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APPROACH TO ADOLESCENT HISTORY TAKING PART 1

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Introduction:

Hi PedsCases listeners. I'm Fanny Cheng, a fourth year medical student at the University of Toronto. I'm Cindy Lin and I'm a third year medical student at Western University. This podcast was developed under the guidance of Dr. Natasha Collia, a pediatric emergency physician at the Hospital for Sick Children in Toronto, and Dr. Jean Suk, a community pediatrician in Ottawa. This two-part podcast addresses an approach to adolescent history taking, with a focus on the psychosocial history, using the SSHADESS mnemonic. This first part reviews the SSHADESS mnemonic while the second is a role play of taking a SSHADESS history.

By the end of this podcast, you will be able to:

1. Understand how to create a safe environment for conducting an adolescent history,
2. Conduct a full adolescent history using the SSHADESS mnemonic;
3. Identify strategies to help foster a trusting physician-patient relationship with an adolescent.

INTRODUCTION

Adolescence is a unique time period in life, bridging childhood and adulthood. Important developmental endeavours of adolescence include learning independence and self-reliance, adopting peer codes and lifestyles, learning to be comfortable with the changes happening within one's body, establishing sexual, ego, and vocational identities, and developing a moral and philosophical code.

You should begin to spend time interviewing adolescent patients alone, without their parents/guardians, when they begin exhibiting psychosocial changes associated with puberty. At every visit, assess them for new stressors and for their overall wellbeing.

OPENING THE VISIT

An adolescent social history can happen in the context of its own visit or compounded with a chief complaint. In either case, building rapport with the adolescent begins the moment they enter your office.

Introduce yourself to the teen first and have them introduce who else is with them. Then go over the order of the visit. Some parents/guardians may wish to stay for the initial portion of the visit, but the social history should be conducted with the teen alone. Allowing the parent to stay can prevent the adolescent from sharing sensitive information. Explain that it is routine practice to spend part of the visit with the adolescent alone, regardless of what the visit is about so they can start to take ownership of their own healthcare. If needed, you can reassure the parents that they will be brought back after your talk with the patient.

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Once you are alone, explain the concept of confidentiality. Be wary that an adolescent may say they understand when they don't actually understand. One trick is to start by asking if they know what confidentiality means. If they say yes, ask them to share their understanding of it. You can then reinforce what they already know: "Confidentiality means that everything we talk about will be kept between the two of us and others in your healthcare team. It will not be passed along to anyone else, including your parents. The only exceptions are: 1) if you are going to endanger your own life, 2) if you plan on harming someone else, or 3) if someone else is harming you. Examples of such scenarios include physical, emotional, or sexual abuse or neglect. In such cases, we can decide together how to involve the appropriate people to ensure everyone is safe."

SOCIAL HISTORY

The leading causes of morbidity and mortality in adolescents include unintentional injuries, suicide, homicide, obesity, STIs, unintended pregnancies, and substance use. A social history allows healthcare practitioners to identify problems earlier and tailor any preventative care or educational counselling to suit the specific needs of the adolescent.

HEEADSSS is an acronym for adolescent social history-taking commonly taught in medical school. In recent years, it has become increasingly common to take the history in a modified order, captured by the acronym SSHADESS, which stands for:

- Strengths/Interests
- School/Employment
- Home
- Activities
- Drugs/Substance Use
- Eating & Emotions
- Sexuality
- Safety

By following the order of this acronym, the conversation starts off on the topic of "Strengths" to emphasize a strengths-based approach and help build rapport upfront. It also naturally progresses from lesser to more sensitive topics. Regardless of which version of the mnemonic you choose to use, the process of obtaining the social history should be tailored to each patient's context instead of using it as a rigid checklist approach.

Now let's look at each aspect of the SSHADESS history in more detail. The opening question for each section is generally open-ended and does not make any assumptions.

<u>1. STRENGTHS/INTERESTS</u>

Talking first about the patient's strengths starts the conversation on a positive note and helps build rapport. It also allows you to learn about some of their protective factors which you can then use during the discussion as praise and reflective interviewing. Examples include:"How would you describe your personal strengths? What do you enjoy doing? What is something you're really proud of?"

<u>2. SCHOOL/EMPLOYMENT</u>

You can open up this topic by saying, "Tell me about school." Ask about how they are doing academically and their plans for the future. Failing grades can indicate an underlying learning or attention disorder and also correlates strongly with psychosocial issues. Ask if school is a safe place for them, if they've been bullied, and if they feel that they belong at school. A high degree of connectedness in school predicts lower rates of substance use, early sexual initiation, violence, and school absenteeism. For older teenagers, ask them if, where, and how much they are working. Working more than twenty hours a week is associated with negative outcomes like emotional distress and substance use.

3. HOME

These questions help you identify protective and risk factors in their home environment. Ask about their living situation and who resides at home with them. These questions avoid the assumption that every adolescent lives in a two-parent household with a mother and a father. Inquire about how they get along with others at home, whether there have been any changes or stressors at home, and whether they have a support person at home. Events like divorce, moving and having people join or leave the household can be very stressful for adolescents, but connection to supportive adults is highly protective against high-risk behaviours.

4. ACTIVITIES

Ask about hobbies, leadership involvement, extracurricular activities, jobs, and religious affiliations. This further develops the therapeutic relationship and provides you with useful information about their support network.

Ask about their friends and supportive people outside their homes, and what they do for fun. Be mindful and probe around vague answers such as “just hanging out,” with refusal to elaborate as this is a possible sign of engaging in risky behaviour and activities that the adolescent is reluctant to disclose.

5. DRUGS & SUBSTANCE USE

This is a sensitive topic and it may be helpful to approach the subject indirectly. Open up the topic by validating that many adolescents want to explore and try new things. Then ask if any of their friends have ever used drugs, smoked, or drank alcohol, and if they have personally ever felt pressured to do the same.

Stay away from the term “recreational drugs” as teens may not understand what this term means. Ask specifically about alcohol, cannabis (marijuana, THC, CBD), ecstasy, MDMA, and cocaine. Also, ask specifically about off-label use of prescription drugs, tobacco, cigarettes, vaping, caffeine-energy drinks and steroids, as many adolescents do not consider these to be substances.

If your patient discloses substance use, perform a CRAFFT screen to screen for a substance use disorder. If smoking or vaping is brought up, assess readiness for smoking cessation. For more details, check out our podcast on Adolescent Substance Use.

6. EATING & EMOTIONS

This is an opportunity for you to screen for eating disorders, body image or self-esteem problems, depression, anxiety, and other mental health concerns. During the COVID-19 pandemic, there has been a significant increase in such presentations.

To screen for unhealthy eating behaviours, ask about body image concerns, dietary intake, and physical activity. Follow up by asking if there have been recent changes in their weight and whether they have been on a diet in the past year.

With respect to mood concerns, adolescents may experience depression differently than adults, often exhibiting it as boredom, irritability, anxiety, sleep disturbances and social withdrawal. Ask directly about self-harm and suicidal ideation. Research has consistently shown that asking about suicidal behaviour does not increase the risk of it happening. One way of asking is: “You’ve told me that you’ve been feeling low. Sometimes, when people feel this way, they consider ending their own life. Have you ever felt so low that you considered or tried ending your own life?” This statement normalizes thoughts of suicide to help patients open up, and uses clear language. Stay away from ambiguous terms, like “harming yourself” when you mean suicide. Some patients who self-harm are not suicidal, but rather, use it as a coping mechanism for emotion regulation.

If your patient discloses suicidal ideation, determine whether they have a specific plan and the ability to carry out this plan. Remember that suicidality is one of the exceptions to confidentiality.

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For a more detailed review on suicidality, listen to our podcast entitled “Approach to Suicidal Ideation and Behaviour.”

7. SEXUALITY

This may be the most sensitive part of the interview. It is important to acknowledge the discomfort that patients may feel about this topic and seek permission to continue. Assure them that they can choose to take a break or move on at any point if they feel uncomfortable.

Do not assume that your patient is cisgender and heterosexual. If not already done earlier, ask for their preferred name and pronoun. Begin with a broad statement that makes no assumptions about their sexuality, like, “Tell me about any romantic relationships you’ve been involved in.” Then, proceed to a more sensitive question: “Since sexual activity can affect your health, are you sexually active in these relationships?”

If a comprehensive sexual assessment is warranted, you can use the 7 Ps framework to cover the following topics: Partners, Practices, Protection from STIs, Past history of STIs, Prevention of pregnancy, Permission (consent) and Personal gender identity. The last two questions can be especially tricky to ask, and it is important to ask them in a non-judgemental way.

Screen for sexual abuse by asking, “Some of my patients tell me that they feel pressured into having sex. Have you ever felt this way?” When asking about gender identity, you can ask, “Some teens feel that the gender they were born with does not match the gender that they identify with. Have you ever felt this way?” A more comprehensive review of taking a sexual history is covered in our podcasts on Sexually Transmitted Infections in Adolescents and Gender Dysphoria.

8. SAFETY

Injuries, suicide, and homicide are major causes of morbidity and mortality in adolescents. It is important to identify related and predictive factors. These include (and are not limited to) gang involvement, access to weapons, texting and driving, seatbelts, and contact with strangers on the internet.

Begin with the most prevalent threats in your community. Do not let your assumptions and biases based on your patient’s socioeconomic, racial or ethnic background lead you to skip taking parts of the history. Ask about what strategies your patient uses for self-protection, conflict resolution and avoidance of violence. With their permission, refer them to appropriate school-based and community organizations that address these issues.

Always add a brief social media screen. While not officially part of the SSHADESS mnemonic yet, the use of technology and social media among teens is at an all-time high and has implications on their physical and mental health. Screen for excessive screen time and contact with strangers on the internet.

CONCLUDING THE INTERVIEW

To wrap up the interview, thank them for confiding in you. You may want to re-emphasize some of the points on confidentiality and let them know that they can reach out to you anytime. You might also find it helpful to add the patient’s own contact information into their medical records instead of just their parents. . If any concerns have been identified during the interview, appropriate follow-up and care plans should be set in place as well.

It can be challenging to cover each topic in detail in a single visit. It’s important to screen for all aspects of the adolescent history but you can add or remove specific questions based on the individual patient. Ultimately, your goal should be to establish a trusting relationship so your patient feels comfortable turning to you for guidance on health-related matters rather than less trustworthy sources. You can revisit any remaining questions for a later visit.

GENERAL TIPS AND TRICKS FOR RAPPORT BUILDING

Here are some general tips and tricks that you can use to build rapport with an adolescent:

1. Identify strengths early – This is one of the main purposes of the SSHADESS mnemonic: establishing rapport with an adolescent by understanding their strengths and reflecting these aspects of their resiliency throughout the interview as needed.
2. Praise – Adolescence is a phase in life where acceptance and affirmations are extremely important. For many at-risk youths, praise is not something they often hear from adult figures in their life. We want to give praise when praise is warranted.
3. Share your concerns – Gently bring up any concerns you may have, especially if it interferes with goals that they have mentioned. Here is an example: "I am concerned that your alcohol use may be a barrier to you graduating from high school."

SSHADESS IN THE EMERGENCY DEPARTMENT

The ER is often the first point of contact for patients with underlying concerns that could be life threatening, like suicidality, eating disorders or substance use. It therefore also can be the most crucial moment to intervene. Although taking a social history takes time, it should be seen as integral to delivering good care. All parts of the SSHADESS history should be screened, but you may spend more time on life-threatening issues and prioritize questions related to the presenting complaint.

Keep in mind that patients can experience heightened emotions in the ER. Maintain a safe amount of distance. Be aware of signs of escalation, including repetition, not wanting to answer questions, physical posturing, defensiveness, fluctuating behaviour, and pacing. If you feel unsafe, do not hesitate to step out. Remember, your safety comes first!

CONCLUSION

This brings us to the end of this podcast. Let's revisit our objectives.

1. Create a safe environment for adolescents by building rapport. Set up the visit from the beginning so that both the patient and the guardian(s) knows it is routine to speak with adolescent patients alone at some time during the visit. Ensure the patient understands what confidentiality means.
2. To recap the SSHADESS strategy, components of the history include Strengths/Interests, School/Employment, Home, Activities, Drugs/Substance Use, Eating & Emotions, Sexuality, and Safety. Starting with strengths helps build rapport and trust. Remember that this is just a framework. Depending on your patient, some components may require more or less time.
3. Take time to foster a trusting physician patient relationship. Give praise when warranted, and share your concerns about worrying behaviour by highlighting how it interferes with any goals and strengths that they have mentioned.

Thanks for listening! Check out Part Two for an example of a SSHADESS interview.

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