Principles of Psychosocial Assessment of Adolescents

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Abstract. Psychosocial and mental health problems are quite prevalent among adolescent worldwide, some data reporting up to 20% of adolescents having such problems. A number of risk factors, familial, individual and societal, have been indentified as contributing to these problems in adolescents. There are also many factors, such as family and societal connectedness, that protect adolescents from engaging in health risk behaviors that lead to psychosocial and mental health problems. A careful psychosocial assessment should be an essential part of adolescent health care. This paper provides a brief review of the principles of psychosocial assessment of adolescents. **[Indian J Pediatr 2003; 70 (10) : 775-780]**
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The major causes of mortality among adolescents in the United States result from preventable causes (motor-vehicle crashes, other unintentional injuries, homicide, and suicide). The major causes of death in Asia, Africa, Eastern Europe and other countries are from disease and war; however, preventable factors such as violence, suicide, and unintentional injuries are becoming more prevalent.

Approximately 20% of adolescents have some type of psychosocial problems that impair their ability to function. Many of these youth would visit the physician's office with concerns about a physical symptom as a means of gaining access to address a psychosocial problem. A brief psychosocial assessment will often be sufficient to detect problems that range from those with minimal negative impact (transitional) to those which represent significant threats to the adolescent's ability to function and mature (Table 1).

Adolescents are vulnerable to psychosocial dysfunction when they suffer physical injuries, psychological trauma, or major changes in their environments especially in the absence of strong support systems. The physician may be the first and only professional that parents and adolescents have trust. Therefore, developing an understanding of the psychosocial issues affecting the health of their adolescent patients can increase the physician's ability to detect and manage psychosocial distress.

Defining Psychosocial

The term psychosocial refers to the interplay between biological, physiological, emotional, cognitive, social, environmental and maturational factors. Each of these factors must be considered when evaluating the problems and needs of adolescents. Acquisition is the primary focus of language, motor, cognitive, perceptual, and psychosocial development in infants and young children. As children mature into adolescents, the focus shifts from acquisition of new skills to the integration and refinement of knowledge, aptitude, and skills. Physiological changes continue along with the rapid changes during puberty, while other skills are being refined (such as adaptive functioning, self regulation, coping abilities, emotional and social functioning evolve from egocentric to embrace concerns and caring about the others, society and world issues in general). All of this maturation has a general trajectory but each adolescent gains or fails to gain mastery in unique ways. This uneven maturation process can cause mild to debilitating problems for some youth.

The Role of Psychosocial Functioning

Psychosocial functioning involves the integration of an adolescent's social, emotional and psychological function (thinking ability, abstract thinking, insight, problem solving, creativity), aptitude and achievement. Many other factors also affect an adolescent's psychosocial functioning including positive and negative life events, familial or interpersonal stress, housing/living conditions or status, physical health status of family members, the family's relationship stability, financial circumstances, socioeconomic status, educational levels, history of mental illness, history of substance use and/or abuse, parental history of incarceration or physical abuse, the presence of a chronic illness (parents, siblings), and a recent death or loss in the family. Individual factors that comprise an adolescent's psychosocial functioning include experiences with successes and failures, presence of family

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connectedness, presence of strong support system, physical health status, presences of mental illness, presence of chronic illness, and academic/educational success or failure, occuptional issues, involvement in high risk behaviors (drinking, smoking, gang membership, deviant behavior, criminal behavior), exposure to violence, involvement with the legal system (juvenile or adult justice system), and presence of deviant behavior.

Examples of Differential Use of the Psychosocial Assessment

The information gathered from a comprehensive psychosocial history facilitates detection of risk factors, resources, and diagnosis of disorders. The analysis and synthesis of psychosocial factors will help the physician determine the severity of risk and symptoms. For example an adolescent who is sad, often cries, isolates himself, is disinterested in activities that he previously enjoyed, and is having difficulty concentrating–would not be diagnosed with major depression if the physician knew that the adolescent's father was just sent to prison and the teenager would no longer have contact with his beloved parent.

The physician might consider referring the adolescent for brief counseling, and perhaps not assigning a mental health diagnosis, but instead indicate that the behavior was the result of the loss of a parent's supprot. If the behavior continued beyond a one year period and the symptoms escalated and included more maladaptive behaviors, then the physician would give the diagnosis of adjustment disorder with depressed mood, refer the patient for counseling, and help the mother establish or reconnect with other support systems in the family and community. If the adolescent was unable to function academically and had thoughts of suicide, then psychopharmacological intervention might also be warranted.

A second example would involve the same symptoms but different antecedents. In this instance a young man had experienced the death of his father last year. Therefore, major depression would not be diagnosed in this case either; instead his emotional state would be considered "due to bereavement". The clinical picture would change drastically if this young man presented with the same clinical symptoms but had a mother who had been diagnosed with manic depressive disorder, and a grandfather who had committed suicide, and an uncle who was hospitalized for major depression. In this instance, the physician would have a much higher index of suspicion that the adolescent may be presenting with early clinical signs of psychopathology and would refer this young man for a complete psychological evaluation and monitor for any increase in symptoms or other risk factors that might warrant psychopharmacotherapy and psychotherapy at the initial stages of assessment. The addition of suicidal attempts and or psychotic symptoms would indicate that a referral to a child psychiatrist would

Table 1. Risk Factors for Experiencing Psychosocial Problems

Familial	Personal Behavior	Peer Relationships
Family history of mental illness	Appearing older than peers	Peer rejection
Abusive or neglectful parent	Being overweight	Inability to make/sustain intimate relationships
Poverty	Chronic illness	History of physical or mental abuse
Parent(s) who has been in prison	Problems with school work	Dating
Divorced parents	Repeating a grade in school	Recently breaking-up with romantic partner
Personal history of physical abuse	Academic failure	Associating with peers who abuse substances
Parent(s) use(s) inconsistent punishment	Smoking cigarettes	Belonging to a gang
Parent(s) use(s) or abuses alcohol	Drinking alcohol	Associating with peers who engage in risk behaviors
Parent(s) use(s) or drugs substances	Smoking marijuana	Intimate with peers who believe violence is acceptable for conflict resolution
Access to guns at home	Riding in cars with a driver who has been drinking	Intimate with peers who engage in deviant behavior
	Sexual activity	
	Spending a lot of time just "hanging out"	
	Dating	
	Rarely or never wearing a seat belt	
	Carrying a weapon	
	Using illegal substances	
	Vomiting to control one's weight	
	Excessive exercise	
	Excessive use of laxatives	
	Binge eating/purging	
	Threatening another person	
	Physically fighting	
	History of suicidal attempts	
	Being a married female	
	Being pregnant	
	Being part of forced labor	

be warranted. The physician would remain involved and ask all treating clinicians to provide written updates. Additionally, the physician would coordinate care and help the parent and adolescent understand treatment.

A third example involves the adolescent who has diabetes. If the adolescent has interested and involved parents, management of the chronic illness is much simpler and the aversive side effects of the disorder can be minimized both physiologically and psychologically. However, the adolescent who has parents who either cannot or will not provide adequate nutrition, guidance, support, and medications or who create a hostile or conflict oriented environment may be at grave risk for experiencing medical, emotional and psychological problems. An adolescent's medical and mental health problems do not exist in a vacuum the severity and impact of these conditions are greatly affected by psychosocial factors such as having (*i*) strong parental support and involvement are strongest protective factors against adverse affects of navigating through psychosocial maturation process; (*ii*) a sense of family (parent– adoleslcent) connectedness; (*iii*) parents who have expectations regarding school achievement; (*iv*) a sense of school connectedness; (*v*) parents who disapprove of early sexual intercourse, of these factors all serve as protective factors against adolescents engaging in risky health related behaviors.

Conducting a Comprehensive Psychosocial History

An accurate and comprehensive psychosocial history (Appendix) will allow the physician to gain access to most of the psychosocial factors that will impact the adolescent's health and aide parents and adolescents in building and maintaining a strong support system.

The guiding principles for conducting a psychosocial assessment are :

1. Collect a psychosocial history.
2. Conduct a brief mental status exam.
3. Determine the content, context, intensity, frequency, duration, situation, persons involved, and impact of the problem.
4. Determine external factors that impact patient's ability to manage problem.
5. Determine the level of risk to the patient, family or others for not resolving the problem.
6. Have the parents and patient identified the desired outcome.
7. Determine if this problem can be appropriately managed in the office or need referral.
8. Request referral sources remain in contact provide feedback to you.
9. Provide explanations, information, and support to adolescent and patients. Remain involved

Table 2. Reasons to Conduct Routine Psychosocial Screening

To identify the individual's strengths and weaknesses
To identify support systems and resources that will facilitate treatment
To identify obstacles or factors that could impede optimal growth and development.
To identify stressors that may exacerbate symptoms.
To differentiate between behaviors that are normal for an adolescent's age, gender, ethnicity, culture, environment, familial circumstances and societal norms
To identify anticipatory guidance to parents of normally healthy adolescents
To identify following developmental disorders;
- *Mental Retardation*
- *Learning Disorders (reading, mathematics, written expression)*
- *Motor Skills Disorders (coordination)*
- *Communications Disorders (expressive, receptive, phonological, stuttering)*
- *Pervasive Developmental Disorders (autism, Rett's, disintegrative, Asperger's)*
- *Attention Deficit Hyperactivity Disorder (combined type, inattentive, hyperactive)*
- *Disruptive Behavioral Disorders (conduct, oppositional defiant, disruptive)*
- *Feeding and Eating Disorders (pica, rumination)*
- *Tic Disorders (Tourette's motor or vocal)*
- *Elimination Disorders (encopresis, enuresis)*
- *Other Disorders of Infancy, Childhood, or Adolescence (separation anxiety, selective mutism, reactive attachment, stereotypic movement)*

To identify following mental health conditions that would impair an adolescent's ability to function; and to facilitate referral, treatment, and monitoring:
- *Substance use or abuse*
- *Mood Disorders (major depression, dysthymia, bipolar)*
- *Anxiety Disorders (panic, agoraphobia, social phobia)*
- *Somatoform Disorders (somatization, conversion, hypochondriasis)*
- *Factitious Disorders*
- *Dissociative Disorders*
- *Sexual and Gender Identity Disorders*
- *Eating Genders (anorexia, bulimia)*
- *Sleep Disorders (insomnia, hypersomnia, narcolepsy, nightmare, sleep terror, sleep walking)*
- *Impulse-Control Disorders (intermittent explosive, kleptomania, pyromania, gambling, trichotillomania)*
- *Adjustment Disorders (with depression, anxiety, disturbance of conduct)*

PSYCHOSOCIAL HISTORY FORM

Appendix

Demographic Data

1. Name/Date of Birth/Chronological Age
2. School Name and Type (Private, Home School, Public, Magnet)
3. Grade/Academic Performance/Type of Education (Regular Special Advanced Classes)/Subjects
4. Who does the adolescent live with?
   Biological/adoptive/Foster Mother; Biological/adoptive/ Foster Father; Step Mother/Father/Grandparents
5. Who lives in the adolescent's home?

Parents/Care/Providers

6. Mother's Name/ Age/ Educational Level/ Occupation
   Father's Name/ Age/ Educational Level/ Occuption
7. Are parents: Married? Separated? Divorced? Deceased? Never Married?
   If parent is single is there a significant other? Does that person live with family?
   Significant Other's Name/Age/Educational Level/Occupation
8. Siblings: Names/Age/Grade/Quality of relationships with patient

Family Mental Health History

9. Parental depression, suicide, anxiety disorders, obsessive/ compulsive disorders, psychosis, schizophrenia, manic depression?
10. Parental substance abuse (alcohol, heroin, cocaine, etc.)?
11. Does the adolescent smoke cigarettes or chew tobacco?
12. Mental Illness or Substance abuse history for grandparents, aunts and uncles and siblings.

Violence Exposure

13. Family Violence (parents, siblings, other family members)?
14. Has patient ever been victim of violence (from parnts, siblings, family member, peers, stranger) including rape, molestation, physical assault, verbal abuse. If yes, where did the violence occur?

Life Changes/Stressful Events

15. Any recent changes in educational status, break up of intimate relationships, current or impending problems with law or police?
16. Any changes in living conditions, parental relationships?
17. Any physical injuries that prevent normal participation in previous activities?

Somatization of Symptoms

18. Is the adolescent currently experiencing any pain or painful symptoms (headache, stomachache, cramps, joint pain)?

Health Status

19. Does the adolescent have any medical illnesses/chronic illnesses?

Sexuality

20. Sexual orientation : Heterosexual, homosexual, undecided?
21. Is/has the adolescent (been) sexually active? if yes, details of sexual practices, hostory of sexually transmitted diseases?

Patient's Mental Status

22. Is the adolescent oriented to person, place, and time?
23. Does the patient have age appropriate recent, short-term, and long term memory?
    (Can tell you recent events in his or life; can tell events from a week and a month ago, can give you
    historical data-birth date, past functioning, from 6 months ago, from a year ago from his or her childhood)
24. Does the adolescent display an appropriate range of affect to the situation and environment?
25. Does the adolescent speak in an appropriate manner articulation, fluency, rate, and tone)?
26. Is there evidence of any hallucinations, delusions, obsessions, or compulsions?
27. Does the adolescent evidence age appropriate judgment and insight?

Suicide/Homicide Assessment

28. Has the adolescent thought about suicide? If yes how will he or she complete the act? (place, time, method, circumstances)? What has prevented action thus far? What keeps him or her from planning?
29. Has the adolescent ever attempted suicide? What did he or she do? What was the outcome?
30. Has the adolescent thought about homicide or attempted homicide? If yes, who does he or she want/tried to kill)? How will he or she complete the act?
31. If the adolescent identified a method of suicide or homicide, does he or she have access to or possession of the identified resource (pills, rope, gun, access to high places)?
32. If the adolescent has a plan for homicide what is preventing them from implementing?

Peer Relationship

33. Does the adolescent have any peer relationships? With whom? What is the quality of those relationships? Does his or her parents approve of the relationships?
34. Does the adolescent date? If yes with parental approval?

Coping Skills

35. How does the adolescent manage conflict, anger, anxiety, sadness, joy, excitement?

Leisure Activities

36. What does the adolescent do for fun?
37. Level of physical activity

Self Esteem/Competence

38. What does the adolescent identify as his or her area of competence?
39. How does the adolescent describe him or herself (verbally or a self-portrait)?
40. How do the adolescent's parents describe him or herself (verbally or a self-portrait)?
40. How do the adolescent's parents describe him or her?

Future Orientation

41. Does the adolescent have any plans for the future? What are they?

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SYMPOSIA SCHEDULE FOR 2003

Transplantation	Aug 2003	Anupam Sibal (India)
Hematology-I	Sep 2003	V.P. Choudhry (India)
Advances in Oncology-I	Oct 2003	L.S. Arya (India)
Hematology-II	Nov 2003	V.P. Choudhry (India)
Hematology-III	Dec 2003	V.P. Choudhry (India)

SYMPOSIA SCHEDULE FOR 2004

Neurology	**Veena Kalra**
Nutritional Disorders	**Kamala Krishnaswamy**
Common Pediatric Surgical Problems	**D.K. Mitra**
Developmental & Behavioral Disorders	**M.K.C. Nair**
Protocols for Managing Severe Infections	**Ashir Kumar**
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