A strength-based approach to adolescent risk reduction

Naomi A. Schapiro, RN, PhD (c), CPNP
Clinical Professor, UCSF School of Nursing
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Traditional Approaches to Risk Reduction

• Risk Assessment
• Anticipatory guidance

• Health Belief Model:
  – Perceived Severity of condition
  – Perceived Susceptibility to Condition
  – Perceived Benefits of Taking Action
  – Perceived Costs of Taking Action Outweighed by Benefits
Traditional Approaches to Risk Reduction

• Health Belief Model:
  – Perceived Severity of condition
  – Perceived Susceptibility to Condition
  – Perceived Benefits of Taking Action
  – Perceived Costs of Taking Action Outweighed by Benefits

• Prompts & Reminders

• Support Self-Efficacy
Traditional Approaches to Adolescent Risk Reduction

- Risk Assessment
  - Deficit model
- Anticipatory guidance

- Health Belief Model:
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  - Perceived Susceptibility to Condition
  - Perceived Benefits of Taking Action

- Leading causes of death & illness in teens related to risk behaviors
  - Accidents
  - Suicide
  - Homicide
  - Drug & alcohol use
  - Sexual activity
  - Increasing prevalence of mental health conditions
Traditional Approaches to Adolescent Risk Reduction

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- Health Belief Model:
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- Psychosocial Screen (HEADSSS) – problem oriented

- Home
- Education
- Activities
- Drugs/Diet
- Sexuality & Abuse
- Suicide/Depression
- Safety
### Sexual Behaviors in US

#### Percentage of Americans Performing Certain Sexual Behaviors in the Past Year (N=5865)

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Teen Sexual Behaviors

• Chlamydia Rates (2008)
  – 15-19 yrs – 1956/100,000
  – 20-24 yrs – 2084/100,000

• Teen pregnancy rates (2006)
  – Overall 7.1%
    • California has highest numbers
    • Highest rates in New Mexico, Nevada, Arizona, Texas, Mississippi
  – Steady decline from 1990 to 2005, rise in 2006
How does knowledge translate to condom use?

Condom Use Rates by Age & Gender
(% of past ten vaginal intercourse acts that included condom use)
(N = 3457)

http://www.nationalsexstudy.indiana.edu
How does the Health Belief Model intersect with Adolescent Development?

• Teens are
  – present oriented
  – less likely to perceive personal susceptibility to adverse consequences
  – ambivalent about authority/messages about what they should do
  – eager for discussions about risky behaviors and mentoring about making their own healthy choices
Strength Based Approaches

• Elicit & acknowledge the teen’s own personal resources & context of their lives

• positive youth development
  – “orients youth toward actively seeking out and acquiring the personal, environmental, and social assets that are the ‘building blocks’ for future success.” (Duncan, 2007, doi:10.1016/j.jadohealth.2007.05.024)
  – Assets associated with positive transitions to adulthood & lower levels of risky behavior
Strength Based Approaches

• Youth are using their increasing cognitive and emotional/social skills to achieve these assets
Consistent with client-centered counseling

- Client-centered counseling (AKA Brief Intervention AKA Motivational Interviewing)
  - Helps client resolve own ambivalence
  - Help increase own confidence to change

- FRAMES
  - Feedback of behavior
  - Personal Responsibility for Change
  - Advice to Change
  - Menu of options for change
  - Empathy for patient/situation
  - Promote Self-efficacy
Adolescent Context: Cognitive/Psychosocial Development
Early adolescence (10-13)

- Little practical experience (taking the bus, filling a prescription)
- Very concrete, very present-oriented
- Very focused on body image, body changes
- Peer group very important
Middle adolescence (14-16)

• Some ability to engage in short-term planning
• ↑ but limited practical experience
• ↑ dating, risk-taking behaviors
• Peer group activities
Late adolescence (16-23)

- Approaching adult cognition, abilities to plan
- ↑ long-term goals
- ↑ life skills
- More independence from peer group
- ↑ drinking, drug use, STDs compared w/ older adults
Risk-taking: is it good or bad for the teen?
Risk-taking: is it good or bad for the teen?

- How does driving promote
  - Independence
  - Mastery
  - Generosity
  - Belonging

- What are developmental concerns related to risk & asset building?
Concept of Risk

• Biopsychosocial view (Jessor, 1991)
• Outcomes of behaviors
  a. social, legal as well as biomedical
  b. positive as well as negative outcomes
Role of Risk in Adolescent Development

1. Gaining peer acceptance and respect
   [Connection]

2. Establishing autonomy from parents
   [Independence]
Role of Risk in Adolescent Development

3. Repudiating norms and values of conventional authority [Independence]

4. Coping with anxiety, frustration

5. Marking transition out of childhood to more adult status [Mastery]

How does risk intersect with Generosity?
Screening for Assets & Risks - SSHADESS

- Strengths
- School
- Home
- Activities & Employment
- Drugs & Diet
- Emotions
- Sexuality, Sexual Abuse
- Safety – youth violence & accidents VERY important – can’t cover today within time frame
Strengths

• Highlighting to frame the rest of the discussion
  – How does youth describe self?
  – How much prompting is needed?
  – Are you surprised by the answers?
    • How does this change your approach?

• Questions:
  – How would you describe your personal strengths?
  – If you were in a job interview, what would you tell a boss about why should be hired?
  – What do your friends say about you?
Strengths

- Jasmine is 16 years old, new to your clinic.
- She spent most of last year in residential or day treatment for multiple psychiatric issues.
- Recently living with mother – was in foster care.
- GPA 1.4 last year.
- Has “friends with benefits” (male) – minimal condom use.

- When asked to describe her skills and best personality characteristics, Jasmine enthusiastically answers: great voice, great friend, loves to read, good concentration.
School - Strengths

How does school build:

• Mastery
• Independence
• Generosity
• Belonging
School - Strengths

• Disconnection from school often a precursor to other risky behaviors (especially middle school)
• What strengths does Jasmine have that could help her succeed in school?
School – Strengths/Risks

• Jasmine had a GPA last year of 1.4
• She changed schools twice in the last year
  – Foster care/instability despite AB 490 protection
• She is upset that her current school doesn’t have a chorus
Emotions

• Beyond depression & anxiety – asking about moods in general
  – What have your moods been like lately?
  – Elicits more anger, frustration, positive descriptions

• Encourages a richer conversation

• Do need to ask about suicidal ideation/attempts
Emotions – depression/suicide

- In the past 12 months
  - 13.8% of HS students seriously considered suicide
  - 6.9% attempted suicide
  - 2% made attempt requiring medical attention
- 33.9% of young women felt sad/hopeless ≥2 weeks in last year
- 19.1% of young men

- Young men – 10.5%
- Young women – 17.4%
  - White – 16.1%
  - Latina – 20.2%
  - Black – 18.1%

- > 50% of all suicides (all ages) committed with firearms in US

2009 YRBSS
Emotions & Bullying/Rejection

• 19.9% of HS students were bullied on school site in the last 12 months
• Recent news reports of suicides – teens bullied because of sexual orientation/gender issues & at least 1 suicide of a bully

http://www.itgetsbetterproject.com/

http://colorlines.com/archives/2010/10/our_love_is_newsworthy_too.html
Suicide and Sexual Orientation

- ↑ risk for gay male youth, bisexual youth
- Risk assoc w/ rejection by family, violence, being homeless
  - Even small ↑ in family acceptance can ↓ risk
  - Risks also related to school bullying

http://familyproject.sfsu.edu/home
Suicide Prevention
Youth Development Approach

• Traditional approaches
  – Assess risk
  – Ask youth to make a no suicide contract
  – Refer
• Some evidence that contracts were not protective

• Youth development
  – Safety
    • Assess risk
    • Refer
  – Ask youth to make a safety plan tailored to levels of suicidality
    • “If I feel X, I will do Y”
  – Ask youth to make a hope box
    • Mementos, objects instill hope, remind of connections, effectiveness

Joiner, 2011
Jasmine - Emotions

• Reluctant to answer questions “Read my chart” – in therapy 3x a week
• Denies current suicidal ideation/plans, + history of past attempts X 2
• Describes moods as “happy at home and with friends, annoyed at school”
Sexual Activity vs. Sexuality

• A normal part of life vs. an area of risk?
  – Research comparing parental approaches in Netherlands vs. US

• A strength-based approach to promoting healthy sexuality
  – A – Autonomy
  – B - Build good relationships
  – C – Foster connectedness
  – D – Diversity & Disparities

http://people.umass.edu/schalet/pubs.html
Sexuality – Youth Development

- Jasmine has not been tested recently for STIs
- When asked about her experience/knowledge about condoms, she replies: “Well if I could get them, I would use them!”
- Cites almost daily psych appointments, lack of access

- A youth development approach
- Asking permission to discuss
  – Can we talk about…
- Assessing knowledge before delivering health messages
  – What do you know about....
- Sexuality in the context of relationships & connection
Safer sex & relationships

• Condom use declines as intimate relationships last longer
• More condom use with side partners
• What is the meaning of condom use within an intimate romantic relationship?
Sexual Orientation in the 21st century

- Current generation of youth less willing to be “labeled” in a category

- Sexual orientation for women may be more fluid than previously thought

- Among 15-19 yr olds, 4.5% of men, 10.6% of women have had same sex contact (CDC, 2005)
Sexual Activity: Are Gender Identity & Sexual Orientation Problems?

- Safety?
  - Schools
  - families
- Disclosure?
- Don’t reduce MSM to HIV risk (youth development approach)
- Possibilities of opposite-gender partners
- Transgender/questioning youth may feel unsafe in all settings, few services
Sexual Activity
Screening/Intervention Issues

• Past/Current Sexual Abuse
  – Provider must report if teen < 18
  – Affects current ability to negotiate partners, safer sex
  – Affects comfort level w/ exams, especially pelvic exam
  – ↑ incidence eating disorders (esp. bulimia)

• Youth Development approach: taking back control & setting boundaries
  – What have you done to help yourself heal?
  – Some survivors have difficulty negotiating safe relationships & sex after sexual abuse – how have you approached this?
Working with Parents

• Pre-adolescents (<10)
  – Encourage discussions re: puberty, body changes
  – Encourage to transmit values on sexual and drug behavior
  – Encourage parental monitoring of/discussion about media with child
  – Encourage development of hobbies, sports, skills
Working with Parents

• Early adolescence: encourage supervision, after-school activities, involvement of other adult role models

• Mid-late adolescence: parent moves from disciplinarian to consultant

• Acknowledge the frustrations, difficulties
• Discuss asset building, reframe teen behaviors in asset building model
Working with Teens

- Tailor screening questions to the teen’s age, developmental level
- Nonjudgmental approach
- Warn of limits of confidentiality
Working with Teens

• Wash your hands!!
Harm Reduction and Teens

- Delaying onset
- Decreasing amount of exposure
- Making the context safer
  - Choosing the environment
  - Avoiding riskier combinations
    - Drinking & driving
    - Drinking & sex
Harm Reduction and Teens

- Protection from adverse consequences
  - Condoms & advance ECP
  - The “no fault” call home
- Easy access to confidential services
- Youth development & harm reduction
  - Involve youth in assessment of risks/safety & development of safety plans
Client Centered Counseling
OARS

• Techniques – getting the adolescent talking
  – Open Ended Questions
  – Affirmations – especially important in stigmatized groups
  – Reflections (3 reflections to every question)
    • Voice inflected downward
    • Communicates “I’m listening” vs. a question
  – Summarize
    • Let me see if I understand what you’ve been saying...
Brief Intervention/Motivational Interview

Rapport – set stage – get permission
Explore ambivalence – OARS

Assess readiness to change (1 to 10 or ruler scale)
  – Importance of change
  – Belief in ability to change
  – Strengths/barriers –
    • “Why a 5 and not a 3?”
    • “Why a 5 and not a 7?”

• Ask for a plan
• Wrap up
Crystal B., 16 y.o.

CC: Here for birth control (OCs)

S- describes self as friendly, sociable, caring

S- 10th grade, GPA 2.2, failed one course, unsure of goals

H – lives with mother & stepfather, 2 younger sibs, gets along well, “but I don’t talk to them”
Crystal B., 16 y.o.

A – “To be honest, I like to drink.” No organized activities at school or community

D- Gets drunk every weekend, blackout X 1, occasional MJ, cigarettes, father w/ hx of alcoholism, sober X 2 yrs
Crystal B., 16 y.o.

- E – Denies suicidal ideation, attempts or depression

- S – Sexually active with 3 lifetime partners, +/- condom use, usually has sex when drunk, denies history of abuse
Crystal B., 16 y.o

• Safety- +/- seatbelt use (75%), no guns in home, does not ride with drunk drivers (“When we drink, we just stay overnight in one place”)
Crystal B., 16 y.o

- Strengths?
- Risks?
Crystal B., 16 y.o

You screen her for STIs and pregnancy
How do you want to focus your counseling?

• How effective would Ocs (her chosen method) be as a method of contraception?
• What would be a youth development way to approach this issue?
Crystal B., 16 y.o

• One week later, Crystal is called back to clinic. Her Chlamydia test is positive.

• How can you use the disclosure of her chlamydia results as a “teachable moment”? 
• How would you start a motivational intervention?
Crystal B., 16 y.o

• “Can we talk about....?”

• “What do you know about ...?”

• “ On a scale of 1 to 10, how confident are you in your ability to use condoms?”
  – What keeps you from being a 7?
Take Home Messages

• Teens have strengths & can be part of the solution
• Teens want to talk about the same risky behaviors you are concerned about – and they want you to understand the context
• You can empathize with parents & encourage parent-child communication WITHOUT violating confidentiality