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Getting into adolescent heads: An essential update

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Jump to: Choose article section... Go

By John M. Goldenring, MD, MPH, and David S. Rosen, MD, MPH

For teenagers, a psychosocial review of systems is at least as important as the physical exam. The popular and effective HEADSS method of interviewing has been expanded to HEEADSSS, focusing on assessment of the **H**ome environment, **E**ducation and employment, **E**ating, peer-related **A**ctivities, **D**rugs, **S**exuality, **S**uicide/depression, and **S**afety from injury and violence.

For most young people, adolescence is a time of growth and development, not illness. When threats to health arise, they are often related to physical and social exploration and experimentation, developmental pressures, and increased risk-taking behavior, all of which are a normal part of adolescent development.

Regrettably, exploration can be dangerous. The most frequent causes of death in adolescents are motor vehicle crashes—more than half of which are related to drug or alcohol use—followed by homicide and suicide. Causes of morbidity include unwanted pregnancy, high levels of sexually transmitted disease, obesity and eating disorders, and the consequences of stress, depression, or other mental health disorders, including alcohol and substance abuse issues. These problems are not easily addressed by physicians with a strictly physiologic orientation, and may not even show up on the standard review of systems that physicians are taught to perform.

The physician who sees adolescents must take an adequate psychosocial history—a psychosocial review of systems, if you will. If this is not done, there is virtually no chance of spotting problems early and making a significant impact on adolescent morbidity and mortality.

While doing his fellowship in adolescent medicine at Los Angeles Children's Hospital, Eric Cohen, MD, refined a system for organizing the psychosocial history that was originally developed in 1972 by Henry Berman, MD. The system, known by the acronym HEADSS, has since been used successfully by adolescent clinics throughout the United States and in many other countries. It structures questions to maximize communication and minimize

stress. Since the HEADSS inventory was described in this publication in 1985,[1] the acronym has expanded to HEEADSSS (or HE^{2}ADS^3), which stands for **H**ome, **E**ducation/employment, **E**ating, peer-group **A**ctivities, **D**rugs, **S**exuality, **S**uicide/depression, and **S**afety. We added the second **E** for eating and the third **S** for Safety (including a "savagery" history about violence) to the original HEADSS acronym to deal with contemporary causes of morbidity and mortality—obesity and eating disorders, and unintentional injury and violence—that were not emphasized in the first article.

The HEEADSSS interview is not meant to compete with the formal guidelines for adolescent preventive care that have been developed by such organizations as the American Medical Association (Guidelines for Adolescent Preventive Services, or GAPS), the American Academy of Pediatrics (Health Supervision III), and the Maternal and Child Health Bureau, Health Resources and Services Administration, of the United States Department of Health and Human Services (Bright Futures). The content of HEEADSSS is exactly the same as that covered by the guidelines. The HEEADSSS interview is a practical, time-tested, complementary strategy that physicians can use to build on and incorporate the guidelines into their busy office practices.

One of the best qualities of the HEEADSSS approach is that it proceeds naturally from expected and less threatening questions to more personal and intrusive questions. This gives the interviewer a chance to establish trust and rapport with the teenager before asking the most difficult questions in the psychosocial interview.

How to use the psychosocial screen

Generally, it is preferable to conduct the psychosocial interview when the adolescent is relatively well, since that is the best time to obtain information under low-stress conditions. If the adolescent is in crisis in your office, however, you have no choice but to attempt to dig out the underlying information related directly to the urgent complaint first. Acute distress sometimes may help you in this attempt because, although it increases vulnerability, it also may increase the potential for trusting and seeking help.

The basic screening interview is designed to be reasonably rapid—otherwise it would not be an efficient tool. With practice, you can do it well in about 20 minutes, in most cases. But recognize that *you will not always be able, in that time, to ask all the questions we discuss here and still leave the teen adequate time to tell his or her story.*

For this reason, Table 1, which summarizes the HEEADSSS interview, presents the suggested questions in three colors. Questions in green are considered essential. There are only a few in each category that you really must explore with every teenager. The questions in blue are next in importance and should be asked of most teenagers if time permits. Finally, the questions in red are for going into more depth when time allows or the situation demands it. If you find that your patient may be depressed, for example, you will spend more time assessing suicide risk and less time letting the adolescent talk about favorite activities, which are likely to be reduced by depression anyway. Each interview is unique and has its own challenges. With practice you can learn to steer the interview within the limits of your time and based on what you are finding.

TABLE 1
The HEEADSSS psychosocial interview for adolescents

Home	Drugs
Who lives with you? Where do you live? Do you have your own room?	Do any of your friends use tobacco? Alcohol? Other drugs?
What are relationships like at home?	Does anyone in your family use tobacco? Alcohol? Other drugs?
To whom are you closest at home?	Do you use tobacco? Alcohol? Other drugs?
To whom can you talk at home?	Is there any history of alcohol or drug problems in your family? Does anyone at home use tobacco?

Is there anyone new at home? Has someone left recently?

Have you moved recently?

Have you ever had to live away from home? (Why?)

Have you ever run away? (Why?)

Is there any physical violence at home?

Education and employment

What are your favorite subjects at school? Your least favorite subjects?

How are your grades? Any recent changes? Any dramatic changes in the past?

Have you changed schools in the past few years?

What are your future education/employment plans/goals?

Are you working? Where? How much?

Tell me about your friends at school.

Is your school a safe place? (Why?)

Have you ever had to repeat a class? Have you ever had to repeat a grade?

Have you ever been suspended? Expelled? Have you ever considered dropping out?

How well do you get along with the people at school? Work?

Have your responsibilities at work increased?

Do you feel connected to your school? Do you feel as if you belong?

Are there adults at school you feel you could talk to about something important? (Who?)

Do you ever drink or use drugs when you're alone?

(Assess frequency, intensity, patterns of use or abuse, and how youth obtains or pays for drugs, alcohol, or tobacco)

(Ask the CRAFFT questions in Table 3)

Sexuality

Have you ever been in a romantic relationship?

Tell me about the people that you've dated. *OR* Tell me about your sex life.

Have any of your relationships ever been sexual relationships?

Are your sexual activities enjoyable?

What does the term "safer sex" mean to you?

Are you interested in boys? Girls? Both?

Have you ever been forced or pressured into doing something sexual that you didn't want to do?

Have you ever been touched sexually in a way that you didn't want?

Have you ever been raped, on a date or any other time?

How many sexual partners have you had altogether?

Have you ever been pregnant or worried that you may be pregnant? (females)

Have you ever gotten someone pregnant or worried that that might have happened? (males)

What are you using for birth control? Are you satisfied with your method?

Do you use condoms every time you have intercourse?

Does anything ever get in the way of always using a condom?

Have you ever had a sexually transmitted disease (STD) or worried that you had an STD?

Suicide and depression

Do you feel sad or down more than usual? Do you find yourself crying more than usual?

Are you "bored" all the time?

Eating

What do you like and not like about your body?

Have there been any recent changes in your weight?

Have you dieted in the last year? How? How often?

Have you done anything else to try to manage your weight?

How much exercise do you get in an average day? Week?

What do you think would be a healthy diet? How does that compare to your current eating patterns?

Do you worry about your weight? How often?

Do you eat in front of the TV? Computer?

Does it ever seem as though your eating is out of control?

Have you ever made yourself throw up on purpose to control your weight?

Have you ever taken diet pills?

What would it be like if you gained (lost) 10 pounds?

Activities

What do you and your *friends* do for fun? (with whom, where, and when?)

What do you and your *family* do for fun? (with whom, where, and when?)

Do you participate in any sports or other activities?

Do you regularly attend a church group, club, or other organized activity?

Do you have any hobbies?

Do you read for fun? (What?)

How much TV do you watch in a week? How about video games?

Are you having trouble getting to sleep?

Have you thought a lot about hurting yourself or someone else?

Does it seem that you've lost interest in things that you used to really enjoy?

Do you find yourself spending less and less time with friends?

Would you rather just be by yourself most of the time?

Have you ever tried to kill yourself?

Have you ever had to hurt yourself (by cutting yourself, for example) to calm down or feel better?

Have you started using alcohol or drugs to help you relax, calm down, or feel better?

Safety (savagery)

Have you ever been seriously injured? (How?) How about anyone else you know?

Do you always wear a seatbelt in the car?

Have you ever ridden with a driver who was drunk or high? When? How often?

Do you use safety equipment for sports and or other physical activities (for example, helmets for biking or skateboarding)?

Is there any violence in your home? Does the violence ever get physical?

Is there a lot of violence at your school? In your neighborhood? Among your friends?

Have you ever been physically or sexually abused? Have you ever been raped, on a date or at any other time? (If not asked previously)

Have you ever been in a car or motorcycle accident? (What happened?)

Have you ever been picked on or bullied? Is that still a problem?

Have you gotten into physical fights in school or your neighborhood? Are you still getting into fights?

Have you ever felt that you had to carry a knife, gun, or other weapon to protect yourself? Do you still feel that way?

What music do you like to listen to?	Green = essential questions Blue = as time permits Red = optional or when situation requires

Remember: You don't have to get everything at the first interview! No one is perfect—including the teen who may "forget to mention" some items or concerns. You can usually arrange further sessions to go into greater depth, ask the questions you were unable to get to in the initial session, and follow-up on or develop an intervention plan. The psychosocial review of systems—like the medical ROS—should be used to generate a "problem list," which can be explored over time, generating therapeutic and counseling interventions. Only in the areas identified as most important, if there is a crisis or impending crisis, must you take immediate action. You cannot expect to change families, school performance, or even dangerous acting-out behaviors overnight.

We are often asked at what age the pediatrician should start doing HEEADSSS interviews alone with the youth. You should begin spending time alone with young people at whatever age they exhibit the early physical and psychological changes associated with puberty. This generally occurs at about 10 years of age in young women and 11 years in young men, but assess each case individually and err on the side of starting early, particularly in the case of young women. Remember, entry into puberty occurs along a bell-shaped curve, and outliers sometimes become the pregnant 13-year-olds that most of us in adolescent medicine have, unfortunately, encountered.

Making a good beginning

The note you strike at the outset of the interview may affect its entire outcome. If the parents are present, it is an excellent policy to introduce yourself to the adolescent first. This gives the adolescent (and adults) a clear message that he or she is the primary patient. Then, try having the adolescent introduce the other people in the room.

Parents, family members, or other involved adults should not be present during the HEEADSSS interview. This does not mean, however, that they should be ignored. Before asking adults to leave the room, always inquire whether they have any concerns to express and assure them of further interaction once the interview is over. You can do this while briefly explaining confidentiality. Excellent parent questionnaires—such as the ones provided by the American Medical Association as part of the GAPS program[2]—are available for parents to fill out before coming to the office or while waiting.

Adults readily grasp the need for confidentiality and for youth to learn to communicate privately with a physician. Most leave the room gladly and with great relief. Persistent objection to leaving a youth alone with the physician is so rare as to suggest the presence of a "family secret" that adults fear will be revealed. If you discuss the topic of confidentiality with adults present, restate and review what you have said after the adults leave the room to be sure the youth understands this important issue (see "Ensuring confidentiality").

Exceptions are inevitable, but even when the adolescent specifically requests that a parent stay, keep in mind that the parent's presence is likely to limit the extent to which the patient will provide sensitive information. Allowing a parent to sit in on the interview also makes it more challenging to exclude the parent at subsequent visits, when the patient may have more private issues to discuss.

It is not reasonable to expect an adolescent to reveal personal information unless confidentiality can be assured. Pediatricians must explain specifically to adolescents that they will be asked very personal questions because the information is integral to our understanding of their health. One should not generally reveal sensitive information to parents or authorities without the teen's permission. Even when disclosure is legally necessary—because of physical or sexual abuse or suicidal or homicidal thinking or behavior, for example—the goal should be for teenagers to make the revelations themselves. The physician's role should be supportive, if at all possible, helping as much as necessary—often, simply by his or her presence.

Do not begin your interview with the teenager by asking, "Why are you here?" Rather, start with innocuous conversation geared to making an observation about the teenager. Comment on the youth's clothing or some other feature that reflects his or her personality, for example. You may already know something about the teenager's lifestyle and interests from previous visits or from other people. Or, you can simply make a comment about your own day or current events. This initial banter helps decrease the patient's anxiety and may encourage him to tell you something about himself.

You also can use the early part of the interview to assess mood, affect, cognitive development, intellectual level, and other important developmental information. In any case, it begins the interview in a lighter, nonthreatening

way. And, once young people start talking, they are likely to keep talking.

Occasionally, you may pick up a message from the teenager's body language—indications that she is depressed, euphoric, frightened, angry, or, occasionally, even intoxicated. Feel free to comment on such an observation. Doing so may cut to the heart of the problem, allowing the teenager to express important feelings or concerns.

Before getting into the psychosocial interview, be sure to touch on other aspects of the history—any current health concerns, for example, and any relevant medical history (although, especially with younger teenagers, the family and past history are best obtained from parents). It is especially important to address the patient's chief complaint before tackling the psychosocial history. If the presenting problem has to do with school or sexual issues, for example, there is no reason not to proceed "out of order" with those aspects of the psychosocial interview. When you reach the psychosocial review, you can leave out what you have already covered. *Nothing about the HEEADSSS interview, including the order of questioning, should ever be treated rigidly*. The interviewer is always wise to proceed according to the dictates of common sense and good clinical instincts.

Last, do not forget to search not only for issues or problems in the history but also for the youth's *strengths*—positive attributes suggesting the presence of resilience. Concomitant positive behaviors may mitigate risks or point to productive interventions or an improved outlook.[3] And, while counseling about risks you have uncovered, also be sure to praise the patient for significant accomplishments or avoiding risks at a difficult time in life (see "Accentuate the positive").

Psychosocial history begins at Home

Questions about the teenager's home environment are generally expected and a good place to begin the psychosocial interview. From the outset, *it is very important not to make assumptions and to ask open-ended questions as often as possible* (Table 2). It is a mistake, for example, to say, "Tell me about your mom and dad." You have assumed that the patient lives with both a mother and father! You may not know that a parent has died recently or that a divorce is in the works. Rather, start by asking, "Where do you live?" or, "Tell me about your living situation." You can follow up by asking, "Who lives with you?" These questions allow the adolescent to describe what is most important in his or her home setting.

TABLE 2
Opening lines, good and bad

Category	Poor	Better
Home	"Do you get along with your mom and dad?"	"Where do you live and who lives there with you?" (No assumptions made)
Education	"How are you doing in school?"	"Tell me about school." Or "What are you good at in school? What are you not so good at?" (Open-ended; harder to answer "OK")
Eating	"What do you eat?"	"Tell me what you think about your weight and shape." or "Tell me about what you like and what you don't like about your body." (Open-ended, can't answer "OK")
Activities	"Do you have any activities outside of school?"	"What do you and your friends like to do for fun?" (Open-ended)
Drugs	"Do you do drugs?"	"What kinds of drugs have you seen around your school or at parties?" Or "Do any of your friends use drugs or alcohol?" (Less personal; eases into a difficult discussion)

Sexuality	"Have you ever had sex?"	"You told me you've been going out with Steve for the past three months. Has your relationship become sexual?" (Context makes question seem natural and less intrusive) OR "Youth is a time of sexual exploration. Tell me about your sexual life." (Open-ended, nonjudgmental)

Go on to find out what relationships are like at home and whether there has been a recent change—moving, running away, being institutionalized, or having someone join or leave the household. Such "change" events are often extremely stressful to teenagers, who prefer a stable environment in which to achieve the developmental tasks of adolescence—separating from parents, connecting with peers, and developing a positive self-image.

Most teenage problems with sexuality, drug use, risk taking, and psychological difficulty are connected, in part, to relationships at home. Young people tend to get into trouble when they do not have, or perceive that they do not have, the support, caring, boundaries, and respect at home that enable them to resist adverse peer pressure and seek counsel from trusted adults.

It is extremely useful to ask whom the teen can trust to discuss difficult personal matters. A connection to supportive adults—parents or others—has been shown to be highly protective against a whole range of health risks and high-risk behaviors.[3] You might have to give some youths hypothetical examples before they grasp the nature of this question. Not being able to talk to and trust adults at home, or at all, is an important finding that, in our experience, is all too common. Lack of trust in relatives, or adults in general, predisposes adolescents to other psychosocial difficulties.

On the positive side, remember to look for and reinforce solid relationships with adults and any evidence that the teenager takes on responsibilities at home, such as caring for younger children or elderly relatives. Such findings indicate increasing maturity.

E is for education and employment

Most of the time that young people do not spend at home they spend at school. They expect to be asked about their education and are seldom threatened by the discussion. Most have come to terms with their school performance; if they have not, this in itself may be a serious problem.

Many interviewers make the mistake of not getting a sufficiently in-depth history about school, asking narrowly focused questions and taking statements at face value. A common error is to ask, "How are you doing in school?" Younger teenagers, in particular, invariably answer "OK," "fine," or "good." These answers carry little meaning, and you must follow up with: "What do you mean by 'OK'?" Instead, try asking: "Tell me about school. What do you like about it, and what don't you like?" or "What are you good at in school, and what are you not so good at?" Such questions can elicit both strengths and weaknesses.

Also ask specifically about academic performance (generally measured by grades). Be particularly concerned if the teenager's performance has changed for the worse recently. A decline in academic performance correlates highly with other psychosocial problems, such as drug use, suicide risk, or acting-out behaviors. Poor school performance also may indicate an underlying learning or attention disorder. This is especially true at transition points such as sixth and ninth grades, when students who have been able to compensate for learning disorders suddenly may start having trouble keeping up with increasing performance expectations. Also, ask what the teenager's relationships are like in school and what extracurricular activities he or she is involved in.

The older the teenager, the more you should expect him or her to have some plans for future education or employment. Early adolescents may have vague ideas about the future; these ideas should begin to solidify in 11th and 12th grades.

When a youth lives in a high-risk environment, begin the school section of the interview by making sure that he or she actually attends school! In many inner city areas, the chronic absenteeism rate for teenagers ranges from 15% to 20% with "over absenteeism" exceeding 40% at times.

Another concern is that many young people are "passed along" from grade to grade, even though they do not have basic reading and writing skills. Ask all high-risk youth whether they have difficulty reading. Using an office questionnaire can double as a screen for reading problems (see "Some thoughts on office questionnaires"). It also may be helpful to check how many schools, and new sets of friends, the student has had to confront in the

last four years.

As young people enter middle and late adolescence, they may develop an employment history through summer jobs or part-time work during the school year. Ask teenagers who are employed part-time how many hours they work each week and whether work interferes with family, school, peer, or other activities. Working more than 20 hours a week has been associated with negative outcomes. It is also helpful to know if teenagers feel forced by economic circumstances to help support their family.

Some physicians may see older teenagers or young adults who are employed full-time. Ask these youth about the number of jobs they hold, their strengths and weaknesses on the job, their satisfaction level, nature of relationships at work, goals, and recent or frequent changes in employment.

Again, remember to look for and recognize successes at school and work. Search for and praise not only academic success but also leadership and achievement in school extracurricular activities or the workplace.

E is also for eating

Stereotypes about adolescent eating habits abound, from growing boys who eat parents out of house and home to weight-conscious girls who barely eat at all. In reality, adolescents often *do* have unhealthy eating habits, making questions about nutrition important, especially as the prevalence of obesity and eating disorders continues to increase. Aim to help all adolescents develop healthy eating (and exercise) habits that can be maintained over a lifetime—diets that are rich in complex carbohydrates, fruits and vegetables, fiber, calcium, and essential vitamins and low in saturated and trans fats, simple sugars, and empty calories.

The increasing rate of obesity has been called a public health crisis.[4] Obesity greatly increases the risk of glucose intolerance, diabetes, hypertension, and heart disease and is now clearly recognized to begin in childhood and adolescence.[5] Eating habits that contribute to obesity are common among adolescents—frequent snacking and excessive consumption of sugared soda and fast food, for example. Sedentary adolescents often snack continuously during the time that they spend in front of the television or computer, compounding their risk. Simple strategies, such as limiting snacking and choosing appropriate portion sizes, can be remarkably helpful in improving adolescent eating habits.

Equally important, physicians should attempt to identify adolescents whose eating habits may signal problems with body image or self-esteem, psychological distress, or outright depression. Frequent dieting, starvation diets, compulsive exercise, or purging are all of concern and often escalate over time, especially in young women. At least half of normal-weight young women surveyed in the US believe they are overweight.[6] Significant overeating, out-of-control eating, or binge eating, with or without concomitant obesity, also demand specific interventions.

To get at eating issues in a teenager's history, we suggest that you ask: "Tell me what you think about your weight and shape" or "Tell me about what you like and what you don't like about your body." Then follow up with specific questions about diet, eating habits, nutritional knowledge and beliefs, and potentially dangerous activities, including pathologic dieting behaviors. And remember the importance of family history in understanding eating and exercise behaviors. It can suggest both genetic predispositions and behavioral risks. Are any significant adults in the teenager's life overweight, dieting all the time, or exercise freaks, and how does the youth view these examples? Remember, of course, to praise good diet and exercise choices when you find them!

Looking at peer-related Activities

When adolescents or young adults are not at home, in school, or at work, they tend to be with their peers. The peer-related activities review is the point in the psychosocial interview that precedes the most sensitive and personal questions. So it is a good idea to sit back and let the youth be the "one up" and tell you about what things he or she really enjoys. Go ahead—ask the young person to teach you about some aspect of his or her culture about which you do not know very much. Youth culture changes rapidly and you may pick up information useful in the care and understanding of many other adolescents besides the one you are interviewing.

The peer group is particularly important in early and middle adolescence, when young people are learning to separate from their parents. At this point, they derive much of their identity and self-esteem from peer activities. Begin by asking, "Tell me what you do with your friends" or "What do you do for fun?" Press for specifics if the teenager does not describe any extrafamilial or extracurricular activities. Ask the names of his or her friends and have the youth tell you something about them. Some young people tell us they have "friends" but cannot readily name names or shared activities. They may be hiding the fact that they are isolated and depressed.

Also, look for indications that friendships are changing. The youth may have joined a higher-risk peer group recently or begun to drift away from peers, suggesting potential isolation and the accompanying risks of depression, anxiety, or some other acute stressor.

Be concerned about teenagers who cannot describe their activities beyond "hanging out." They may be at higher risk than teens who talk about favorite activities with friends, such as sports, dancing, hobbies, games, or even shopping. Be especially concerned about adolescents who describe being "bored all the time." This is a red flag for depression, which occurs often in the adolescent years.

We ask young people to tell us how much reading they do for fun. Teenagers who read *anything* outside of classroom requirements are generally doing better in school and at home and have a better prognosis for going on to college or full employment than those who do not. Give reading youths the kudos they deserve!

We also ask teenagers about the kinds of television programs they watch and the amount of time they spend watching TV. Lately, we have begun asking similar questions about computer video games. Young people who watch TV or play computer games for more than two hours a day may be using these activities to avoid homework or interaction with peers or family. You may uncover a lack of parental connection and control. For others, TV or video gaming becomes a mesmerizing fantasy drug. Moreover, young "couch potatoes" are at substantially higher risk of obesity.

It is important to ask young people of driving age if they drive, if they have their own car (or, if not, from whom they borrow a car), and who pays for the car and insurance. This can be useful information later in the interview when you address safety issues.

On to Drugs

The drug history must be sensitive and frank. With younger adolescents, we usually approach the topic obliquely: "We have discussed what you and your friends do to have fun. Do any of your friends use drugs or alcohol (or get drunk or high)?" *Young adolescents are often quite willing to tell us about their friends' behavior when they would not tell us about themselves nearly as readily.*

We next observe that, when young people get together, there is considerable pressure to be "one of the crowd." Then we might ask, "In social situations, do you ever feel pressured by friends to use drugs or alcohol?" Often the young person will admit sheepishly that he or she has tried something, which leads to a discussion of specific circumstances, types of substances tried, and frequency and intensity of use. In middle-to-late adolescence, you may be able to ask more directly about drug use, without reference to friends.

We also ask specifically about alcohol abuse, because alcohol is the number one drug used in adolescence, and about tobacco, because many teens do not consider smoking or chewing tobacco to be a form of "drug use." Make sure that young people understand that tobacco and alcohol are both potentially addicting drugs. Ask older teens and college-age youth whether they use "club drugs" such as Ecstasy. Use is all too common and sometimes considered "no big deal." Many youth are oblivious to the serious dangers of these drugs.

In recent years, we have begun to discuss use of anabolic steroids, especially when interviewing male athletes. Many young athletes have an inkling that steroids are risky, but they need to know the specific dangers posed by their use. Moreover, increasing numbers of nonathletes are taking anabolic steroids for cosmetic purposes.[7]

You also need to know whether the adolescent is taking risks such as driving under the influence of drugs or alcohol or riding with drivers who are intoxicated. *Between 20% and 40% of youths surveyed admit to riding with an intoxicated driver within the past year.*[8] Our first goal in counseling is to prevent such overtly dangerous activity and then to determine whether the substance use is a significant problem or a passing experiment. To do this, we must look at the adolescent's drug use in the context of the overall psychosocial picture revealed in the rest of the interview and determine whether it is interfering with social growth. The CRAFFT questions (Table 3) are a brief, validated, office-friendly tool useful in the initial assessment of the substance-using teen.[9]

TABLE 3
The CRAFFT questions

Have you ever ridden in a **C**AR driven by someone who was high or had been using drugs or alcohol?

Do you ever use alcohol or drugs to **R**ELAX, feel better about yourself, or fit in?
Do you ever use drugs or alcohol when you are **A**LONE?
Do you **F**ORGET things you did while using drugs or alcohol?
Do your family or **F**RIENDS ever tell you that you should cut down your drinking or drug use?
Have you ever gotten into **T**ROUBLE while using drugs or alcohol?
Two or more "Yes" answers suggest high risk of a serious substance-use problem or a substance-use disorder
Source: Knight J, Sherritt L, Schrier L, et al[9]

If a teenager uses drugs more than occasionally, you will need work with him or her to acknowledge the risks and make some changes—ideally by developing some form of contract to eliminate the problem behavior and following up on the results of your efforts. The goal should always be to have the adolescent reveal the nature of the substance use to his or her parents whenever possible. You can do great good by offering to serve as mediator in that process. However, substance use can remain confidential as long as there is no clear and immediate threat to life or limb and the adolescent agrees to work on the drug problem.

The Sexual history

Next, you must address what may be the most sensitive, private part of the interview for the adolescent: the sexual history. Especially with younger adolescents, approach gently from the point of view of friends, in much the same way you approach the drug history. You might observe: "We've talked about some of the friends you hang out with. Tell me about any of your friends who are starting to be in romantic relationships." To older adolescents simply say: "Tell me about any romantic relationships you've been involved in." The open-endedness of such questions allows adolescents to tell us that they are having relationships with people of the same sex, opposite sex, or both.

From asking about relationships, it's a short step to asking teenagers whether or not they have been involved in *sexual* relationships: "Since sexual activity can affect your health, can you tell me: Have any of your relationships involved sexual activity and if so, what kinds?" Again, this question is open-ended and allows the teenager to elaborate. With older teens or young adults, you can sometimes say: "Tell me about your sexual life" or "tell me about your sexual relationships."

Once you have gotten past the initial questions, always try to obtain a complete sexual history, asking *exactly* what the young person is doing, under what circumstances, and with whom. Do not ask, "Are you having sex with someone?" because the definition of "having sex" is subjective and even culturally defined. Rather, if possible, ask explicitly what sexual activities are taking place. Be cautious, however: The line between a comprehensive history and voyeurism can be difficult to determine or can be misunderstood by the teenager. A less explicit history may be preferable, especially at the first visit and especially with younger teenagers or a very uncomfortable patient. You can pursue a more complete history during subsequent visits.

If the teenager is reluctant to answer or wonders why you are asking these questions, restate your interest in preventing pregnancy and sexually transmitted infection. It is also helpful to acknowledge the discomfort most patients feel about discussing this topic. Say, for example: "I know that this may be embarrassing for you, but it is still very important. I ask these questions of all my teenage patients." Always ask youths about their knowledge of fertility, contraception, and sexually transmitted infections. You might add: "Many people do not have anyone knowledgeable to talk to about sex. We're always happy to answer any questions you have."

Do not assume that adolescents who are having sexual intercourse are comfortable about it. Ask about whether they enjoy their sexual behavior and whether their sexual experiences are pressured or coerced. Many young women, but also a surprising number of younger men, do not enjoy sexual activity because they are anxious or uncertain about it, or they feel as if they are being forced into undesired situations by peer expectations or pressure. Sometimes, you can serve as a trustworthy adult who gives youths permission *not* to be sexually

active until they feel more comfortable.

Given the high prevalence of sexual abuse of children and adolescents, including "date rape," it is essential to ask teenagers if they have ever had uncomfortable sexual experiences, such as being touched sexually when they did not want to be touched, or if they have been forced into any sexual activity. *If you do not ask explicitly for this information, particularly with young males, it will not be forthcoming.*

A history of abuse may not come out on the first interview, but the very fact that you ask and show interest establishes rapport and gives the young person a chance to trust you, so that he or she may feel safe enough to reveal the facts at a later time. It is surprising how often adolescents have a "sigh reaction," in which they take a deep breath and think to themselves, "I think I am going to trust," then disclose one of their deep, dark secrets (drug use, alcohol use, sexual concerns, or abuse).

Ultimately, the greatest impediment to an adequate sexual history is not embarrassed teenagers who refuse to confide in the doctor but, rather, physicians who are uncomfortable with sexuality and therefore do not take a good sexual history. You must be willing to ask sensitive questions, and you must be capable of frank, nonjudgmental counseling. You can offer opinions, feelings, and advice, but only if the teenager solicits them, and only if you clearly label them as such. *If you cannot become knowledgeable about, and comfortable with, adolescent sexuality, you probably should not care for teenagers and young adults.* You have to be as comfortable with sex as you are with diarrhea. Remember, most people are not entirely comfortable with either!

Screening for Suicidality and depression

A recent report of the US Surgeon General documented an extraordinarily high prevalence of depression in this country and highlighted the fact that depression often first appears during adolescence.[10] Every psychosocial interview must, therefore, include screening for symptoms of depression.

Teenagers often exhibit depression in atypical ways. "Boredom" is a frequent presenting symptom, and you should suspect depression in any adolescent who describes being "bored all the time." Irritability, anxiety, "moodiness," and social withdrawal also are common presenting features. A difficult interview with an uncooperative or angry adolescent should always lead you to consider the possibility of depression. Fewer teens than you might expect report sadness or crying or identify their symptoms as depression. Similarly, vegetative signs of depression, such as sleep and appetite disturbances, do not occur as often in teenagers as in adults.

Many of the items in the depression screen (Table 4) may already have been covered in the psychosocial history: family problems, changes in school performance, changes in friendship patterns, sexual acting-out, and drug or alcohol abuse. Other items to investigate include a history of mental health problems or suicide in family members or close friends.

TABLE 4
What to look for on the depression screen

Sleep disturbances (usually sleep induction problems; also, early or frequent waking or greatly increased sleep and complaints of increasing fatigue)
Change in appetite or eating behavior
Feelings of "boredom"
Family history of depression, suicide attempts, or other mental health problems
Serious suicidal ideation or plan
Emotional outbursts and highly impulsive behavior
Social withdrawal or isolation
Feelings of hopelessness

History of past depression, suicide attempts, or counseling
Recent increase in drug or alcohol use, acting out, or recent change in school performance
Recurrent "accidents"
Increase in somatic symptoms, such as headache or abdominal, chest, or back pain
Diminished affect, avoidance of eye contact during the interview
Preoccupation with death (clothing, music, media, art)
Green = essential Blue = as time permits

When depression seems likely, ask directly and clearly about self-harm. Asking about suicidal behavior does not precipitate or trigger it, and clinicians should not be reluctant to question patients unambiguously—for example, "You've told me that you've been feeling bad lately. Have you felt so bad that you've thought seriously about hurting yourself?" Adolescents attempt suicide more often than we realize, so physicians should not be surprised if a teenager has thought about suicide or has even made an attempt. Any suicidal ideation should prompt a more careful assessment of the patient's suicide risk and will likely require a referral (sometimes urgently) to a mental health provider. Previous suicide attempts are a strong risk factor for future attempts and completed suicides. Remember, most adolescents, if they are honest, will admit to having thought about suicide at one point or another. The clinical question is: How serious is the ideation, planning, or actual behavior?

Some adolescents who would never contemplate suicide nevertheless harm themselves. Self-mutilation, usually by cutting, has become increasingly common, generally among girls and generally beginning at a relatively young age. Teenagers who engage in cutting, or "carving," describe it as a mood stabilizing behavior, used to regulate uncontrollable anxiety. In other words, cutting helps some teenagers who feel as if they are losing control to regain control. Adolescents who cut themselves are clear that they are not suicidal. Nevertheless, the psychopathology that leads to cutting also increases the risk of suicide.

We suggest asking specifically about sleep patterns during the suicide and depression part of the interview. Teenagers who are anxious or depressed often have difficulty falling asleep. Generally, it takes them more than 30 minutes to fall asleep and often more than one hour. Although many adolescents have occasional sleep problems, difficulty falling asleep and sleeping well more than once or twice a month may be significant. As adolescents emerge into young adulthood, the adult sleep disorder pattern of frequent or early waking becomes more prominent.

Even young people who are secretive about other parts of the history or have difficulty with trust often will reveal a sleep disturbance. Sleep problems tend to make adolescents feel miserable and are a considerable nuisance to an otherwise healthy, active teenager.

Some adolescents increase their total amount of sleep considerably when depressed. They are seldom difficult to identify because they also exhibit the body language of depression: reduced affect, reduced eye contact, and limited interaction. They may communicate only in whispers or mumbles, and their conversation may seem to move in slow motion.

A final S, for safety (and savagery)

As we enter the 21st century, the major threats to youth health are preventable, and the major causes of morbidity and mortality are violent—injuries, suicide, and homicide. The world is a dangerous place for many young people. Bullying, domestic violence, sexual abuse, and date rape have become part of the social landscape. School violence has become a media staple. While tragedies such as the one that occurred at Columbine High School in Colorado are rare, the precursors to such tragedies are alarmingly common. In many urban communities, as many as one in four youths surveyed report carrying a weapon to school.[11] Drug-dealing youth gangs use their profits to purchase increasingly deadly arsenals of weapons—and use the weapons on each other. Innocent bystanders get caught in the crossfire. Assessing these risks by asking teenagers about safety must now be part of the psychosocial interview. If you practice in an area where youth violence is endemic, or epidemic, you may want to consider this final S category as a double S, standing for safety and savagery, or savage behavior. This will serve as a reminder of the importance of taking a violence history in

your particular patient population.

Safety concerns are as relevant in suburban environments as in urban ones. *Family violence, which does not respect a social or socioeconomic boundary, increases the risk of teen violence several fold.*[12] Dating violence, including date rape, is reported by as many as 25% percent of teenage and young adult women, crossing all economic and social boundaries.[13]

Begin the safety history with a statement of concern, as shown in Table 5. Proceed to questions about the most relevant threats to the patient. In some settings, they may be school violence and guns; in other settings, they may be sporting injuries and injuries related to wheeled vehicles. Even though you address the safety issues most prevalent in the patient's community first, do not skip any part of the history based on assumptions about the youth's racial, ethnic, or economic status.

TABLE 5
Screening for safety and violence

Opening questions: Safety
Accidents are the number one cause of death and injury in youth. What are you actively doing to prevent accidents and injury from happening to you?

Follow-up:
Wheeled vehicle and bicycle safety?
Sports safety?
Any friends or people known to youth who were injured and whose injury could have been avoided through safety practices?

Opening questions: Violence (savagery)
Violent behavior is an increasing threat for many American youth. Tell me how violence has affected your life?

Follow-up:
Have you ever felt unsafe
- At home?
- In school?
- In your neighborhood?
- On a date or in a relationship?

Have you ever witnessed violence? Where? When? (Ask young teens especially about bullying at school.)

What strategies can you use to defuse or avoid violence?

(For high-risk youth, ask about criminal activity and a history of incarceration, including friends and family.)

No matter where you practice, be sure to ask all adolescents about violence in their immediate, everyday environment. Find out what strategies they use to avoid violence, assess their conflict resolution skills, and ask what they do for self-protection. (No gangs? How about local bullies, or an abusive parent?) Ask specifically whether they carry or own a weapon, because an easily available weapon is a time bomb, just waiting to escalate a verbal altercation into a potentially fatal disaster.

Youth who experience frequent exposure to violence need to learn strategies for defusing or avoiding conflict and safely retreating from it. Many schools and community organizations offer programs on conflict resolution and avoiding violence.[14] Find out about such programs in your area so that you can make referrals and actively encourage their growth. Make immediate and concrete suggestions to the teenager about simple things that he or she can do to get help quickly in violent situations, including seeking aid from responsible adults. We find that many young people respond to violence with violence because that is all they know—from their homes, streets, movies, and TV. Giving them the opportunity to consider other strategies can open their eyes to alternatives they have never even begun to consider.

Table 5 also suggests open-ended questions about other safety concerns. Ask particularly about vehicle safety

and sports and recreational activities, some of which you may have discussed earlier in the interview. Ask about driving while intoxicated or riding with drivers who are impaired, if you have not done so already.

Ask every teen—male or female—explicitly about sexual abuse and sexual violence. Recent evidence clearly demonstrates the high prevalence of these threats, how rarely they are disclosed by teens, and the poor performance by health-care professionals at inquiring about them.[15] We have been impressed by how often teenagers reveal a history of sexual abuse or date rape if they are given the opportunity to do so in a safe and supportive setting. Disclosure may mitigate some of the health-risk behaviors that have been shown to be associated with a history of abuse—for example, substance abuse, tobacco use, and binge-purge behaviors. So if you forgot to ask about adverse sexual events during the sexual history, this is the time to do it!

Last, we ask adolescents to tell us if anyone they know could have avoided an injury by using the safety practices we discussed. This helps to make our advice more concrete. Almost all teens can recall at least one instance from their own circle of friends and family—or from their own experience!

Wrapping it up

We often end the psychosocial interview by asking teenagers to sum up their life in one word, or to give us the overall "weather report" for their life (for example, "sunny with a few clouds," "very sunny with highs all the time," and "cloudy with rain likely"). Or, we may ask them to tell us what they see when they look in the mirror each day. Again, look specifically for teenagers who tell you they are "bored." Adolescence may be stressful, challenging, and nerve-wracking, but it should never be boring. When teenagers use that word, it is a significant red flag.

We also make sure we have asked teenagers to tell us whom they can trust and confide in if they have problems. This is especially important if we have not already identified a trusted adult in the family. We then remind patients that they now have another adult—the physician—who can be trusted to help with knotty problems and answer thorny questions honestly. We emphasize that we are interested in them as whole persons and that we want to help them to lead a fuller, healthier life.

Be sure to give young people an opportunity to express any concerns that have not been covered in the interview. Remind them that they are welcome to call at any time or come back to the office to talk about anything they have forgotten to tell us. We have found e-mail to be a great bridge between patients and physicians that can maintain a dialogue between appointments.

For teenagers who engage in significant health-risk behaviors, we express our concern openly and then ask if they are willing to change their lives or are interested in learning more about ways to deal with their problems. This leads to a discussion of potential follow-up and therapeutic interventions.

Many adolescents do not recognize dangerous behavior patterns because they see their activities not as problems *but as solutions*. Our challenge is to help these teenagers see dysfunctional behaviors as the problems that they are and help them to develop better strategies for dealing with them (see "On giving anticipatory guidance").

As discussed, it is important to acknowledge those parts of the adolescent's life that are going well. In most cases, you can identify strengths and potential; discussing *both* strengths and problems provides a balanced view (Table 6).

TABLE 6
Characteristics of resilient teenagers

Home
Connected, caring parents or family members
Acceptance of responsibility
Chores
Care of siblings or other relatives

Education and employment
Better than average school performance
Feelings of connection to school
Limited employment (fewer than 20 hr/wk)

Strong participation in extracurricular school-related activities, including sports

Activities
Leadership among peers
Religious affiliation

Drugs
Pledge to abstain
Refusal skills

Sexuality
Pledge to abstain
Refusal skills
Consistently responsible sexual behavior

Suicidality
No personal or family history of suicide
Access to a confidant
Successful coping skills
Substance-free

Safety
Seat belt and helmet use
Conflict resolution skills
Substance-free
Refusal to ride in cars with potentially intoxicated driver

We ask patients if we can provide information on any of the topics we have discussed in the interview, especially sexuality and drugs. Be sure to provide whatever educational materials young people are interested in as quickly as possible. The "prepared moment" for learning is right away, when issues are uppermost in the youthful mind.

Do not be afraid to ask young people for some feedback about how the interview went and how they are feeling at the end of it. This is an expression of validation and respect that you, as a powerful adult, can give to a young person. Be assured patients will get the message, even if they are too astonished or shy to offer opinions. Listen respectfully, and if the youth's opinion about how things went differs from your own—you have another great opportunity for discussion! (See "Are they lying?")

As noted, the psychosocial history can be done well in 20 to 30 minutes, depending on the nature of risk factors identified, the amount of discussion and education needed, and the intervention to be arranged. Remember: You may not be able to cover every topic comprehensively at the first interview, and the teenager may not reveal all at the first encounter. But by using the HEEADSSS approach, you should be able to identify which youths you need to see again for further evaluation.

So try getting into the HEEADSSS of your adolescent patients. You'll be glad you spent the time and made the effort!

Dedication

This article is dedicated to the memory of Eric Cohen, MD. Eric did not invent the HEEADSSS inventory, but he realized its potential and taught it to a generation of residents and adolescent medicine fellows at the Los Angeles Free Clinic High Risk Youth Project of the Los Angeles Children's Hospital Division of Adolescent Medicine. Later, he also taught it to hundreds of medical students at the University of Southern California School of Medicine, where he headed the Introduction to Clinical Science course.

Eric was one of the finest clinicians and teachers in the history of adolescent medicine. He was with us all too short a time, and we miss him terribly. But in that time he gave us so much. He would be pleased to know that, first, HEEADSSS is the method used most often to interview youth about psychosocial issues and, second, the original version of this article, which he inspired and coauthored, is the most requested reprint from *Contemporary*

Pediatrics in its 20 years of publication.

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A call for your comments

Many readers have considerable experience interviewing young people. We ask you please to share your thoughts, methods, clinical experience, and anecdotes with the authors and with other readers through the Readers' Forum (at cpletters@advanstar.com) or Contemporary Pediatrics, 5 Paragon Dr., Montvale, NJ 07645.

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Ensuring confidentiality

Confidentiality should be discussed with all adolescents at the beginning of the psychosocial interview. Each physician must determine the limits of confidentiality based on the specific laws of the state he or she practices in, and his or her own comfort. State-by-state guidelines are available from the American Medical Association and the National Center for Adolescent Health and Law.[1,2]

There are two schools of thought on confidentiality. One advocates acknowledging to teens that some legislated and ethical limits on confidentiality may exist. For example: "During this visit, I will ask you some very personal questions to get to know you better. The answers may be sensitive and personal. I promise they will be confidential—that means just between you and me. I will not tell your parents, your teachers, or anyone else about them unless you give me permission. The only exception is that if I find that you or anyone else has been physically harmed or is about to be physically harmed, I am required to take immediate action. What we say remains in this room until you say otherwise, or unless one of my partners needs to know in order to care for you while I'm away. They make the same promises of confidentiality. I hope that you will trust me with the truth about these difficult questions." The legally required exceptions—homicide, suicide, physical or sexual abuse—may or may not be spelled out.

The second school of thought does not favor specifying limits. Adherents of this view point out that, almost universally, when a patient reveals suicidal, homicidal, or abusive behavior to the doctor, it is basically a cry for help and the patient will be relieved rather than angry when told the information cannot be kept secret.

Either approach can work. In both cases, most sexual and drug abuse information can be kept confidential initially. Where to draw the line with severe drug abuse that may represent de facto suicidal behavior is always a source of controversy. What is important is that each interviewer must know his or her own limits of confidentiality and feel comfortable with them.

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Accentuate the positive

Health professionals have a bad habit of searching for problems to the exclusion of all else. They tend to look for and pick out the negative. When you talk to adolescents, we recommend that you purposely search for positives in the history. Look for examples of past difficulties that your patient has successfully overcome; the ability to adapt to and overcome adversity is known as resilience and is highly protective against a wide range of bad outcomes.[1] In patients with a history of success "against the odds," search for protective factors that can be built on (see Table 6). Be sure to praise the adolescent when you find such a positive in the history.

A little bit of positive reinforcement goes a long way toward improving self-esteem and cementing a positive, trusting relationship with the young person. You would be amazed to realize how many youth, especially those at high risk, never hear any praise from adults! If all you heard all day was criticism, how would you feel?

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Some thoughts on office questionnaires

Many pediatricians perform psychosocial screening of adolescents by using office questionnaires. Some innovative screening methods involve interaction with a computer, which young people seem to enjoy.[1] Although these techniques may be useful, we find there is no substitute for direct, face-to-face communication. The psychosocial interview described in the accompanying article helps to establish rapport and trust and elicits vital information, such as body language, that a questionnaire cannot reveal.

Moreover, many adolescents do not answer questionnaires or even anonymous computer questions fully or genuinely, especially when it comes to sensitive issues such as sex and drugs. They need to be convinced through person-to-person communication that it is safe to make revelations in these areas. Questionnaires can get you started (and may be especially useful for obtaining information from parents), but you still need to do a well-organized psychosocial interview.

If you choose to use questionnaires, the GAPS questionnaires, available from the American Medical Association, are well-validated and highly recommended.[2] There is no need to reinvent the wheel.

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On giving anticipatory guidance

In any health-care visit, giving anticipatory guidance is essential to educate patients and help prevent problems. We need to continue this practice into adolescence and young adulthood —involving both adult caretakers and the developing youth. Anticipatory guidance can demystify the physical changes that are taking place and help prepare patients and families for the psychosocial challenges that lie ahead. Always, we are working to reduce risks and avoid morbidity and mortality.

Delivering anticipatory guidance is as much art as science. Some clinicians choose to provide guidance as they go through the HEEADSSS interview. This approach may offer more immediacy and relevance, particularly if it can be done interactively as a discussion with the teen. The risk of the "guide as you go" approach is the possibility of missing the bigger picture and spending time on issues that, with the benefit of hindsight, might best have been deferred.

The more traditional approach of providing anticipatory guidance as a summary at the end of the visit also has its pros and cons. This approach allows the clinician to prioritize what will be discussed based on a "finished" and more complete history. It also facilitates history-taking by allowing the adolescent to keep talking rather than giving up the floor each time the provider has some guidance to offer. On the other hand, saving anticipatory guidance to the end of the visit may not take full advantage of the "prepared moment," when a patient may be most receptive to advice or guidance.

Whatever your style, go with your feelings. They are almost always correct, especially with experience behind you. Be flexible, and even combine the approaches described here depending on the patient and the course the interview takes.

Are they lying?

We are often asked: "How can we trust what teenagers say about drug use or sexual activity? Aren't they lying?"

Certainly, youths as well as adults are known to underestimate or misreport alcohol and drug use. Occasionally, teens even overreport (if you are going to be "bad," be the "baddest"!). In the end, it does not matter.

In our experience, if we establish good rapport, we can get a good idea of which teens are having psychosocial difficulty. It does not matter if we ascertain and precisely quantify every risky activity. HEEADSSS is a screening tool. We fully expect to follow up over time, which will clarify the situation.

The important point is to establish communication and demonstrate your willingness to discuss sensitive issues. You can only hope that over time, the youth will trust you with the whole truth about his or her problems. In our experience, to paraphrase Mark Twain, we succeed—mainly. We guarantee, however, that if the psychosocial interview is not part of our care of young people, we will fail—definitely!

John Goldenring, David Rosen. Getting into adolescent heads: An essential update. *Contemporary Pediatrics* January 2004;21:64.