Zona Pediátrica.com
Zona Profesionales
Argentina
Julio, 2004

Social and health characteristics of adolescents with conduct disorder in Spain

Author:
Gonzalo Oliván-Gonzalvo, M.D.
Division of Pediatrics and Adolescent Medicine
Social Services Institute of Aragón
Government of Aragón, Zaragoza, Spain

Address for correspondence:
Gonzalo Oliván-Gonzalvo, M.D.
Division of Pediatrics and Adolescent Medicine
Avda. de las Torres 93, 1ºF
Zaragoza 50007, Spain
Tel.: +34-976-33 27 01 Fax: +34-976-33 27 01
e-mail: g.olivan@comz.org

Abstract

Background: To assess the social and health characteristics among adolescents admitted to institutional care because of behaviour disorders and who were diagnosed of conduct disorder.

Methods: Diagnostic assessment and formulation for conduct disorder, psychiatric comorbidity, and health disorders according to guidelines.

Results: 170 adolescents (56.5% boys) with DSM-IV diagnostic criteria for conduct disorder were assessed (50.9% of the total admissions). Of these, 71.8% had come from homes where both parents were no present, 22.9% had come from dysfunctional families, 43.5% showed maltreatment histories, 40% presented psychiatric comorbidity, and 55.3% presented physical health problems.

Conclusion: Spanish adolescents with conduct disorder admitted to institutional care showed a high incidence of family maladaptation/dysfunction, abuse and neglect, psychiatric comorbidity, and physical health problems.

Keywords: Adolescence. Conduct disorder. Comorbidity. Spain.

Zona Pediátrica.com
Zona Profesionales
Argentina
Julio, 2004

Introduction

Conduct disorder is a common childhood psychiatric problem that has an increased incidence in adolescence. The primary diagnostic features of conduct disorder include aggression, theft, vandalism, violations of rules and/or lying. For a diagnosis, these behaviours must occur for at least a six-month period. Conduct disorder has a multifactorial aetiology that includes biologic, psychosocial and familial factors.[1]

The objective of the present study was to assess the sociofamiliar environment, maltreatment histories, psychiatric comorbidity and physical healthcare needs among adolescents admitted to a short-term institutional foster-care facility in Zaragoza City (Spain), because of disruptive behaviour disorders and who were diagnosed of conduct disorder.

Methods

A retrospective cross-sectional study was performed over an 6-year period (1997--2002). All the adolescents who were admitted to a short-term institutional foster-care facility because of disruptive behaviour disorders were included for the study. Within 72 hours of admission, a diagnostic assessment for conduct disorder was performed according to the practice guideline for the assessment and treatment of children and adolescents with conduct disorder developed by the Committee on Conduct Disorders of the American Academy of Child and Adolescent Psychiatry.[2] Diagnostic formulation for conduct disorder and for comorbid psychiatric disorders was performed identifying target symptoms according to Diagnostic and Statistical Manual of Mental Disorders (DMS-IV; American Psychiatric Association, 1994). Physical health assessment included a medical, psychosocial and environmental history, a complete physical and anthropometric examination, a vision and hearing screening, and a laboratory assessment with those tests indicated by historical or physical findings.[3, 4]

Results

During the study period, 170 adolescents with DSM-IV diagnostic criteria for conduct disorder were admitted to the juvenile facility (50.9% of the total admissions because of disruptive behaviour disorders). Of these, 56.5% were male and 43.5% were female, ages ranging between 11 and 17 years, with an average age of 14.7 years.

With regard to sociofamiliar environment, 32.3% of adolescents had come from homes with only the mother present; 28.2% from homes where both parents were present; 14.1% from homes with either parent and his/her partner present; 10.6% from homes with only the father present; 9.4% from homes of relatives; and 5.3% from homes of other caregivers. Of the interviewed adolescents, 22.9% had come from dysfunctional families with problems of delinquency (11.8%), alcohol/drug abuse (7.6%), and psychiatric illness (3.5%).

Concerning the maltreatment histories, 43.5% of adolescents were shown to have suffered some form of maltreatment by parents, relatives, caregivers or other persons. Of these, 52.7% reported neglect; 50% physical abuse; 28.4% emotional abuse; and 8.1% sexual abuse.

Psychiatric comorbidity was observed in 40% of the assessed adolescents. The most frequent comorbid mental disorders were psychoactive substance use disorder (20.6%), attention-deficit/hyperactivity disorder (16.5%), and mood disorders (depressive and bipolar) (11.2%). Less prevalent were post-traumatic stress disorder (9.4%), anxiety disorders (6.5%), specific developmental disorders (6.5%), and other psychiatric disorders (1.7%). Nearly 30% of these showed more than one psychiatric comorbid disorder.

With regard to physical healthcare needs, at least one physical health problem was observed in 55.3% of the assessed adolescents. The most frequent health problems were dental (28.8%), visual (21.7%), nutritional (12.3%) [obesity (5.9%), malnutrition (4.1%), iron deficiency anaemia (2.3%)], and dermatologic (10%). Less prevalent health problems included incomplete immunization status (8.8%), orthopaedic (7.6%), respiratory (7%), pregnancy (5.4%), growth delay (5.3%), otic (2.9%), digestive (2.3%), sexually transmitted diseases (2.3%), hepatitis B/C infection (1.7%), and diabetes (0.6%).

Zona Pediátrica.com
Zona Profesionales
Argentina
Julio, 2004

Discussion

This study indicates that several Spanish adolescents with conduct disorder admitted to institutional care come from monoparental and/or dysfunctional families, with a high incidence of abuse and neglect, psychiatric comorbidity, and physical health problems.

Concerning the sociofamiliar environment, the results of this study agreed with the extensive evidence of associations between family maladaptation/dysfunction and maltreatment histories with an increase in risk for conduct disorder symptomatology.[5, 6] Regarding the comorbid mental disorders of these adolescents, the current and prior mental disorders (substance abuse, externalising disorders and depression) were consistent with those documented in previous studies.[7] Concerning the physical healthcare needs, we observed that this population is especially in need of dental, visual, nutritional and dermatologic services. These physical health problems are probably caused by a variety of environmental factors, including past physical or psychosocial abuses, disorganized home, lack of supervision, life-style habits, and a lack of prior health care.[4]

The levels of family dysfunction, maltreatment, mental disorders and physical health problems in these adolescents are higher than those in the general adolescent population and almost as severe as those reported among delinquent youths under the care of Juvenile Correctional System and among runaway and homeless adolescents in Spain.[8-12]

It's common knowledge that early recognition and intervention may prevent the progression from conduct disorder to antisocial personality disorder, and that as a chronic condition, conduct disorder requires extensive treatment and long-term follow-up.[2, 7] For these reasons, we believe that the time in institutional care presents a unique opportunity to coordinate the physical and mental health therapeutic, sociofamiliar, educational, vocational and legal service needs of this high-risk population.

Zona Pediátrica.com
Zona Profesionales
Argentina
Julio, 2004

References

1. Searight HR, Rottnek F, Abby SL. Conduct disorder: diagnosis and treatment in primary care. Am Fam Physician 2001; 63: 1579-88.
2. Steiner H. Practice parameters for the assessment and treatment of children and adolescents with conduct disorder. American Academy of Child and Adolescent Psychiatry. J Am Acad Child Adolesc Psychiatry 1997; 36 (10 Suppl): 122S-39S.
3. Oliván-Gonzalvo G. Características sociales y estado de salud de los menores que ingresan en centros de acogida [Social characteristics and health status of children entering foster care centers]. An Esp Pediatr 1999; 50: 151-5.
4. Oliván-Gonzalvo G. Niños y adolescentes en acogimiento transitorio: problemas de salud y directrices para su cuidado [Children and adolescents in foster care: health problems and guidelines for their health care]. An Pediatr (Barc) 2003; 58: 128-35.
5. Meyer JM, Rutter M, Silberg JL, et al. Familial aggregation for conduct disorder symptomatology: the role of genes, marital discord and family adaptability. Psychol Med 2000; 30: 759-74.
6. Burke JD, Loeber R, Birmaher B. Oppositional defiant disorder and conduct disorder: a review of the past 10 years, part II. J Am Acad Child Adolesc Psychiatry 2002; 41: 1275-93.
7. Loeber R, Burke JD, Lahey BB, Winters A, Zera M. Oppositional defiant and conduct disorder: a review of the past 10 years, part I. J Am Acad Child Adolesc Psychiatry 2000; 39: 1468-84.
8. Andrés MA, Catalá MA, Gómez-Beneyto M. Prevalence, comorbidity, risk factors and service utilisation of disruptive behaviour disorders in a community sample of children in Valencia (Spain). Soc Psychiatry Psychiatr Epidemiol 1999; 34: 175-9.
9. Oliván G. The health profile of Spanish incarcerated delinquent youths. J Adolesc Health 2001; 29: 384.
10. Oliván-Gonzalvo G. Adolescentes delincuentes: problemas de salud y recomendaciones sanitarias para centros de reforma juvenil [Delinquent adolescents: health problems and health care guidelines for juvenile correctional facilities]. An Esp Pediatr 2002; 57: 345-53.
11. Oliván G. The health status of delinquent gypsy youths in Spain. Eur J Public Health 2002; 12: 308.
12. Oliván G. Maltreatment histories and mental health problems are common among runaway adolescents in Spain. Acta Paediatr 2002; 91: 1274-5.