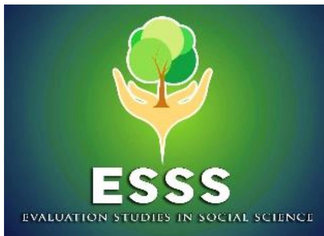

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Case report on Assessment and Management of Conduct Disorder of a 12-year-old

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Abstract

Case reports can be valuable in medical and psychological research, providing detailed and comprehensive information about specific cases. A detailed case report can provide insight into the identification of specific symptoms and behaviours displayed by the child, contributing to diagnosis, improving understanding, and informing treatment Strategies/options used to manage their condition. This information can be used to inform future research and treatment strategies for similar cases. Client Q.T. was a 12-year-old boy who presented with complaints of inappropriate age behaviour and being a slow learner. In formal assessment: Slosson Drawing Coordination Test (SDCT); Ravens Progressive Matrices (RPM); Draw a Person I.Q; Draw a Person (Personality); and the Clinician-Rated Severity of Conduct Disorder were used. In the informal assessment: clinical interviews; mental state examinations; and subjective ratings were used. The Client was diagnosed with conduct disorder. The management plan was devised based on cognitive behavioural therapy techniques such as motivational interviews, Family therapy, art therapy, and social therapy. A total of 14 sessions (60 minutes/ per week) were conducted. A case report on assessing and managing conduct disorder in a 12-year-old can offer valuable insights into the disorder and inform future research and treatment strategies.
The prevalence rate of conduct disorder is within the global range in our environment and tends to affect younger children. Policies should be implemented to screen these children at the school entrance to render appropriate health intervention.

Keywords: *Conduct disorder; I.Q Assessment; Child and adolescence; Cognive-Behavioural-Therapy, Nigeria.*

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INTRODUCTION

Conduct disorder (CD) is a common childhood psychiatric problem that has an increased incidence in adolescence and generates significant impairment of daily functioning. It is defined as a pattern of repetitive behaviour where the basic right of others or social norms or rules is violated (Ebikabowei, 2021). Conduct disorder primarily involves aggression toward people and animals, property destruction, theft, and serious rule violations (American Psychiatric Association, 2013). The prevalence of conduct disorder may vary depending on the population studied, the diagnostic criteria used, and the assessment methods. According to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the prevalence of conduct disorder in children and adolescents ranges from 1–10% worldwide. According to Polanczyk et al. (2015), the worldwide prevalence of CD in children and adolescents is estimated at 2.1%, according to data from 41 studies. There is limited data available regarding the prevalence of conduct disorder in Nigeria. However, studies conducted in Nigeria suggest that conduct disorder is a significant mental health issue among school children. For example, a study conducted by Akpan et al. (2020) reported that conduct disorder was the most prevalent mental health disorder among in-school adolescents in Nigeria, with a prevalence rate of 9.8%. Another study by Ojuope and Ekunudayo (2020) found that the prevalence of conduct disorder among secondary school adolescents in Ondo State, Nigeria, was 14.5%.

Over the past decades, research has shown that multiple factors may contribute to the behavioural symptoms of CD, which include genetic, environmental, and social factors (Pardini & Frick, 2013). For instance, according to Salvatore and Dick (2018), if researchers can identify specific genetic or environmental risk factors for CD, they may be able to develop targeted interventions that focus on these factors. This could involve, for instance, developing preventive strategies that target specific risk factors before the onset of symptoms or tailoring treatments to address the unique needs of individuals based on their specific risk factors (Salvatore & Dick, 2018). Moreover, a better understanding of the underlying causes of CD could inform the development of more effective and evidence-based treatments. Furthermore, researchers may be able to identify specific brain regions or neural circuits disrupted in individuals with CD, which could provide a target for new treatments, such as brain stimulation or cognitive-behavioural therapy (Mayberg, 2009; Månsson et al., 2021). A more rigorous etiological understanding of CD could be highly beneficial in refining future treatments and interventions.

Conduct disorder (CD) is a global mental health concern that increases the risk of several public health problems (violence, weapon use, teenage pregnancy, substance abuse, and dropping out of school). Numerous empirical studies have been conducted worldwide to investigate its prevalence, risk factors, and treatment options. Similarly, in Nigeria, several studies have been conducted on CD, specifically regarding its prevalence and risk factors. A literature review on CD worldwide shows that many empirical studies have investigated various aspects of this disorder. For instance, a study by Johnson et al. (2015) conducted at the University of Sydney, Australia, showed that children with childhood-onset CD displayed greater cognitive impairment, more psychiatric symptoms, and committed more serious violent

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offences. The finding of severe executive impairment in both childhood- and adolescent-onset groupings challenges the assumption that adolescent-onset antisocial behaviour is a normative process. As Scott et al. (2016) observed, early intervention and treatment of CD can lead to better outcomes and improved quality of life for affected individuals.

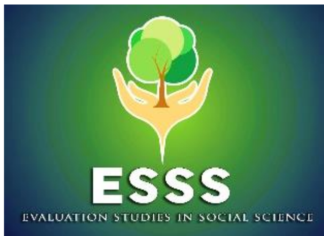
In Nigeria, there have also been several empirical studies on CD, focusing mainly on its prevalence and risk factors. For instance, a study by Ojuope (2021) in Ondo State found that the prevalence of CD among secondary school students was 14.5% and identified factors such as family disruption, poverty, and peer influence as risk factors for CD. Another study by Oladeji, Makanjuola & Gureje (2010) across 21 states in Nigeria found that a history of childhood maltreatment was associated with an increased risk of developing CD in adulthood. Despite the growing number of empirical studies on CD conducted globally and in Nigeria, there is still a need for more research in this field. For instance, additional research is required to determine the efficacy of various CD treatment options, particularly in low-resource countries like Nigeria. More investigation is also required to pinpoint the particular CD risk factors and protective variables specific to Nigeria and other low- and middle-income nations, where socioeconomic and cultural factors may contribute to a larger disease prevalence.

Treatment for conduct disorder typically involves a combination of therapies and medications (Hambly et al., 2016; Ward, 2021).

1. Therapy: Different types of therapy can be used to treat conduct disorder, including:
   - Cognitive-behavioural therapy helps individuals identify and change negative patterns of thinking and behaviour that contribute to their conduct disorder.
   - Family therapy: Family therapy involves working with the individual's family members with conduct disorder to improve communication and reduce conflict within the family.
   - Multisystemic therapy: This type of therapy involves working with different systems that are involved in the individual's life, such as family, school, and community, to address the factors that contribute to conduct disorder.
2. Medication: Medications are sometimes used to treat conduct disorder, particularly when the individual has other psychiatric conditions such as ADHD, anxiety, or depression. A psychiatrist may prescribe stimulants, antidepressants, and mood stabilizers.

Assessment of conduct disorder involves a thorough evaluation of the individual's behaviour, history, and mental health (Mohan, Yilanli & Ray, 2023). The assessment may include the following:

- Clinical interviews with the individual and their family members
- Psychological testing to assess cognitive functioning and emotional status
- Observation of the individual's behaviour in different settings, such as home, school, and community.
- Review of medical and family history



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METHODOLOGY

Case Study

Bio-Data

Name: Q.T.
Sex: Male
Age: 12 years
Religion: Christian
Tribe: Yoruba
Reason for referral: I.Q Assessment
Source of referral: Child and Adolescent Clinic
Address: #34 xxxxx Street, Ibadan, Ogun State
Informant: Client/mother
Date: xx/0x/2022
Hospital Number: 0xxxxx6
DOB: xxth March, 2010
Educational level: J.S.S.1
State of origin: Xxxxxx

Introduction

Master Q.T. was a 12-year-old male student, dark in complexion, appeared fit, of average height, well-groomed for his chronological age, with no evident sign of deformity, who was initially referred for I.Q. assessment.

Presenting Complaints

Inappropriate age behaviour – 4 years
Slow learner – 7 years

History of Presenting Complaints

According to the Client's mother, it was first reported by the Client's teachers that the Client displayed inappropriate behaviour toward classmates. However, as parents, "we saw it as a child who does not want people to take him for a ride", the Client's mother added. The Client's mother mentioned that, even as a child when the Client is angry, he disturbs everyone around at that moment; more so, at the extreme, the Client uses whatever object is handy on his classmates.

The Client's mother expects the Client to work in accordance with his age; however, the Client's behavioural patterns were only sometimes in tandem with his age. The Client's mother mentioned that the Client was still bedwetting, had poor judgment, did not obey instructions, played with children far below his age, spoiled or destroyed things around without provocation, did not feel remorseful when he hurt others, disorganised the sitting room, and tore almost all his books.

From the report from the Client's teachers in school, the Client does not complete notes and does not pay attention in class, as the Client is easily distracted and disturbs other class

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members. The same reason client is being punished today; the Client repeats the same over and over again. The Client does things when asked not to do so, in a strange manner, especially in an unsettling pattern.

The client talks to himself; the Client talks without caution, does not mind the repercussion of what is said or done, causes trouble regularly in school, and, to the extreme, injures classmates. When the Client is punished by the class teacher and any of the Client's classmates laugh during the punishment, the Client transfers aggression to the classmate who laughs by using a weapon (a stick or pebble) on them.

The Client's mother reported that the Client likes domestic animals; however, when playing with these animals, the Client is unsure when to stop hurting them. The Client beat up animals and even other children without consideration, and when asked, the Client stated, “it is all play; I do not mean to hurt anyone". The Client's mother also reported that some time ago, when the Client was between the age of 5 and 6, the Client defecated and used the faeces to rub his face. At about the same period, the Client was caught drinking water from the toilet cistern attached to the water closet. The Client's mother also stated that the Client does not care about his behaviour toward others; sometimes, the Client is manipulative and steals at school or home.

In the case of being a slow learner, the Client's mother mentioned that, as parents, they know that some children are slow to learn and that with age, such will fade off. After a long period of waiting, they realised that something was wrong, owing to the fact that the Client's result from school was always below expectation. Compared to classmates and even the Client's younger sibling, the Client's performances in school and even simple house chores were always poor. Even after the Client is taught, the Client does things his way.

Past Medical History

There was no significant medical history reported. However, 41 days after birth, the Client was said to have had jaundice, which was successfully treated. However, the severity of the jaundice was not mentioned.

Past Psychiatry History

Nil to note.

Family History

The Client's mother reported that the Client was from a monogamous family with two children.
Father: Mr T. was a 46-year-old teacher in xxxxx, Oyo State.
His highest level of education was an M.Sc in Educational management.
Mother: Mrs T. was a 38-year-old teacher in xxxxx, Oyo State.
Her highest level of education was B.Sc in Home Economics.
1st child: The Client was the first child.
2nd child: JHA was a 10-year-old student of xxxxx Grammar School, Iseyin, Oyo state.

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The Client's relationship with his parents was cordial. According to the Client's mother, the Client's father sees nothing wrong with the Client and describes the Client as normal. It was added that the Client's father portrayed similar characteristics when growing up; however, the Client's father was not as violent as the son, the Client's mother reported.
The Client's relationship with his younger brother is cordial. Although, the Client beats up his younger brother with little or no provocation. The Client does not care if his parents/teachers do not do things for him. There is no known history of mental illness in the family, as reported by the Client's mother. The Client's parents are responsible for the Client's upkeep.

Personal History (Pregnancy, Labor and Neonatal)

The Client was born on the XXth of March 2010. The Client's mother stated that the Client's pregnancy was taken to full term and was delivered through spontaneous vaginal delivery. The Client did not cry naturally at birth but was forced to cry. It was also reported that the developmental milestone of the Client was eventful. The Client started crawling at eight months old; the Client did not walk until 22 months old and then did not talk until about age three.

Educational History

The Client started school at about age two with the St. xxxxx nursery/primary school, xxxxx. The Client's mother was his teacher during his Nursery school days. The Client left St. xxxxx nursery/primary school for another school (name of school withheld), where he started and completed his primary education. During his primary school days, the Client was aggressive towards other children, but it was not seen as a problem. People (including parents) felt the Client was a tough person. Although, the Client also struggled academically, with poor grades. The Client is presently in Junior secondary class one, in XXXX grammar school, where he was referred for psychological evaluation. In his present school, the Client still fights, abuses people, and uses foul or inappropriate language, resulting in several punishments.

Occupational, Psychosexual, Psychoactive Substance and Forensic Histories were all nil to note.

Premorbid Personality

The Client was friendly, engages in sports like football, always wants to assist others, destructive, aggressive, steals, cruel to animals, manipulative, does not like obeying instructions and is sometimes happy.

Present Living Condition

The Client has never been separated from his parents from birth to date. There was no serious illness in childhood.

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Psychological assessment

This was carried out in two forms
• Informal psychological assessment
• Formal psychological assessment

Informal assessment

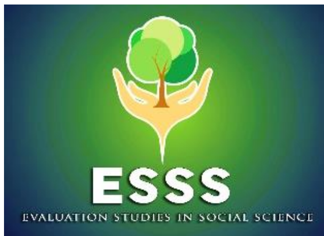
• Observation
• Clinical interview

An interpersonal process called a clinical interview is intended to start a therapeutic connection while gathering assessment data (Sommers-Flanagan, Zeleke & Hood, 2015). It has been and still is the typical starting site for patients looking for mental health care. The clinical interview gives healthcare professionals their first chance to establish a therapeutic relationship and understand the client's presenting issue (Pashak & Heron, 2022).

Mental State Examination

The mental status examination methodically evaluates the client's cognitive and behavioural abilities (Gilla, Rana & Deepak, 2021). It contains descriptions of the client's appearance, overall behaviour, level of consciousness and alertness, and motor and vocal activity. It influences attitude and insight, the response elicited in the examiner, thought and perception, and, lastly, higher cognitive abilities. The clinically most pertinent cognitive processes are attention, language, memory, constructional ability, and abstract reasoning (Gilla, Rana & Deepak, 2021).

Appearance: well-kept and groomed.
Mood: sad 5/10
Affect: flat
Speech: coherent
Thought: Good
Judgement: poor
Insight: Partial
Cognition: well-oriented in time, place and person.
• Subjective ratings of Client's problems
Pre- and post-level subjective assessments were completed to assess the client's condition's progress and evaluate the efficiency of the therapy intervention. Regarding his current issue, the client provided subjective assessments. The scores ranged from 0 to 10, with 0 denoting "not at all" problematic behaviour and 10 denoting "severely troublesome behaviour."



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Formal Assessment

1. Slosson Drawing Coordination Test (SDCT) by Slosson (1967).
2. Standard Progressive Matrices (SPM) by Ravens (1936).
3. Draw a Person: I.Q by Goodenough (1926).
4. Draw-A-Person (D-A-P- Personality) by Buck, 1948.

Test-Taking Behaviour

The Client was calm and cooperative, with a short attention span. However, the Client returns to the test after a short time of distraction.

RESULT AND ANALYSIS

SDCT

The Client had an error score of 21, which reveals an Accuracy score of 42%, which is below the norm for a Nigerian male (Oshodi, Adeyemi & Suleiman, 2012; Aroyewun, 2012). The implication is that there is a possible brain dysfunction, owing to the fact that there is an eye-hand coordination problem, and the Client could not replicate what was presented.

SPM

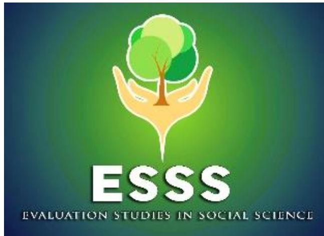
The Client obtained a score of 14, which lies below the 5th percentile rank of grade V (Iloh, Chidiebere, Iloh et al. 2021). This implies that the Client is "Intellectually defective".

DAP: I.Q

The Client obtained an I.Q score of 64, a raw score of seven and a percentile rank of "less than one". The qualitative description of the I.Q score indicates that the Client is "significantly impaired". The raw score indicated that the Client is functioning at age 4-3 years old, and a normative population score of 2.34 was obtained (Ezenwa, Abamara & Ojiaku, 2010).

D-A-P- Personality

Arms short: Lack of striving and ambition with feelings of inadequacy.
Eyes usually small: Self-absorption, introspective tendencies, reaction formation against voyeuristic tendencies.
Feet unusually small: Constrictions, dependence, various psychosomatic conditions.
Hands Mitten-Like: Aggression, currently repressed or suppressed, possible regressive tendencies.
Head unusually large: Paranoia and narcissism.



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Neck omitted: Impulsivity and possible organicity.
Shoulders omitted: Possible brain damage conditions.
Further evaluation with an abridged version of the Vineland Adaptation Scale reveals that:
a) Cognitive Functioning: The Client could recognise money; could recognise colour; could write numbers and alphabets; could operate a mobile phone; could read and write; could carry out simple arithmetic calculations.
b) Social Functioning: The Client goes on errands; can identify when clothes are dirty; can put on his clothes; however, under supervision; can bathe himself; plays with other children, however, below his age; can sit properly; can put on shoes properly.
c) Communicative Functioning: The Client could express himself; does not follow instructions; is not responsive to command; does not report issues to parents.
d)Emotional Functioning: The Client was calm/restful; does not sleep talk/sleepwalk; throws tantrums; bites fingers; used to steal but does not do so anymore.
e) Sensorimotor Functioning: The Client could climb stairs and descend on his own; could run without assistance; could walk by himself; could eat alone.

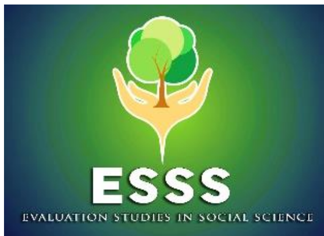
Finding of Interventions

Impression

Mild intellectual disability based on low performance in academic functioning concerning reading, writing, comprehension of language and logical reasoning compared to the Client's age group.
Fair cognitive functioning
Fair sensorimotor coordination
Fair social functioning
Poor emotional functioning
Standard Progressive Matrices are indicative of performance below the 5th percentile.
Slosson's result indicates a possible brain dysfunction
DAP IQ is suggestive of a 4-3years level of functioning
DAP (personality) results indicate behaviour aberration

DISCUSSION

The report from the caregiver about behaviour is suggestive of conduct disorder (CD). Based on the number of issues and the harm they do to others, the Clinician-Rated Severity of Conduct Disorder (American Psychiatry Association, 2013) evaluates the severity of the conduct issues the person is experiencing. On a 4-point scale, the Clinician-Evaluated Severity of Conduct Disorder is rated as Level 0 = None, 1 = Mild, 2 = Moderate, and 3 = Severe. The healthcare professional is required to assess all pertinent data for the client and, using clinical judgment, choose the level that best captures the severity of the client's condition. Going by the presenting complaints, the Client's severity level was "Moderate".



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Management Plan

A management plan was devised, and short-term and long-term goals were formulated to help the client deal with his problem.

Prognosis

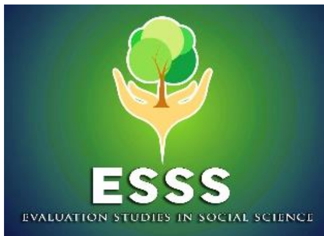
According to the American Psychiatry Association (2013), Childhood-Onset Conduct Disorder [CD] is a condition characterised by at least one symptom of conduct disorder (Diagnostic and Statistical Manual of Mental Disorders criteria—Fifth Edition, [DSM-5]) prior to 10 years of age. Nobody is exactly sure why it only happens in a small percentage of people, although genetics, birth circumstances, social environment, and upbringing appear to have a significant impact. The CD is often linked to behavioural issues like Attention Deficit Hyperactive Disorder (ADHD), anxiety, and mood disorders.

Psychological Treatment

- Supportive therapy: The therapist helps the client develop techniques for controlling their emotions and behaviour while encouraging them to communicate their experiences, ideas, and feelings. Those experiencing a challenging period or going through a significant life shift, such as a divorce, job loss, or chronic disease, may find this sort of treatment especially beneficial. Supportive therapy can help people become more resilient and enhance their overall quality of life by offering empathy, validation, and useful suggestions.
- Parental education concerning behavioural modification for bedwetting and some maladaptive behavioural patterns: A bedwetting alarm is one way to deal with the problem, and it can help kids learn bladder control by waking them up when they start wetting the bed. Parents can learn how to activate the alert and support their kids during the procedure.

  Parents can learn techniques like positive reinforcement, where desirable behaviours are rewarded with praise or other positive consequences, or time-out, where a child is briefly removed from a situation when engaging in undesirable behaviours, to deal with maladaptive behaviour patterns like tantrums or non-compliance.

  It is crucial to remember that behavioural modification techniques ought to be customized to the particular requirements of the child and family and that parents ought to collaborate closely with a licensed therapist or healthcare provider to create a unique treatment strategy. It is also critical to approach behavioural change with a supportive and upbeat mindset, as this can be more successful than negative or punishing methods.
- Specialised education which is individualised, backed with reinforcement, to improve the Client's academic performance: Positive reinforcement, which entails rewarding the client for positive behaviours like doing homework or receiving a high score on an assignment, is one efficient strategy. Incentives can be crafted to the person's tastes and



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interests and can be as straightforward as verbal appreciation or as concrete as a modest prize.

Specialised education might include particular tactics to fit the client's learning needs and style in addition to reinforcing. For instance, visual aids or frequent breaks can help a client with attention deficit hyperactivity disorder (ADHD) stay focused. A customer with dyslexia, however, might profit from specialist reading education.

It is crucial to remember that a licensed professional should provide specialised education with expertise working with people with comparable needs, such as a teacher, tutor, or educational therapist. To ensure the client is making significant improvement, it is also crucial to involve parents or guardians in the process and routinely check in on their progress.

- Patient is educable and trainable if the underlying causative factors that caused poor attention are treated.

Summary of Therapeutic Intervention

The effectiveness of the therapy was evaluated on both a quantitative and qualitative basis. A second evaluation was conducted to determine the client's level of improvement during the sixth session, which is around halfway through the sessions. The Draw-A-Person test (personality) was also given during this time, as was previously mentioned. The final evaluation was conducted at the conclusion of the 14th session to determine the degree of progress.

Subjective Rating of Problems

At the post-assessment, subjective ratings of the issues were collected to determine whether the solution was effective.

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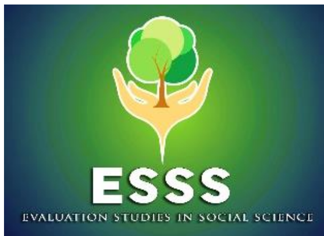

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