Ain Shams University
Institute Of Postgraduate
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Assessment of Creativity In Children With Conduct Disorders

A Thesis
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(Medical Dep.)

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DISCUSSION AND JUDGMENT COMMITTEE

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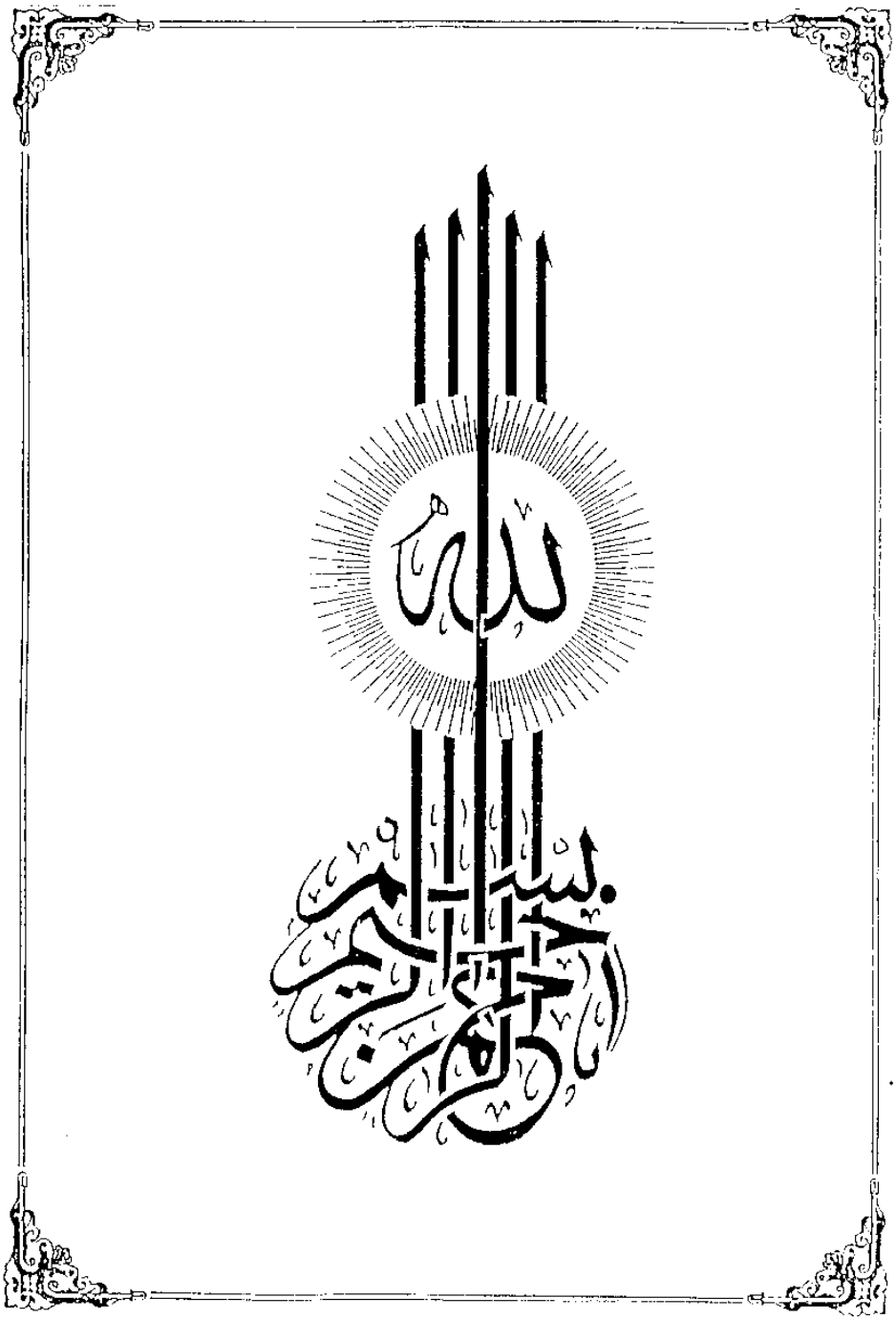

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INTRODUCTION AND AIM OF THE WORK

Introduction:

Development of creative thinking has tremendous importance for us both as individuals and a society.
Often researchers define creativity as flexibility of thinking or fluency of ideas or it may be the ability to come up with new and novel ideas or to see things in new relationships or to think in ways that are different from other people.

Regarding normal children usually creativity is thought of as being constructive and productive behavior that can be seen in action or accomplishment.

The child is born creative. We should be aware of psychological and physical restriction that the environment places on children to inhibit their natural curiosity and exploratory behavior.

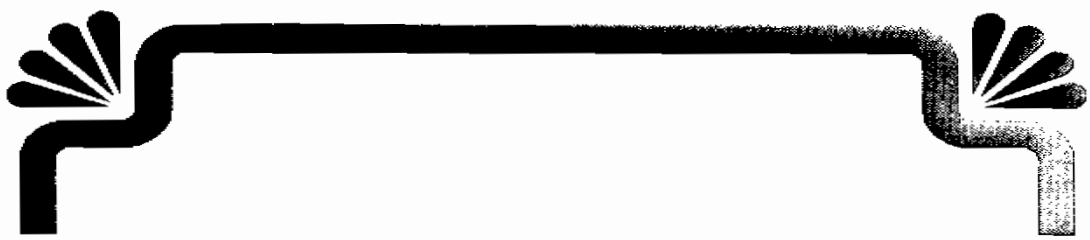
Conduct disorder is the commonest psychiatric disorder in late childhood and adolescence nearly two-thirds of 10 and 11 years old with psychiatric disorders were found to have conduct disorder.

It was also found that treating children with conduct disorder through group psychotherapy that enhance the young person self-esteem or provide them with opportunity to learn new social and vocational skills for example, drama, dance... can be help.

So, assessment of creativity among children with conduct disorder will allow us to know the difference between normal children and children with conduct disorder regarding creativity and to understand their creative abilities as their creative behavior could be motivated in constructive and productive way as a part of management.

Aim of the Work:

Assessment of creativity in children with conduct disorder compared to normal children in order to help the specialist in guidance and management.



REVIEW OF LITERATURE

CONDUCT DISORDER

Conduct Disorder is one of the most common psychiatric disorders in children and adolescent between the ages of 4 and 16(Rubins,1991).

It is characterized by a perssitent pattern of behaviour in which the patient violates the basic rights of the others (Shamsie & Hluchy, 1991). Conduct disorder is a serious diagnosis. Some studies demonstrate that up to 40% of those who had been diagnosed as having conduct disorder in childhood continued to have serious psychological disturbances in adulthood (Robins, 1970) (Rutter & Giller, 1983).

Moreover, parental antisocial behavior appear to predict similar behavior in the children (Robins & Earlss, 1986).

EPIDEMIOLOGY

Valid figures for exact prevalence of conduct disorder are difficult to obtain partly due to difficulty in nosology and classification, and partly due to different methods used.

Epidemiological studies suggest that certain conduct symptomatology (e.g. fighting, destructiveness, lying and stealing) are relatively frequent at different points in the normal development of children.

The prevalence of conduct disorder reveals some alarming numbers. Rutter et al. (1970), found in the Isle of Wright Community Survey that over three percent of ten years old had conduct disorder and almost three-quarters of all boys and one-third of all girls considered to be psychiatrically disturbed were diagnosed as having conduct disorder.

Kazdin (1987), reported that from one-third to one-half of all children and adolescents referring to clinic involved antisocial behavior aggressiveness and conduct problems.

6.7% of ten years old showed the same diagnosis in Australia (Connell et al, 1982). And in Queens Land (Offors et al, 1987).While it was 7.9 % of 7 years old in New Zealand (McGree et al, 1984).

Recent Changes In American Nosology

The American system in both the 1980 and 1987 editions of the American Psychiatric Association's *Diagnostic and Statistical Manual* splits what would be called conduct disorder in ICD-9 and -10 into conduct disorder and oppositional disorder. The 1980 edition DSM-III was confusing because it offered what appeared to be two

independent and incongruent definitions of conduct disorder, one in the section on "Disorders Usually First Seen In Childhood" and another as the description of the childhood stage of antisocial personality (American Psychiatric Association, 1980).The definition in this section on childhood disorders resembled ICD-9 in separately describing undersocialized and socialized disorder. In addition, it made a cross-cutting distinction between aggressive and non-aggressive conduct disorder of both types, so that it was actually a set of four disorders: undersocialized aggressive, undersocialized non-aggressive, socialized aggressive and socialized non-aggressive. For each, only one symptom was required if there was a "pattern of (non)aggressive conduct for at least 6 months". To qualify as a case of the aggressive form, the conduct had to include robbery or violence against persons or property. To qualify as a case of the non-aggressive form, the conduct had to be chronic violations of rules, running away, lying or stealing. For a case to qualify as undersocialized, there could be no more than one of five indicators of being "socialized": enduring friendships, altruistic behavior, feeling guilt or remorse, refraining from blaming others, and showing concern for others; the socialized had two or more of these five indicators.

Seventeen symptoms were mentioned in describing conduct disorder, only seven of which closely corresponded to the ICD-9 symptoms (compare columns 1 and 2 of *Table* 1). An additional three

Table 1. Symptoms of conduct and oppositional disorders listed in DSM manuals or ICD glossary (Robins,1991).

	ICD - 9	DSM - III	ICD - 10	DSM - III - R
All four				
Defaint	U	O	C	O
Disobedient	U	C,O,A	C	O
Aggressive (fighting)	U	C,A	C	C,A
Destructive	U	C,A	C	C,A
Tantrums	U	O	C	O
Stealing	C	C,A	C	C,A
Lying	U	C,A	C	C,A
Truancy	S	C,A	C	C,A
All but ICD - 10				
Quarrelsome	U	O		O
All but ICD - 9				
Runaway		C,A	C	C,A
Firesetting		C	C	C,A
Robbery, mugging		C	C	C,A
only two				
Teasing	U			O
Bullying	U		C	
Disturbed Relationships	U	U		

(Cont'd)	ICD - 9	DSM - III	ICD - 10	DSM - III - R
Blames others		U		O
Breakins		C		C
Cruel to animals			C	C,A
Sexual Coercion		C		C,A
Cruel to people			C	C,A
Promiscuous, sexual miconduct	C	A		
Unique				
Stay out late	S			
Stubborn		O		
Negativistic		O		
Lack empathy		U		
Lack guilt		U		
Lack loyalty		U		
Substance Abuse		C,A		
School suspension		A		
Delinquency		A		
Underachievement		A		
Touchy				O
Angry				O
Spiteful				O
Bad Language				O
Weapon Use				C,A

Key; U = un- or undersocialized conduct disorder; S = Socialized conduct disorder;

C = conduct disorder, unspecified or both U and S; O = oppositional disorder;

A = antisocial personality childhood symptomps.

of the ICD-9 symptoms appeared in oppositional disorder. Eight of the 12 childhood symptoms of antisocial personality overlapped with conduct disorder. The overlap between the conduct disorder and childhood antisocial personality symptoms can be seen in column 2 of Table 1. In addition, antisocial personality required three childhood symptoms before the age of 15, rather than requiring a duration of 6 months.

In the newer American nomenclature, DSM-III-R (American Psychiatric Association, 1987), the four conduct disorders in DSM-III have become a single disorder with three suggested subtypes: group, solitary aggressive, and underentiated. The 'solitary aggressive' subtype roughly corresponds to DSM-III's 'undersocialized aggressive' category, and the 'group' subtype roughly corresponds to ICD's socialized category of the combination of DSM-III's socialized aggressive and non-aggressive disorders.

DSM-III-R still listed 12 childhood symptoms of antisocial personality, as DSM-III did, but they are not the same 12. Gone are DSM-III's symptoms of early substance use, early sexual experience, and academic underachievement (all three are now "Associated Features"), chronic violation of rules, and the two consequences of problem behavior - juvenile arrest and school expulsion (which now appear as "Complications"). The six symptoms replacing these are