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## Hard Questions to Ask After a Cry for Help

By PERRI KLASS, M.D.  
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Some time ago I got an e-mail message from one of my students: She couldn't come to class. She was having terrible problems, her life had fallen apart, she was just sitting and crying. She was sorry, but her assignment would be late.

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Immediately, my mind went back to a familiar acronym: Headsss. The letters stand for [an interviewing technique](#) developed in 1991 for adolescent patients — H for home (the doctor starts by asking about the teenager's home situation), E for education and employment, A for activities.

And then, in a progression meant to move from less sensitive topics to touchier subjects, it is on to D for drugs and finally the three S's: sexuality, [suicide](#) and safety.

These are not easy questions to ask — even home and education may be fraught subjects for many adolescents. Sometimes a teenager will say, "If I tell you something, will you absolutely promise to keep it a secret?"

And the pediatrician must respond with the truth — or, much better, establish the rules with every patient, before the question even comes up. "I say this in front of the parent and the teen," Dr. Michelle S. Barratt, a professor of [pediatrics](#) at the [University of Texas](#) Medical School at Houston, told me. "I'm going to talk to your teen about some things that are easier to talk about without a parent in the room, and I'm going to keep things confidential unless it's life-threatening." And I use those words.

No, these aren't easy conversations. "There's been a fear that talking to children or adolescents about suicide is somehow suggestive or puts them at higher risk," said Dr. Benjamin N. Shain, head of child and adolescent [psychiatry](#) at NorthShore University HealthSystem outside Chicago. "Repeated studies have shown this is not the case."

Dr. Shain was the lead author of the [American Academy of Pediatrics' 2007 statement](#) on suicide and [suicide attempts](#) in adolescents. As a psychiatrist, he has experience treating adolescents who have attempted suicide, and he is a strong advocate for screening in primary care settings.

In fact, asking the question does not awaken thoughts of suicide — suicidal ideation, as we call it. [A 2005 study in The Journal of the American Medical Association](#) looked at more than 2,000 New York State high school students in a randomized controlled trial; those screened were not more likely to report suicidal thoughts in the following days.

Dr. Kenneth R. Ginsburg, an adolescent medicine specialist at the Children's Hospital of Philadelphia and the author of "A Parent's Guide to Building Resilience in Children and Teens" ([American Academy of Pediatrics](#), 2006), would prefer to think in terms of a different mnemonic: Sshadess. That first S reminds you to start the conversation by asking about the teenager's strengths — about what is going well in your patient's life — and move from there to school, home and activities before approaching drugs.

And before you get to the S's, there is the E for emotion, which, Dr. Ginsburg said, should be much more than screening for [depression](#). "If you start by asking boys if they're depressed or sad, most boys will deny that," he told me. "If you start by saying, 'So, are you stressed out?' — every boy, no matter how big and strong, every girl, no matter how much she wants to portray herself as being in control, will admit to stress."

Markers for depression may help identify adults at risk for suicide, but they are not a reliable way to screen adolescents. "Only about half of kids who kill themselves are depressed in the way that we think about depression — sad, not taking care of themselves, not sleeping or sleeping too much, not eating or eating too much," Dr. Ginsburg said. The other half may be impulsive, angry, disappointed, trying to get even.

Dr. Shain said adolescents often changed their ideas and their plans. So an assessment has to go beyond the feelings of the moment to include thoughts they have had, dangerous ways they have behaved and the important questions of intent and ambivalence.

"Sometimes you'll get an 'I don't know' answer," he explained, "which might be ominous, might mean they don't know or might mean they don't want to tell you."

If a teenager does acknowledge thinking about suicide, there are many more questions to be asked. Dr. Lydia A. Shrier, director of clinic-based research on adolescent and young-adult medicine at Children's Hospital Boston, said some

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young people chronically struggled with these issues.

"If I responded every time they said, 'Yes, I have these thoughts,' by sending them to the E.R., they would spend their lives there," Dr. Shrier said. "You have to ask, but then you have to get the rich detail of somebody's internal experience."

The point of asking, after all, is to help. That means helping in a crisis, of course. "I tell patients, 'If you tell me that you want to kill yourself and you can't tell somebody when you have those feelings and you can't make a safety plan with me, then I can't let you leave this office,'" Dr. Shrier said. But it also means finding therapeutic resources for those who are struggling and helping them understand they are entitled to feel better.

"Kids don't want it to be ignored," Dr. Ginsburg said. "It's a cry for help. No one wants to know that their cry for help was ignored."

"They might act angry. But what you're communicating is: 'I really listened, I heard you. I'm going to see that you get help, I'm going to take the action you deserve.'"

I e-mailed back to my student, "Please come to class." And when she did, I asked her how she was doing. She replied that she was seriously stressed.

I wanted to do a full Headsss assessment. But I was her teacher, not her doctor. So I suggested, as delicately as I could, that with all the stress in her life, she might want to go to student health services, where counseling was available. I walked her over, to make sure she got there.

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