

Research Article

Assessment of Disruptive Behaviour Disorders Among In-School Adolescents in Lagos State, Nigeria

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Abstract

Disruptive Behaviour Disorders (DBDs), comprising Conduct Disorder (CD) and Oppositional Defiant Disorder (ODD), represent significant mental health concerns among adolescents due to their adverse effects on academic achievement, interpersonal relationships, and psychosocial development. Despite the growing burden of these disorders, there is a paucity of empirical evidence on their prevalence among adolescents attending secondary school in Lagos State, Nigeria. The research therefore examines the assessment of disruptive behaviour disorders. The quantitative research employed a descriptive survey design and 915 participants comprising males 49.5% ($\text{mean}_{\text{age}} = 14.94$, $\text{SD} = 1.57$). The research employed a multistage sampling technique. The findings revealed that disruptive behaviour disorders were highly prevalent among the adolescents, with 90.4% exhibiting moderate to severe symptoms and 16.4% falling within the severe category. The prevalence of adolescents at risk of Conduct Disorder was 35.4%, while 83.4% were at risk of Oppositional Defiant Disorder. The results further showed that female adolescents displayed significantly lower levels of DBDs compared to their male counterparts. The study concluded and recommended that DBDs (CD and ODD) are common among in-school adolescents in Lagos State and therefore school administrators, management, and owners should employ psychological intervention in addressing the rising disruptive behaviour symptoms among adolescents.

Keywords

Disruptive Behaviour Disorder, Conduct Disorder, Oppositional Defiant Disorder, Sex, Adolescents

1. Introduction

Adolescence is often regarded as a transitional stage connecting childhood to adulthood and a critical stage of human development marked by increased and fast physical, cognitive, and emotional development and social changes. During this period, young people strive to establish their identity, develop

independence, and adapt to increasing academic and social demands. While most adolescents successfully navigate these developmental transitions, some exhibit behavioural problems that interfere with their learning, interpersonal relationships, and overall adjustment. Among these behavioural problems, disruptive behaviour has become a growing concern in

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schools worldwide because of its adverse effects on students, teachers, and the educational environment [1].

Disruptive behaviour refers to a pattern of behaviours that interfere with the teaching and learning process, violate established school rules, or negatively affect the classroom and school environment [2]. Such behaviours include aggression, bullying, defiance, excessive talking, classroom misconduct, truancy, vandalism, fighting, and refusal to comply with instructions. These behaviours disrupt academic activities, hinder effective classroom management, and negatively influence the educational experiences of both teachers and fellow students [3, 4]. Although occasional misconduct is considered a normal part of adolescent development, persistent disruptive behaviour may indicate underlying emotional, psychological, family, or environmental difficulties that require timely assessment and intervention [5].

Disruptive behaviour can vary in severity, frequency, and duration, ranging from relatively minor classroom disturbances to more serious forms of aggression and antisocial conduct [6]. If left unaddressed, these behaviours may escalate over time, increasing the risk of poor academic achievement, school suspension or expulsion, substance use, delinquency, and difficulties in adulthood. Studies have shown that adolescents who consistently exhibit disruptive behaviours often experience problems with emotional regulation, social relationships, and academic engagement, making them more vulnerable to long-term psychosocial challenges [1, 7-9]. Consequently, early identification and the implementation of appropriate behavioural and psychological interventions are essential for promoting positive developmental outcomes and improving the overall school climate [10, 11].

Several theories have been used to explain how children and adolescents develop disruptive behaviour, but two relevant theories were explained. The Social Learning Theory (SLT), theorised by Albert Bandura [12], and Ecological Systems Theory (EST) propounded by Urie Bronfenbrenner [13].

The SLT [12] suggests that our behaviour is a result of our exposure to other people's behaviour in a social setting, and we learn this through observation, imitation, and modelling. According to the theory, individuals acquire new behaviours by observing the actions of others, particularly parents, siblings, peers, teachers, and media figures. When observed behaviours are rewarded or reinforced, individuals are more likely to imitate and repeat them. Conversely, behaviours that are punished are less likely to be adopted.

Bandura asserted that attention, retention, reproduction, and motivation are the important factors through which learning occurs. First, an individual pays attention to a model's behaviour. Second, the observed behaviour is retained in memory. Third, the individual develops the ability to reproduce the behaviour. Finally, motivation, influenced by expected rewards or punishments, determines whether the behaviour is performed. In the context of disruptive behaviour among in-school adolescents, the theory suggests that adolescents may

learn behaviours such as aggression, bullying, classroom disruption, truancy, fighting, and defiance by observing significant others in their homes, schools, communities, or through the media. If such behaviours receive approval from peers or are not adequately corrected by parents and teachers, they are likely to be repeated and become established patterns of behaviour. Therefore, Social Learning Theory provides a useful framework for understanding how disruptive behaviours develop and why interventions that promote positive role models and appropriate reinforcement can reduce these behaviours.

The EST [13] proposes that human development and behaviour are influenced by multiple environmental systems that interact with one another. The theory identifies five interconnected systems: the microsystem, mesosystem, exosystem, macrosystem, and chronosystem. The microsystem consists of the adolescent's immediate environment, including family, school, peers, and teachers. The mesosystem refers to the interactions between these settings, such as communication between parents and teachers. The exosystem includes environments that indirectly influence the adolescent, such as parents' workplaces, educational policies, and community resources. The macrosystem comprises cultural values, beliefs, traditions, and societal norms that shape behaviour. The chronosystem reflects changes over time, including life transitions and significant historical or social events that influence development. The theory suggests that disruptive behaviour does not arise from a single cause but results from the interaction of individual characteristics with family, school, peer, community, and societal influences. For example, ineffective parenting, poor school climate, association with deviant peers, exposure to violence, and socioeconomic challenges may collectively increase the likelihood of disruptive behaviour among adolescents.

The prevalence of disruptive behaviour among in-school adolescents has become a significant public health and educational concern across many countries. Globally, epidemiological studies have reported varying prevalence rates of disruptive behaviour disorders, largely attributable to differences in diagnostic criteria, assessment instruments, sampling procedures, and cultural contexts. In a comprehensive systematic review and meta-analysis, Tatsiopoulou et al. [14] examined the worldwide prevalence of disruptive behaviour disorders among children and adolescents. The study reported considerable regional variations, with prevalence estimates of 14.53% in Asia, 9.86% in Africa, 30.64% in America, and 30.44% in Europe. The authors concluded that disruptive behaviour disorders constitute an emerging global public health concern requiring coordinated preventive and intervention efforts across educational and healthcare systems. Similarly, Mohammadi et al. [15] conducted a systematic review of Conduct Disorder among children and adolescents and reported a global prevalence estimate of approximately 8%. The study highlighted that Conduct Disorder remains one of the leading behavioural disorders affecting adolescents and emphasized the importance of early identification and intervention to prevent

progression into more severe antisocial behaviours during adulthood. Cross-national epidemiological evidence also demonstrates substantial differences in the prevalence of Conduct Disorder across countries. Bachmann et al. [16] investigated Conduct Disorder using population-based data from several developed countries. Their findings revealed relatively low prevalence estimates of 0.1% in Denmark, 0.3% in Norway, 1.1% in the United States, and 3.1% in Germany. The authors suggested that differences in diagnostic practices, mental health policies, healthcare accessibility, and cultural perceptions of behavioural disorders may account for these variations. Conversely, studies conducted among high-risk populations have reported considerably higher prevalence rates. Blakey et al. [17] examined adolescents residing in inner-city London and reported a 16% prevalence of Conduct Disorder, attributing the high rate to socioeconomic deprivation, exposure to violence, family dysfunction, and adverse environmental conditions. Likewise, Xie et al. [18] investigated Conduct Disorder among juvenile delinquents in China and found that 58.7% of participants met the diagnostic criteria for Conduct Disorder, with adolescent-onset Conduct Disorder accounting for 90.94% of the identified cases. These findings accentuate the close relationship between disruptive behavioural disorders and juvenile offending. Further evidence from Asia was provided by Li et al. [19], who investigated the prevalence of ODD and CD among children and adolescents in China. The researchers reported a combined prevalence of 17.5%, highlighting that disruptive behavioural disorders represent a significant mental health burden among Chinese school-aged children. The study further identified family conflict, poor parental supervision, and adverse psychosocial experiences as major correlates of these disorders.

Within the African context, research on disruptive behaviour disorders remains relatively limited but has consistently demonstrated that behavioural disorders constitute an important mental health concern among school-aged children. Ojo and Ojo [20] reported that 88% of the adolescents exhibited moderate to high levels of disruptive behaviour disorders. Kyeva et al. [21] reported an occurrence rate of 11.34% for Conduct Disorder among secondary school students in Kenya. The authors emphasized that inadequate parental monitoring, poverty, exposure to community violence, and school-related stress significantly contributed to disruptive behavioural outcomes among adolescents.

Evidence from Nigeria similarly indicates the presence of disruptive behaviour disorders among children and adolescents. Kumuyi et al. [22] investigated Conduct Disorder among adolescents in Southwestern Nigeria and found that 9.6% of participants exhibited severe symptoms of Conduct Disorder. The study identified dysfunctional family environments, peer delinquency, and socioeconomic disadvantage as important risk factors for the development of disruptive behaviours.

Earlier Nigerian research by Frank-Briggs and Alikor [23]

reported a prevalence of 15.82% for Oppositional Defiant Disorder among children and adolescents. The researchers observed that persistent oppositional behaviours frequently co-occurred with emotional and behavioural difficulties, reinforcing the importance of early diagnosis and intervention.

More recently, Arinde et al. [24] examined psychiatric comorbidities among Nigerian secondary school students diagnosed with Oppositional Defiant Disorder. Their findings revealed a high prevalence of co-occurring disorders, particularly Attention-Deficit/Hyperactivity Disorder (ADHD) and Conduct Disorder, both of which were associated with poorer academic performance and increased psychosocial impairment. The authors recommended comprehensive psychological assessment and multidisciplinary interventions to improve educational and mental health outcomes among affected adolescents.

Animashaun et al. [25] investigated the prevalence of ODD among 905 secondary school students and found that 82.0% of the students displayed moderate to severe levels of ODD symptoms. No significant sex differences were observed. Similarly, Bankole et al. [26] examined the prevalence of CD and its demographic correlates among 905 secondary school students and found that 36.79% of the students displayed moderate to severe symptoms of CD. Unlike the findings of Animashaun et al. [25], the study revealed a significant sex difference, with male students reporting significantly higher levels of Conduct Disorder than female students.

Disruptive behaviours contribute to poor academic achievement, increased rates of school suspension and expulsion, peer conflicts, teacher stress, classroom disruption, and school dropout [27]. They also reduce instructional time, weaken students' engagement in learning, and negatively affect the overall quality of the educational environment [2]. Beyond the school setting, adolescents who frequently display disruptive behaviours often experience difficulties in forming healthy social relationships and adapting successfully to societal expectations [5]. If left unaddressed, disruptive behaviour may persist and progress into more severe forms of antisocial behaviour, including substance abuse, juvenile delinquency, violence, and criminal activities during late adolescence and adulthood [1]. Such long-term consequences not only affect the individuals involved but also place substantial social and economic burdens on families, schools, healthcare systems, and society as a whole [28].

In Nigeria, disruptive behaviours such as bullying, aggression, fighting, classroom disorderliness, truancy, verbal abuse, and defiance have increasingly been reported among secondary school students [29]. These behaviours not only disrupt classroom instruction and interfere with effective teaching and learning but also create unsafe school environments that negatively affect students' academic performance, emotional well-being, and psychosocial development [30].

Evidence from studies conducted in Nigeria indicates that disruptive behaviour is influenced by multiple interacting factors, including ineffective parenting practices, poor parental

monitoring, peer pressure, exposure to community violence, inadequate school discipline, teacher-student conflicts, and unfavourable school environments [31, 32]. Negative school experiences, including poor teacher support, lack of student engagement, and weak enforcement of school rules, have been linked to increased behavioural problems among in-school adolescents [33, 34].

Despite the growing body of literature on disruptive behaviour among adolescents, there remains a need for further empirical studies examining its prevalence, patterns, and associated factors among in-school adolescents in diverse educational and socio-cultural settings. Although previous studies have identified several individual, family, peer, and school-related determinants of disruptive behaviour, the influence of these factors may differ across geographical locations, cultural contexts, and socioeconomic environments. Consequently, findings from one setting may not be directly applicable to another, highlighting the importance of generating context-specific evidence to inform effective prevention and intervention strategies [1, 5].

Furthermore, limited evidence from many local communities, particularly in developing countries such as Nigeria, underscores the need for additional research to better understand the nature and extent of disruptive behaviour among in-school adolescents. Hence, the main objective of this study is to assess disruptive behaviour and examine the difference in disruptive behaviour among male and female in-school adolescents.

2. Materials and Methods

2.1. Study Design

This research employed a descriptive survey design and was conducted among secondary school students in four education districts in Lagos State, Nigeria (District I, IV, V and VI). The selected districts have 450 public and 399 private schools with a population estimate of over 600,000 students across the districts. However, 8 schools (4 public and 4 private) were randomly selected across the four districts. Ajao Estate Secondary School (112 students), Standard Highmark School (128 students), FESTAC College (106 students), Quality Focus School (101 students), Hanniel Private School (112 students), Ikotun High School (149 students), Ogunlade College (97 students), Birrel Avenue High School (110 students).

2.2. Sample and Sampling Technique

The sample size was determined using a statistical software programme (G*Power). T-tests with difference between two independent means (two groups) were used, Cohen's $d = 0.50$; $\alpha = 0.05$, and Power = 0.95. The calculated sample size was 210, after which a 10% attrition rate was added to make 231, but the sample was increased to 915 to strengthen the generalisation of the research outcome. 453 males representing

49.5% and 462 females representing 50.5% took part in the study. The mean_{age} was 14.94, and the Standard Deviation was 1.57.

A four-stage multi-stage sampling technique was utilised to select adolescents from secondary schools within Lagos State. At the initial stage, four (4) of the six (6) education districts (Districts I, IV, V, and VI) were selected through simple random sampling, employing the balloting without replacement method. Subsequently, schools within each selected district were stratified into public and private categories. Schools were then drawn from each stratum using a table of random numbers, while the administration of research instruments to students within their respective classrooms was carried out through convenience sampling.

2.3. Measures

The Conduct and Oppositional Defiant Disorder Scales (CODDS), developed by Raine et al. [35], is a 26-item self-report instrument for children, modelled on the DSM-5 [36]. It comprises two subscales: 8 items assessing oppositional defiant disorder and 18 items assessing conduct disorder, each rated on a 3-point scale (never, sometimes, often) and summed to yield subscale scores. Raine et al. [35] reported internal consistency reliabilities of 0.83 and 0.84 for the Oppositional Defiant Disorder and Conduct Disorder subscales, respectively, while the present study's pilot test yielded a Cronbach's alpha of 0.86 for disruptive behaviour. As no normative cut-off scores currently exist for the CODDS, scores were classified using a criterion-referenced, mean-based approach [37], with the sample's mean and standard deviation serving as benchmarks. Scores one standard deviation below the mean were classified as minimal, that one standard deviation above as severe, and scores within this range as moderate. Based on the sample's mean ($M = 11.52$, $SD = 7.03$), the following cut-offs were established: None (0), Minimal (0.01-3.74), Moderate (3.75-18.66), and Severe (18.67 and above).

2.4. Procedures

Ethical approval was obtained from the Redeemer's University Ethical Review Board (Reference Number: RUN/REC/2024/244) before the commencement of data collection. Subsequently, an introductory letter was secured from the researcher's institution and submitted, along with other requisite documents (application letter, research proposal, and questionnaire), to the Lagos State Ministry of Basic and Secondary Education and the Lagos State Head of Service to obtain formal permission to conduct the study. Upon approval, the researcher proceeded to seek consent from the principals of the selected schools to administer the questionnaires to students, during which the objectives and intentions of the study were duly communicated to the school administrators. Permission was subsequently granted by the respective school authorities.

The selected students were approached within their classrooms, where parental/guardian consent and assent forms were distributed for completion at home. Only students who returned signed parental consent forms were subsequently administered the questionnaire. Prior to data collection, the researcher assured participants of the confidentiality of their responses and explained the purpose of the study. Due to the geographical dispersion of the sampled schools, the fieldwork spanned a period of two weeks. Four research assistants, all psychology graduates from Lagos State University, were recruited and trained over four weeks before questionnaire administration.

3. Results

Prevalence of Disruptive Behaviour Disorders

Table 1. Severity of the CD, ODD and DBDs.

Disorder	None	Minimal	Moderate	Severe
Conduct Disorder	0	0.01 - 4.36	4.37 - 9.45	9.46 - 32.00

Table 2. Prevalence of DBDs in Study Area.

Variable	N	Mean	SD	Prevalence				
				None	Minimal	Moderate	Severe	Prevalence
CD		4.35	4.67	172 (18.8%)	419 (45.8%)	211 (23.1%)	113 (12.3%)	324 (35.4%)
ODD	915	7.18	3.56	20 (2.2%)	132 (14.4%)	600 (65.6%)	163 (17.8%)	763 (83.4%)
DBDs		11.53	7.03	13 (1.4%)	75 (8.2%)	677 (74.0%)	150 (16.4%)	827 (90.4%)

Table 2 presents the descriptive statistics and prevalence of CD, ODD, and DBDs among the secondary school students. For CD, respondents obtained a mean score of 4.35 ($SD = 4.67$). Based on the classification of severity, 18.8% ($n = 172$) reported no symptoms of CD, 45.8% ($n = 419$) exhibited minimal symptoms, 23.1% ($n = 211$) had moderate symptoms, while 12.3% ($n = 113$) experienced severe symptoms. Combining the moderate and severe categories indicates that 35.4% ($n = 324$) of the respondents exhibited clinically relevant levels of conduct disorder symptoms.

For ODD, the respondents had a mean score of 7.18 ($SD = 3.56$). Only 2.2% ($n = 20$) reported no symptoms, while 14.4% ($n = 132$) exhibited minimal symptoms. The majority of the respondents (65.6%, $n = 600$) experienced moderate symptoms, and 17.8% ($n = 163$) reported severe symptoms. Overall, 83.4% ($n = 763$) of the respondents fell within the moderate-to-severe range, suggesting a high prevalence of oppositional

Disorder	None	Minimal	Moderate	Severe
Oppositional Defiant Disorder	0	0.01 - 3.15	3.16 - 10.50	10.51 - 18.00
Disruptive Behaviour Disorders	0	0.01 - 3.74	3.75 - 18.66	18.67 - 49.70

Note: No symptoms: No identification of symptoms of disruptive behaviour disorders.

Minimal symptoms: Adolescents in this group exhibited minimal signs of disruptive behaviour. This suggests relatively well-adjusted behavioural patterns, with little to no indication of oppositional or conduct-related issues.

Moderate symptoms: Adolescents in this group display noticeable signs of disruptive behaviours, though not at clinically concerning levels. They may benefit from early-stage behavioural support or preventive interventions.

Severe Symptoms: Adolescents in this category showed significantly elevated levels of disruptive behaviour. Their scores suggest patterns consistent with serious behavioural challenges, which may require psychological evaluation and structured interventions such as ABA.

defiant disorder symptoms.

Regarding DBDs, which represent the combined manifestation of disruptive behavioural problems, respondents obtained a mean score of 11.53 ($SD = 7.03$). Only 1.4% ($n = 13$) reported no symptoms, whereas 8.2% ($n = 75$) experienced minimal symptoms. Most respondents (74.0%, $n = 677$) reported moderate symptoms, while 16.4% ($n = 150$) experienced severe symptoms. Altogether, 90.4% ($n = 827$) of the respondents exhibited moderate-to-severe levels of disruptive behaviour disorders.

The findings indicate that disruptive behavioural problems were common among the adolescents studied. The prevalence of moderate-to-severe CD was 35.4%, while 64.6% exhibited either no or minimal symptoms. In contrast, ODD showed a substantially higher prevalence, with 83.4% of respondents reporting moderate-to-severe symptoms. The highest preva-

lence was observed for overall DBDs, where 90.4% of the respondents fell within the moderate-to-severe category.

These findings suggest that ODD symptoms were more prevalent than CD symptoms, and when both disorders were considered collectively as DBDs, the overwhelming majority

of respondents exhibited moderate or severe disruptive behavioural symptoms. This underscores the significant burden of disruptive behaviour disorders in the study population and highlights the need for early identification and targeted psychological and behavioural interventions.

Table 3. Summary table of *t*-test for independent means showing the difference between male and female in disruptive behaviour disorder.

	Sex	N	X	SD	df	t-value	Sig
Disruptive Behaviour Disorder	Male	453	12.86	7.86	913	5.76	.000
	Female	462	10.23	5.83			

From Table 3, it can be revealed that there is a significant difference in disruptive behaviour disorder between males and females [$t(913) = 5.76, p < .01$]. The result could further reveal that male students score higher on the measure of disruptive behaviour disorder compared to their female counterparts.

4. Discussion

This study assessed the prevalence of DBDs among in-school adolescents in Lagos State, Nigeria. The findings revealed a disturbingly high prevalence of disruptive behavioural problems among the study participants. Specifically, 90.4% of the adolescents exhibited moderate to severe levels of DBDs, with 16.4% falling within the severe category, while only 8.2% demonstrated minimal symptoms. These findings suggest that disruptive behavioural disorders constitute a significant mental health concern among secondary school students in Lagos State, highlighting the need for early identification, preventive interventions, and school-based behavioural management programmes.

Further analysis of the specific dimensions of DBDs showed varying prevalence rates for Conduct Disorder (CD) and Oppositional Defiant Disorder (ODD). With respect to Conduct Disorder, 45.8% of the respondents exhibited minimal symptoms, whereas 23.1% and 12.3% demonstrated moderate and severe symptoms, respectively. Overall, 35.4% of the adolescents were classified as being at risk of Conduct Disorder. This finding indicates that more than one-third of the adolescents displayed persistent behavioural patterns characterised by aggression, rule violation, deceitfulness, destruction of property, or serious violations of social norms, all of which are hallmark features of Conduct Disorder.

The findings were even more pronounced for Oppositional Defiant Disorder. Only 14.4% of the adolescents demonstrated minimal symptoms, while 65.6% exhibited moderate symptoms and 17.8% reported severe symptoms. Consequently, approximately 83.4% of the respondents were identified as being at risk of ODD. This exceptionally high prevalence suggests that a considerable proportion of adolescents

experience persistent patterns of irritability, frequent temper outbursts, defiance, argumentativeness, and hostility toward authority figures. These behaviours not only disrupt classroom learning and interpersonal relationships but may also serve as developmental precursors to more severe externalising disorders, including Conduct Disorder, if left unaddressed.

The high prevalence of DBDs observed in this study corroborates growing global evidence indicating an increasing burden of disruptive behavioural disorders among children and adolescents. For instance, Tatsiopoulou et al. [14], in a global meta-analysis, reported regional variations in the prevalence of disruptive behaviour disorders, with prevalence estimates of 9.86% in Africa, 14.53% in Asia, 30.44% in Europe, and 30.64% in America. Although the prevalence rates reported in the present study are considerably higher than these regional estimates, the findings reinforce concerns that disruptive behavioural disorders remain a significant public health issue affecting adolescents worldwide.

Similarly, the findings partially support those of Mohammadi et al. [15], who reported a global prevalence of 8% for Conduct Disorder among children and adolescents. Likewise, Bachmann et al. [16] documented relatively low prevalence rates of Conduct Disorder across several countries, including 0.1% in Denmark, 0.3% in Norway, 1.1% in the United States, and 3.1% in Germany. These comparatively lower prevalence rates may be attributable to differences in diagnostic criteria, assessment instruments, cultural contexts, and the availability of child mental health services across countries.

Conversely, the findings of the present study are more consistent with those of Blakey et al. [17], who reported a 16% prevalence of Conduct Disorder among adolescents living in inner-city London, and Xie et al. [18], who found that 58.7% of juvenile delinquents in China met the diagnostic criteria for Conduct Disorder, with adolescent-onset Conduct Disorder accounting for 90.94% of the identified cases. Similarly, Li et al. [19] reported a prevalence of 17.5% for Oppositional Defiant Disorder and Conduct Disorder among children and adolescents in China.

Within the African context, the findings also align with previous empirical studies reporting the existence of disruptive behavioural disorders among adolescents; for example, Ojo and Ojo [20] reported that 88% of the adolescents exhibited moderate to high levels of disruptive behaviour disorders, Kyeva et al. [21] reported an 11.34% prevalence of Conduct Disorder among secondary school students in Kenya, Kumuyi et al. [22] found that 9.6% of adolescents in Southwestern Nigeria exhibited severe symptoms of Conduct Disorder, while Bankole et al. [26] reported that 36.79% of participants were classified as having a moderate to high risk of CD.

Similarly, Frank-Briggs and Alikor [23] reported a 15.82% prevalence of Oppositional Defiant Disorder among Nigerian children. Furthermore, Arinde et al. [24] found a high prevalence of psychiatric comorbidities, particularly Attention-Deficit/Hyperactivity Disorder (ADHD) and Conduct Disorder, among adolescents with Oppositional Defiant Disorder, with significant implications for academic performance and psychosocial functioning, while Animashaun et al. [25] reported that 82.0% of participants were classified as moderate or high risk.

The findings further revealed that male students exhibited significantly higher levels of disruptive behaviour disorders than their female counterparts. This finding is consistent with the study by Bankole et al. [26], who reported that male students exhibited significantly higher levels of Conduct Disorder than female students. The authors attributed this difference to greater tendencies among males toward externalising behaviours, including aggression, impulsivity, and rule-violating behaviours. However, the present finding contrasts with that of Animashaun et al. [25], who found no significant gender difference in disruptive behaviour among adolescents.

The considerably higher prevalence rates observed in the present study may reflect the unique socio-environmental challenges confronting adolescents in Lagos State, including rapid urbanisation, family instability, exposure to adverse childhood experiences, peer influence, socioeconomic inequalities, and increasing academic pressures. These factors may heighten adolescents' vulnerability to disruptive behavioural problems and emphasise the importance of adopting comprehensive prevention and intervention strategies involving families, schools, mental health professionals, and policy-makers.

5. Limitations and Future Research

Despite these important contributions, the study is not without limitations. First, the use of a descriptive research design limits the ability to establish causal relationships among the variables investigated. Second, the study relied primarily on self-report measures, which may be susceptible to recall bias, social desirability bias, and response distortion. Third, although the sample was drawn from selected secondary schools in Lagos State, the findings may not be fully generalisable to

adolescents outside the study area or to out-of-school adolescents who may experience different psychosocial circumstances.

In light of these limitations, future studies should consider the use of multi-informant assessments, incorporating reports from parents, teachers, and caregivers alongside adolescents' self-reports to improve the accuracy and validity of behavioural assessments. Future investigations should include adolescents from diverse geographical locations and educational settings across Nigeria to enhance the generalisability of findings.

6. Conclusion

This study investigated the prevalence of Disruptive Behaviour Disorders (DBDs). The findings revealed that disruptive behaviour disorders constitute a significant mental health concern among adolescents in Lagos State. A significant proportion of the respondents exhibited moderate to severe symptoms of DBDs, with Oppositional Defiant Disorder being more prevalent than Conduct Disorder. The study further demonstrated that significant gender differences were observed, with male adolescents exhibiting higher levels of disruptive behaviour disorders than females. The findings contribute meaningfully to the existing body of knowledge by providing contemporary evidence on the prevalence of disruptive behaviour disorders among Nigerian adolescents.

Abbreviations

DBDs	Disruptive Behaviour Disorders
CD	Conduct Disorder
ODD	Oppositional Defiant Disorder
SLT	Social Learning Theory
EST	Ecological Systems Theory

Author Contributions

Taiye Emmanuel Ojo: Conceptualization, Data curation, Formal Analysis, Investigation, Methodology, Project administration, Resources, Supervision, Validation, Writing – original draft, Writing – review & editing

Ofade Seviyon Maulome: Conceptualization, Methodology, Resources, Writing – original draft, Writing – review & editing

Rayyan Opeyemi Shobowale: Conceptualization, Methodology, Resources, Writing – original draft, Writing – review & editing

Kehinde Hannah Alabi: Resources, Writing – review & editing

Iyabode Tolulola Giwa: Resources, Writing – review & editing

Data Availability Statement

The data used for the study will be made available upon request.

Conflicts of Interest

The authors declare no conflicts of interest.

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