This is a text version of a podcast from Pedscases.com on "**An Approach to Dealing with Challenging Behavior and Mood Changes in Adolescents**" These podcasts are designed to give medical students an overview of key topics in pediatrics. The audio versions are accessible on iTunes or at www.pedcases.com/podcasts.

An Approach to Dealing with Challenging Behavior and Mood Changes in Adolescents

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Introduction

Hi, my name is Nicole Fledderman and I am a medical student at Western Michigan University Homer Stryker M.D. School of Medicine (WMed). This PedsCases podcast was developed in collaboration with Dr. Priscilla Woodhams, Assistant Professor in the Department of Pediatric and Adolescent Medicine at WMed. This podcast will review the approach to dealing with challenging behavior and mood changes in adolescents.

Adolescence is a challenging transition for children, and teens can present with a number of concerning behaviors including emotional lability. This podcast will help differentiate normal behavior and behavior that requires more diagnostic consideration and treatment. I would also suggest reviewing the podcast that focuses specifically on approaching adolescent patients.

Case Presentation

Let's start with a case to provide some context. You have just received a call from the mother of one your female patients, 14-year-old Sara. The mother is very worried about Sara who she reports has been acting moody and angry lately. Sara's grades have been slipping and the littlest thing can lead to a shouting match and angry outburst. Her mother reports that she has tried talking to her daughter, but whenever she does, her daughter brushes her off and says, "everything is fine; just leave me alone." She doesn't know what to do next. You suggest that she bring her daughter in for an assessment in the office. The mother agrees and they come in later that week. At the start of the appointment Sara's mother confides how difficult it was to even get her daughter to come in for the appointment and how she wants you to give her daughter a drug test. How do you respond to the mother's request for a drug test? How will you begin the conversation with the daughter? What will you do or say if the daughter confides in you but asks you to keep it from her mother?

Learning Objectives

At the end of this podcast, the learner will be able to:

1. Review the 3 situations when confidentiality may be broken when working with an adolescent patient.
2. Describe the variations in state law within the United States (U.S.) and in provinces and territories within Canada regarding a minor's right to consent to treatment without their parent's consent.
3. Identify medical conditions that can cause agitation and moodiness in adolescents and describe how to diagnose these conditions.

4. Describe situations in which drug screening is appropriate in adolescents.

Initial Approach and Confidentiality

Just like any other issue brought to your attention as a medical professional, the best place to start is by obtaining a history and performing a physical exam. The main goal of the initial history in this case is determine whether this adolescent has a medical condition that requires further investigation and management or whether she is simply displaying normal adolescent behavior or normal adolescent response to stress.

Since the patient is an adolescent, it is critical to interview the patient both with and without the parent present. Prior to asking the parent to leave the room, you should review the patient's past medical history and family history, as well as elicit any concerns the parent has regarding their child. Let the parent know that you talk to all your adolescent patients without their parents present to give them a chance to practice managing their own healthcare as well as give them the opportunity to discuss any topics or ask any question they might feel uncomfortable discussing with their parent present. Explain that after you have finished talking privately you will ask the parent to return. Before the parent has left the room, you should introduce the concept of confidentiality including what it means, the limits of confidentiality, and how situations that require confidentiality to be breached will be handled. As with adults, confidentiality means whatever is shared with you as a physician will not be shared with others including parents or guardians without the adolescent's consent. There are, however, three important situations in which the physician has the right to break confidentiality without an adolescent's consent:

1. If the patient is a danger to him or herself
2. If the patient is a danger to others
3. If the patient is being abused. (1)

If you are a medical learner, you should also emphasize that you will share everything discussed with your preceptor.

Once you have established an understanding of confidentiality, explain what questions you will ask. It is important to establish a rapport with the patient and make sure they feel comfortable, perhaps by finding some common ground. It is not unusual for the adolescent to be quite resistant and suspicious of the clinician to start with, especially given the premise of the encounter.

Next, you want to begin gathering a history to better understand what has been happening lately. This includes discussing various psychosocial aspects of the adolescent's life. These aspects can be remembered using the mnemonic HEEADSSS which stands for **h**ome situation, **e**ducation/**e**mployment, **e**ating, **a**ctivities and peers, **d**rugs, **s**exuality, **s**uicide and depression, and **s**afety from injury and violence. Difficulties or changes in any one of these areas could be the trigger responsible for changes in personality and behavior. Thus, it is crucial to gain a thorough understanding of these aspects of your patient's daily life. (1, 2)

For more information about how to approach an adolescent history and discussing sensitive topics with adolescent patients, review the Adolescent Medicine podcast (2).

Differential Diagnosis

Challenging behavior in an adolescent is frequently a part of normal development, but it also may suggest significant medical or psychiatric illness. Regardless of whether you are a primary care physician, pediatrician or a psychiatrist, it is important to consider medical causes of the adolescent's challenging behavior before initiating treatment for mental illness or referral to a psychiatrist. There are numerous medical conditions that can cause agitated and moody

behavior in adolescents; however, consideration of laboratory investigations and imaging should only be embarked upon if there are concerning symptoms on history or signs on physical exam. Possible diagnoses to consider include: anxiety, depression, adjustment disorder, eating disorder, hypo- or hyperthyroidism, post-concussion syndrome, pregnancy, and/or drug/alcohol use. Rare considerations include: electrolyte imbalances, Wilson's disease, epilepsy, heavy metal intoxication, vitamin deficiencies, autoimmune disorders such as lupus or autoimmune encephalitis, and a brain tumor. Many of these rare conditions however would have additional signs and symptoms, and awareness of these is helpful in sorting through the differential diagnoses.

Differentiating Normal Adolescent Behavior from Concerning Behavior
It is not uncommon for parents to come to you wondering whether their child is acting like a typical adolescent or is demonstrating signs and symptoms due to mental illness, drug use, or behavioral problems. It is normal for adolescents to be moody due to the hormonal and physical changes that are a part of puberty. While no one behavior alone is indicative of normality or abnormality, it is important to take into the account the nature, intensity, severity, and duration of the problem (3).

Here are some examples of typical teen behaviors contrasted with concerning behavior in adolescents that would be cause for concern (4).
Socially
Normal: Wanting to spend more time with peers and less time with family.
Cause for concern: Not wanting to spend time with either family or friends (i.e. avoiding all social activity).

Sleep
Normal: Needing more sleep, reluctance to get up early for school.
Cause for concern: Sudden changes in energy level (i.e. sleeping abnormally long or not being able to sleep at all), absolute refusal to attend school.

Appetite
Normal: Developing a larger appetite during growth spurts.
Cause for concern: Sudden changes in appetite (i.e. consistent overeating or undereating accompanied by quick fluctuations in weight).

Appearance
Normal: Worrying about physical appearance and trying to fit in.
Cause for concern: Sudden and significant changes in eating behaviors, over-exercising, and other indications of eating disorders.

Rebelliousness
Normal: Some light risk-taking or experimenting with sex, alcohol, or drugs.
Cause for concern: Extremely risky behavior and/or delinquent behavior including disregard for house rules, parents' concern, or laws of society; turning to cutting as a form of emotional and physical release.

Mood
Normal: Sadness and anxiety following fights with friends or a breakup with a significant other.
Cause for concern: Sadness or anxiety that doesn't correct itself or decrease in intensity after a few days to a couple of weeks; unusually intense or rapid mood swings that occur consistently.

Work up

In many behavioral problems in adolescents, no laboratory investigations are indicated. However, if there are specific findings on history and physical pointing toward a specific diagnosis, you can order investigations accordingly. A general evaluation for medical disorders in an adolescent presenting with fatigue and mood or behavior changes should include complete blood count (CBC), thyroid panel, and iron studies. The results of these studies can be used to rule out anemia, hypothyroidism, and hyperthyroidism as the cause of these changes. If the patient was sexually active or worried about pregnancy, then a urine pregnancy test should be included.

In addition to some laboratory tests, the work-up for challenging behavior and mood change in an adolescent should also include some mental health screening. There are numerous tools available to help physicians screen for depressive disorders, anxiety disorders, eating disorders, and other mental health conditions. For example, the Patient Health Questionnaire (PHQ-9A) is a 5-minute, 9 question screening questionnaire that helps physicians quickly screen for depression in adolescents.

Drug Testing in Adolescents

Although the behavioral and mood changes seen in adolescents can often be considered a normal part of development, there is a possibility that they could be due to experimentation with recreational or prescription drugs. Additionally, concerned parents may ask you to test their child for drugs. For this reason, the question of drug testing may come up in clinical practice and you should be aware of how to appropriately handle the situation.

Depending on the situation, the value of drug testing varies. In the outpatient setting, drug testing is rarely useful and can impair the clinician-patient relationship. Suggesting drug testing can impair the clinician-patient relationship by implying that you don't trust your patient's response to your questions. While drug testing may seem like the most expedient answer to a difficult question, it does not change how you would treat an individual with a substance abuse problem or the fact that substance abuse treatment is most successful when the patient is ready and willing to change. Clandestine outpatient drug testing without the patient's knowledge is never advised.

However, in emergent situations such as when patients present with altered mental status, accident victims, following a suicide attempt, in the presence of toxidromal symptoms, or unexplained seizures drug testing is indicated and may be lifesaving. In such emergent situations, consent can be inferred. Ideally, drug tests should serve as an adjunct to the history rather than a replacement. (5)

Minors Right to Confidential Consent to Treatment

Primary care physicians and those caring for minors need to be aware of the right of minors to consent to healthcare related to sexual activity, substance abuse, and mental health care. Both the age at which minors can consent to treatment without their parents being notified and the specific aspects of healthcare that they can consent to varies depending on state and provincial laws. It is well recognized that minors who are infected with sexually transmitted infections, who abuse drugs and alcohol, or suffer from emotional or psychological problems may avoid seeking care if they must involve their parents. On the other hand, not all minors are mature enough to make such important decisions without their guardians. In the U.S., most states have laws specifying a specific age at which minor gain the right to consent to confidential treatment (6, 7). In most Canadian provinces, there is no age of medical consent; instead, the determining factor in a child's ability to provide or refuse consent is maturity or mental and emotional capacity to

understand the risks and benefits of treatment (8, 9, 10). Due to differing state and provincial laws, it is important to educate yourself on the laws regarding minor consent and confidentiality where you practice.

Case Revisited

After eliciting all of the mother's concerns, you politely ask her to step into the waiting room so that you can talk to Sara in private. You begin your conversation with Sara by introducing the concept of confidentiality. Sara seems to be relieved when she realizes anything she says will stay between the two of you. As you go through the HEEADSSS interview, you learn that Sara hasn't been feeling like herself for a while. She says she has been feeling tired and irritable, but doesn't know why. She also has been feeling down lately and hasn't been enjoying things she used to like to do. You ask her for an example. After reaffirming that everything she says is confidential, Sara explains that she used to love going to the mall and hanging out with friends, but not anymore. She admits that she even tried smoking some marijuana in hopes that it would help her loosen up and enjoy being with friends more. You ask her if that was the only time she has used marijuana. Sara explains that was the first and only time she has ever done drugs and she never wants to do it again as it just made her sleepy. You decide to order a CBC, urine pregnancy test, thyroid panel, and iron panel as you are concerned that Sara's symptoms could be due hypothyroidism or anemia.

In the course of the private conversation with Sara and on her PHQ9 questionnaire, Sara also indicated that she is not suicidal as evidenced by her response that over the past 2 weeks she has never had thoughts that she would be better off dead or of hurting herself. You bring this up and ask her if she did feel suicidal, would she feel comfortable letting her mother know. She says yes, and you provide Sara with information regarding a suicide prevention hotline. You also discuss this with her mother when she returns to the room. Her mother agrees that if Sara comes to her saying she is feeling suicidal, they will call the hotline and/or take her to the local emergency room that has a pediatric psychiatrist on call.

A couple of days later the results of Sara's urine pregnancy test come back negative and her CBC, thyroid panel, and iron panel were all normal. You call Sara and her mother and ask them to schedule an appointment to come back and discuss the results of the tests you completed. When they come in you explain that the laboratory tests were all normal. You also explain that Sara scored a 14 out of a possible 27 on her PHQ-9 indicating that she is suffering from moderate depression. You explain that depression is a medical condition that can be treated with counselling alone and sometimes with both counselling and medication. For the type of depression Sara has, you discuss she may benefit from talking to a therapist, specifically using "cognitive behavior therapy". This approach helps the adolescent understand the situations that cause depressive thoughts and feelings, work on increasing activity and pleasant events, identify and modify negative/depressive thoughts, teach relaxation strategies, and develop problem solving strategies to cope with conflict and distress (11). Additionally, if her symptoms do persist or worsen that then you can discuss the possibility of prescribing Sara an antidepressant. You share some websites and booklets with information on adolescent depression with the family. Sara and her mother seem relieved and agree to schedule an appointment with a therapist. You thank them for coming and remind them to call you if anything else comes up.

Conclusion

Last, let's end by reviewing some key points from this podcast:

- Your interactions with adolescents should remain confidential unless the adolescent is at risk to harm themselves or others, or if others are harming or abusing them.

- The exact age at which adolescents gain the right to consent to their own medical treatment, including: mental illness, substance abuse, or sexual activity varies depending on an individual state's or provincial laws.
- It is important to rule out medical conditions as the cause for changes in mood and behavior before making a referral to psychiatry. In most cases, primary care physicians or pediatricians do not need to refer their patients to psychiatry unless they suspect more serious conditions such as bipolar disorder and schizophrenia or if a patient is experiencing a treatment resistant depression.

This brings us to the end of this PedsCases podcast on the approach to dealing with challenging behavior and mood changes in adolescents. Thanks for listening!

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