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Behaviour Disorders of Childhood and Adolescence: Implications for Education in Nigeria

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Abstract

Behaviour disorders in childhood and adolescence are a growing concern in Nigeria, with significant implications for the educational system. This study examines the prevalence, characteristics, and impact of behaviour disorders, such as Attention Deficit Hyperactivity Disorder (ADHD), Conduct Disorder, and Anxiety Disorders, on students' academic performance, social relationships, and overall well-being. A comprehensive review of existing literature and empirical data from Nigerian schools reveals a lack of awareness, inadequate support services, and insufficient teacher training in addressing behaviour disorders. The findings highlight the need for a multidisciplinary approach to address these issues, including: teacher training on behaviour management and support strategies, integration of mental health services into school systems, promotion of inclusive education practices, encouragement of parental involvement and community engagement and development and implementation of evidence-based interventions. The study recommends policy changes and implementation of support services to address behaviour disorders in Nigerian schools. By addressing behaviour disorders in childhood and adolescence, Nigeria can improve educational outcomes, reduce social and emotional difficulties, and promote a healthier and more productive society.

Keywords: *Behaviour; Disorders; Childhood; Adolescence; Education; Mental Health; Teacher Training; Support.*

Introduction

All young children display impulsive or deviant behaviour occasionally. Sometimes, this is a part of a normal emotional reaction, but if these behaviours are extreme or outside the norm for their level of development, it could be a sign of a behavioural disorder. Children's misbehavior in schools has become a topical

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issue in the Nigerian society of today. The general consensus is that children of today exhibit more deviant behaviours than their counterparts in the past. Childhood and adolescence disorders encompass a wide variety of behavioural problems which range from pervasive developmental disorders, which may severely affect many aspects of development and are clearly abnormal, to the less severe developmental disturbances which are exaggerations of behaviour problems shown by most children e.g. truancy and stealing. Therefore, not all-aberrant behaviour should be characterized as disordered. For example, bed-wetting, exhibiting tantrums (shouting excitedly and wildly, not being able to talk by a certain age and so on) may not be too deviant.

Family bereavement, moving a home suddenly or starting school may cause some disturbances in children's behaviour for a short period. These more or less situational behaviour disorders are relatively normal but when they become prolonged or profound, there are indications that underlying problems that require thorough investigations. In an attempt to curb these maladaptive behaviour, school authorities and teachers have adopted some drastic measures such as physical punishments and other ruthless measures. The school scene in many cases is characterized by children's expulsion from school, child flogging and detention after school, making a child kneel under the sun, and the use of derogatory and denigrating words such as 'mumu', 'coconut head' and other uncomplimentary words. Many children have become so used to these labels and probably so enraged that they sometimes plan counter attacks either covertly or overtly. According to Denga and Akuto, some children simply show gross immunity to all these drastic and hostile punishments [1].

Why Focus on Childhood and Adolescence Disorders?

Some childhood and adolescence disorders resemble disorders in adults. But as similar s they may look, childhood and adolescence disorders are best considered separately for specific reasons. For instance, in most childhood disorders, unlike adult disorders, ag is an important factor in assessment of symptoms. For example, a two-year-old who assaults a new baby in the house is acting normally; a ten-year old who does the same thing is not acting normally. Bed-wetting to a three-year old may be normal, but abnormal in a fourteen-year old. The second reason for a focus on childhood and adolescence disorders is, the period from infancy through adolescence is filled with many rapid changes that even very normal children may develop temporary psychological problems. The third reason is that the disorders of childhood and adolescence differ in course and outcome from adults' psychological disorders. The less severe childhood disorders are transitory. Children for example, are more likely than adults to recover from phobias. Lastly, unlike adults most children do not think

of themselves as suffering from psychological problems. Therefore, it is important that adults recognize the psychological problems that children are prone to and help them out of it.

Since parents often attribute most abnormal behavior in children to witchcraft, remote controls, charms and so on. The knowledge of psychopathology will enable parents and teachers understand childhood problems and thus take appropriate steps to correcting them. If parents are aware that complications during pregnancy and childbirth are associated with disorders like hyperactivity, hearing defects, infantile autism and delinquency symptoms and so on, such problems will be better managed. Additionally, to attain the goal of universal primary education which is one of the goals of Sustainable Development Goals (SDGs) a focus on the disorders of children is essential as this will arrest the problems and enhance school enrolment, retention and performance. Ignoring or paying inappropriate attention to such disorders among children constitutes a big obstacle to the attainment of the Sustainable Development Goals. This chapter intends to examine the various definitions of psychopathology, the prevalence and types of some psychopathological disorders that impair the proper functioning of children in schools, their classifications, possible causes, effects and treatment approaches. This knowledge will improve teachers' ability to recognise abnormal and normal behaviour in school children and take appropriate steps to help. Finally, the implications of childhood and adolescence behaviour disorders for the Sustainable Development Goals.

Method

The research methodology adopted in this paper is a literature study approach. The study of literature is the same as research in general, but the data obtained by the researcher is secondary data using the literature study method. Some steps that the researcher will take in preparing this article include: first, the researchers search for and collect reference sources that are relevant to the theme of this research. Second, several scientific papers that have been collected are then processed and elaborated, to comprehensively explain the inter-sections of this article. Third, the behaviour disorders of childhood and adolescence: implications for education in Nigeria.

Result and Discussion

The Clarification of Concepts

Behaviour Disorder

Behavioural disorders are very common in children and involve a pattern of disruptive behaviours that can cause problems at home and in social settings. If left untreated in childhood, behaviour disorders can have a detrimental effect on a person's ability to maintain and hold down a job or perform well socially. The US Department of Health Services describes behavioural disorders as involving "a pattern of disruptive behaviours in children that last for at least six month and cause problems in schools, homes and in social situations." They are those behaviours that are detrimental to other people, which neither promotes learning nor interpersonal relationship. Akuto and Ojogbane, define it as a concept which refers to either the study of mental illness or mental distress, or the manifestation of behaviours and experiences, which may be indicative of mental illness or psychological impairment [2]. They use the concept interchangeably with psychopathology which they used to denote behaviours or experiences, which are indicative of mental illness, even if they do not constitute a formal diagnosis. Psychopathological behaviours are certainly a fusion of maladaptive behaviours and body disorders. This means human behaviour influences body functioning and disorders can influence behaviour. For instance, brain injury can lead to psychological manifestations; depression and anxiety can affect physical health of an individual. Behavioural disorders are different from the challenging behaviours children sometimes display. Almost all children will have tantrums, or act in aggression, angry, or defiant at some point. While challenging, these behaviours are a normal part of childhood development. Often, they are the result of some strong emotions that the child is expressing in the only way they know how. As a result, healthcare professionals only diagnose a behavioural disorder when the disruptive behaviours are severe, persistent and outside the norm for the child's developmental stage. Behavioural disorders are also different from autism spectrum disorder (ASD), which is an umbrella term for neuro developmental conditions that affect how some children communicate, socialize and process sensory stimuli. ASD may cause behaviours in children that caregivers find unusual or challenging but these are the result of how they experience the world.

Behavior Disorders of Childhood and Adolescence

Prevalence

Knopf, reported that surveys in the United States and Great Britain have shown that 7 percent of children have moderate to severe disorders and 15

percent mild disorders. The big question is when these problems begin. The age at which behaviour problems in childhood begin is not fixed [3]. Bootzin et al, reported that admission rate begins to increase for children with behaviour problems from age six to seven years in the West. This corresponds to the age of beginning school. It appears the stress of starting school coupled with home situation may exacerbate psychological problems in children [4]. Rosen et al, said behavioural problems peak at the age of 14/15 years. This peak may probably reflect the inherent developmental difficulties or crises period of adolescence [5]. Eme, stated that in every age group, clinic admission rates are higher for boys than girls, sometimes 2 or 3 times higher [6]. In Nigeria, children's behaviour in school has become a major topic of unfavourable discussion recently. Such behaviours range from mild forms of stealing, cheating, bullying, truancy, hooliganism etc. Other more disturbing forms include; mood disorder, attention deficit, hyperactivity, anxiety and so on.

For everyday mild behaviour problems at primary and secondary school levels in Nigeria, school authorities use various aversive measures such as scolding, flogging, kneeling, suspension or even expulsion from schools to curb these abnormal behaviors[1]. Yet due to the effect of poverty and globalization leading to further weakening of our social systems that check such problems in our society, such behaviors seem to be on the increase. Moreover, the more severe behavioural problems are not well attended to because they are not within the competence of the teachers[2]. This problem is compounded by inadequate numbers of guidance counsellors in schools arising from insufficient numbers of rained counsellors and the general unwillingness of government/school authorities to engage and support guidance counsellors to provide counseling services in the school.

In spite of these gaps, we cannot overlook the serious consequences of more severe behavioural problems on children's academic performance and social adjustment in the Nigerian school system. Denga and Akuto, warned that unresolved learning difficulties arising from behaviour disorders in children may become compounded in adulthood and impair a total adjustment in later life [7].

Types of Childhood Behavior Disorders

The following sections looks at specific behaviour disorders common in children and their symptoms.

1. Disruptive Behavior Disorders

Disruptive behaviour disorders constitute behaviors that constantly break the rules, disrupt the lives of those around them and defy authority. While oppositional behaviour is common in very young children and teens, in extreme

cases it can require professional assessment and intervention. They are characterized by poorly controlled, impulsive, action out behaviour in situations in which self-controlled is expected. This happens due to failure to learn self-control at appropriate ages. For instance, hungry infants cannot be expected to be patient and not cry[3]. However, when they are toddlers and preschoolers, expectations for behavior control behavior by command don't touch this, do that etc. Children who have not learnt these skills but continue to be disruptive, impulsive and aggressive, are at high risk for school adjustment difficulties, learning problems and peer rejection [8]. Disruptive behaviour can be classified into two distinct categories. In oppositional defiant disorder, the rules broken are chiefly those within the family and school; regular temper tantrums, failure to accept responsibility for bad behaviour and frequent defiance of parents and teachers[4]. In conduct disorders, aggressive behaviours threaten others, like people and animals; bullying, lying, stealing and truancy may also be identified.

(a) Attention Deficit Hyperactivity Disorders (ADHD)

ADHD is one of the most common behavioural problems among children, adolescents and adults. In children it causes difficulty focusing attention. It can also cause hyperactivity and impulsivity. There are three ADHD subtypes with the diagnosis depending on the symptoms the child displays most often. The subtypes are: a) inattentive type, b) hyperactive impulsive type and c) combined type. A child with inattentive type ADHD may:

- ✓ Find it difficult to pay attention;
- ✓ Become easily distracted;
- ✓ Have difficulty focusing on tasks, particularly long tasks such as reading;
- ✓ Start tasks but forget to finish them;
- ✓ Appear not to listen to instructions or to forget them.

A child with hyperactive-impulsive type ADHD may:

- ✓ find it difficult to stay still or remain seated
- ✓ fidget a lot by tapping the hands, feet, or moving around in their seat
- ✓ run around or climb things when it is not appropriate
- ✓ frequently interrupt conversations or games
- ✓ have difficulty waiting for their turn
- ✓ have trouble talking or playing quietly

A child with combined ADHD will exhibit a mixture of the above behaviours. Doctors often diagnose ADHD after the age of 6. This is because the symptoms can be more apparent when a child starts school, and struggles to adjust to quieter, sedentary activities.

Effects of ADHD on School Performance

This inability to focus and sustain attention has a serious effect on the academic performance of children. Children with ADHD have great difficulty following instructions and finishing assigned tasks. They frequently even cannot remember what they set out to do. Consequently, however intelligent they are, they often have severe learning problems. They are extremely disruptive in the classroom, making incessant demands for attention. Children with ADHD also show poor social adjustment[5]. They disrupt games, get into fights, refuse to play fair and throw temper tantrums. Such behavior does not make them popular with their peers [9]. Klein and Mannuza found out that ADHD continues into adolescence at which point, it sometimes branches into anti-social behaviour. Many ADHD children also develop conduct disorders [10].

ADHD children exhibit serious lack of attention. In fact, they cannot concentrate on one thing for more than 5 minutes before moving their attention to another more interesting thing to them. A teacher therefore needs to keep their attention from wavering[11].

(b) Conduct Disorder (CD)

Children with Conduct Disorder tend to violate basic social rules and the rights of others. This can have a significant impact on someone's academic, social and home life. It can develop both in childhood and adolescence.

The symptoms of Conduct Disorder (CD) include:

- ✓ Aggression, which may result in physical fights, bullying behaviour, forcing someone into sexual activity (rape) and animal cruelty.
- ✓ Destruction of property, such as setting fires or damaging possessions.
- ✓ Deceitfulness, such as lying or tricking others.
- ✓ Significant rule-breaking, such as not going to school, running away, or stealing.

Many young people with CD have difficulty interpreting the behaviour of others. For example, they may believe a person is behaving in a hostile way toward them when they are not. This causes them to escalate toward aggressive or violent behaviour[6]. People with CD may also have difficulty feeling

empathy, or have another condition, such as anxiety or post-traumatic stress disorder that affects their thoughts and behaviour.

Akuto and Ojogbane, divided the syndrome into two types; the first is the solitary type characterized by a lack of emotional attachment and by aggressive anti-social behaviour. Children in this category are the closet parallel to adult antisocial personalities. They may lie, steal, set fires, break into houses and constantly get into fights with others [12]. What is most striking about them is not their aggressive behaviour but their apparent callousness. Children who fit into this category seem to be precociously devoid of feelings [13]. They often have no real friends, and show little attachment to their families and the feeling is often mutual[7]. The second type of conduct disorder which is the group type differs markedly from the solitary aggressive type in that it includes normal emotional attachment[8]. Children in this category have friends, indeed, they belong to a gang, and are decent and loyal to their members. Regardless of specific diagnosis, children with conduct disorders are a cause for grave social concern whether in gangs or on their own, these children commit many crimes, many of which are serious.

Etiology of Conduct Disorders

Psychoanalytic view explains that antisocial and delinquent behaviour in children are symptoms of an underlying anxiety conflict in a child. These conflicts result from an inadequate relationship with the parents. This inadequate relationship may result from either emotional deprivation or overindulgence. In the case of emotional deprivation, if childhood conflict is not resolved the super ego does not develop adequately. Such children become unable to form close persona; relationships with others. In the case of overindulgence, the child displays aggression freely and does not develop internal control over aggressive behavior [14]. Working with families of conduct disordered children, Patterson, expressed the view that antisocial behaviour is the result of parental failure to effectively punish misbehaviour. The child's failure to learn to respect authority generalizes to the school feeding, resulting in poor academic performance and peer relations [15].

Consequences of Conduct Disorders

Conduct Disorders pose a grave social concern. In the US, about 72,000 juveniles are housed in correctional institutions for antisocial behaviour [16]. In Nigeria, the rising wave of crime among youths is indicative of these problems. Conduct disorders are associated with poor disciplinary, academic problems and negative interaction with peers [17]. Conduct disorders unlike some childhood and adolescents most often persist into adulthood. Conduct disorders in

adulthood are often expressed in criminal behaviour, antisocial personality and problems in marital and occupational adjustments [18].

(c) Oppositional Defiant Disorder

Children and adolescents with ODD display an ongoing pattern of hostile behaviour toward authority figures, such as parents, caregivers, or teachers. Unlike conduct disorder, children with ODD tend to violate minor rules, rather than major rules and social norms. The child often losses his or her temper, defies rules, refuses to do chores and blames others for his or her mistakes [19]. The deficient behaviour is mainly directed towards parents, teachers and others in authority.

The signs of ODD include:

- ✓ Temper tantrums and irritability
- ✓ Argumentative behaviour, such as constantly questioning rules
- ✓ Persistent stubbornness, which may manifest as a refusal to follow instructions or apologize for behaviour
- ✓ Provocative behaviour, such as intentionally annoying or upsetting others
- ✓ Spiteful or vindictive attitude

It is worth noting that some clinicians have criticized the concept of ODD, arguing that it medicalizes normal child behaviour. It is common for children to behave angrily or defiantly when they are unhappy, so it can be difficult to distinguish between ODD and behaviour that is related to stress. Doctors can only diagnose ODD if the behavior has been persistent for 6 months, causes constant disruption at home or school, and is not the result of another mental health condition.

(d) Intermittent Explosive Disorder (IOD)

This disorder is often diagnosed in children over the age of 6. Children and teens with this disorder exhibit the following symptoms:

i. Frequent outbursts that are out of proportion to the situation.

ii. Violent words and actions'

iii. Behavior that causes damage to property and harm to both animals and humans.

(e) Obsessive-Compulsive Disorder (OCD)

OCD is characterized by persistent, uncontrolled, and intrusive thoughts, urges, and actions. Symptoms may include:

i. Engaging in activities such as continual washing and cleaning,

ii. Repeating mantras or prayers,

iii. Adhering to rigorous schedules,

iv. A desire for things to be symmetrical and in order,

v. Repeatedly counting and checking things,

vi. Excessive worry about germs.

OCD is a debilitating disorder that can make it extremely difficult to function normally. OCD can lead to additional issues such as bipolar illness, depression and anxiety.

(f) Bipolar disorder

Bipolar disorder can start in childhood and continue throughout adulthood. It is a hereditary disorder that is frequently misdiagnosed or misidentified as ADHD. Bipolar disorder is characterized by frequent mood swings, in which the child alternates between feeling euphoric to deeply depressed.

(g) Anxiety disorder

According to Zimbardo and Radl, anxiety is the experience of apprehension and dread without an appropriate or causal determinant [20]. Bootzin et al, see it as a state of increased physiological arousal and generalized feelings of fear and apprehension. Everybody experiences anxiety. Anxiety disorder in children can cause them to have trouble sleeping or face difficulty performing at school or in social situations. The most common types of anxiety illness are Separation Anxiety Disorders and Avoidant Disorders [21].

(1) Separation Anxiety Disorder (SAD). This refers excessive and persistent anxiety upon being separated from parents, home and other caregivers who the children are attached to [22]. It peaks at about 12 months and then gradually disappears. In some children, however, it does not disappear but persist well into the school years. Children with this disorder are typically clinging and demanding, putting considerate strain on their parents. Parents-child conflicts then are common with separation anxiety disorder and of course exacerbate it, since the parents' annoyance makes the child all the more fearful of abandonment[9]. This conflict may also extend to other areas. They may refuse

to attend school and consequently their academic progress comes to a halt. Furthermore, since they cannot go to school or camp or other children's houses, they make no friends or lose the friends they had. Separation anxiety may produce such physical symptoms as vomiting, diarrhea and headaches. Other symptoms include enuresis, nightmares and somatic complaints as dizziness. Stomachaches and nausea (Holmes, 2013) [23]. During adolescence, the most frequent symptoms of separation anxiety disorder involve physical complaints on school days.

(2) Avoidant disorder. Children with this disorder feel severe anxiety in situations that involve contact with strangers or peers [24]. It is similar to social phobia or avoidant personality disorder in adults. Fear of strangers is normal in children from about 8 months; most overcome it by about 21/2 and 3 years. The persistence of fear of strangers and peers becomes a problematic behaviour [25]. Consequences: - the response of children with this disorder is withdrawal. The withdrawal reaction interferes with the establishment of friendships, this result in very few friends for such children, they develop low rate of interaction with peers, deficit in social skills, anxious and unhappy[10]. They are hypersensitive to rejection and criticism. This disorder may interfere with their academic progress and their social adjustment in general. Other effects might be low self-esteem and depression.

(3) Over Anxious Disorder: This disorder in children and adolescents is characterized by excessive worry about future or past events, over concern about performance and constant need for assurance [26]. The cause may be genetic or environmental. Mothers of such children, may model excessive anxiety in interpersonal relationship with their children. Bootzin, said it is more common in families where parental love is made conditional or consistently on 'good' behaviour [27].

Consequences: children with this disorder tend to have severe doubts about their own capabilities and likeableness. Such doubts lead them to constant approval-seeking behaviour. This pervasive anxiety tends to breed failure, because, often, it creates the very problems that were anticipated.

Risk Factors Associated with Behavioural Disorders in Children

According to MedicineNet, the following are risk factors for behavioural disorders in children:

1. Sex /gender: behavioural disorders are more likely to affect boys than girls. It is unknown if the cause is hereditary or related to experiences with socialization.

2. Brain development: studies have reported that children with ADHD were noted to have less activity in regions of the brain that regulate attention.
3. Learning disabilities: Reading and writing difficulties are related to behavioural issues. Children with learning disabilities are two times more likely to develop behavioural problems.
4. Anger issues: Children who are difficult to control and exhibit aggressive tendencies from an early age are more likely to have behavioural issues later in life.
5. Family relationships: Behavioural problems are more common in dysfunctional homes, characterized by domestic violence, neglectful parenting or substance abuse.

(h) Habit Disorders

The term habit disorders can be traced to the writings of Knight Dunlap in his book Habits: Their Making and Unmarking. As an experimental psychologist, Dunlap was interested in the nature of the learning process, and he believed that a wide range of problem behaviours developed through learning processes and could therefore be unlearned [28]. They may occur in isolation or in the context of other childhood disorders. For instance, sleeping disorders usually accompany childhood anxiety; so is sleeping and eating disorders. Specific habit disorders include: Eating disorders, elimination disorders and sleep disorders.

1. Eating Disorders:

The eating disorders of childhood and adolescence lie in the murky waters between those of adulthood anorexia nervosa and bulimia nervosa, and the feeding disorders of childhood[11]. Early-onset eating disorders include anorexia nervosa. The younger the child, however, the more likely he or she is to present an 'typical' picture. Some children refuse to eat; some overeat while others prefer to eat "junk" food [29]. Irregular eating tends to affect health adversely and can thus disrupt learning.

Freud and other psychologists have found that eating is related to a person's emotional life, and thus forms a crucial part of one's development. Children's feelings about eating are tied to their feelings about those who feed and care for them. Due to the close relationship, eating disorders such as obesity and anorexia reveal emotional problems. Whether anorexia nervosa or bulimia nervosa (binge eating), the implication is that they spoil the child and make eating the focus more than learning.

2. Elimination Disorders

These disorders relate to conflict developed in toilet training during childhood. Such training may run contrary to a child's natural impulses. Elimination disorders Enuresis and Encopresis, i.e. lack of bladder or bowel control respectively.

Consequences: these disorders also disrupt school learning by creating other emotional problems of stigmatization due to rejection from peers.

3. Sleep Disorders

Sleep is essential for good health and is an important part of child and family life. Sleep supports homeostatic, cognitive, immune, and cardiovascular functions and is fundamental for a child's growth and development. Sleep disruptions can lead to cognitive and emotional challenges and affect family dynamics [30].

Sleep disorders include Obstructive Sleep Apnea (OSA) which are recurrent episodes of partial or complete upper airway obstruction associated with arousals, awakenings, or oxygen desaturations despite the respiratory effort. OSA disrupts normal sleep patterns and ventilation and is a cause of morbidity in children, Childhood Insomnia which are sleep or wake disturbances characterized by difficulties in initiating or maintaining sleep, ultimately leading to chronic sleeplessness, Parasomnias which are undesirable physical events or experiences during sleep onset, within sleep, or during arousal from sleep (Meltzer et al, 2010) [31].

Implications of the knowledge of childhood and adolescence disorders for education in Nigeria

Some of the behaviour disorders of childhood and adolescence explained here ae typical in Nigeria's pre-primary, primary and secondary schools with their attendant negative consequences. A focus on behaviour disorders in Nigeria's schools is very important because the abnormalities of childhood and adolescence need to be better understood for effective handling. Besides, there is the need for the attainment of educational goals in Nigeria which focuses on 'achievement of universal primary education and closure of the gender gap in education' [32]. Concerns for behaviour disorders in children at these levels will contribute to narrowing the gender gap in education as well as provide opportunities for children of all categories to benefit from universal education.

The knowledge of classification, nature of presentation, etiology and management strategies as well as effect on academic and social adjustment will help parents, teachers, counsellors and other relevant agencies to assist children

overcome such problems. Teachers particularly will have a better understanding of factors behind children's behavioral problems and take informed decisions on appropriate measures to help rather than generalize the same forms of punishment for all misconducts.

Parents' awareness of the fact that the root causes of some children's behaviour disorders is in the home may improve the handling of their children. This should dissuade parents from attributing the cause of behavioural problems in their children to witchcraft, remote control practices etc. consequently, this will improve children's well-being and ensure a healthier school population for improved performance, productivity and development in the Nigerian education section. The knowledge of behaviour disorder gives teachers a better understanding of individual child and thus equipping them to handle individual cases. As in normal human beings, where there are individual differences, so also there are differences in behavior patterns of children of school age. Knowledge of behaviour disorders enables the teacher to individualize his teachings to give more attention to children with abnormal behaviour. Teachers can adapt programmes that will particularly motivate and arouse interest in children with some behaviour problems (e.g. hyperactive or attention deficit disorders) for better achievement in schools.

Counselors need to know psychological problems in childhood and adolescence so that they will be able to adapt, modify and relate with children with such problems. Counselors who identify children with cognitive, psychomotor and behavioural problems will also be in a position to manipulate the environment to suit the children or make appropriate referrals.

Conclusion

In conclusion, behaviour disorders in childhood and adolescence pose significant challenges to the educational system in Nigeria. The prevalence of disorders such as ADHD, conduct disorder, and anxiety disorders among Nigerian students necessitates a comprehensive approach to address these issues. The implications for education are far-reaching, affecting not only the individual child but also the learning environment and society at large. To mitigate these challenges, it is essential to integrate mental health services into school systems, provide teacher training on behaviour management and support strategies, promote inclusive education practices, encourage parental involvement and community engagement and develop and implement evidence-based interventions. By acknowledging the impact of behaviour disorders on education in Nigeria, we can work towards creating a more supportive and inclusive learning environment. This will enable students to reach their full potential, achieve academic success, and become productive members of society.

Ultimately, addressing behaviour disorders in childhood and adolescence is crucial for building a brighter future for Nigeria.

In addition, essentially a preventative approach via the use of several agents of socialization (home, school and mass media) is necessary. Treatment and management of these abnormal behaviours in children is a joint concern of parents, teachers, school counselors, the peer group, religious organizations, media and the society generally.

Author Contributions

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Conflict of Interest

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