Creating Healthy Opportunities:
Conversations with Adolescent Health Experts

An Interview with Richard Kreipe, MD, Conducted by Karen Brown

A PROJECT OF THE PARTNERS IN PROGRAM PLANNING FOR ADOLESCENT HEALTH (PIPPAH) INITIATIVE

Author and Interviewee Biographies

KAREN BROWN

Karen Brown is a public radio reporter and freelance writer who specializes in health care. Her work frequently appears on NPR and in national magazines and newspapers. She has also produced several radio documentaries on mental health topics, including childhood bipolar disorder, siblings of the mentally ill, and post-traumatic stress disorder. She has won numerous national awards, including the Edward R. Murrow Award and Daniel Schorr Journalism Prize, as well as journalism fellowships, most recently the 2008-09 Kaiser Media Fellowship in Health. Her work is featured online at www.karenbrownreports.org.

RICHARD E. KREIPE, MD

Richard E. Kreipe is Professor of Pediatrics and Adolescent Medicine Fellowship Director at the University of Rochester, NY; Board Certified in Adolescent Medicine. Dr. Kreipe is currently past-President of the Society for Adolescent Medicine (SAM). He co-edited the first Textbook of Adolescent Medicine, and is currently co-editing the Textbook of Adolescent Health Care to be published by the American Academy of Pediatrics. In recognition of his achievement as an interdisciplinary educator, he has received 12 faculty teaching awards, the Andrew W. Mellon Dean's Teaching Scholar Award, and was the SAM Visiting Professor in Adolescent Medicine for 2003. He was also the recipient of the American Academy of Pediatrics Section on Adolescent Health Adele D. Hofmann Award for 2003. He is the Principle Investigator at the University of Rochester in the New York State Department of Health Center of Excellence for the Assets Coming Together (ACT) for Youth public health initiative, a long-term, statewide, community-based effort to promote positive youth development. Dr. Kreipe is the Medical Director for the Western New York Comprehensive Care Center for Eating Disorders. He also serves on the New York State Governor's Children's Cabinet Advisory Board.

Acknowledgements

"Creating Healthy Opportunities: Conversations with Adolescent Health Experts," was commissioned by the Partners in Program Planning for Adolescent Health (PIPPAH) initiative of the Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA). The views presented are those of the interviewees and do not necessarily represent the views of the MCHB, HRSA, or any individual PIPPAH grantee.

PIPPAH grantees include the following organizations:

- American Academy of Pediatrics
- American Bar Association Center on Children and the Law
- American College of Preventive Medicine
- City**M**at**CH**, Board of Regents, University of Nebraska Medical Center
- Healthy Teen Network
- National Association of County and City Health Officials
- National Conference of State Legislatures
- National Institute for Health Care Management (NIHCM) Foundation

PROFILE:

Richard Kreipe, MD

PROFESSOR OF PEDIATRICS, DIVISION OF ADOLESCENT MEDICINE,
GOLISANO CHILDREN'S HOSPITAL AT STRONG

"What I really try to focus in on, especially with this strength-based, youth development approach, is that inside every person there is good, and what we have to do is really bring it out."

Dr. Richard Kreipe assumes the best about people. That's not just a social attitude; it's a medical framework. And he says it's served him well as a national leader in the field of adolescent health.

"Focus on the positive qualities of youth," he says. "Try to reinforce in an intentional way factors that protect against a number of high-risk behaviors, but do that in a context of actually working with young people, so that they're a part of the process of determining what happens."

This "positive youth development approach" to adolescent health is one Kreipe has practiced for three decades. [For more information about positive youth development, see box page 4.] He directs the training program for adolescent medicine at the University of Rochester, New York, and he is past president of the Society for Adolescent Medicine. He also sees patients in his clinical practice at Golisano Children's Hospital in Rochester, and advocates for adolescent health programs on the state and national level.

"Adolescents are a very important population to focus on because they have unique needs," he says. "They are no longer children, they're not yet adults, and also they are going through some tremendously important developmental changes during that time."

Positive youth development (PYD) is an approach that recognizes the adolescent's need to experiment, try new things, and stretch the limits of what's acceptable (sometimes to their detriment), but at the same time, it's an approach that embraces rather than fears those things. PYD accepts that adolescents have a need for healthy relationships with their peers and with adults, and that they have the right to give input into their own life choices. While PYD may be implemented in many different ways, it's generally based on a belief that, with appropriate supports linked to normal adolescent growth and development, teens have much to offer society. Most importantly, when adolescents feel involved in their own health, and respected for what they bring to it, they are more likely to grow up with higher self-esteem, a respect for their physical and mental well-being, and the skills to make wise behavioral decisions.

"What I really try to focus in on, especially with this strength-based, youth development approach, is that inside every person there is good," says Kreipe, "and what we have to do is really bring it out."

As reasonable as this approach may seem to many in the field of adolescent health today, it hasn't always been universally accepted in the broader field of medicine, which Kreipe says has sometimes been too mired in the patrician style of dictating choices from a doctor in a white coat, and a sense that adolescents need to be reigned in rather than celebrated.

Kreipe has spent much of his professional life trying to build bridges between those schools of thought – to make the case that treating adolescents with a positive approach is not only humane, but it improves their health outcomes. While Kreipe is a pediatrician by training, he says this approach can be used successfully by many other professionals who cross paths with adolescents, including social workers, nurses, youth advocates, lawyers, and school administrators.

"Focus on adolescents' strengths instead of just focusing on their risks and

liabilities. We need to increase protective factors for kids. It's not that we don't try to decrease risk factors, so we do try to eliminate poverty and other kinds of things, but we also need to realize that when a young person feels like there is an adult in their life who listens to them – other than their parents – that's good, and if they have many adults like that, it's even better. Kids who go to school and feel like they're not connected to school at all, they drop out. Kids who somehow feel like they're connected to school do much better."

Kreipe began to advocate for a positive youth development approach in the late 1970s. Fresh out of a pediatric residency in Philadelphia, he came to realize that adolescent health deserved its own sub-specialty because adolescents have unique needs and challenges, but it too often got subsumed in pediatrics or internal medicine.

Since then, the field has come into its own. As of 1994, doctors can become board certified in adolescent medicine. But Kreipe says he has struggled for decades to attract enough medical school graduates into the specialty (there's a notion – incorrect, he maintains – that they don't get paid as well, or don't need as much additional training as is required.) He has also worked to establish a due respect for the field commensurate with other specialties, and to standardize the training requirements. Kreipe oversees a three-year adolescent medicine fellowship program that stresses both clinical and research abilities, as well as the significant challenge of getting through to teenagers.

"I think that one of the major elements lacking in the training of physicians... is the ability to communicate effectively with adolescents," he says. "Both expressing oneself and listening, and having an adolescent express and listen, [are skills] that really need work and a lot of practicing."

The first step, he says, is to learn how young people communicate with each other, using methods that many health professionals of his generation, from all disciplines, might find alien. That means accepting the trends and habits of adolescents in a positive way rather than resisting them. In some cases, it might require adult professionals becoming more skilled in communication technology.

"I think there is much more resistance for adults to learn about youth, than for youth to learn about adults. If we want to get together with other adults, we schedule a meeting or a conference call. Adolescents will IM [instant message] each other or blog. So, I think we need to realize that …young people communicate in different ways. And rather than saying, 'they have to learn our ways,' I think we have to say, 'we have to learn their ways.'"

Kreipe says another prerequisite for professionals, of all types, who want to help adolescents is to actually like them and care about their well-being – qualities that you can't always teach. "I think adolescents tend to be the most misunderstood group of individuals," he says. "What we as professionals don't understand, we fear."

Kreipe says he's met colleagues over the years who openly admit that they don't like teenagers. One incident in particular made him realize how doctors can let their own fears and preconceptions shape their clinical abilities, not to mention their bedside manner. It was a Saturday morning at the hospital, and a 16-year-old girl had been admitted to an adolescent unit with a pelvic inflammatory disease, which is often associated with sexual activity. When the hospital staff put her in a shared room with a severely retarded girl, another doctor protested because the doctor felt a sexually active teenager would be harmful to the more vulnerable child. But when Kreipe arrived on the scene, he found that the teenager was actually reading a book aloud to the child.

Family dynamics are also central to Kreipe's approach, and that includes encouraging parents to let their children start making their own health care decisions. "This may be the last chance we really get to change people's health behavior," he says. "So what I like to point out to parents when we first see a kid who's maybe 10, 11 years of age, is that, as time goes on, we are going to be spending more time with your son or daughter and less time with you as parents. Because by the time he or she is 18 years of age, he or she can go see a doctor and you might not know anything about it. So, what we need to be working on is gradually helping the young person become a better consumer of health care."

At the same time, Kriepe says that all teen-oriented professionals would do well to open their minds to what adolescents have to teach. Kreipe says he's learned as much about health care from the young patients themselves as from reading books or attending conferences. For instance, he says he developed his treatment for anorexia nervosa, one of his key areas of clinical practice, by listening to his patients.

"With my very first patient, I didn't know what to do. And I said, this is a fascinating young lady though. She's got serious medical problems as a result of her starvation. She also has serious family conflict issues. She has no self-confidence, her identity is totally not what I would think it would be like and yet she's extremely bright. What's this all about? And so, rather than going right to the books, I spent a lot to time listening to patients and trying to understand where patients are coming from."

From there, he's been able to fine-tune his approach to look at the illness from a more developmental perspective, rather than as a strict mental illness.

"I think there is much more resistance for adults to learn about youth, than for youth to learn about adults. If we want to get together with other adults, we schedule a meeting or a conference call. Adolescents will IM [instant message] each other or blog. So, I think we need to realize that …young people communicate in different ways. And rather than saying, 'they have to learn our ways,' I think we have to say, 'we have to learn their ways.'"

"Yes – they have depression, yes – they have anxiety, yes – they have some obsessive compulsive traits," he says. "But other people have those things and don't develop an eating disorder. So the way I like to look at it is there [are] biological underpinnings, and I think that over time, we will learn that people who develop eating disorders are biologically different, possibly related to...hard-wiring in the brain."

If more professionals take this approach, looking more closely at normal adolescent development as it informs behavioral choices, they can steer blame away from the parents while making families more sensitive to developmental issues. That in turn would, ideally, lead to partnerships – with the patient, with the family, and with schools. That's not always an easy sell, especially when the would-be partners are not used to working together. For instance, he believes educators and physicians should be in frequent contact about troubled young people, and yet they rarely share information with each other. "I think everybody feels absolutely overwhelmed with the things they have to do," he says. "What we're trying to do is to work more efficiently so that we can actually reduce the number of problems overall."

He remembers one case in which a high school girl was having unexplained fainting spells. The episodes mimicked seizures, but the doctors couldn't figure out any medical cause for them. So Kreipe, who was brought in as a consultant, decided to talk to the school nurse. She told him that the girl got a lot of attention from a principal whenever she had spells, thereby reinforcing them. That information allowed the doctors to change the treatment protocol (the principal stopped coming to help) and work on underlying stresses and conflicts. "If we can develop a system of communication where we can talk to each other and listen to each other," Kreipe says, "that really makes things go much better."

When Kreipe is not consulting on the hard-to-solve clinical cases, he's working as an advocate for better adolescent health policies and programs. He strongly encourages advocates to push policy makers in their own states towards a more positive youth development approach and to use a model adopted in New York State. He says advocates in New York were able to link the strength-based development model to state funding.

"The implication was that any program in New York State that had to do with youth had to have a positive youth development approach to it," says Kreipe. "So it couldn't be 'risk aversion' programs, or just the old 'open up a rec room for Friday nights.' It really had to have the components of youth development. It has to include youth in an early, early stage. It focuses on character, and competence, and confidence, and all of those kinds of things."

Without that approach, he worries that states will continue with a "risk reduction" approach, shown to be much less effective in promoting good decision-making among teens – in part, because that approach is so fragmented.

"So you have a teen pregnancy prevention program; you have a sexually transmitted infection reduction program; you have a violence reduction program; you have things that are all in silos that don't necessarily talk to each other."

Instead, he supports integrative programs that involve partnerships with hospitals, clinics, schools, and community groups, and he fights against programs that have mostly ideological roots.

"I think we need to advocate against policies that would set adolescent health backwards," says Kreipe. "I think the best example of this is the issue of abstinence-only education." He says that approach to pregnancy prevention – when used on its own, without a more comprehensive educational approach – has been proven ineffective, and yet many school systems still use it.

Kreipe's most immediate goal, however, is getting more medical students to enter the adolescent medicine specialty, to shore up the ranks of well-trained clinicians and researchers. Currently only about 500 physicians are board-certified in adolescent medicine, but he thinks that's starting to increase. He's particularly optimistic about the young generation that's now graduating from medical school – a generation that is, of course, closest in age and experience to the adolescents they will treat.

"I think they are more idealistic. So I'm very encouraged that we're going to start seeing an influx of people doing adolescent health, especially if we can put the positive spin on it that it deserves." ■

Positive Youth Development

By Kristin Ware

What is Positive Youth Development?

- A positive youth development (PYD) model creates programs for youth focused on constructive assets that can be developed rather than negative behaviors that should be avoided.

What are the main attributes of Positive Youth Development?

- Focus on strengths, rather than problems or risk factors.
- Youth voice and true engagement of youth as leaders, partners, and contributors, not simply "clients," and giving them key roles in actions or organizations.
- Focus on relationships between adults and youth as an essential outcome.
- Involvement of all community members not just those with specific ties to youth.
- A long term approach that "recognizes the importance of ongoing, positive opportunities and relationships to help young people succeed as adults."

What does Positive Youth Development look like?

PYD emphasizes positive outcomes:

- **Traditional:** Programs geared towards prevention tend to focus on common negative outcomes in the lives of teenagers – drug use, pregnancy, suicide, homelessness, and truancy.
- **PYD:** While prevention is still a desirable outcome, these programs focus on highlighting the positive things that youth can accomplish. For example, programs may encourage youth to take on leadership roles, volunteer in the community, or explore their abilities in the arts. These programs focus on highlighting and developing qualities that youth already possess – motivation, compassion, and creativity.

PYD involves all youth in the community:

- **Traditional:** These programs tend to target youth that have been identified as having risk factors. Examples include programs aimed at youth in foster care or youth who have been truant or involved in the juvenile justice system.
- **PYD:** Programs that are available to all youth promote positive social interaction, encourage leadership, and give youth a chance to feel as though they belong. These programs not only help youth develop confidence and social competency, but they also avoid some of the harmful stigmatization that can occur in traditional programs.

PYD enables resiliency by providing a network of support:

- **Traditional:** Frequently programs for youth have been run by just one stakeholder in the community, for example, D.A.R.E., a program run by local law enforcement designed to prevent teen drug use.
- **PYD:** These programs aim to make youth more resilient by providing them with a community-wide support network. The programs are not run by one entity, but involve collaboration between schools, law enforcement, businesses, and private citizens. For example, a community could create a young entrepreneurs program that utilizes the support of schools, local businesses, and private citizens and is aimed at encouraging youth to recognize their strengths and interests.

What does the research say?

A 1998 review of evaluations of positive youth development programs found that many of these programs were able to demonstrate "positive changes in youth behavior, including significant improvements in interpersonal skills, quality of peer and adult relationships, self-control, problem solving, cognitive competencies, self-efficacy, commitment to schooling, and academic achievement." The programs also led to reductions in unhealthy behaviors including aggression, risky sexual activities, drug and alcohol use, smoking, and violence.

Sources and Resources:

- Barton, William H. and Jeffrey A. Butts, "Building on Strength: Positive Youth Development in Juvenile Justice Programs," Chapin Hall Center for Children, 2008, available at http://www.jdaihelpdesk.org/Docs/Documents/LIT%20TABLE%20Chapin%20Hall%20Building%20on%20Strength_Final.pdf (last visited 7/10/09).
- Ferber, Thaddeus, Elizabeth Gaines and Christi Goodman, Strengthening Youth Policy: National Conference of State Legislatures Research and Policy Report, "Positive Youth Development: State Strategies," October, 2005, available at http://www.ncsl.org/Portals/1/documents/cyf/final_positive_youth_development.pdf (last visited 7/8/2009).
- "Positive Youth Development Resource Manual," ACT for Youth Center of Excellence, available at http://www.actforyouth.net/?ydManual (last visited 7/8/09).
- Restuccia, Dan and Andrew Bundy, "Positive Youth Development: A Literature Review," August 2003, available at http://www.mypasa.org/failid/Positive_Youth_Dev.pdf (last visited 7/8/09).
- Schwartz, Robert G, "Juvenile Justice and Positive Youth Development," available at http://www.ppv.org/ppv/publications/assets/74_sup/ydv_7.pdf (last visited 7/8/2009).