter school, countless opportunities for learning will surely have been lost (*William & Michael, 1992*).

Despite modern audiological techniques, hearing impairment still goes undetected in many children. All infants, hearing and deaf alike, babble, coo, and smile. Later on, deaf children tend to stop babbling and vocalizing because they cannot hear themselves or their parents, but a baby's silence may be mistakenly attributed to other causes. Unfortunately, many hearing impaired children have been erroneously labeled mentally retarded or emotionally disturbed. Some have even spent years inappropriately placed in institutions because nobody realized that their problem was deafness rather than mental retardation or emotional disturbance. To avoid such misplacements in the future, efforts are continually made to conduct screening tests for hearing impairment and to educate doctors, teachers, and parents to recognize the signs of hearing loss in children (*William and Michael, 1992*).

The accurate assessment of hearing in young children is a highly specialized work of a team of experts, but much valuable information can be obtained from a careful and detailed history. Congenital deafness most commonly presents itself through lack of response to speech or through lateness or defect in the child's own speech. The hearing should be investigated with the utmost thoroughness in any child whose speech developed later or badly.

It is true that the backward child is late in talking and that there do appears to be some families in whom, for no apparent reason, speech develops late in several of their members and sometimes in several generations. It is also true that little or nothing can be done to hasten the speech of the backward child or the familial late-talker. But herein lies the difference: Something can and should be done for the child whose speech is retarded by deafness and his language can be developed to its fullest potential if his handicap is recognized early and training is begun without delay. *(Rutter, 1973).*

The more severe the deafness, the earlier to be detected by the parents. In cases of total or subtotal deafness it is mostly suspected within the first year, usually because the child shows none of the normal reactions to the loud noises.

Many children who are born partially deaf learn to lip-read quite spontaneously. They listen with their eyes and deafness should always be suspected in the child who looks with rapt attention at the speaker's lips

When a mother thinks her child is deaf, she is very rarely wrong and it is unforgivable to dismiss a mother's conviction without a most careful and thorough examination of the hearing.

With the rare exception of congenital atresia of the external auditory canal, physical examination of the ears is entirely negative and X-Rays are of limited value. Since the deafness is of the sensorineural type in the vast majority of children born deaf, their handicap can be diagnosed only by the functional examination of hearing *(Perrin & Mc.Lean, 1988)*.

Diagnostic Tests in Infants and Young Children:

In testing the hearing of adults, we ask them to tell us whether or not they hear certain sounds. It is obviously impossible to do this with infants and young children, and we must employ a variety of play techniques in which the child is taught to do something, not to say something, every time he hears a sound.

The first requirement of all hearing tests in young children is a natural and friendly atmosphere. A separate room is essential and it should be effectively sound-proofed. Small tables and chairs must also be available, together with a good selection of toys and testing apparatuses.

No child will co-operate fully until he has been allowed to settle in, and one must be prepared to allow at least a half, often three-quarters, of an hour for each child at each attendance. Several attendances may be necessary, preferably at short intervals, before he has learnt to know his new friends and to enjoy the games he is asked to play with them. The interview can only be regarded as entirely satisfactory when the child is reluctant to leave at the end of it ! *(Bellman, 1987)*.

Some of the children who attend audiology clinics have already had experience of hospital, and every doctor or nurse is likely to be associated with pain or discomfort.

It is not surprising that the child's confidence in the "man in white" is almost certainly undermined , and the team of an audiology unit should dress normally. 'No white coats' should be the rule.

It is of the utmost importance to establish rapport with every child and the first lesson to be learnt by those who are not familiar with the handling of children is that one must be prepared, quite literally, to get down to the child's own level - if necessary, on bended knees.

In performing full diagnostic tests of hearing, it is customary nowadays to start always with faint sounds, but the final range of testing sounds must depend ultimately on the degree of deafness and this can often be anticipated by careful attention to the details of the history. The choice of tests is based much more on the experience than on any written formula. It must be remembered that one is referring not to the child's chronological age but to his mental age, and that the backward child will respond at a considerably lower level than the brighter one. *(Aichorn 1964).*

Most of the tests of hearing in infants and young children can be said to fall into one or other of the two main groups: simple distraction techniques and conditioning techniques:

A- Distraction Techniques:

It is rarely possible to train a child to perform a purposeful conditioned response to sound before the age of about 3 to 3 1/2 years. In children under this age we must therefore look for simpler responses.

In testing the small child; it is of the utmost importance that to make him able to see or feel the source of the testing sound. The child who is deprived of hearing at, or soon after birth will often develop his other senses to a remarkable degree and we must be careful not to cast shadows over him as we approach. The child may even turn to the odour of a highly scented hair-cream or face powder. *(Baker, 1971).*

Before testing, he must be distracted by his toys. If he is not distracted at all, he will tend to look a round and watch the person who is going to test him; if he is distracted too much, he may become so engrossed in the game he is playing that he will not respond to sounds which are within his hearing capacity. It is not easy to distract an infant just enough (not too little and not too much) but it is pointless to begin any formal testing until this point has been reached.

The new-born baby usually respond to loud sounds with the so called Moro or "Startle" reflex which is "a sort of jerky extension of the spine and limbs, followed by a quick bowing movement of the arms over the chest, usually accompanied by a cry". This general withdrawal response is a primitive protective reflex and is present up to the age of about six months, but thereafter the child begins to localize sound and commonly responds by a simple turning of the head towards their source. Sometimes the response is so slight that it can only be recognized by the highly skilled observer. *(Knoph, 1979)*

The child may blink or open his eyelids, occasionally he will give a faint smile and not uncommonly, in the first year of life, the response is a 'negative' one, in so far as he will merely cease to do whatever he is doing at the moment when he hears the testing sound.

Perhaps the easiest time to test the infant is that short period of the half-awareness when he is just about to wake from the natural sleep.

A variety of testing sounds will have to be used before one can gain a fairly accurate impression of the hearing capacity and no test of hearing can be regarded as complete until some attempts have been made to assess the child's reaction to the human voice.*(Steer et al.1961).*

B- Condition Techniques:

From the age of about 3 or 3 1/2 years onwards, attempts can be made to 'condition' the child to carry out some simple act every time he hears a sound.

The child is seated at a small table with a nest of coloured beakers, opposite to him sits the observer and beside him the examiner. The child is encouraged to look and to listen as a xylophone bar is struck and after the observer has picked out the beakers two or three times, she holds the child's hand on the top remaining beaker and helps him to lift it out when he sees or hears the xylophone being struck again by the examiner. This is repeated as often as necessary until he appears to understand what is required of him. He is then allowed to do it by himself. As soon as he has learnt this "look and listen" game, the examiner goes behind him and the observer beckons him to listen. Every time he hears the sound, he will now pick out another cup and the examiner can go further and further away from him until he finds the greatest distance at which the child responds to this particular testing sound.

C- Audiometry in Children:

All the above tests, distraction and conditioning, are known as "free field" tests because the testing sounds are made in a free field at some distance from the ears. Both ears are therefore tested at one and the same time and it is difficult or impossible to exclude unilateral deafness by these methods.

The experienced technician can usually produce a reliable theshold response at about the age of 3 or 3 1/2 years. Occasionally there is some initial difficulty in persuading a child of this age to put on the headphones of the ordinary audiometer.

In 1947 Dix and Hallpike described their "peep-show" audiometer in which no headphones had to be worn. Seated in front of the peep-show, the child was conditioned to press a button every time he heard a sound, and each time he presses, a picture is lighted up. *(Corenll, 1986)*

The development of sophisticated instruments and techniques has enabled audiologists to detect and describe hearing impairments with increasing precision. Most instruments used to test hearing now incorporate computers into their design (*Kelly, 1987*).

To obtain a hearing level on an audiogram, the child must be able to detect a sound at that level at least 50% of the time. A child with a hearing impairment does not begin to detect sounds until a high level of loudness is reached. For example a child who has a 60 dB hearing loss cannot begin to detect a sound until it is at least 60 dB loud, in contrast to a child with normal hearing, who would detect that same sound at a level between 0 and 10 dB.

Degree of Hearing Impairment:

An individual's hearing impairment is usually described by the terms mild, moderate, moderately severe, severe, and profound as follows:

Hearing level	Range (d.B.)	Hearing level	Range (d.B.)
Normal	- 10 - 26	moderately severe	56 - 70
mild loss	27 - 40	severe	71 - 90
moderate loss	41 - 55	profound	91 or more

(*William and Michael, 1992*)

The level of hearing loss required for children to be considered deaf for educational placement purposes has changed considerably over the past decodes. In the 1960, many children with average hearing losses of 50, 60 or 70 d.B were routinely enrolled in special schools and classes for deaf children. Today, however, those children are regarded as hard of hearing rather than deaf, thanks to improved methods of testing, amplification and teaching. According to *Connor (1986)*, "Only children with losses greater than 90 d.B who had prelingual losses should be considered deaf".

PREVENTION OF HEARING HANDICAP

A- Prevention of Ear Disease:

The most relevant measures for prenatal prevention of ear disease have been given by *Bergstrom (1976)*:

- Prior to Conception:
  Rh-immune human gamma globulin.
  Rubella vaccine
  Influenza vaccine
  Genetic counseling for those with history of hereditary deafness.

- During Pregnancy:
  Adequate treatment of maternal syphilis.
  Avoidance of teratogens (irradiation and drugs).
  Avoidance of ototoxic drugs.
  Avoidance of potential hypoxia.
  Intrauterine transfusion for erythroblastosis foetalis.
  Amniocentesis for genetic and certain viral diseases.
  Interruption of pregnancy if indicated.
  Meticulous prenatal care.

- After Labour:
  Avoidance of ototoxic drugs.
  Avoidance of high noise level exposure.
  Avoidance of any foreign objects in the ear.
  Avoidance of measles, scarlet fever and meningitis.
  Proper treatment meningitis.
  Aural hygiene.
  Adequate nutrition.
  Proper medical care for otitis media.

B- Prevention of the handicapping effects through early identification and education:

The occurrence of ear disease is unavoidable, but there are measures that will prevent the impact of its effect on those who suffer from accompanying hearing loss. Early identification of the hearing loss and proper educational procedure can ameliorate in large part the devasting effects that can result. In these terms both hearing screening procedures and zealous educational methodologies can be seen as preventive measures.

Screening tests of hearing in infants and young children:

The diagnosis of congenital deafness is still far to be established. How often one hear the tragic story from the mother of a deaf child that she has taken her worst fears to her family doctor, only to be told that "he'll be all right when he's a little older" or "lots of children speak

late" or "nothing can be done till he's five, so don't worry"?. Not uncommonly she has tried for months or even years to persuade her medical attendants that her child is deaf, before the chance meeting with another parent of a deaf child or the chance reading of some journalist's story brings her to some special clinic where facilities exist for the diagnosis and treatment of the handicap. Congenital deafness can and should be diagnosed in the first year or so of life and that no child is too young to have his hearing examined. *(Bellman, 191187)*

It has been argued that such screening tests should be limited to those children who are known to be, for one reason or another, "at risk". These include:

- all children who have a family history of deafness.
- all children whose mothers have had rubella or other virus infections in the first three or four months of pregnancy.
- all babies who have had any birth injury.
- all children who may have acquired deafness in the early months of life especially from meningitis or measles.
- all children with cerebral palsy or other congenital abnormalities.
- all children who have delay or defect in speech.

In all screening tests, every child who fails to produce normal responses must be referred as soon as possible to a specialized clinic, where the cause of failure will be determined. It is customary to use faint sounds to which the normal child is likely to respond, but the choice of the actual method will depend, of course on the age of the child, and there are at least two age-groups in which these tests should be carried out; sometimes during the first year of life, and as soon as possible after entry to school at the age of 6. In addition, the hearing should be screened, in any child whose progress stops suddenly. *(Sanders, 1971).*

The "First Year" Test:

All children should be examined within the first year of life and it is not suggested that the screening tests of hearing should be carried out as isolated tests, but rather that they should be incorporated within the framework of the general examination.

The normal infant is easily tested between the 7th and 9th months, when it is a relatively simple matter to examine him with the distraction techniques. The sounds used should be faint but it is also important that they should be meaningful. A child at this age will pay little or no attention to the banging of a drum or the clapping of hands, but he will nearly always react briskly to the much fainter sounds which have meaning to him in his everyday activities; the soft call of his name in his mother's voice, the sound of his rattle; or the clinking of a spoon on a cup; especially if he is bottle fed.

The child, seated on his mother's lap, is distracted by an observer and the test can be started as soon as he has settled down. Each ear should be examined separately at a distance of 3 feet or more, and the examiner should stand to each side of the child, just outside the range of vision. The normal reaction of the hearing child is brisk turning of the head but he will often show no response at all if the sound is made immediately behind him or immediately above the head.

These simple distraction tests will certainly pick out children with severe degree of hearing loss and, if they are properly performed by a skilled examiner, will also bring to light some of the slighter degrees of partial deafness in many other children.

The Primary "School Entry" Test:

As soon as possible after the age of 6 years, every school entrant should have a further screening test. This serves to pick out those children who have passed through the coarser mesh of the earlier screen; it will also pick up those who have acquired deafness in the intervening years, or those who suffer from a progressive deafness of congenital origin.

The method most widely used is the "sweep frequency" test . It can be performed by the experienced operator at the rate of one child every three minutes, but it is a pure tone test and does not tell us anything about the child's understanding for speech. It should therefore be combined with another "voice and whisper" test. The words should be spoken in a whispered voice at a distance of 6 feet and the child will pass the test if he can hear and understand all the words in each ear at this distance. *(Bitter, 1976).*

PSYCHOLOGICAL AND BEHAVIORAL CHARACTERISTICS OF THE HEARING IMPAIRED CHILDREN

Hearing loss can have profound consequences for some aspects of a person's behavior and little or no effect on other characteristics. Everyone knows the question, "if you were forced to choose, which would you rather be - blind or deaf?" On first impulse most of us choose deafness, probably because were rely upon sight for mobility and because many of the beauties of nature are visual. But in terms of functioning in language-oriented society, the deaf person is at a much greater disadvantages. (*Hallahan and Kauffman, 1982*).

Language Skills:

Hearing impaired children - even those with superior intelligence and abilities - are at a great disadvantage in acquiring language skills. A prelingually hearing impaired person must exert a great deal of effort to read and write with acceptable form and meaning (*Norris, 1975*).

When standard measures of reading and writing achievement are used with deaf students, examiners typically find that the student's vocabularies are smaller and their sentence structures are simpler and more rigid than those of hearing children of the same age or grade level. Many deaf students tend to write sentences that are short, incomplete , or improperly arranged. They may omit endings of words and have difficulties in differentiating questions from statements. (*Meadow, 1980*).

The vast majority of hearing-impaired people do have some speech. The old term "deaf-mute" reflected the attitude that deafness automatically means an inability to speak. The current view is that although hearing impairment is a great barrier to normal speech development, there are very few, if any deaf individuals who cannot be taught some speech. One of the reasons for this change is the growing body of evidence that almost no children are born with absolutely no hearing sensation. *Fry (1966)* claimed that when a child is said to be unable to hear at all, the diagnosis may be the result of the wrong testing methods and faulty observation.

The fact remains that, without extensive training, the hearing impaired child will not develop normal English language comprehension and production. *Carhart (1970)* noted that the child who is totally deaf will grow up mute without special training.

Those who lose hearing after having been exposed to the experience of speech, even for as short a period as one year, can be trained much more easily in all language arts, even if formal training begins some years after they have become deaf. It seems as if even a short exposure to language, a brief moment during which the curtain has been lifted and oral communication established, is sufficient to give a child some foundation on which much later language training can be based (*Lenneberg, 1966*).

Many factors cause the child born with a hearing impairment to have a more difficult time with English language acquisition than the child who acquire an impairment after a period of time. Three of the most obvious disadvantages the hearing-impaired child faces are that:

- He receives inadequate auditory feedback when he makes sounds.
- He receives inadequate verbal reinforcement from adults.
- He is unable to hear adequately an adult language model.

Inadequate auditory feedback and verbal reinforcement are often cited as reasons for the deaf child's particular pattern of babbling as an infant (*Ling and Ling, 1978; Schow and Nerbonne, 1980*). The deaf infant enters the babbling stage at the same time as the normal infant, but soon abandons it. It is though that this is because normal infants are reinforced by hearing their own babbling and by hearing the verbal responses of adults. The deaf child, not being able to hear himself or others, is not reinforced. The lack of feedback has also been named as a primary cause of the deaf child's poor speech production. As *Fry (1966)* stated, the normal child learns to associate the sensations he receives when he moves jaws, mouth and tongue with the auditory sounds these movements produce. The hearing-impaired child is obviously handicapped in this process. In addition, the hearing impaired child is deprived of an adequate adult model. He has a difficult time hearing the sounds of adults speech which the normal child can imitate.

For most children, the educational process builds on the impressive linguistic skills the child has already acquired to develop expertise in academic areas such as arithmetic, science, social studies, and reading. For deaf children the mastery of such linguistic skills can not be used as a basis for instruction. Rather, much of the curriculum is designed to teach deaf children basic English skills and concentrates on individualized instruction in speech, English grammar, and use of residual hearing. It is mentioned here to emphasize how the importance of language and communication overrides so many aspects of the development and functioning of the deaf individuals (*Moores and Moores, 1989*).

Individuals with similar losses may process speech very differently from one another, as a result of a variety of factors. These factors influence the success or failure of the hard of hearing child in

educational or social situations. Included factors are the type, extent and onset of the loss, the progression of the loss, if any; the onset of use of amplification, the onset of habilitations especially auditory training, the expectation of the family and teachers as well as those of the hearing-impaired child; academic; perceptual and cognitive potential and opportunity for learning. These factors can account for varying degrees of communicative and adjustment problems: limited language, poor understanding of speech, and defective speech articulation as well as academic, social and vocational problems. (*Berg, 1971*).

As children are often judged (by adults as well as their peers) on their abilities to express themselves and be understood, it becomes most important that early training include speech remediation with particular emphasis on the rhythm and tonal expression of speech. An interesting, "alive" pleasant voice with much expression adds to the communication situation and fosters further social contact with teachers, peers, family and future co-workers.

Deaf people are far more dependent upon visual language symbols than are hearing people (*Falkenberg and Olsholt, 1991*).

The signed languages of deaf people have shown that fully expressive languages can arise outside the mainstream of spoken languages that exhibit the complexities of linguistic organization found in all spoken languages. Thus the human capacity for language is not linked to some privileged cognitive-auditory connection (*Bellugi, et al., 1989*).

It was found that language ability was not related to any other aspect of peer relations. Thus the impact of language ability seems limited (*Lederberg, 1991*).

Intellectual Ability:

The intellectual ability of hearing-impaired children particularly those classified as deaf, has been a subject of much controversy over the years. There have traditionally been two very different points of view: One states that conceptual ability is deficient in the hearing-impaired because thought depends on language (*Vygotsky, 1962*). The other states that thought is possible without language, so only language-related concepts are difficult for the hearing-impaired. (*Furth, 1964, 1971*) A more recent point of view is that the hearing impaired individual has, in sign language, a true language. Any difficulty he may have on conceptual tasks is therefore due not to poor language ability itself, but rather to inadequate communication between hearing-impaired persons and those around them. (*Liben, 1978*).

Because the influence of hearing loss on English language development is great, many have assumed that cognitive or intellectual development is also affected. This belief has been kept alive primarily

because some psychologists and educators have equated language with cognitive abilities. *Vygotsky (1962)*, for instance, theorized that the early speech of children becomes interiorized as inner speech, and inner speech is the equivalent of cognitive thought. Thus, according to this view the intellectual growth of a person would parallel language development; and a severely hearing-impaired individual would also be handicapped in cognitive ability.

Hans Furth is the strongest advocate of the position that though is possible without language. He believes that deaf children are not necessarily slower intellectually than hearing children. Besides conducting his own studies, Furth (1964, 1971) has reviewed experiments designed to compare the concept development of deaf with hearing children. He concluded that the results support the idea that the thinking processes of hearing and deaf children are similar.

In the late 1970s professionals began to questions Furth's position that language and therefore language-related concepts are deficient in the deaf. More and more professionals are recognizing that manual sign language is a true language with its own rules of grammar (*Bellugi and Klima, 1987 and Wibur, 1979*). They now believe that Furth's position on language must be qualified to mean English language. Any problems the hearing impaired may have on conceptual tasks are due to the relative lack of communication between them and the "hearing" society which uses only standard spoken English (*Liben, 1978*).

The range of intellectual functioning and intellectual ability for deaf children appears to be the same as for hearing children. The major difference between a deaf and a hearing child may not be in innate ability but rather due to the fact that the deaf child as a rule just does not have the same communicative opportunities as the hearing child. Very few deaf children, less than 5%, have deaf parents, so the most parents of deaf children have had no previous exposure to the condition and are not adept in manual communication, i.e., signs and finger-spelling. A common outcome is a child of intellectually normal potential but an experiential and informational deficit. (*Moores and Moores, 1989*).

The main effects of deafness on the intellectual ability have been noticed in the areas of intelligence and educational achievements. These will be presented in turn:

Intelligence:

Research on intelligence of the deaf has been conducted for generations. A review of research in the first half of the twentieth century by *Pinter et al., (1941)*, reported that the results were frequently confusing and even contradictory. However, Pinter noted a definite trend and concluded that the deaf scored around 10 points below the

hearing, placing them within the normal range, but definitely under their hearing peers.

These results were at complete variance with a later review by *Vernon (1967)*, who analyzed 31 studies on deaf children from 1930 to 1966 comparing them either to a control group of hearing children or to hearing norms. He reported that the deaf children had superior scores in 13 of the studies and inferior scores in 11 of the studies. In the remaining 7 studies there were no significant differences in the scores. Vernon concluded that deaf children function as well as the hearing in a wide variety of tasks that measure thinking .

Goetzinger, (1978) concluded that children with hearing loss compare well with hearing children in verbal reasoning when the language is within their understanding and facility. There inferiority and breadth of language are not due to an innate inferiority related to hearing loss.

Hallahan and Kauffman, (1991) found that today most authors agree that if non-verbal tests are used, especially if these tests are administered by sign language, hearing-impaired students are not intellectually retarded.

Anderson and Sisco (1977), standardized the performance scale of the Wechsler Intelligence Scale for Children-Revised, (WISC-R) on a sample of 1228 deaf children and developed norms for deaf children between the ages of 6 to 17 years. They found relatively little difference between the mean score for the hearing (100) and the deaf (96) although there was some variation across subtests; for example, the deaf children, on the average, scored higher than the hearing children on Object Assembly and lower on Picture Arrangement. The benefit of Anderson and Sisco's norms is that it is now possible to evaluate a deaf child's performance on the WISC-R relative to both deaf and hearing peers.

After reviewing many papers on intelligence of deaf, *Moores and Moores (1989)*, concluded that deafness imposes no limitation of cognitive abilities. As a group, deaf people function within the normal range of intelligence and display the same diversity as the hearing population.

Deaf children of deaf parents have a mean IQ on performance tests of intelligence that is significantly higher than deaf children of hearing parents. This is attributed to the fact that hearing parents never use sign or fingerspelling with their deaf children. *(Brill, 1960)*.

A deaf child who has the opportunity to learn and use manual communication from a very early age begins his cognitive growth, which makes it possible for him to utilize the various thinking

processes as a result of having a symbol system. This is reflected by his scores on a performance intelligence test. So early manual communication is beneficial to deaf children (*Meadow, 1960*).

Educational Achievement:

A child's success or failure in school is obviously of importance to the psychologist as well as to the educator. Hence, there have been a number of studies comparing normal and hard of hearing children on such educational indicators as grade repetition and scores from standardized educational achievement tests. Generally, it was found that the hard of hearing repeated more grades and were likely to be retarded in educational achievement (*Cornelius, 1979*).

Henry (1961) studied the impact of low, middle and high frequency hearing loss upon educational achievement. Significant difference in threshold between the best and poorest readers were found for those subjects with middle and high frequency losses.

Fisher (1966) studied vocabulary and basic school subjects in 83 hard of hearing children in the public schools. They has mean hearing level of 38 d.B with a range of 20-64 d.B. Their mean chronological age was 10 years. Although these children were normal in I.Q as measured with the Raven's progressive matrices, nevertheless, they were substantially retarded in vocabulary and in basic school subjects.

Bowe (1972), studied the educational, psychological and occupational aspects of the non white deaf population. He found that the individuals studied appeared to be severely under-educated and under - employed in comparison to white deaf. He attributed these findings to the fact that the non-white deaf are isolated from the hearing, and from the social services by their deafness, race and indirect discrimination.

Sonson, (1976), studied the relationship between sociometric status and reading achievement, and selected variables for integrated hearing impaired children was major topic of his study. He choosed a sample of 42 hearing impaired children of age ranging from 7 to 12.4 and I.Q. 73 to 126 with a mean of 93, the degree of deafness ranged from moderate to profound hearing loss. Age of onset of deafness ranged from birth to four years of age. He found a significant relationship and recommended additional research to be conducted on the performance of hearing impaired children whose age of onset was at a time other than at birth.

Keller (1980), studied the effects of unilateral hearing loss upon educational achievement. Recent evidence suggests that children with relatively minor hearing impairments may be at a developmental disadvantage. A survey was conducted, and 97 children with unilateral hearing losses were identified on the basis of audiometric testing. A comparison of scores (Stanford Achievement Test and Metropolitan

Achievement Test) obtained by the deaf children using class and national norms with 23 sibling controls, yielded no significant differences, although study group scored lower on all subscales. So unilateral hearing loss is considered a risk factor for production of developmental problems.

On the other hand, the results of a study of the relationship between unilateral hearing loss and academic achievement by *Bernero, (1982)* revealed that of five achievement subjects, only language was affected significantly by unilateral impairment. However, the total variance in scores explained by unilateral impairment was only 0.1%. No relationship was found between achievement scores and level of hearing in the impaired ear.

Casey (1982), performed a descriptive study of the academic achievement levels and dermographic characteristics of main streamed hearing-impaired students. Academically, reading and comprehension levels were significantly below grade level with the discrepancy increasing in severity with age. A significant negative correlation was found between reading achievement and severity of the hearing loss. Arithmetic scores were generally higher than those of reading, and indicted low average achievement levels. The correlation between arithmetic achievement and degree of hearing loss was not significant.

In their description of educational achievement of deaf children; *Moores and Moores, (1989)* stated: "There is no doubt that deaf children have consistently scored lower on standardized test of achievement than would have been predicted on the basis of their normal intellectual capacity. As measured by instruments such as Standard Achievement Test, the typical 18-year-old deaf student scores between the fourth and fifth grade level in reading and perhaps around the seventh grade in arithmetic computation. As a rule, the more that a particular subject matter depends on knowledge of English language, the lower most deaf children score on standardized tests".

Moores (1990), said that hearing impaired students are in need of much more intensive instruction, especially in academics, than they typically receive in order to make up for the disadvantages of their hearing loss. This have already resulted in that hearing impaired students with intensive and systematic instruction were only one year below their hearing peers in reading achievement.

Several research studies have demonstrated that deaf children of deaf parents have higher reading achievement than do deaf children of hearing parents. This is due to the ability of deaf parents to communicate better with their children through the use of sign language (*Hallahan and Kauffman, 1991*).

An early identification of the hearing loss less than 75 d.B facilitates the attendance in normal class in ordinary schools. (*Parving, 1992*).

Success in school is an important focus for preventive efforts. Failure in school quickly limits a child's future as it will limit future employment opportunities and is a frequent concomitant of later psychological dysfunction. That is why homebound instruction is necessary for children unable to attend school Tutoring resource assistance or special education may be necessary for children to maintain optimal performance (*Lehr, 1984*).

Personality and Emotional Adjustment:

There have been a number of studies comparing normal and hard of hearing children in emotional adjustment. Historically, *Habbe (1936)*, administered a battery of behavior rating and adjustment scales to normal and hard of hearing subjects equated for chronologic age, school grade, nationality, intelligence and socioeconomic level. He concluded that, the hard of hearing children tended to be more introvertive and submissive than those with normal hearing.

In an important study, Rutter et al., (1970), compared normal and hard of hearing children in several areas of adjustment. Although the two groups did not differ in submissive behavior, there was a tendency for aggression to appear in subjects with hearing losses of greater than 40 d.B. The groups did not differ statistically in introversion - extroversion, yet, there was tendency toward better adjustment in the normal subjects. Children with greater hearing loss appeared to be less emotionally stable. As a result of his study, Rutter concluded that hard of hearing children were not as well adjusted as normal hearing children, and were inclined to be introverted.

There have been a number of studies comparing normal and hard of hearing children concerned with such factors as personal and social adjustment (*Fisher, 1966*), ability to handle frustration and acceptance and rejection by classmates. It was concluded that, differences in personal and social adjustment favoring the normal children were observed when hearing losses were about 40 d.B. (*Fisher, 1966*). Although hard of hearing children were not accepted as well by their classmates, there was a great deal of overlap. It is suggested that his hard of hearing subjects handled their frustration more constructively than their normal hearing controls.

In his attempt to explain the impact of hearing loss on personality, *Silverman, (1970)*, stated that "To understand the psychological changes which accompany the hearing loss, it is necessary first to comprehend how normal hearing operates. In order to make the explanation as simple as possible, we shall discuss normal hearing as though it occurred on three levels:

1) On the social level, hearing is used to comprehend language. Words are symbols for objects around as and for activities. Since language is symbolic in its nature, we shall call this level of auditory function: the symbolic level.

2) Sound also serves as a direct sign or signal for events to which we make constant adjustments in daily living. At this level it is not the word "bee" (which is the symbol for the actual bee itself), but the sound of its angry buzz that makes us jump. This level of auditory function we shall call the signal, or warning level.

3) Finally, and most basically, sound serves neither as symbol nor as warning but simply as the auditory background of all daily living. These incidental noises maintain our feeling of being part of a living world and contribute to our own sense of being alife. We are not conscious of the important role which these background sounds play in our comfortable merging of ourselves with the life around as, because we are not aware that we hear them, nor is the deaf person aware that he has lost these sounds, he only knows that he feels as if the world is dead. The real importance of this third level of hearing is the creation of a background of feeling, which the psychologist calls an affective tone.

"Hearing" is, of course, a combination of all these processes. At any given moment all are going on simultaneously. We hear on all the three levels at same time. We hear the symbols of language, the signal of the ringing of the telephone, and we react to the background of sounds which we do not consciously discriminate and of which we are not aware."

The most obvious handicap which the hearing impaired suffers is in communication, but *Silverman (1970)* argued that "The deprivation of background noises was mot intimately related to the feelings of depression to which the hearing impaired were prone. This was produced by the feeling of detachment, unreality and isolation that deprivation produced". He added that "The deafness accentuates the sensitivity of persons to feel that conversation interrupted upon their entrance into a room must have been about them or that half-heard remarks were critical and unfriendly. Deafness also may make an oversensitive person unduly suspicious of hostility in those around him. Deafness seems to be a powerful stimulus to any latent paranoid trend in the personality. Possibly because of the invariable association between depression and deafness".

In his review of the past research, Cornelius (1979) stated that: "In general, the majority of the research has indicated that deaf children are not as well adjusted as their hearing peers. In addition, there is a higher incidence of immaturity among the deaf, and they tend to be

more egocentric, rigid and neurotic. Yet, much that is negative in the behavior of deaf children may be improved through educational and character-forming procedures."

"It has been suggested that hearing loss produces psychological disturbance in several different ways:

First, the consequent social isolation is inherently stressful.

Second, communication which does take place will be distorted. The emotional connotations of speech lead to loss of loudness and time to some hearing-disabled individual. This may lead to limitation of the quality as well as quantity of social interaction.

Third, hearing impairment is stigmatized, and this is inherently stressful.

Fourth, the inability to understand some of what is said produces ambiguity in social interaction. This allows suspicious believes to develop, and this can lead, in predisposed individuals, to the formation of delusions of persecution. It is not clear if other delusions, for example of grandeur, are also suggested to occur. Paranoid states encompass delusions of persecution and of grandiosity. Certainly there seems no reason why hearing disabled should not be susceptible to both (*Stephens, 1987*).

One of the research work reviewed by *Moores and Moores (1989)*, reported that deaf subjects were egocentric, irritable, impulsive and suggestible. The stated that: "Recently, there has been growing interest, but little information, concerning social-emotional adjustment of deaf students in mainstreamed settings and of acceptance by hearing peers. One of the authors (*Moores, 1978*) currently is involved in a study of students in public schools in self-contained and integrated classes. Preliminary results suggest a somewhat lower self-image among the integrated students. However, this cannot be considered as caused by class placement".

Mahapatra (1974), reasoned that most of the psychological effects of hearing loss would be expected to appear at a higher degree in patients with a bilateral loss, rather than an unilateral loss.

Boyce and Vernon (1970), stated that: "Hard of hearing seem to reflect more psychological disturbance than the deaf. They frequently share the problem of marginal people in any group, that of identification. A person born hard of hearing may not be able to find full acceptance among the normal-hearing or the deaf. Whereas association with the hearing ideally offers a wider range of friends and interests, it may be at the price of frequent rejection or a subservient role. Association with the deaf is sometimes perceived as psychologically threatening in the sense that deafness is a magnification of their own real or perceived deficiencies".

Social Adjustment:

Social and personality development in the normal population depends heavily on communication. Social interaction, by definition, is the communication of ideas between two or more people. In the hearing population, language is by far the most common way messages move between people. Because of the heavy dependance on language, it is no wander that many investigators have found the hearing-impaired to have personality and social characteristics different from those of people who have normal hearing ability (*Mc Connell, 1973*).

As Meadow (1975) has pointed out, severe emotional disturbances are more prevalent in the deaf than in the hearing. Rather, the deaf have more "problems of living": higher arrest rates, and more marital, social, and vocational problems.

Whether or not a hearing-impaired child will develop behavioral problems depends on how well others in his or her environment accept the disability (*Moores, 1978*).

As with other physical and sensory impairments, it is not the hearing impairment itself but how individuals in the child's environment, particularly parents, respond that determine whether the child will show behavioral problems. When there is only one deaf child among the family of hearing persons, it often happens that the deaf child is excluded from the affairs of the family. It is tedious for a hearing member of the family to explain things to the deaf child, and it is easy to leave the deaf child out of the family discussions and decision making. Meanwhile, hearing children not only hear, they overhear much of what goes on in the home, even the fights that their parents have and their telephone conversations with personal and business associates. The deaf child does not benefit from this informal education about the affairs of living, and such an experiential deficit can have long-lasting effects on the child's social adjustment and development of social competence (*Hoemann and Briga, 1981*).

Because they are frequently cut off from communicating with the population of large, hearing-impaired children often grow up in relative isolation. This is particularly true if they do not have hearing-impaired parents and peers with home they can interact nonverbally. It is probably the need for social interaction and acceptance that is the most influential in leading many hearing-impaired individuals to associate only with other hearing-impaired persons. The hard of hearing, and especially the deaf more than any other disabled group, tend to mix socially with people like themselves (*Hallahan and Kauffman, 1982*).

Of all physical disabilities, deafness is the only one that makes its members part of a natural community. Therefore, although we do not find blind or crippled subgroups in society, we are justified in referring

to a deaf community as societal subgroup. This major difference between deafness and other disabilities must never be forgotten. Deafness creates an underlying community that provides for all but a few individuals a social-psychological basis of belonging. This belonging to a community is probably the single most important factor working in favor of the deaf individual (*Furth, 1973*).

Meadow (1980) concluded that the overportectiveness found in most families with hearing parents and a deaf child probably retards social development.

Moores and Moores (1989) stated that the development of a healthy, early parent-child relationship faces many difficulties in families with hearing parents and deaf children.

The social adjustment of the hearing-impaired children may be deficient. The hearing-handicapped as a group are not as well accepted by their normally hearing classmates, although there may be a wide range of acceptance of hearing-handicapped children as individuals.

Poorer general classroom performance and social adjustment were noted by teachers for the hearing-impaired children in their regular classes, compared with the normally hearing peers, while pupils in special classroom programms (hard of hearing and oral-training units) generally are rated in the acceptable range of social adjustment by both special and regular classroom teachers. Parents of hearing-impaired children in regular classes judged their children to be less popular with other children, to strain more frequently in listening to conversation, to be less interested in conversation, and tire easily or appear restless, to understand other children less frequently while playing, and to play the radio or T.V. too loudly. They noted their hard-of-hearing children tending to need more parental approval, interrupting others while talking, and using their hearing losses as the basis for their problems. Normally-hearing children described their hearing-impaired peers as being quite, not speaking plainly, and having problems that sometimes make school difficult (*Steer et al., 1961*).

The behavior of hearing-impaired children who use amplification can vary tremendously from child to child, even with those who have similar losses. This is affected by many factors, particularly significant are the child's use of his residual hearing, his own self-image and his communication skills. An educational programm that emphasizes children's use of visual cues (speech reading or finger-spelling and sign language) will produce children who monitor their world visually. Educational programms that emphasize listening skills, regardless of the extent of the unaided loss, will produce children who are able not only to monitor their worlds auditorily but often to make better use of combined visual and auditory cues, as well. (*Martin, 1975*)

IMPACT OF DEAFNESS ON THE FAMILY

The problem of the deaf from birth is quite different from that of the man or woman who has become completely deafened after school age or in adult life. The hard of hearing person whose deafness has developed slowly over the years is different again. But for all of them the handicap is the same - the handicap of the silent world, the difficulty of communicating with the hearing and speaking world.

The child who is born deaf, or who has acquired deafness early in life, is subjected to all the frustrations of the hearing child. But to these, it is added the further frustration of his inability to communicate with his family and friends by the quickest method possible - speech.

The family is a delicately poised system designed to meet the needs of its individual members. The "intrusion" of the handicapped child often disrupts the delicate balance and, therefore, families frequently need help to restore a healthy dynamic in which all members can nurture their personal growth.

Parental Reactions:

Parental reactions to the handicapped child are predictable, regardless of what specific handicap is involved, and include: anxiety, shock, denial, guilt, anger, fear and hopefully, eventual acceptance. The severity of the hearing loss will have a direct relationship to the intensity of these reactions. A profound bilateral loss is easier to detect because of the consistent lack of responses to normal environmental sounds and will be noticed earlier than a mild to moderate hearing loss. The later can be discovered early if there are hearing sublings in the family who serve as a basis of comparison for the family (*Ross et al., 1964*).

Adams (1987) stated that the reaction of parents of the deaf takes the following forms:

a) **Anxiety:** The parent's anxiety about their suspicions usually leads them to seek a diagnosis, hoping that their suspicions will be proved false. Once the hearing loss is confirmed, parents frequently respond with denial and seek other opinions, hoping for a diagnosis of normal hearing or a surgically reversible loss. The number of doctors consulted increases with the severity of the handicap.

b) **Shock:** This is a natural defence mechanism and protects the individual from information which he or she does not want to hear.

c) **Denial:** When the protective effects of shock wear off, parents try to find "evidence" that their child can hear. The fat that deafness is an invisible handicap frequently aids parental denial.

d) Guilt: The parents may feel guilt as they search for a cause or something or someone to blame; themselves, the doctors, or God.

e) Anger: Feelings of anger at having a deaf child may be mixed with grief or mourning over the "loss" of the normal child they expected and is examplified in the question "Why me?". Some parents become hostile and bitter and their anger may be directed at the clinician. In cases of suspected genetically-caused hearing loss, there may be parental fears that other children will also be deaf. Cosequently parents may not wish to have more children.

f) Acceptance: Eventually most parents work through these feelings and adjust to, although not always accept, having a deaf child. They take a constructive action to help them. This involves the parents learning about deafness and how it affects the child's development and education.

g) Other reactions: Two disturbed reactions can occur: rejection or overinvolvement. Rejection can be overt and direct or can be covert and more subtle. Overinolvement occurs when one parent, usually the mother, devotes all of her time to the deaf child and to deafness-related activities, ignorning the emotional needs of other family members, including the spouse, siblings and herself.

The impact of a deaf child on the family will vary depending on the following: the emotional stability of the parents, the strength of the marital relationship, the presence of additional handicaps, the religion of the family, the number or siblings and the order of the affected child and the reason and attitude towards the pregnancy.

Having a deaf child causes enormous stress within the family. Other children may feel that they are being ignored and sometimes one parent may feel neglected. Worries about the child's education are very real since there may not be a suitable local school. There is no doubt that having a deaf child throws a considerable financial burden on the family *(Adams, 1987)*.

Psychological Needs of Parents:

Parents need supportive counselling by a trained professional, preferably in a group with other parents of deaf children, to allow ventilation of these feelings and to realize that these feelings are normal. It is also helpful if, during this process, the parents are exposed to deaf adults to realize that profoundly deaf people can live normal and productive lives.

So the parents must accept hearing loss as permanent and irreversible, and also accept the child as a child first and a deaf-child second, and also accept the implications of the hearing loss. The parent

must know basic information about hearing loss: its degree and its kind, child management and future educational planning.

The deaf child is first of all a child and therefore he has the same emotional needs for love, acceptance and security from parents that hearing children have. This cannot be over-emphasized because the development of the child's basic self-concept is dependent upon his relationship with his parents. This basic acceptance should include free, easy, unambigious, two-way communication, which for most deaf children means total communication. It also means ensuring that the deaf child feels being included in the family activities but at the same time realizing that some activities may not be appropriate for a profoundly deaf child. Senson impairment can have profound effects on children deveopment. *(Hindley and Brown, 1994)*

Parents of preschool children need help in determining which behaviors or problems are attributable to deafness and which are because of ages or stages of development e.g. parents of two-years old deaf child frequently blame deafness for their child's stubborn, negative behavior without realizing that this behavior is not uncommon in many two-years old hearing or deaf.

Parents also may need help in learning how to avoid being over-protective and thereby restricting the deaf child's range of opportunities. It is not uncommon for deaf children to be much older than hearing children before learning to ride a bicycle because of parental fear that the deaf child will get hit by a car. Parents may be reluctant to allow a deaf child to go freely around the neighborhood, frequently a younger sibling is sent to accompany his older deaf brother, which adds to the annoyance of the latter. So hearing loss in children is considered one of the important form of sensory deprivation. *(Saad, et al., 1996).*

Parents of older preschool and elementary school- age children are naturally much more interstead in educational possibilities, achievement levels and vocational opportunities.

Age-Related Problems:

There are specific psychological problems which vary with the age of the child; preschool age, elementary school age and adolescence.

Preschool Age: Temper tantrums and lack of communication are two main problems in deaf children. The deaf-preschool child is usually pulled, dragged, taken to various places for evaluation and treatment without an adequate understanding of where, why, or how long. It is not surprising that he may respond frequently with tantrums because the communication barrier results in so much frustrating. Often this is the preschool deaf child's only means of communication. Although

tantrums also occur in hearing children, they have been observed to occur more frequently and persist until later age among deaf children.

The everyday dilemmas of living with a deaf preschool-age child are difficult: How do you convey to a young deaf child with minimal language that "I don't like that behavior but I still love you"?. If a four years old deaf child starts crying after he's gone to bed. How do you determine if he's sick, had a nightmare, is experiencing pain (especially internally), or is frightened by the shadows on the walls?. How do you explain the death of a relative or a pet to a deaf preschooler with minimal language?. This task is difficult even with a hearing preschool-age child but almost impossible without language.

The communication barrier reduces the parent-child interaction because it is easier to abandon communication than to repeat things several times, also frequent repetitions hoping that the child will understand can be frustrating to the parent. As with other handicaps, it becomes easier for parents to do things themselves than to attempt to have the deaf child do them. Hearing disabilities due to their interactive nature, strongly affect intimte relationship that lead to social isolation and emotional impact. *(Hetu, 1994).*

Another factor that serves to damage the parent-child relationship is the effect on the mother of having a child who cannot communicate with her. Most mothers of hearing children find it very frustrating to live with a two-year-old whose speech is only partly intelligible and frequently sounds like a foreign language. But the mother of a hearing child knows that, in another year, this problem will vanish and her child will have the expressive language with which to communicate. Although mothers of deaf children may subconsciously have this hope, their everyday experiences destroy this.

Parents of deaf preschool-age children frequently report two other problems in addition to lack of communication and tantrums; fear of the dark and the desire to sleep with their parents. When a deaf person is put in a dark room, it is extremely frightening because it is similar to being deaf and blind with environmental clues being reduced. When a hearing child is put in a dark room, he can still use his hearing for environmental awareness and realizes that his parents and siblings are still near. The deaf child cannot use audition and thus become terrified. Leaving a night light in the child's room is a simple but effective solution. *(Rutter and Hersov, 1977).*

Of course, the desire of the young deaf child to sleep with his parents is a problem not unique to deaf children. However, judging from clinical experience, it occurs more frequently and is allowed to continue longer than with hearing children. Part of the problem is related to parental guilt over having a deaf child, consequently, their reluctance to punish or set limits is increased. The presence of hearing

difficulties pushed the parents to over protect their children. *(Olweya et al., 1993).*

Professionals have identified additional problems with preschool-age deaf children:

1) The emphasis on formal schooling, which involves sitting and paying attention, and on group conformity at a much younger age than for hearing children.

2) The functioning of parents, particularly mothers, teachers of their children, thereby becoming overinvolved in teaching rather than enjoying their deaf child.

3) The overlooking of emotional needs by parents because they become so involved with the child's speech.

(Best, 1997)

The preschool years are considered the most important years for formation of basic personality and language development and it is in these critical years that the deaf child suffers most.

Elementary School Age: Socialization problems for deaf children with other children usually do not occur until around five or six years of age.

Many children go to a residential school for deaf at this age. Residential placement initially can be traumatic for the child. The child feels rejected and abandoned by the family; contact with the family is difficult to maintain because the child cannot telephone and at this young age cannot read letters from or write letters to the family. Many children in residential schools only go home for holidays which increase the emotional distance from the family, although some residential schools are awars of this problem and are sending children every weekend.

The residential-school tends to be safe and protective environment that insulate deaf children from the "outside" world. Despite these drawbacks, there are two assets: the deaf child socializes with peers with whom he can communicate and identify and also accepting his deafness. Disorders resembling adult ones can occur in childhood. *(Harrington, 1994).*

Adolescence: The identification problems of the moderate to severe hard-of-hearing adolescent present a unique situation. If the child has gone through public schools and aware that he is not hearing. This puts the adolescent in a quandary: He is neither hearing nor deaf. Therefore with which group does he identify?. Having experienced rejection by hearing peers for being "deaf" (although in reality he is not

deaf) he may now experience rejection by deaf peers for being "hearing".

Garretson (1969) discussed the social adjustment of young deaf people, about age of 19 years, leaving a school for the deaf. About 40% partially withdrew from the hearing society into the world of the deaf with its various organizations. About 5 - 10% were taught to deny their deafness, thereby totally identifying with hearing people and rejecting the deaf group. This group met with only partial success because of constant communication barriers. More than half of the young people leaving the school for the deaf accepted their deafness realizing that they are living in a hearing society. They socialized with both hearing and deaf people but their identification was as a deaf persons.

Adolescence is also a difficult time for parents. They become now acutely aware of the jobs for which their child can and cannot qualify. They are truly faced with the reality of having a deaf child.

When the deaf child reaches adolescence, the parent frequently has another crisis and feel that the schools have not been effective in training the child with good communicative and or vocational skills; the child of 16 or 17 years is still not able to communicate. The parent must realize once again the responsibilities of parenting, and a crisis reaction similar to that experienced at the time of the diagnosis of deafness takes place. That later crisis, though is more emotionally difficult because the parent really experiences "failure" in a very deep sense: failure that can no longer be leavened by any fantasy as it often was in the preschool years that the child would be a very "successful" deaf person. The feelings of shock, anger, depression, guilt, and so on, all emerge once again. At that point, the parent needs very badly the support and help of a sensitive professional. *(Mandel, 1971).*

For most parens, the fundamental issue of parenting is one of "letting go", that is, allowing the child responsibility that he can handle successfully, if the parent uses no controls at all, the child may experience many failures, which will reduce his self-esteem; on the other hand, if the parent does not let the child take any responsibility this also reduces the child's self-esteem. The sensitive parent needs to operate somewhere between those two extreems.

Parents of special-needs children frequently underestimate their child's ability and do not allow him enough freedom to make mistakes.

Kaplan and Sadock (1989) mentioned that parents of deaf children not only have to provide their children with special medical, educatinal and social services but also need to learn the features of behvioral and developmental progress that are unique to the particular sensory handicap.

Normal adolescence is a painful experience for both the parent and the deaf child. The child is fulfilling his biological mandate to separate from the parent and to establish himself as a functioning adult. The parents needs to readjust constantly to the gradual changing reality of the child's impending adulthood.

Following are some examples of responses to questionnaire about being the parent of a deaf adolescent:

- The major problem facing parents of a teen-aged deaf child:
  "Seeing him struggle to blend in with his peer group 'all of whom hear'. He wants to be with his peer group".
  "She does not understand why she has to be deaf, and I really don't have the answers for her, and it is hard for her to communicate with hearing people, and it frustrates her".

  "The amount of dependency required of me because of the lack of companionship of her peers due to deafness".

- The uniqueness of parenting a deaf child:
  "The extra time required to assist with language acquision and homework assignments (clarification and understanding)".
  "We lack the necessary subtlety of vital communication available to parents of normal-hearing teenagers".
  "I expect I'll have a lot more trouble 'letting go' and letting her be independent".

- The major problem as the deaf child see it (as reported by parents):
  "She is behind most children her age at school".
  "Lack of acceptance by others".
  "Making close friends and keeping them".
  "Peer acceptance".
  "An embrassment that sometimes he is not understood by people; a desire for independence and still being dependent on others in dealing with the outside world".

Deaf Children of Deaf Parents:

Deaf children with deaf parents have several advantages. First, they have the highest intelligence levels among deaf children (*Gentile & Rambin, 1973*) partly because their etiology (heredity causes less damage to the brain than do agents such as rubella). Also most of them have been exposed to clear, unambiguous communication since early infancy. Second, deaf children of deaf parents have been found to have better social and emotional adjustment *(Mindel & Vernon, 1971)*: *Meadow (1968)* noted that they do significantly better in areas like "maturity", "responsibility", "independence", "sociability" and "appropriate sex-role behavior" areas in which many deaf people have been found deficient.

Impact of Deafness on Inter-Family Relationship:

The family is a delicately poised system designed to meet the needs of its individual member. The "intrusion" of the handicapped child often disrupts the delicate balance and, therefore, families frequently need help to restore a healthy dynamic in which all members can nurture their personal growth:

Husband - Wife Relationship:

The parent education programm can and does place an enormous amount of strain on husband - wife relationship.

Since the mother is receiving the education and the relevant information, the father often find himself in a passive role, abdicating the full responsibility for these decisions to his wife. Many men in a traditional family setting, in which the man is expected to make all the important decisions, find that role-reversal very difficult to accept. It may be difficult, however, for the husband to accept direction from his wife, since it often seems like criticism. That situation can lead to arguments and defensiveness on the part of both husband and wife, and obviously it requires a restructuring of their relationship which can be very painful. *(Grahm, 1973).*

The mixed-parent group, in which unrelated husbands and wives meet together, is very helpful toward overcoming the patents' defensiveness. The men seem to listen more to a woman other than their wives as she talks about problems of relating with her husband; they can listen without having to take responsibility for any of the recounted behavior and they can listen objectively while still relating material to their own experiences. The women also respond nondefensively to the man's complaints. After several mixed-parent sessions, it is necessary to have a complete husband-and-wife group meeting to process what has transpired in the mixed sessions.

The mothers frequently complain that they do not get enough emotional support from their husbands and as a result, they are the sole family members who are confronting the emotional issues. The women seem, however, to be comfortable in dealing with the emotional issues than do the men. *(Mind, 1983).*

Many marriages complicated by special needs-children have ended in divorce. In the families observed, the parents' divorce seemed to be precipitated by the added stress of the hearing-impaired child on an already weak relationship. On the other hand, parents have reported the opposite outcome; that is, marriages have been strengthened by the experience of having a deaf child, whose presence becomes a rallying point for the parents as well as for the rest of the family.

Parents - Grandparents Relationship:

The grandparents, like most nonprofessionals, lack information and knowledge about deafness. Consequently, their children (the parents of hearing-impaired child) frequently know far more than they do, and they are also much further advanced emotionally. Furthermore, if the mother and father seek support from their parents, frequently it is not available.

Many parents complain that their parents are a real burden to them rather than a support, that is the grandparents push them to go to another doctor or to seek some cure - such as acupuncture - when the parents are well passed that denial point in their development. Very often, the grandparents respond with anger and become very hostile.

Not all the relationships between parents and grandparents are negative. Occasionally, the grandparents have been capable than the parents and have assumed primary care of the child.

Parents frequently discover that the child's grandparents are an important resource for them, although not in the way they had originally expected, grandparents frequently provide assistance, via very necessary baby-sitting, so the parents can have sometime out. Grandparents can also provide very necessary parenting to the deaf child' siblings in the family when the parents are overwhelmed by the demands of the handicapped child. *(Afford, 1987).*

Siblings - Relationship:

If not handled properly by the parents, the handicapped child can present enormous emotional problems for the normal sibling. Very often, the sibling gets proportionately less of his parent's time and energy because so much is being taken up by the handicapped child. It is not uncommon for siblings to develop a pseudosensory deficit in an effort to gain some parental attention.

Siblings are frequently asked to assume many responsibilities at a much earlier age than they would be ordinarily, if there were not a handicapped child in the family; for example, they are often called on to baby-sit while the harried parents are rushing off another parent' meeting or doctor's appointment. Also, the sibling may feel and respond to the parents embarrassment and may not want to be seen with, or to take of, the handicapped child in public. The sibling needs to be incorporated into all family discussion regarding his own welfare, he also needs attention in his own right. That balance is not always easy for the parents to accomplish because they are expending so much energy on the handicapped child, on their own relationship, and on their relationship with their own parents. *(Afford, 1987).*

Problems also arise in terms of unborn siblings. Parents are frequently faced with painful decision of whether or not to have another child -especially when the deaf child is the first born.

Deaf Children of Deaf Parents:

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Schlesinger (1969) aptly summarized these findings:

- Clinical studies, experimental evidence, and anecdotal material indicate that the interaction of deaf parents and their deaf children may be markedly different from that of hearing parents and their deaf children. These differences in interaction may be traced to influences of reaction to diagnosis, with subsequent coping mechanisms affecting parents of child rearing and early parent-child communication.

- Deaf parents of deaf children appear to expect the diagnosis and to accept it at a much earlier age. They cope with the crisis of diagnosis more easily and quickly, while their hearing counterparts prolong and intensify it. Even following the diagnosis deaf parents appear to be more comfortable with their deaf children, admit to fewer eating and toilet training problems, and permit earlier independence and autonomy. Once the initial diagnosis is made, deaf parents are less likely to seek confirmatory diagnosis or miraculous cure.

- Early parent-child communication is a traumatic issue between hearing parents and their deaf children. Although the hearing parents talk to and in front of the child, they can only guess at his level of understanding. Although the child may watch carefully and understand the nonverbal messages, he does not know the symbols, the words his parents use until much later, and he cannot reproduce them.

- Most deaf parents, however, use sign language with their deaf and hearing children. Deaf parents, as they communicate to and in front of the child, can test the child's understanding more easily, can learn the symbols, the signs the parents use and learn to understand and reproduce them more easily. These deaf children

may be the only ones who learn a language naturally, playfully, as a "mother tongue". They may also be the only deaf children who learn language at a very early age which may indeed be the critical age.

Parents of deaf children and how to guide them:

Whether a hearing-impaired child will develop behavioral problems or not depends on how well those in the child's environment accept the disability (*Moores, 1982*).

Just as with other physical and sensory impairments, it is not the hearing impairment itself but how individuals in the child's environment, particularly parents, respond that largely determines whether the child will show behavioral problems (*Loeb and Sarigiani, 1986*).

Parents of deaf children not only have to provide their children with special medical, educational and social services but also need to learn the features of behavioral and developmental progress that are unique to the particular sensory handicap. (*Kaplan and Sadock, 1989*).

Opinions differ about how to manage the misbehavior of hearing-impaired children. Parents of the hearing impaired generally manifest one of the two attitudes towards their offsprings. There are those who believe their hearing-impaired child should be treated as normal to insure the child's integration into mainstream society. On the other hand, some parents believe that because their child is different, the child should be treated differently. The disciplinary form used relates directly to parents perception of child's handicap.

The most common discipline technique applied by successful parents was discussion with explanation. Giving the child a choice to stop the misbehavior or to suffer the consequences was the second most common technique used. On the other hand, the unsuccessful group applied scolding as the disciplinary technique used most frequently. It is important to note that no significant differences were found regarding the parents' perceived incidence of misbehavior, choice of discipline techniques, success in handling misbehavior, or attitude about discipline relative to their children's age or sex.

Successful parents perceive misbehavior in their offspring as occurring to a lesser degree than do unsuccessful parents. One possible explanation is that parents who see themselves as successful may be better able to control the misconduct of their children in implementing particular behavioral management strategies. Another explanation might be that successful parents are better able to discuss with their child a particular discipline procedure because of the higher level of competence in communication. A third possibility is that the successful

parents may be more likely to have offspring who actually exhibit inappropriate behavior less often than the offspring of unsuccessful parents (*William and Tidwell, 1988*).

Deaf children find themselves isolated from the typical childhood milieu and deficient in age-appropriate social skills. Social skill-training is an area of growing interest and offers a clear intervention approach. Participating in a support group related to a child's illness may have a number of therapeutic effects. First, parents may benefit from increased knowledge by promoting a sense of mastery. Second, there is a cathartic experience of sharing impressions of being a parent of a child with chronic illness. Parents' perceptions may be challenged by group members and acceptance may result (*Perrin and Mac Lean, 1988*).

The presence of handicap in the child may provoke rejecting fatalistic or other unhelpful attitudes in the parents and others. These may affect the child's self esteem and may be associated with adverse rearing practices. (*Baker, 1988*).

Psychotherapy with children is characterized by the need for parental involvement due to the reality of the child's dependent state. With preschool-age children the entire therapeutic effort may be directed towards the parents without any direct treatment of the child. In recent years, there have been increasing efforts to shift the focus from the child as the primary patient to the concept of the child as the family's emissary to the clinic (*Kaplan and Sadock, 1991*).

It is of utmost importance to involve parents of deaf children in many forces that have an impact on the lives of their children (*Bitter, 1976*).

MANAGEMENT OF THE HEARING IMPAIRED CHILDREN

Man is a social creature; he derives his livelihood and his pleasure from communication, through sight and hearing, with others and with his environment. Deafness will impair this communication and, if present from birth, may hinder or even prevent its development. Children born with hearing loss prelingually have a much greater problem than those who acquire deafness after language development. Furthermore, children with mild or moderate hearing loss do not usually present as many management problems as those born with a severe or profound loss (*Adams, 1987*).

In the field of rehabilitation, there are many hundreds of programmes for the deaf and hard of hearing persons. The early intervention programmes for the deaf faced severe obstacles. Most importantly, there was no real care of well-trained preschool teachers of the deaf. Consequently, there were very few teacher trainers qualified to prepare people to work with very young deaf children. In addition, there were no documented successful preschool programmes which could serve as models for those springing up across the country and there were no tested curricula available which could be incorporated or used with moderate adaptation. Because of a lack of curricular materials specifically designed for very young deaf children, many teachers inappropriately used watered-down curricula originally developed for older children. Also the programmes were almost exclusively oral - only, i.e. they did not allow the use of sign or fingerspelling. In addition, the authors have no knowledge of, or can find no evidence of, the employment of deaf teaches in preschool programmes prior to 1970 (*Moores and Moores, 1989*).

The Importance of Early Detection:

Fisher (1983) published a fascinating review of the development and maturation of the hearing system in normal infants and in those with a hearing loss. The hearing impaired child will have difficulty with speech perception and may therefore have delayed or absent speech and language development. Fisher postulated that, for optimum development of speech and language, the auditory pathway must be stimulated from a very early age to allow it and the higher centers to mature properly.

The benefits of early detection and initiation of management of deafness have been known for many years. A survey of the countries of the European Economic Community demonstrated that achievements in these fields are far from adequate (*Martin, 1982*).

Some authors have suggested that children with recurrent or chronic middle ear problems show evidence of delayed language development and educational achievement (*Hamilton, 1972 and Bergstrom, 1980*).

Deafness in children is discovered in one of the following ways:

a) The child fails in a screening test of hearing.
b) The child is known to be "at risk" of having a hearing loss.
c) Parental suspicion.
d) The child fails to develop speech and language in the normal ways. (*Adams, 1987*).

Screening

Screening programmes to identify children who have abnormal hearing are in use in many counties. The early screen is normally carried out at some time during the first year of life, and the aim of this programmes is to identify, at an early age, children who are hearing impaired, and in particular those who need amplification, in order to start the rehabilitative programme as soon as possible. This is supplemented in may areas by preschool screening, which should identify any children who may have been missed at the earlier screen, particularly those with mild losses, high frequency losses and persistent middle ear effusion. Further screening is frequently carried out at school entry and at intervals during school life, and the aim of these screens is predominantly to identify those children with middle ear disease, although some sensorineural hearing losses are first identified at this time (*Bellman, 1987*).

Pre-school Screening:

The tests used to screen hearing are usually conditioning technique in free field using a range of pure-tone plus a test of speech discrimination. This is supplemented in some areas by tympanometry. This screen is carried out in order to identify those children with sensorineural hearing loss missed by earlier screens, particularly those with mild or high-frequency losses, and also these children with persistent middle ear effusions, with resultant hearing problems.

School Screening

Screening of children for hearing problems has been carried out for over 50 years in schools in various countries, but the distribution of screening is patchy (*Bellman, 1987*).

Fish (1981) argued that school screening was very effective and should be extended to all areas. He reported on the validity of impedance measures in school screening and found that moderate sensorineural hearing losses were not identified by impedance studies including stapedial reflex thresholds, as might be expected, and that tympanometry failed a significant number of children who passed a

sweep test carried out at the same time. The two procedures took the same length of time. Tympanometry alone thus appears to be too sensitive as a tool for routine screening, particularly in view of the fluctuant nature of many middle ear effusions, although if repeated it will identify those children with persistent problems.

Whichever method of screening is favoured, and at whatever age, there is agreement between the professionals involved that it continues to be an essential tool in identifying hearing impairment in infants and children, so that the adverse consequences of hearing loss can, so far as possible, be averted *(Bellman, 1987)*. In addition, screening is considered by many professionals as an essential step of the management procedure.

Management:

Cornelius, (1978) suggested the following for improving language "For children of mild or moderate hearing loss: Generally speaking, these children require hearing aids as soon after diagnosis as possible. It is not unusual for a diagnosis of hearing loss in the mild and moderate classifications to be confirmed during the first year of life. Thus remedial procedures may be initiated to overcome the language retardation. This statement does not imply the use of highly formalized procedures with very young children. A natural approach which emphasizes the usual" mother to child talk" is effective.

As the child reaches 3 years, the parents should make copious use of story telling with appropriate picture books. Correction of speech production and auditory discrimination errors are better taken care of incidentally as children at this age level have limited attention span. *(Rutter, 1973)*.

After the child enters preschool, more formal work in lipreading and auditory training is usually necessary. The objective is to reduce the language lag as effectively as possible before the child enters the regular school. In the past, children with moderate hearing loss have too frequently been left to struggle for themselves. With just a minimum of effort, these children should be able to get along in the regular school. They will require special placement in the classroom, a teacher who understands their problems, special efforts by teachers to educate classmates about the implications of hearing loss, and individualized help with classework. "He added "There is no reason why children with hearing loss of 40 to 55 d.B should not succeed in the regular classroom, providing intelligence and adjustment are normal and there is no learning problem".

Under the title "The education of hearing-impaired children" *Adams (1987)* wrote: "The ideal outcome is a child with good speech who can progress normally through the education system and integrate fully into a society which communicates mainly by the oral-

aural channel. In the author's experience, this is possible, even with profoundly deaf children, although with this group, it is the exception rather than the rule". He also postulated several factors upon which the child's ability to acquire normal, or intelligible speech depends on the following:

a) The extent of the hearing loss, and its pattern.
b) The child's ability to use the residual hearing.
c) The time of onset of the hearing loss.
d) The child's personality ad motivation.
e) The child's intelligence.
f) Sufficient exposure to communication systems, especially speech. This requires considerable motivation on the part of the parents.

Adams, (1987) also stressed the integration of hearing impaired children into ordinary schools

On the other hand, *Kernohan, Lucas and Muter, (1981)* stressed the role of parents in the programmes and they defined the information that should be given a parents, viz:

a) Explanation of the child's hearing loss, with special references to the frequencies involved.
b) The difference between vowels and consonants and the importance of each to speech.
c) The effects of amplification on speech and which parts of speech the child is likely to receive.
d) The effects of background noise.
e) How to look after the hearing aids.
f) The importance of talking normally to the child.

Much of the information in speech is contained in transitions between phonemes, speech rhythm and intonation patterns. In the hearing impaired child this information is vital and is lost if the child is spoken to in an artificial or exaggerated manner.

Other investigators stressed the management of the adjustment of the auditory impaired children, of these was *(Hadley, 1985)* who said "In many instances, audiologic habilitation which includes the use of hearing aids, lessons in lip-reading, placement in front of the classroom, and the education of the parents, teachers and the children's classmates is effective in alleviating problems and in bringing about better adjustment. When psychotherapy is indicated the conventional techniques, involving environmental manipulation, insight, emotional release from tension, supportive relationship and socialization, may be employed".

Regarding the school's programsme, there are a number of suggestions for handling the special problems of hearing-impaired children in the regular class. Most of these recommendations are based

on a common-sense understanding of the special problems of such children. The primary adaptations, the teacher will need to make, involve the physical characteristics of the classroom:

1) In order to allow the child to make full use of the visual and auditory cues he or she relies upon so heavily, the child's seat should be in front of the room-preferably to one side, so that he or she can have better view of both teacher and classmates (*Martin, 1975*).

2) Auditory and visual distractions should be kept to a minimum. Although such distraction may not always be under the control of the teacher, expressive noises from the hall, the rooms, and the outside should be eliminated, specially when the teacher is talking. Environmental noises are also a problem for the child with a hearing aid, since aid, since all noises are amplified for him or her (*Stassen, 1973*).

3) The teacher should be careful not to turn his or her back to the class and talk while writing on the blackboard (*Sanders, 1971*).

4) New vocabulary should be introduced both orally and in writing (*Sanders, 1971*).

5) The teacher should encourage the child to ask questions. When it is necessary to repeat something, the teacher should try to rephrase the instructions. Some words and phrases are easier to lipread than others, and rephrasing increases the chances that the child will be exposed to words he or she can understand (*Mc Connell, 1973*).

6) The teacher should make every effort to use visual aids. The use of transparencies on an overhead projector is a good way to do this. Simply writing instructions on the blackboard is another good method. (*Hallahan and Kauffman, 1982*).

There are number of communication and instrumental methods, these will be presented briefly:

(A) Communication Methods:

1) Oralism:

Children educated in this system use only speech and lip-reading as a means of communication. Signing of any sort is strongly discouraged or even prevented. Oralism argue that the ability of a child to develop speech is inhibited if the child is allowed to communicate by signing. Oralism assumes that the brain of the hearing-impaired child remains capable of learning speech and language at least to puberty or during the first few years of life.

2) Finger Spelling:

This, on its own, is a slow means of comminution. It is a

"spelling out" of the English alphabet by various finger positions on one hand.

3) Cued Speech:
Some speech sounds, such as M, P, B or K, D, L can not be distinguished by lip reading alone. Cued speech uses eight different hand shapes in four different positions close to the speaker's mouth to enable the child to discriminate the lip movement.

4) Signing system "Manualism":
These are methods of communication preferred for those who are profoundly deaf and who can not benefit from the oralism. Here we use the hands in different positions to give by each position a definite meaning. There are the American Sign Language, British Sign Language, Paget-Gorman sign system, Signed English "signs taken from British sign language with artificially developed "sign markers" to indicate tense, word ending, ... etc.". (*Adams, 1987*).

5) Total communication:
Involves using a combination of speech, gestures, formal signing, finger spelling, speech reading, reading and writing. Supporters of total communication argue that providing sensory input through different channels auditory and visual - enhances the possibility of language development.

(B) Instruments used (Hearing aids):
A basic feature of any programme for hearing-impaired children is the use of hearing aids. Advances in technology have increased the usefulness of these devices to such an extent that teachers of the deaf need to know their advantages and limitations well. A nationwide survey (*Karchmer and Kirwin, 1977*) found that 79 percent of hearing-impaired students use hearing aids at least some of the time in the classroom. In fact 67 percent reported that they used a hearing aid all the time in the classroom.

Hearing aids differ in size, cost and efficiency. The various kinds range from wearable hearing aids to group auditory training units that can be used by a number of children at the same time:
The wearable hearing aids: is the type most familiar to the general public, comes in a number of models. Some are inserted within the external auditory canal, some are built into glasses, and some are placed behind the ear. The most powerful kind of wearable aid consists of a unit worn on the clothing with an attached earpiece. In general, the more inconspicuous the hearing aid, the less powerful it is. With recent advances in the manufacture of miniature transistors, however, the efficiency of very small units has increased dramatically (*Hallahen and Kauffman, 1982*).

Group auditory trainers: are used in school situations in which it is desirable to provide amplification for a group of children. Because they do not need to be small enough to wear, group trainers are usually more powerful and give better sound quality than wearable, individual aids. For a long time, a major limitation of a group unit was that it confined the movements of both teacher and children. The teacher's microphone and the children's headphones were plugged into the auditory unit. But wireless F.M. system that allow mobility are now available (*Niemoeller, 1978*). The quality of the amplification of F.M. systems, however, is still a problem (*Ling, 1975*), and they have a restricted high-frequency range.

There are many misconceptions regarding the use of hearing aids; here are a few of the most common ones:

1- There is a widespread belief that a person with sensorineural losses cannot benefit at all from a hearing aid. Although sensorineural losses are generally not as easily helped by amplification, they can be helped to some extent. Sanders, in fact, claims that because of medical advances, sensorineurally impaired persons are major candidates for hearing aids (*Sanders, 1971*).

2- Some people believe that hearing aids are never appropriate for mild or severe deficits. The fact is that; there are no hearing losses too mild or too severe to prevent a person from trying a hearing aid. (*Sanders, 1971*).

3- It is often mistakenly assumed that losses in the high-frequency range cannot be corrected by a hearing aid. This was true when hearing aids could only be worn on the body; rubbing of the hearing aid on the clothing generated low-frequency sound which was then amplified "drawing out" the high-frequencies (*Sanders, 1971*).

4- Some people believe a hearing aid allows its user to hear just like those with no hearing loss. This is not true; "no hearing aid can ever compensate completely for a hearing loss" (*Niemoeller, 1978*). If all the nerves, or nerves of a specific frequency, are completely destroyed, no amount of amplification will enable the individual to hear these sounds. In general, hearing aids simply make sounds louder. Any distortions in hearing that are present (as they frequently are in cases in which there is sensorineural loss) are not corrected. In fact, since hearing aids are not perfect, they themselves sometimes create distortion or "blurring" of sound. (*Sander, 1971*).

MATERIAL & METHODS

SUBJECT AND METHOD

A) Selection of School:

Subjects were selected from El-Amal Primary School for Deaf Children in Shoubra district, Cairo, It has 13 classrooms for all grades "class 1 to class 8" according to the system of primary schools for deaf Children in Egypt. It offers services for the surrounding regions in Shoubra, Zawya, Matarya, ... Total number of students was 322 (168 boys and 154 girls) at the time of this study during the school year 1995-1996.

El-Amal School for Deaf Children is one of the governmental free state-school with no admission fees and accepts only deaf children without mental retardatin or severely handicapping diabilities.

B) Technical design:

Permission to carry out the research was obtained from Shoubra Educational Authority (El-Sahel Department) and the school director.

A meeting was arranged with the teachers, social workers, psychologists and secretaries to discuss the objectives and steps of this study.

C) Selection of the subjects:

All school children (322) were candidates for the study but 22 were excluded because:

- Four are epileptics (but under medical control)
- Two have poliomyelitis affecting one leg.
- The others don't continue the study as there was no cooperation from the side of the parents.

D) Subjects:

300 deaf children age ranged from 5 - 13 years, both boys and girls.

E) Duration of the study:

The duration of this study was 3 1/2 months beginning from 1st October 1995.

F) Type of the study:

It was both a cross sectional and retrospective study.

G) Method:

Each child was subjected to the following:-

1. **History taking (parent's questionnaire): Appendix I**
   This was to clarify the following items:-
   a) Complaints.

   b) Developmental history of the child including the following data:
      - Prental history: pregnancy, delivery, child at birth.
      - Type of feeding, lactation period, mothers' reaction to nursing and weaning.
      - Milestones of growth, a e.g teething sitting, standing, walking and talking.
      - Emotional features of infancy as well as neurotic traits in early childhood.
      - Physical diseases in infancy with emphasis on the diseases that could be complicated by deafness e.g. otitis media, mumps, measles, ...

   c) Present history:
      - If any behavior or conduct disorder of the child; onset, course, duration and its relation to any particular events.
      - Sleeping habits, sexual disorder, eating, secretory, speech disorder, hyperactivity, agression, antisocial behavior disorders.
      - Behavior of the child at home and the methods used for correcting misbhavior.
      - Scholastic achievement and scholastic difficulties.
      - Parental reaction to child' misconduct.
      - Obedience, activities, hobbies and friends of the child.

   d) Family history:
      It included information about family characteristics:
      - Physical and psychiatric illnesses in the family.
      - Mother - father relationship: divorce, severe conflict, frequent quarrel, separation.
      - Parents' cansanguinity.

   e) Deafness history:
      It was including inforamtion about deafness of the child: onset, course, age at onset, cause and use of hearing aids. Also change of behavior after deafness and

parental reaction towards their child's deafness.

All children in conduct group were found to have deafness in the prelinguistic period.

The parent's questionnaire was structured in Al-Azhar psychiatric department. It was applied in a research concerning an epidemiological study of conduct disorder in 3 primry schools children by *Hamouda (1984)*. The reliability and validity of the questionnaire were tested.

The deafness history (included in the parent's questionnaire) was applied in a research concerning the behavior disorders in deaf children by *Wafaa, M. (1993)*.

2. Parents interview:

This interview was done with the available parent - most of the cases were mothers to conclude the following data:

- Personality of the parents.
- Quality of their marriage.
- Parental attitude towards the child.
- Emotional status of the mother.

3. Teacher questionnaire: Appendix II

The classroom teacher and social worker were interviewed to fill this questionnaire. It included information about conduct disorder and behavior of the child in the school; aggression towards classmates or property, stealing, respect to school rules, ... etc. It also included information about attention and concentratin in the classroom, increased motor activity, impulsivity and scholastic achievement.

This quesstionnaire was also aplied by Hamouda (1984).

4. Family questionnaire: Appendix III

This was filled by one member of the child's family and it included the following items:

- Parents professions.
- Income.
- Family size.
- Siblings.
- Birth order.
- Housing.
- Socio-economic status.

The last item was evaluated from: housing, income and profession of father then was classified according to Davis classification of socio-economic status *(Oluwya, 1988)*.

5. **Child' interview and exazmination: Appendix IV**

This examination sheet was applied by Aziz E. (1983) in a study of behavior disorder in deaf children and it included the following:

- Assessment of the verbal and non-vebral behavior.
- The child's social interaction.
- His attitude towards the family member and also towards the examiner.
- Motor behavior.
- Physique, features, clothes and Rt. or Lt. handed.

6. **Physical and neurological examination:**

This was done to exclude any child with physical or neurological abnormalities (other than deafness). Four children were excluded from the study as they have epilepsy and another two because they have poliomyelitis affecting one leg.

7. **Audiological assessment:**

- Abnormalities of and around pinna, ear canal or tympanic membrane were noted.
- Other abnormalities that may suggest a genetic exaplanation of hearing impairment were observed e.g. white fore-hair ....
- Audiological evaluatin: this was done using pure tone audiometry to determine the type and degree of hearing loss. The audiograms were already done for each deaf child on entering the school and yearly.
- The degree of hearing loss was classified as follows:

41-55 d.B	=	Moderate H.L.
56-70 d.B	=	Moderately severe H.L.
71- 90 d.B	=	Severe H.L.
90 +	=	Profound

(William and Micheel, 1992).

8. **Psychological assessment: I.Q. testing. Appedix V**

By using "Good-Enough-Harris Draw a Person Test": *(Good enough, 1931)*. In this test; the examiner was

instructed to draw a picture of a man and a woman, was instructed to draw the very best figure that he can. Emphasis was placed on the child's accuracy of observation and the development of conceptual thinking. Scores were given for inclusions of individual parts and clothing details. A total of 51 scorable items were selected on the basis of age, differentiation, relatiopn to total scores of the test and relation to group intelligence test scores. This test gives an idea about the level of mental maturity of the child which depends on:-

- Perception of similarities & differences.
- Abstraction.
- Generalizatioin.

The level of I.Q was classified as follows:

96 : 105	=	Average
86 : 95	=	Below average.
76 : 85	=	Borderline

(DPM I 1979)

9. Parental attitude:

By applying "Parental Attitude Inventory" ... Appendix VI

This inventory was prepared by Ismail, M & Fam R. and was applied to the available parent to know the attitude that is followed by father/mother towards their child behavior and misconduct. It included 68 questions to be answered by the available one or both parents.

10. Diagnosis:

The diagnosis of the cases of conduct disorder in the present study was based on the diagnostic criteria of D.S.M. III R (1987).

After applying the above mentioned procedures, the prevalence of conduct disorder among deaf children was calculated. This conduct disorderd deaf children were compared with a control grouip of 30 children of both boys (26) and girls (4) who were selected by random sample from the same school to be matched with the conduct group as regards age, sex and socioeconomic status.

STATISTICAL TECHNIQUES

SPSS was used for data analysis. For data description; percents were used for qualitative data and mean ± standard deviation for quantitiative data. "Chi-Square Test" & "Fisher Exact" were used for comparing proportions and "T-Test" for comparison of means.

1) Prevalence Rate:-

Definition: The prevalence of a disease in population is the proporation of that population heaving the disease at a given point in time.

$$\text{Prevalence} = \frac{\text{Number of individual having the disease}}{\text{Total number of individuals in the group}}$$

The number encompasses both new and on going cases of the disease.

2) Mean ($\bar{x}$):-

$$\bar{X} = \frac{\Sigma X}{N}$$

When

$\bar{X}$ = Is the mean
N = Is the nubmer of cases
X = Is a variable which presents any one of the patients in the group.
Σ = Sigma indicating the sum of all the individual values.

(Pipkin; 1989)

3) Standard Deviation (S.D):-

It is the square root of the variance. It gives an astimate of the average deviation around the mean.

$$S.D = \sqrt{\frac{\Sigma X^2 - (\Sigma X)^2}{n - 1}}$$

4) CHI Square (X^2):-

It is a measure of discripancy exiting between observed frequency and expected frequency *(Pipkin, 1984)*

$$X^2 = \Sigma \frac{(E - O)^2}{E}$$

When

E = Expected Frequencies
O = Observed Frequencies
Σ = Sigma indicating the sum of all the patients to be taken

5) T-Test:-

$$T = \frac{X_1 - X_2}{\sqrt{\frac{SD_1^2 \times n_1 + SD_2^2 \times n_2}{(n_1 - n_2) - 2}}}$$

For the value of T, consult tables at the degree of freedom $(n_1 + n_2 - 2)$ to find out the level of significance (P-value).

6) Fisher Exact Test:-

	CASE	CONTROL	TOTAL
Positive	A	B	A+B
Negative	C	D	C + D
TOTAL	A + C	B + D	A + B + C + D = N

$$*P \text{ value} = \frac{(A + B)!\,(C + D)!\,(A + C)!\,(B + D)!}{A!B!C!D!N!}$$

N! = N (N-1) (N-2) .....(4) (3) (2) (1)
N = A + B + C + D

*P value is two tailed in methodology

RESULTS

TABLE (1):- Prevalence of Conduct Disorde in Deaf Children

DIAGNOSIS	TOTAL	N	%
Conduct Disorder	300	40	13.33

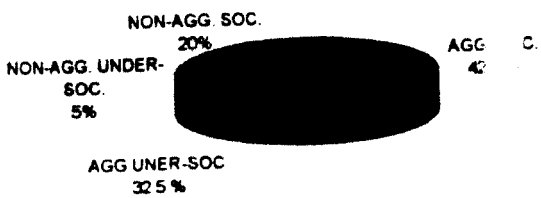
Graph No. (1):- Prevalence of conduct Disorder in Deaf Children

From table No. (1) and graph No. (1), it is observed that; t e prevalence of conduct disorder in deaf children was 13.3%.

TABLE (2):- Subgroups of the Conduct Disordered Deaf Children

GROUP	N	%
Aggressive socialized	17	42.5
Aggressive undersocialized	13	32.5
Non-aggressive undersocialized	2	5.0
Non-aggressive socialized	8	20.0
TOTAL	40	100

GRAPH No. (2):- Subgroups of the Conduct Disordered Deaf Children

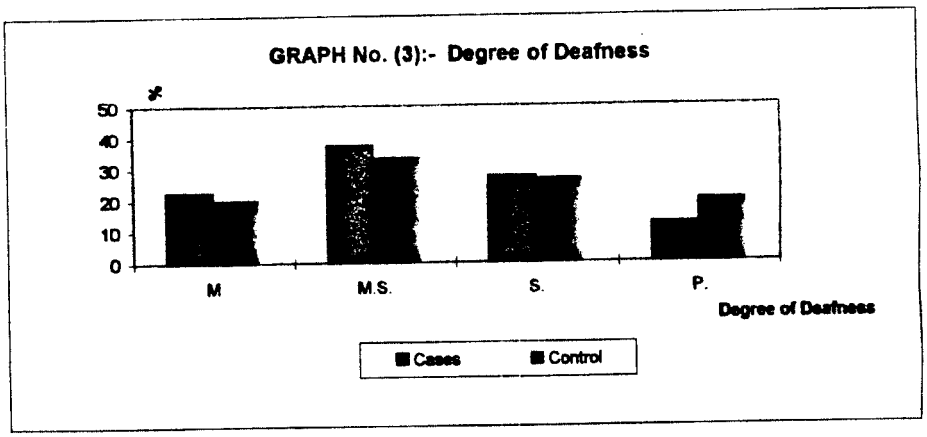


From table No. (2) and graph No. (2), it is observed tha he commonest subgroup is aggressive-socialized (42.5%) and the least co on was non-aggressive-undersocialized (5%).

TABLE (3):- Degree of Deafness of Cases Vs Control

DEGREE OF DEAFNESS (d.B.)	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
41-55	9	22.5	6	20.0	0.002	0.97
56-70	15	37.5	10	33.3	0.010	0.91
71-90	11	27.5	8	26.6	0.040	0.8
90+	5	12.5	6	20.0	0.270	0.6

* P value is significant if ≤ 0.05



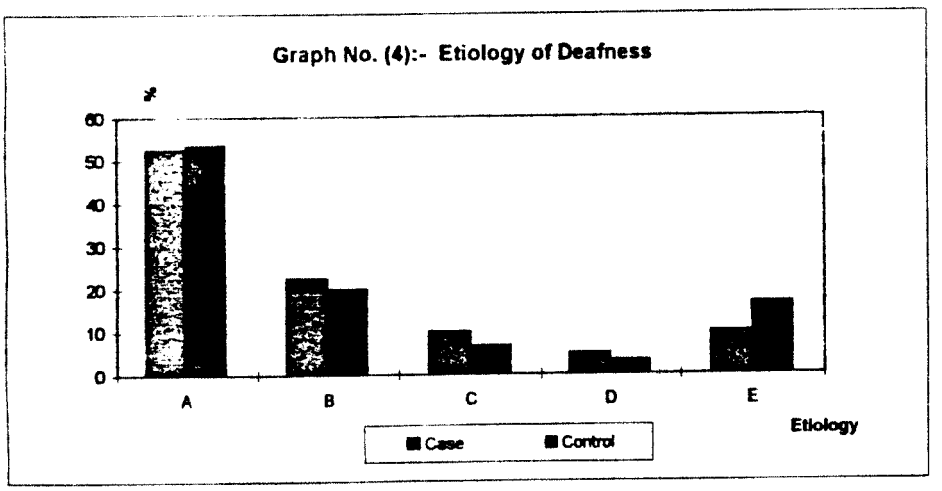
M. = Moderate hearing loss (41-55 d.B)
M.S= Moderately severe hearing loss (56-70 d.B)
S. = Severe hearing loss (71-90 d.B)
P. = Profound loss (90 +)

From table No. (3) and graph No. (3), it is observed that, there is high proponderance of cases with moderately severe hearing loss (37.5%) than the control group (33.3%) with no statistically significant difference between cases and control groups.

TABLE (4):- Etiology of Deafness in Cases Vs Control

ETIOLOGY	CONDUCT (40)		CONTROL (30)		X^2	* P value
	N	%	N	%		
Hereditary hearing loss.	21	52.5	16	53.5	0.03	0.86
Chronic S. otitis media	9	22.5	6	20.0	0.002	0.97
Post meningitic	4	10.0	2	6.7	0.004	0.48
Post rubella	2	5.0	1	3.3	0.06	0.6
Others	4	10	5	16.7	0.22	0.6

* P value is significant if $\leq$ 0.05



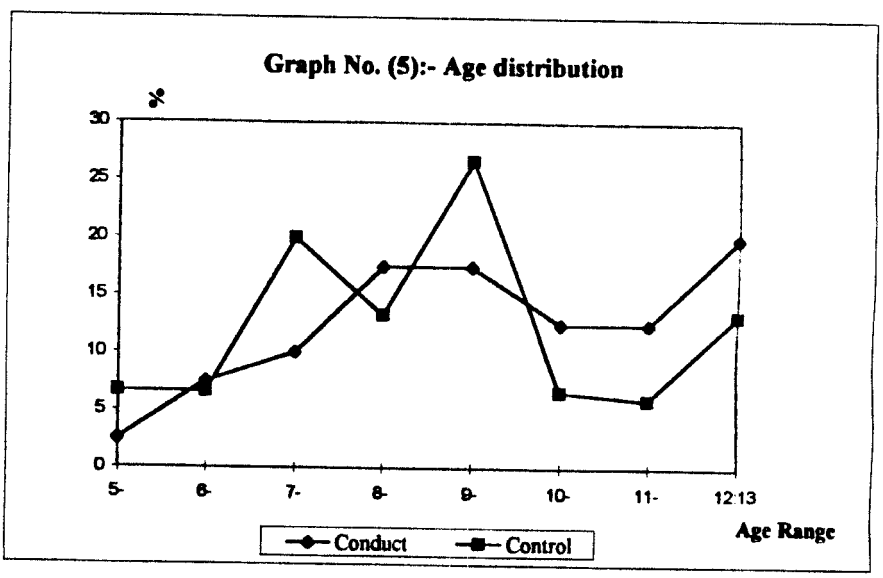
A: Hereditary hearing loss
B: Chronic suppurative otitis media
C: Post meningitic
D: Post rubella
E: Others

From table No. (4) and graph No. (4), it is observed that the most common cause of deafness in conduct and control groups was hereditary hearing loss (52.5% & 53.5% respectively), this was followed by chronic suppurative otitis media (20% each) and there was no statistically significant differences between the two groups.

TABLE (5) :- Age Distribution of Cases Vs Control

AGE RANGE	CONDUCT (40)		CONTROL (30)		* P value
	N	%	N	%	
5-	1	2.5	2	6.67	
6-	3	7.5	2	6.67	
7-	4	10.0	6	20.00	
8-	7	17.5	4	13.30	
9-	7	17.5	8	26.67	
10-	5	12.5	2	6.67	
11-	5	12.5	2	6.00	
12-13	8	20.0	4	13.30	
Mean age	9.3 ± 2.10		8.7 ± 2.14		0.2

* P value is significant if < 0.05

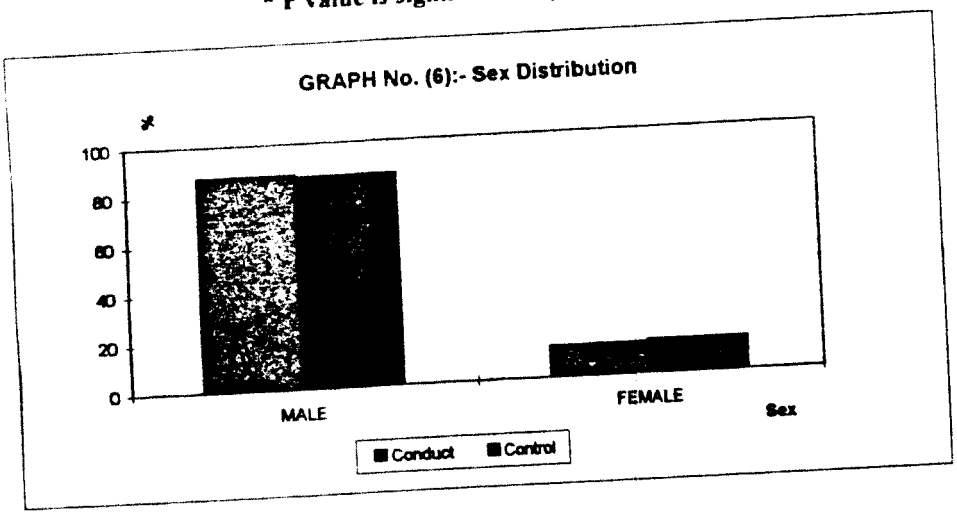


From table No. (5) and graph No. (5) it is apparent that; the age of both groups ranged from 5 to 13 years and the mean age of cases was 9.3 +2.10 while for the control group was 8.7 ± 2.14 and there was no statistically significant difference between the cases and control groups.

TABLE (6) :- Sex Distribution of Cases Vs Control

SEX	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
Male	35	87.5	26	86.6	0.07	0.79
Female	5	12.5	4	13.3		
TOTAL	40	100	30	100		

* P value is significant if ≤ 0.05

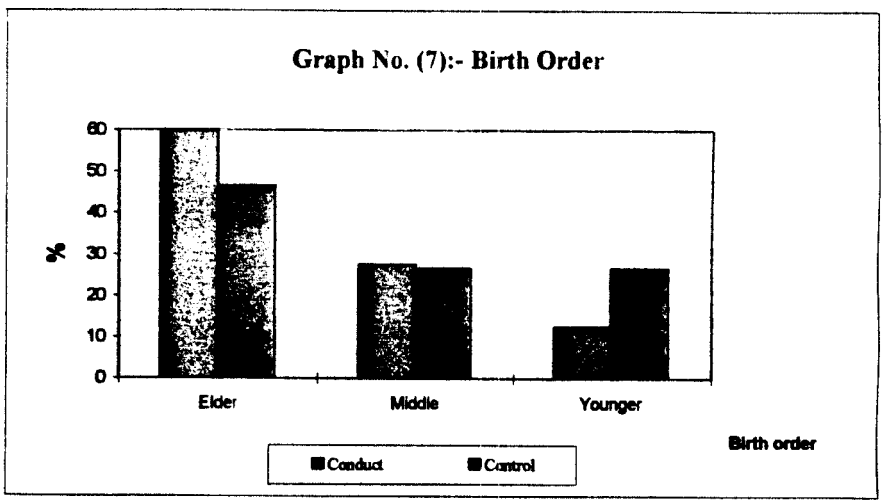


From table No. (6) and graph No. (6), it is apparent that; male was the commonest sex in the conduct (87.5%) and control group (86.6%) with no statistically significant differences.

TABLE (7):- Birth Order of Cases Vs Control

Birth order	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
Elder	24	60.0	14	46.6	0.9	0.6
Middle	11	27.5	8	26.7		
Youngest	5	12.5	8	26.7		

* P value is significant if ≤ 0.05

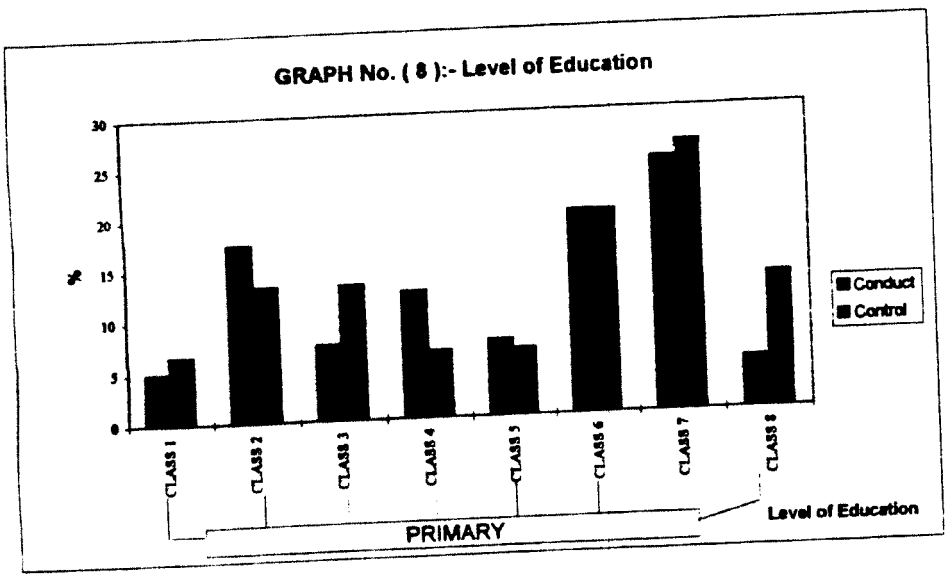


From table No. (7) and graph No. (7), it is observed that, "elder child" was more prevalent in the conduct (60%) than control group (46.6%). "The youngest-child" was commoner in the control (26.7%) than conduct group (12.5%). There were no statistically significant differences between the two groups.

TABLE (8) :- Level of Education of the cases Vs Control

LEVEL OF EDUCATION	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
PRIMARY SCHOOL						
Class 1	2	5	2	6.6	0.05	0.8
Class 2	7	17.5	4	13.3	0.02	0.9
Class 3	3	7.5	4	13.3	0.16	0.9
Class 4	5	12.5	2	6.6	0.16	0.6
Class 5	3	7.5	2	6.6	0.11	0.6
Class 6	8	20.0	6	20.0	0.09	0.6
Class 7	10	25.0	6	20.0	0.04	0.7
Class 8	2	5.0	4	13.3	0.64	0.9

* P value is significant if ≤ 0.05

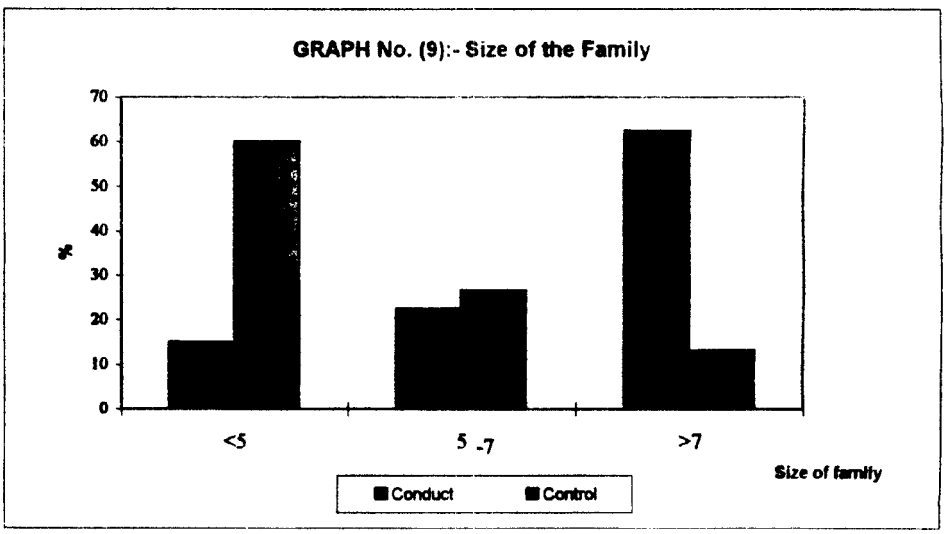


From table No. (8) and graph No. (8), it is evident that. there was high proponderance of the 'seventh class' in the case (25%) and control group (20%). There was no statistically significant differences between the two groups.

TABLE (9) :- Size of the Family

SIZE OF FAMILY	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
<5	6	15	18	60.0	13.5	0.001
5-7	9	22.5	8	26.6	0.01	0.9
>7	25	62.5	4	13.3	15.1	0.001

* P value is significant if ≤ 0.05



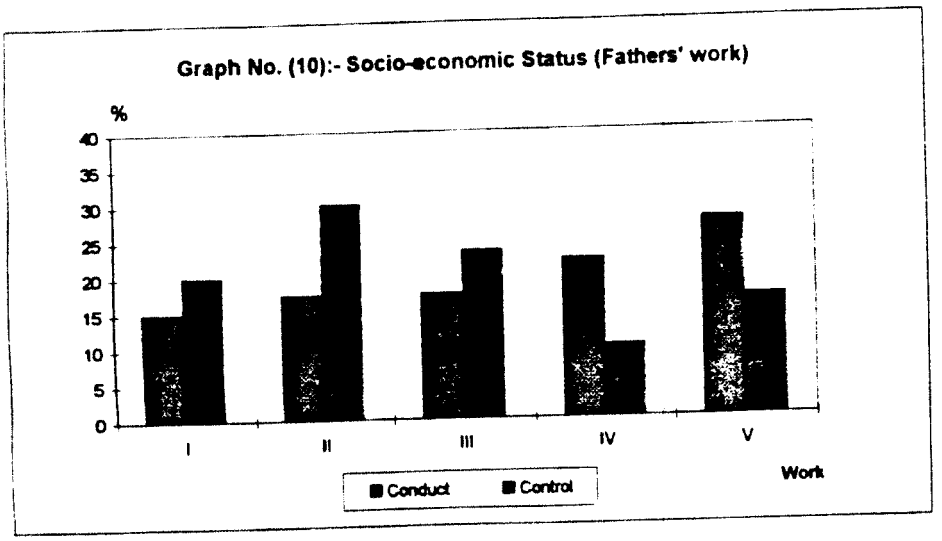
From table No. (9) and graph No. (9), it is apparent that; concerning 'family members more than 7', there was high proponderance in the case group (62.5%) than the control group (13.3%) with highly statistically significant difference as P = 0.001.

Concering 'family members less than 5' , it was commoner in the control (60%) than case group (15%) with highly statistically significant difference as P = 0.001.

TABLE (10):- Socio-economic Status (Fathers' work) of Cases Vs Control

SOCIO-ECONOMIC STATUS "WORK OF FATHERS"	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
Class I: Pofessional.	6	15.0	6	20.0	0.05	0.8
ClassII: Semi professional	7	17.5	9	30.0	0.34	0.9
Class III:- Skilled.	7	17.5	7	23.3	0.09	0.8
Class IV:- Semiskilled.	9	22.5	3	10.0	1.10	0.3
Class V:- Unskilled.	11	27.5	5	16.7	0.60	0.4

* P value is significant if ≤ 0.05



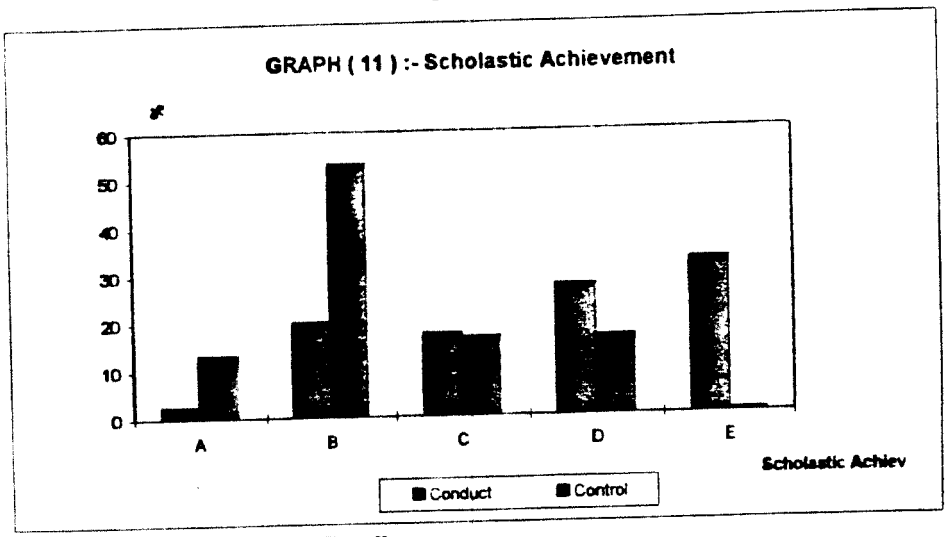
I : Professional
II : Semi-professional
III : Skilled
IV : Semiskilled
V : Unskilled

From table No. (10) and graph No. (10), it is apparent that; in the case group: class V (27.5%), class IV (22.5%) were the most frequent while in the control group; class II (30%) and class III (23.3%) were the most common. There is no statisitically significant difference between the two groups.

TABLE (11):- Scholostic Achievement of Cases Vs Control

ITEMS	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
Excellent	1	2.5	4	13.3	1.60	0.98
Very good	8	20.0	16	53.3	7	0.007
Good	7	17.5	5	16.6	0.05	0.8
Average	11	27.5	5	16.6	0.6	0.4
Bad	13	32.5	0	0.0	9.9	0.002

* P value is significant if ≤ 0.05



A Excellent
B Very good
C Good
D Average
E Bad

From table No. (11) and graph No. (11), it is apparent that; scholastic achievement was bad in (32.5%) of conduct and non in control group and there was highly statistically significant difference as P = 0.002.

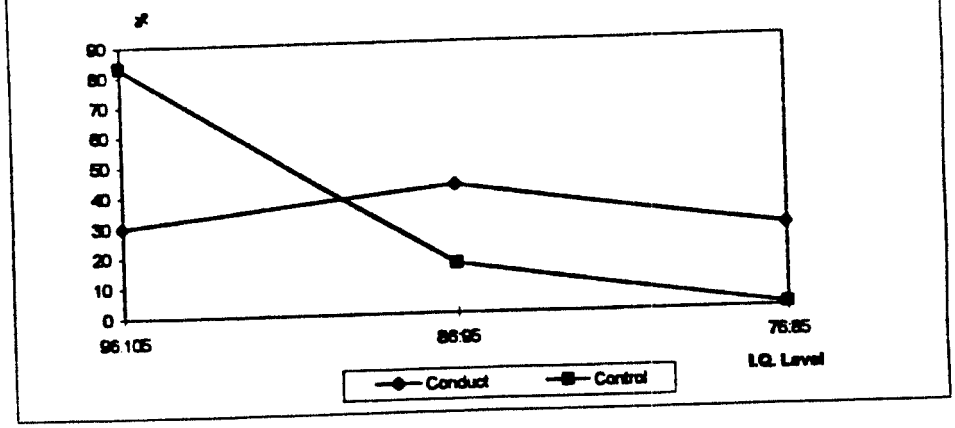
Scholastic achievement was very good in (53.3%) of control and (20%) of case group and there was statistically significant difference as P = 0.007.

TABLE (12) :- I.Q. of Cases Vs Control

I.Q. LEVEL	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
96:105	12	30.0	25	83.3	17.5	<0.001
86:95	17	42.5	5	16.7	4.2	0.04
76:85	11	27.5	0	0	7.8	0.005

* P value is significant if ≤ 0.05

GRAPH No. (12) :- I.Q. Level



Average = 96:105
Below avarage = 86:95
Borderline = 76:85

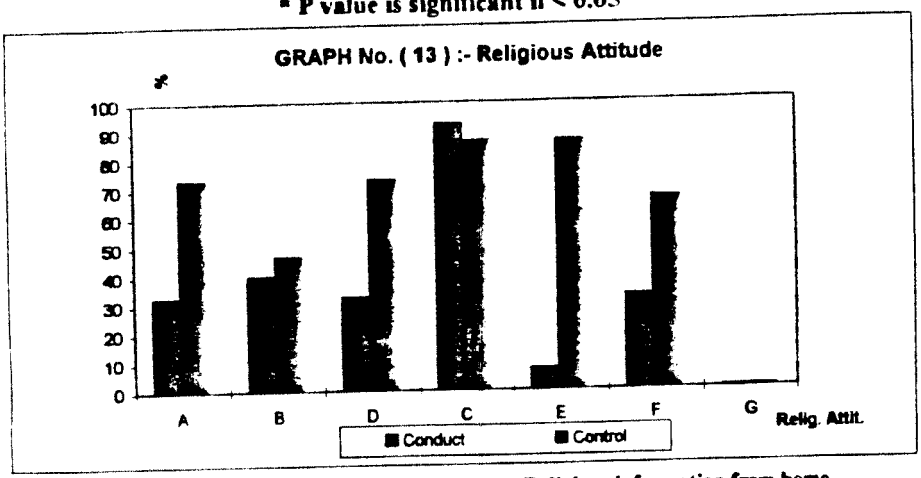
From table No. (12) and graph No. (12), it is apparent that; there was high proponderance of "average I.Q." in the control (83.3%) and case group (30%) with highly statistically significant difference as P < 0.001.

There was also high frequency of case group with "borderline I.Q." (27.5%) and non in the control group with statistically significant difference as P = 0.005.

TABLE (13) :- Religious Attitude of the Cases Vs Control

RELIG. ATTIT.	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
Praying.	13	32.5	22	73.3	9.80	0.002
Fasting.	16	40	14	46.6	0.09	0.8
Going to mosq./ch.	13	32.5	22	73.3	9.80	0.002
Source of relig. information:-						
School	37	92.5	26	86.7	0.16	0.6
Home	3	7.5	26	86.7	41.10	<0.001
Mosq./Ch.	13	32.5	20	66.6	11.21	<0.001
T.V/Radio	0	0	0	0	0.00	0.0

* P value is significant if < 0.05



A :- Praying
B :- Fasting
C :- Going to mosq./ch.
D :- Religious information from school
E :- Religious information from home
F :- Religious information from mosq./ch.
G :- Religious information from T.V/Radio

From table No. (13) and graph No. (13) it is apparent that; there was high proponderance of praying and going to mosq./ch. in the control (73.3 % each) than case group (32.5% each) with highly statistically significant difference as P = 0.002.

Mosq./Ch. as a source of religious informatin to the child was commoner in control (66.6%) than conduct group with highly statistically significant difference as P < 0.001

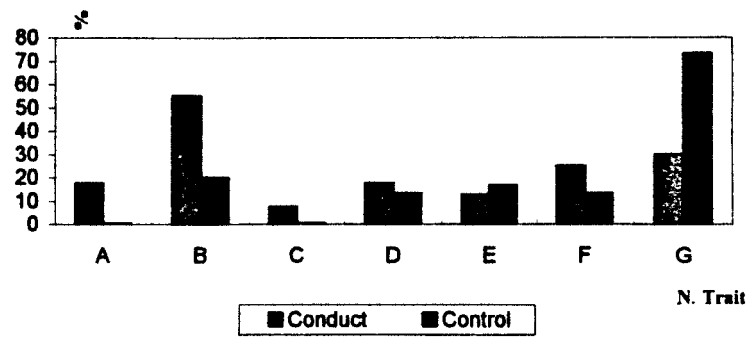
The home as the source of religious information was commoner in control (86.7%) than case group (7.5%) with highly statisitcally significant difference as P <0.001.

TABLE (14) :- Neurotic Traits in Cases Vs Control

N. TRAIT	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
Nocturnal enuresis.	7	17.5	0	0	4.05	0.02
Temper tantrum.	22	55.0	6	20.0	7.3	0.006
Thunb suckling.	3	7.5	0	0.0	0.34	0.25
Nail biting.	7	17.5	4	13.3	0.02	0.9
Headache	5	12.5	5	16.7	0.02	0.9
Increased appetite.	10	25	4	13.3	0.82	0.36
Decreased appetite.	12	30	5	16.7	1.01	0.31

* P value is significant if $\leq$ 0.05

GRAPH No. (14):- Neurotic Traits



A : Nacturnal enuresis
B : Temper tantrum
C : Thumb suckling
D : Nail biting
E : Headache
F : Increased appetite
G : Decreased appetite

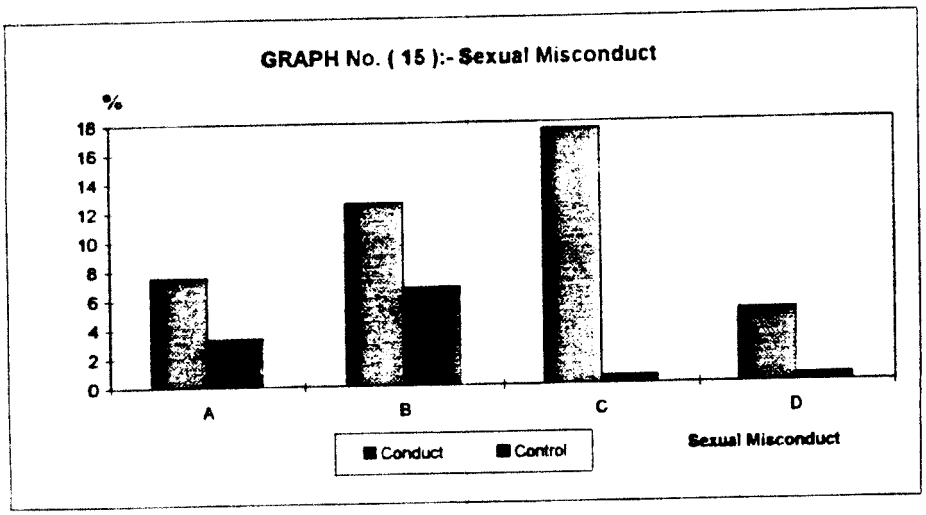
From table No. (14) and graph No. (14) it is apparent that; the neurotic traits of statistically significant differences between the cases and control groups were:-

- Nocturnal enuresis :- was commoner in the conduct (17.5%) and non in the control group with statistically significant difference as P = 0.02.
- Temper Tantrum :- was more proponderant in the conduct (55%) than control group (20%) with statistically significant difference as P = 0.006.

TABLE (15):- Sexual Misconduct in Cases Vs Control

SEXUAL	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
Exposing genitalia	3	7.5	1	3.3	0.05	0.42
Manipulating his sex organs	5	12.5	2	6.7	0.16	0.35
Sexual act with same sex	7	17.5	0	0.0	4.1	0.0
Sexual act with other sex	2	5.0	0	0.0	0.27	0.32

* P value is significant if < 0.05



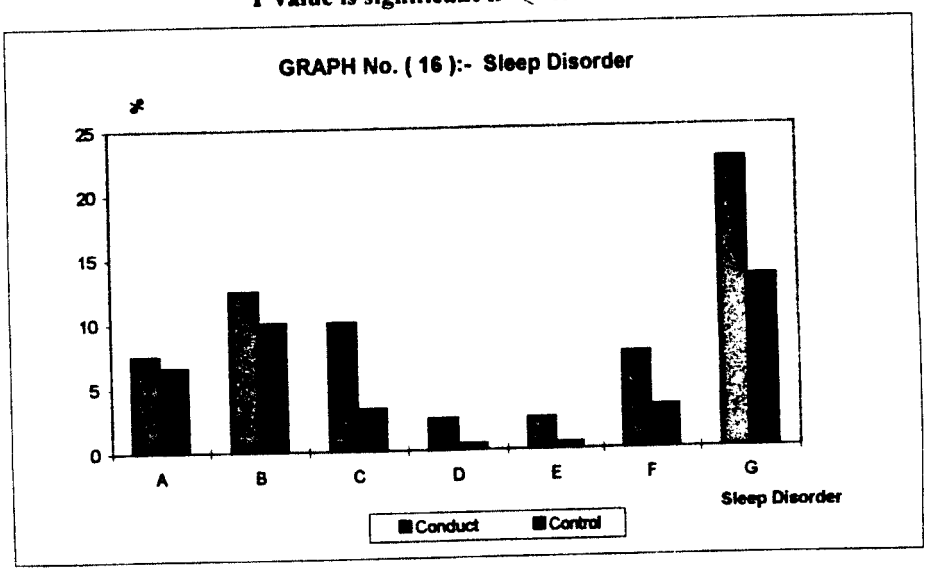
A : Exposing genitalia
B : Manipulating his sex organs
C : Sexual act with same sex
D : Sexual act with other sex

From table No. (15) and graph No. (15), it is observed that, concerning "sexual act with same sex", it was more proponderant in the conduct (17.5%) and non in the control group with statistically significant difference as P = 0.01.

TABLE (16):- Sleep Disorder in Cases Vs Control

SLEEP DISTURBANCE	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
Hypersomnia	3	7.5	2	6.6	0.11	0.6
Early insomnia	5	12.5	3	10.0	0.003	0.5
Late insomnia	4	10.0	1	3.3	0.36	0.3
Walking during sleep	1	2.5	0	0.0	0.02	0.8
Talking during sleep	1	2.5	0	0.0	0.02	0.8
Night mares	3	7.2	1	3.3	0.05	0.42
Night terrors	9	22.5	4	13.3	0.44	0.5

* P value is significant if ≤ 0.05



A : Hypersomnia
B : Early insomnia
C : Late insomnia
D : Walking duringg sleeps
E : Talking during sleep
F : Night mares
G : Night terrors

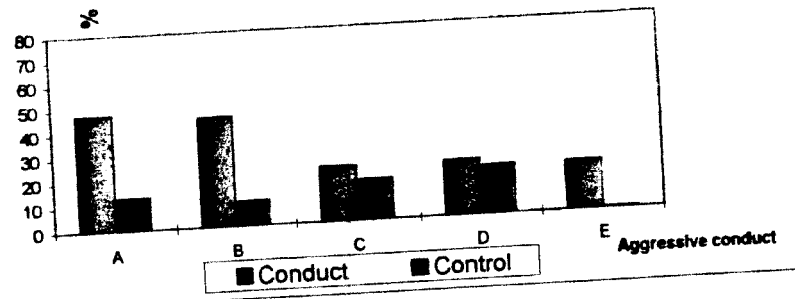
From table No. (16) and graph No. (16), it is apparent that; sleep disorder was commoner in conduct than control group; night terrors were more prevalent in conduct (22.5%) than control group (13.3%). Also insomnia (early and late) was more proponderant in conduct (22.5%) than control group (13.3%) and the differences were statistically insignificant.

TABLE (17) :- Aggressive Conduct at School as Presented by School Teacher of Cases Vs Control

AGGRESSIVE CONDUCT	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
Frequent quarrel with C.M.	19	47.5	4	13.3	7.5	0.005
Physical violence with C.M.	18	45.0	3	10.0	8.4	0.003
Verbal agg. towards C.M.	9	22.5	5	16.7	0.09	0.8
Snatches C.M. things.	9	22.5	6	20.0	0.002	0.96
Spoils C.M. belongings.	8	20.0	0	0	4.9	0.008

* P value is significant if $\leq$ 0.05

Graph No. (17):- Aggressive conduct at school as presented by school teacher



A : Frequence quarrel with classmates
B : Physical violence towards classmates
C : Verbal aggression towards classmates
D : Snatches classmates things
E : Spoils classmates belongings

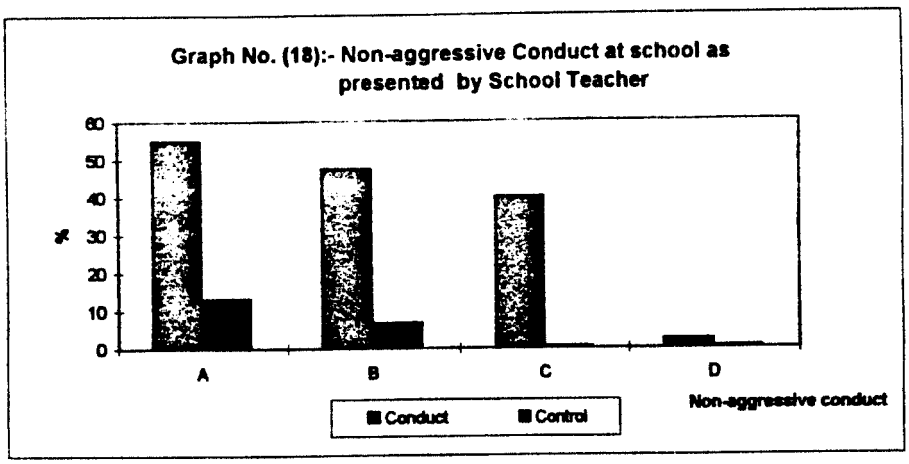
From table No. (17) and graph No. (17), it is apparent that aggressive conduct was more proponderant in the conduct than control groups. The items which have statistically significant differences were:

- Frequent quarrel with classmates:-was commoner in the conduct (47.5%) than control group (13.3%) with statistically significant difference as P = 0.005.
- Physical violence with classmates:- was more proponderant in the conduct (45 %) than control group (10 %) with highly statistically significant difference as P = 0.003.
- Spoils classmates belongings:- was more prevalent in the conduct (20.0%) and non in the control group with statistically significant difference as P = 0.008.

TABLE (18) :- Non-aggressive Conduct at School as Presented by School Teacher of Cases Vs Control

NON-AGGRESSIVE CONDUCT	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
Frequent absence from school	22	55.0	4	13.3	11.1	<0.001
Frequent lie at school	19	47.5	2	6.7	11.7	<0.001
Steals from classmates.	16	40.0	0	0.0	13.4	<0.001
Steals from teacher	1	2.5	0	0.0	0.02	0.6

* P value is significant if < 0.05



A : Frequent absence from school
B : Frequent lie at school
C : Steals from classmates
D : Steals from teaxher

From table No.(18) and graph No. (18), it is apparent that non-aggressive conduct at school as presented by school teacher was more proponderant in the case then control group. The items with statistically significant defferences were:

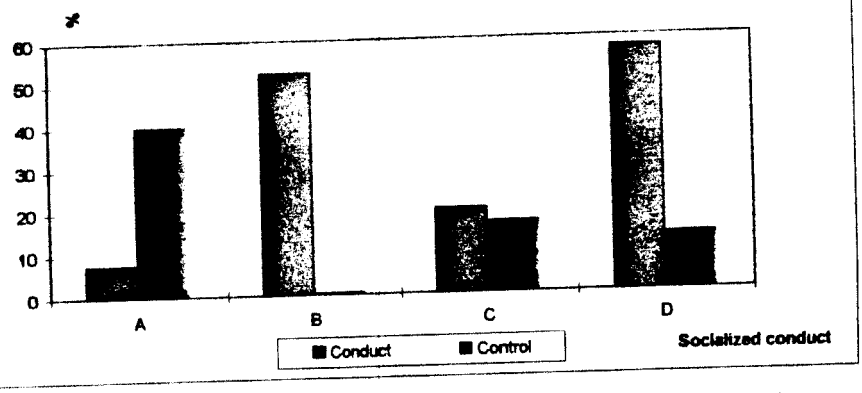
- Frequent absence from school:- was more prevalent in the case (55%) than control group (13.3%) with highly statistically significant difference as P < 0.001.
- Frequent lie at school:- was commoner in the case (47.5%) than control group (6.7 %) with highly statistically significant difference as P< 0.001.
- Steals from classmates:- was more frequent in case (40%) and non in control group with highly statistically significant difference as P < 0.001.

TABLE (19):- Socialized Conduct at School as Presented by School Teacher of Cases Vs Control

SOCIALIZED CONDUCT	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
Friendship lasting more than 6 months.	3	7.5	12	40.0	8.9	0.003
Having a group of mis-behaving C.M.	21	52.5	0	0.0	20.1	<0.001
Putting blame on others.	8	20.0	5	16.7	0.002	0.96
Inform on others.	23	57.5	4	13.3	12.3	<0.001

* P value is significant if ≤ 0.05

Graph No. (19):- Socialized Conduct at School



A: Friendship lasting more than 6 months.
B: Having a group of mis-behaving classmates.
C: Putting blame on others.
D: Inform on others.

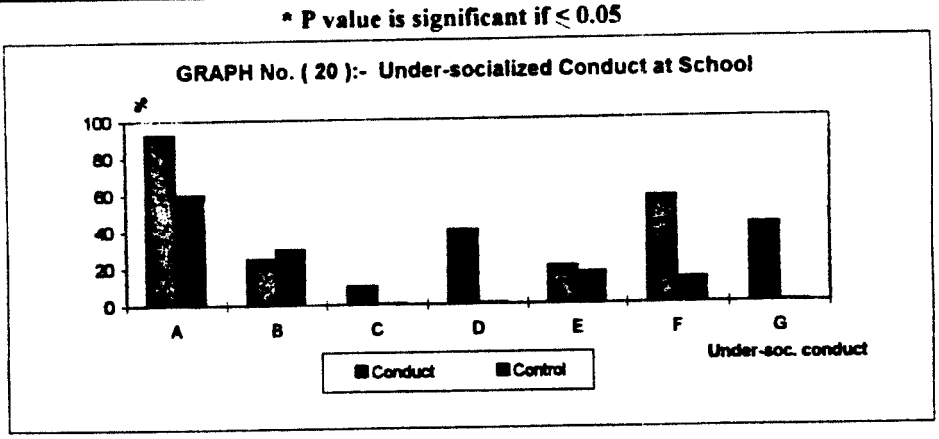
From table No. (19) and graph No. (19), it is apparent that; socialized conduct was more proponderant in the case then control group. The items which have statistically significance differences were:-

- Friendship lasting more than 6 months:- was more prevalent in the control (40%) than case group (7.5%) with highly statistically significant difference as P = 0.003.
- Having a group of mis-behaving classmates:- was commoner in the case (52.5%) and non in the control group with highly statistically significant difference as P < 0.001.
- Inform on others:- was more frequent in the conduct (57.5%) than control group (13.3%) with highly statistically significant difference as P < 0.001.

TABLE (20) :- Under-socialized Conduct at School as Presented by School Teacher of Cases Vs Control

UNDER-SOCIALIZED CONDCUT	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
Friendship lasting less than 6 months.	37	92.5	18	60	8.9	0.003
Friends (more than 2) among C.M.	10	25.0	9	30.0	0.04	0.8
Disliked by C.M.	4	10.0	0	0.0	1.5	0.2
No respect to C.M. rights.	16	40.0	0	0.0	13.4	<0.001
Putting blame on others.	8	20.0	5	16.6	0.002	0.96
Inform on others.	23	57.5	4	13.3	4.1	0.01
Doesn't conform to school rules.	17	42.5	0	0.0	14.6	<0.001

* P value is significant if ≤ 0.05



A : Friendship lasting less than 6 months
B : Friends (more than 2) among classmates
C : Disliked by classmates
D : No respect to classmates' rights
E : Putting blame on others
F : Inform on others
G : Doesn't conform to school rules

From table No. (20) and graph No. (20), it is observed that; under-socialzied conduct was more prevalent in the conduct than control group. The variables which have statistically significant differences were:

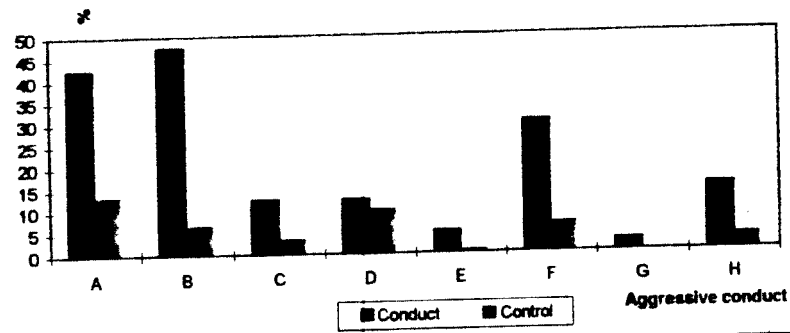
- Friendship lasting less than 6 months:- was commoner in the conduct (92.5%) than control group (60%) with highly statistically significant difference as P = 0.003.
- No respect to classmates' rights:- was more proponderant in the conduct (40%) and non in the control group with highly statistically significant difference as P< 0.001.
- Inform on others:- was more frequent in the conduct (57.5%) than control group (13.3%) with statistically significant difference as P = 0.01.
- Doesn't conform to school rules:- was more prevalent in the conduct (42.5%) and non in the control group with highly statistically significant difference as P <0.001.

TABLE (21) :- Aggressive Conduct at Home as Presented by the Parents of Cases Vs Control

AGGRESSIVE CONDUCT	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
Frequent quarrel.	21	42.5	4	13.3	9.8	0.002
Physical violence.	19	47.5	2	6.6	11.7	<0.001
Physical violence during play.	5	12.5	1	3.3	0.85	0.2
Verbal aggression.	5	12.5	3	10.0	0.003	0.5
Set fire to harm others.	2	5.0	0	0.0	0.27	0.3
Lie to harm others.	12	30	2	6.6	4.4	0.03
Killing pets.	1	2.5	0	0	0.02	0.6
Aggression towards property.	6	15.0	1	3.3	1.45	0.2

* P value is significant if ≤ 0.05

Graph No. (21):- Aggressive Conduct at Home



A : Frequent quarrel
B : Physical violence
C : Physical violence during play
D: Verbal aggression
E : Set fire to harm others
F : Lie to harm others
G : Killing pets
H : Aggression towards property

From table No. (21) and graph No. (21), it is apparent that; aggressive conduct at home as presented by parents was more prevalent in the conduct than control group. Symptoms that have statistically significant differences were:

- Frequent quarrel :- was commoner in the conduct (42.5%) than control group (13.3%) with highly statistically significant difference as P = 0.002.
- Physical violence:- was more proponderant in the conduct (47.5%) than control group (6.6%) with highly statistically significant difference as P < 0.001.
- Lie to harm others:- was commoner in the conduct (30%) than control group (6.6%) with statistically significant difference as P = 0.03.

TABLE (22):- Non-aggressive Conduct at Home as Presented by Parents of Cases Vs Control

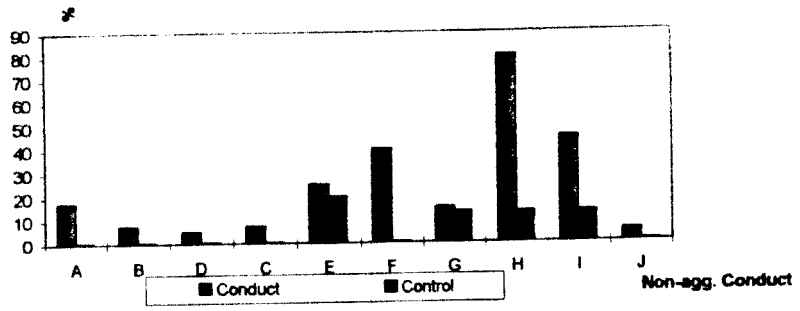
NON-AGG. CONDUCT	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
Stay late by night.	7	17.5	0	0.0	4.05	0.02
Truancy.	3	7.5	0	0.0	0.34	0.25
Runaway.	2	5.0	0	0.0	0.60	0.5
Runaway with others.	3	7.5	0	0.0	0.34	0.25
Steals valuables from home.	10	25.0	6	20.0	0.24	0.62
Steals from friends.	16	40.0	0	0.0	15.60	<0.001
Steals from outside.	6	15.0	4	13.3	0.03	1.0
Disobey the norms at home.	32	80.0	4	13.3	30.50	<0.001
Frequent lie.	18	45.0	4	13.3	7.00	0.004
Like to set or play with fire.	2	5.0	0	0.0	0.60	0.5

* P value is significant if ≤ 0.05

From table No. (22) and graph No. (22) it is observed that symptoms of non-aggressive conduct were commoner in the case than control group as presented by parents. The symptoms that have statistically significant differences were:-

- Stay late by night: was more prevalent in the case (17.5%) and non in the control group with statistically significant difference as P = 0.02.
- Steals from friends: was more proponderent in the case (40%) and non of the control group with highly statistically significant difference as P < 0.001.
- Disobey the norms at home: was commoner in the case (80%) than control group (13.3%) with highly statistically significant difference as P < 0.001.
- Frequent lie: was more prevalent in the case (45%) than control group (13.3%) with statistically significant difference as P = 0.004.

GRAPH No. (22):- Non-aggressive Conduct at Home



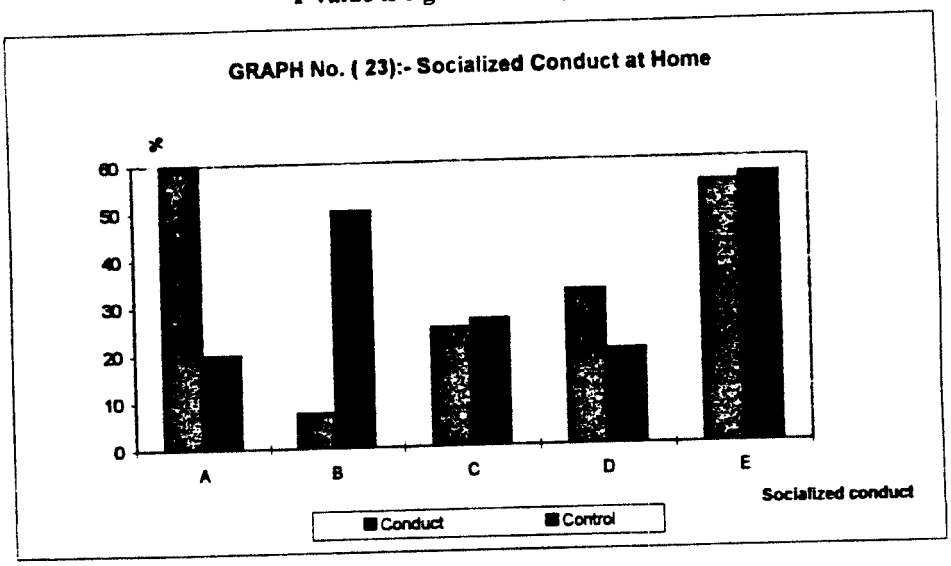
A :- **Stay late by night**
B :- **Truancy**
C :- **Runaway**
D :- **Runaway with others**
E :- **Steals valuables from home**
F :- **Steals from friends**
G :- **Steals from outside**
H :- **Disobey the norms at home**
I :- **Frequent lie**
J :- **Like to set or play with fire**

TABLE (23) :- Socialized Conduct at Home as Presented by Parents of Cases Vs Control

SOCIALIZED CONDUCT	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
Friendship more than 6 months	24	60.0	6	20.0	9.6	0.002
Current friends more than 2	3	7.5	15	50.0	14.1	<0.001
Inform on others	10	25.0	8	26.7	0.014	0.9
Putting blame on others	13	32.5	6	20.0	0.79	0.4
Extending himself to others for advantage	22	55.0	17	56.6	0.011	0.9

* P value is significant if ≤ 0.05

GRAPH No. (23):- Socialized Conduct at Home



A : Freindship more than 6 months
B : Current friends more than 2
C : Inform on others
D: Putting blame on others
E: Extending himself to others for advantage

From table No. (23) and graph No. (23), it is observed that, variables of socialized conduct at home that have statistically significant difference between case and control groups were:-

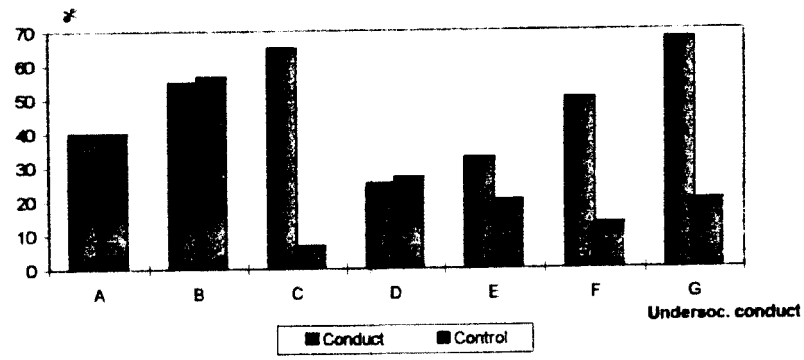
- Friendship more than 6 months:- was commoner in the case (60%) than control group (20%) with highly statistically significant difference as P = 0.002.
- Current friends more than 2:- was more proponderant in the control (50%) than case group (7.5%) with highly statistically significant difference as P < 0.001.

TABLE (24):- Undersocialized Conduct at Home as Presented by Parents of Cases Vs Control

UNDERSOC. CONDUCT	CONDUCT (40)		CONTROL (30)		X^2	*Pvalue
	N	%	N	%		
Friendship less than 6 months.	16	40.0	12	40.0	0.061	0.8
Exends himself to others for advantage.	22	55.0	17	56.6	0.011	0.9
Current friends less than 2.	26	65.0	2	6.7	21.9	<0.001
Inform on others.	10	25.0	2	6.7	0.014	0.9
Putting blame on others.	13	32.5	6	20.0	0.79	0.4
Lie to harm others.	20	50.0	4	13.3	8.67	0.003
Doesn't conform to home rules.	27	67.5	6	20.0	13.67	<0.001

* P value is significant if ≤ 0.05

GRAPH No. (24):- Undersocialized Conduct at Home



A : Friendship less than 6 months
B : Extends himself to others for advantage
C : Current friends less than 2
D : Inform on others
E : Putting blame on others
F : Lie to harm others
G : Doesn't conform to home rules

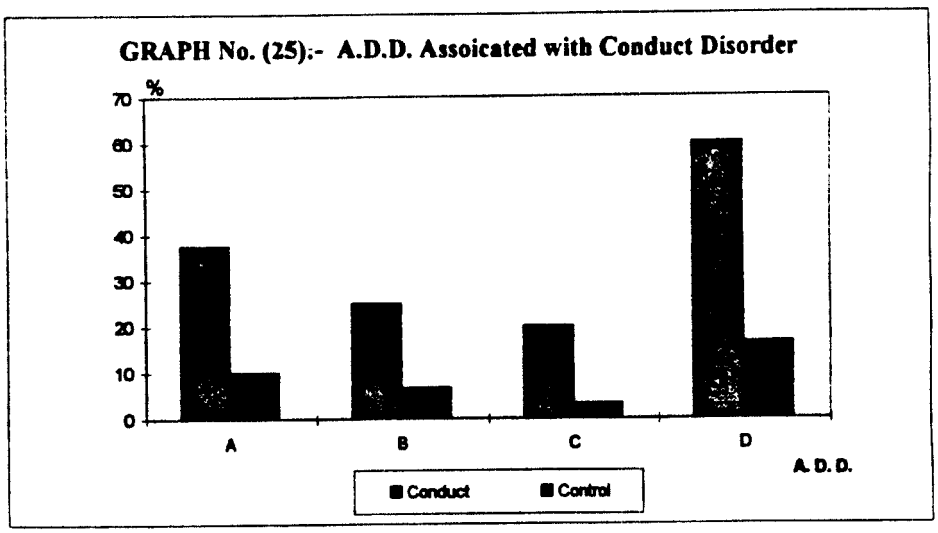
From table No. (24) and graph No. (24), it is apparent that undersocialized conduct at home was commoner in the conduct than control group. The variables that have statistically significant differences between the two groups were:-

- Current friends less than 2:-was more proponderent in the case (65%) then control group (6.7%) with highly statistically significant difference as P<0.001
- Lie to harm others:- was commoner in the case (50%) than control group (13.3%) with highly statistically significant difference as P = 0.003.
- Doesn't conform to home rules:- was more prevalent in the case (67.5%) than control group (20%) with highly statistically significant difference as P < 0.001.

TABLE (25):- A.D.D. Associated with Conduct Disorder of Cases Vs control

ATTENTION DEFICIT DISORDER	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
Restlessness	15	37.5	3	10.0	5.42	0.02
Inattention	10	25.0	2	6.7	2.87	0.09
Impulsivity	8	20.0	1	3.3	2.89	0.09
Poor scholastic achievement	24	60.0	5	16.6	11.5	<0.001

* P value is significant if ≤ 0.05



A : Restlessness
B : Inattention
C : Impulsivity
D : Inability to concentrate
E : Poor scholasic achievement

From table No. (25) and graph No. (25), it is apparent that A.D.D. was commoner in the case than control group. Variables that have statistically significant differences were:-

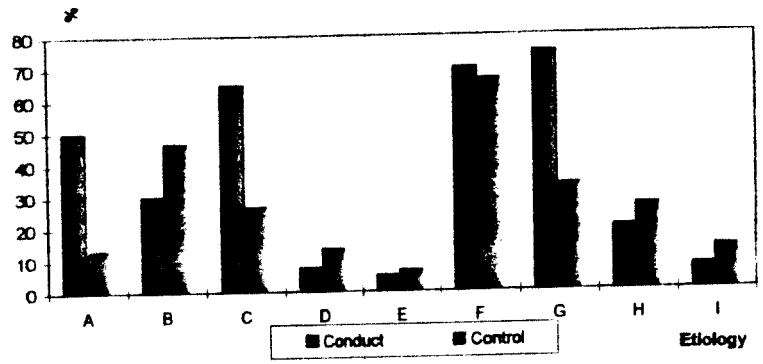
- Restlessness: was more proponderant in the case (37.5%) than control group (10%) with statistically significant difference as P = 0.02.
- Poor scholostic achievement: was more prevalent in the case (60%) than control group (16.6%) with highly statistically significant differenceas as P < 0.001.

TABLE (26):- Possible Etiological Factors Related to Birth and Early Development of Cases Vs Control

ETIOLOGY	CONDUCT (40)		CONTROL (30)		X^2	* P value
	N	%	N	%		
Maternal illness during pregnancy.	20	50.0	4	13.3	6.67	0.003
Difficult labour.	12	30.0	14	46.7	1.38	0.23
Delayed milestones.	26	65.0	8	26.7	8.60	0.003
Sudden weaning.	3	7.5	4	13.3	0.16	0.9
Delayed weaning.	2	5.0	2	6.7	0.05	0.8
History of fever.	28	70.0	20	66.6	0.001	0.97
History of accident.	30	75.0	10	33.3	10.50	0.001
History of hospitalization.	8	20.0	8	26.7	0.13	0.7
History of operation.	3	7.5	4	13.3	0.16	0.9

* P value is significant if ≤ 0.05

Graph No. (26):- Possible Etiological Factors Related to Birth and Early Development



A : Maternal illness during pregnancy
B : Difficult labour
C : Delayed milestones
D : Sudden weaning.
E : Delayed weaning
F : History of fever
G: History of accident
H: History of hospitalization
I : History of operation

From table No. (26)and graph No. (26), it is observed that; some etiological factors have statisitically significant differences between case and control groups, these were:-

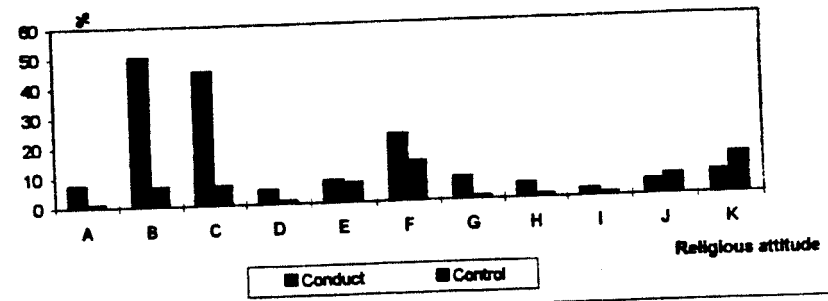
- Maternal illness:- was more proponderant in the case (50%) than control group (13.3%) with highly statistically significant difference as P = 0.003.
- Delayed milestones:- was commoner in the conduct (65%) than control group (26.7%) with highly statistically significant difference as P = 0.003.
- History of accident:- was more frequent in the case (75%) than control group (33.3%) with highly statistically significant difference as P = 0.001

TABLE (27):- Some Etiological Factors Related to the Family of Cases Vs control

ETIOLOGICAL FACTOR		CONDUCT (40)		CONTROL (30)		X^2	*P value
		N	%	N	%		
Separation		3	7.5	0	0.0	0.34	0.25
Poor emotional relation		20	50.0	2	6.7	12.99	<0.001
Frequent quarrel		18	45.0	2	6.7	10.5	0.001
Covertly incompatible relation		2	5.0	0	0.0	0.6	0.5
Consanguinity		3	7.5	2	6.7	0.11	0.7
Family history of deafness		9	22.5	4	13.3	0.44	0.5
Family history of psychiatric illness		3	7.5	0	0.0	0.34	0.25
History of psychiatric illness:	Father	2	5.0	0	0.0	0.6	0.5
	Mother	1	2.5	0	0.0	0.02	0.8
History of physical illness:	Father	2	5.0	2	6.7	0.05	0.8
	Mother	3	7.5	4	13.3	0.16	0.9

* P value is significant if ≤ 0.05

GRAPH (27):- Some Etiological Factors Related to the Family



A : Separation
B : Poor emotional relation
C : Frequent quarrel
D : Covertly incompatible relation
E : Consanguinity
F : Family history of deafness
G: Family history of psychiatric illness
H: History of psychiatrie illness (F)
I : History of psychiaric illness (M)
J : History of physical illness (F)
K: History of physical illness (M)

From table No. (27) and graph No. (27), it is apparent that , the two factors that have statisitically significant differences between case and control groups were:-

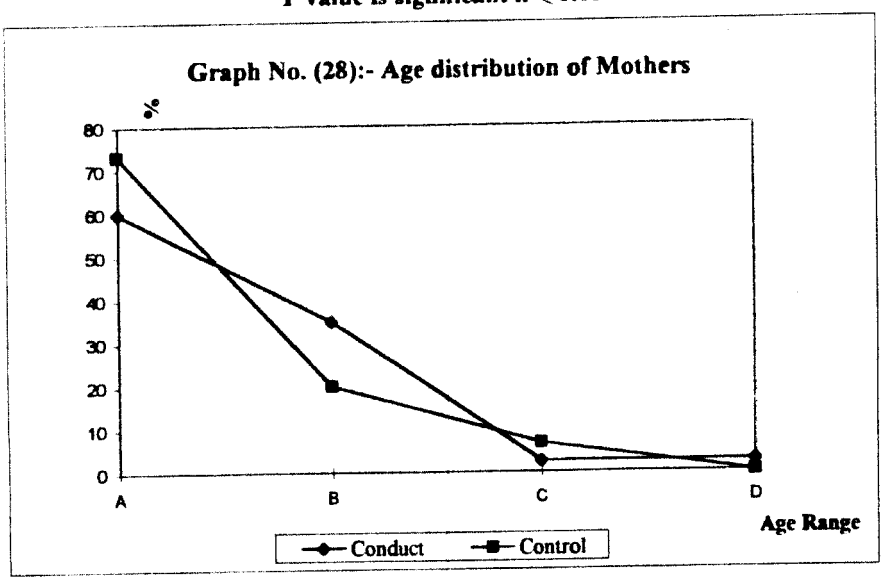
- Poor emotional relation:- was commoner in the case (50%) than the control group (6.7%) with highly statistically significant difference as $P < 0.001$.
- Frequent quarrel:- was more prevalent in the case (45%) than control group (6.7%) with highly statistically significant difference as $P = 0.001$.

TABLE (28):- Age Distribution of Mothers of Cases Vs Control

AGE RANGE (YEARS)	CONDUCT (40)		CONTROL (30)		* P value
	N	%	N	%	
25-35	24	60.0	22	73.3	
36-45	14	35.0	6	20.0	
46-55	1	2.5	2	6.7	
56-65	1	2.5	0	0.0	
Mean age	34±2.3		28±2.4		0.6

* P value is significant if ≤ 0.05

Graph No. (28):- Age distribution of Mothers



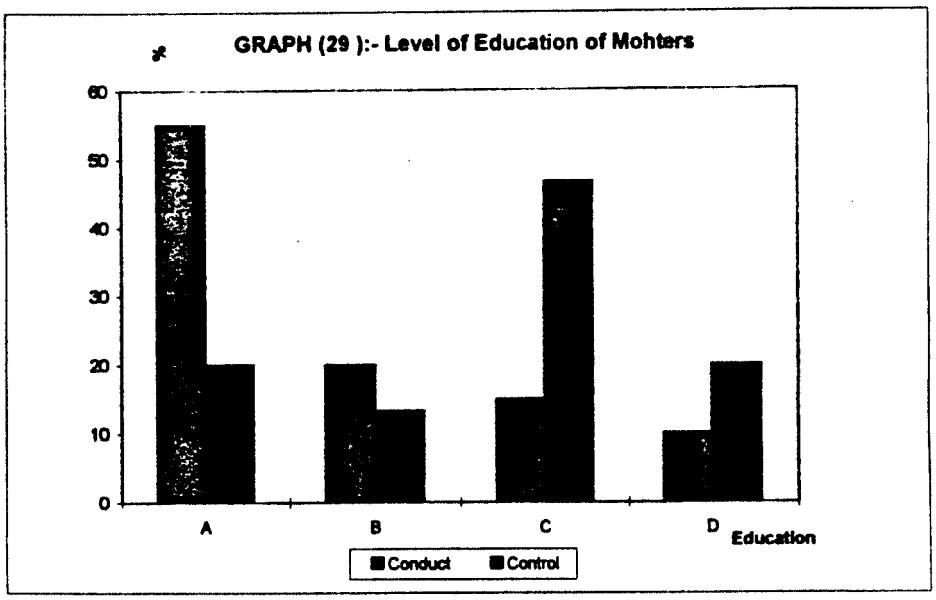
A: (25-35)
B: (36-45)
C: (46-55)
D: (56-65)

From table No. (28) and graph No. (28), it was observed that; the commonest age range was (36-45) for the cases (60%) and control group (73.3%) with no statistically significant difference.

TABLE (29):- Level of Education of Mothers of Cases Vs Control

EDUCATION	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
Illitrate	22	55.0	6	20.0	7.30	0.006
Read and write	8	20.0	4	13.3	0.17	0.68
Technical school	6	15.0	14	46.6	6.90	0.008
University	4	10	6	20.0	0.70	0.4

* P value is significant if ≤ 0.05



A: Illitrate C: Technical school
B: Read and write D: University

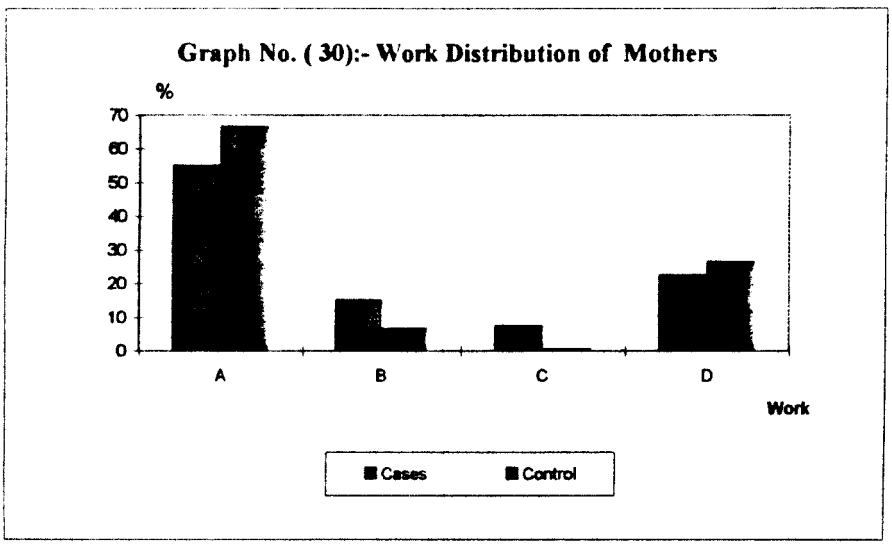
From table No. (29) and graph No. (29), it is apparent that illitracy was more prevalent in the case (55%) than control group(20%) with statistically significant difference as P = 0.006.

Mothers who were graduated from technical school were commoner in control (46.6%) than conduct group (15%) with statistically significant difference as P= 0.008.

TABLE (30):- Work Distribution of Mothers of Cases Vs Control

WORK	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
House wife.	22	55.0	20	66.6	0.54	0.45
Pedlar.	6	15.0	2	6.6	0.49	0.24
Farmer.	3	7.5	0	0.0	0.34	0.25
Employe.	9	22.5	8	26.6	0.02	0.9

* P value is significant if ≤ 0.05



A : House wife
B : Pedlar
C: Farmer
D: Employe

From table No. (30) and graph No. (30), it is observed that; being house wife was the commonest for mothers of control (66.6%) and case group (55%) with no statistically significant difference.

TABLE (31):- Religious Attitude of Mothers of Cases Vs control

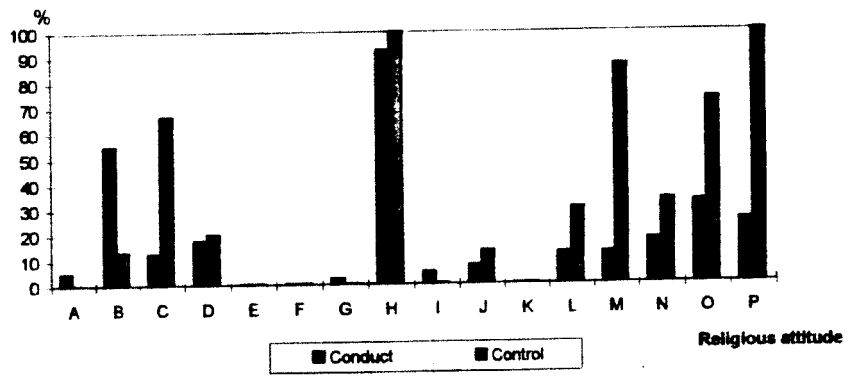
RELIGIOUS ATTITUDE	CONDUCT (40)		CONTROL (30)		X2	*P value
	N	%	N	%		
PRAYING:						
Never pray.	2	5.0	0	0.0	0.6	0.5
Irregular pray at home.	22	55.0	4	13.3	11.0	<0.001
Regular pray at home.	5	12.5	20	66.6	19.6	<0.001
Pray once a week at mosque/church.	7	17.5	6	20.0	0.00	0.96
Pray frequently at mosque/church.	0	0.0	0	0.0	0.00	0.0
FASTING:						
Never fast.	0	0.0	0	0.0	0.00	0.0
Occasionally fast.	1	2.5	0	0.0	0.02	0.8
Regular fast.	37	92.5	30	100.0	0.88	0.25
Fast more than usual.	2	5.0	0	0.0	0.26	0.32
SOURCE OF RELIGIOUS INFORMATION:						
Occasionally reads religious books.	3	7.5	4	13.3	0.16	0.9
Regularly reads religious books.	0	0.0	0	0.0	0.0	0.0
Join or watch religious session or lecture.	5	12.5	9	30.0	2.28	0.13
RELIGIOUS INSTRUCTION TO THE CHILD:						
Encourage to pray.	5	12.5	26	86.7	35.3	<0.001
Encourage to fast.	7	17.5	10	33.3	1.56	0.21
Encourage to go to mosque/church.	13	32.5	22	73.3	9.80	0.002
Encourage to learn in religion.	10	25.0	30	100.0	36.40	<0.001

* P value is significant if ≤ 0.05

From table No. (31) and graph No. (31), it is observed that; there was more concern of the mothers of the control group in religion than the case group. th variables with statistically significant differences were:-

- Irregular pray at home:- was commoner in the case (55%) than control group (13.3%) with highly statistically significant difference as P < 0.001.
- Regular pray at home: was commoner in the control (66.6%) than conduct group (12.5%) with highly statistically significant difference as P < 0.001.
- Encourage to pray:- was more prevalent in the control (86.7%) than case group (12.5%) with highly statistically significant difference as P < 0.001.
- Encourage to go to mosq./ch.: was more prevalent in the control (73.3%) than conduct group (32.5%) with highly statistically significant difference as P = 0.002.
- Ecnourage to learn in religion:- was more prevalent in the control (100%) than case group (25%) with highly statistically significant difference as P< 0.001.

Graph No. (31):- Religious Attitude of Mothers



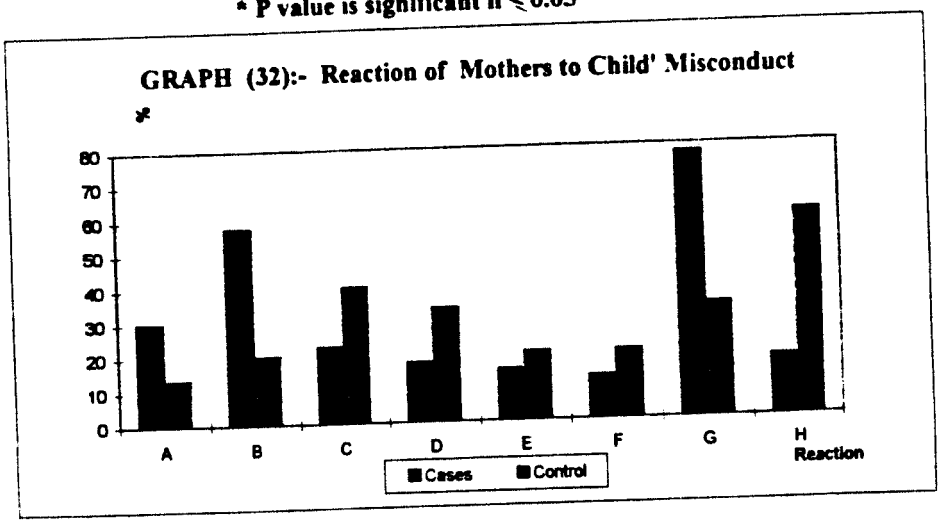
A : Never pray.
B : Irregular pary at home.
C : Regular pray at home.
D : Pray once a week at mosq./ch.
E : Pray frequently at mosq./ch.
F : Never fast.
G : Occasionally fast.
H : Regular fast.
I : Fast more than usual.
J : Occasionally reads religious books.
K : Regularly reads religious books.
L : Join or watch religious session or lecture.
M: Encourage to pray.
N : Encourage to fast.
O : Encourage to go to mosq./ch.
P : Encourage to learn in religion.

TABLE (32):- Reaction of Mothers to Child' Misconduct in Cases Vs Control

REACTION	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
Neglect.	12	30.0	4	13.3	1.80	0.17
Defend.	23	57.5	6	20.0	8.50	0.003
Blame.	9	22.5	12	40.0	1.70	0.20
Dispute.	7	17.5	10	33.3	1.60	0.20
Threaten.	6	15.0	6	20.0	0.05	0.80
Frighten.	5	12.5	6	20.0	0.27	0.60
Beat.	31	77.5	10	33.3	12.00	<0.001
Encourage to stop misconduct.	7	17.5	18	60.0	11.70	<0.001

* P value is significant if ≤ 0.05

GRAPH (32):- Reaction of Mothers to Child' Misconduct



A: Neglect
B: Defend
C: Blame
D: Dispute
E : Threaten
F : Frighten
G : Beat
H : Encourage to stop misconduct

From table No. (32) and graph No. (32), it is apparent that; the mothers' reactions that have statisitically significant differences between cases and control are:

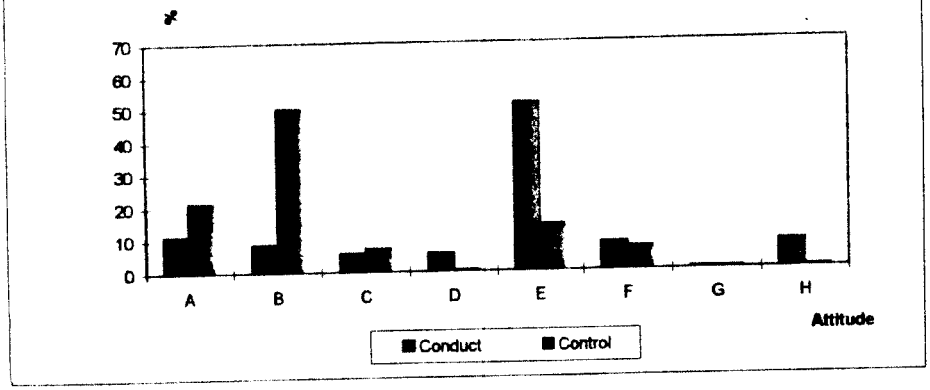
- Defend: was more proponderant in case (57.5%) than control group (20%) with highly statistically significant difference as P = 0.003.
- Beat : was commoner in case (77.5%) than control group (33.3%) with highly statistically significant difference as P < 0.001.
- Encurage to stop misconduct:- was more prevalent in the control (60%) than case group (17.5%) with highly statistically significant difference as P < 0.001.

TABLE (33):- Parental Attitude (Mothers) of Cases Vs Control

ATTITUDE	CONDUCT (35)		CONTROL (28)		X^2	*P value
	N	%	N	%		
Authoritarianism.	4	11.2	6	21.3	0.70	0.4
Over-protection.	3	8.4	14	50.0	12.30	<0.001
Negligence.	2	5.6	2	7.1	0.05	1.0
Psychological pain.	2	5.6	0	0.0	0.27	0.32
Harshness.	18	51.4	4	14.2	6.60	0.01
Spoiling.	3	8.4	2	7.1	0.11	0.6
Vascillation.	0	0.0	0	0.0	0.00	0.0
Differentiation.	3	8.4	0	0.0	0.34	0.25

* P value is significant if ≤ 0.05

Graph No. (33):- Parental Attitude (Mothers)



A: Autharitarianism
B: Over- protection
C: Negligence
D: Psychological pain
E: Harshness
F: Spoiling
G: Vascillation
H: Differentiation

N.B: Number of mothers who answered "Parental Attitude Inventory" were 35 of conduct and 28 of the control group.

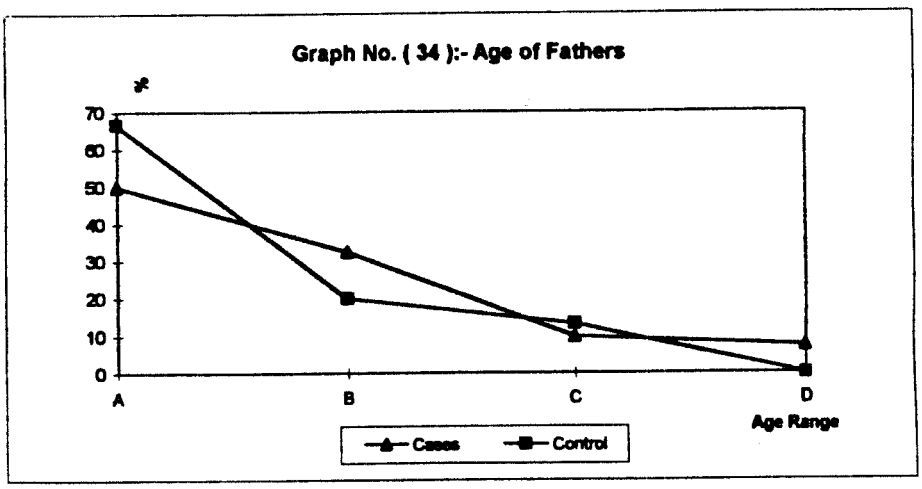
From table No. (33) and graph No. (33), it is observed that; out of all parental attitudes (mothers); only over-portection and harshness have statistically significant differences:-

- Over-protection:- was more prevalent in the control (50%) than case group (8.4%) with highly statistically significant differece as $P < 0.001$.
- Harshness :- was commoner in the case (51.4%) than control group (14.2%) with statistically significant difference as $P = 0.01$

TABLE (34):- Age of Fathers of Cases Vs control

AGE RANGE (YEARS)	CONDUCT (40)		CONTROL (30)		*P value
	N	%	N	%	
30-40	20	50.0	20	66.7	
41-50	13	32.5	6	20.0	
51-60	4	10.0	4	13.3	
61-70	3	7.5	0	0.0	
Mean age	41 ± 2.4		38 ± 2.3		0.6

* P value is significant if ≤ 0.05



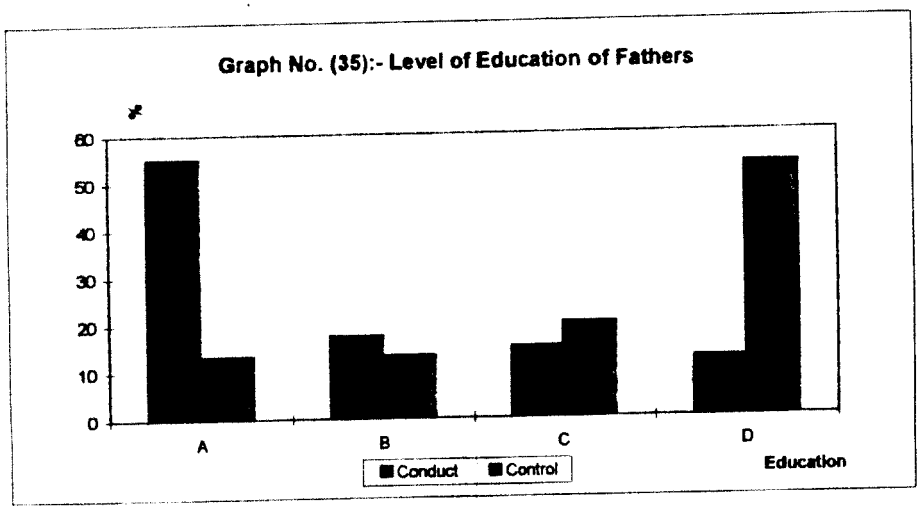
A: 30-40
B: 41-50
C: 50-60
D: 61-70

From table No. (34) and graph No. (34), it is apparent that; most of the fathers of control and case groups were in the age range of 30-40 years (66.7% & 50% respectively) and there was no statistically significant differences between the two groups.

TABLE (35):- Level of Education of Fathers of Cases Vs Control

EDUCATION	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
Illiterate.	22	55.0	4	13.3	11.00	<0.001
Read & write.	7	17.5	4	13.3	0.02	0.9
Technical school.	6	15.0	6	20.0	0.05	0.8
University.	5	12.5	16	53.3	11.70	<0.001

* P value is significant if ≤ 0.05



A : Illitrate
B : Read and write
C : Technical school
D : University

From table No. (35) and graph No. (35), it is observed that; most of fathers of case group (55%) were illitrate in comparison to control group (13.3%) with highly statistically significant difference as P.< 0.001.

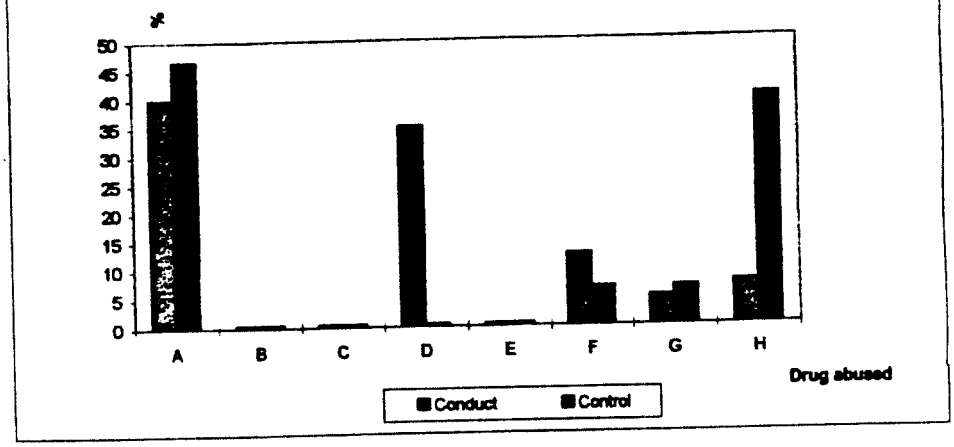
Also (53.3%) of fathers of control group were graduated from university in comparison to case gorup (12.5%) with highly statistically significant difference as P < 0.001.

TABLE (36):- Distribution of Drug Abuse by Fathers of Cases Vs control

DRUG ABUSED	CONDUCT (40)		CONTROL (30)		X^2	*P value
	N	%	N	%		
Cigarettes	16	40.00	14	46.60	0.09	0.8
Hashish	0	0.00	0	0.00	0.00	0.00
Alcohol	0	0.00	0	0.00	0.00	0.00
Cigarettes + Hashish	14	35.00	0	0.00	11	<0.001
Cigarettes + Alcohol	0	0.00	0	0.00	0.00	0.00
Minor transquilizer	5	12.50	2	6.70	0.16	0.35
Others	2	5.00	2	6.70	0.05	1.0
No Drug abuse	3	7.50	12	40.00	8.9	0.003

* P value is significant if ≤ 0.05

GRAPH (36) :- Distribution of Drug Abuse by Fathers



A :Cigarettes
B : Hashish
C : Alcohol
D : Cigarettes + Hashish
E : Cigarettes + Alcohol
F : Minor tranquilizer
G : Others
H : No drug abuse

From table No. (36) and graph No. (36), it is observed that; there was high proponderance of fathers of case group (35%) abusing (Cigarettes + Hashish) and non of the control group and the difference was highly statistically significant as P. < 0.001.

Also (40%) of fathers of control group were not abusing drugs in comparison to (7.5%) of case group and the differnece was highly statistically significant as P = 0.003.

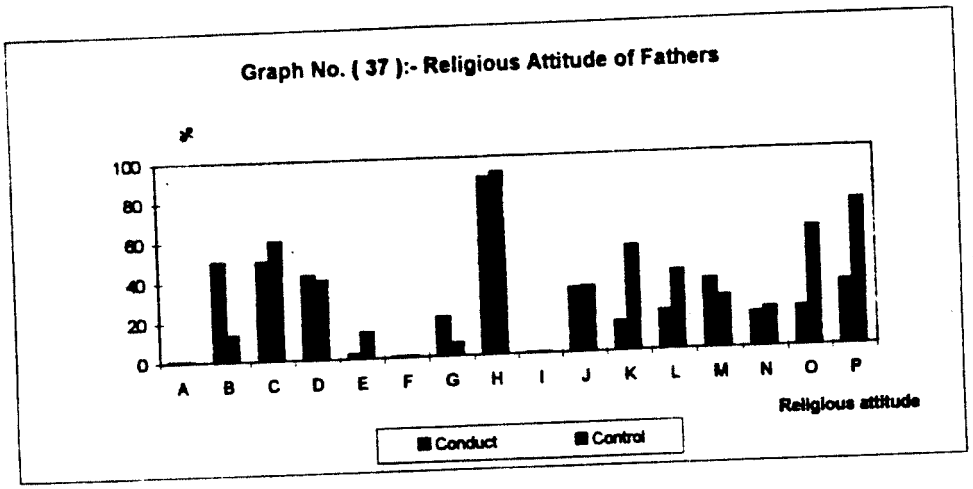
TABLE (37):- Religious Attitude of Fathers of Cases Vs control

RELIGIOUS ATTITUDE	CONDUCT (40)		CONTROL (30)		X2	*P value
	N	%	N	%		
PRAYING:						
Never pray.	0	0.0	0	0.0	0.0	0.0
Irregular pray.	20	50.0	4	13.3	8.7	0.003
Regular pray at home.	20	50.0	18	60.0	0.34	0.6
Pray once a weekly moseque/church.	17	42.5	12	40.0	0.001	0.97
Pray frequently at mosque/ church.	1	2.5	4	13.3	1.6	0.2
FASTING:						
Never fast.	0	0.0	0	0.0	0.00	0.0
Occasionally fast.	8	20.0	2	6.7	1.5	0.2
Regular fast.	36	90.0	28	92.3	0.00	0.8
Fast more than usual.	0	0.0	0	0.0	0.00	0.0
RELIGIOUS INFORMATION:						
Occasionally reads religious books.	13	32.5	10	33.3	0.03	0.9
Regularly reads religious books.	6	15.0	16	53.3	9.9	0.002
Join or watch religious session or lecture.	8	20.0	12	40.0	2.4	0.1
RELIGIOUS INSTRUCTION TO THE CHILD:						
Encourage to pray.	14	35.0	8	26.6	0.23	0.6
Encourage to fast.	7	17.5	6	20.0	0.00	0.96
Encourage to go to mosque/church.	8	20.0	18	60.0	10.10	0.001
Encourage to learn in religion.	13	32.5	22	73.3	9.80	0.002

* P value is significant if < 0.05

From table No. (37) and graph No. (37), it is apparent that there was more proponderance of fathers of control group who WERE concerned with religion than case group. The variables which have statistically significant differences were:-

- Irregular pray at home:- was more prevalent in the case (50%) than the control group (13.3%) with highly statistically significant difference as P = 0.003.
- Regularly reads religious books:- was commoner in the control (53.3%) than case group (15%) with highly statistically significant difference as P = 0.002.
- Encourage to go to mosq/ch.:- was more proponderance of fathers of the control (60%) than case group (20%) with highly statistically significant difference as P = 0.001.
- Encourage to learn in religion:- was commoner in fathers of control (73.3%) than case group (32.5%) with highly statistically significant difference as P = 0.002.

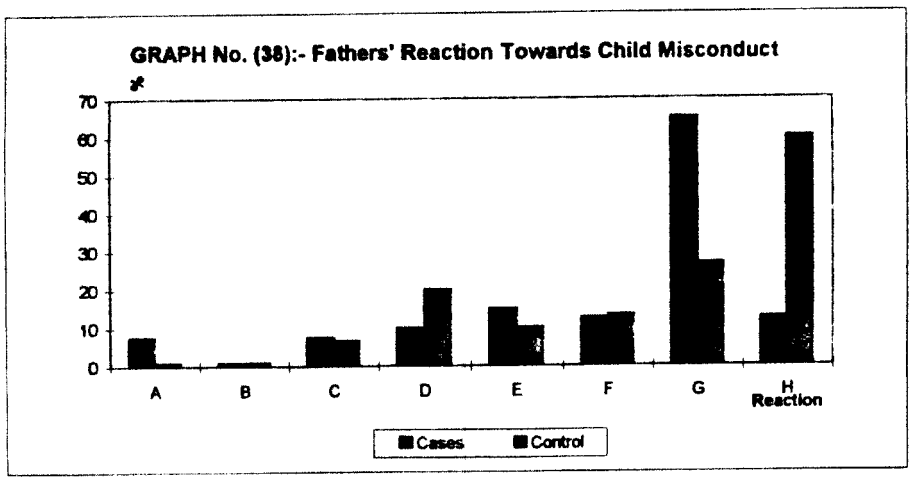


A : Never pray.
B : Irregular pary at home.
C : Regular pray at home.
D : Pray once a week at mosq./ch.
E : Pray frequently at mosq./ch.
F : Never fast.
G : Occasionally fast.
H : Regular fast.
I : Fast more than usual.
J : Occasionally reads religious books.
K : Regularly reads religious books.
L : Join or watch religious session or lecture.
M : Encourage to pray.
N : Encourage to fast.
O : Encourage to go to mosq./ch.
P : Encourage to learn in religion.

TABLE (38):- Reaction of Fathers To Child' Misconduct of Cases Vs Control

REACTION	CONDUCT (40)		CONTROL (30)		X^2	* P value
	N	%	N	%		
Neglect.	3	7.5	0	0.0	0.34	0.25
Defend.	0	0.0	0	0.0	0.00	0.0
Blame.	3	7.5	2	6.7	0.11	0.7
Dispute.	4	10	6	20	0.70	0.4
Threaten.	6	15.0	3	10.0	0.07	0.8
Frighten.	5	12.5	4	13.3	0.07	0.8
Beat.	26	65.0	8	26.7	8.60	0.003
Encourage to stop misconduct.	5	12.5	18	60.0	15.40	<0.001

* P value is significant if ≤ 0.05



A : Neglect
B : Defend
C : Blame
D : Dispute
E : Threaten
F : Frighten
G: Beat
H: Encourage to stop misconduct

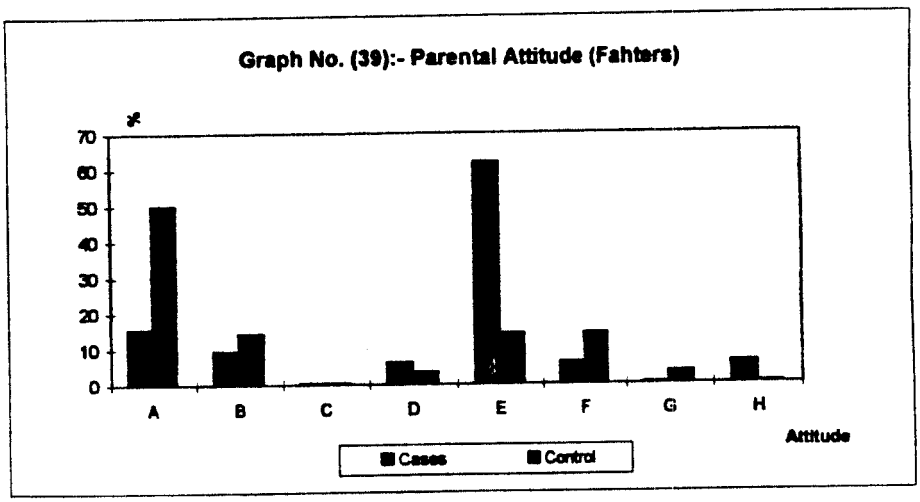
From table No. (38) and graph No. (38), it is observed that; fathers' reaction towards the child' misconduct differ from conduct to control group . The reactions that have satistically significant differences were:

- Beat : was commoner in the conduct (65%) than control group (26.7%) with highly statisitically significant difference as P = 0.003.
- Econourage to stop misconduct:- was more prevalent in the control (60%) than conduct group (12.5%) with highly statistically significant difference as P <0.001.

TABLE (39):- Parental Attitude (Fahters) of Cases Vs Control

ATTITUDE	CONDUCT (32)		CONTROL (28)		X^2	*P value
	N	%	N	%		
Authoritarianism.	5	15.5	14	50.0	8.50	0.003
Over-protection.	3	9.3	4	14.2	0.60	0.43
Negligence.	0	0.0	0	0.0	0.00	0.0
Psychological Pain.	2	6.2	1	3.5	0.11	1.0
Harshness.	20	61.9	4	14.2	8.70	0.003
Spoiling.	2	6.2	4	14.2	1.50	0.39
Vascillation.	0	0.0	1	3.5	1.40	0.42
Differentiation.	0	0.0	0	0.0	0.00	0.0

* P value is significant if ≤ 0.05



A : Authoritarianism
B : Overprotection
C : Negligence
D: Psychological pain
E: Harshness
F: Spoiling
G: Vascillation
H: Differentiation

From table No. (39) and graph No. (39), it is observed that, out of all parental attitudes (fathers); only two attitudes have statistically significant differences:-

- Authoritarianism:- was more prevalent in the control (50%) than case group (15.5 %) with highly statistically significant difference as P = 0.003.
- Harshness :- was more proponderent in the case (61.9%) than control group (21.3%) with highly statistically significant difference as P = 0.003.

DISCUSSION

DISCUSSION

Hearing loss is considered one of the most common and important forms of sensory deprivation. At least one of every 16 Americans has some degree of hearing loss and may use a variety of communication modes. Estimates of the number of children with hearing impairment vary considerably. Such things as differences in definition, population studies and accuracy of testing contribute to the varying figures *(Mc Entee, 1995)*.

Bamford and Saunders, (1991), reported that; approximately 1 in 1000 children have moderate to severe congenital and early onset hearing impairment, rising to 4 in 1000 if acquired losses are included, yet other authorities have concluded that approximately 5% of all school children have hearing impairments, many of them, however, are not considered severe enough to require special educational services.

In Egypt, approximately 3 in 1000 primary school children have various degrees of hearing loss *(Wassila and Mahasen, 1994)*.

In Egypt, there is no routine screening of hearing on entering primary schools, so it is difficult to get the true incidence of deafness among our school children as mild cases of hearing loss and those who have unilateral losses pass unnoticed and are usually incorporated with hearing children in the ordinary schools.

Hearing is the primary sensory modality for acquisition of speech and language, providing a fundamental basis for social adjustment and normal psychological development. Even mild or unilateral hearing loss during childhood has been shown to have a negative impact on language and child behavior. More severe hearing loss presents a major handicap for normal psychological development *(Northern and Downs, 1984)*.

Hearing disabilities, due to their interactive nature strongly affect intimate relationships that leads to social isolation and emotional impact. *(Hetu et al., 1994)*.

Deafness in childhood has a major implication for the child functioning in his physical, psychological and social terms. This is added to the emotional trauma, the diagnosis of deafness has on the child's family, can explain the high prevalence of conduct disorders among deaf children. The more profound the deafness and the earlier the onset, the greater the effect. *(Hindlay and Brown, 1994)*.

The mother's reactive depression upsets important developmental processes during "critical periods", resulting in emotional and cognitive developmental interferences which may not respond to later intervention. Many of the difficulties of deaf children and adolescents such as their problems with affect modulation, frustration tolerance and learning disabilities may be referable to the emotional trauma that occur during this period. *(Rothstien, 1975)*.

The mother, without being aware of deafness, may feel rejected or deprived by her infant's failure to respond to her stimuli. The deaf infant's failure to elicit maternal response results in lack of maternal stimulation. *(Williams, 1970; Mindel, 1971 and Lesser, 1972)*.

Mahapatra (1974), postulated that emotional consequences of hearing impairment are the result of sensory deprivation and social isolation. The psychological effects of hearing loss would be expected to a far higher degree in patients with bilateral loss, rather than unilateral loss, and the severe degree than the moderate and mild degrees of hearing loss.

Prevalence of Conduct Disorder:

In this study, the prevalence of conduct disorder in deaf children, in El-Amal School for Deaf Children in Shoubra district at Cairo, was 13.3% (diagnosed according to DSM III criteria). There is higher prevalence of aggressive socialized group than non-aggressive under-socialized group. The ratio was 8.5 : 1.

Among the studies in Egypt concerning conduct disorder in children (normal hearing) was that of Hamouda (1984), in his study on primary school children in Kafr El-Sheikh and Cairo. He found that the prevalence of conduct disorder in the Urban as presented by a primary school in Cairo was 7.46% Vs 3.93% in the rural areas as presented by children of the primary school in Kafr El-Eheikh. They were mostly of the socialized type. The ratio of socialized VS udner socialized was 5:1.

El-Sherbini et al., (1987), in a similar study on the primary school (normal hearing) children in the City of Tanta, Egypt, found that the prevalence of conduct disorder was 5.3% which is somewhat higher than that in the previous study. This difference is due to that; in El-Sherbini's study the prevalence was the total sum of the children having individual antisocial symptoms, while Hamouda's study, the prevalence was children having the diagnosis of conduct disorder according to DSM III.

Werner et al., (1968) in his study on the 1955 birth Cohort of normal hearing boys and girls on the Island of Kauai, Hawai, found the prevalence of persistent overt aggressive behavior including acting

out of problems; lying, destructiveness, ... etc. to be 7%. In the Istle of Wight Study by Rutter et al., (1970); the prevalence of conduct disorder was 4% among 10 and 11 years old children. Rutter (1973), conducted a similar study on same aged children in London and revealed that, the prevalence of conduct disorder was twice as the previous study.

The higher prevalence of conduct disorder in deaf than in normal hearing children can be attributed to the fact that; the deaf child is subjected to all the frustrations of the hearing child. But to these, it is added the further frustration of his inability to communicate with his family and friends by quickest method possible: speech. The deprivation of background noises was most intimately related the feeling of depression to which the hearing impaired were prone. This was produced by the feeling of detachment unreality and isolation that deprivation produced. *(Silverman, 1970)*.

The higher prevalence of aggressive socialized group in this study agrees with that of Hamouda's study (mentioned before). This may be attributed to the style of the Egyptian Culture, where there are close family relationships within the nuclear as well as the extended family. Also the nature of the Shoubra district, as those children are coming from areas where houses are narrow and close to each other, and may be more than one family sharing the same flat. Also children are left playing together most of the time in the streets either in the absence of parental supervision or the presence of ignorant and/or illitrate parents. So they are exposed to bad models of identification.. This, in turn, is reflected on the nature of the behavior of these children.

DEAFNESS:

Hearing loss is considered one of the most common and important forms of sensory deprivation *(Saad et al., 1996)*.

In the current study, all children were deaf (conduct and control groups) and the degree of hearing loss ranging from 41 d.B to 90 + d.B with no statistically significant difference between the two groups.

It is noticed that, there is no children in El-Amal School who have mild hearing impairment nor unilateral hearing loss, this can be attributed to the fact that these children pass usually unnoticed in the ordinary schools and most of them suffer from poor scholastic achievement. Here is the importance of routine screening of children on entering nursery or elementar schools for early detection and proper treatment of children with mild and unilateral hearing loss.

In the present study, the causes of deafness of children in conduct and control groups were as follows; hereditary hearing loss (52.5% & 53.3% respectively), chronic suppurative otitis media (22.5% & 20%

respectively), post-meningitic (10% & 6.7% respectively) post-measles (5% & 3.3% respectively) and others. There was no statistically significant differences between the conduct and control groups.

Reviews of the literature on causal factors in childhood deafness, in fact, indicate that somewhere between 25 and 50 percent of all childhood deafness is due to heredity *(Hoemann and Briga, 1981)*.

Hereditary factors can be implicated in about one third of hard-of-hearing patients. *(Sataloff and Sataloff, 1992)*.

The most common cause of acquired hearing loss in children is chronic suppurative otitis media. *(Kenna et al., 1986)*. This is probably due to lesser immunity and greater incidence of exposure to upper respiratory infection than adults. *(Ruper and Raman, 1991)*.

Prevalence of C.S.O.M among Egyptian primary school children is 1.48%, in which bilateral ear disease was accounted for 21.8% of these cases, all of them had various degrees of hearing loss. *(Wassila and Mahasen, 1994)*.

Otitis media with effusion is one of the commonest chronic otological condition of childhood. It indicates a middle ear effusion without pain, redness or bulging of the tympanic membrane. A great number of cases, especially in older children, have a silent onset without a clinically evident antecedent of acute otitis media; however others, especially in younger children, it is often unresolved stage of acute otitis media. *(Gates, 1993)*.

Meningitis is a common cause of deafness in early childhood and still one of the serious infectious diseases in clinical practice. 76.4% of children suffering from meningitis developed sensorineural hearing loss which varied between mild hearing loss to total deafness. *(Aust, 1994)*.

Severe to profound deafness has been found in 4 - 8% of children with histories of maternal rubella, and it has also been recognized following asymptomatic maternal infection. *(Schuknecht, 1974)*.

SOCIO-DEMOGRAPHIC FACTORS:

Concerning the sociodemographic factors in the cases of this study, factors that might have an influence on the development of conduct disorder as age, sex, birth order, family size, socioeconomic status.

Age Distribution:

In this study, the mean age of conduct group was 9.3±1.10 years while that of control group was 8.7 ± 1.14 years with no statistically significant difference between the two groups.

This agrees with *Hamouda (1984)* who found in his study that; the mean age of conduct disorder was 9.9 ± 1.1 years. Also *Wolf (1985)* found that; the mean age was 8.9 ± 1.4 years. *Beract (1986)* in his study concluded that the mean age was 8.2 ± 1.7 years, and *Jenings (1985)* found that the mean age was 9.6 ± 1.2 years.

The age peak for aggressive under-socialized group was somewhat younger (8 : 10 years). This may be due to the nature of their behavior; that is considered to be disturbing for both the family and school. It can, thus, be easily detected by both parents and teachers. We can also observe that the non-aggressive socialized group has somewhat elder age peak (11 : 13 years). This is may be attributed to the fact that; their misbehavior is not manifest. The absence of physical interference with others in addition to their good social relations make their misbehavior passed undetectable. Also, their misbehavior may be acceptable among family members; later on when they reach elder age, they start to deal with others in the wider community and their misbehavior then becomes manifest.

Conduct disorder usually diagnosed in elder children because at a younger age, those children are found to be emotionally tied to their parents. Their behavior even if severely aggressive may be either denied or accepted as a part of normal behavior for their age and rationalized by being spoilt for they are still young. Any misbehavior can be easily detected and corrected by parents who consider themselves responsible for their children.

Sex Distribution:

In the present study; conduct disorder was found to be more preponderant in the boys than girls The male/female ratio was 7 : 1. In the control group the ratio was 6.5 : 1 with no statistically significant differences between the two groups.

Stainback and *Stainback (1980)*, in their study on the prevalence of conduct disorder found that; the male/female ration ranging from 3 : 1 up 7 : 1, while *Strachan (1981)* found that; among 79 youngsters who were fire setters, only there was one girl. Also *Jacobson (1984)* in his study on 104 children who were fire setters found that male/female ratio was 5.2 : 1.

Hamouda (1984) reported in his study that; conduct disorder is commoner in boys and the male/female ration was found to be 6 : 1 in

the rural area and 9.8 : 1 in the urban area and *Werry et al. (1987)* agreed with previous studies and concluded that the male/female ration was 4 : 1.

In our culture; female misconduct is usually dealt with within the family so as not to bring shame to the name of the family. A small percentage is usually referred for psychiatric consultation thus males are more presented in the family.

Mostly studies of children under six, reveal that boys are signifantly more agressive than gilrs *(Latif, 1996)*.

Boys are more likely to be overtly aggressive. This is because of the permissive attitude of the family and the society for this overt aggression. On the other hand, female role tend to be more submissive. This is encouraged by the family. Any aggressive behavior conducted by girls is culturally rejected. This agrees with *Patterson (1967); Minton et al., (1971); West (1985) and Wolf (1985)*.

The hormonal pattern and body built of boys cause more activity and increase contact with other children in the community which gives them the chance for imitating and reinforcing each other' behavior. This provokes more aggression and increases the tendency for misconduct in boys. This agrees with *Eme (1979)*, while *Yeudal (1980)* added that neurohormonally controlled gender differences in brain development render males more susceptible to minimal brain damage (dominant hemisphere dysfunction) and hence more liable to develop all forms of conduct disorder.

Child Birth Order:

Children are affected by the spacing of births and by the number of siblings, the smaller the gap between births, the greater the likelihood of jealousy between the children. The youngest of a large family has a different childhood from the only child or the child who is born years after the next oldest in the family, he is apt to be spoilt and petted not only by his parents but by his grown up siblings. Ordinal position in the family has its effect on children. First born tend to achieve more highly than their younger siblings and are slightly more at risk for developing emotional disorders, this can be explained by the fact that parents tend to pay more attention to and stimulate their first born but at the same time are more anxious in their approach. *(Oluwya, 1988)*.

In the present study; elder child was more preponderant in the conduct (60%) and control group (46.6%), this followed by middle ordered child in the conduct (27.5%) and control group (26.7%) and

there were no statistically significant differences between the two groups.

The increasing incidence among elder child may be due to the fact that being the elder, he may be considered a precious child therefore spoilt and always forgiven for his misbehavior. Also being the elder; he may cause his family to be more demanding expecting from him unusual success even if beyond his abilities or capacity. This may cause the child to be involved in misconduct to compensate for or to overcome his inadequacy. This view agrees with *Koller (1971); Hamouda (1984); and Armanios (1985).*

The high presentation among middle ordered child may be due to the fact that being in the middle may cause the child to feel lost between the elder sibs who are taking all the care and a younger sib who is taking all the attention from parents. Also being in the middle may be less supervised and cared for by parents. The child may therefore be involved in misconduct seeking for attention. He may adopt the misconduct due to the influence of a delinquent neighborhood in the absence of family supervision. This view agrees with *Hare & Shaw (1965) and Fahmy (1987).*

Although many authors mentioned the child' birth order in the study of the psychological condition of the child as *(Baker 1971)* & *(Rutter and Hersov 1977)*, there are few reliable statistical studies of the influences of birth order on the child's personality and his subsequent reaction to stress.

Level of Education:

Due to the nature of the handicapping condition, deafness, special education is offering to these children. Primary school for deaf children is divided into 8 classes instead of 5 classes in ordinary schools.

In the present study; the conduct group children were mainly in 7th class (25%), then 6th class (20%), then 2nd class (17.5%) while the control group; children were mainly in the 6th and 7th (20%). There were no statistically significant differences between the two groups.

The high prevalence of the conduct group children at 6th and 7th classes which represents the pre-adolescent age when the misconduct of the child is considered an attitude used to attract attention of others, or to satisfy the needs to be recognized and admired and to feel different from other youngsters. This was confirmed by the view of *Burk (1962)*; it is the age at which the child starts to move freely in the community and is passing identity crisis. This crisis represents a conflict between dependency relationship of childhood and a desire to be separated from the family, searching for his identity away from the field of family

supervision. He starts to be more attached to others outside the family i.e. extrafamilial groups, that may influence his behavior in the absence of family supervision. He may be involved in antisocial acts either solitary or as a member in a group. Parents may bring him for psychiatric consultation so as to save him from being accused by higher authorities. Disorders resembling adult ones can occur in childhood *(Harrington, 1994)*.

There is low prevalence in the children at 1st and 2nd classes which corresponds to the age of about 5 - 8 years, when the children are emotionally close to both parents and teachers, so their behavior may be considered a form or a variant of normal behavior, that is culturally accepted. The presence of the emotional tie or the closeness of the child to the adults in the community makes his behavior either denied or rationalized.

Truancy as a part of non-aggressive conduct was common in the conduct group. The child may pretend to go to school while he is not. The recurrent absence may be not discovered by parents till he is expelled from school. This is more to occur in deaf children who have normal hearing parents because of the difficult communication with their children.

Size of The Family:

In the present study; families of more than 7 members were more proponderant in the conduct (62.5%) than control group (13.3%) . On other hand, families of less than 5 members were more prevalent in control (60%) than conduct group (15%). The differences were statistically significant.

Children from families of more than five members tend to have a lower level of intelligence, perform less well at school, are twice to develop conduct disorder and more liable to become delinquent *(Rutter & Modge, 1976); (Rutter & Gerald, 1985)* and *(Fahmy, 1987)*. This may be because of the presence of emotional deprivation, lack of community cohesion as well as the presence of despair and anger towards the larger society. *(Minuchin, 1967)*.

Robertsd (1971) added that; such families are mostly dependent on one inadequate source of income. The rate of parental physical and mental illness is higher in these families reflecting the imposed strains for caring for large number of children. While *West (1979)* mentioned that; the main cause of delinquency in large number of sibs is the competition among children for limited parental resources of care and attention.

On the other hand, *Wolman (1977)* mentioned that; there are certain advantage in being one of large family; this enable the child to share with others especially the parent's affection and sibs, they also reacted to stress with a minimal reaction.

Socioeconomic Status:

In the present study; (50%) of the conduct group families were of low socioeconomic state belonging to class V (27.5%) and class IV (22.5%), while (50%) of the control group families were of high socioeconomic state belonging to class II (30%) and class I (20%) and there is no statistically significant difference between the two groups.

This findings support the idea that; within a papulation, the prevalence of conduct disorder increases as one descends the social class ladder. Support for this was provided by *Rutter et al., (1975), Mc-Conville (1983) and Armanious (1985).*

This can be explained by being in the lower social class increases the chance of being anxious because of the multiple stresses and multiple frustrations upon them.

Scholastic Achievement:

Concerning the scholastic achievement; 60% of cases had poor scholastic achievement (32.5% bad and 27.5% average) compared to 16.6% of the control group and the difference is statistically significant.

Most of the control group (53.3%) were very good in scholastic achievement in comparison to (20%) of the conduct group and the difference is statistically significant.

This is consistent with *Sherbini et al., (1981); Hamouda (1984); Olweya (1988) and Shaheen (1990).*

There are several points which are considered as a triggering for poor academic achievement in the cases:

1) **Temperamental influences:**
   Attention is an important part of any learning task, and the cases in this study had difficulty in maintaining their attention.

2) **Lack of motivation:**
   Children' educational attainments are significantly associated with the attitudes of their parents towards schooling.

3) **Avoidance of learning:**
   As a part of a rebellion against adult.
   Or; some children may associate learning with punishment

and so avoid it.

4) **Impaired function:**
Underachievement may arise because of the general impairment of a child's psychological function.

5) **Deafness:**
Because of deafness, some children are over protected, loose time in consultation of physicians, hearing aids follow-up, operations, ...

Hallahan and Kauffman (1991) reported that deaf children have scored lowr in academic achievement notably in reading, spelling and mathematics on standardized tests.

On the other hand, *Abdel Baky et al., (1993)* found no difference between deaf and hearing children.

INTELLIGENCE:

In this study, it is observed that in the conduct group I.Q. was average (30%), below average (42.5%) and (27.5%). While for the control group the ratios were the following (83.3%) and (16.7%) and non respectively. There were statistically significant differences between the two groups.

There is no children in the conduct nor control group had I.Q. less than 75 because El-Amal Primary School for Deaf accept only children with I.Q. above this level.

(37.5%) of the cases had borderline intelligence and this agrees with *Douglas et al. (1968)* and *Richard et al., (1979)* who concluded that; low I.Q. in early childhood is associated with both emotional symptomatology and delinquency. The rates of antisocial behavior is generally higher than in general population.

The children with borderline intelligence are characterized by being immature and thus are easily led and suggestible by others in the community. Being influenced by others, they may be involved in conduct disorder. Also borderline intelligence is usually associated with scholastic difficulties that may lead the child to react against school rules and thus become involved in antisocial behavior. This agrees with *Corbell (1985)* who added that the child with borderline intelligence may react with aggressive and hostile behavior directed towards playmates. Also scholastic difficulties may be present. In addition, truancy and involvement in antisocial acts may be appreciated and encouraged by other peers with conduct problems.

Low I.Q. and delinquency were considered to be linked together. The children with low I. Q. are unable to control their actions *(Conklin, 1995)*.

West (1982) found that the averagae I.Q. of boys who had stopped by police for antisocial acts, was 101, compared with an aerage of 108.

After reviewing many papers on intelligence of deaf, *Moores and Moores (1989)*, concluded that deafness imposes no limitation on cognitive abilities. As a group, deaf people function within the normal range of intelligence and display the same diversity as the normal hearing population.

Deaf children of deaf parents have a mean I.Q. on performance tests of intelligence that is significantly higher than deaf children of hearing parents. This is attributed to the fact that hearing parents never use sign or fingerspelling with their deaf children *(Brill, 1960)*.

A deaf child who has the opportunity to learn and use manual communication from a very early age begins his cognitive growth, which makes it possible for him to utilize the various thinking processes as a result of having symbol system. This is reflected by his scores on performance intelligence test. So early manual communication is beneficial to deaf children. *(Meadow, 1960)*.

During performance of Good-enough-Harris Drawing a Person Test; 2 cases and 3 in control group with profound hearing loss had drawn persons with no ears at all, while 3 cases and 2 in control groups with moderately severe hearing loss had drawn persons with very large ears. This can be explained by the fact that; in the first situation the deaf children ignore the ears because they don't feel or appreciate their importance while in the second situation, the deaf children over exagerate the importance of the ears because they are suffering from their handicapping in dealing with the society.

RELIGIOUS ATTITUDE:

In the present study; it is apparent that there was little interest of the cases in religion as (32.5%) only of them pray while (73.3%) of the control group pray. Also going to mosque/church was commoner in the control (73.3%) than conduct group (32.5%). The home as a main source of religious information to the child was more prevalent in the control (86.7%) than conduct group (7.5%). The mosque/church as a source of religious information was commoner in control (66.6%) than conduct group (32.5%). The differences were statistically significant.

Most of children in the conduct (60%) and control group (53.3%) not fast. This is due to young age of the children as El-Amal School

accepts children at the age of five are incorporated in this study. Also parents, especially mothers, usually discourage fasting of their deaf children due to overprotection and fears of their health due to the nature of their handicapping condition.

Due to lack of religious information and weak religious attitude of the cases; most of these children have no guilty feeling towards their misbehavior, so conduct disordered child can justify their misbehavior and avoid guilt because they have impaired ego function.

Children with lack of the mature conscience's capacity for experiencing appropriate guilt and defects in impulse control (ego defect) are prone to sudden explosive behavioral out bursts to discharge the sweeps of rage to which they are so vulnerable.

Concerning the religious atmosphere surrounding the cases; it is apparent that there is little interest in religion of parents of conduct than control group; encouraging the children to go to mosque/church was commoner in mothers of control (73.3%) than conduct group (32.5). Also encouraging children to learn in religion was more frequent in control (100% mothers & 60% fathers) than control groups (25% mothers & 32.5% fathers).

Concerning the religious rituals performed by parents at home; it is observed in this study that; there was weak religious attitude of the parents of conduct than control group; regular praying at home was more prevalent in mothers of control (66.6%) than conduct group (12.5%). Also irregulr pray at home was commoner in fathers of conduct (45%) than control group (13.3%). The difference were statistically significant.

There was under presentation of other religious rituals, religions information and religions instruction to children in conduct than control group and the differences were statistically insignificant.

It is concluded that conduct disordered deaf children are deprived from healthy moral and religious ways of upbringing. They are in need of more religious instruction through the mosque or church and enriching the religious atmosphere at home through the parents. They elevates the religious spirit of the children and decreases their aggressive and antisocial behavior. Religions teaching and Koran texts are employed in symbolic and near magical ways in the rehabilitation process *(Jilek, 1987)*.

Neurotic Traits:

In this study; nocturnal enuresis was more preponderant in the conduct (17.5%) and non in the control group. Also temper tantrum

was commoner in the conduct (55%) than control group (20%) with statistically significant differences.

Other neurotic traits as thumb suckling, nail biting, increased and decreased appetite were more prevalent in the conduct than control group but statistically insignificant difference.

Childhood enuresis can indicate an underlying problem as benign as developmental immaturity or as serious as urinary tract obstruction or psychiatric disturbance. Although, generally a benign symptom, it causes considerable distress to both parent and child *(Foxman et al., 1986)*.

Most of the neurotics wet bed at a rate of at least once a week and the age of then ranged between 5 - 8 years. Nocturnal enuresis was commoner with violent brother, excess parental control in the form of overprotection, overcrowding at home, dependency and dark phobia.

In previous studies, nocturnal enuresis was recorded in 6.9% in hearing children *(Foxman et al., 1986* and *Olweya, 1988)*.

The high prevalence of nocturnal enuresis in conduct than hearing children can be explained by the fact that;, the emotional tension, anxiety and difficulties in dealing with the society during the day is reflected during the night as enuresis. Also dark phobia was a main cause of enuresis in deaf children.

The high incidence of dark phobia in the deaf children can be explained by the fact that; when the deaf child is in a dark room, it is extremely frightening because it is similar to being deaf and blind with environmental clues being reduced while when a hearing child is put in a dark room, he can still use his hearing and realizes that his parents and siblings are still near. The deaf child cannot use audition and thus become terrified. That is why, it is advisable to leave a night light in the deaf child's room *(Saad et al. 1996)*.

Temper tantrum was a distressing symptom for both the child and his parents. The child during attack of tantrum may injure himself. It occurred at age of 5 - 9 years in the cases of this study but it usually begin during pre-school period and was associated with deficient parental control, broken family and low socioecnomic class.

In a previous study in Egypt; temper tantrum was (19%) of hearing children *(Helmy, 1982)*.

The high prevalence of temper tantrum among conduct in comparison to hearing children can be explained by the fact that, the deaf child is usually pulled, dragged, taken to various places for

evaluation and treatment without an adequate understanding of where, why, or how long. So it is not surprising that, the child responds frequently with tantrums because the communication barrier results in so much frustration. Often, this is the only means of communication in the deaf child and it is not surprising for the deaf child to respond with tantrum just on seeing "man in white" even before examining him, and that is why it is better for the team of the audiology unit to dress normally. No white coats should be the rule.

SEXUAL MISCONDUCT:

Disorders resembling adult ones can occur in childhood *(Harrington, 1994)*.

In the present study; sexual misconduct is more presented in the conduct than control group. The most proponderant misconduct was sexual act with the same sex which was commoner in conduct (17.5%) and non in control group with statistically significant difference.

Manipulating sex organs was more prevalent in conduct (12.5%) than control group (6.7%) with statistically insignificant difference.

The presence of sexual misconduct indicates the presence of precocious sexual activity as one of the symptom of conduct disorder, which agrees with I.C.D. (1979) and D.S.M,II.R (1987). The precocious sexual activity reflects the presence of incompatible father - mother relationship which affects the mother - child relationship where the mother may physically abuse the child to the extent that it represents a serious threat for his masculinity. This is clear from history of physical abuse in the form of beating and harshness attitudes of both parents which were highly represented in the conduct group as a mode of upbringing. This agrees with *Hanghard & Jilly (1988)* who stressed the presence of history of sexual, physical or substance abuse in the families of conduct disordered children. It also goes with Meek (1984) who added that distorted mother-child relationship may be at once erotized and inhibiting. The mother is likely to be prudish and yet fascinated with her son's sexual thoughts and behavior at least to the extent that, she prefers her son's companionship to that of her inadequate marital partner. There is a lack of counter balancing strength from the child's father.

Sexually-abused victims exhibit more behavioral and emotional problems than normal children *(Valliere, Bybee and Mou·bray, 1988)* and therapeutic intervention is indicated for them *(Franken and Van Stalk, 1990)*.

Handicapped children may be at increased risk to be sexually victimized *(Garbarino, 1987)* and therapy should be tailored to fit a particular handicapping condition *(Sullivan et al., 1992)*.

SLEEP DISORDERS:

Disorders of sleep in childhood frequently present diagnostic and therapeutic puzzles to pediatricians, neurologists or psychiatrists called upon by distressed parents to solve them. Fortunately, the last three decades have seen a tremendous increase in our understanding of normal sleep and its disorders.

In the present study; sleep disorders were more prevalent in the conduct than control group. The most common disorder was night terrors which were commoner in conduct (22.5%) than control group (13.3%). Also insomnia (early and late) was more proponderant in the conduct (22.5%) than control group (13.3%). The differences are statistically insignificant.

In a previous study in Egypt; the prevalence of sleep disorders in hearing children was (8.8%) compared to 2% of the control group with statistically insignificant difference. The most common sleep disorders were frightening dreams and insomnia in the form of interrupted sleep or delayed onset. (Olweya, 1988).

Sleep disorders were associated with excess parental control; mainly in the form of over-restriction and biological factors in the form of chronic otitis media and adenoids.

Sleep disorders are commoner in deaf than hearing children due to the anxiety and frustration the deaf children have during communication with hearing persons especially the peer group, who usually refuse to play with them. This is added to the darkness of the room and in the dark; the deaf child is deprived also from the visual sense - beside deafness - so he feels that he is not only deaf but also blind, this adds to his anxiety before falling asleep .

AGGRESSIVE CONDUCT AT SCHOOL:

In the present study; it is apparent that aggressive conduct was highly prevalent in conduct in comparison to control group as presented by the school teacher; frequent quarrel with classmates was higher prevalent in conduct (47.5%) than control group (13.3%). Also physical violence with classmates was commoner in the conduct (45%) than control group (10%). Spoiling of classmates' belongings also presented a problem of the conduct (20.5%) and non of the control group. There were statistically significant differences between the two groups.

Aggression represents a main feature in the conduct disorder; according to *Robert et al., (1984)*, it is a form of behavior directed towards the goal of harming or injuring another living being who is motivated to avoid such treatment.

Baron (1980) added that accidental failure to harm should be included. Aggression may take the form of physical or verbal aggression towards persons, animal or property.

Gerkowitz (1978) mentioned that frustration leads to hightened aggression. Baron (1978) added that exposure to aggressive models can serve to trigger similar actions on the part of others on the scene.

Donnerstein and *Wilson (1976)* found that loud and unpleasant noise may facilitate or initiate the occurrence of interpersonal aggression. Baron and *Bell (1976)* observed the same as regarding exposure to excessive heat for it may cause person to feel uncomfortable and unpleasant and have shortened temper and so set the outbreak of collective violence.

Rutter and Hersove (1985) mentioned that films and television may have some impact on attitudes and behaviors and hence may play some part in the predisposition to violent acts. It may increase the acceptance to violent solution to personal frustration or problems that seem both permissible and normal.

Most of the aggressive children have a childhood history of rejection by at least one parent. Usually they have psychopathic parents who may have a criminal record or hisotry of alcoholism *(Latif, 1996)*.

When children are neglected, abused psychologically and/or physically and when their essential needs are not met with, then they introject such an experience as bad and ultimately it is projected onto the society, which is viewed as being indifferent to their nurturing needs. *Keith (1984)* added that being raised by controlled, rejecting, frustrating, neglecting, helpless or violent parents, may lead to internalization of the dissociability and criminality of such parents from the side of the child, by defensively identifying with the aggressors, doing to others as had been done to him.

The increased aggressive behavior at school may be due to dissatisfaction of their needs at home which is both a depriving and a depressive environment. This is experienced by the child as equivalent to aggressive act against him. His aggression at school may represent a call for help from others, or a need to be recognized and admired by others in the environment. It may be a way to achieve a certain status

that gives him a feeling of power or uniqueness among his classmates either alone or through being a member of a gang group in the socialized type. These behaviors are conducted more at school to avoid the punitive environment at home to feel more powerful and secure among the gang group at school, or to call for attention from the side of the school teacher who may be able to be more understandable. School teacher also can help to and can arrive this call to the parents at home. This can be explained by Knoph (1979) who found that; in cases with aggressive antisocial behavior, there may be impaired to faulty ego function in the form of a low frustration tolerance, inability to cope with inner feeling of anxiety and fear, poor control and disorganization when guilt is aroused. There may be also low responsivity to normal challenges of life, high responsivity to inner impulses and inability to perceive external reality. This is manifested by blaming others for their actions or engaging in infantile fantasies.

Aichorn (1964) found that, the aggressive child is skilled to provoke anger and mistreatment by others so that they can justify misbehavior and avoid guilt.

NON-AGGRESSIVE CONDUCT AT SCHOOL:

In the present study; the non-aggressive symptoms as presented by school teachers were more prevalent in conduct than control group. Frequent absence from school was the most common symptom in conduct (55%) and (13.3%) in control group while frequent lie at school is next common in conduct (47.5%) and (6.7%) in control group. Stealing from classmates was more proponderent in conduct (40%) and non in control group. The differences were statistically significant.

In a study conduct by Hersove in (1960), on 50 children referred for truancy from school; he found that; the children are coming from large families where home discipline was inconsistent. They experienced parental absence both in infancy and in later childhood. They changed school frequently. Their standard of work was poor. The truancy was an indiction of a conduct disorder that often involved other antisocial or delinquent behavior

Tennets' study (1969) on 65 truant boys found that they have some neurotic features coexisting with the conduct disorder such as marked anxiety about going to school, anxiety about events at home when at school, psychiatric symptoms of an affective type and returning home when truanting from school rather than roaming alone or in company.

Barker (1981) mentioned that truancy often accompanies other antisocial behavior. It is different from school refusal in which neurotic anxiety prevents the child getting to school The truant is not prevented by anxiety but by a stronger desire to do something else for

example, play in the park or just sit at home playing or watching television. On one common form; the child leaves home and return there at the appropriate times, but without having attended school. The parents think he is at school and the school staff often conclude he is sick. It is surprising how long this can sometimes continue. If both parents are working during the day, the child may sit at home unknown to them, ignoring anyone from school who comes to the house, and even destroying letters from the school. Sometimes parents actively encourage the truany, perhaps to have help with housework or shopping, or with feeding the baby. Most truants are poor pupils at school (unlike school refusers who usually have good academic records), and their consequent failure to get satisfaction from school work is an additional factor in discouraging attendance.

Lying is less narcissitic than stealing for it requires an avoidance and thereby involves another human being. The primary motive in lying is to deceive the self. The listener is utilized only as a support to that internal operation. This is corroborated by the extent to which the liers come to believe their own fabrication. *(Noshpitz, 1984)*.

Lying must be evaluated within the social norms extent in the child's family and social group. In many families, lies are utilized to avoid not only unpleasant confrontations but even necessary and difficult problem solving. *Meek (1984)* considered that parents of lying youngsters often utilize deceiful and corput parenting practices and personal behavior.

Stealing is the commonest antisocial behavior. It occurs in about 5% of primary school for hearing children *(Solf, 1967)*.

Repeated stealing is often a sign of poor impulse control in children with poor parental models who are deprived or who live in a subculture where stealing has other meaning *(Wolff, 1971)*.

Stealing represents a poor development of the ego and superego with no parental sanctions against stealing and the child rarely experiences guilt *(Lewis, 1976)*.

Concerning the stealing as a symptom represents an unsatisfactory parent-child relationship. It may be a form of non compliance to unskilled parents, but specially to parents who are themselves delinquent and inadequately attached to the child *(Patterson, 1982)*.

Stealing may appear in response to transient family stresses in an otherwise basically functional family unit. Illness in a sibling may transiently results in a relative neglect of other youngster who feels deprived and may respond by stealing. If other siblings are clearly

favoured with affection and gifts, the deprived youngster may devise his own symptom for equalizing the distribution of wealth. Emotionally cold parents are usually the target where the youngster utilizes the stolen objects from cold parents as symbiotic for the withheld affection. Thus stealing may begin as an effort to cope with a threat to a dependency relationship; "since you refuse to give me what I need, I will have to take it". If the frustration within the relationship becomes chronic, the stealing becomes more ingrained (Meek, 1984).

SOCIALIZED CONDUCT AT SCHOOL:

In the present study it is apparent that; informing on others as presented by school teacher was highly prevalent in the conduct (57.5%) than control group (13.3%). Also having a group of misbehaving classmates was more frequent in the conduct (52.5%) and non in the control group. On the other hand friendship lasting more than six months was commoner in the control (40%) than conduct group (7.5%). The differences were statistically significant.

"Informing on others" represents a form of aggression without violence directed towards the goal of harming or injuring another person who is motivated to avoid such treatment. So it is a form of a dependency relationship and immaturity that colour the relationship in conduct disordered deaf children.

It is observed that; informing on others was commoner with over-restrictive fathers who usually resort to corporal punishment for discipline and also in families with low socioeconomic class.

The conduct disordered children are less fearful of punishment, less anxious, less matue neurologically, more eager for excitement and have greater propensity for violence *(Mc. Cord, 1983)*.

Having a group of misbehaving classmates was common in the conduct disordered deaf children; as being deaf they have dependency relationship together forming a gang. Through this gang; the conduct disordered deaf child feels a sense of security and can commit antisocial acts and crimes that he is not couraged enough to do it alone. At the same time he is usually admired and attract attention of other members in the gang. This is more prevalent in children whose parents are occupied all the day in work and in the oversized families.

Although deaf children usually gather in groups, yet friendship lasting for more than six months was highly prevalent in the control than conduct group. This is can be attributed to the fact that; conduct group children were frequently absent from school, inform on others, liers, frequent quarrel with their classmates and steal from them. This

was more prevalent in children with broken families due to death of one parent or divorce.

This agrees with *(Hetu, 1994)* who recorded that; hearing disabilities due to their interactive nature, strongly affect intimate relationships that lead to social isolation and emotional inpact.

UNDER-SOCIALIZED CONDUCT AT SCHOOL:

In the present study it is observed that; undersocialized symptoms were more prevalent in the conduct than control group at school as presented by school teacher. This is apparent in friendship lasting less than 6 months which was commoner in the conduct (92.5%) than control group (60%). Also no respect to classmates' rights was more proponderant in the conduct (40%) and non in the control group. 'Inform on others' was more frequent in the conduct (57.5%) than control group (13.3%) and also "doesn't conform to school rules" was commoner in conduct (42.5%) and non in the control group. The differences were statistically significant.

The absence of long lasting friendship may be due to the maladaptive ways by which the child is trying to make or gain entrance into a friendship in order to avoid his feeling of loneliness. These cause him to be unaccepted and rejected by others. It may be experienced as severe frustration that is translated into a feeling of severe aggressive act directed towards himself with lack of satisfaction of his needs of belongingness and security. He feels more and more isolated and lonely. He may be harsh in his attitude in dealing with others and may respond by being more aggressive and antisocial.

This view agrees with Szurek and Berline (1969) who found that the deviant behavior of an undersocialized child is not merely a reflection of his failure to incorporate the norms of the society but a series of maladaptive mechanisms by which he is trying to gain entrance to group membership and toward off isolation. Being unaccepted by others, his attitude may be hardened toward suffering of others and not feel any guilt over his aggression. The sense of loneliness and futility never leaves him.

The children who have severe degree of hearing loss frequently express feelings of depression, withdrawal and isolation *(Meadowt, 1985).*

'No respect to classmates' rights was commoner in conduct group and was associated with corporal punishment as parental attitude in dealing with their children. The sense of loneliness and anxiety of being rejected from his classmates let the conduct disordered child apprehensive and aggressive towards them without guilt feeling.

This view agrees with Meeks (1984) who found that the ego of the antisocial youngster is seriously impaired in his relationship with his parents. He commonly uses them as ancillary ego agents. All the time he is trying to deny that their intervention are desired or helpful. The lack of remorse of conscious guilt over actions and the nonchallange regarding the rights of others and the importance of social norms is organized into verbalized philosophy of life which is selfish callous and amoral.

'Doesn't confirm to school rules' was more frequent in conduct. This can be attributed to the failure of these children to incorporate the norms of the society, anxiety, feeling of loneliness and lack of security.

AGGRESSIVE CONDUCT AT HOME:

In the present study it was observed that; aggressive conduct at home as presented by parents is more prevalent in the conduct than control group. Frequent quarrel and physical violence were more frequent in conduct (52.5% & 47.5% respectively) than control group 13.3% & 6.6% respectively). Lie to harm others was commoner in the conduct (30%) than control group (6.6%). The difference were statistically significant.

The increased frequency of symptoms of aggressive behavior at home was due to consisttutional factors as broderline intelligence (37.5% of the cases), difficult labour (50% of the cases) and delayed milestones of development (60% of the cases). These factors had statistically significant differences.

Family circumstances have an influence on the development aggression in the conduct group; incompatible mother-father relationship in the form of poor emotional relation (50%) and frequent quarrels between parents (45%), illiteracy of mothers (55%) and drug abuse by fathers, (cigarettes & hashish), (35%). There were statistically significant differences between the conduct and control groups.

The mode of upbringing of children leaves its impact on the child's behavior. Aggression was commoner in children where beating is the father and mother reactions to the child' misconduct (65% & 77.5% respectively) and harshness is the attitude of father (46.4%) and mother (51.4%) in the discipline of their children. This agrees with the view of Rutter and Cox (1985); children who have cold rejecting and critical parents who tend to produce a feeling state of frustration within the child; these feelings enhance or cause an arousal of anger and produce a motive to inflict injury. Aggressive behavior is always a consequence.

Families of overtly aggressive children often oxhibit coercive interchanges, whereas parents of covertly antisocial youngsters tend to display poor child monitoring *(Patterson et al, 1984)*.

Parents frequently resort to physical punishment and restraint, rather than verbal discipline and explanation. This is due to the nature of the handicap of their children (Mandel 1971). As the deaf child grows older, the problems created by his handicap inevitably increases. He experiences rejection by normal hearing peers, heavy academic demands and a growing awareness that he will never be entirely normal. His sense of isolation and stigmatization increases as he grows older. That is why hyperactivity, aggressions and assaultive behavior were next only to over dependency and nervous tics in the disturbed deaf children. (Schlesinger and Meadow, 1972).

NON-AGGRESSIVE CONDUCT AT HOME:

In the present study; non-aggressive conduct at home as presented by parents was more prevalent in the conduct than control group. 'Disobeying the norms at home' was highly presented in the (13.3%) conduct (80%) than control group. Also stealing from friends was commoner in the conduct (40%) and non in the control group. Frequent lie was more prevalent in the conduct (45%) than control group (13.3%). Staying late by night was commoner in the conduct (17.5%) and non in the control group. The differences were satsitically significant.

'Disobeing the norms at home' may represent a form of unsatisfactory parent-child relationship where satisfaction of the basic needs of the child is not there. It may represent a revenge from a frustrating and rejecting environment.

The overall complaint of parents is that, they tried every system of discipline from harsh punishment to letting the child to do what he or she wants, and "it has not worked". These symptoms are significant only if they have persisted for at least a year, if they are so obvious that relatives and friends as well as the parents have noticed them, and if they have disrupted the family in specific ways. Both parents should think that the child's behavior is different from behavior of the children of the same age *(Graham, 1973)*.

Most antisocial children or adolescents disregarded rules, have no respect for adults, and have generally defiant attitude towards authority. *(Gersten et al., 1976)*.

Stealing from friends is a common symptom in the conduct group. In a pervious study in a hearing children; its prevalence was 5% of primary school children *(Wolff, 1971)*. The difference between this result and the present study can be due to the fact that; being

handicapped children they are over-protected and spoiled from the side of parents particularly mothers to the extent of not respecting the rights and property of others since early childhood. Also the anxiety. frustration and difficulty that deaf children have on dealing with people let them to project their own hostility onto others in the form of stealing from them even trivial thigns. *(Friedman, 1975)*.

Stealing may be a form of non-compliance to unskilled parents, but specially to parents who are themselves delinquent and inadequately attached to the child *(Patterson, 1982)*.

This agrees with *Meeks (1984)* who said that; stealing is an effort to cope with a threat to a dependency relationship "since you refuse to give me what I need, I will have to take it". The youngster who started stealing has an underlying feeling of being unloved and rejected by parents. Once he steals he also lies and this elicit the very response of anger and disapproval, this reinforces the child's craving for affection which leads to persistence of symptoms.

Lying must be evaluated within the social norms extant in the child's family and social group. In many families; lies are utilized to avoid not only unpleasant confrontations but even necessary and difficult problem solving. Parents of lying youngsters often utilize deceiful and corrupt parenting practices and personal behavior. *(Meek, 1984)*.

SOCIALIZED CONDUCT AT HOME:

In the present study, socialized conduct at home as presented by parents was more prevalent in the conduct than control group. Friendship lasting more than six months was commoner in the conduct (60%) than control group (20%). But 'current friends more than two' iwa more proponderant in the control (50%) than conduct group (7.5%). The differences were statistically significant.

Friendship lasting more than six months is commoner in conduct group because the children of this group tend to have a stable relationships and to extend their relationships in order to be rewarded for their misbehavior among the gang group they have. At the same time they have lasting friendship in order to be able to misbehave as a member of a group. So there is lasting friendship but the friends here are misbehaving children.

'Current friends more than two' is more prevalent in the control than conduct group because the control group children are more or less psychologically stable and have normal interpersonal social relations and don't have the symptoms of conduct disorders as stealing, lying aggression. .... that let the friends to be away from them.

'Extending himself to others for advantage' was highly represented in the conduct (55%) and control group (56.6%) but the difference is statistically insignificant. This may reflect the attitude of people in these days.

UNDER-SOCIALIZED CONDUCT AT HOME:

It is apparent, in the present study, that under-socialized conduct at home as presented by parents was more prevalent in the conduct than control group. 'Doesn't conform to home rules' was highly prevalent in the conduct (67.5%) than control group (20%). Also 'current friends less than two' was commoner in conduct (65%) than control group (6.7%). 'Lie to form others' was more proponderant in the conduct (55%) than control group (13.3%). The differences are statistically significant.

'Doesn't conform to home rules' can encompass merely ignoring the request to protesting and actively resisting each request. An extreme form of this is negativism which is "an exaggerated form of resistance", occurring when a child becomes stubborn or contrary, often doing quite the opposite of what the parents wish. (Herbert, 1978).

Most children who are described by their parents as seriously disobedient and resistant to discipline are described by their teachers as presenting the same problems in classroom.

The high prevalence of 'doesn't conform to home rules' in deaf children can be attributed to the fact that; hearing parents are unable to teach their children how to regulate their interpersonal behavior by a set of external rules and values. On the other hand, these parents do what pleases their children at the moment *(Herbert, 1978)*.

"Current friends less than two" was commoner in the conduct group children because their antisocial behavior that let neighbour' friends to go away from him either by themselves due to aggression and frequent quarrel or due to instruction of their parents due to stealing, lying or sexual misconduct. This increased feeling of loneliness and isolation and hence they become more anxious, irritable and more aggressive.

'Lie to harm others' is a severe form of social aggression that directed harm others. Lying is less narcissistic than stealing for it requires ana avoidance and thereby involves another human being. The primary motive in lying is to deceive the self. The listener is utilized only as a support to that internal operation. Lie to harm others occurs when the child is subjected to considerable frustration with the result that their anger and aggressiveness are increased and reflected on others in a passive way - lying - to harm them.

ATTENTION DEFICIT DISORDER:

In the present work; it is apparent that A.D.D was more prevalent in the conduct (20%) than control group (3.3%) depending on DSM III classification. (15%) of the conduct and non in control group had A.D.D. with hyperactivity but (5%) have A.D.D without hyperactivity and the differences were statistically significant.

The most frequent symptoms of A.D.D were; poor scholastic achievement (60% & 16.6%) of conduct and control groups respectively and restlessness (37.5% & 10%) in conduct and control group respectively. The differences were statistically significant.

The presence of A.D.D symptoms in conduct disordered-deaf children especially hyperactivity and impulsivity were also confirmed by Lewis & Shanack (1977) as well as Werry et al., (1987) who added that; these symptoms cause the child to be more prone to accidents, injuries and hospitalization in their lives. The same result was agreed with DSM IIIR (1987) where impulsivity and hyperactivity are considered associative criteria with conduct disorder in childhood and may justify the diagnosis of attention deficit hyperactivity disorder. Also the proposed draft of I.C.D-10 (1987), where the diagnosis of hyperkinetic conduct disorder and attention deficit disorder with hyperkinesia are present together to the extent that distinction of either of the two disorders is difficult. The symptoms of conduct disorder in the present work may be secondary to the presence of A.D.D. which may led to poor scholastic achievement which favour the development of aggressive antisocial behavior in the children. In this situation, from an etiological point of view, the genesis of conduct disorder may have an organic base. This agrees with *DSM IIIR (1987)*.

Children with attentional deficits are at high risk for the development of antisocial behavior. *(Stephen et al., 1994)*.

Mind (1983) mentioned that, antisocial behavior in the form of aggressive rebellions against social values may develop as a secondary reaction in hyperkinetic children who are unable to succeed in an academic setting, who are unable to develop satisfactory peer relationship, and who find rejection at home and school. That is why symptoms of A.D.D are over represented in conduct group.

Deviant behavior is not merely a reflection of failure of the conduct disordered child to incorporate the norms of society but also maladaptive mechanism by which he is trying to get entrance to a group of membership towards off isolation.

The majority of cases with A.D.D in the present work are the first-ordered child, belonging to oversized families (more than 7) and socioeconomic class IV.

Conduct disorder and attention deficit diorder were the most common in the study of *Kruesi (1992).*

ETIOLOGICAL FACTORS RELATED TO BIRTH AND EARLY DEVELOPMENT:

In the present study it is observed that; the possible etiological factors related to birth and early development that can attribute to conduct disorder were more prevalent in the conduct than control group. History of accident was the most frequent factor in conduct (75%) than control group (33.3%). Also delayed milestones was commoner in the conduct (65%) than control group (26.7%) . Maternal illness during pregnancy was more prevalent in conduct (50%) than control group (13.3%). The differences were statistically significant.

History of accident may represent a serious injury the child has been exposed to that may need hospitalization (20%). Hospitalization in itself forms a stressful situation for those children in addition to the stress of maternal separation secondary to it. The accident may be due to deafness or due to complication of impulsivity associated with conduct disorder. The exposure of the child to an accident may form a secondary gain for the child where it allows the existence of spoiling attitude and overprotection from the side of parents particularly the mother who usually feel guilty. So it is not surprising that the mother gives the child more care, respond to all his demands, needs and wishes and this allows more dependency relationship which is in favour of the spoiling attitude that may aid in the genesis of conduct disorder. This agrees with Lewis (1984) who found that both organic and constitutional factors may serve to make a youngster more difficult to socialize and increases the tendencies towards antisocial behavior. Also Afford (1987) mentioned that children of all ages may be exposed to a motor vehicle accident. A major sequel of accidents is head injury which in turn is associated with increased risk of emotional and behavioral problems including conduct disorder.

'Delayed milestones of development' may be the result of neurodevelopmental disorder that leads to difficult or impaired socialization.

Delayed milestones of development may be associated with either severe or mild degree of mental retardation, *(Cerbell, 1985).* Pathological emotional attachment from the side of the mother towards the retarded child is expected. This relationship is either in the form of rejection or increased attachment. This results in genesis of aggressive and antisocial behavior.

Sensory impairment can have profound effects on childrenn' development. The more profound the impairment and the earlier the onset, the greater the effects *(Hindley and Brown, 1994)*.

Maternal illness during pregnancy; may be the cause of her child's deafness e.g ototoxic drugs to treat urinary tract infection during pregnancy, or exposure to rubella and deafness predispose to antisocial behavior. Also premature labour and birth difficulty with secondary cerebral infection or head injury. Those may be considered as important etiological factors resulting in the neurodevelopmental disorder. This agrees with *Backwin & Backwin (1972) and Hamouda (1984)* who found that maternal illness during pregnancy as well as neonatal trauma or infection to central nervous system may predispose to the occurrence of conduct disorder.

Another opinion is that maternal rejection of that pregnancy and sequel of emotional disturbance of the mother during and after pregnancy may be reflected on the mother-child relationship. She may reject or even neglect the child. This in turn may be responsible for the genesis of conduct disorder. This agrees with *Chess & Hassibi (1978)* who found that the mothers of antisocial children tend to be always neglectful and unavailable.

A variety of behavior problems such as overactivity, defective concentration, tics, emotional lability have been found correlated with the occurrence of toxaemia in pregnancy or anoxia at birth *(Illingwarth, 1975)*.

ETIOLOGICAL FACTORS RELATED TO FAMILY:

In the present study, it is observed that there were some etiological factors that can be the cause or a precipitating factor for genesis of conduct disorder. These factors were related to the family circumstances and were more prevalent in the conduct than control group. Poor emotional relation between parents was highly prevalent in the conduct (50%) than control group (6.7%). Also frequent quarrel between parents was commoner in the conduct (45%) than control group (6.7%). The differences were statistically significant.

Rutter (1979) stressed the negative effect of hostile marital relationship on child development than divorce and permanent absence of one parent.

Emery S'Oleary (1982) agreed that marital unhappiness and conflicts are related to behavior problems including aggressive and antisocial behavior. He added that children whose parents engage in higher levels of interpersonal conflicts, observe the modeling of conflictual problem solving styles which may be emulated in the sibling

relationship.

Rutter and Giller (1983) pointed the association of marital discord hostility and quarreling as well as family disruption, with conduct disorder and later delinquency.

The high prevalence of hostile marital relationship in the conduct group in the current work may be an attributing factor to the development of conduct disorder in their children as the parents represent a bad figure of identification and imitation by their child. Also the frequent quarrel between parents increases the anxiety and tension in their children and this is reflected as antisocial behavior.

Perrin and Mc.Lean (1988) concluded that, the incidence of divorce is not higher than among the general population. However, marital strain can result from increases in stress that are imposed on parents in bringing up a chronically sick child.

The child, on the other hand - may be the cause of poor emotional relation between parents as because of his handicapping condition - deafness - the mother always busy with her child in the routine daily work as eating, dressing, toilet training and dealing with auditory professionals to the extent of neglecting her duty towards the father who feels that he has no role and responds by quarreling with the mother and harshness towards the child and beating him for misconduct. The punishment tends to initiate resistance or rebellion in the child and also promote counter hostility within the child towards his father and this may lead to internal aggression (shyness and introversion) or external aggression (violence and antisocial behavior).

Recent work emphasizes the enormous range of coping resources displaced by families in relation to both practical and emotional difficulties. The move is toward understanding children with chronic diseases (deafness) and their families as normal people coping with specific stressors *(Kazak, 1989)*.

Perrin and Mc. Lean (1988) argue that children with chronic illness are best understood is "normal children in an abnormal situation".

PARENTS OF CASES

A- MOTHERS:

- Age Distribution

In the present work, it is apparent that; most of the mothers were in the age range (25 -35) in the conduct (60%) and control group (73.3%), the next age range was (36 - 45) in the conduct (35%) and control group (20%). There was no statistically significant differences between the two groups.

This means that the age of mothers was not a reliable factor in the genesis of conduct disorder in the conduct group. But, it is observed that, most of the mothers were young and this means that at time of early development of their children, these mothers were young in age and so immature in their relations, lacking experience in modes of upbringing, disciplining and directing their children during a critical period of their development which is considered the base of their developing personalities.

- Level of Education:

In the present work, illitrate mothers were more prevalent in conduct (55%) than control group (20%). This was followed by mothers who were graduated from technical schools (46.6%) of control and (15%) of conduct group. The differences were statistically significant.

Knight and West (1975) & Rutter and Gerald (1985) found that low social states have associated with persistent conduct disorder. This agrees with the result of their studies where illitracy, poor housing, low family income, overcrowding and parental negligence were common.

Chess and Hassibi (1978) said that; the mothers of children with antisocial behavior tend to be always neglectful and unavailable. They may have been delinquent during their childhood. The discipline she applied is more dependent on her mood rather than on the child's misconduct.

- Work Distribution:

"House wife" was the most prevalent work of mothers of conduct (55%) and control group (66.6%). This was followed by 'employe' in (26.5%) of mothers of control and (22.5%) of conduct group. The differences were statistically insignificant.

This doesn't agree with Richman et al. (1982) who found that; the working mothers are more irritable and unable to meet their children's emotional needs and this contributes to the genesis of childhood aggression.

Concerning the house wives, they spend a lot of time at home looking after their children. At the same time, fathers are mostly out earning their living. This might cause the mothers to be more intrusive and dominating to the extent that provoking aggression in their children. Conduct disordered children are always a member of large families, of low socioeconomic states. These cause the mother feels tense and anxious. She might even feel inadequate to fulfill and cope with the demands and the needs of all the family members. The discipline she applies is always dependant on her mood. Thus the child is utilized to demonstrate her inadequacy. The child is only a smoke screen behind which she can conduct her various family problems and even her marital problems which she cannot deal with. The child becomes the cause of all her difficulties. This may provoke more aggressive and antisocial behavior in the child. Another factor is that, those mothers being living in a low standard with poor housing are responsible for such a large number of children they might feel fed up of noise and crowed, they let the children spend most of the time outdoors playing with other children who might suggest antisocial and aggressive behavior in the absence of any parental supervision. Children may even initiate each other's behavior. A child may be easily misled by deviants and criminals who might be the models to imitate or identify with in the street.

- **Religious Attitude:**

It is apparent in the present work, that; there was little concern in religion of mothers of conduct than control group. As regards the religious rituals; irregular pray at home was commoner in conduct (55%) than control group (13.3%), while regular pray at home was more prevalent in control (66.6%) than conduct group (12.5%). The differences were statistically significant.

Regular fast was very common in both conduct (92.5%) and control group (100%) with statistically insignificant difference.

There was little concern about learning or gaining religious information in both the conduct and control groups. Concerning the religious instructions directed to the children; encouraging the child to pray was commoner in the control (86.7%) than conduct group (12.5%). Also encouraging the child to go to mosque/church was more prevalent in control (73.3%) than conduct group (32.5%). Encouraging the child to learn in religion was more preponderant in the control (100%) than conduct group (25%). The differences were statistically significant.

This agrees with *Berman (1984)* who found that failure to maintain sufficient control over the aggressive drive at any developmental phase may become a source of delinquency especially in children exposed to pathological environmental conditions of

aggressiveness and neglect.

Religion is the most important controlling factor over the aggressive drives in the human beings from early childhood up to adulthood. The deficiency in the religious attitude from the parental side, the absence of a religious atmosphere at home as well as the discrepancy between the religious behavior of the mother and her religious instruction or directions to the child (i.e what is said & what is done) may cause a state of unsecurity that might be reflected on the behavior of both parents and child. This in turn might facilitate the appearance of antisocial behavior.

- Reaction of Mother to Child' Misconduct:

It is observed in current study that, beating was the most frequent reaction of the mothers to their children' misconduct (77.5%) in conduct and (33.3%) in control group. "Defend" was also highly prevalent in conduct (57.5%) than control group (20%). On the other hand encouraging the child to stop misconduct was commoner in control (60%) than conduct group (17.5%). The differences were statistically significant.

Beating is a common form of punishment in the present work, this is can be explained by the fact that, the conduct disordered child, being deaf, the mother finds difficulty in communication with him in explanation of what is right and what is wrong, so she resorts to beating for his misconduct. Also beating is the usual mode of punishment in low socioeconomic state especially in overcrowded houses with family member more than 7, where the mother has no time in explaining to her child his mistakes, so she resort to the easiest method to apply in discipline which is beating.

On the other hand, mothers can resort to defending the child and taking his side especially with anxious and irritable fathers. Because of the handicapping condition - deafness - the mother overprotects her child and usually try to deny the child' misconduct.

Encouraging the child to stop misconduct is the best reaction on dealing with children. It was commoner in control than conduct group. The mothers of control were of socioeconomic classes II and III, family members are from 5 - 7 and can read and write. These mothers understand well how to deal with their handicapped children, giving instruction and explanation and sympathy to their handicapped children.

- Parental Attitude (Mothers):

In the present work, it is apparent that; harshness was the most common attitude followed by mothers in upbringing their children in conduct (51.4%) than control group (14.2%). Over-protection was more

prevalent in control (50%) than conduct group (8.4%). The differences were statistically significant.

Harshness, as a parental attitude in upbringing the child tends to influence the child positive emotional and social development. Those mothers are often cold and rejecting towards their children, this affects the child sense of humanity and makes him incompetent in performing adequate social roles. This in turn will give a sense of frustration which provokes aggressive and antisocial behavior.

This agrees with *Jenkins (1970)* who stressed that; the undersocialized aggression occurs typically as a reaction to frustration within the family. While according to Blesky (1981) warm parental relationship provides an emotional support which facilitate the formation of security and stimulation of relationship and thus contributes to healthy socio-emotional development. On the other hand, parental hostility in child rearing was considered by *Meeks (1984)* to be strongly related to the development of antisocial behavior. While *Werry et al. (1987) and Body et al. (1987)* noticed the presence of an increased tendency for inconsistent punitive lax discipline together with lack of parental supervision in parents of children with conduct disorder.

Overprotection was commoner in control group due to the handicapping condition - deafness - of their children let the mothers overprotect their children even on the expense of her health, husband and other children.

The presence of the hearing difficulty pushed the parents, especially mothers, to over pratect their children. In spite of that, some of the parents tried to behave with deaf children in a way not markedly different from others. Many of the parunts used persuasion in a trial to correct behavior, although the nature of the disability leading to difficulties in communication between parents and deaf children. However, persuasion was coupldd with beating in most of cases *(Abdel Baky, 1993).*

B- FATHERS:

- Age Distribution:

Most of fathers of the conduct and control groups were in the age range 30 - 40 years (50% & 66.7% respectively). Next was the age range 41 - 50 years (32.5%) in conduct and (20%) in control group. There was no statistically significant differences between the two groups.

This means that, the age of fathers was not an important factor in the development of conduct disorder of the children.

- Level of Education:

Most of the fathers of conduct group (55%) were illitrate (13.3% of

control group). On the other hand (53.3%) of the fathers of control group are graduated from university (12.5% of conduct group). The differences were statistically significant.

Illitracy is a great problem in the genesis of conduct disorder of the children. Illitracy. Illitracy, in fathers, leads to irregularity at work, low income, spending most of the time outdoors earning his living. spending little time at home and share a little in directing, instructing and disciplinning the children.

Illitracy also let fathers unable to deal with their children in psychologically stable manner as they are always anxious, tense, feel a sense of insecurity and always thinking how to satisfy the essential needs of their children.

Highly educated fathers of the control group, on the other hand, are regular in their work, have high constant income, can read above methods on dealing with their handicapped children, not abuse drugs and spend more time at home in instructing and disciplinning their children.

- **Drug Abuse:**

It is observed in this work that;, (35%) of fathers of conduct and non of the control group were abusing cigarettes and hashish. On the other hand (40%) of fathers of control and (7.5%) of fathers of conduct group were not abusing any drug. The differences are statistically significant.

Drug abuse is money consuming and leads to deprivation of the family finances. This forms a stress on the children who may compensate for their needs by being involved in conduct disorder.

Drug abuse is responsible for many physical health problems that will be reflected on the family in the form of psychological, economic and social stressors *(Meeks, 1984)*.

The type of drug abused provokes some behavioral changes on the fathers that can be easily imitated by their children.

This agrees with *Faringtton et al. (1975)* who noted that persistent social difficulties including excessive drinking, frequent unemployment and abnormalities of personalities of either parents are also associated with antisocial behavior in the children.

Rutter and Gerald (1985) mentioned that conduct disordered children are mainly of large family with low income and poor housing.

Most of the aggressive children have a childhood history of

rejection by at least one parent. Usually they have psychopathic parents who may have a criminal record or history of alcohlism *(Latif, 1996).*

- **Religious Attitude:**

It is apparent in this study that; there was little interest in religion in fathers of conduct than control group. As regards religious rituals; irregular praying was commoner in conduct (50%) than control group (13.3%). The difference was statistically significant. Regular fasting was highly represented in both conduct and control groups (90% & 92.5% respectively) but the difference was statistically insignificant.

There was a statistically significant difference between conduct and control groups concerning regularity in reading religious books (15% & 53.3% respectively) and in encouraging the child to go to mosque / church (20% & 60% respectively) and also in encouraging the child to learn in religion (32.5% & 73.5% respectively).

Religion forms a consistent discipline that helps to regulate healthy relationships between parents and children. It aids the parents to keep their temper. It helps the father to fulfill his needs, his rights and duties towards his family. It also helps the father in disciplinning and directing his children to the right way of living and behavior within the family and larger community.

Deficiency in sticking to religious directions may lead to the absence of ideal discipline. The father may be himself involved in social misbehavior. He may know nothing about his duties towards the family members. He is a bad model for identification. Being away from the religious spirit, he may encourage his children to be involved in antisocial behavior. This agrees with *Meek (1984)* who mentioned that; in families where the youngster is encouraged to steal in order to meet pathological emotional needs, the youngster's right to privacy and possession is not recognized, protected and defend from intrusions of the parents and siblings. The concept of morality is slowly internalized. The youngster continues to steal because of simple adaptation to a social system where property rights are not defined and mutually respected.

- **Fathers' Reaction to Child' Misconduct:**

It is apparent in this study that; the most common reaction in dealing with child's misconduct was beating in the conduct (65%) in comparison to (26.6%) in the control group. On the other hand encouraging the child to stop misconduct was commoner in in control (60%) comparison to (12.5%) of conduct group. The differences were statistically significant.

The increased incidence of beating for misconduct among conduct group may form a source of pressure or stress that provocates further

misconduct as a form of rejecting against the father reaction. This agrees with *Rutter and Cox (1985)* who found that fathers who punish frequently or severely, tend to have children who are more aggressive and disruptive. They referred this to the fact that punitive fathers are usually cold and rejective. They often fail to provide adequate reward for the non-aggressive behavior. Punishment may be disruptive for children in its effects by causing anxiety and resentment. Children may thus be reinforced by the satisfaction of getting their fathers angry and making them loose control. Also aggression may be a way of identifying with the father to feel more strong. This is stimulated by physical abuse of children from the father'side. This agrees with Huges and Barad (1983) and Lampher (1985) who found that physical abuse in children have a great influence on the occurrence of behavioral problems including antisocial behavior particularly in preschool children.

Farrington (1983) in his study on 400 youngster boys aged 8 years to adulthood, determined that; those youngsters who went on to commit violent acts were twice as likely to have been the recipient of harsh punishment from their parents as the group of non-violent youth.

West and Farrington (1973) referred to family community and peer environment as etiological factors in the development of antisocial behavior. They mentioned that eratic, punitive, inadequate or permissive parental supervision and disciplinary styles have been linked with the development of both child and adult psychosexual maladjustment.

Another view is that; the aggressive punitive attitude (beating) of the father may be a form of failure of the father to understand the child's temperament that is expressed by the child in the form of aggressive behavior. This may lead to the development of aggressive antisocial behavior. This agrees with *Thomas et al. (1968)* who mentioned that; the parent may fail to recognize the youngster's need for special training or assistance. Thus there is a poor fit between the child's temperamental characteristics that prevent him from meeting the family expectations leading to provocation of aggressive antisocial behavior.

- **Parental Attitude (Fathers):**

In the present study, it is observed that; the most common attitude followed by fathers in upbringing their children was harshness (61.9% in conduct & 14.2% in control group). On the other hand, authoritarianism was the most prevalent in conduct group (50%) in comparison to (15.5%) in control group. The differences were statistically significant.

This agrees with *Meeks (1984)* who stated that, parental hostility, uninovlvement in child rearing and harshness are strongly related to the development of antisocial behavior.

Kays (1968) mentioned that; extreme parental supervision, authoritarianism and punitiveness without acceptance, warmth and love tend to be related to increased tendency for aggressive antisocial behavior.

Singer (1974) noted that; the parents of antisocial youngsters utilize discipline which is characterized by rigid and exacting policies.

Werry et al. (1987) noticed that; there are increased inconsistent punitive or lax discipline together with lack of parental supervision in families of conduct disorder.

Hetherington et al. (1971) and Rutter & Giller (1985) in their studies; noticed that the aggressive socialized boys were associated with variable patterns of paternal dominance while Rutter (1980) found paternal dominance and permissiveness in socialized group and confilictual maternal dominance and restrictiveness in undersocialized group.

Harshness tends to initiate resistance or rebellion in the child, also promote counter hostility within the child and may lead to internal aggression (shyness and introversion) or external aggression (violence and antisocial behavior).

Mindel and Vernon (1971) reported that; parents of deaf frequently resort to physical punishment and restraint rather than verbal discipline and explanation due to the nature of the handicap that makes explanation difficult. Meanwhile, parents who punish frequently or severely tend to have children wo are more aggressive or disruptive because they have been provided with a moel of aggression or loss of control.

It is difficult to coin antisocial acts of the deaf children as causes of or effect on the fathers' attitudes. *(Abdel-Baky, et al., 1993).*

RECOMMENDATION

RECOMMENDATION

We confirm the previous recommendations provided by *Bergstrom (1976), Chess (1975) and Bakwin and Bakwin (1963)* aiming at the end of this work to prevent the occurrence of deafness in infancy and early childhood and for the unavoidable cases, early detection of them and providing the best methods for management and at last, rehabilitation for those who were diagnosed late.

Also for the deaf children; early diagnosis of patients "at risk" of having conduct disorder for prevention and early management. And for conduct disordered deaf children; management and rehabilitation of them on a scientific basis.

These can be achieved by the followings:

- Proper ante-, intra., post- natal cares for all pregnant mothers to avoid causes leading to deaf new-born infant. (Bergstrom, 1986).

- Proper medical, surgical management of cases of otitis media in childhood, which still constitute a high percentage of cases of deafness in childhood *(Gates, 1989)*.

- Special care for children "at risk"; who have family history of deafness, history of exposure of the mother to rubella early during pregnancy, toxaemia of pregnancy, prematurity, difficult or assisted labour, anoxia during neo-natal periods and exposure to meningitis during early childhood. These children are only a minority of the total number of deaf children but it includes the majority of those who have handicapping disabilities. This group is advised to be screened and examined periodically until they acquire language, and to detect deafness early for better management.

- Screening testing for all children entering elementary schools in order to early detect cases of deafness for better management.

- Most authorities, that are dealing with deaf children, encourage all who come in contact with deaf children to talk a great deal in front of them (Bakwin & Bakwin, 1963). Talking is often helping if it is close to the child's ears and accompanied by verbal and tactile demonstrations. Most of deaf children can be taught to talk The parents must be very observant, beginning with the infant's babbling and keep their deaf children "bathed in sound".

- Encouraging mothers of deaf children to maintain and develop the residual hearing, whatever little, the child may have. This necessitate the provision of a hearing aid when indicated for the child. We must help mothers to get ride of the old belief that; using

an aid may cause hearing to deteriorate and the children are reluctant to accept hearing aids until they are older; as the modern type of small, light weighted, ear level, hearing aid can be tolerated by children in the first year of life.

- The deaf children must be considered as a "normal" children with a disability. So they require all the general care which a normal child should receive in the way of food, shelter, medical supervision, education and provision of an environment in which he can develop socially and emotionally, but because of his handicapping; it may be necessary to provide all or part of this care in a special means. So, the best is to consider him a normal child an abnormal situation *(Perrin and Mac Lean 1988)*.

- The school of deaf must help to create an environment that facilitate both emotional and cognitive development, and also help to break down the child's dependency and to foster independence and responsibility in deaf children.

- Periodic counselling of parents of deaf children supervised by professional specialists; aiming at emotional support of the parents and helping them to ventilate their feeling in an open discussion, accept their deaf children as deafness is a permanent and irreversible change and manage their children in well - balanced manner. Also an important role is to provide the parents with information about early detection of behavior disorders in their deaf children.

- The deaf child must have a program of "education of living" which help him, disabled as he is, to adjust himself to live within the limitation of his disability but, within those limitations, to live full, useful and happy life as possible.

- Schools of deaf are advised to have highly specialized team, the members of which must have in addition to their own specialized knowledge and skills, a basic understanding of their work with good training on it.

- Deaf children with signs of the "difficult child": irregularity, withdrawal, native mood, intensity and slow adaptability to changes, are most at risk for development of behavioral and conduct disorders. This is a test of temperament of the child which is the way in which an individual characteristically reacts to a situation, also has an influence on the child's adaptation to his handicap. A "difficult child" requires unusually firm consisted handling on the part of his parents and teachers in terms of his particular behavioral style *(Chess, 1975)*.

SUMMERY

- A large study is to be conducted on primary schools for deaf children and the other group is to be taken from these deaf children or youngsters accused by the police in order to be able to find the exact or a nearly exact prevalence of conduct disorders in deaf children in Egypt. It is essential to arrange with the different authorities how to tackle this serious and damaging disorder from different angles. Also to discuss how to get use of these patients in our society after treatment.

- Early detection of conduct disorder in the deaf children and try to investigate the presence of a possible organic pathology and to manage as early as possible.

- Special care should be directed to family relations, mode of upbringing and traits of management of the aggressive as well as the antisocial tendencies in both parents and their children.

- We should pay attention to the influential role of the mosque/ church in directing the youngsters and parents to the right modes of conduct and relatedness in order to give the ideal models for identification that helps in the prevention of development of conduct disorder.

- Special care should be directed to deaf children in mosque/church with special classes and expert persons who can teach tem religion by their own language.

- Finally we suggest the arrangement and planning of programs that help the early management and rehabilitation of deaf children with conduct disorder. This can be fulfilled through a team work including psychiatrists, psychologist and social workers. This requires the supported efforts of the Ministries of Health, Social Affairs, Education and the Ministry of Justice. The efforts of the institute of Criminality and Social Affairs and Social women association are also needed to facilitate the communications with these authorities.

SUMMARY

CONDUCT DISORDER IN DEAF CHILDREN

Deafness is one of the common handicaps met with in childhood and is being implicated with psychological disorders, most important is conduct disorder which is more prevalent in the deaf than normal hearing children.

Conduct disordered deaf children constitute a definite problem to their families. They may be considered to have the worst prognosis among childhood psychiatric disorders perhaps with the exception of childhood psychosis.

In Egypt, the prevalence ad clinical picture of delinquency in deaf children is still unsolved. The aim of this work is to through light on the prevalence of conduct disorder among deaf children in El-Amal Primary School for Deaf Children in Shoubra, Cairo, the possible etiological factors including constitutional, environmental, organic factors as well so family pethology were studied. The conduct disordered deaf children (40) were compared with a control group (30) from the same school selected by random sample.

This thesis included two main parts; a review of literature and a clinical work:-

A) The Theoretical Part:-

It included the introduction and aim of the work, followed by definition and different nosologies of conduct disorder. Then the epidemiology of conduct disorder in different culture with special emphasis on age, sex, birth order, family size and socioeconomic level. Then the etiology and psychopathology. The social factors included familial factors and psychosocial stressors i.e marital discords, divorce, parental illness, criminality and violence and the effect of punishment. The organic factors included child temperament, genetic factors and biochemical aspects. The next chapter was concerned with the individual antisocial behavior conducted by those patients such as stealing, fire setting, truancy, runaway reaction, lying, cruelty to animals, sexual assault and vandalism. Emphasis on the psychopathology of aggression and violence was considered as they represent the main features of conduct disorder. The next chapter

included the differential diagnosis which included some disorders which were characterized by some of the features of conduct disorder may be present. Then the psychological assessment, treatment and prognosis of conduct disorder were included.

Deafness in childhood was then discussed in the next chapters. It included definition, incidence, etiology, diagnosis, prevention and treatment of deafness in children. Then the impact of deafness on the family, parental reaction to deafness, effect of deafness on the relationships between family members. The implication of deafness in childhood and the characteristics of deaf children were included.

B) The Clinical Work:

1- An epidemiological study on the prevalence of conduct disorders in deaf children in El-Amal Primary School for Deaf, the result was 13.3%.

2- The conduct disordered deaf children (40 cases) were diagnosed according to DSM IIIR criteria and were compared with a group (30) deaf children who were selected randomly from the same school. Psychological, neurological and physical examination were done to all the conduct and control groups.

For the conduct disordered children; sociodemographic data, profile of different forms of conduct disorder, etiologic factors related to birth and early development and study of family profile were studied. The results were as follows:-

a) Sociodemographic data:-

The mean age of the conduct group children was 9.3 $\pm$ 2.10 male/female ratio was 7 : 1. I.Q. was "average level" and "below average" in (72.5%). These children were the elder in (55%). Socioeconomic states were low "class IV & V in (50%). These children had little concern in religion in comparison to control group with statistically significant difference.

b) Neurotic traits:-

The most prevailing neurotic traits were temper tantrum in (55%) of conduct and (20%) of control group. Nocturnal enuresis was commoner in conduct (17.5%) and non in control group with statistically significant differences.

c) Sexual disorders:-

These disorders were commoner in conduct than control group. The most prevalent was sexual act with the same sex (17.5%) of conduct and (6.7%) of control group with statistically significant difference.

d) Sleep disorders:-

They were more prevalent in conduct than control group as night terrors (22.5% and 13.3% respectively) and insomnia (early and late) which were commoner in conduct (22.5%) than control group (13.3%) with statistically significant differences.

e) Profile of different forms of conduct disorders:-

- The aggressive form: most common and was presented by:
  - * at home: physical violence (47.5%), frequent quarrel with sibs (42.5%) and lie to harm others (30%).
  - * at school: frequent quarrel with classmates (47.5%), violence with classmates (45%), and spoiling classmates' belongings (20%).

- The non-aggressive form: presented by:
  - * at home: disobedience to the norms at home (80%) frequent lie (45%) and stealing from friends (40%).
  - * at school: frequent absence from school (55), frequent lie (47.5%) and stealing from classmates (40%).

- The socialized form: presented by:
  - * at home: friendship more than 6 months (60%), extend himself to others for advantage (55%).
  - * at school: inform on others (57.5%) classmates (52.5% having of misbehaving.

- The undersocialized form: presented by:
  - * at home: not conforming to rules at home (67.5%), having friends less than two (65%).
  - * at school: doesn't conform friendship lasting less than 6 months (92.5%) to school norms (42.5%), no respect to others' rights (40%).

f) Etiological factors related to birth and early development:-

History of accidents in early childhood (75%), delayed milestones of development (65%) and maternal illness during pregnancy (50%) were commoner in conduct than control group with statistically significant differences.

g) Familial background:-

From the results we can observe that:-

1- The mothers of conduct group:

The mothers were mainly illiterate (55%) house wives (55%) belonging to age group 25-35 years (60%), with little interest in religion. They used either to beat the child (77.5%) or defend him (57.5%) for his misconduct. The most presenting mode of upbringing (attitude) was harshness (51.4%).

2- The fathers of conduct group:

The fathers were mostly belonging to the age group 30-40 years (50%). A good percentage of them (55%) were illitrate. They mostly labourers (47.5%). They were mostly drug abusers (e.g cigarettes smoking in 40% & combination of cigarettes and hashish 35%). This affects the family income.

h) Family Profile:

Form the present study we can observe that; the families of conduct disordered deaf children were a large family of more than seven members, low socioeconomic status class IV & V in (50%). The low income-families have imposed strains for caring of a large number of children, may develop frustration in achieving their basic life maintenance tasks, this will evoke anger of hostility towards the large society. The father was the only source of family income. Short tempered relationship between father and mother (45%). Incompatible marital relationship (50%) in the form of frequent quarrel and troubles was always there.

Beating was the main mode of upbringing (65%) and parental attitude was harshness in (61.9%). There was little interest concerning religion in both parents (performance, attitude, instruction and directions to their children) which was reflected in the form of a lack in the discipline and system at home. From the thesis we can conclude that:-

1- Neglect and abuse, excessively rigid and severe discipline, placement of the child out of the home, rage and diminished self-esteem for which the youngster strives to compensate by seeking power and status, by asserting aggressive superiority over others, all these predispose to the build up of rage and resentment that plays important role in development of criminal personality.

2- Most of the patients have no guilty feeling towards their behavior. So conduct disordered child can justify their misbehavior and avoid guilt because they have impaired ego function.

3- Children with lack of the mature conscience's capacity for experiencing appropriate guilt and defects in impulse control (ego defect), are prone to sudden explosive behavioral outburst to discharge the sweeps of rage to which they are so vulnerable.

Recommendations

- Care must be given to oversized families with low socioeconomic class to avoid the occurrence of conduct disorders in their children. This can be achieved by financial and social support and giving advise to the ideal methods of upbringing their children.

- Routine screening of children on entering primary schools for early detection of hearing impaired children. This is important for detection of mild to moderate hearing loss and unilateral losses who are usually missed.

- Treatment of hearing loss in children before development of language skills to avoid communication problems with others which have psychological impact on the deaf child.

- Early detection of conduct disorders in the deaf children and treat them physically, socially and psychologically.

- Condensed courses for teachers of deaf children for characteristics of deaf children and recent method of their education.

- Cooperation between parents and teachers for education of deaf children and treatment of conduct disordered cases.

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مقياس الإتجاهات الوالدية

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الملخص العربى

الأضطراب التصرفى فى الأطفال الصم

يمثل مرض الأضطراب التصرفى فى الأطفال بأنماطه المختلفة مشكلة كبيرة بالنسبة للأسرة والمجتمع نتيجة لصوره الإجرامية العنيفة مما يجعله من أسوأ الأضطرابات النفسية .

والصمم من أكثر الإعاقات التى تصيب الأطفال ويؤدى الى تأثير كبير على الطفل وعلى اسرته مما يؤثر بدرجة كبيرة على سلوكه ويؤدى الى زيادة نسبة الأضطراب التصرفى فيهم عن الأطفال الذين يسمعون.

ومعدل إنتشار الأضطراب التصرفى فى الأطفال الصم لم تحسم بعد بصورة محددة فى الدراسات التى أجريت فى المجتمعات المختلفة. ولهذا تم إجراء هذه الدراسة كمحاولة لمعرفة مدى إنتشار الأضطراب التصرفى فى الأطفال الصم وأنماطه المختلفة وأسبابه وطرق الوقاية والعلاج.

وقد إشتملت هذه الدراسة على جزئين:-

الجزء الأول:-

مراجعة نظرية لمرض الإضطراب التصرفى فى الإطفال وتشمل تعريف المرض ومظاهره وأعراضه وأنماطه فى التقسيمات المختلفة للأمراض النفسية. كذلك معدل إنتشاره فى مصر والبلدان الآخرى. وكذلك أسباب المرض سواء إجتماعية أو أسرية أو وراثية وكذلك طريقة تشخيص المرض وطرق الوقاية منه والعلاج.

ويشمل الجزء النظرى أيضا مراجعة للصمم فى الأطفال وتشمل تعريف الصمم وأنواعه ودرجاته وأسبابه وطرق التشخيص المختلفة وكذلك طرق الوقاية والكشف المبكر للصمم فى الأطفال وطرق العلاج المختلفة. وأيضا تأثير الصمم على الطفل وعلى شخصيته وسلوكه وعلاقاته بأفراد الأسرة والآخرين وكذلك تأثير صمم الطفل على أسرته.

الجزء الثانى:-

الجزء العملى فى الدراسة وقد تم عمل الدراسة على ٣٠٠ طفل من مدرسة الأمل الإبتدائية للأطفال الصم بشبرا وذلك لتشخيص حالات الأضطراب التصرفى فيهم. وأعتمدنا فى التشخيص على الدلالات التشخيصية للتشخيص الأمريكى الثالث للأمراض النفسية DSM III. وقد تم مقارنة المجموعة التى تعانى من الأضطراب التصرفى فى الأطفال الصم بعينة ضابطة من الأطفال الآخرين اختيروا عشوائيا من نفس المدرسة.

وقد أثبتت الدراسة ان مرض الأضطراب التصرفى منتشر فى الأطفال الصم بنسبة ١٣,٣ ٪. ومتوسط عمر الأطفال الذين يعانون منه ٩,٣ ± ٢,٣٤سنة . وهو أكثر شيوعا فى الذكور عن الأناث بنسبة ١:٧. ومستوى الذكاء فى المجموعة المريضة والضابطة "متوسط" على مقياس (رسم الرجل لجوود أنف هاريس) وأعراض التوتر النفسى اكثر إنتشارا فى المجموعة المريضة عن المجموعة الضابطة والفروق ذات دلالة احصائية. واكثر هذه الأعراض هى:-

- نوبات الغضب (٥٥ ٪)
- وقضم الأظافر (١٧,٥ ٪)
- وفقدان الشهية (٣٠ ٪)
- ومص الأصابع (٧,٥٪)
- التبول الليلى اللاإرادى (١٧,٥ ٪)

- الإضطرابات الجنسية:- ١٧,٥ ٪ فى المجموعة المريضة & ٦,٧٪فى المجموعة الضابطة والفروق ذات دلالة إحصائية
- إضطرابات النـــوم:- ٢٢,٥ ٪ فى المجموعة المريضة & ١٣,٣ ٪ فى المجموعة الضابطة والفروق ليست ذات دلالة إحصائية.

ولدراسة الأعراض المرضية للأضطراب التصرفى فى الأطفال الصم نجد أن الأعراض ذات دلالة إحصائية هى:-

- النمط العدوانى :- هو الأكثر انتشارا وأعراضه

بالمنـــزل :- هى العنف فى المنزل (٤٧,٥٪)
والشجار الدائم مع الأخوة والأصدقاء (٤٢,٥٪)
والكذب ليؤذى الآخرين (٣٠٪) .
فى المدرسة :- الشجار بأستمرار مع زملائه بالفصل (٤٧,٥٪)
والعنف مع زملائه (٤٥٪)
وتخريب ممتلكاتهم (٢٠٪).

- النمط الغيـــر عدوانـــى :- اعراضه

بالمنـــزل :- هى عدم الأمتثال لنظام المنزل (٨٠٪)
والكذب بأستمرار (٤٥٪)
والسرقة من المنزل (٤٠٪)
التأخر ليلاً خارج المنزل (١٧,٥٪)
فى المدرسة :- هى الغياب المتكرر عن المدرسة (٥٥٪)
والكذب بأستمرار (٤٧,٥٪)
والسرقة من الزملاء (٤٠٪)

- النمـط الإجتماعـــي :- اعراضه

بالمنـــــزل:- هى عمل علاقات مع الآخرين من اجل مصلحته (٥٥٪)
صداقات تدوم أكثر من سته أشهر (٥٢,٥٪).
فى المدرسة:- عدد الإصدقاء اقل من اثنين (٦٥٪)
يبلغ عن زملائه (٥٧,٥٪)
الأنضمام لشلة من اصدقاء السوء فى المدرسة (٥٢,٥٪)

- النمط الغير إجتماعى:- فأهم اعراضه

بالمنـــــزل:- هو عدم الإلتزام بنظام المنزل (٦٧,٥٪)
يكذب ليؤذى الآخرين (٥٠٪)
فى المدرسة:- صداقاته مع الزملاء لاتتعدى سته شهور (٥٢,٥٪)
عدم الإلتزام بنظام المدرسة (٤٢,٥٪)
لايحترم حقوق الآخرين (٤٠٪)

وبدراسة الأسباب التى تؤدى الى مرض الأضطراب التصرفى فى الأطفال الصم وجدنا ان هناك أسباب كثيرة "بجانب الصمم" تؤدى الى حدوثه ومنها:-

- اسباب متعلقة بالولادة ومراحل النمو الأولى:-

وجدنا ان الاسباب التى لها فروق ذات دلالة إحصائية هى :

تعرض الطفل لحادث (٧٥٪)
وتأخر مراحل النمو (٦٠٪)
ومرض الأم اثناء الحمل (٥٠٪)

- أسباب متعلقة بالأسرة:-

الأمهات:- معظم امهات هؤلاء الأطفال يعانون من الأمية (٥٥٪) ربـات منـزل (٥٥ ٪) وتـتراوح أعمارهن من ٢٥:٣٥ سنة (٦٠ ٪) وغير مهتمات بالنواحى الدينية. وقلـة إهتمـام الأم بالدين (صيام - صلاه - معلومات دينية - قراءة الكتب الدينية) كانـت هـىالمؤثر الأعظم فى الأضطراب السلوكى لأطفالهن حيث ان الدين هو اقصر طريق لتدعيم السلوك الأخلاقى وخلق مفهوم الصح والخطأ من خلال الثواب على التصرف الصحيح والعقاب على التصرف الخاطئ. وأسلوب معاملة الطفل عندما يخطئ هو الضرب (٧٧,٥٪) والدفاع عن الطفل عندما يخطئ (٥٧,٥٪). واسلوب التشئة المتبع هو القسوة(٥١,٤٪) . فالمصدر الرئيسى للعدوانية لدى الأطفال هو الأحباط من فشلهم فى الحصول على

الأحتياجات الأساسية من الحب والأمان من الأسرة وذلك لما تبديه بعض الأمهات من أهمال لأطفالهن لسبب او لآخر.

الآبـــاء: عمر الأباء يتراوح مـن٣٠:٤٠ سنـة (٥٠٪) . ومعظمهـم يعانـون مـن الأميـة (٥٥٪) ويعملـون كعمـال (٤٧,٥٪) ويدخنـون السـجائر (٤٠٪) والسجائـر والحشيش (٣٥٪) وهذا يؤثر على الدخل الشهرى للأسرة . والضرب هـو أسـلوب معاملة الطفـل عندما يخطئ (٦٥٪) . اما اسـلوب التشئة المتبـع فهـو القسـوة (٦١,٩٪). والتسـلط (٨٠ ٪). وايضا غير مهتمين بالنواحى الدينية . إن إفتقـاد الطفل للتربية السليمة نتيجة عـدم ارتبـاط الابـاء بـالدين. يفقـد الطفـل المعرفة بالسـلوكيات والاخلاقيات التى يحثهـا عليـه دينه ومن ثم لا يتعلم تطبيق هذه المعايير فى وجود الحافز.

- اسباب تتعلق بمستوى المعيشة:-

وجدنا ان عـدد الإفراد الأسـر فى هـؤلاء الأطفـال كبـير (يزيـد عـن سـبعة أفـراد) فى (٦٢,٥٪) والأب هو المصـدر الوحيـد للدخـل وإنخفـاض المسـتوى المعيشـى (٥٠٪ مـن الطبقـة الرابعة والخامسـة) وإنخفاض المستوى الإقتصادى والإجتماعى يعرض الأسرة لضغوط نفسية لقلة الدخل ومسـتولياتهم تجاه رعاية عدد كبير من الأبناء مما يولد شعور بالإحباط فـى حصولهم على متطلبات الحياه الاساسية وهـذا يؤدى الى الشـعور بالإحبـاط ممـا يولـد العدوانيـة نحو المجتمـع . والعلاقة متوترة دائما بـين الآباء والأمهـات (٤٥٪) ووجـود عـدم توافق نفسـى بين الزوجين (٥٠٪) فى صورة التشاجر والمشاكل باستمرار بينهما. ووسيلة العقاب المتبعـة فى الأسـرة هى الضرب (٦٥٪) واسلوب التشئة القسوة (٦١,٩٪) . ولايوجد اهتمام بالدين الإ قليـلا سـواء من عدم ممارسة الشعائر الدينية وعدم إعطاء النصائح والأرشادات لإطفالهم فى المـنزل فالإهمـال والعنف أو وضع نظم شديدة وصلبة للطفل او قضاء الطفـل اوقات طويلـة خـارج المنزل يخلق حالة من ضعف الثقة بالنفس لدى الطفل والتى يحاول أن يعوضها بأظهـار القوة او العنـف على الآخرين وهذا هو حجر الأساس فى بناء الشخصية العدوانية وظهور أعراضهـا التـى يعـانى منهـا الأسرة والمجتمع.

فالطفل يعبر عن معاناته النفسية بالسـلوك المضطرب او يكـون لديه نقـص فـى الأنـا الأعلى الـذى يعتبـر بمثابـة السـلطة الداخليـة فـى توجيـه سـلوك الطفـل الى السـلوك السـوى . كذلـك اضطراب الأنا والذين يتمثل فى عدم الاحساس بالذنب فى المواقف التى تستلزم ذلك.

التوصيات:-

- يجب الأهتمام بالأسر الكبيرة العدد وذات المستوى المعيشى المنخفض حتى يتسنى لها وقاية أبنائها من مرض الأضطراب التصرفى. ويجب رعايتها مادياً واجتماعياً وإعطائها الأرشادات للطرق التربوية السليمة فى تنشئة الأطفال والتعامل معهم ومع مشكلاتهم.

- يجب الأهتمام بالصمم فى الأطفال بعمل مسح شامل للسمع فى الأطفال عند دخول المدرسة للكشف المبكر وعلاجه على أساس علمى سليم وتوصية الأباء والأمهات لكيفية التعامل مع طفلهم الأصم وايضا كيفية الكشف المبكر لمرض الإضطراب التصرفى لديهم حتى نهتم بعلاجهم عضوياً ونفسياً الى جانب العلاج الإجتماعى بدلا من توقيع عقوبات عليهم.

- تعيين اخصائى سمعيات وأخصائى نفسى لكل منطقة تعليمية للكشف الدورى على هؤلاء الأطفال سمعياً ونفسياً.

- عمل دورات تدريبية مكثفة للمدرسين فى مدارس الصم لمعرفة أهم الخصائص المميزة للأطفال ضعاف السمع وكيفية التعامل معهم وأحدث الطرق المتبعة فى العملية التعليمية لهؤلاء الأطفال.

- ضرورة التعاون الوثيق بين المدرسين وأولياء الأمور للمساعدة فى العملية التعليمية وعلاج الأضطراب التصرفى فى الأطفال الصم.

المستخلص العربى

الأضطراب التصرفى فى الأطفال الصم

اسم الباحث :- طبيب عصمت عزيز بسخرون

الدرجة :- دكتوراه دراسات الطفولة الطبية

المستخلص :- الرسالة مكونة من جزئين

الجزء الأول:-

يشمل مراجعة نظرية لمرض الأضطراب التصرفى فى الأطفال مع التركيز على أسبابه سواء وراثية او أسرية او إجتماعية وخطورة هذا المرض على الأسرة والمجتمع.

وايضا يشمل مراجعة نظرية للصمم عند الأطفال وطريقة التشخيص والوقاية والعلاج مع التركيز على أهمية الكشف المبكر للصمم عند الأطفال.

الجزء الثانى:-

وهو الجزء العملى وقد تم عمل الدراسة على ٣٠٠ طفل من مدرسة الأمل الإبتدائية للأطفال الصم بشبرا لمعرفة مدى إنتشار الإضطراب التصرفى فيهم. وقد تم تطبيق استجوابات خاصة بالوالدين والمدرس تشمل أسئلة عن مراحل نمو الطفل الأولى وسلوكه فى المنزل والمدرسة وأحوال الأسرة الإجتماعية والعلاقات الموجودة داخل الأسرة. وايضا اختبار رسم الرجل لمعرفة درجة ذكاء الأطفال وقد تم مقارنة هذه العينة بعينة ضابطة اختيرت عشوائيا من نفس المدرسة وكانت نتائج البحث كالآتى:-

معدل انتشار الأضطراب التصرفى فى الأطفال الصم هو ١٣,٣ ٪ ومتوسط عمر الأطفال ٩,٣ ± ٢,٣٤ سنة. والذكور أكثر من الإناث (١:٧) . وأعراض الأضطراب التصرفى بأنماطه المختلفة أكثر انتشاراً فى المجموعة المريضة عن المجموعة الضابطة والفروق ذات دلالة إحصائية.

وأهم هذه الأعراض:-

العنف فى المنزل	٪٤٧,٥
الشجار الدائم مع الأخوة والأصدقاء	٪ ٤٢,٥
عدم الالتزام بنظام المدرسة	٪٤٢,٥
السرقة من المنزل	٪٤٠
الكذب ليؤذى الأخرين	٪٣٠
الأنضمام لشلة من أصدقاء السوء فى المدرسة	٪٣٠

وقد تبين أن الأسباب ترجع الى المستوى المعيشى المنخفض لأسر المجموعة المريضة وكثرة عدد الأفراد الأسرة وعدم إهتمام الأسرة بالدين وإدمان الأباء للمخدرات. وكذلك إستخدام الضرب والعنف كوسيلة لتربية أطفالهم.

الكلمات المفتاحية:-

الأضطراب التصرفى	الصمم	العنف
العدوان	إجتماعى	سلوك

APPENDIX "A"

١ - إسـم الطفـل:-

٢ - الـــــن:-

٣ - الجنـــــس:- رقم مسلسل:-

٤ - المدرســـــة:-

٥ - السنة الدراسية:-

٦ - رقـم الفصـــل:-

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١ - مانوع المدرسة؟

١ - إبتدائى عام ٢ - إبتدائى خاص ٣ - إبتدائى ازهرى

٢ - مانوع منطقة المدرسة؟

١ - مدينة ٢ - ريف

٣ - ماعمر الطفل؟

١ - (٥-٦) ٢ - (٦-٧) ٣ - (٧-٨)

٤ - (٨-٩) ٥ - (٩-١٠) ٦ - (١٠-١١)

٧ - (١١-١٢)

٤ - ماجنسه؟

١ - ذكر ٢ - أنثى

٥ - ماجنسيته؟

١ - مصرى ٢ - سودانى ٣ - فلسطينى

٤ - أخرى عربية ٥ - اخرى اجنبية

٦ - ماديانته؟

١ - مسلم ٢ - مسيحى ٣ - أخرى

٧ - ماالصف الدراسى للطفل؟

١ - (١) ٢ - (٢) ٣ - (٣)

٤ - (٤) ٥ - (٥) ٦ - (٦)

بياناتك عن الأفراد الذين يقيمون مع الطفل:-

٨ - هل الأب على قيد الحياة؟

١ - نعم ٢ - لا

إذا كانت اجابة برقم (٢) يسأل السؤال رقم (٩) إذا كانت الإجابة رقم (١) يسأل عن رقم (١١):-

٩ - ماعمر الطفل عند وفاة والده؟

١ - اقل من عامين ٢ - أقل من ٤ سنوات ٣ - أقل من ٦ سنوات

٤ - أقل من ٨ سنوات ٥ - أقل من ١٠ سنوات ٦ - أقل من ١٢ سنة

١٠ - ماعمر الأب؟

١ - (٢٠-٣٠) ٢ - (٣٠-٤٠) ٣ - (٤٠-٥٠)

٤ - (٥٠-٦٠) ٥ - (٦٠-٧٠) ٦ - (أكبر من ٧٠)

١١ - ماتعليم الأب؟

١ - أمي ٢ - يقرأ ويكتب ٣ - إعدادية
٤ - مؤهل متوسط ٥ - مؤهل عالى ٦ - دراسة عليا

١٢ - ماالعمل الحالى للأب؟

١ - فلاح ٢ - عامل ٣ - موظف
٤ - تاجر ٥ - بالجيش ٦ - لايعمل
٧ - أخرى

١٣ - ماالوقت الذى يقضيه الاب بالمنزل؟

١ - طول اليوم ٢ - نصف اليوم ٣ - ساعات قليلة
٤ - يأتى الى البيت نادرا ٥ - لايأتى الى البيت اطلاقا ٦ - أخرى

١٤ - اين يعيش الأب؟

١ - مع الأسرة والطفل ٢ - مستقل ٣ - اخرى

إذا كانت اجابة برقم (٢) أو (٣) يسأل من رقم (١٥)،-

١٥ - هل يوجد بديل للأب؟

١ - نعم ٢ - لا

١٦ - مادرجة قرابته للطفل؟

١ - جده ٢ - عمه ٣ - خاله
٤ - اخيه الأكبر ٥ - زوج امه ٦ - قريب من الاسرة
٧ - غير قريب

١٧ - هل الأم على قيد الحياه؟

١ - نعم ٢ - لا

إذا كانت اجابة برقم (٢) أو (٣) يسأل من رقم (١٨) وإذا كانت الإجابة رقم (١) يسأل من رقم (١٩)،-

١٨ - ماعمر الطفل عند وفاه أمه؟

١ - اقل من عامين ٢ - أقل من ٤ سنوات ٣ - أقل من ٦ سنوات
٤ - أقل من ٨ سنوات ٥ - أقل من ١٠ سنوات ٦ - أقل من ١٢ سنة

١٩ - ماعمر الأم؟

١ - (٢٠-٣٠) ٢ - (٣٠-٤٠) ٣ - (٤٠-٥٠)
٤ - (٥٠-٦٠)

٢٠ - ماتعليمها؟

١ - أميه ٢ - تقرأ وتكتب ٣ - إعدادية
٤ - مؤهل متوسط ٥ - مؤهل عالى ٦ - دراسة عليا

٢١ - ماعمل الأم الحالى؟

١ - ربة بيت ٢ - فلاحة ٣ - عاملة
٤ - موظفة ٥ - لاتعمل ٦ - اخرى

٢٢ - كم من الوقت تقضيه الأم برفقة الطفل؟

١ - طول اليوم ٢ - نصف اليوم ٣ - ساعات قليلة
٤ - لاتراه الا نادرا ٥ - لاتراه اطلاقا ٦ - اخرى

٢٣ - هل تصلى الام؟

١ - لاتصلى ٢ - لاتصلى بانتظام ٣ - تصلى بانتظام

٤ - تصلى بالمسجد/ الكنيسة مرة اسبوعيا ٥ - تصلى بالمسجد / الكنيسة بكثرة

٢٤ - هل تصوم الأم؟

١ - لاتصوم ٢ - احياناً تصوم ٣ - تصوم بانتظام

٤ - تصوم كثيراً

٢٥ - هل تثقف الأم دينيا؟

١ - أحيانا تقرأ كتباً دينيه ٢ - تقرأ كتباً دينية بانتظام ٣ - تحضر اوتشاهد ندوات دينية

٢٦ - هل تقدم الأم الإرشادات الدينية للطفل؟

١ - تشجع الطفل على الصلاه

٢ - تشجع الطفل على الصوم

٣ - تشجع الطفل للذهاب للجامع/ الكنيسة

٤ - تشجع الطفل على تعلم الدين

٢٧ - اين تعيش الأم؟

١ - مع الطفل ٢ - مستقلة مع الطفل ٣ - مستقلة

٤ - اخرى

إذا كانت اجابة برقم (٣،٤) يسأل رقم (٢٨).-

٢٨ - هل هناك بديل للأم؟

١ - نعم ٢ - لا

إذا كانت اجابة برقم (١) يسأل رقم (٢٩).-

٢٩ - من هو بديل للأم؟

١ - عمته ٢ - خالته ٣ - جدته

٤ - زوجة ابيه ٥ - قريبة من الاسرة ٦ - غير قريبة

٧ - أخرى

٣٠ - ماعمرها؟

١ - (١٠-٢٠) ٢ - (٢٠-٣٠) ٣ - (٣٠-٤٠)

٤ - (٤٠-٥٠) ٥ - (٥٠-٦٠) ٦ - (٦٠-٧٠)

٣١ - مادرجة تعليمها؟

١ - امية ٢ - تقرأ وتكتب ٣ - إعدادية

٤ - مؤهل متوسط ٥ - مؤهل عالى ٦ - دراسة عليا

٣٢ - ماعمل بديل الأم؟

١ - ربة بيت ٢ - فلاحة ٣ - عاملة

٤ - موظفة ٥ - لاتعمل ٦ - اخرى

٣٣ - هل الوالدان منفصلان؟

١ - نعم ٢ - لا

إذا كانت اجابة برقم (١) يسأل رقم (٣٤).-

٣٤ - ماسبب الانفصال؟

١ - الطلاق ٢ - السفر ٣ - الموت

٤ - المرض ٥ - الخلاف ٦ - أخرى

٣٥ - ماعمر الطفل عند الإنفصال؟

١ - اقل من عامين ٢ - أقل من ٤ سنوات ٣ - أقل من ٦ سنوات

٤ - أقل من ٨ سنوات ٥ - أقل من ١٠ سنوات ٦ - أقل من ١٢ سنة

٣٦ - هل للطفل اخوة؟

١ - نعم ٢ - لا

إذا كانت اجابة برقم (١) يسأل رقم (٣٧)،-

٣٧ - كم عدد اخوته؟

١ - (١) ٢ - (٢) ٣ - (٣)

٤ - (٤) ٥ - (٥) ٦ - (٦)

٧ - (٧) ٨ - (٨) ٩ - (٩)

١٠- أكثر

٣٨ - مادرجة التعليم للاخوة؟ (يكتب عددالذين تنطبق عليهم الصفة اسفلها؟)

١ - أمية ٢ - تقرأ وتكتب ٣ - إعدادية

٤ - مؤهل متوسط ٥ - مؤهل عالى ٦ - دراسة عليا

٣٩ - ما عملهم؟ (يكتب عددالذين تنطبق عليهم المهنة اسفلها)

١ - فلاح ٢ - عامل ٣ - موظف

٤ - تاجر ٥ - بالجيش ٦ - لايعمل

٤٠ - ماترتيبه بين اخوته؟

١ - الأكبر ٢ - فى الوسط ٣ - الأصغر

إذا كان ذكرا يسأل السؤال رقم (٤١) وإذا كانت انثى يسأل السؤال رقم(٤٢)،-

٤١ - ماترتيبه بين الذكور؟

١ - الأكبر ٢ - فى الوسط ٣ - الأصغر

٤٢ - ماترتيبها بين الاناث؟

١ - الأكبر ٢ - فى الوسط ٣ - الأصغر

وراثة المرض (التاريخ العائلى):-

٤٣ - هل توجد صلة قرابة بين الوالدين؟

١ - نعم ٢ - لا

إذا كانت الإجابة برقم (١) يسأل رقم (٤٤)

٤٤ - مادرجة القرابة بين الوالدين؟

١ - اولى ٢ - ثانية ٣ - من الاقارب فقط

٤ - لا قرابة

٤٥ - هل يعانى احد افراد الاسرة من مرض عصبى او نفسى؟

١ - نعم ٢ - لا

إذا كانت الإجابة برقم (١) يسأل رقم (٤٦)،-

٤٦ - ماهو هذا المرض؟

١ - شلل ٢ - صرع ٣ - صداع نصفى

٤ - ضمور فىالاعصاب او العضلات ٥ - تخلف عقلى

٦ - هوس ٧ - إكتئاب ٨ - فصام عقلى

٩ - اخرى

٤٧ – هل سبق ان وجه الى احد الوالدين تهمة؟

١ – نعم ٢ – لا

٤٨ – هل سبق ان ادخل احد الوالدين الى السجن او المحكمة؟

١ – نعم ٢ – لا

٤٩ – ماسبب ذلك؟

١ – سوء السلوك ٢ – جناية ٣ – سبب سياسي

٤ – مخالفة قانونية ٥ – اخرى

٥٠ – هل يدمن الاب اى من؟

١ – الخمر ٢ – الحشيش ٣ – العقاقير

٤ – الافيون ٥ – اخرى

٥١ – هل يصلى الأب؟

١ – لايصلى ٢ – لايصلى بانتظام ٣ – يصلى بانتظام

٤ – تصلى بالمسجد/ الكنيسة مرة اسبوعيا ٥ – يصلى بالمسجد / الكنيسة بكثرة

٥٢ – هل يصوم الأب؟

١ – لايصوم ٢ – احياناً يصوم ٣ – يصوم بانتظام

٤ – يصوم كثيراً

٥٣ – هل يتثقف الأب دينيا؟

١ – أحيانا يقرأ كتباً دينيه ٢ – يقرأ كتباً دينية بانتظام ٣ – يحضر اوتشاهد ندوات دينية

٥٤ – هل يقدم الأب الإرشادات الدينية للطفل؟

١ – يشجع الطفل على الصلاه

٢ – يشجع الطفل على الصوم

٣ – يشجع الطفل للذهاب للجامع/ الكنيسة

٤ – يشجع الطفل على تعلم الدين

التاريخ التطوري للطفل:-

٥٥ – هل كانت الام اثناء حملها فى الطفل؟

١ – مريضة جسمانياً ٢ – مريضة نفسياً ٣ – تتعاطى عقاقير

٤ – كانت تستخدم وسيلة لمنع الحمل ٥ – مصابة بحصبة المانى

٦ – استخدمت بعض الطرق بقصد الإجهاض ٧ – اخرى

٥٦ – هل كانت للام رغبة فى انجاب الطفل؟

١ – نعم ٢ – لا

٥٧ – هل كان للاب رغبة فى إنجاب الطفل؟

١ – نعم ٢ – لا

٥٨ – هل كانت الأم تفضله نفس الجنس؟

١ – نعم ٢ – لا

٥٩ – هل كان الأب يفضله نفس الجنس؟

١ – نعم ٢ – لا

٦٠ – كيف كانت الولادة؟

١ – ولادة مبكرة ٢ – طبيعية ٣ – قيصرية

٤ – متعسرة لم يستخدم فيها الات ٥ – متعسرة استخدم فيها الات

٦ – اخرى

٦١ – هل حدث له اثناء الولادة؟

١ – إختناق ٢ – إصابة عصبية ٣ – اصابة بدنية
٤ – صفراء ٥ – نزف مبكر ٦ – اخرى

٦٢ – كيف كانت حالة الام بعد الولادة؟

١ – طبيعية ٢ – نزف ٣ – حمى
٤ – اضطراب جسماني اخر ٥ – اضطراب نفسي ٦ – اخرى

علامات النمو المبكر للطفل:-

٦٣ – كيف كانت تغذيته في السنة الأولى؟

١ – من ثدى أمه ٢ – من ثدى اخرى ٣ – من مصدر خارجي

٦٤ – متى استطاع الجلوس بدون مساعدة؟

١ – أقل من سنة ٢ – من ٦-٩ شهور ٣ – اكثر من ٩ شهور

٦٥ – متى استطاع المشي بدون مساعدة؟

١ – اقل من سنة ٢ – من ١٢-١٥ سنة ٣ – من ١٥-١٨ سنة
٤ – اكثر

٦٦ – في اى سن تم فطامه؟

١ – اقل من سنة ٢ – من سنة الى سنة ونصف ٣ – سنتين
٤ – ثلاث سنوات ٥ – اكثر

٦٧ – كيف تم فطامه؟

١ – فجأة ٢ – تدريجياً

٦٨ – متى بدأ الكلام؟ (استطاع ان ينطق كلمة واحدة)

١ – اقل من سنة ٢ – سنة ٣ – من سنة الى سنة ونصف
٤– سنتين ٥ – ثلاث سنوات ٦ – اكثر

٦٩ – متى بدأ وتم التحكم في التبول اثناء اليقظة؟

١ – اقل من سنتين ٢ – سنتين ٣ – ثلاث سنوات
٤ – اكثر ٥ – لم يتم للآن

٧٠ – متى تم التحكم في التبرز اثناء اليقظة؟

١ – اقل من سنتين ٢ – سنتين ٣ – ثلاث سنوات
٤ – اكثر ٥ – لم يتم للآن

٧١ – هل ادخل الحضانة؟

١ – نعم ٢ – لا

إذا كانت الإجابة برقم (١) يسأل رقم (٧٢)

٧٢ – في أى سن ادخل الحضانة؟

١ – سنة ٢ – سنتين ٣ – ثلاث سنوات
٤ – اربعة سنوات ٥ – خمسة سنوات

٧٣ – مانوع الحضانة؟

١ – في مكان عمل الام ٢ – في مكان عمل الاب ٣ – بعيده عن أى منهما
٤ – عند احدى الجارات ٥ – عند احدى القريبات ٦ – ليس بها مكان للعب
٧ – بها مكان للعب

التاريخ المرضى السابق:-

٧٤ - هل اصيب بأى من الأمراض الاتية؟

١ - حمى ٢ - حصبة ٣ - شلل اطفال
٤ - صرع ٥ - صرع مع سخونة

٧٥ - هل حدث له حادث اثر عليه؟

١ - نعم ٢ - لا

٧٦ - هل سبق ان ادخل المستشفى ونوم بها؟

١ - نعم ٢ - لا

إذا كانت الإجابة برقم (١) يسأل رقم (٧٨)

٧٨ - ماهى المدة التى قضاها بالمستشفى؟

١ - (١-٣) ايام ٢ - اسبوع - شهر ٣ - (١-٣) شهور
٤ - (٣-٦) شهور ٥ - (٦-١٢) شهر ٦ - اكثر من سنة

٧٩ - ماهو السبب؟

١ - مرض جسمانى ٢ - مرض نفسى ٣ - حادث
٤ - عملية جراحية ٥ - اخرى

٨٠ - هل لديه اعاقة جسمانية ؟

١ - نعم ٢ - لا

إذا كانت الإجابة برقم (١) يسأل رقم (٨١)

٨١ - ماهو السبب؟

١ - حادث ٢ - مرض ٣ - شلل
٤ - جراحة ٥ - اخرى

٨٢ - هل سبق ان العهد الى قسم البوليس؟

١ - نعم ٢ - لا

إذا كانت الإجابة برقم (١) يسأل رقم (٨٣)

٨٣ - ماهو السبب؟

١ - اعتداء جسمانى ٢ - سرقة ٣ - تحطيم الاشياء
٤ - اخرى

العلاقات الإجتماعية:-

٨٤ - هل يرتبط الطفل بشده بأى من؟

١ - والده ٢ - والدته ٣ - اخيه الاكبر
٤ - اخته الكبرى ٥ - بأحد الاقارب ٦ - بأحد المعارف
٧ - غير مرتبط

٨٥ - مانوعية العلاقة بين والد الطفل او البديل عنه وبين الطفل؟

١ - يشجعه دائما ٢ - يدافع عنه دائما ٣ - يضربه
٤ - يؤنبه ٥ - يخوفه ٦ - يخاصمه
٧ - يهدده ٨ - يسخر منه ٩ - لايهتم

٨٦ – مانوعية العلاقة بين والدة الطفل او بديلتها وبين الطفل؟

١ – تدافع عنه ٢ – تقف ضده دوما ٣ – تؤنبه
٤ – تضربه ٥ – تخوفه ٦ – تخاصمه
٧ – تهدده ٨ – تسخر منه ٩ – لاتهتم به

٨٧ – ماطبيعة العلاقة بين والدى الطفل؟

١ – الانفعال والثورة لأتفه الاسباب ٢ – الشجار الدائم
٣ – الاهمال للبيت والاولاد ٤ – المخاصمة

٨٨ – هل يشاجر الطفل كثيراً من أى من؟

١ – أخواته الاصغر منه ٢ – أخواته الاكبر منه ٣ – مع رفاقه الاكبر
٤ – مع رفاقه الاصغر ٥ – مع اندادة

٨٩ – هل للطفل اصدقاء؟

١ – كثيرين ٢ – قليلين (اقل من ثلاثة) ٣ – خارج المدرسة
٤ – فى المدرسة فقط ٥ – اكبر منه سناً ٦ – اصغر منه سناً
٧ – ذكور فقط ٨ – أناث فقط

٩٠ – فى علاقته باصدقائه هل؟

١ – يستفيد من وراء هذه الصداقة ٢ – يحبهم لمصلحته فقط
٣ – يمكن ان يفقد عليهم (يشى بهم) ٤ – لايتمسك بصداقتهم
٥ – استمرت اكثر من ٦ شهور ٦ – يثق بهم
٧ – استمرت علاقته بهم اقل من ٦ شهور ٨ – يتمسك بهم
٩ – يحبهم دون مصلحة مباشرة
١٠ – يرغب فى قضاء كل وقته معهم

٩١ – هل حدث للأسرة فى حياة الطفل أن أنتقلت؟

١ – من مسكن الى آخر فى نفس الحى ٢ – من حى الى آخر
٣ – من مدينة الى أخرى ٤ – من قرية الى المدينة
٥ – من دولة الى أخرى

٩٢ – عندا يخطئ الطفل هل يعاقب؟

١ – نعم ٢ – لا

إذا كانت الإجابة برقم (١) يسأل رقم (٩٣)

٩٣ – مانوع العقاب الذى يوقع عليه؟

١ – الضرب ٢ – التأنيب ٣ – الخصام
٤ – السخرية منه ٥ – الحبس فى حجرة ٦ – المنع من الخروج والفسحة
٧ – منع المصروف ٨ – الطرد من البيت ٩ – اخرى

٩٤ – بما تتميز طريقة التربية ؟

١ – بالقمع ٢ – بالكبت ٣ – بالعزلة
٤ – بالفتور فى المعاملة ٥ – بالحماية المفيدة

سلوك الطفل وعاداته:-

٩٥ – هل يذهب الطفل عادة الى المسجد او الكنيسة؟

١ – نعم ٢ – لا

إذا كانت الإجابة برقم (١) يسأل رقم (٩٦)

٩٦ – مامعدل ذهابه؟

١ – اكثر من مرة اسبوعيا ٢ – مرة واحدة اسبوعيا ٣ – اقل من مرة اسبوعيا
٤ – لايذهب

٩٧ – هل يتلقى تعليماً دينياً خارج المدرسة؟

١ – نعم ٢ – لا

٩٨ – هل يصلى الطفل؟

١ – لايصلى ٢ – لايصلى بانتظام ٣ – يصلى بانتظام
٤ – يصلى بالمسجد/ الكنيسة مرة اسبوعيا ٥ – يصلى بالمسجد / الكنيسة بكثرة

٩٩ – هل يصوم الطفل؟

١ – لايصوم ٢ – احياناً يصوم ٣ – يصوم بانتظام
٤ – يصوم كثيراً

١٠٠ – مانوع الانشطة التى يفعلها الطفل؟

١ – رياضية ٢ – ثقافية ٣ – اجتماعية
٤ – جوالة ٥ – اخرى

١٠١ – مانوع الرياضة المفضلة لديه؟

١ – المصارعة ٢ – الملاكمة ٣ – الكاراتيه
٤ – الكرة ٥ – السباحة ٦ – اخرى

١٠٢ – مانوع القراءة المفضلة لديه؟

١ – الروايات البوليسية ٢ – قصص البطولة ٣ – كتب علمية
٤ – اخرى

١٠٣ – مانوع الافلام التى يفضلها والمسلسلات التليفزيونية؟

١ – البوليسية ٢ – المصارعة والكراتيه ورعاة البقر
٣ – افلام الرعب ٤ – الدرامية ٥ – الكوميدية

١٠٤ – هل يشاهد افلام الفيديو؟

١ – نعم ٢ – لا

١٠٥ – اين يشاهدها (افلام الفيديو)؟

١ – فى البيت ٢ – عند الأصدقاء ٣ – عند أقاربه
٤ – عند الجوان

١٠٦ – هل للطفل شهرة بين أقاربه او أخواته او رفاقه بأنه؟

١ – مصارع ٢ – قوى ٣ – عنيف
٤ – مفترس ٥ – جبان ٦ – عظيم
٧ – كذاب ٨ – ضعيف ٩ – لص
١٠– عدوانى

١٠٧ – هل يتميز سلوك الطفل عادة؟

١ – بالصراع المستمر بينه وبين أخوته ٢ – بالغيرة من الأخرين
٣ – بالصراع المستمر بينه وبين رفاقه ٤ – بعدم الثقة فى الآخرين
٥ – عدم أحترام شعور الآخرين ورغباتهم ٦ – بالثورة لأتفه الأسباب
٧ – بكراهية السلطة فى البيت والمدرسة ٨ – بعدم حب النظام
٩ – بمحاولات الخدع والمكر عند محاصرته ١٠– التهرب من أداء واجبه

١٠٨ - هل يتسم سلوك الطفل داخل البيت؟

١ - بأنه لايمكن تركه وحده
٢ - لايستطيع إكمال واجبه
٣ - بكثرة الحركة
٤ - مندفع فى تصرفاته
٥ - عدم الأنتظام فى ملابسه وأدواته
٦ - يأكل بطريقة متقطعة
٧ - لاينتهى من فعل الأشياء ويندفع فى غيرها
٨ - بالأرق فى نومه
٩ - لايستجيب لفعل الشئ عندما يطلب منه

١٠٩ - هل يتميز الطفل بأنه؟

١ - عنيد
٢ - مجادل
٣ - يفعل عكس مايطلب منه
٤ - مطيع لرفاقه فقط
٥ - يصمم على رأيه دون اعتبار لرغبات الاخرين
٦ - مطيع لوالديه فقط
٧ - مطيع لوالديه ومدرسيه فقط
٨ - مطيع لمدرسيه فقط
٩ - مطيع للجميع

١١٠ - الى اى درجة يكون عنيف فى سلوكه ؟

١ - يدفع الأطفال بشدة
٢ - يتشاجر معهم
٣ - يضربهم
٤ - يتغلب عليهم
٥ - يحدث بهم اذى
٦ - يسبهم
٧ - يقتل الحيوانات الصغيرة (قطة مثلا)
٨ - يحطم الأشياء

١١١ - هل يسرق؟

١ - نعم
٢ - لا

إذا كانت الإجابة برقم (١) يسأل رقم (١١٢)

١١٢ - هل الاشياء التى يسرقها؟

١ - لاقيمة لها
٢ - لها قيمة
٣ - من البيت
٤ - من المدرسة
٥ - من المحلات
٦ - من أخوته
٧ - من رفاقه
٨ - من آخرين
٩ - يسرقها وحده
١٠ - يسرقها برفقة اخرين

١١٣ - هل السرقة التى يسرقها؟

١ - مصحوبة بعنف جسمانى
٢ - بالخطف والهرب
٣ - بالمواجهه مع الضحية

١١٤ - هل يكذب؟

١ - نعم
٢ - لا

إذا كانت الإجابة برقم (١) يسأل رقم (١١٥)

١١٥ - هل كذبه عبارة عن؟

١ - أنكار اخطاءه
٢ - دفاع عن نفسه
٣ - كذب دائم
٤ - يختلق روايات
٥ - تلفيق تهم للآخرين

١١٦ - هل يميل الطفل لأشعال النيران؟

١ - نعم
٢ - لا

إذا كانت الإجابة برقم (١) يسأل رقم (١١٧)

١١٧ - عندما يشعل النيران؟

١ - لايؤذى أحد
٢ - يؤذى بها نفسه
٣ - يؤذى بها الآخرين

١١٨ - هل يحدث أحيانا؟

١ - ان يتأخر فى العودة الى المنزل
٢ - يهرب من المنزل طيلة النهار
٣ - يهرب من المنزل ليلة او أكثر
٤ - يهرب من المدرسة أحياناً
٥ - يهرب بمفرده
٦ - يهرب برفقة آخرين
٧ - يستدعى ولى أمره لإستلامه من البوليس

١١٩ - عندما يرتكب اى من الأخطاء السابقة ويواجه بها فهل؟

١ - يبدو كما لو كان ضميره يؤنبه
٢ - يهرب من المنزل طيلة النهار
٣ - يهرب من المنزل ليلة او أكثر
٤ - يهرب من المدرسة أحياناً
٥ - يهرب بمفرده
٦ - يهرب برفقة آخرين
٧ - يستدعى ولى أمره لإستلامه من البوليس

١٢٠ - هل يحدث له؟

١ - فقدان الشهية
٢ - زيادة الشهية
٣ - مص الأصابع
٤ - قضم الإظافر
٥ - غثيان متكرر
٦ - قئ متكرر
٧ - مغص متكرر
٨ - حركة معينة لازمة له
٩ - يأكل مواد لاتصلح للأكل

١٢١ - هل يعانى من؟

١ - امساك مستمر
٢ - إسهال متكرر
٣ - تبليل نفسه ببوله أثناء اليقظة
٤ - التبول أثناء النوم
٥ - تلويث نفسه ببرازه أثناء اليقظة
٦ - التبرز أثناء النوم

١٢٢ - بالنسبة لنوم الطفل هل؟

١ - ينام كثيراً
٢ - لديه أرق أول النوم
٣ - نوم متقطع
٤ - لديه أرق بعد فترة
٥ - لديه كوابيس أثناء النوم
٦ - لديه نزعات ليلية
٧ - يمشى أثناء النوم
٨ - نوبات من فقدان الوعى

١٢٣ - هل هو؟

١ - كثير اللعب باعضائه التناسلية
٢ - يحب تعرية جسده
٣ - يرتكب بعض الأفعال الجنسية مع الجنس المخالف
٤ - يرتكب بعض الأفعال الجنسية مع أنداده

١٢٤ - هل يشكو أى من الأعراض الجسمانية الآتية؟

١ - صداع مستمر
٢ - رعشة باليدين
٣ - برودة بالأطراف
٤ - همدان الجسم

١٢٥ - هل تنتابه نوبات متكررة من فقد الشعور (لمدة لحظات)؟

١ - نعم
٢ - لا

١٢٦ - هل يحدث له نوبات من السلوك الغريب (الشاذ) لايذكرها ولايشعر بها؟

١ - نعم
٢ - لا

١٢٧ - هل تنتابه نوبات من التشنج؟

١ - نعم
٢ - لا

إذا كانت الإجابة برقم (١) يسأل رقم (١٢٨)،-

١٢٨ - ماهو اصفاتها؟

١ - تصاحبها سخونة ٢ - بفقد وعيه أثنائها ٣ - تحدث به إصابات جسمانية

٤ - يبلل نفسه (يتبول)أثنائها ٥ - تأتيه أثناء النوم ٦ - تأتيه أثناء النهار

٧ - تأتيه أمام الآخرين

١٢٩ - بالنسبة لحالته الوجدانية هل؟

١ - يشعر بحزن أكثر من المعتاد

٢ - فقد الإهتمام بأصدقائه

٣ - أصبح لايستمتع بالأشياء التى كان يستمتع بها من قبل

٤ - أصبح ينام كثيراً

٥ - يغيب عن المدرسة بسبب حالة الحزن هذه

٦ - بدأ يلوم نفسه على كل شئ

٧ - حاول الأنتحار

٨ - أصبح يفكر فى الأنتحار

٩ - أصبح مسروراً بصورة مزعجة

١٠ - قليل النوم والشهية كثير الحركة

١٣٠ - بالنسبة لسلوكه فى المدرسة هل؟

١ - حدث أن طلب ولى أمره بسبب إضطراب سلوك الطفل فى المدرسة

٢ - يخاف من المدرسة جداً

٣ - يكثر تغيبه عن المدرسة

٤ - إنجازه الدراسى لايتناسب مع مستوى زكائه

١٣١ - ماهو موقف الوالدين من إنحراف سلوك الطفل؟

١ - الرفض السلبى

٢ - محاولة التقويم

٣ - الضرب

٤ - الطرد من المنزل

٥ - القاء المسئولية على رفاقه

٦ - التغطية على أفعاله

٧ - الوقوف بجانبه مهما كان مخطئاً

APPENDIX "B"

إستمـــارة المـــدرس

- إســم المدرسـة:-
- السنة الدراسية:-
- اســم التلميذ:-
- رقــم الفصــل:-

هل يعانى الطفل (التلميذ) أى من الحالات الآتية أثناء تواجده بالمدرسة بصفة ثابتة ومتكررة.

١	- عدم القدرة على الإنتباه؟	نعم	( )	لا	( )
٢	- عدم القدرة على التركيز؟	نعم	( )	لا	( )
٣	- عدم الأستقرار أثناء الدرس (متململ فى جلسته)؟	نعم	( )	لا	( )
٤	- الأندفاع وعدم التحكم فى تصرفاته؟	نعم	( )	لا	( )
٥	- نقص التحصيل الدراسى؟	نعم	( )	لا	( )
٦	- كثرة الشجار مع زملائه؟	نعم	( )	لا	( )
٧	- الأعتداء على زملائه جسمانياً بالضرب؟	نعم	( )	لا	( )
٨	- الأعتداء على زملائه بالسب او التهجم؟	نعم	( )	لا	( )
٩	- عدم أحترام رغبات وشعور زملائه؟	نعم	( )	لا	( )
١٠	- يكذب دائماً؟	نعم	( )	لا	( )
١١	- يكذب ليدافع عن نفسه فقط؟	نعم	( )	لا	( )
١٢	- يلفق تهماً لزملائه؟	نعم	( )	لا	( )
١٣	- يسرق أشياء خاصة بزملائه؟	نعم	( )	لا	( )
١٤	- يخطف أشياء زملائه؟	نعم	( )	لا	( )
١٥	- يعتدى على زملائه بالضرب لأخذ ممتلكاتهم؟	نعم	( )	لا	( )
١٦	- يسرق أشياء تخص المدرسة؟	نعم	( )	لا	( )
١٧	- يتلف أشياء المدرسة أو يحطمها؟	نعم	( )	لا	( )
١٨	- يتلف أشياء زملائه أو يحطمها؟	نعم	( )	لا	( )
١٩	- ليس له أصدقاء بين زملائه فى المدرسة؟	نعم	( )	لا	( )
٢٠	- يتدخل فى نشاط أو لعب زملائه بطريقة تضايقهم؟	نعم	( )	لا	( )
٢١	- غير مرغوب من زملائه؟	نعم	( )	لا	( )
٢٢	- لايلتزم بنظام المدرسة؟	نعم	( )	لا	( )
٢٣	- يتغيب من المدرسة بدون أذن؟	نعم	( )	لا	( )
٢٤	- يزوغ من المدرسة؟	نعم	( )	لا	( )

شكرا للسيد الأستاذ (او الأستاذة) حسن تعاونهم معنا.

APPENDIX "C"

إستمارة الوالدين (او من ينوب عنها)

- إسم المدرسة:-
- السنة الدراسية:-
- اسم التلميذ:-
- رقم الفصل:-

السيد ولى أمر التلميذ

تحية طيبة وبعد.....

نرجو من سيادتكم التعاون معنا وذلك لفحص حالة (التلميذ) الصحية والنفسية وذلك ضمن إجراء بحث على تلاميذ المدارس الإبتدائية لمعرفة مدى إنتشار إضطرابات السلوك بينهم ..... وإذا كان الطفل يعانى أى من الحالات الآتية بصفة ثابتة ومتكررة (التى بالامثلة الآتية) فنرجوا وضع علامة (✓) أمام كلمة (نعم) التى فى نفس السطر وإذا كان لايعانى من الحالة المسئول عنها توضع علامة (✓) أمام كلمة (لا) التى فى نفس السطر أيضا.

١	– هل يشكو الطفل من صداع متكرر؟	نعم	( )	لا	( )
٢	– هل يتبول الطفل على نفسه (يبلل فراشه أثناء النوم)؟	نعم	( )	لا	( )
٣	– هل تحدث له نوبات من فقد الشعور (او السرحان)؟	نعم	( )	لا	( )
٤	– هل تحدث له نوبات من الصرع (التشنج)؟	نعم	( )	لا	( )
٥	– هل الطفل كثير الحركة لدرجة تقلق الوالدين عليه؟	نعم	( )	لا	( )
٦	– هل من عادته كثرة الشجار (والمشاكل) مع أخوته او رفاقه؟	نعم	( )	لا	( )
٧	– هل يعتدى على أخوته بالضرب؟	نعم	( )	لا	( )
٨	– هل يعتدى على أخوته بالسب او الشتم او السخرية منهم؟	نعم	( )	لا	( )
٩	– هل الطفل لايحترم شعور أخوته اورغباتهم؟	نعم	( )	لا	( )
١٠	– هل يعتدى على أخوته او رفاقه (الذين يلعب معهم) بالضرب؟	نعم	( )	لا	( )
١١	– هل يقتل الحيوانات الصغيرة (مثل القطط والكلاب)؟	نعم	( )	لا	( )
١٢	– هل يوجد له أصدقاء (أصحابه يعنى)؟	نعم	( )	لا	( )
١٣	– هل يصاحبهم من أجل الأستفادة من ورائهم؟	نعم	( )	لا	( )
١٤	– هل أستمرت علاقته بأى من أصدقائه لمدة ستة أشهر أو أكثر؟	نعم	( )	لا	( )
١٥	– هل يرى الوالدين أن أصدقاء الطفل سيئين (رفاق سوء)؟	نعم	( )	لا	( )
١٦	– هل يحطم الأشياء او يتلفها خارج البيت او داخله؟	نعم	( )	لا	( )
١٧	– هل يحترم نظام البيت؟	نعم	( )	لا	( )
١٨	– هل يتأخر فى طريق عودته من المدرسة للبيت؟	نعم	( )	لا	( )
١٩	– هل يتأخر خارج البيت ليلاً؟	نعم	( )	لا	( )
٢٠	– هل يهرب من البيت أحياناً لمدة ليلة أو أكثر؟	نعم	( )	لا	( )
٢١	– هل يهرب من البيت برفقة أخرين؟	نعم	( )	لا	( )
٢٢	– هل الطفل عنيد يرفض تنفيذ مايؤمر به؟	نعم	( )	لا	( )
٢٣	– عند معاقبته او مواجهته بأخطائه هل يهدد بترك البيت؟	نعم	( )	لا	( )
٢٤	– هل يسرق اشياء ذات قيمة من البيت (مثل الفلوس)؟	نعم	( )	لا	( )
٢٥	– هل يسرق مايخص اخوته من لعب او فلوس؟	نعم	( )	لا	( )
٢٦	– هل يسرق أشياء من خارج البيت؟	نعم	( )	لا	( )

٢٧ - هل يخطف حاجات غيره من أخوته او رفاقه؟ نعم ( ) لا ( )
٢٨ - هل يضرب الأطفال الآخرين ويأخذ ماممهم؟ نعم ( ) لا ( )
٢٩ - هل يكذب كثيراً؟ نعم ( ) لا ( )
٣٠ - هل يكذب فقط عندما يجد نفسه فى مازق حرج؟ نعم ( ) لا ( )
٣١ - هل يلفق تهماً للآخرين (يعنى يكذب ليضرب الآخرين)؟ نعم ( ) لا ( )
٣٢ - عندما يخطئ هل يلقى باللوم على غيره؟ نعم ( ) لا ( )
٣٣ - عندما يواجه بأخطائه هل يحاول الهرب منها بمكر وخداع؟ نعم ( ) لا ( )
٣٤ - هل يحب اللعب بالنار وإشعال الحرائق؟ نعم ( ) لا ( )
٣٥ - هل يؤذى بالنار نفسه او غيره؟ نعم ( ) لا ( )
٣٦ - هل الطفل مشهور بين رفاقه بأنه شرس أو عدوانى؟ نعم ( ) لا ( )

معلومات خاصة بالطفل المعوق سمعيا:-

٣٧ - هل الطفل عنده:-
( ) ضعف سمع ( ) فقد كلى للسمع

٣٨ - هل يسمع بالسماعة:-
( ) نعم ( ) لا
( ) احيانا

٣٩ - كم كان عمر الطفل وقت حدوث فقد السمع او ضعفه؟
( )

٤٠ - هل حدث هذا:-
( ) فجأه ( ) تدريجياً

٤١ - هل حدث:-
( ) إزدياد ( ) تحسن
( ) إستقرار فى حالة ضعف السمع

٤٢ - كم كان عمر الطفل وقت إكتشاف هذه الإعاقة؟ .....

٤٣ - متى تم إلتحاقه بمدرسة الأمل للصم الإبتدائية؟ .....
(أذكر اسم المدرسة التى التحق بها الطالب - وتاريخ الإلتحاق - وسنه وقت الإلتحاق بها)

٤٤ - ماالذى سبب حدوث الصمم؟ او ضعف السمع؟ .....

٤٥ - هل هناك أحد من الأقارب كالأخوه أو الأب أو الأم أوالخال او العم او الجد...الخ يعانى من ضعف سمع أو صم؟
( ) نعم ( ) لا
إذا كان نعم من هم ( )

٤٦ - هل تغير سلوك الطفل بعد حدوث الصمم او ضعف السمع (أن وجد) عن سلوكه قبل ذلك:-
(إذا كانت الإجابة بنعم فحاول أن تذكر السلوك الذى تغير) .....

٤٧ - ماهو شعور الأم والأب والإخوة تجاه الطفل المصاب؟ .....

٤٨ - كيف تتعامل الأسرة مع الطفل المعاق سمعيا؟
( ) رعاية وحماية زائدة ( ) معاملة كأى طفل عادى
( ) رفض له او نبذ لسلوكه ( ) عدم إشراكه فى حياتهم الإجتماعية

شكراً لتعاونكم معنا من أجل مصلحة الطفل.

اسم ولى الأمر ( )
توقيعـــــــه ( )

APPENDIX "D"
PSYCHIATRIC EXAMINATION OF CHILDREN
5 - 13 YEARS

- Complaint of the parents and its relation to any particular event:
- Course and duration of any disorder in the behavior of the child:
- **Preliminary observation:**
  1. General appearance (body built, scars in the face, congenital anomalies).
  2. Dressing: if it is appropriate to age and sex?
  3. Mood and emotional state:-
     (happy, depressed, anxious)
  4. Attitude towards the family members.
  5. Indication of social adjustment:-
     (number of friends, preferable play, leader or follower).
  6. Right or left handed.
- **Psychiatric Examination:-**

A) Motor behavior:
- Quantity: a) hyperactive. b) hypoactive.
- Qualitity: a) inco-ordinated. b) stereotypes.

B) Relation with interviewer:-
- Eye: Avoidance (autistic) or fixed direction (depressed; apathy) or normal.
- General social rsponse:
  a) Passive (depressed or apathetic)
  b) Little response: (mentally retarded)
  c) Resistent (antisocial)
  d) Treat the doctor as an object (autistic)
- Smiling resposne: (absent in neurotics and antisocial children).

C) Verbal behavior:
1. Failure of speech development.
2. Quantity of spontaneous speech.
   a) decreased.
   b) increased.
3. Content of speech: logical or not, hallucination.

D) Non-Verbal expression of affect:
1. Anxiety (elevated eye brows, dilated pupils).
2. Depression (crying with no tears, eyes narrowed, angle of mouth is downwards).
3. Apathy (lack of mobility and social contact, face is devoid of emotions).
4. Anger (boring teeth, clenching fists, stamping, destructiveness).

- **Parents:**
  1. Emotional attitude towards the child.
  2. Personality of father and mother.
  3. Specific features (violence, drinking, criminal behavior).

APPENDIX "E"

إختبار رسم الرجل (جود إينـاف هاريس)
مؤشر لقياس درجة الذكاء

اسـم التلميـذ:

تاريـخ الميـلاد:

تاريخ الاختبار:

إسـم المدرسـة:

درجة الإختبار:

العمر الفعلـى:

العمر الزمنـى:

نسـبة الذكـاء:

إختبار رسم الرجل (جود إيناف هاريس)

معايير التصحيح

الرقم	الأجزاء التى تحسب عنها الدرجات	الرقم	الأجزاء التى تحسب عنها الدرجات
١	الرأس	٢٨	تناسب اليد
٢	الساقين	٢٩	تناسب الذراعين
٣	الذراعين	٣٠	تناسب الساقين
٤	طول الجذع أطول من العرض	٣١	الذراعين والساقين من بعدين
٥	الكتفين	٣٢	تناسب القدمين
٦	أتصال الذراعين والساقين بالجذع	٣٣	الكعب
٧	أن تكون فى مكانها الطبيعى	٣٤	تأذر حركى
٨	وجود الرقبة	٣٥	الخطوط واضحة وقوية
٩	أن تكون الركبة متصلة بالرجل او الجذع	٣٦	خطوط متصلة اتصال واضح
١٠	وجود العينان	٣٧	ان يكون الرأس بدون انتظام مقصود
١١	الأنف	٣٨	ان يكون الجذع بدون أنتظام مقصود
١٢	الفم	٣٩	ان يكون الذراعين والساقين من بعدين
١٣	الأنف والفم من بعدين والشفتان ظاهرتان	٤٠	تقاطيع الوجه متناسبة من بعدين متشابهين
١٤	وجود تجاويف الأنف	٤١	الأذن
١٥	الشعر موجود	٤٢	تفاصيل الأذن وفى مكانها الصحيح وتنسيقها
١٦	الشعر موجود على أكثر من جانب من الرأس	٤٣	تفاصيل العين والحاجب والرموش
١٧	الملابس	٤٤	إنسان العين
١٨	قطعتان من الملابس غير الشفاف	٤٥	شكل العين وتنسيقها وتناسبها
١٩	عدم شفافية الملابس - أكمام او بنطلون	٤٦	البروفيل العام
٢٠	اربع قطع من الملابس	٤٧	الذقن والجبهة
٢١	ملابس كاملة بدون تناقض	٤٨	تفاصيل الذقن والجبهة
٢٢	الأصابع	٤٩	الذقن البارزة
٢٣	عدد الأصابع	٥٠	بروفيل بخطأ واحد
٢٤	وجود الأصابع مبعدين وطولها اكبر من عرضها	٥١	بروفيل بدون أخطاء
٢٥	صحة رسم الإبهام		
٢٦	مفاصل الساقين أو الركبة أو الفخذ أو كلاهما		
٢٧	تناسب اليد		

APPENDIX "F"

مقياس الاتجاهات الوالدية
(المعـــدل)

تأليـــــف

الدكتور/ محمد عماد الدين اسماعيل الدكتور/ رشدى فام منصور
الدكتور/ نجيب اسكندر ابراهيم

بيانات تستكمل قبل بدء الأستخبار

****

إسم البلد: مركز محافظة تعداد السكان بالتقريب

المدة التى قضاها المستخبر فى المدينة وفى الريف

جنس المستخبر السن بالتقريب سنة

جنيه

نوع أسرة المستخبر: جماعية أم زوجية الدخل فى الشهر (فى المتوسط)

نوع العمل او المهنة بالتفصيل عدد أفراد الأسرة وترتيبهم

مستوى التعليم: مستوى السكن:

لايقرأ ولايكتب عدد الحجرات:-

يقرأ ويكتب فقط الحـــــــى:-

حاصل على الشهادات الآتية: الإيجار الشهرى بالتقريب:-

تسجيل الاستجابات:-

ينبغى على الباحث إن يسجل الاجابات كما يلفظ بها المبحوث تماما. كما ينبغى ان يملأ البيانات الخاصة بملاحظاته عن المقابلة فى نهاية الاستخبار.

١ - بيحصل ساعات إن الراجل ومراته فى البيت يختلفوا فى تربية الأولاد.... ياترى إيه الحاجات اللى أنتم ساعات تختلفوا فيها فى تربية الأولاد؟

(أ) تعمق: إيه فى نظرك الأسباب اللى خلت كل واحد منكم يبقى له رأى بالشكل ده؟

(ب) تعمق: هل دائما (إنت أو هوه أو هيه) اللى كلمته بتمشى؟

(جـ) تعمق: يعنى مين منكم اللى كلمته بتمشى فى الآخر؟

٢ - طيب ولما بتختلفوا مع بعض على اللى لازم تعملوه مع الواد عشان يتربى ويكون الواد ساعتها موجود معاكم - ياترى بتعملوا إيه ؟

٣ - يعنى هل تفتكر أيه سهل الواحد يوفق بين الراجل والست لما يكونوا مختلفين فى معامله وتربية الأولاد؟

٤ - ساعات الأب والأم يكون فهم عيل بيسمع الكلام وهادى وعيل تانى مابيسمعش الكلام فيقوموا يجبوا الهادى الكويس ويبقوا متضايقين من التانى - ياترى بتعملوا إيه أنتوا فى الحالات دى؟

(أ) طيب ياترى مين من العيال اللى كان بيسمع الكلام أكثر من إخواته ومين اللى كان مابيسمعش الكلام؟

٥ - فيه ناس رأيها إن العيل الشقى لازم يتأدب، تقوم مثلا تحرمه من المصروف - تهزؤه - تضربه - تعايره بأخوه - عشان يتحسن، وفيه ناس مش من رأيها كده - أنتم ياترى كنتم بتعملوا إيه لما الواد يتشاقى؟

(أ) طيب مين ياترى اللى كان بيتشاقى من العيال أكثر من غيره؟

٦ - إيه أكثر حاجة بتخليك تتضايق من ولد من ولادك أكثر من الباقيين؟

٧ - طيب ياترى فيه حاجة بتخليك تتضايق من ولد من ولادك أكثر من الباقيين؟

(أ) تعمق: طيب ومين هوه؟

٨ - فيه ناس رأيها إن الأب اللى يسمح لابنه أنه يناقشه أو يرد عليه يبقى غلطان لأن دايماً رأى الأب بيكون هوه اللى صح وفيه ناس رأيها غير كده - ياترى إنت رأيك إيه؟

٩ - فى سن كام تقريبا بتخلوا العيل يروح يشترى حاجة لنفسه او للبيت؟

١٠ - ياترى لما العيل بيجى يخرج لازم يستأذن ويقول الأول أنا خارج؟

١١ - ياترى لازم حد يخرج وياه ولايمكن يخرج لوحده؟

١٢ - فى سن كام تقريبا يقدر يخرج لوحده؟

١٣ - ياترى لازم يقول هوه رايح فين وحايجى إمتى؟

١٤ - ياترى بيقول لك إبنك عن العيال اللى بيخرج معهم؟

(أ) ياترى بتحاول تقول له فلان حقك ماتخرجش معاه وفلان ده مافيش مانع تصاحبه ولاإيه؟

١٥ - ياترى بتحاول فى العادة إنك تعرف العيال اللى بيلعب إبنك معاهم ولامابتهتمش؟

(أ) طيب مين ياترى من العيال اللى كنت بتدقق معاه فى الحاجات دى أكثر من الباقيين؟

١٦ - فيه ناس تقول إن الصغير يبقى له منزلة خاصة - يعنى معزه - وفيه ناس تقول الكبير - وفيه يقول البنت يبقى لها منزله يعنى معزة عن الولد - وفيه اللى يقول الولد - وفيه ناس كمان تقول الإبن الكبير (البكر) يبقى له معزه عن بقية أخواته، وفيها ناس تقول آخر العنقود.ياترى انت بتحب الصغير أكثر ولا الكبير؟

(أ) تعمق: وليه

(ب) ياترى إنت بتحب الإبن البكر اكثر ولاإيه؟

(جـ) تعمق: وليه

١٧ - ياترى انت تحب البنت أكثر ولاّ الولد (لما يكونوا فى سن بعض تقريبا)

(أ) تعمق: وليه؟

(ب) تعمق: طيب ماتقدرش والله تقول لى مثل يورى إزاى كنت بتفضل حد عن الثانى فى المعاملة؟

١٨ - العيل قبل مايكون قدر يمشى أو يتكلم ساعات يفضل يعيط على طول أو مايرضاش يرضع أو ينام مثلاً - إنتم كنتم بتعملوا إيه فى الحالات دى؟

١٩ - إيه أنسب سن فى رأيك الواحد يبتدئ يؤدب فيه العيل ويربيه؟ يعنى مثلا..... بمجرد مايبتدى يمشى - لغاية سن ٣ - لغاية سن ٥ - بعد سن ٥ سنين- ولاإيه؟

٢٠ - ايه أنسب طريقة تؤدب بيها العيل لما مايسمعش الكلام؟

٢١ - وإذاماجابتش نتيجه - ياترى بتعمل إيه ساعتها؟

(أ) تعمق: مين ياترى اللى كنت بتعمل معاه كده؟

٢٢ - فيه ناس ماتهتمش كتيرا بحكاية تاديب العيل وتقول أهو شوية شوية حيعرف ويتعلم - وفيه ناس تانية تقول لك إن ماكنش الواحد ياخده بالشدة مرة واحدة عمره بعد كده ماحيعرف الصح من الغلط ياترى انت رأيك إيه؟

٢٣ - فيه ناس رأيها إنه إذا كان الواد من دول بيتضايق من حاجة فى البيت زى الأكل والشرب او المذاكرة (أو الضيوف) أو غيره حقه أنه يتكلم ويقول لوالديه إن الحاجات دى بتضايقه وفيه ناس تقول لا مايصحش العيل يعدل على اللى فى البيت - ياترى انتوكنتوا بتعملوا إيه؟

٢٤ - أنا دلوقت حاسالك شوية أسئلة - الحقيقة إن الأم هى المفروض أنها اللى تقدر تفيدنا فيها ، لكن أنا أحب أعرف رأيك برضه فى الحاجات دى على قدر ماتقدر.....(هذا إذا كان المفحوص ذكراً بالطبع) فهل تقدر تقول لى إيه السن اللى فى نظرك لازم العيل يتفطم فيها؟

٢٥ - طيب وانتو فطمتم عيالكم فى سن كام تقريباً؟

(أ) تعمق: يعنى الأولانى فى سن كام والثانى والثالث؟

٢٦ - وياترى كنتم بتفطموهم إزاى؟

(أ) تعمق : طيب الأولانى فطمتموه إزاى والثانى؟

(ب) إذا لم يتضح من إجابة المفحوص ماإذا كانت طريقة الفطام فجائية أم تدريجية

تعمق : يعنى فيه ناس تفطم عيالها مرة واحدة، وفيه اللى يحط حاجة مرة على الثدى. وفيه الى يفطم شوية شوية ويدى للعيل رضعه صناعى لغاية مايتفطم ياترى انتو كنتم بتعملوا ايه؟

٢٧ - في أى سن تخلوا الأولاد ينزلوا لوحدهم الشارع او الحارة؟

٢٨ - العيال لما بتلعب سوى بتبقى تلاقيهم مرة يهزروا ومرة بتخانقوا ومرة يتصالحوا - عارف انت شقاوة عيال - ياترى انت بتعمل إيه لما واحد من العيال يضرب حد من إخواته؟

(أ) ولما حد من العيال يضرب حد تانى من الشارع؟

(ب) طيب ولما إبنكم هوه اللى يكون حد ضربه من عيال الشارع؟

٢٩ - فيه ناس رأيها إن أكبر غلط إن الواد من دول يشوف بنت تكون ولامواخذه مش متغطيه - أو يعرى نفسه أو يقول كلمة عيب او حاجة زى كده - وفيه ناس تقول مش مهم بكره يكبر - ياترى انتو كنتم بتعملوا إيه؟

٣٠ - الواحدساعات بختار فى مستقبل أولاده - يعنى حيطلعوا إيه وحايعيشوا لنفسهم إزاى ! إيه رايك انت فى المشكلة دى؟

(أ) تعمق: يعنى تحب أولادك يطلعوا إيه مثلا؟

٣١ - ياترى العيال الصغيرين بيتعبوكم لما تكونوا عايزينهم ينامو؟

(أ) تعمق: وإذا مارضيوش ينامو او قعدوا يعيطوا مدة ومش راضيين يسكتوا بتعملوا إيه؟

٣٢ - المفروض إن العيل لما يكبر مايتصرش على روحه ففيه ناس تقول لازم الواحد يعلم العيل الحكاية دى ، وناس ثانية تقول لأ العيل من نفسه يتعلمها ياترى انتم كنتم بتعملوا إيه مع عيالكم؟

(أ) تعمق: طيب وإيه الطريقة اللى لقيتم انها بتخليه مايتصرش على روحه؟

٣٣ - إيه فى نظرك السن اللى لازم الواد يتعلم فيه إنه يبطل يتصرف على نفسه؟

٣٤ - العيال ساعات تقول كلام عيب ، انتم ياترى كنتم بتعملوا ايه لما بقولوا كلام من ده؟

٣٥ - العيال ساعات يعملوا حاجات زى مثلاً يعروا نفسهم - ساعات مثلا تلاقيهم بمدوا إيدهم مثلاًولامؤاخذه على حتت مايصحش يمدوا إيدهم عليها ففيه ناس يهتموا بأنهم يمنعوهم من كده وفيه ناس تقولك مش مهم دول عيال صغيرين - ياترى انتو كنتم تهتموا بكده ولا لا؟

(أ) طيب لما حد من العيال كان يعمل كدة انتم كنتم بتعملوا إيه؟

(ب) ومين كان بعمل كده أكثر من اخواته؟

٣٦ - العيال ساعات يحبوا يقلدوا بعض ولما عيل يشوف حد فى إيده حاجة ماتكونش عنده يقولك انا عاوز من دى او من دى . ففيه ناس تقول لك مايصحش تخلىَ العيل يتعود على أنه يبص لحاجة غيره - وفيه ناس تقول لا - إحنا مانخليش العيل يبق عاوز حاجة ومانجيبهالوش، فيجيبوا له اللى يطلبه. ياترى إنتم كنتم بتعملوا إيه؟

٣٧ - بتحصل احيانا إنك تلاقى العيل من دول مايوعاش ولايفهم إن أبوه مش فى مقدوره إنه يجيب له اللى هوه عاوزه - ويفضل عشان كده يلح فى أنه عاوز طلبات مخصوصة وحاجات مخصوصة كنتم بتعملوا إيه ياترى فى الحالات دى؟

٣٨ - فيه ناس يفضلوا إن القرايب كلهم يكونوا قريبين من بعض عشان ينفعوا بعض - وناس تقولك بالعكس القرايب زى العقارب. إيه رأيك انت فى الحكاية دى؟

٣٩ - فيه ناس تقول لازم تشجع العيل إذا حد ضربه أو شتمه إنه يشتكيه للمدرس بتاعه وفيه ناس تقول إنه لازم يتصرف بنفسه. ياترى إنتم كنتم بتعملوا إيه؟

٤٠ - فيه ناس تقول لك الواد الكويس لازم من صغره يسمع كل كلمة يقولها له أبوه ومايجادلش فيها - وناس تانية تقول لأ ده الواد لازم يبقى له رأى حتى من صغره عشان بالتدريج يبقى له شخصية يعتمد على نفسه. إنتم ياترى كنتم بتعملوا إيه؟

٤١ - فيه ناس تقول لك لازم الأب مرة يشد ومرة يرخى يعنى مايبقاش شديد على طول ولا لينَ على طول . ياترى إنتو كنتم بتعملوا إيه؟

٤٢ - فيه ناس رأيها إن الآباء اللى بيعلموا اولادهم انهم يطيعوهم على طول الخط دول الآباء اللى عاوزين نكثر منهم وفيه ناس تقول غير كده. إيه رأيك أنت؟

٤٣ - فيه ناس رأيها إن كون العيل يطلع كويس او مش كويس ده يرجع لطينة العيل ذات نفسه. لما تكون طينة ومعدنه كويس اهو يطلع كويس سواء علمته ماعملتوش أولادهم- ولما يكون بعيد عنك - طينته وحشه مافيش فايدة معاه مهما تعمل ومهما تربى. انت إيه رأيك فى كده؟

٤٤ - فيه ناس تقول إن الأب او الأم إذا كانوا حيفتحوا عنيهم للعيال مرة اللهم إنهم مش خالصين من شكاويهم ومشاكلهم. وفيه تقولك إن الواحد لازم يبقى صدره واسع للعيل دايماً. ياترى إنتم كنتم بتعملوا إيه؟

٤٥ - ساعات العيال يحبوا يعرفوا ويفصصوا ويحطوا مناخيرهم فى كل حاجة ومايبطلوش أسئلة. ففيه ناس تقولك انت لوفتحت عينك لأسئلتهم دى مش حتخلص - وناس تقول بالعكس. انتم كنتم بتعملوا إيه ياترى؟

٤٦ - ساعات لما يحصل خلاف بين الاب والأم - الأولاد يتدخلوا فيه ويمكن يدافعوا عن الآب ضد الأم او يدافعوا عن الأم ضد الأب - وفيه ناس يمنعوا تدخل الأولاد خالص. إنتم كنتم ياترى بتعملوا إيه؟

٤٧ - فيه ناس تقول إن الأب الكويس هو اللى دايماً يمشى كلمته على كل اللى فى البيت وفيه ناس تقول غير كده. إنت ايه رأيك؟

٤٨ - العيال ساعات أسئلتها تكثر ويسألوا عن حاجات يعنى عيب السؤال فيها زى مثلا الواد او البنت تقولك ياباما أو ياماما انا اتولدت منين او انا جيت منين او مثلا تقول اشمعنا انا مش زى أخويا او اختى - واخد بالك - حاجات زى كده. فيه ناس تقولك لازم الواحد يسمع كلام العيل ويحاول بردك يجاوبه على قدر عقله او مفهوميته - وناس تانية تقول لك إن الأصول إن الواحد يشكم العيل من الأول ويوقفه عند حده أول مايسمع منه أسئلة من النوع ده - يقوم يحرم تانى يفكر أو يسأل فى الحاجات دى - ياترى إنتم كنتم بتعملوا إيه مع عيالكم فى الحكاية دى؟

(أ) تعمق: طيب مين ياترى من الأولاد كنتم بتعملوا معاه كده أكثر من بقية إخواته؟

٤٩ - فيه ناس تقولك إن الواحد لازم يعامل العيال كلهم زى بعض وفيه ناس تقول لأ الواد اللى يسمع الكلام غير اللى مايسمعش - ده تحبه وده ماتحبوش . إيه رأيك انت؟

٥٠ - ياترى فيه مواعيد مخصصة للأكل لازم العيل من دول يقعد مع العيله وياكل وياهم؟

(أ) تعمق: إذا كانت هناك مواعيد مخصوصة قائلا طيب ولما عيل يتأخر عن الميعاد بتعملوا إيه؟

٥١ - العيال ساعات هى اللى تختار أصحابها وساعات الوالدين هم اللى يقولوا الواد فلان ده هوه للى تصاحبه او فلان ده ماتصاحبوش - ياترى انتم كنتم بتقولوا إيه؟

٥٢ - لوفرض أن ابنكم معاه فلوس بتاعته هوه ياترى يقدر يصرفها زى ماهو عايز ولاإيه؟

٥٣ - لما يتكونوا حتشتروا له هدوم ولاحاجة مين ياترى اللى يختارها له - إنتم ولاهوه ولامين؟

٥٤ - فيه ناس تقول مايصحش إن الوالدين يدوا فرصة أبدا للعيل إنه يتكلم على حد لحسن يقول له حاجة او يعلمه حاجة غير اللى علمها له أبوه وأمه - ياترى انتم كنتم يتعملوا إيه فى الحكاية دى؟

٥٥ - فيه ناس لما أبنها حد يضربه أو يكلمه كلمة كده ولاكلمة كدة يعلموه أنه ياخد حقه بإيده وفيه ناس تقولك ده لازم احنا اللى ناخد له حقه بنفسنا - وفيه ناس اللى كمان لاتعمل كده ولاكده وتقول لابنها ياأبنى إحنا مش ادهم - ومالكش دعوه بيهم تانى . ياترى انتم كنتم بتعملوا إيه لما إبنكم حد يكلمه أو يضربه؟

٥٦ - فيه ناس تفكر كثير فى مستقبل أولادها - ياترى حيطلع إيه لما يكبر وناس ماتشغلش بالها كثيربالحكاية دى وتقول كل واحد بياخد نصيبه . إنتم ياترى إحساسكم إيه من الناحية دى؟

٥٧ - ساعات الواحد يحس إن الدنيا صعبة ومطالبها كثير والواحد يبقى مش عارف يلحق على إيه ولاعلى إيه, وطبعاً وجود الأولاد بيزود الحمل على الواحد - وصحيح الضنى غالى لكن همه سبب التعب برضه. أنت رأيك إيه فى مشكلة العيال دى؟

(أ) ياترى مين من أولادك اللى كنت حاسس إنه حمل عليك أكثر من غيره؟

٥٨ - فيه ناس رأيها تربى عيالها بنفسها مهما كانت الظروف . وفيه ناس دلوقت تقول لك الدنيا إتغيرت والأحسن أنه مادام الأب بيعمل كل جهده ومع كده مش قادر يربى العيال يبقى حقه يشوف لهم مؤسسة ولاحاجة تكون تقدر ترعاهم . ياترى انتم نفضلوا إيه؟

(أ) تعمق: إذا كانت الإجابة بالإيجاب قائلا. ياترى دى حاجة تفضلها بالنسبة لكل العيال اللى حق الواحد يعمل معاهم كده؟

(ب) تعمق: إذا كانت الإجابة بالإيجاب قائلا: زى مين؟

٥٩ - فيه ناس تقول لك ان لازم الواحد يعز الولد عن البنت وفيه ناس تقولك لاه كلهم زى بعض. أيه رأيك انت ياترى؟

٦٠ - الواد لما يكون وحش فى حاجة - فيه ناس تقول لك حق الواحد دايما يفكره باللى احسن منه عشان يتحمس ويبقى زيهم - وفيه ناس تقول لك لامفيش داعى لكده. أنتم ياترى كنتم بتعملوا إيه؟

٦١ - تفتكر فى سن كان تقريبا حق الأب يشوف لأبنه صنعة او شغله يجيب منها قرش؟

(أ) تعمق قائلا: الفلوس اللى يجيبها الواد من دول من شغله حقه. فى رأيك انت يعمل بها إيه اويوديها فين؟

٦٢ - لما يكون الواد فى المدرسة - فيه ناس تقولك خليه يلعب ويطنطط عشان ينبسط وفيه ناس تقول لك مايخسرش التلميذ الا اللعب وماحقوش يبقى وراه غير المذكرة . انتم ياترى كنتم بتعملوا إيه؟

٦٣ - فيه ناس تقولك لازم تفهم العيل دايما إد إيه أبوه وأمه بيشقوا وبيتعبوا عشان يربوه لأن العيال مايبقوش داريانين بتعب الوالدين عشانهم - وفيه ناس تقولك مفيش داعى لكده. انتم كنتم بتعملوا إيه ياترى؟

٦٤ - العيال ساعات عينها تفتح وتوصل لأنها ترد على أبوها وامها وتبجح. فيه ناس تقولك إن أحسن طريقة فى الحالات دى إن الواحد يشكمه من الأول فيقوله مثلا إذا ماكنش البيت ده عجبك الباب مفتوح - وإذا الواد زودها يطرده عشان يتادب . ياترى انتم كنتم بتعملوا إيه لما العيال تسوق فيها وتبجح؟

٦٥ - فيه ناس رأيها ان احسن طريقة تسكت العيل او تخليه يعمل حاجة انت عاوزها انك تاخذه على قدر عقله وتوعده بكذا او بكذا (يعنى تقول له حاجيب لك الشى الفلانى او الشى الفلانى) يقول الواد يطاوع الكلام وبعد كده اهو بينسى الحاجة اللى وعدناه بيها. انتم كنتم بتعملوا أيه؟

(أ) تعمق: (إذ قال إن الواد لم يكن ينسى ماوعده به) قائلا: طيب وكنتم بتعملوا ايه ساعتها؟

٦٦ - فيه ناس تقول إن الطفل او الواد من حقه إنه يبقى له رأيه حتى إذا كان رأيه ده غير رأى ابوه او أمه - وفيه ناس تقوم لأ لازم يسمع الكلام. إيه رأيك إنت؟

٦٧ - فيه ناس تقول لازم الوالدين يعملوا كل اللى يقدروا عليه عشان مايخليش العيل يسمع اى كلمة قبيحة يقولها حد أمامه او يعرف أى حاجة عن علاقة الراجل بالست اللى مفروض ان الكبير بس اللى يعرفها. وفيه ناس تقول لامش مهم . إيه رأيك أنت؟

٦٨ - ناس تقول إن ضرب العيل بعد مايغلط هو أحسن طريقة وأقصر طريقة علشان يتصلح ويبقى كويس . ياترى أنت رأيك إيه؟

جامعة عين شمس
معهد الدراسات العليا للطفولة

شكـــــــر

أشكر السادة الأساتذه الذين قاموا بالإشراف وهم:-

١ - الأستاذ الدكتور / حامد أحمد الذياط
استاذ الأطفال جامعة عين شمس
٢ - الأستاذ الدكتور/ مصطفى محمد الدشار
أستاذ مساعد الأنف والأذن والحنجرة جامعة عين شمس
٣ - الأستاذة الدكتورة/ علوية محمد عبد الباقي
أستاذ مساعد دراسات الطفولة بمعهد الدراسات العليا للطفولة.
٤ - الأستاذة الدكتورة/ ليلى حسن
أستاذ مساعد الصحة العامة والإحصاء كلية الطب جامعة القاهرة.

الهيئات والأشخاص الذين تعاونوا معي في البحث وهم:-

١ - مدرسة الأمل للصم والبكم :
مديرة المدرسةوالمدرسين والأخصائيين النفسيين والإجتماعيين.
٢ - الوحدةالصحية المدرسية بالمظلات:-
الأطباء والممرضات والفنيين

جامعة عين شمس
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﴿رسالة دكتوراه﴾

إسم الطالب: عصمت عزيز بسخرون

عنوان الرسالة: الأضطراب التصرفى فى الأطفال الصم

أسم الدرجة: دكتوراه

لجنة الإشراف

١ - الأستاذ الدكتور/ حامد أحمد الخياط

أستاذ طب الأطفال جامعة عين شمس

٢ - الأستاذ الدكتور/ مصطفى محمد النشار

أستاذ مساعد الأنف والأذن والحنجرة جامعة عين شمس

٣ - الاستاذة الدكتوره/ علوية محمد عبد الباقى

أستاذ مساعد دراسات الطفولة بمعهد الدراسات العليا للطفولة

تاريخ البحث ١٩٩١/٣/٣١

الدراسات العليا

ختم الإجازة

إجيزت الرسالة بتاريخ ٢٠ / ٢ / ١٩٩٧

موافقة عميده المعهد بالتفويض

٦ / ٩ / ١٩٩٧

موافقة مجلس الجامعة

/ / ١٩٩

جامعة عين شمس
معهد الدراسات العليا للطفولة

اسم الطالب : عصمت عزيز بسخرون

الدرجة العلمية : الدكتوراه

القسم التابع له : الدراسات الطبية

اسم المعهد : معهد الدراسات العليا للطفولة

الجامعة : جامعة عين شمس

سنة التخرج : ١٩٩٨

سنة المنح : ١٩٩٧

جامعة عين شمس
معهد الدراسات العليا للطفولة
قسم الدراسات الطبية

الإضطراب التصرفي في الأطفال الصم

رسالة مقدمة للحصول على درجة دكتوراه الفلسفة
في
دراسات الطفولة (قسم الدراسات الطبية)

من الطبيب

عصمت عزيز بسفرون

ماجستير دراسات الطفولة قسم الدراسات الطبية

تحت إشراف

أ.د. حامد الخياط
إستاذ طب الأطفال
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أ.د. مصطفى النشار
استاذ مساعد الأنف والأذن والحنجرة
معهد الدراسات العليا للطفولة

أ.د. علوية عبد الباقى
أستاذ مساعد طب الأطفال النفسى
معهد الدراسات العليا للطفولة

جامعة عين شمس
١٩٩٧