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PSYCHOTIC SYMPTOMS MANIPULATION IN CONDUCT DISORDER – CHALLENGES IN CLINICAL SETTING

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Abstract:

Introduction: Conduct Disorder (CD) is characterized by a persistent and significant pattern of conduct in which the fundamental rights of others are violated or rules of society are not followed. The disorder is diagnosed in adolescence or childhood period by behaviors such as aggression, deceitfulness, property destruction along violation of rules with repetitive and persistent for a period of one year.

Method and Results: The clinical observation and findings on psychological assessment encompassed by detailed case history, mental status examination, assessments, and rating scales suggested the diagnosis of Conduct Disorder (CD) with the pseudo-hallucinations after encountering a psychotic patient in the clinical setting.

Conclusion: The intensive clinical observation and examination of the presence of psychosis is vital to differentiate the accurate and pseudo-hallucinations (psychotic symptom manipulation) in children who violate rules and fall under the diagnosis of Conduct Disorder (CD). The clinical setting needed to be examined before initiating the case history.

Keywords: Conduct Disorder (CD), Pseudo-hallucination, Un-socialized Conduct Disorder, Psychotic symptoms, Manipulation in Conduct Disorder.

Abbreviations:

CD: Conduct Disorder; ICD-10: International Classification of Disease– 10; VADPRS: Vanderbilt ADHD Diagnostic Parent Rating Scale; CBCL: Child Behavior Checklist

Introduction:

Conduct Disorder (CD) is characterized by a persistent and significant pattern of conduct in which the fundamental rights of others are violated or rules of society are not followed. The disorder is diagnosed in adolescence or childhood period by behaviors such as aggression, deceitfulness, and property destruction along with violation of rules with repetitive and persistent for a period of one year.

Clinical Features: The CD has clinical features such as frequent lying, unusual or severe temper tantrums, stealing or robbery, running away from home and school, physical violence such as rape, fire-setting, assault or breaking-in, use of weapons, excessive levels of fighting or bullying, cruelty towards other people and animals, truancy from school, defiant proactive behaviors and persistent disobedience, 6 months/or longer duration

Types of Conduct Disorder: 1. Confined to the family context – the clinical features of CD are entirely confined to one's home environment with family members 2. Unsocialized conduct disorder – a persistent combination of aggressive or dissocial characteristics in relationships with other children 3. Socialized conduct disorder - a persistent combination of aggressive or dissocial features will occur when the child or adolescent is generally well-integrated within their peer group.

Epidemiology: The prevalence of conduct disorder varies from 5.8% to 8.7% in India, the rate among boys is greater in the general population ranging from 6% to 16% while the rate among girls ranges from 2% to 9%. Conduct disorder may have its onset early before 10 years of age or in adolescence in most cases. Children with early onset conduct disorder are at greater risk for persistent difficulties within one's society. More common is socialized (group) conduct disorders where the individual claims loyalty to their group. The unsocialized (solitary) type is a more serious disorder with usually severe underlying psychopathology. Conduct disorder especially the socialized type may improve markedly and may lead well-adjusted lives in society in their adulthood. But with severe symptomatology has a more chronic course and may be diagnosed with Dissocial or antisocial personality disorder after 18 years of age.

In this case report, we detailly described Master. AR is a 13-year-old male who reported auditory hallucinations. The case goes from autism spectrum disorder with psychosis due to poor eye contact and problem behavior or childhood psychosis to a diagnosis of CD with in-depth investigation and acknowledgment through several sessions.

Case Report:

Master. AR was normal till the age of 5 years. In 2016, his parents noticed that he was not listening and following their instructions. He initiated deviant behaviors such as telling lies, tearing his notebooks in school, playing with other children till late at night, and not obeying his mother's request. The parents often beat the child or shout at him for his problem behaviors but he continues everything. In 2017, his parents saw extra pencils, and erasers in his school box other than his. When they enquired about it, Master. AR said that he brought with him money but

his parents did not provide him with any pocket money. So, they doubted his behavior. They confront him for his stealing behavior. In school, teachers found that he was stealing others' properties in which they also complained about his behavior to his parents. His lies for even a small thing such as what he done with friends, and his refusal to go to school by making silly excuses were increased. He used to tear his notebooks to avoid writing homework.

Current Presentation:

In 2020, he started to use more abusive words toward his classmates which creates fights between them often. He also starts to steal more coin money from his home, class, and relative's house, and steal eateries from grocery shops when the shopkeeper turns aside. Two shopkeepers found his stealing behavior and complained to his mother about it. By stealing money, he used to buy junk foods and ice-creams. The patient tried to see his sister while she was changing her dress but she thought he was a small boy. Then after a while, he started to sneak on his sister while she was changing so she became cautious about him. His paternal aunt also complained to his mother that he was not talking with her by making eye contact and that he was always looking at her breasts. Then his mother started to notice and she found that what she said was true and he was maintaining eye contact with males. He had sleep disturbance for the past year, he used to roam around the house at night. His neighbor asked his mother that at night they hear unusual sounds jumping, and walking from their house. Mother said it might be some other sounds. Then she noticed that the patient was climbing over the slaps of their home, trying to use mobile phones, and walking around. By the time he tried to search for things that he could steal from his home. He also set fire to his neighbor's kid's toys which were kept outside of their home. He broke his home television and blamed his neighbor's kid but after a huge fight between his family and neighbor, his father confronts him then he accepts that he has broken it. He also took expired tablets from the garbage along with his neighbor's kid felt dizzy and was taken to the hospital. His father also reported that he used to be accompanied by older children/adults than his age and return home at night. Due to his rude, verbally abusive, stealing, and saying lies his mother got complaints continuously from his school.

Clinical Presentation of Pseudo-Hallucination and Interview about it in Mental Status Examination (MSE):

The patient reported that he had heard 3 voices for the past 3 years one voice was a young boy named Dinesh, his mother named Shanthi, and his sister. He said that the boy Dinesh was asking him to steal so that he was stealing others' things but his mother and sister are asking to not to listen to his instructions (Dinesh's instructions). But he never said this to his parents or reacted toward the voices.

Mental Status Examination in multiple sessions as follows.,

- First session - He said that he was hearing a boy named Dinesh's voice he was asking him to steal and Dinesh's mother and sister were saying not to steal.

Sample: *Examiner* – Are you hearing any kind of sounds or voices that are not presented in your environment?

Patient – Yes, I am hearing some voices.

Examiner – What are the voices? Is that a sound or a human voice like some other people are talking?

Patient: One boy and 2-woman voices.

Examiner – What are they saying or talking about?

Patient: The boy is asking me to steal and the other two women are asking me not to steal.

Examiner: Are you hearing right now?

Patient: Yes, I am right now also.

- Second session - He said that he hears Dinesh, his father, and his mother's voices in the same context.
- Third and fourth sessions - He said that he was hearing Dinesh, his sister, and his father's voice with the above content.
- The period of hearing voices reported by him varies session by session like 3 years to 1 year and to 2 years.
- During every session, the patient was confused about the voices whether it was the mother or father of Dinesh, and what he said in the last session.

After some inquiry found that while the patient was waiting to visit the psychiatrist, he heard the other patient's conversation with the psychiatrist about hearing voices. So, he started to say that he was stealing because of his auditory hallucinations.

- In a session, the examiner asked the patient about the hallucinatory voices that he was imagining for the sake of stealing.

Sample: *Examiner* – Do you hear those voices?

Patient – I heard occasionally.

Examiner – What is the possibility of hearing those voices?

Patient – Nothing is there like that.

Examiner – Have you ever realized that is fake or unreality?

Patient – That is all coming out of my mind.

Examiner: So, you are imagining it? Perhaps, those types of imagination help you to escape from scolding for stealing behavior?

Patient: Yes, somehow it helps me.

Assessments: The Vanderbilt ADHD Diagnostic Parent Rating Scale (VADPRS) was administered to diagnose the presence of CD. The child obtains high scores of 12/14 items under the conduct disorder domain in VADPRS. On the Child Behavior Checklist (CBCL), the child has a clinical range of externalizing behaviors.

Diagnosis: F91.1 Unsocialized Conduct Disorder

- Repetitive and persistent pattern of dissocial, aggressive, or defiant conduct
- Associated with adverse psychosocial environment such as unsatisfactory family relationships, failure at school
- Significant pervasive abnormality in the patient's relationships with other children - excessive level of fighting due to the use of abusive words
- Male gender
- Temper tantrums, severe destruction of properties, setting fire, repeated lying, truancy from school, defiant proactive behavior, and persistent severe disobedience.
- period of more than 6 months

Challenges in Clinical Setting:

The clinical psychiatric or psychology setting plays a vital role in the examination and evaluation of a diagnosis. In the above case study, a 13-year-old boy may be misdiagnosed due to his report of auditory hallucinations. However, after an in-depth investigation, it revealed that the child heard a case history taking of another patient who went to the psychiatrist before him regarding hearing voices asking the other patient to do some behavior. This in turn gives the child an idea about the auditory hallucinations and he used it when he asked regarding his stealing behavior by bringing up his friend's name in the voices. The manipulating behavior of the CD is an essential character with a standard range of intelligence. The setting of a psychiatrist or psychologist needed to be private as much as possible. If the child does not reveal the truth behind the auditory hallucinations even after many sessions, then the diagnosis may lead to the psychotic presence and prescribing of anti-psychotics which is a high risk to the child or any other person. The detailed case history and periodic MSE administration for the case give a clear picture of the use of auditory hallucination to escape from his natural stealing behavior.

Conclusion:

The case study provides the importance of intensive clinical observation and examination of the presence of psychosis is vital to differentiate the accurate and pseudo-hallucinations in the children who violate rules and fall under the diagnosis of Conduct Disorder (CD). The clinical setting needed to be examined before initiating the case history.

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