Original Study

Medical Students' Acquisition of Adolescent Interview Skills after Coached Role Play

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ABSTRACT

Study Objective: To develop and evaluate an educational activity designed to teach the adolescent Home, Education and employment, Eating, Activities, Drugs, Sexuality, Suicide/depression, and Safety (HEADS) examination.
Design, Setting, Participants, Interventions, and Main Outcome Measures: Participants were third-year medical students in their pediatric clerkships. Students received an article on the HEADS interview and attended an adolescent medicine educational session. The session included individualized goal-setting and coached role play. Students' skills in doing a HEADS interview were evaluated through a standardized patient encounter (SPE) with a checklist and a retrospective pre- and post-test survey. The SPE checklist was used to assess whether the students included questions in 6 key areas of a HEADS interview.
Results: One hundred fifty-two students participated. During the SPE, 90% of students queried the adolescent's home life, 91% education, 82% activities, 84% drug/substance abuse, 95% sexual history, and 61% symptoms of depression. Pre- and postintervention data were compared using the Kruskal-Wallis Test and showed a statistically significant difference in the students' ability to list key topic areas of the HEADS exam ($P < .001$) and to use the skills needed for an adolescent interview using the HEADS exam ($P < .001$).
Conclusion: After an introduction to the HEADS examination, most students covered almost all of the topic areas of this screening interview during a SPE. Only three-fifths of the students, however, included questions about symptoms of depression. Coached role play with goal-setting facilitated effective learning of this approach to adolescent interviewing.
Key Words: Adolescent medicine education, Medical education, Coached role play, HEADS interview

Introduction

Adolescents, who constitute 13% of the population in the United States, have specific health care needs, and addressing their needs requires skillful communication. Although pediatric residents must complete a rotation in adolescent medicine, other residents receive inconsistent training, although most family physicians, surgeons, obstetricians/gynecologists, and internal medicine physicians as well as many subspecialists care for adolescents in their practices.[1,2] National organizations have called for increased preparation for health care providers to better work with adolescents. The Institute of Medicine report on adolescent health services noted that existing adolescent health care training across health care provider disciplines fails to address adolescents' specific health needs.[3] Professional organizations, including the North American Society for Pediatric and Adolescent Gynecology (NASPAG), American Academy of Pediatrics, Physicians for Reproductive Health, American Nurses Association, and the Society for Adolescent Health and Medicine, have recognized the unique needs of adolescents and have advocated for more training in this area.[4–9]

Although pediatric residencies require an adolescent medicine rotation, even with this residency training, practicing pediatricians believe they are less competent to care for adolescents than for infants or children.[2] Because residents in other specialties receive inconsistent adolescent medicine training, their training as medical students has greater importance. Most studies have focused on resident training in adolescent medicine, although the 2008 William T. Grant Foundation Conference on Improving Adolescent and Young Adult Health recommended incorporating more teaching and mentoring in adolescent health education for medical students.[10–13] Few data exist, however on medical student education in adolescent medicine. The amount and content of instruction about adolescent care currently offered to medical students nationally is unknown. A few articles describe using adolescent standardized patients for instructional or assessment purposes.[14,15] In our previous study using an adolescent objective structured clinical examination case the focus was to conduct an interview with an adolescent coming in to initiate contraceptive care.[16]

In response to the needs for education about pediatric and adolescent gynecology (PAG), NASPAG[4] developed the Short and Long Curriculum.[17,18] An evaluation study of the short curriculum showed improved self-reported knowledge in PAG after residents used the NASPAG Short Curriculum to guide self-study, even without access to PAG-trained faculty.[19] However, we still need specific approaches to teach

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the needed skills and clear evidence of skill development after specific educational interventions. As noted in the Short as well as Long Curriculum, skills for communicating with adolescents are a critical component of basic education in PAG.[17,18] One specific and practical way to equip medical students, residents, and others who provide care for adolescents with the skills needed to communicate with this population is to teach them to do a Home, Education and employment, Eating, Activities, Drugs, Sexuality, Suicide/depression, and Safety (HEADS) interview. The HEADS interview is recognized as a useful approach to communication with adolescents and is also part of the NASPAG Short as well as Long Curriculum.[17,18]

The HEADS framework provides an organized approach to adolescent interviewing that starts with nonthreatening topics like home and school and progresses to more personal questions regarding substance abuse, depression, and sexuality to assist the adolescent in being more comfortable in communicating with the health care provider. The HEADS approach to adolescent interviews was developed in 1972 by H. Berman in Seattle and refined and taught by E. Cohen as a psychosocial risk assessment instrument.[20] A HEADS interview addresses the following areas: home, education, activities, drug use, sexual behavior, and suicidality/depression. More recently, an additional E for eating and S for safety have been added in response to concerns about obesity, eating disorders, and issues regarding safety and accidents.[21] In 2014, Klein et al updated the HEADS assessment to include response to the effect of the media.[22] There is also evidence that the HEADS interview yields valid data when used to screen for mental disorders.[23,24]

We developed a specific approach to teaching and assessing adolescent communication to medical students.[25] The purpose of this study was to develop and evaluate the effectiveness of this educational activity in teaching the skills needed to do the adolescent HEADS examination.

Materials and Methods

The Colorado Multiple Institutional Review Board approved this study. The study participants were third-year medical students completing their pediatric clerkship. Three weeks before the educational session, students received an email with an article on the adolescent HEADS interview to read (the same article referenced in the Short and Long NASPAG Curriculum).[21] They were instructed to read the article and arrive at the session prepared to write a learning goal related to performing a HEADS examination that they wished to achieve by the end of the class session.[25]

Lesson Plan

Students (16-20 per session) and a facilitator (an adolescent medicine physician) sat in a circle during the 1.5-hour educational activity. At the start of the session the facilitator asked the students whether they had read the article. This was followed by the facilitator introducing the session by sharing the goal and an outline of the session. The students described the content of the HEADS interview and discussed some of the challenges of the adolescent interview. On the basis of their reading of the article, the learners then each wrote a learning goal for their session. The facilitator requested volunteers to play the roles of physician and adolescent. The first role play portrayed an adolescent not engaged in high-risk behavior. This was followed by a group debrief. The next scenario portrayed an adolescent who was involved in some risk behaviors, again followed by a group debrief. The activity continued as time allowed. Details including the goal, standardized patient encounter (SPE) check list, case training guide, and rationale are all available in our previously published curricular activity.[25]

Standardized Patient Checklist

The students' skills in doing a HEADS interview were evaluated at the end of the clerkship (3 weeks after the teaching session) through a SPE with a checklist. The medical school simulation center provided trained standardized patients. The checklist consisted of 22 items in 5 areas: sexual history, menstrual/obstetric history, substance abuse, social history, and patient education, to assess whether the students addressed these topics of the HEADS interview. The standardized patients scored the checklist.

Retrospective Pre-/Post-Test Survey

A retrospective pre-/post-questionnaire was used to assess knowledge and confidence in the skills students gained for doing a HEADS interview (Table 1). This type of questionnaire is administered after an educational

Table 1
Retrospective Pre/Post Questionnaire Administered to Medical Students at the Completion of their Pediatric Clerkship to Assess Knowledge and Confidence in Skills Gained for Doing a HEADS Interview

Question	Response	Before Pediatric Clerkship (N = 149)	After the Pediatric Clerkship (N = 149)
I can list the 8 topics that are part of the adolescent HEADS interview	No	92	8
	At least 4 of 8	54	56
	Yes	3	85
I have performed a complete HEADS interview with an adolescent	Never	118	52
	1-2 times	26	65
	2-5 times	4	24
	More than 5 times	1	8
I have the skills to conduct a compete HEADS interview with adolescents on my own	None of the skills	46	4
	At least 50% of the skills	96	88
	All of the skills	7	57

HEADS, Home, Education and employment, Eating, Activities, Drugs, Sexuality, Suicide/depression, and Safety.

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