
The Adolescent Patient

Interview: Adolescent Confidentiality and Consent

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Interviewing an adolescent provides a transition from the pediatric encounter where the history is primarily provided by the parents, and the teen may or may not be able to provide his or her perspective. The adolescent is available for observation and some interaction, but the primary line of communication is with another adult, the parent. Interviewing the parent is often a good prelude to the adolescent interview, as the parent generally provides a more thorough family history, which may also be an important educational experience for the adolescent patient. The parental perspective and the observation of the interaction between parent and teen provide clinical information that helps to understand the family dynamic. But the stance is really to speak to both generations together, discussing confidential care, setting boundaries, and describing the contract upon which clinical care may be based. At that point, moving the parent to the waiting room is important to transition to the interview of the adolescent, which establishes the basis of the clinical relationship. The developmental aspects of early, middle, and late adolescence set the adolescent interview apart from the child and adult interview.

Approaching the adolescent from a clinical stance of neutrality is key. Nonjudgmental inquiry is essential to establishing the rapport that may develop into a supportive clinical relationship. Most adolescents enjoy talking about themselves

to a supportive and nonjudgmental listener. The clinician's role will also influence the investment and willingness of the adolescent to open up and speak honestly about what is going on in his or her life. If the clinician's role is to provide primary care that is ongoing, helpful, and available, an adolescent may be more likely to trust and invest in the relationship. If the clinician's role is evaluative or episodic, it may be more difficult to establish the trust that would enable honest disclosures. Assurances of confidentiality, particularly those established with the parent in the adolescent's presence, provide the basis for the development of a doctor-patient relationship that is open and honest. Being explicit about the limits of confidentiality, that is, harming oneself or others, is reassuring to the parents that their adolescent's safety is a priority.

In assisting an adolescent to tell his or her history, it is useful to open the interview with the context of the clinical relationship and the purpose of the visit. If the focus is on a particular medical complaint, a chronologic approach to the onset and development of symptoms allows the adolescent to tell the story as he or she has experienced it. Pulling back from the specifics and asking concrete questions, such as hospitalizations, operations, medications, and allergies, may trigger the history of particularly salient aspects of the medical history.

In the context of the past medical history, asking chronologic questions about the teen's development in the various domains of functioning often provides another structure for unfolding a history. In the physical domain, any periods of time of weight loss, abrupt weight or height gain may open up the adolescent's feelings about his/her rapidly changing body. Dating the onset of the development of secondary sexual characteristics and how the developmental pattern unfolded transitions into more private clinical material and sets the context for more sensitive historical questioning about sexual contact. The repeated pattern of questioning with onset, subsequent pattern, and last episode may be applied to each sensitive area and establishes a flow to the interview that defuses some of the intensity. For example, inquiring about the first menses and assisting the

adolescent's memory with memory joggers (e.g., what grade?) may help an adolescent return in her memory to that time and assists her in the forward progression of remembering the pattern of her menses such as monthly, skipping months, multiple menses within a month. The more recent history, such as the last menses, then becomes more reliable because there is an active use of memory. This same patterning can then be applied to sexual contact: actively remembering the first contact; subsequent partners and sexual practices; with most recent contact, partner, and practice tending to be more reliable. If there is no sexual contact, the open ended and chronologically factual approach tends to make it easier to share that and explore how the adolescent is thinking about sexuality, and when he/she may anticipate that sexuality may be part of his/her life. Answers may vary from not knowing, to waiting for marriage, to next month, but at least the chronologic flow has been established as part of the clinical relationship.

This same pattern of questioning may be applied to substances such as cigarettes, alcohol, and other drugs, and the neutral chronologically factually based questioning makes the pattern of use clearer, from experimentation, to use, to abuse. This approach to eliciting the history makes subsequent interventions and referrals easier as the adolescent may experience how the pattern of use leads to consequences that need intervention.

Applying this pattern of questioning to other domains such as school may also clarify areas of difficulty requiring intervention. Areas of strength and weakness may be explored as you progress through the chronologic facts of preschool, primary, middle, and high school from the adolescent's perspective and then checked with the parents when they rejoin at the end of the visit. Similarly, asking about how the family has changed over time and how the adolescent's relationship with family members is experienced now may yield valuable information about the family context as the adolescent is separating, individuating, and establishing more autonomy. The potential for the family to be supportive and to accommodate the assumption of more responsibility in tandem with the development of more autonomy may be explored as well

as the resistances to this transition. The other members of the family are engaged in their own developmental change, and this may at times cause tensions or withdrawal of supportive supervision, which may lead to vulnerability in the adolescent and derail healthy development.

More episodic or cross-sectional screening may be done using Home/Education/Activities/Drugs/Sex/Substances (HEADSS) or other screening tools, but the sensitivity of the material may not yield accurate information if the adolescent is not engaged in the flow of the clinical interview.

Screening for mental health issues should be performed using standardized tools such as the Pediatric Symptom Checklist or through applying this pattern of chronologic questioning to the domains of basic functions particularly eating, sleeping, and peer relationships. Disordered eating and sleep may be explored through 24-h recalls or patterns of eating as well as patterns of sleep that may change dramatically during adolescence. Behavioral issues with peers such as bullying, isolation, violence, peer pressure, or inability to articulate one's own perspective have developmental as well as psychological impact and early identification and intervention may have a major impact during this critical period of growth and development.

In summary, the adolescent interview should be approached from a nonjudgmental, neutral clinical stance to engage the adolescent in telling his or her history with an attentive, supportive listener within a context of confidentiality. Screenings may use a chronologic approach, which brings the adolescent to the beginning of any particular developmental domain or behavior and may elucidate the pattern of development of behaviors, which may facilitate early identification and intervention easier. Standardized screenings may also be employed such as the HEADSS, SIGECAPS, and Pediatric Symptom Checklist but may not elicit a full understanding of the development of problem behaviors.

After completion of the physical examination, the adolescent's privacy should be maintained while dressing or the clinician should leave the room. The clinician can then counsel the teen in private; afterward, the parent should be invited to return to the examining room for the summation and conclusion of the visit as well as to answer any questions.

Adolescent Confidentiality and Consent

Each state has its own laws in respect to a minor's ability to consent for health services. These services may include pregnancy-related care, contraceptive or family planning services as well as prevention, diagnosis, and treatment of sexually transmitted infections. Other services that may be available by a minor's consent include HIV/AIDS testing and treatment, drug or alcohol counseling and treatment, outpatient mental health services and examination, diagnosis, and treatment after a sexual assault. The reader is encouraged to seek out state-specific information (Please see Further Readings for suggested resources).

Fear of disclosure prevents some minors from seeking health-care services. Confidentiality rests on the specific categories of minors who may consent to their own treatment. Those minors who are able to consent may also be responsible for payment of their treatment.

In general, the parent or legal guardian must consent to the non-emergency care of a child less than 18 years of age. Consent is not required for healthcare providers to render emergency treatment although the providers should make every effort to notify the parent or guardian and document such efforts in the patient's record.

Federal and Massachusetts's laws carve out exceptions that allow minor patients to consent for their own medical treatment without parental involvement (see Sects. [Emancipated Minors](#), [Mature Minor](#), and [Minors Seeking Services](#) for below).

Emancipated Minors

A minor is emancipated if at the time care is sought, he or she is:

1. Married, widowed, or divorced (can consent to abortion or sterilization).
2. A member of the armed forces.
3. Pregnant or believes herself to be pregnant.
4. Parent of a child.
5. Living separate and apart from his/her parent or legal guardian and managing his/her own financial affairs.

6. In addition, if the minor believes he or she to be suffering from or to have come into contact with any diseases defined by the Department of Public health as dangerous to the public health, except that in this instance, the minor may consent only to the diagnosis and treatment of the disease.

Usually, adolescents who fall into categories 1–6 cannot consent to abortion or sterilization. Additional documentation is required whenever a minor makes healthcare decisions. The physician must document which category is being relied on and why the physician believes the category applies.

Mature Minor

A physician or other practitioner can determine the following:

1. The minor is mature enough to make informed decisions and
2. It is in the minor's best interest to be treated without parental involvement. Additional documentation is required.

Both of the above factors must exist. An adolescent is not a mature minor simply because he or she has the maturity to consent, and it is convenient to accept the consent because a parent is not present. The provider has to affirmatively determine that involving the parents is not in the adolescent's best interests.

Minors Seeking Services for

1. Emergency contraception as a victim of a sexual assault.
2. Drug treatment: Drug-dependent minors 12 years and older seeking treatment for drug dependence must be found to be drug-dependent by two or more physicians. The minor may consent only to medical care related to the diagnosis and treatment.
3. Voluntary admission or outpatient treatment at a licensed mental health facility (if the patient is 16 years or older).
4. Family planning services through Department of Public Health Programs receiving federal funding under Title X. It should be

noted that for minors seeking family planning services outside of a family planning agency, the default is to treat the patient as a mature minor and provide such services confidentially including emergency contraception if requested unless the surrounding circumstances are such as to persuade otherwise.

Bear in mind that there are formal forensic cognitive psychology evaluations that can be done, but physician documentation requires the reasoning underlying the decision to allow minors to consent. The clinician is encouraged to consult with an attorney who is familiar with the laws of the particular state. In some emergency situations, a judge's order may be needed.

Sources

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