



Paidéia

ISSN: 0103-863X

paideia@usp.br

Universidade de São Paulo

Brasil

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Paidéia, vol. 22, núm. 53, septiembre-diciembre, 2012, pp. 315-323

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Survey of Behavioral/Emotional Problems in an Adolescent Outpatient Service

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Abstract: This study's objective was to identify the main behavioral and emotional problems perceived by adolescents attending an outpatient service. A total of 320 adolescents were included in the study. The respondents were not undergoing psychotherapy and self-applied the Youth Self Report in the ambulatory's waiting room. The main problem reported was Anxious/Depressed. Male adolescents obtained higher scores for Social Problems and lower scores for Delinquent Behavior, while females obtained lower scores for Somatic Complaints and higher scores for the Anxious/Depressed scale. Social Problems were associated with the initial phase of adolescence. In terms of incidence, less than one quarter of the adolescents presented problems, suggesting that adolescence is not a period of turbulence. Some adolescents require a more detailed evaluation because they reported behaviors indicative of mental disorders. We conclude that there is a need for mental health workers to integrate the health staff providing care to adolescents.

Keywords: adolescents, behavior disorders, public health service, depressive anxiety, health

Levantamento de Problemas Comportamentais/Emocionais em um Ambulatório para Adolescentes

Resumo: Este estudo teve como objetivo identificar os principais problemas comportamentais e emocionais percebidos por adolescentes que frequentam um ambulatório de saúde. Participaram 320 adolescentes que não estavam em atendimento psicoterápico e que responderam, na sala de espera de um ambulatório, o Youth Self Report. O principal problema relatado foi Ansiedade/Depressão. Os meninos obtiveram escores mais altos em Problemas Sociais e mais baixos em Comportamento Delinquente; as meninas apresentaram-se com menos problemas no agrupamento Problemas Somáticos e com mais problemas em Ansiedade/Depressão. Quanto à faixa etária, observou-se que Problemas Sociais esteve associado ao início da adolescência. Quanto à incidência, menos de um quarto dos adolescentes apresentaram-se com problemas, sugerindo que a adolescência não é um período de turbulência. Observou-se que alguns adolescentes necessitam de uma avaliação mais detalhada, pois relataram comportamentos indicativos de transtornos mentais. Conclui-se a necessidade de profissionais de saúde mental integrarem a equipe de saúde que atende adolescentes.

Palavras-chave: adolescentes, distúrbios do comportamento, serviços de saúde pública, ansiedade depressiva, saúde

Estudio de Problemas Conductuales/Emocionales en una Clínica para Adolescentes

Resumen: El objetivo del estudio fue identificar los problemas comportamentales y emocionales notados en adolescentes que frecuentan una clínica de salud. Participaron 320 adolescentes, que no estaban en psicoterapia y que respondieron, en la sala de espera, de una clínica de salud, al Youth Self Report. El principal problema relatado fue Ansiedad/Depresión. Los niños obtuvieron calificaciones más altas en Problemas Sociales y más bajas en Comportamiento Delincente; las niñas se presentaron con menos problemas en el grupo Problemas Somáticos y con más problemas en Ansiedad/Depresión. En lo referente al rango de edad, se observó que Problemas Sociales estuvieron asociados al inicio de la adolescencia. En lo referente a la incidencia, menos de un cuarto de los adolescentes se presentaron con problemas, sugiriendo que la adolescencia no es un periodo de turbulencia. Se observó que algunos adolescentes necesitan una evaluación más detallada, pues relataron comportamientos indicativos de trastornos mentales. Se concluye que existe la necesidad de que profesionales de salud mental integren el equipo de salud que atiende a adolescentes.

Palabras clave: adolescentes, trastornos de la conducta, servicios de salud pública, ansiedad depresiva, salud

Adolescence is the period between the ages of 10 and 19 years old (World Health Organization [WHO], 2008). Entering middle school coincides with changes taking place in

terms of physical, social and cognitive development (Burke, Brennan, & Roney, 2010). Evolutionary changes represent both a stimulus and a challenge for the development of human beings, as well as a source of difficulties (Schulenberg, Maggs, & Hurrelmann, 1997). Poorly managed changes may lead to increased tension between parents and children, mental health issues, and the adoption of risk-taking behaviors such

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as the consumption of alcohol and other drugs (Costello, Foley, & Angold, 2006; Dallo & Martins, 2011). Even though the period of adolescence, in comparison to earlier developmental stages, presents a lower prevalence of acute diseases (Bee & Boyd, 2011), adolescents still require medical care both to treat (chronic or acute) conditions and health problems arising from behavior that put their lives or health at risk (Vitalle et al., 2010). A total of 10% to 25% of young individuals present some type of mental condition (Merikangas et al., 2010).

Emotional maladjustment is a problem that has worsened in recent decades with chronic and severe consequences. There seems to be a relationship between health problems during adolescence and behavioral problems (Costello et al., 2006; Pacheco, Vitalle, Montesano & Pedromônico, 2003). A study conducted in an outpatient clinic for children and adolescents with obstructive sleep disorders (Uema, Vidal, Fujita, Moreira, & Pignatari, 2006) reported that one quarter presented externalizing disorders. Children and adolescents with epilepsy presented more behavioral and emotional problems than the control group, especially the boys (Høie et al., 2006). Zashikhina and Hagglof (2007) found similar results when studying adolescents with chronic diseases, especially girls with asthma and boys with epilepsy. Adolescents with inflammatory bowel disease presented more symptomatic behaviors such as anxiety and depression, social problems, thought problems, and somatic complaints (Väistö, Aronen, Simola, Ashorn, & Kolho, 2009). Children who become anxious in the face of dental treatment also presented more indicators of stress and emotional and behavioral problems (Cardoso & Loureiro, 2005). Mota, Bertola, Kim and Teixeira (2010) observed that children with Noonan Syndrome presented behavior indicative of anxiety/depression and aggressiveness. Fontes Neto et al. (2005) interviewed mothers of children and adolescents with atopic dermatitis and observed that these patients presented more internalizing and externalizing problems than the control group, especially anxiety and depression, thought problems and aggressiveness.

Behaviors that negatively affect social relationships are more evident at the beginning and at the midway point of adolescence, between 11 and 16 years old (Pacheco, Alvarenga, Reppold, Piccinini, & Hutz, 2005). A Swiss epidemiological study reported that older adolescents, assessed by the Youth Self Report (YSR), presented slightly more attention deficit than younger adolescents (Steinhausen & Metzke, 1998). Older Greek adolescents, assessed by the same instrument, also presented more problems, especially in the domain of Delinquent Behavior (Roussos et al., 2001). Other studies, however, show that behavioral problems and externalizing problems diminish with age, while internalizing problems increase with age (Crijnen, Achenbach, & Verhulst, 1997; Merikangas et al., 2010).

It seems that antisocial behavior is more common among boys, though girls have also presented externalizing problems (Donaldson & Ronan, 2006; Pacheco et al., 2005; Silva, 2003). Depressive symptoms may also emerge during adolescence: 40% of adolescents are described by parents and teachers as being unhappy, sad or depressive (Achenbach & Edelbrock,

1981). Giannakopoulos, Tzvara, Dimitrakaki, Ravens-Sieberger and Tountas (2010) observed, after interviewing adolescents at school, that there were no differences in relation to gender or age among those who had a medical appointment in the past four months or were hospitalized in the past year in comparison to those who did not have medical appointments in the same period. However, those who had been hospitalized reported poorer physical wellbeing and more emotional and behavioral problems. Chronic diseases seem to be accompanied by behavioral and emotional changes.

According to the Guidelines for Adolescent Preventive Services, every adolescent should attend at least one routine medical appointment a year to assess his/her medical and psychosocial condition; the service should be appropriate for the individual's age and stage of development (American Medical Association [AMA], 1997). Identifying the characteristics of the population using health services is necessary to improve care delivery (Silvares, 1989). Health workers need to identify those using the service and the needs of its clientele to provide a more comprehensive and individualized health approach. This study's objective was to identify the main behavioral and emotional problems perceived by the adolescents attending an adolescent outpatient service.

Method

Participants

Information was collected from the medical records of 320 adolescents not undergoing psychological/psychiatric care and who were cared for from 2004 to 2006 in an adolescent outpatient service at the Pediatrics Department of the *Universidade Federal of São Paulo*. The respondents' average age was 14.694 years old ($SD = 1.968$). A total of 120 (37.5%) adolescents were males with an average age 14 years old ($SD = 2$) and 200 (62.5%) were females with an average age of 15 years old ($SD = 2$). A total of 27 medical records were excluded because they lacked information concerning the instrument used or because they did not report whether the patients were undergoing any psychological or psychiatric care. The sample was divided according to age groups: initial adolescence (11 to 13 years old), midway adolescence (14 to 16 years old) and final adolescence (17 and 18 years old). The initial adolescence group was composed of 94 adolescents, 50 (53.19%) of which were females; the midway adolescence group was composed of 163 adolescents, 100 (61.35%) were females; and the final stage adolescence group was composed of 64 adolescents, 51 of which (79.69%) were females.

Instrument

The instrument used to evaluate behavioral problems was the Youth Self Report (YSR) (Achenbach, 1991). This instrument is used in more than 60 different cultures and has been employed internationally in epidemiological studies as part of

the diagnostic process and to compare behavioral/emotional problems among cultures (Achenbach et al., 2008; Ferdinand, 2008; Honkalampi et al., 2009). Researchers have developed studies using the family of tools developed by the Achenbach System of Empirically Based Assessment (ASEBA), in order to identify individuals with a high risk of psychiatric disorders and who, therefore, require more detailed evaluation (Marteleto, Schoen-Ferreira, Chiari, & Perissinoto, 2011; Oliveira-Monteiro, Negri, Fernandes, Nascimento, & Montesano, 2011). The version used in this study was provided by the current representative of ASEBA in Brazil.

The instrument is structured to obtain answers concerning the adolescent's competencies and problems experienced in the six months prior to the form's completion. Time spent to answer the instrument is approximately 20 minutes. The YSR is composed of 138 items written in the first person present tense organized in two parts: (1) refers to the adolescents' competencies and their involvement in various activities, social relationships, and academic performance and (2) refers to the evaluation of behavioral problems and socially desirable behavior, and is structured around 118 items of clinical relevance through a Likert scale (Achenbach, 1991). This study focused on the second part of the instrument. The items' factor analysis enabled the organization of the instrument into scales (internalizing and externalizing) and the grouping of syndromes (Achenbach et al., 2008).

Because there is no Brazilian standard, we adopted the original American standard-values in the analysis. The raw score obtained on the YSR for each of the scales and syndromes is converted into T scores that express the raw score – sum of items – in terms of its distance in standard deviation units, establishing an average of 50 and a standard deviation of 10: $T = z(10) + 50$. A large part of Brazilian studies use this form of correction (Borsa & Nunes, 2008; Pacheco et al., 2003; Schoen-Ferreira, 2007). The adolescents can be classified into the non-clinical range (fewer problems) or into the clinical range (more problems). Many Brazilian studies use this form of analysis to verify this instrument's results (Dall'Agnol, Fassa, & Facchini, 2011; Schoen-Ferreira, Aznar-Farias, & Silveiras, 2003).

Procedure

Data collection. The adolescents were invited to self-apply the YSR while waiting for their appointments in any of the specialties: adolescent medicine, speech therapy, dental

care, physical education, psychology, psychiatry or nutrition, as part of the patient's outpatient routine. An active search was performed in the patients' medical records to identify those who had already completed the instrument's complete form and reported no psychotherapy or psychiatric treatment at the time.

Data analysis. The adolescents' answers to the YSR were analyzed through the Assessment Data Manager (ADM), software specifically developed to analyze ASEBA's family of tools. When checking the answers provided to the YSR's items, the program classifies adolescents into Clinical, Borderline and Non-clinical ranges (Achenbach, 1991). The categories Borderline and Clinical were grouped according to the manual, thus, two categories remained: Clinical (more behavioral problems) and Non-clinical (fewer behavioral problems). The percentages of individuals classified into the clinical and non-clinical ranges in each of the scales and syndromes were computed and the Chi-square test for independent samples was used for the statistical analysis; $p \leq 0.05$ was adopted.

Ethical Considerations

The research project that originated this study was approved by the Ethics Research Committee at the Universidade Federal of São Paulo (CEP nº 0985.07) and was also authorized by the ambulatory's director board.

Results

This study's results report to the percentage of adolescents attending an outpatient service who perceived the presence of behavior indicative of some psychological suffering and are classified into the clinical range (more problems). The main problem reported by the adolescents was anxiety/depression (22.5%). The scale Externalizing and the scales Anxious/Depressed, Delinquent Behavior, and Aggressive Behavior were associated with the female gender (Table 1). It is important to note that most adolescents were not considered to be within a clinical range on any of the scales, with the exception of the Total Problems scale. Adolescents of all age groups were classified into the clinical range (Table 2), though only the Social Problems scale ($p = 0.005$) was associated with age (initial adolescence).

Table 1

Percentage of Adolescents who Obtained Clinical Scores on the Youth Self Report's Scales and Syndromes by Gender

Syndromes/Scales	Male	Female	Total	p^*
	n (%)	n (%)	n (%)	
Withdrawn	17 (14.2)	16 (8.0)	33 (10.3)	0.079
Somatic complaints	14 (11.7)	18 (9.0)	32 (10.0)	0.441
Anxious/depressed	18 (15.0)	54 (27.0)	72 (22.5)	0.013*

Continue

Table 1
Continuation

Syndromes/Scales	Male	Female	Total	<i>p</i> *
	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	
Social problems	20 (16.7)	36 (18.0)	56 (17.5)	0.761
Thought problems	12 (10.0)	25 (12.5)	37 (11.6)	0.498
Attention problems	19 (15.8)	46 (23.0)	65 (20.3)	0.123
Delinquent behavior	8 (6.7)	34 (17.0)	42 (13.1)	0.008*
Aggressive behavior	14 (11.7)	44 (22.0)	58 (18.1)	0.020*
Internalizing problems	44 (36.7)	91 (45.5)	135 (42.2)	0.121
Externalizing problems	31 (25.8)	83 (41.5)	114 (35.6)	0.005*
Total problems	73 (60.8)	94 (47.0)	167 (52.2)	0.016*

Note. * $p \leq 0.05$.

Tabela 2
Percentage of Adolescents who Obtained Clinical Scores on the Youth Self Report's Syndromes and Scales by Age Groups

Syndromes/Scales	Inicial	Média	Final	<i>p</i> *
	11 a 13 anos <i>n</i> (%)	14 a 16 anos <i>n</i> (%)	17 e 18 anos <i>n</i> (%)	
Withdrawn	5 (10.4)	16 (9.9)	12 (10.3)	0.973
Somatic complaints	8 (16.7)	15 (9.3)	9 (8.1)	0.235
Anxious/depressed	10 (20.8)	31 (19.7)	31 (27.9)	0.232
Social problems	16 (33.3)	21 (13.0)	19 (17.1)	0.005*
Thought problems	8 (16.7)	17 (10.6)	12 (10.8)	0.486
Attention problems	8 (16.7)	31 (19.3)	26 (23.4)	0.557
Delinquent behavior	3 (6.3)	21 (13.0)	18 (16.2)	0.232
Aggressive behavior	8 (16.7)	28 (17.4)	22 (19.8)	0.843
Internalizing problems	19 (39.6)	61 (37.9)	55 (49.5)	0.148
Externalizing problems	13 (27.1)	56 (34.8)	45 (40.5)	0.253
Total problems	21 (56.3)	73 (54.7)	153 (46.8)	0.372

Note. * $p \leq 0.05$.

Discussion

The YSR is part of ASEBA, which became the most used and studied screening system assessing emotional and behavioral problems in the world. There are no Brazilian standards for it, even though the ASEBA tools have been used in Brazil for more than ten years. For this reason, the results obtained from Brazilian adolescents are compared to those of North-American adolescents (Marteletto et al., 2011; Rocha, Araújo, & Silveiras, 2008; Sarmiento, Schoen-Ferreira, Medeiros, & Cintra, 2010), which may lead to less accurate results since the cultural aspect is not taken into account (Achenbach et al., 2008). Different scores are obtained in other countries (Donaldson & Ronan, 2006; Roussos et al., 2001). Achenbach et al. (2008) and Crijnen et al. (1997) state, however, that scores vary more within the same population than among distinct populations. Another problem faced by professionals using the ASEBA screening tools in Brazil is that, until recently, there was no single Brazilian version, though Rocha et al. (2008) showed that the semantic version did not obtain different results.

We note that the instrument used in this study was self-applied by the adolescents while they waited for their consultations and is, therefore, based on their own perceptions. They may have either emphasized or minimized some

aspect(s) of their behavior. Even though the YSR is considered a reliable and valid self-reporting tool (Aebi, Metzke, & Steinhausen, 2009; Doyle, Mick, & Biederman, 2007), a complete evaluation should contain data from interviews both with the adolescent and his/her guardian. Such an evaluation is not presented in this study since its objective was not to diagnose psychopathologies but identify individuals with a high risk for psychiatric disorders requiring a more detailed evaluation or differentiated care.

Adolescents are more susceptible to behavioral problems indicative of mental disorders (Burke et al., 2010; Dall'Agnol et al., 2011). These kinds of behaviors should be taken seriously by health workers because they not only significantly interfere in daily life but may also hinder a healthy developmental process, thus hindering evolutionary tasks and entrance into adulthood. Merikangas et al. (2010) stress that mental disorders during adolescence require preventive actions and interventions to be implemented at this age or even during childhood. This study enabled us to collect information concerning emotional and behavioral problems among adolescents who attended an ambulatory service; such information can support the organization and planning of psychological care delivered to patients.

This study's results indicate that all the scales included adolescents classified as clinical (many behaviors indicative of

problems in that specific domain), which indicates a need for mental health workers in adolescent outpatient services – most adolescent outpatient services do not provide mental health care (Secretaria de Estado da Saúde de São Paulo, 2008) – or when this is not a feasible alternative, the need to refer adolescents to a facility where they can receive proper care.

The Guidelines for Adolescent Preventive Services (AMA, 1997) considers it necessary to inform parents or caregivers about adolescents' physical, social and psychological development, including signs and symptoms indicative of mental disorders. Burke et al. (2010) also deem this guidance important since, in addition to improving intrafamily communication and wellbeing among its members, mental health information may also work as a protective factor. Many parents may consider their children's behavior, such as skipping classes, locking themselves in the bedroom without talking to anyone, and physically attacking other people, as typical of adolescence and not mention it to their health professional. Some health workers may also consider such behaviors typical and see them as being part of "Normal Adolescence Syndrome" (Aberastury et al., 1980), but these may actually be signs of psychopathologies. Parents and guardians need to be aware of what and what not to expect at this age because parents are the ones bringing their children to medical appointments. Despite the adolescents' greater independence and autonomy, adults still are the ones deciding whether help is required, as well as when and where it is required.

Anxious/Depressed was the scale with the highest percentage of adolescents classified in the clinical range, especially girls. This result is compatible with other findings in the literature addressing this subject (American Psychiatric Association [APA], 2002; Merikangas et al., 2010; Orton, Riggs, & Libby, 2009). Even though everyone experiences temporary sadness, for some this feeling has such a strength that it affects social relationships, everyday life, and general well being (Compas et al., 1993). In these cases, help is required.

According to Costello et al. (2006), adolescence seems to be a period when there is a risk of developing depressive or anxious behavior. Even though genetics may play a role, stressful factors may also trigger such conditions (Kendler, Gardner, & Lichtenstein, 2008). Adolescence requires individuals to face new and stressful situations such as body changes that occur during puberty, reorganization of family roles, social changes arising from the way school is structured, and those changes concerning the need to enter adulthood, such as increased responsibility, choosing an occupation, making commitments, and increased autonomy and independence (Bee & Boyd, 2011). A child may enter adolescence without having developed the skills necessary to cope with this stage's requirements and feel overwhelmed and, consequently, develop depression and/or anxiety.

More so than boys, girls presenting other behavioral problems can also experience depressive symptoms (Hintikka et al., 2009). When girls enter adolescence they become aware of their social gender condition and the differences in

the way they are treated (Abramo & Branco, 2005; Bee & Boyd, 2011). Job and social opportunities are different for both genders. The expectations perhaps necessary for the adolescent to adapt to the reality she now faces may be different (Schoen-Ferreira, 2007). These two factors – biological and social – can lead girls to deal with more difficulties during adolescence, triggering depressive or anxious behavior. Social conditions individuals face when entering adolescence are different depending on gender. Female adolescents have fewer opportunities to develop and are more susceptible to depression. Honkalampi et al. (2009) reported significantly higher averages for females on all scales and syndromes; the highest average was obtained on the Anxious/Depressed scale, similar to this study's findings. Although both genders benefit from mental health preventive measures and interventions, the need for programs differentiated by gender in this age group is apparent. Based on this study's findings, services directed to girls should focus more on depression and anxiety.

The frequency with which female adolescents were classified into the clinical range of Delinquent Behavior and Aggressive Behavior was greater than that of male adolescents, a finding that differs from those reported in the literature (Nurmi, 1997; Vasey, Kotov, Frick, & Loney, 2005), though some studies have also found a relationship between the female gender and externalizing problems, often associated with depression (Silva, 2003; Honkalampi et al., 2009). Female adolescents are currently more assertive than male adolescents and many of their behaviors are alike, though girls judge themselves by a different standard. Behaviors considered 'female' such as being withdrawn, shyness, submissiveness and passiveness, still remain in the social imaginary, consequently, girls are judged more rigorously when they act aggressively. A more confident and entrepreneurial behavior is often confused with aggressive behavior because it sometimes hurts, injures or destroys (Silva, 2003). The results suggest there is a need for programs enabling the development of social skills.

The only scale associated with age was Social Problems, in which more adolescents in the initial stage were classified as being in the clinical range. Difficulties in social relationships are common causes of anguish among adolescents (Honkalampi et al., 2009). There is an association between the beginning of puberty and social anxiety, especially among those who develop secondary physical characteristics before their peers (Blumenthal, Leen-Feldner, Trainor, Babson, & Bunaciu, 2009). The beginning of adolescence leads to many changes that mainly affect the child's autonomy (Schoen-Ferreira, 2007; Schulenberg et al., 1997). If once the child felt protected by adults, these same adults pressure her/him to take on responsibilities. There are many changes adolescents may feel unable to cope with. One example is when adolescents enter the fifth grade: new school, many teachers (there is not a single teacher as a reference point), there is a need to make new friends and solve problems by themselves. Up to the fourth grade, the adolescent is part of the older kids group and they know everything about the school, while in the fifth grade, new students become part of

the youngest group and do not know how the new school functions. The status of new student is usually less prestigious than that of senior student and the adolescent needs to learn rapidly how to behave in this new academic context. Many parents also start delegating more responsibilities to their children concerning their health, such as going to medical consultations by themselves or taking medication without proper monitoring (Schoen & Vitale, in press). It is likely that this large number of changes demanded at the beginning of adolescence may trigger more social-related problems.

Few participants in this study were in the final stage of adolescence. Many older adolescents work, which hinders going to outpatient clinics and having routine exams. A facility intending to be inclusive should seek alternative locations, times, and forms of delivering care to meet the needs of this clientele, who usually only seek medical care in urgent/emergency situations. Mental health workers should organize according to the clientele's needs and characteristics (Schulenberg et al., 1997). Group psychotherapy should include different age groups and care should be provided at different times in order to take into account the patients' school hours. Individual care is usually more flexible and allows better arrangement with school and work hours. The fact that adolescent outpatient services are separated from pediatric and adult outpatient services shows there is a concern to provide a facility specifically for delivering care to adolescents, apart from infants and children. The waiting room itself should have equipment appropriate to this age group, e.g. chairs with appropriate height and magazine content.

The scale comprising the second highest number of adolescents classified in the clinical range was Attention Problems. The tasks adolescents have to perform require conscious and specific focus on certain aspects. The adolescent needs to understand that most tasks require conscious and continuous effort to maintain their attention span. However, some adolescents seem not to have developed the required skills in the previous stages and fail in the face of such demands (Schoen-Ferreira, 2007). Others do not understand that desire *per se* is not sufficient to perform tasks; tasks need to be done even if they are not enjoyable. Thus, adolescent outpatient services and/or schools should provide psychopedagogy services.

Another aspect that may trigger problem behaviors in the Attention Problems scale is related to sexuality, when adolescents become interested in changes taking place in their bodies and may become bedazzled with themselves and the opposite sex. Every professional caring for adolescents should be qualified to talk with and advise adolescents and their families concerning affective-sexual development (AMA, 1997). If professionals feel uncomfortable in providing such guidance, the service should offer the possibility of providing the consultation jointly with a psychologist.

We observe in studies addressing patients with chronic diseases (Mota et al., 2010; Uema et al., 2006; Väistö et al., 2009; Zashikhina & Hagglof, 2007) that there is a similar or

smaller percentage of adolescents attending outpatient services classified in the YSR's clinical range. However, compared with the control groups (Hintikka et al., 2009), more patients in this study presented behavioral or emotional problems. Hence, professionals working with this age group should, in addition to developing technical skills from their specific field (e.g. medicine, speech therapy, nutrition), also broaden their knowledge concerning cognitive, social, and behavioral development at this age, as well as acquire notions of psychopathology (Cardoso & Loureiro, 2005; Fontes Neto et al., 2005). Problems experienced during the period of adolescence tend to persist throughout adult life to a moderate degree and a high incidence of problems during adolescence is a risk factor for the emergence of psychiatric disorders in adulthood (Honkalampi et al., 2009; Welham et al., 2009).

Conclusion

We verified that 10% to 22.5% of the studied adolescents presented problems in some emotional area that required a more detailed evaluation. This study's findings do not indicate adolescence is necessarily a turbulent and tense period. The main behavioral and emotional problems reported by the adolescents attending the outpatient service were related to Anxious/Depressed (22.5%), Attention Problems (20.3%) and Aggressive Behavior (18.1%). Social Problems were associated with the beginning of adolescence (11 to 13 years old).

Scientific studies addressing adolescence indicate the need for professionals from different health fields to pay attention to the development of adolescents in order to understand the range of biopsychosocial changes that take place after puberty (Vitale et al., 2010). Health workers should be attentive to the characteristics inherent to this age group and be sensitive to the difficulties adolescents and their families face and also share the responsibility for caring for the adolescent's health with all those involved: the adolescent, family and the health staff. Psychologists are important professionals who not only offer different types of services, but also participate in meetings/supervision in other health fields and are able to share knowledge concerning behavioral and emotional problems and human development.

Since adolescents are often cared for by pediatric specialists or referred to adult services, there are issues specific to this phase, especially those related to psychosocial development and psychopathologies, that need to be disseminated and become known. Some needs, whether they are related to routine consultations, with or without physical and/or emotional problems, or related to the prevention of potential problems, require a new approach from health workers caring for adolescents. The development of a new *modus operandi* in clinical care provided to adolescents should include the cooperation of different health fields, including Psychology, supported on scientific knowledge and on a proposition to enable the integral development of human beings (Vitale et al., 2010).

It is worth noting that the data refer to the results obtained in a screening tool adolescents completed in an ambulatory's waiting room, that is, the respondents may not have the necessary maturity to observe themselves and identify some behavioral and emotional problems. This study used only the answers provided by the adolescents, which may minimize or maximize the importance of their behavior. It would be interesting to verify whether the parents or guardians also perceive the same behavioral problems reported by their children or if they perceive even other problems the adolescent may not have perceived or reported. Likewise, it would be interesting to verify in the respondents' medical records whether the health workers have ever made any observation concerning behavioral or emotional conditions. Additionally, those adolescents classified in the YSR's clinical range could undergo a more specific evaluation that would either support or rule out information provided in the outpatient waiting room. Finally, this is a cross-sectional study that may have a longitudinal follow-up if the routine of applying the instrument during the adolescents' future return visits is kept.

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Received: Mar. 21st 2011

1st revision: Nov. 10th 2011

2nd revision: Feb. 16th 2012

Approved: Jul. 3rd 2012

How to cite this article:

Valverde, B. S. C. L., Vitalle, M. S. S., Sampaio, I. P. C., & Schoen, T. H. (2012). Survey of behavioral/emotional problems in an adolescent outpatient service. *Paidéia (Ribeirão Preto)*, 22(53), 315-323. doi:<http://dx.doi.org/10.1590/1982-43272253201303>