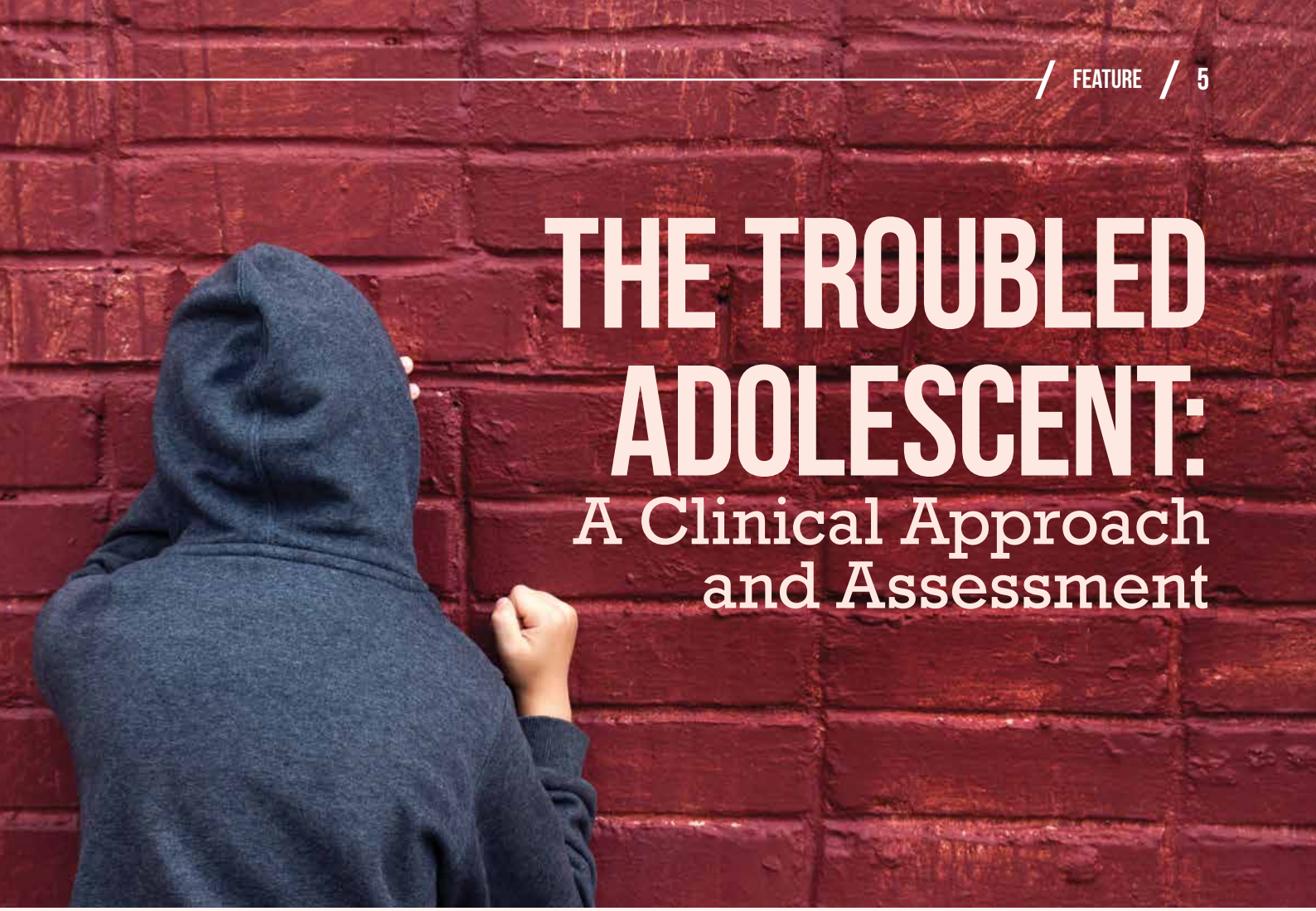

THE TROUBLED ADOLESCENT:
A Clinical Approach and Assessment

Engaging the adolescent is the key to a successful therapeutic "doctor-patient relationship". Using the adolescent development screening framework HEADSS[1], followed by a sensitive physical examination, forms an important therapeutic baseline. An understanding of the concerns and developmental tasks of adolescence is vital in order to detect abnormal behaviour. Knowledge of local youth resources and early referral for more complex problems is advisable.

The Lancet recently commissioned a report on global adolescent health and well-being in May 2016 and it states: "During adolescence, an individual acquires the physical, cognitive, emotional, social and economic resources that are the foundation for later life health and well-being".[2] The report calls for more global investment into adolescent health and well-being programmes, better awareness of young peoples' health needs and training for health professionals to address these needs.

Adolescents or young people (ten to 24 years of age) usually enjoy good physical health but have to bear a host of psychological and emotional stresses in this developmental phase. During this period, they have to deal with the conflicting pressures presented by society, their family members and their peers, at a time when they are self-conscious and self-centred.

Coupled with these pressures is an inner conflict that seems to be a prerequisite for growing up — a necessity to assert independence, together with a continuing need to rely on parental support. Any obstacle or family dysfunction that impedes the achievement of developmental tasks (Table 1) will exaggerate the conflict and result in maladaptive behavioural problems such as acting out, school truancy, sexual promiscuity, substance abuse, etc. Moreover, the brain development also undergoes changes during adolescence. Studies in adults suggest that most mental disorders begin before 25 years of age, most often between 11 to 18 years.[3] Therefore, it is important for clinicians to distinguish between "normal" and "abnormal" adolescent

Table 1: Developmental tasks of adolescence

1. Establishing identity and self-image
2. Separating from the family
3. Establishing an adult sexual role
4. Making career and vocational choices

behaviours. What are normal mood swings and puberty blues, such as angst, defiance and moodiness, versus persistent anxiety, depression and anti-social behaviours? When is dieting to lose some weight a normal behaviour rather than an early sign of an eating disorder such as anorexia nervosa or bulimia nervosa? Is a mono-syllabic adolescent male patient lacking eye contact just being quiet and shy, or exhibiting features of autism spectrum disorder (ASD) and disconnectedness?

In order to assess the adolescent appropriately, physicians need to firstly engage with them during the consultation and then proceed to discuss the presenting problems. After which, when a physical examination is performed, extra sensitivity needs to be put in place as the adolescent is often very conscious about his/her developing body and body image.

ENGAGING WITH THE ADOLESCENT PATIENT

Empowering young people and building trust begins in the waiting room. It is important to greet the adolescent patient first before greeting their parents. It is also important to be friendly, respectful and non-judgemental, in order to gain his/her trust. Often, relating to parents is also a challenge during consultation and the physician should be tactful in his/her approach to ensure that the needs of both the adolescent and his/her parents are being met. It is preferable to see them together first to observe their interaction before seeking an opportunity to spend some time alone with the adolescent. The common practice is to first see them together, then ask their permission to see the adolescent alone for a short period, before inviting the parents back in for feedback after assessment. However, some adolescents may choose to have a parent present in the room throughout the consultation and that wish has to be granted. It is advisable to seek another opportunity to see the adolescent alone during follow-up visits. The physician is the advocate for the adolescent patient and provides the care that he/she needs.

Confidentiality is a key issue when seeing the adolescent alone so that a trusting relationship is built between the physician and the patient. Exceptions to this obligation must be explained from the outset that if the adolescent reveals self-harm, suicidal intent, being subjected to physical/sexual abuse and/or intent to harm others, then the physician has to notify others in their best interests to keep them safe. The physician should always try to encourage the adolescent to share sensitive information with their parents, as their support often helps in their well-being, and will help them cope in the future. Once trust and confidentiality are agreed upon, the consultation can then commence. The physician should listen and take the adolescent's distress seriously.

ASSESSING THE TROUBLED ADOLESCENT

When assessing a troubled adolescent with features of abnormal behavioural problems, be it emotional, social or psychological, the physician must take into account the severity and chronicity of the problem, and the adolescent's development. These relate to their independence, body image, relationship with peers, school performance and perceived identity. Using the HEADSS framework (Table 2), a comprehensive assessment of the adolescent's total environment will provide much needed information in distinguishing normal adolescent adjustment reactions versus abnormal behaviours that require more comprehensive and complex assessment and management. Often, mental health problems such as depression, anxiety, eating disorders and ASD can be identified and appropriate referrals can be made.

Two challenging clinical presentations will now be discussed to illustrate the approach for each "troubled" adolescent patient: excessive dieting in a female adolescent, and assessing and detecting ASD in a disengaged young male.

NORMAL DIETING VS AN EATING DISORDER

When a thin adolescent female patient who is accompanied by her mother presents to the physician because she is losing weight and refusing to eat, one has to have an index of suspicion that an eating disorder may be present. Apart from excluding a physical cause for the weight loss by taking a comprehensive medical history, performing a thorough physical examination and ordering appropriate basic laboratory tests, it is essential to take a dietary history, and eating and exercise patterns since the onset of the weight loss. A history of preoccupation with food and calories, bingeing and self-induced vomiting and excessive exercise despite weight loss, points to an eating disorder. Using the HEADSS assessment, the physician would also be able to detect the progressive withdrawal from peers and other social activities with the family, and the onset of depression. Once the diagnosis is confirmed, the management starts with a clear explanation of the illness to the patient and her family members.

Management techniques in counselling adolescents with eating

Table 2: The HEADSSS approach

H	**Home**
E	**Education/employment/eating/exercise**
A	**Activities/peers**
D	**Drugs/cigarettes/alcohol**
S	**Sex/sexuality (abuse)**
S	**Suicide/depression screening/other symptoms**
S	**Safety/spirituality**

disorders require tact and sensitivity. It also depends on the training and competence of the physician and the severity of the problems. Often, individual and family therapy are required, and referrals to the psychologist/psychiatrist and a multidisciplinary team that includes a dietician will ensure optimal outcome and recovery. The physician maintains a liaising role, monitors the physical conditions of the young person and provides support for the family.

ADOLESCENTS WITH ASD

The diverse expressions of the symptoms of ASD pose diagnostic challenges to clinicians. Individuals with ASD may present at various times of development, including adolescence, as symptom expression may vary over the course of development. Some of the symptoms of ASD can include disconnection with others and inappropriate emotional outbursts, which can be similar to normal adolescent rebellious defiant behaviours. There are also psychiatric co-morbidities associated with ASD, such as depression, anxiety, schizophrenia and obsessive compulsive disorders. Hence, when a male adolescent presents with "behavioural" problems, it is important to exclude ASD using the adolescent development screening HEADSS framework first to distinguish between normal and abnormal behaviours. The lack of engagement and eye contact, history of social isolation, poor school performance, repetitive ritualistic habits and lack of emotional responses would alert the physician to the presence of ASD and refer the adolescent for further assessment. As the diagnosis of ASD in an adolescent is often challenging, there are specific screening tools developed by the National Institute for Health and Care Excellence and the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, among others. These will not be discussed further in this article.

The primary care physician who has the index of suspicion that the adolescent has ASD ought to refer the adolescent to experienced clinicians for a more comprehensive assessment. This often involves a multidisciplinary team of health professionals, including clinical psychologists and psychiatrists, who will assess the young person based on their own assessments. The observations of teachers and parents in various contexts of the young person's growth and development will also help with diagnosing ASD. After the diagnosis, the primary care physician often provides comprehensive whole person care to the patient for other healthcare needs. Parental support is vital as family members usually encounter major stresses and family dynamics are often disrupted.

HEALTH SERVICES INTERVENTIONS

Adolescents have special healthcare needs and in order to deal with the emerging health issues that they face, health services ought to respond to the challenges of providing appropriate care for them. Youth-friendly clinics have been established in some countries to care for young people as they find most medical clinics more suited to children or older adults. Others provide a multidisciplinary service model for at-risk youths with substance abuse or psychological/behavioural problems.

In order to encourage young people to seek medical assistance when they are distressed, all healthcare providers need the knowledge and skills to respond to the complex health issues as they go through adolescence.

In summary, the key to successfully identifying problems in the troubled adolescent lies in the initial doctor-patient relationship and the physician's awareness of the developmental issues in adolescence. At the same time, the physician has to win the confidence and approval of the parents to avoid sabotage. Counselling and working with adolescents is one of the most challenging and rewarding experiences in medical care. ◆

PROFILE

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