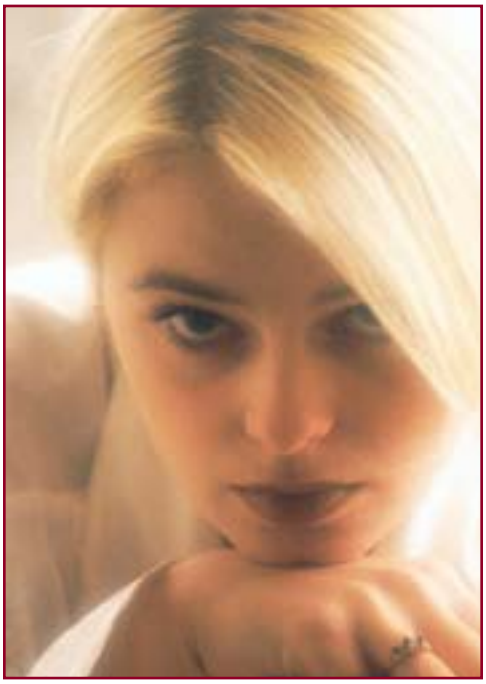

Treating Adolescents: A Survival Guide

Treating adolescents does not have to provoke anxiety. It can be a rewarding experience if one knows how to navigate these unchartered waters. This article identifies the three stages of adolescence and guides general practitioners on the best approach to handling office visits.

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For decades, the period of life known as the teenage years has presented a serious challenge to family, educators and physicians. In 19th century Western society, teenagers did not exist — one was a child until the age required for factory work. Children were seen as small adults and were raised and disciplined accordingly. Those children who were from a privileged background usually ended up in the military.

Today we think of ourselves as enlightened and socially progressive with regards to raising our children. We have become overwhelmed by dealing with "little adults" between the ages of 10 and 20. Western society has few cultural traditions that

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Summary

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- The media and societal perception of adolescent behaviour do not reflect reality. A total of 80% of teens cope well in their development process.
- The most trusted source of information among teens is friends, follo wed by the Internet, and lastly, an adult.
- The lack of comfort adolescents experience with their family doctor remains a problem.
- The potential to intervene early reduces the risk to an adolescent's physical and mental health.
- School-based clinics provide on-site access for health services and encourage confidentiality; a prerequisite for successful outcomes.
- Understanding developmental stages is crucial when evaluating adolescent problems and concerns.

mark the transition from childhood to adulthood (*i.e.*, Judaism: the bar mitzvah). This cultural vacuum is filled with just about anything, much like the characters in *The Lord of the Flies* (a book and movie). Behaviours, ranging from gang membership and its associated violence to affluent peer groups relentlessly piercing and tattooing parts of their bodies, have become the norm. While many parents are frustrated with this sort of behaviour, there is reason to hope through understanding adolescent development.

Adolescence is characterized as a series of developmental stages in which young people learn to become independent and adult-like. Despite the perception of adolescence as a time of emotional turmoil, driven by ever-increasing hormonal fuel, most teenagers get through this period with few problems. A total of 80% of all adolescents cope well with the development process. This is despite having to cope with disrupted families, bullying, school performance, issues of sexuality and risks of pregnancy, to list a few conditions. It is the remaining 20% that pose the greatest challenge.

The Role of Family Medicine

Intuitively, most doctors realize teenagers can suffer as adults do. Unfortunately, most adolescents' ability or willingness to access the health-care system is limited. A teen may see his/her family doctor or go to a walk-in clinic or emergency room. Most seek advice from friends and the Internet before discussing their problems with an adult (not necessarily a parent). Providing a single, reliable source for health-care and health related information is one of the difficulties encountered when trying to treat teens.[1,2]

As family practitioners, we must stress to our adolescent patients why it is important to have one "regular" doctor. We must provide continuity of care and be accessible to meet their needs. Our practice should be oriented towards the family in order to better understand the dynamics of, and interactions between, your adolescent patient and his/her parents (who may also be your patients). It is of utmost importance to communicate effectively your role in his/her health-care. A direct, honest

approach, as well as a description of your practice philosophy, is essential. The more a patient understands where you are coming from and why you are treating him/her in a certain manner, the more he/she will comply.[3,4]

Our goal is not only to prevent illness and accidents, but also to intervene earlier in pre-existing conditions (*i.e.*, eating disorders, diabetes, addictions, *etc*). Inevitably, we are confronted with situations that may conflict with our own moral code. It is crucial to be non-judgmental and to refer patients to another doctor if one is uncomfortable with, or ambivalent about, the patient's needs.[5,6]

Adolescent Development

Adolescence, like childhood, can be divided into stages of development: early, middle and late. The earliest stage occurs in girls aged 11 to 13 and in boys aged 12 to 14. They are concerned about body image and sexual changes, in comparison with others their own age. Adolescents have to adapt to new school environments and the concomitant social pressures. They have a conflict between their dependence upon their parents and their desire to be more independent. In other words, they want to leave their parents, but still need them. They have an inability to comprehend future consequences of their actions. The effects of illness at this stage reflect a threat to their physical integrity and mastery of their environment.

During the middle stage (girls 13 to 16; boys 14 to 17) body image and sexual identity consolidate. Adolescents adapt to their school environment, but their struggle for independence continues. Peer pressure is a dominant influence on their behaviour. In this stage, frontal lobe development nears completion. Some teens will mature earlier than others. Many, though, will partake in risk-taking behaviours as they are given more responsibility (*i.e.*, driver's licenses). Illness can threaten their independence and sexual identity.

Over the age of 17, adolescents develop a crystallization of identity and a desire to plan for the future. Peer groups become less important. They begin to seek more intimate relationships. Illness during this stage interferes with higher education and career planning.

Approach to the Adolescent

While adolescent health care is one of the areas identified by the Canadian College of Family Physicians where residents require more training, the realities of budget cuts have led to a low level of prioritization for this discipline. Adolescents often obtain care in a haphazard manner through different walk-in clinics, the emergency room, their friends, or perhaps not at all.

When the authors visit the classroom, they ask students how many have their own family doctor. Most will raise their hands. The follow-up question is: "How many of you feel completely comfortable talking to your doctor about any subject?" Few, if any, hands remain raised. This response is universal for the hundreds of classes the authors have visited. This lack of trust is one of the greatest obstacles in providing effective, preventative care.

As physicians, we tend to be less comfortable when dealing with the sensitive issues of our adolescent patients. How does one approach the adolescent patient? How do we prepare ourselves to talk to a 13-year-old *versus* a 16-year-old? How do we sit in our chair? Do we take notes while they are speaking? Do we glance at our watches? Although these questions might seem superfluous, they embody an approach that can contribute to either a strong or weak doctor-patient relationship.

Family physicians can be more successful communicating, assessing and treating teens. Common obstacles are patient fears of breached confidentiality being ignored, judged or mistreated. Many family physicians raising their own teens may fall into a transference-countertransference trap. Physicians often wind up coming across as a parent or, conversely, as a "friend." Neither approach is helpful in communicating and establishing a trusting bond with teenage patients.

Further, adolescents are masters of body language and are very sensitive to signs that their doctor is disinterested in what they have to say. A nonjudgmental, interested, confidential and supportive manner is more likely to help establish trust with an adolescent patient. Once that is achieved, his/her problems become much easier to treat; in particular, by ensuring a more compliant patient.

The Office Visit

In evaluating the teenage patient, tailor your approach to his/her stage of development. The most important question we must ask ourselves is: "What is the patient's agenda?" When an adolescent presents with what may seem to be a minor complaint, there could be a more serious underlying problem. He/she may be afraid to bring it up. This is known as the "foot-in-the-door" technique. It presents an opportunity for the physician to better understand the patient. If you suspect an ulterior motive in your adolescent patient's visit, a simple and direct approach is best. The authors ask: "Sometimes it is difficult for patients to bring up issues bothering them. You appear to be concerned about something. Is there something else on your mind that is important to you?"

It is critical to educate your patient prior to examining him/her. Adolescents want to know why they are being subjected to potentially embarrassing and uncomfortable procedures. This is especially true for

gynecologic exams. It is rare for a patient to refuse an exam if he/she feels his/her concerns are adequately addressed. Avoid medical jargon and provide information in a manner consistent with his/her developmental stage.

While examining your youngest adolescent patients, it is helpful for them to know you consider them to be physically normal. In the middle stage, give pause and concern about how their medical condition will affect their ability to remain in a peer group. In the late phase, it is helpful to explain how their condition can affect their long-term plans.

Allow your patient to make his/her own decisions. This reinforces his/her desire to be more independent and demonstrates your respect for his/her judgment.

School-based Clinics (SBC)

School-based clinics (SBCs) have been instituted to provide convenient, confidential and effective treatment and education.[7-10] The notion of school-based clinics is not new. SBCs have been in operation in the U.S. for more than two decades in one form or another. There is reason to believe SBCs can reduce morbidity and mortality in teens through early or timely intervention. The Headstart program, work-

ing with inner city children and teens in U.S. cities, has stimulated greater outcomes, not only in behaviour and intelligence, but also in academic and professional performance *(www2.acf.dhhs.gov/programs/hsb).*

Early intervention in conditions such as depression, addiction, abuse, pregnancy risk and eating disorders should make a substantial difference in the short and long-term outcome. Screening adolescents for problems, such as sexually transmitted diseases, should enable them to avoid some of the difficulties affecting adults today.

It is important to keep in mind that SBCs are not intended to replace the existing family doctor's relationship with his/her adolescent patient. Trust and confidentiality are of paramount importance — they constitute the prime directive of adolescent care and are the challenge of adolescent medicine. Adolescents are concerned their family doctor will talk to their parents about their problems. Rightly or wrongly, that is their consistent impression and perception of family practice. The authors try to reverse this trend by working in conjunction with parents and doctors. While it is critical to ensure confidentiality, the authors routinely encourage their patients to disclose their problems.

There has been a lot of research published in the U.S. about SBCs, but the outcomes have not been as good as one would hope. For the most part, SBCs have been proscribed from dealing with culturally sensitive issues, such as sex education and, teen pregnancy.

In Canada, universal health care has created a climate very conducive to the development and support of SBCs. Such clinics could be started in all schools across the country for a fraction of the cost of a $100-million, anti-smoking campaign. SBCs would also provide the counseling and follow-up necessary to keep teens from relapsing into their nicotine habit.

Conclusion

Treating adolescents does not have to provoke anxiety. It can be a rewarding experience if one knows how to navigate these uncharted waters. It is regrettable that more attention has not been spent on educating doctors about adolescent medicine during residency. The authors encourage family medicine programs to incorporate some training on treating adolescents in their standard curriculum, as is recommended by the College of Family Physicians. The authors believe the SBC model is the best template to use. CME

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