UNIT NO. 2

ADOLESCENT FRIENDLY CONSULTATION

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ABSTRACT

An adolescent friendly consultation requires a doctor to negotiate the challenges of handling an intellectually and often socially adept individual who may regard doctors with suspicion or even as agent of parents seeking to interfere with or control their lives. The three pre-requisites for a adolescent friendly consultation are a) the right situation, b) the right person and c) the right questions. Useful techniques for communicating with adolescents are a) active listening, b) reflecting feelings and c) avoiding communication barriers. The HEADSS assessment is an interview instrument to obtain medical and psychosocial information of the adolescent. Risk assessment is a necessary skill to acquire when dealing with adolescents.

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INTRODUCTION

Adolescence is a difficult period to define exactly. It is often described as a transition between childhood and adulthood but is controversial in whether it is a stage of development or merely an ill defined period of physical, emotional and social change. Many commonly regard adolescence as the age from 13 to 21 years. This means that children entering secondary school would be considered adolescents. The upper limit in terms of age is more controversial as some consider 18 to 21 years as being young adulthood, particularly in the Singapore context where the young men are doing their national service. We prefer a less rigid definition that marks adolescence as the onset of puberty. Adolescence represents an intriguing series of physical as well as emotional changes. For the adolescent, menarche and the first nocturnal emissions of a "wet dream" mark a period of physical maturation. It is a time of growing up with a developing sense of self control and destiny. At the same time, there is great emotional vulnerability as the teen seeks to bolster his individuality and ego through intimate relationships and self discovery.

Doctors are faced with the same difficulties when seeing this group of patients as they would be when seeing children, but with the added sophistication of having to handle an intellectually and often socially adept individual. Adolescence has been described as a period of challenges and expectations that span both childhood and adulthood and can be paradoxical at times[1]. Nonetheless, the doctor must learn to negotiate these challenges to help the adolescent who has unique medical needs and risks.

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UNDERSTANDING ADOLESCENTS

The term adolescent friendly consultation may be inappropriate at times as some adolescents may regard doctors with suspicion or even as agents of parents seeking to interfere with or control their lives. Before understanding how to conduct useful consultations, it is important to recognise five key differences between assessing a full fledge adult and an adolescent:

1. An adolescent may not initiate the consultation and may be reluctant to reveal private aspects of their lives in front of their parents.
2. Adolescent expectations may not mirror those of their parents or guardians.
3. Adolescent may function differently in different settings so it is important to obtain information from multiple sources and not just from parents but from peers in school and school staff.
4. The adolescent's functioning and problems must be approached from a developmental context. An adolescent who stalks a classmate after being threatened with a breakup may be using inappropriate means of coping due to inexperience.
5. There is a need to form therapeutic alliances with more than just the adolescent, such as the family members, the school staff and other community resources.

CONDUCTING ADOLESCENT-FRIENDLY CONSULTATION

There are three prerequisites for conducting the adolescent friendly consultation:

The right situation

By this I mean that the environment for the consultation must be right. Adolescents do not like to be treated like children and the consultation room should be clinical enough not to appear like a nursery class. Make sure that all conversations start with the adolescent in the room and refrain from speaking to parents and guardians privately without the explicit assent of the young person. Balancing this with the need to secure the respect and trust of the adults is something that the family doctor must do well. Try to see the adolescent with the family members initially, explaining to the adolescent the need for separate interviews when necessary.

The right person

Not every doctor is good with adolescents. Characteristics of an adolescent friendly doctor would be one who shows compassion and kindness yet firm when necessary without the appearance of being harsh. A warm personality is always useful. It is particularly important not to be seen as being aligned with parents or teachers but to show respect to the

adolescent as an individual with privileges and rights. Being able to negotiate the adolescent's needs with the other adults' expectations is key to being an adolescent friendly doctor. It is good practice to start speaking with the adolescent followed by separate sessions with parents and allowing for combined interviews of the whole family. Do observe the dynamics of the family interaction such as sitting arrangements and how the family members interact during the interviews.

The right questions

Essentially the interview should be spent on trying to understand the adolescent and the reasons for presenting to the doctor. The purpose of the interview is to establish the answers to several questions;

- Who is this adolescent? This answer will help the doctor understand the background, family and educational level of the adolescent. It will help the doctor understand the context in which the adolescent presents with their problems.
- What is the problem? This is the presenting problem that the child presents with and the doctor should know this at the end of the interview.
- How/Why did the problem arise? This question helps the doctor answer the etiological factors in the adolescent's difficulties such as personal and environmental factors.
- What other problems must we consider? Helps to look for multiple problems that the adolescent face. For example, an adolescent with epilepsy may also have learning disabilities and financial difficulties which reduce his/her access to treatment.
- What are the expectations of the family and the child? This final question helps the doctor remember that the adolescent and their families may have entirely different reasons for seeing the doctor other than for a diagnosis. For example, the adolescent may need a medical certificate to be excused from an activity. Knowing the expectations allow us to meet it or explain why it cannot be achieved.

COMMUNICATING WITH ADOLESCENT

To properly communicate, some useful techniques are shared below:

Active listening

Active listening is about focusing on the adolescent you are speaking to, in order to understand what he or she is saying. As the listener, you should then be able to repeat back in your own words what they have said. This does not mean you agree with, but rather understand, what they are saying. Listen with your ears but also with your eyes and other senses. Use non verbal cues to acknowledge that you understand such as nodding or saying "uh-huh". Don't always agree or disagree but encourage the train of thought. Actively respond to questions and use your body position (e.g. lean forward) and attention to encourage the adolescent and signal your interest. Give the speaker time and space for rest after talking and express appreciation for the sharing to build rapport and encourage dialogue. Check if you have understood by restating the key points and summarising what was said. Ask questions if unclear. Another way of showing understanding is to paraphrase by stating what is being said in your own words.

Reflecting feelings

This is a way of asking about or acknowledging feelings that are attached to what is being said. Sometimes, this can be obvious (e.g. the adolescent starts to speak in a fierce tone) but at other times, it can be subtle (e.g. adolescent looks down because he is sad). Making a tentative or tactful approach is often best. Also, especially regarding the emotional component of messages, both listening and looking for verbal and nonverbal cues – the tone and volume of the voice, facial and other bodily gestures, eye contact and physical distance - will facilitate more accurate reflection.

Communication barriers

These can be divided into 2 main areas:

Those that obstruct doctors from communicating with the adolescent

In this category, it can be things such as doctor having way too many patients and not enough time to speak with their patients. Physical barriers such as a desk between the patient and doctor can sometimes prevent effective communication. Setting a consultation table with a comfortable chair on the side of the desk (rather across it) makes the doctor more accessible. Adolescents like to be able to connect easily with their doctors and one way is to offer an email address for patients to ask questions. Some doctors are afraid that patients will deluge them with mail. Make it clear to the adolescent that replies will be when you are able and do not raise expectations that you will always answer instantly. An adolescent friendly website can also be set up if you intend to work widely with young people.

Those that obstruct adolescent from seeking advice from the doctor

These barriers would include being aloof and difficult. Understanding the culture and lingo of youths are important in allowing them to feel comfortable with you. Many adolescents have a natural distrust of adults so it is imperative that you put the adolescent at ease from the very beginning. Common teachings such as, "Don't speak until you're spoken to" and "Children should be seen and not heard" result in many adolescents holding back from communicating their thoughts and feelings to others.

STRATEGIES FOR ESTABLISHING RAPPORT

There are many ways to establish rapport and here are some strategies to employ:

- A proper introduction by the doctor to the adolescent and their parents or guardians are critical in establishing rapport. I usually advise doctors to explain their roles and

what they are trying to do. Do not assume the adolescent is aware of the purpose of the visit, which may have been arranged by other adults including school teachers and counselors.

- Spend time discussing about the background of the adolescent such as their family composition, where they stay and what outside activities including hobbies. Get them to talk about their school and their peers. This will usually set the adolescent at ease and provides valuable information in understanding the adolescent.
- If the adolescent is willing and open to talking, letting the adolescent talk for awhile on topics or areas they feel like talking about. This will also help them to be more comfortable. However, be prepared for personal questions and if you don't feel comfortable, just state how you feel and move on.
- Be prepared with a standard set of questions but do allow deviations so as to move the conversation along. It is usually good to move from less threatening health subjects such as review of systems to more difficult topics such as sexuality and drugs.
- Take the adolescent seriously and even if you disagree with the comments, do not dismiss them lightly. Do not take copious notes and spend all your time staring into your computer screen. Adolescents may mistake that for lack of interest and rapport is lost.
- Deal with the expectations and concerns of the adolescent instead of just speaking with the parents. These may be diametrically opposite and the good doctor must find an acceptable middle ground.

DESIGNING CLINICS FOR ADOLESCENTS

The space that adolescents are seen for their care can also be helpful in their overall care. Adolescents prefer not to be treated as children and prefer private waiting areas. Materials in the waiting area and clinical offices appropriate for their age group is helpful. The examination table should not face the door and curtain should be available for privacy. If possible the desk in the office should be oriented so that the adolescent sits beside the desk, not across it. If space permits, a sofa settee would be a better way to communicate from.

Time can be a problem with the adolescent visit particularly for the first visit. More time should be allotted for this visit to allow for discussing their past medical and psychosocial history. Multiple visits to the doctor is acceptable and can be planned beforehand to complete the assessment process which may include a physical examination. Most adolescents attend school so afternoon appointments are usually preferred.

It is helpful to place books, pamphlets, hot line numbers (such as Samaritans of Singapore's hotline 1800-221-4444 or other help lines such as Pregnancy Crisis Service (Family Life Society) 6339-9770, Touchline 1800-377-2252) and reliable web site information in the waiting room or office on topics such as puberty, mental health, sexually transmitted diseases, sexuality, and contraception.

HEADSS ASSESSMENT

There are several methods that can be used to obtain medical and psychosocial information. Traditionally this is through a face to face interview with the adolescent and family members. Another method is through a structured self addressed interview form. There has been a growing interest in using computerised assessment protocols some of which are web-based. Some adolescents may actually prefer this. One approach that was developed at the Children's Hospital of Los Angeles is the HEADSS interview. This is an interview instrument for finding out about issues in adolescents' lives. It was developed by Cohen and colleagues[2,3]. It consists of a self report around the acronym HEADSS.

Home

Where does the adolescent live and who lives with the young person? Do they have their own room? What are relationships like at home? What do parents do for a living? Have the adolescent been institutionalised or Incarcerated before? Were there any recent moves? Has the adolescent ever run away from home? Are there new people in home environment? One method of chronicling this may be through drawing a genogram.

Education and employment

Ask about the school /grade performance – any recent changes? Was the child in learning support programmes? Any dramatic past changes? Favourite subjects – worst subjects (include grades)? Any years repeated/classes failed? Suspension, expulsion, dropping out? Future education/ employment plans? Any current or past employment? Relations with teachers and employers – school or work attendance?

Activities

What kind engaged, by themselves or with peers (what do you do for fun?, where? when?) With family? Any sports – regular exercise? Religious activities, clubs, projects? Hobbies – other activities? Reading for fun – what? Television – how much weekly – favourite shows and music? Does the young person drive? History of arrests or probation?

Drugs

Use of legal (e.g. sleeping pills) or illegal drugs? Use by peers? Use by young person? (include smoking, alcohol) Use by family members? (include smoking, alcohol) Amounts, frequency, patterns of use/abuse? Source – how paid for?

Sexuality

Orientation? Degree and types of sexual experience and acts? Number of partners? Masturbation? History of pregnancy/ abortion? Sexually transmitted infections – knowledge and prevention? Contraception? Frequency of use? Comfort with sexual activity, enjoyment/pleasure obtained? History of sexual/ physical abuse?

Suicide/Depression

Symptoms of depression including low mood, loss of interest in previously enjoyable activities (anhedonia), sleep disorders (usually induction problems, also early/frequent waking or greatly increased sleep), tiredness and fatigue, appetite/eating behavior changes (either reduced or increased), feelings of guilt and sense of hopelessness, becoming withdrawn and isolated, suicidal thinking, inability to concentrate and focus on schoolwork.

Other symptoms of note include: History of past suicide attempts, depression, psychological counseling, history of suicide attempts in family or peers, history of recurrent serious 'accidents', psychosomatic symptomatology, suicidal ideation (including significant current and past losses), looking sad on interview, avoidance of eye contact – depression posturing, preoccupation with death (clothing, media, music, art).

RISK ASSESSMENT

Risk assessment is a necessary skill for doctors to acquire when they deal with adolescents. The purpose is to assess for risky behaviours and to see if the adolescent is of danger to themselves (e.g. suicidal) or to others (e.g. aggression). A full risk assessment is beyond the scope of this article and doctors who are interested are advised to read further in the subject. Two important aspect of risk assessment are described below.

Suicide risk assessment

The critical question to ask in suicide risk assessment is whether the adolescent has thoughts of killing themselves. The assessment should them move towards 6 main areas of:

- Hopelessness of the situation and in the emotion of the adolescent;
- Suicidal intention (in terms of motivation and planning);
- Lethality (dangerousness) of the method;
- Environmental resources such as family and friends;
- Mental state of the adolescent and evidence of the 3 most common conditions associated with suicidality; Schizophrenia, Mood disorders and Substance Abuse and Dependence;
- Demographic risks varies from country to country but in Singapore, being male, older age (between 15 to 19) and ethnicity (Indians and Chinese) are notable risk factors.

Risk of violence assessment

Violence can be predicted and if a doctor needs to assess if an adolescent is likely to be aggressive. The following are some predictive factors, if present indicate increased risk of violence:

- Seriousness of the aggressive act;
- Nature and quality of the act;
- Characteristics in the victim;
- Evidence of intention and motive to hurt;
- Was the aggression in a group or self directed;
- Attitude towards the act and victim empathy;
- Evidence of compassion for others and towards animals;
- Past behaviour and previous offences.

RECOMMENDED READINGS

Cai YM, Fung D (1998): Help your child to cope: Understanding Childhood Stress. Times Editions, Singapore.

Graham P (2004): End of Adolescence. Oxford University Press. UK

Ang R, Fung D (2006): Seeing Red: Help your child deal with anger at home and in public. Singapore National Printers, Singapore

REFERENCES

1. Coupey SM. Interviewing adolescents. Pediatr Clin North Amer 1997; 44 (6): 1349-64.

2. Goldenring, J, Cohen, E (1988) Getting into adolescents heads. Contemporary Pediatrics, July: 75-80.

3. Cohen, E, MacKenzie, R.G., Yates, G.L. (1991). HEADSS, a psychosocial risk assessment instrument: Implications for designing effective intervention programs for runaway youth. Journal of Adolescent Health 12 (7): 539-44.

LEARNING POINTS

- **Adolescents may regard doctors with suspicion or even as agents of parents seeking to interfere with or control their lives.**
- **Important to recognise the key differences between assessing a full fledge adult and an adolescent.**
- **The right situation, the right person and the right questions are pre-requisites for conducting the adolescent friendly consultations.**
- **Active listening, reflecting feelings and awareness of communication barriers are useful techniques for communicating with adolescents.**
- **HEADSS assessment is a tool to obtain medical and psychosocial information of an adolescent.**
- **Risk assessment for suicide or violence is essential when dealing with troubled adolescence.**