A Challenge for the Pediatrician: The Adolescent Interview
Amy Middleman, MD

A CHALLENGE FOR THE PEDIATRICIAN: THE ADOLESCENT INTERVIEW

AMY B. MIDDLEMAN, MD
I will be talking about the adolescent interview. The goals for this talk are for the audience to understand why the adolescent interview is different from the general pediatric interview. I will discuss how you can set the stage for a successful adolescent interview and how to obtain critical psychosocial information from teens.
Why is the adolescent interview different? Adolescence is a unique developmental stage of pediatrics. It is an exciting time. It can be divided into early, middle and late development. Early adolescence is when puberty is starting. Kids are starting to get concerned about whether they look normal, they start to spend more time in their room and on the phone, and they have groups of friends that are of the same gender. In the middle stage of adolescence, teens begin to test themselves, separate themselves from the family, and figure out who they are. Cognitive development changes and abstract thought processes develop. Where before you might have had to talk to them in concrete terms, you can now discuss with them health risks in an adult manner. It’s also important that they want to be treated differently and should be. They will eventually be going to an adult doctor and they’ll be responsible for their own medical information. We address that issue in our initial visits. It is also important that adolescents know and understand your policies for confidentiality. In Texas, physicians have the right not to maintain confidentiality. One of the most important aspects of adolescent medicine is that we shift toward psychosocial information and emphasize behaviors.
Regarding morbidity and mortality, we see a shift from disease and trauma to the results of one’s own behavior. The top three killers of adolescents (15-24 years of age) are motor vehicle accidents, homicide and suicide. In at least 45% of motor vehicle deaths we see involvement of alcohol.
The Youth Risk Behavior Survey is distributed by the Centers for Disease Control and Prevention. It is done every two year in schools. It is a random cluster design. They choose schools from all over the country. It gives us information on where trends are going with regard to risk behaviors. They conduct the surveys in grades nine through twelve. The surveys give us a snapshot of the behaviors that lead to the morbidity and mortality among this population. These surveys are collecting information from a population that is still connected to our system. It underestimates, though, what is truly happening as it does not capture out-of-school, truant, and homeless youth. Seventeen percent of surveyed youth carried a weapon at least once in the previous thirty days. Five percent carried a gun. This is why it is always so important to ask your adolescent patients where they are in terms of depression. Nineteen percent considered suicide in the past twelve months. That’s a tremendous number. The concern is that when they consider suicide, teens don’t often have a lid on their impulsivity. So the impulsiveness factor plays a major role in suicide among adolescents.
Seventy percent have tried cigarettes at some point in their life, and 25% smoked at least one cigarette every day for 30 days. Fifty percent had at least one alcoholic drink at least one day of the past 30 days. Forty-seven percent had marijuana, 9.5% cocaine, 50% have had sex in their lifetime. The national mean age of sexual debut in this country is 16, but for those people who are working in very urban areas, usually the mean age of sexual debut is around 14. And at least 8% report having had sex before the age of 13 years. So it’s important to keep that in mind as well as we see our adolescent patients. There is a lot of screening that needs to be done for these folks.
How do you really set the stage for success? I work in an adolescent medicine clinic. I see only adolescents. So it’s very easy for me to have a setup that’s adolescent friendly. But for physicians who see a lot of children as well, it’s important to consider what you want to do for your adolescent patients, and whether or not you might want to set up something a little different for them. Some suggestions include scheduling adolescents, for example, on all Thursday afternoon and evening. That can really be helpful because then adolescents don’t walk in, see screaming babies and mothers about three years older than they are, and think they’re in the wrong place and leave. If you schedule adolescent patients all together, they see other adolescents in the waiting room. You can clear the toys away. You can work with the decor a little bit to look a little bit more adolescent-friendly. The problem is that when you do have Mickey Mouse on the walls, it makes it a little bit hard to say, “Okay, now I want you to take responsibility for your own health.” If you really want your patients to take responsibility, you have to actually give them the respect. I think it is helpful to change the waiting areas. It is important to have appropriate pamphlets available for teens and their families during the appointment wait time. You may want to have some pamphlets in the exam room where the patient is alone because it’s very unlikely that a patient will pick up an STD pamphlet with their mother and little brother waiting with them. But you can certainly have in the waiting room, pamphlets on talking to your daughter about sex or the first pelvic exam. But the really sensitive pamphlets, where you want to get information to teenagers that are at highest risk, it’s nice to have those in the exam room because you almost always leave the patient alone to dress or undress, and they can get those pamphlets and put them in their knapsack without anyone knowing.
Setting the Stage (continued)

- Establish the first adolescent visit as a new visit with new rules
- Emphasize new responsibilities of the patient
- Discuss game plan with parents and teens together
- Establish and discuss confidentiality policies with patients and families

When I see an adolescent patient for the first time, I establish with the patient that this is going to be very different from the pediatric visits they’ve probably had in the past. It may not be, but it may very well be. If you see a lot of pediatric patients, it might be helpful to determine an age at which you’re going to draw a line and revise the relationship a little bit. We have teen advisory board meetings for our section, and what they tell us is, “I love my pediatrician. I go to him all the time. But he’s like my dad. I can’t talk to him about sex!” So unless there is a significant shift in the way you set up the relationship, you may not send them the message that it is okay to talk about this stuff now. It is important to emphasize new responsibility for the patient. I tell them, “I’m your doctor. I’m not your mom’s doctor. So I’m going to be asking you all the questions. Now on your first visit, you’re probably going to have to ask your mom some questions about your past medical history and your family history. All I ask in return is that you remember the information, so that you can give me the information next time.” I discuss the game plan for the visit with parents and patients in the room together, so there is no confusion.
It is important to know your state’s laws regarding confidentiality and competence of care for minors, and to remember that parents have access to the chart unless under certain conditions – and again, it changes state by state – it would do more harm to the patient to have the parent see the chart. These laws do get very involved, and it is important to have some familiarity when you’re embarking on this. It’s important to establish exceptions for confidentiality for patients, and I make it very clear. I tell them that I will keep the information confidential unless I feel they are at significant risk of harm, or going to harm someone else. That gives me some leeway. So if they’re using cocaine daily, I will consider that to be significant risk of harm. I make sure that they understand that sexual abuse is something I must disclose, and that their parents will know by the end of that visit. I also make clear that if they tell me they are going to harm or hurt someone else, that I’m going to need to discuss that with a parent that day. I also tell them that if I’m going to break confidentiality, I will always tell them first. They will always have the option to discuss it with their parent alone first. I can help them discuss it with their parent, or I can tell their parent. One way or another, that information will get across.

It is important to have some methodology established to send confidential labs. For example, you have a sexually active teen who wants a pelvic exam. You want to send a GYN probe and you don’t want the parents to know. You have to have some sort of policy. If you’ve decided you are going to provide confidential care for those situations, you have to have some policy for sending those labs. The laws are written very specifically that physicians in Texas may keep information about these issues confidential from the parent. It does not say must. So it does depend on the Physician: and it is important to go over all of those policies with your patients before you see them. What do I do when I find that a girl is pregnant? It is very physician-dependent. You may keep that confidential, or you may not. The way we usually handle
it in our clinic is if a girl is pregnant, we usually ask her and encourage her to share this information with parents. We always encourage people to share information with parents because a lot of times teens don't realize that their parents are actually their greatest allies, and usually are best equipped to help them through these sorts of situations. And we try to get them past the, “Oh, my gosh, my mom will kill me!” stage.

In our clinic, if the adolescent is adamant that she does not want her parents to know, we will maintain her confidentiality as long as she continues to seek appropriate care that puts neither her nor the fetus at risk. So if she takes responsibility for making and showing up for the OB appointment, getting her blood pressure and urine checked, and coming in every week, then we usually will allow them to disclose the information in a way that they are most comfortable. At every visit we encourage them to disclose that information. It’s important, whatever your policies are, to make sure that your patients know them before they start disclosing sensitive information to you.
The Importance of Confidentiality

- Increases willingness to disclose information and seek health care
- Increases adolescents’ perceptions of receiving adequate health care
- Health professional organizations support provision of confidential care to teens: AMA, SAM, APHA, ACOG, AAP

It is clear that confidentiality is extremely important in terms of the delivery of care to adolescents. It increases willingness to disclose information and seek health care. It increases adolescent perceptions of receiving good health care. And almost all of the health professional organizations support the provision of confidential care for adolescents.
How do you obtain all of this health information? A monograph for the guidelines for adolescent preventative services has been developed by the American Medical Association. It is very clear about what is expected during an adolescent visit. A complete physical examination is only recommended once during early adolescent years, once during middle adolescent years, and once during late adolescent years. Annual visits are not necessarily for this full physical examination. Considering the causes of morbidity and mortality among adolescents, it is important to look at the psychosocial environment of these patients and screen them for health risk behaviors regardless of what their physical examination shows. The guidelines are hard to get done in a half hour visit.
So, what do we do? Well, first of all, while the patient and the parent are still in the room, I get a family tree. It is very important when getting an adolescent history, because there are questions that you can ask during the family tree that give you tremendous insight into the psychosocial environment of the patient, which will help you understand the risk for this patient. There is a theory of a clustering of risk behaviors, the Jessor and Jessor theory that is very well known in adolescent medicine. Essentially it says that the psychosocial environment plays a tremendous role in the risk-taking behavior of adolescents. Adolescent risk behaviors tend to cluster because the same psychosocial environment that engenders initiating smoking also is going to engender potential depression, potential early sexual debut, etc. So the family tree is an extremely important piece of information to get. It helps in the understanding of the medical issues and the family relationships. After you’ve asked about the family history of hypertension, cancer, liver disease, kidney disease, seizure disorder, asthma, etc., it is then important to ask about family history of mental illness, suicide, depression, eating disorders, alcohol abuse or drug abuse. All of these can play a major role in whether or not your patient is at risk for those very same things.
This is a sample tree. This is not as unusual as you would think. Here’s a 14-year-old girl with a 34-year-old mother and a 43-year-old father. The mother had her when she was 20. That, you know, doesn’t put her at tremendous risk for abuse or those sorts of things that we know happen with teen pregnancies. To develop the family tree, my questions usually are, “How old is your mom? How old is the dad? Are your mom and dad still together?” Then, “How many children do your mom and dad have together? Same mom and same dad? Does your mom have any other children with anyone else? Does your dad have any other children with anyone else?” If you were to ask her, “How many brothers and sisters do you have?” this 14-year-old girl will probably say, “One sister and three brothers.” But it doesn’t give you any clue as to the complicated social relationships that she might be dealing with in her family. And that is what is critical to understand. It’s also really important to see, what dad is involved in. Dad is an alcoholic. Would you know that if you had just asked, “Is there any family history of heart disease, lung disease, etc.?” When you got to liver disease in your family history list, you might have gotten the information. But if it hadn’t progressed to cirrhosis, you would have missed it. That is an important thing to know about a family when you’re assessing risk for an adolescent. Usually we ask simply, “Is there any history of significant drug use or alcohol use in the family?” Sometimes parents will pull me aside if it’s having a significant effect on the family. They really want the physician to know, to get the whole picture. It’s wonderful how open families are when asked these important health questions.
We use the HEADDS mnemonic. There are different versions, but all of them basically have the same components. It's the way of getting a psychosocial history from the patient in an organized way. We always have the parent leave the room before we start the HEADDS portion of the exam. I don't have the patient change clothes because these are personal questions. Because you have to develop a rapport with patients, it is hard to do that with a patient naked, shivering on the table and wishing they had their underwear on.
The H in HEADDS stands for Home. In our interview process, we try to go from the least sensitive questions to the most sensitive questions. We ask, “Who lives at home? Does everyone get along? Is there any violence? What do the parents do for work? Are there any recent family stressors?” “How is the patient punished?”
If you ask a patient how he does in school the answer is 98.5% of the time “fine.” You have to ask what their grades are because “Fine” could mean D’s, and “Fine” can mean A’s. Ask them, “What were your grades last semester? What did you get specifically?” “What is your favorite subject in school? What is your least favorite subject? What do you want to do when you get older? How are you going to get there?” It is important in developing a relationship with adolescents, for them to know that you care about them as people and not just as numbers clicking through the door, because I think that adolescents have this idea that just about everyone is treating them as a number.
Activities

- What happens after school...
- Hobbies...
- Sports...
- Television...
- Friends...
- Support systems...

In activities I ask them “What do you like to do after school?” Understanding their involvement in extracurricular activities, sports, television, friends can be very helpful. If an adolescent patient can’t identify a best friend, that should be a red flag for you. If an adolescent patient can’t tell you the last time they had a really good knee slapping time that should be a red flag for you because 19% of kids who are depressed considered suicide in the past twelve months.
Diet and exercise are your prevention category and a great way to screen for eating disorders. A 24-hour diet recall only takes a couple minutes. You can get a good sense of what they’re eating, and usually you can make some interventions in disordered eating patterns. Veggies, calcium, iron are usually woefully low in these patients. A lot of times we will recommend a multivitamin for some of these patients. And it’s important that they exercise.
Depression

- Sleep, appetite, guilt, hopelessness, irritability, social withdrawal...
- History of depression/counseling...
- Thoughts of suicide...
- Prior suicide attempts...

One of the most important things to recognize about adolescents is that their expression of depression may not be the same as it is among adults. Adolescents who act out may very well be showing signs of depression. Irritability, truancy, self-medication with drugs, all of these can be signs that patients may be depressed. Their behavior may make you and their parents angry. In that way it sometimes is not recognized as depression; it is thought to be something else. Ask if they’ve ever had a history of depression counseling, thoughts of suicide, prior suicide attempts, which is the number one predictor of suicidality.
I always ask the drugs part first. When you ask about drugs, it’s important to ask how much, the frequency, and whether they consider this a problem. We can sometimes strategize together to decide whether or not they are at significant risk of harm, and whether or not they are going to do something about their behaviors if they’re concerned. Inhalant use is important to ask about because about 30% of inhalant deaths are first time users. Usually it is 11 and 12-year-olds who are starting to experiment with inhalants. You will want to do some anticipatory guidance about that. With regard to sex, I just ask it directly “Have you ever had sex?” You also need to ask “Well, what does that mean for you? Have you had sex with males? Females? Or both?” At least 10% of kids are questioning their sexuality and their sexual orientation in the high school years, so it’s very important not to alienate them by using a heterosexual bias, and then potentially alienating them from the medical health care system for years because they are feeling very pigeonholed. A lot of times when you ask the question, “Are you having sex with males, females, or both?” you get a laugh or look of indignation. It’s important to model tolerance, “That question may seem odd to you, but lots of people choose to live different ways, and that doesn’t make them any different.” Those types of comments allow them to feel comfortable disclosing differences to you because they may very well be testing your response. If you react in a different way, “Oh, I know I have to ask that question...” You’ve shut the door. So it’s very important to model tolerance and be as nonjudgmental as possible. Hopefully we can help them with some healthy decisions and choices. I then ask about protection from STD’s. I keep that very separate from protection from pregnancy because they are different things now. I also ask about sexual abuse or sex trade work. We deal with some homeless youths. I think that’s a particularly important question for kids who’ve been on the street or who have been truant a lot. They may feel the need to trade sex for shelter, clothing, food, and drugs. Finally, I usually ask if the patient carries a weapon, if they feel unsafe, what are their fighting behaviors, have they ever been approached to be in a gang?
Once you get this information, it can often be overwhelming. The Guidelines for Adolescent Preventative Services has a GAPS strategy, which gives physicians permission to slow down, gather the information, and assess it further. If you see something that’s concerning, ask more questions. Problem identification means to identify what the true problems are. For me it’s a prioritization process. If you’ve got 15 minutes to half an hour, and you’ve just found they’re abused at home, they are taking cocaine, they thought about suicide last week, your head is going to explode if you try and actually take care of all that in 15 minutes. It’s an overwhelming prospect. I usually deal with one problem, and make sure they come back for the other problems over multiple visits. Make sure you have a medical diagnosis of some kind - menstrual cramps, acne or something that they can come back for medically. Often psychosocial problems really need repeat visits and are really not recognized for billing or insurance purposes. So you can address them during follow-up medical visits. And it’s important to start strategizing about solutions.
Here are some helpful hints for the whole visit. Ally yourself with the patient. It’s important that the patient feels that you are their doctor, and that you are not going to discuss everything with their parent. At the end of the visit, I always have the parent come back in the room. Before I invite the parent back in, I usually ask the patient “Is there anything that we discussed today that you would prefer I not discuss with your parent in the room?” Then they can tell me specifically what they don’t want me to talk about. If I have a problem with what they don’t want to discuss, we talk about it before the parent comes in the room. It’s a nice way to really get a gauge of what the patient really is concerned about. The patient may be more concerned about you telling the parent that she’s smoking three cigarettes a day than she is about you telling the parent that she’s having sex. If I can share as much as possible with the parents in order to help the team move forward, then that’s what I want to do. It’s important to avoid judgments, encourage patient autonomy, ask open-ended questions, avoid cultural and heterosexual bias, and model tolerance. I failed to mention that when I talk about confidentiality, and about the questions I’m about to ask with the parents out of the room, I also make sure I let them know that I ask everyone all of these questions. “These are standard questions. I’m not writing a novel. I just really want to get at how I can best help you preserve your health.” That can help because adolescence is a very egocentric time. It’s very helpful to congratulate and reinforce positive health behaviors. Because so much of adolescent behavior can be dangerous, it’s really important that kids not come to the doctor to hear only lectures but also to hear, “That’s really terrific that you’ve stayed away from alcohol. I congratulate you. That’s a really great way to stay safe.” Congratulate them on the good things they’re doing as well as give them helpful information on the not-as-good.
Summary

- Adolescent health care requires a shift in approach and focus
- Adolescents must be taught to interact independently and take responsibility for visits with health care providers
- An extensive psychosocial history is a key component for premium adolescent health care

I hope I have conveyed that adolescent health care requires a shift in approach to the patient, that adolescents must be taught to interact independently and take responsibility for the visits that they have with the health care arena, and that an extensive psychosocial history, including a family tree, and delving into some of those more personal issues, can really be helpful in providing the best adolescent health care.
I did include some selected references. If you’d like more, feel free to contact me. You can get a copy of YRBS data online at the CDC Web site, and I believe most of the GAPS information you can receive from the AMA Web site.

With regard to testing an adolescent for drugs when requested by the parent, it’s a dilemma for a lot of physicians. I usually ask the parent why they want the child drug tested and what they hope to gain. The dialogue may go something like this:

**Physician:** “Why do you want the drug test? What will it help you with?”

**Parent:** “Well, I want to know if she’s taking drugs.”

**Physician:** “Well, what makes you think she is taking drugs?”

**Parent:** “Well, she’s got this behavior, her grades are going down, I don’t like her friends.”

**Physician:** “So have you talked to your child about that?”

**Parent:** “Well, yes, I’ve told her I don’t want her being around those friends.”

**Physician:** “But have you talked to her about drugs? Have you asked her if she’s taking drugs?”

**Parent:** “Well, she says no.”

**Physician:** “Okay. So let’s take a step back. If I do the drug test, what will that accomplish?”

**Parent:** “Well, I’ll know she’s taking drugs.”
Physician: “Well, you already have a pretty good basis to judge whether or not there’s something wrong. It’s really whether there’s something wrong that you need to know. Something is obviously going wrong. Does your daughter want the drug test?”

Parent: “No. She said she will absolutely not have the drug test.”

Physician: “Well, so how are we going to accomplish some sort of understanding if, you want a drug test, she said no, and we force her to get a drug test. What will that accomplish?”

Parent: “Well, I’ll know she’s taking drugs.” If a kid is taking drugs, then the parent probably already has a sense. It’s not really whether or not you confirm it. It’s what’s going to go on with that relationship and how they’re going to manage it. If I get a drug test on a patient who doesn’t want the drug test, I’ve essentially told the patient, “I’m your mom’s doctor. I’m not your doctor.” I’ve also said, “This medical system is not safe for you. It doesn’t really matter what you want. I’m going to do what I want.” And I don’t think I’ve helped that parent-child relationship because what they really need to do is talk more about it. The kid may not admit that they’re taking drugs, but then again, what difference does the admission really make, because that’s not really the problem. The problem is risk behaviors and health and safety. So usually what I do is, I say, “Well, let’s go in and ask your child if she’s willing to be drug tested. If she’s not, then we have to discuss why we will or will not drug test her.” In most cases we do not drug test. If the patient says no, that tells me that we may have a drug issue here. I probably already know that from other things. The real key is getting the child to talk to the parent and share that with the parent. The mother may be entitled to have the drug testing done. It doesn’t have to be at my clinic. It can be somewhere else. I feel strongly that if I have made an alliance with that patient, expect them to come back to see me, and help them with their health care, I need to find another way around that situation that maintains the patient’s trust in the health care system.