Screening Adolescents in Clinical Practice: Promoting Strengths to Prevent Problems

Sheryl Ryan, MD
Yale University School of Medicine

Paula Duncan, MD
University of Vermont School of Medicine
Learning Objectives

- Describe the major health issues facing adolescents and the underlying factors driving high risk behaviors
- Understand the theories of positive youth development that support a strength based approach to providing clinical preventive services to adolescents
- Discuss the recent update of the AAP’s Bright Futures and the strength based approach recommended for screening and counseling adolescents
A typical adolescent in clinic……..

A 15 year old male comes into the clinic for his annual physical and to have his sports forms completed………………

– He has no specific complaints, no significant past medical history and a medical ROS is completely normal
– His mother is with him and she just wants to make sure he gets checked out for any medical problems that might crop up on the physical exam…………
– What are the areas you need to be concerned about with this young man and how do you do about assessing and managing them?
Morbidity and Mortality in Adolescents

Generally a healthy group

- Low incidence of serious medical problems, especially those not already present in childhood
- Mortality --- leading cause is injury
- Morbidities --- behaviorally determined
Mortality data for youth and young adults aged 10–24, Connecticut, 2003–2005

- Homicide: 10.2%
- Motor Vehicle Crashes: 28.1%
- Other: 31.4%
- Suicide: 10.6%
- Injuries: 19.8%
Leading Causes of Mortality
Ages 15-19 years

- Homicide: 14.10%
- Malignancies: 5.50%
- MVAs: 38.70%
- Other Unintentional Injuries: 11.10%
- Suicide: 12.00%
- Other: 18.60%

NAHIC Data, UCSF, 2003; http://nahic.ucsf.edu/
Morbidity and Adolescents:

- Mental Health Problems
  - Depression, suicide, anxiety, stress-related problems, family dysfunction, ADHD
- Obesity
  - Poor nutrition, sedentary lifestyles
  - Medical consequences occurring earlier
- Sexuality-related
  - STD’s, pregnancy
- Injuries – intentional and unintentional
- Dental problems
Percentage of students who felt sad or hopeless for 2 or more weeks, or considered, planned or attempted suicide one or more times during the past 12 months.
Percentage of students who ever had sexual intercourse by grade, gender, and race-ethnicity.
Morbidity and Mortality

Most health problems directly or indirectly caused by behavioral, environmental or social issues

- Driven by developmental changes occurring during this time and social/environmental contexts surrounding adolescents
- Many patterns established that also determine adult health
- Thus, adolescent is a key time for health promotion and disease prevention

Access to appropriate care often key obstacle
Behavioral Morbidities

Consequences of typical health risk behaviors in teens

- High risk sexual behaviors
  - STDs and pregnancy
- Substance use and abuse
- Risky recreational vehicle use
- Interpersonal violence
Tasks of Adolescence

1: Establishing *Identity*.
2: Becoming *Independent*.
3: Developing body *Image* awareness.
4: Establishing *Interpersonal* relationships.
5: *Intellectual* awakening (growing from concrete to abstract thinking).

Normal Stages & Tasks of Adolescence

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<thead>
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<th>Autonomy</th>
<th>Identity</th>
<th>Thinking</th>
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<td>Onset and tempo variable</td>
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<td><strong>Middle</strong></td>
<td>$E$ advanced more than $F$</td>
<td>Limit-testing, experimental behavior</td>
<td>Who am I?</td>
<td>Transitional</td>
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Adolescent Autonomy: Becoming Independent

- Limit-testing (challenging rules)
- Experimental behavior (smoking, alcohol, marijuana)
- Risk-taking (D.U.I., Ø contraception)
- Need for control (resisting authority)
Adolescent Thinking and Health Care:

*Intellectual Awakening*

- **Concrete operations**
  - Focus on *immediate benefits* of change

- **Egocentrism**
  - Do not emphasize long term complications
  - Form therapeutic alliance

- **Personal fable**
  - Provide information of personal relevance

- **Imaginary audience**
  - Reassure about normalcy
What can we do as providers?

- Assess social/behavioral risk factors
  - Screen for behaviors
  - Guidelines – e.g. Bright Futures

- Intervene early
  - Assess level of risk
  - Refer those with more extensive involvement

- Prevention/health promotion
  - Anticipatory guidance based on risk assessment
    - Engaging and developmentally appropriate
    - *Strength-based approach!*
Strength-Based Approach

- Raise adolescents’ awareness of their developing strengths
  - Importance of their role in well-being and health
- Motivate and assist them in taking this responsibility
- Acknowledge that risk-taking is way of learning about environment – “developmental drives”
- Encourage positive learning opportunities and experiences
Strengths-Based Approaches

Based on positive youth development paradigms

– “A child that is problem-free isn’t necessarily fully prepared for adulthood” – Karen Pittman
Positive Youth Development Approaches

- Primary movement originated from community development field
  - Search Institute’s Developmental Assets
  - Catalano and Hawkins Communities that Care model
  - Karen Pittman
  - America’s Promise
  - NYS Act for Youth – youth programming
The Deficit Reduction Paradigm

- Focus on a problem
  - e.g. High-risk behaviors, poverty

- The goal - eliminate or control risks

- The targets are *vulnerable* children and youth

- Strategies include expansion of services, treatment, intervention or prevention programs

- Professionals take the lead

- Crisis-management mentality; reactive
The Asset-Building Paradigm

- Problem is rupture in community infrastructure - not individuals
- The goal is to promote or enhance developmental assets, protective factors
- The targets are *all* children and youth
- Strategies include mobilizing individuals within a community to act on a shared vision for positive development
- Vision-building perspective; more hopeful

The 5 Cs

- Contribution
- Confidence
- Competence
- Connection
- Character

Karen Pittman, the Forum for Youth Investment, 2003
Risk-taking Behaviors by Asset Level

Number of Assets

- Alcohol
- Tobacco
- Marijuana
- School Truancy
- Eating Disorder
Assets and Thriving

Number of Assets

- 0-10: 3%
- 11-20: 13%
- 21-25: 34%
- 26-30: 51%
- 26-30: 75%

Success in School
Volunteer Service

Legend:
- Light blue: Success in School
- Purple: Volunteer Service
Percent prevalence of risk factors among students involved vs not involved in after school activities

- Ever had sex: 35.3% (involved) vs 35.3% (not involved)
- Drank alcohol: 45.0% (involved) vs 48.0% (not involved)
- Binge drank alcohol: 25.0% (involved) vs 29.3% (not involved)
- Smoked tobacco: 30.5% (involved) vs 30.0% (not involved)
- Smoked marijuana: 16.2% (involved) vs 15.6% (not involved)
Percent prevalence of risk factors by whether student says that parents usually know where they are.

- Ever had sex: 39.7% usually know, 62.2% rarely or never know.
- Drank alcohol: 44.4% usually know, 55.6% rarely or never know.
- Binge drank alcohol: 24.7% usually know, 75.3% rarely or never know.
- Smoked tobacco: 18.2% usually know, 81.8% rarely or never know.
- Smoked marijuana: 24.7% usually know, 75.3% rarely or never know.
Publications, survey information, and program information are available on the following web sites

www.ct.gov/dph search CSHS

www.ct.gov/sde/healthyconnections