What teenagers want: Tips on working with today's youth

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Do you have an adolescent-friendly practice? Adolescents, especially boys, underutilize the health care system (1). Youth tend to use emergency departments or drop-in clinics, making it difficult to develop an ongoing relationship with a medical professional. Even though they are generally a healthy population, we know that adolescents have medical needs that must be addressed. Twenty per cent of teenagers in North America have a serious health problem, most commonly, obesity, asthma and eating disorders (2). Furthermore, the top three causes of death in the 12- to 18-year-old age group – motor vehicle traffic-related injury, suicide and homicide (3) – are not related to disease, but to modifiable risk-taking behaviours. Altering these behaviours requires partnership with the teenager. Thus, building a trusting and ongoing relationship with a provider becomes central to preventive health maintenance in this population. The goal of the present paper was to enhance the health provider's ability to partner with teens by offering clinical pearls in the area of history-taking, providing practical pointers for negotiating the difficult issues around confidentiality and tips on integrating the role of families in the setting of adolescent-friendly health care.

YOUTH TALK

Adolescents are often remarkably forthcoming about themselves when they feel safe. Keys to creating such an atmosphere includes the assurance of confidentiality, a nonjudgemental approach and recognition of the youth's personal autonomy. Conveying a nonjudgemental attitude requires critical examination of one's own beliefs, acceptance that those beliefs might not be universally shared, and recognition of how the teenagers' beliefs and actions might pose a potential threat to their health. Focusing on health promotion rather than value promotion allows health care providers to build a nonjudgemental and inviting atmosphere.

Interview adolescents alone

No matter how open teenagers are with their parents, or how low risk their behaviour may appear to be, sensitive issues should be broached with the teenager alone. Teenagers will spare their parents from hearing information that is in some way painful or that will risk altering the parent's perception of the teenager. Creating that 'alone time' depends on how the office is set up, as well as the age of the adolescent. Calling patients from the waiting room yourself allows some control as to who will be brought into the examining room, initially. Older adolescents typically feel comfortable coming in alone, and parents can be reassured that they will have an opportunity to speak with you later in the encounter. With the younger or very anxious adolescent, or in situations in which the parent is already in the room (such as an emergency room visit), an abbreviated history can be obtained which should address the immediate concerns of the parents, as well as allow the parent or caregiver to provide key details (this is also an obvious time to obtain the family history). Parents can then be asked for some time alone with the adolescent as a means of getting to know them better and addressing any of their own health concerns. For the most part, parents are usually quite willing to do this, if a few minutes are taken upfront to explain the concept of adolescent-friendly care.

Screen for high-risk behaviours

The popular HEADSS (4) psychosocial screening tool is presented in Appendix A. There is no doubt that addressing psychosocial risks is time consuming. Teens are less likely to be forthcoming if they perceive that their provider is going through the motions versus being genuinely interested. Therefore, a quick run-through of a checklist is likely to have a low yield. Pose open-ended questions and practice active listening to favour a more thorough discussion. When short on time, one strategy is to address one or two psychosocial domains at each visit. Otherwise, assume you get only 'one shot' at risk reduction, given teens' sporadic use of the health care system. Because of the high mortality and morbidity associated with depression, all teens should be screened for depression, beyond the HEADSS interview (Appendix B) (5).

Paper and pen (6) or on-screen tests (7) have been developed to prescreen for high-yield areas of discussion. This can provide an efficient alternative to the 30 min to 45 min required for the HEADSS interview. The obvious caveat is that all positive responses must be addressed.

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'Sometimes the teenagers I see have questions about sexuality, but are uncomfortable or afraid to ask. Do you have any questions? I usually ask all my patients if they are attracted sexually to (or interested in) women, men or both? What about you?'.

Or

'Lots of teenagers tell me they have tried drugs when they are out with their friends. Do your friends use any drugs? Have you experimented with any drugs? How about cigarettes, alcohol or marijuana?'

Figure 1) *Examples of how to ask about sexuality and substance use, using normalizing statements*

'Some teenagers I meet have thought about cutting down on their marijuana use because while they like the feeling the high brings, they do not like the feeling the day after. Have you ever felt that way? Have you ever thought you might like to cut back?'

Figure 2) *Example of assessing openness to change*

Get personal

Because the HEADSS interviewing strategy provides a graduated approach from less sensitive to more sensitive areas, it can serve the dual purpose of screening and developing a rapport with the teenager. Providers often worry that questions about sexuality and substance use seem voyeuristic. Both parties are more at ease when the goal of identifying potential health risks is clearly articulated and is seen by both as part of the medical monitoring of teenagers. Normalizing the questions (Figure 1) is a useful technique to foster open dialogue. Furthermore, teenagers should be informed that they have the right not to answer if they do not want to.

Attend to both explicit and implicit information

Teenagers will sometimes use peculiar phrasing or awkward pauses to cue you to an issue they want to talk about, but are not sure how to broach. The long pause before answering whether they are 'sexually active' may be because they are embarrassed, but it may also be because they are trying to decide whether you are interested in hearing about heterosexual vaginal intercourse only, or other sexual interactions as well.

Provide the facts

During the HEADSS psychosocial interview, provide feedback in a factual manner as issues arise instead of an authoritative lecture at the end of the visit. Teenagers are interested in a care provider who displays honesty, experience and knowledge (8). Furthermore, teenagers usually see through the practice of physicians using 'their' slang expressions in an effort to try to relate to them. Remember that while your ultimate objective in risk behaviour counselling may be elimination of all risk behaviour, this is not a realistic objective for any one patient over their lifetime, let alone for one interview. Motivational interviewing (9) is a technique proven to have benefits in this population. This approach can be summarized by providing feedback during the history (educating around risks and benefits, while promoting a sense of responsibility within the teenager). Furthermore, you want to assess where the teenager stands with regard to their openness to change (Figure 2). This ranges from 'not even considering it' to 'thinking about it' to 'ready for action'.

'I am worried about you. I am concerned that you are putting yourself at risk for a sexually transmitted infection or pregnancy by not using condoms or birth control with your boyfriends. Does it make sense to you that I am concerned? I know we have talked about this before, but I wanted to check in and find out if there is anything you think I can do to help you with this'.

Figure 3) *Example of an "I" statement of concern*

It may help to envision your role as attempting to gently nudge adolescents to the next stage. When they are ready for action, you should be armed with a few strategic suggestions and a list of community resources that are available to help. When the situation arises, where high-risk behaviours do pose a risk to the young person's health, use 'I' statements to express concern instead of the 'You' statements, which imply blame and are perceived as alienating (Figure 3).

Involve the patient in the decision of when the parent is present and what information is shared

Some patients prefer to have the parent present during the physical examination, while others do not. Ask patients whether they would prefer you to explain the diagnosis and treatment plan to the patient and parent together. If the parent or caregiver is brought in just at the end of the visit, be clear to establish with the teenager what information they would like to keep confidential. Partner with the teenager by anticipating questions that their parents may have, and discuss with them how they would want their concerns to be addressed.

WALKING THE TALK: THE IMPORTANCE OF CONFIDENTIALITY

Providing confidential health care to adolescents is not always straightforward, and often causes a great sense of uneasiness among medical practitioners (10). Uncertainties can arise as a result of complex dilemmas that may challenge the provider's ethical as well as legal responsibilities. (11) Adolescent patients 'buy' into the doctor-patient relationship with an expectation that their confidences will not be revealed to others without their consent. For paediatricians and family doctors who have cared for children, and have come to know their parents well, the concept of not disclosing medical information to the parents can be uncomfortable. Despite this, it is vitally important that physicians offer confidential care.

As a group, adolescents repeatedly tell us that confidential care matters (8,12). Ford et al (13) showed that when a health visit is started with a brief discussion about confidentiality (Figure 4), adolescents are more willing to disclose sensitive information, and report a greater intent to return to the health provider for further care. Furthermore, the number one reason given by teenagers for not accessing health care is confidentiality (14). Interestingly, a recent study (15) examined whether adolescents who forgo health care due to confidentiality concerns differ from adolescents who forgo health care for other reasons. Boys with confidentiality

'Everything we are going to talk about is confidential – that is we do not need to talk about it with your parents unless you would like to. There are a couple things, however, that I cannot keep secret and you need to know about:

If you tell me you are going to hurt yourself or someone else, I have to let others know.

If you are under x years, and you tell me that someone has hurt or abused you in anyway, I have to let someone know as well.

Does this make sense? Any questions?'

Figure 4) *Example of an explanation of confidentiality and its limits*

Attention: Adolescent Friendly Office

Our staff would like to inform patients and parents that information obtained from adolescent patients will be treated as confidential. If you have questions or concerns regarding this practice or would like further information, please talk to your doctor. Thank you.

Figure 5) *Example of a poster outlining the practice of confidentiality*

TABLE 1
Tips for making your practice 'teenager friendly'

- Health providers have committed to having teenagers in the practice
- Health providers have committed to providing confidential care
- Front office staff are coached on interacting with teenagers
- Front office staff are sensitive to confidentiality issues
- Waiting room has developmentally appropriate posters, reading materials, etc
- Condoms are available for distribution
- Contraception and emergency contraception are available for distribution
- Resource lists for teenagers are available (local, help-lines and Web sites) (Appendix C)

concerns were more likely to suffer depressive symptoms and experience suicidal ideation and suicide attempts than their nonconfidentiality-concerned counterparts. Girls with confidentiality concerns were also more likely to report these mental health risks and risky sexual behaviour.

Laws and practices pertaining to the extension and limits of confidentiality for teenagers vary across provinces and are beyond the scope of the present article. In general, adolescent patients should be aware that the limits of confidentiality apply specifically to issues of safety. For example, risk of self-harm, harm to others, and abuse and risk of abuse in youth.

Educating adolescents and their caregivers about confidentiality for teenagers is key. For example, posters outlining the practice of confidential health care can be placed in waiting areas in an effort to introduce the topic as well as to set the tone for an adolescent-friendly practice (Figure 5). Table 1 lists other suggestions to make your practice teenager friendly.

ALL IN THE FAMILY: BUILDING BRIDGES

Adolescents do not live in isolation; rather, they are interdependent on their families and friends as they make the transition into adulthood. In the vast majority of situations, families are an incredible source of support for the well-being of their youth. The family-centred care (FCC) approach is based on the understanding that the family is the primary source of strength and support, and recognizes that the perspectives and clinical information provided by both the adolescent and the family are very important for decision making (16). The Canadian Paediatric Society also has a family-friendly adolescent health care statement (17) which is also useful.

- **Dignity and respect –** *Health care practitioners listen to and honour patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.*
- **Information-sharing –** *Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information to effectively participate in care and decision making.*
- **Participation –** *Patients and families are encouraged and supported in participating in care and decision making at the level they choose.*
- **Collaboration –** *Patients and families are also included on an institution-wide basis. Health care leaders collaborate with patients and families in policy and program development, implementation and evaluation; in health care facility design; and in professional education, as well as in the delivery of care.*

Figure 6) *Core concepts of patient- and family-centred care. Data from reference 16*

- *16-year-old brought to emergency department*
- *Father suspects drug use and asks for 'secret' drug screen*
- *Drug screen ordered without adolescent's consent*
- *Results are positive*

Figure 7) *The 'secret' drug screen request*

1) Dignity and respect
- *Respect violated for the teenager.*

2) Information-sharing
- *Teenager was unaware of specimen collection purpose and processes.*

3) Participation
- *Teenager's voice and expertise not invited.*

4) Collaboration
- *Teenager was excluded as legitimate family-centred care partner.*

Figure 8) *The family-centred approach as applied to the 'secret' drug screen*

At first glance, it may seem that the tenets of FCC (Figure 6) may be in conflict with respecting the rights of the adolescent concerning confidentiality and privacy, but in actuality, they work to protect all family members' rights and access to information, and foster active participation in the youth's care.

But how does the FCC approach apply to adolescent health? (Figures 7 and 8 list examples). Overall, the approach of FCC prepares youth to participate in medical decision making, and assists families of youth to move from primary decision maker to consultants. It also supports medical professionals to see the young adult as the leader of the health care team and helps build bridges between the youth and their family when dealing with challenging and sensitive issues, while respecting their basic rights to confidentiality.

CONCLUSION

Although the task of counselling a teenager, who has experienced a sexual assault, is suffering from an eating disorder or may be struggling with depression, can appear to be quite daunting, asking the 'tough' questions and providing an

empathic 'space' allows providers to initiate conversations that will hopefully provide the first step to comprehensive adolescent health care. Adolescents who are concerned about confidentiality, 'vote with their feet'. It is imperative to review the right to, as well as the limits of, confidentiality with every teenager who is interviewed, regardless of the setting. The failure of adolescents to seek appropriate medical care, not only contributes to morbidity and mortality in this age group, but also creates public health challenges in many domains. Families are often youths' greatest resource and models, such as the FCC, can be applied to help navigate decisions and dilemmas while balancing caregivers' legitimate concerns with youths' right to confidential health care.

APPENDIX A
The HEADSS psychosocial screening tool

Home	Tell me what your homelife is like?
	Who is at home?
	How does everyone get along?
	Family members/ages/health/substance use/psychiatric history?
Education and employment	Name of school/grade/marks
	Likes/dislikes at school – why?
Activities	What do you like to do for fun on weekends?
	Do you feel like you have enough friends?
	Do you have a best friend?
	Sports/exercise?
Drugs and dieting	Have you tried cigarettes? Alcohol? Marijuana?
	(If experimenting, cover all class of drugs: hallucinogens, amphetamines, rave drugs, anabolic steroids, inhalants, injectible drugs, crack cocaine and over-the-counter medication) Do you have concerns with your weight/shape?
	Have you tried to change your weight/shape in anyway? What methods?
Sexual identity and activity, suicide and safety	Are you interested in the same sex, opposite sex or both?
	Are you dating someone now? Are you having sexual intercourse? What do you use for protection? (sexually transmitted infections or pregnancy?)
	Have you heard of emergency contraception?
	Have you ever had a pelvic examination, a Pap smear or a sexually transmitted infection screening?
	Have you lost interest in things you used to enjoy?
	Have you had any thoughts about hurting/killing yourself? Others?
	Have you been feeling sad, down or depressed much of the time?
	Do you regularly wear seatbelts in the car, helmets when biking, etc.
	Does anyone at home own a gun?
	Has anyone ever hurt you or touched you in an inappropriate way?

Adapted from <http://chipts.ucla.edu/assessment/Assessment_Instruments/Assessment_files_new/assess_headss.htm> (Version current at December 21, 2007).

APPENDIX B
Screening questions for depression

- Over the past two weeks, have you felt down, depressed or hopeless?
- Over the past two weeks, have you felt little interest in doing things?

APPENDIX C
Internet resources for teenagers

- Canadian Health Network (section on youth) <www.canadian-health-network.ca>
- Canadian Association for Adolescent Health <www.youngandhealthy.ca>
- Society of Obstetricians and Gynecologists of Canada <www.sexualityandu.ca>
- Pediatric Health Care Alliance Teen Growth <www.TeenGrowth.com>
- Advocates for Youth <www.advocatesforyouth.org>
- American Social Health Association <www.iwannaknow.org>
- Advocate for Youth for Gay, Lesbian, Bisexual, Transgender, and Questioning Youth <www.youthresource.com>
- MTV collaboration with Kaiser Family Foundation <www.itsyoursexlife.com/>

Versions current at December 11, 2007

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