An Approach to the Adolescent for the Primary Care Clinician

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The clinician should take into account all developmental aspects when evaluating the adolescent patient. Adolescents will frequently present underlying concerns in an indirect manner, as "functional" complaints, excessive concerns over minor ailments, or nonverbal cues. The clinician should relate to the adolescent patient in a direct, interested, and sincere manner aimed at developing mutual respect and trust. Confidentiality of visits should be extended. Physical examination of adolescents should be performed with sensitivity and awareness of areas of concern. The primary care clinician can provide comprehensive physical and emotional health care to most adolescents.

The adolescent patient provides a unique challenge to the primary care clinician. Dramatic advances in physical and psychological development result in a growing and occasionally overwhelming awareness of self and related concerns. In a state of physical or emotional discomfort, the adolescent may present a sketchy and confusing picture to health care professionals. Recognition of the developmental stages of adolescence and the manner in which health concerns may be presented can be of assistance in evaluation and treatment of adolescent problems.

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Adolescent Growth and Development

With the exception of the first year of life, no other period results in growth as rapidly as adolescence.[1] In addition to sexual development, body mass is increased 50 percent and the final 20 to 25 percent of linear growth is achieved. Over a period of approximately four years adult physical development is attained. The psychological stages of adolescence are classically defined as early, mid, and late.[2]

The main task in *early adolescence* (girls age 11 to 13 years; boys age 12 to 14 years) is awareness and acceptance of sexual development. Early adolescents tend to be narcissistic and increasingly concerned with body image. They experience an early drive toward emancipation, but are still ambivalent about their dependency needs. Illness during early adolescence is perceived as a threat to physical integrity and interference with striving toward mastery and control of their environment.

Mid-adolescence (girls age 13 to 16 years; boys

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age 14 to 17 years) is the peak time of struggle for independence from parental control. The peer group has a dominant influence on behavior. A realistic body image and a functional sexual role are established. Illness during mid-adolescence is perceived as a threat to independence as well as to body image and sexual identity. The peak incidence of initial psychotic disorders occurs during mid-adolescence.[3]

During *late adolescence* (age 17 to establishment of complete independence) physical growth is virtually complete and the major task is crystallization of a stable identity. Illness during this stage presents a threat to dating relationships, potential childbearing, and educational or career plans.

Dysfunction in any of the developmental phases of adolescence can lead to behavioral changes or somatic complaints. Awareness of the adolescent patient's progression through the developmental stages and the implications of illness during each stage can assist the clinician in anticipating difficulties encountered with illness.[4]

Presenting Symptoms

Frequently an adolescent will present a noncontroversial complaint to gain access to the clinician. Primary concerns, either realized or subconscious, may not be disclosed until mutual trust is established. Psychosomatic or "functional" complaints (eg, headache, abdominal pain, fatigue) and excessive concern manifested by repeated visits for minor ailments (eg, minimal rash, muscle strain, rhinitis) are extremely common during adolescence. Malingering is rarely the motivation for adolescent medical visits. Occasionally, symptoms appear to be symbolic of underlying concerns, such as abdominal pain in the female who fears pregnancy. At other times symptoms appear to be patterned after a model, as in the anxious boy with chest pain whose father recently suffered a myocardial infarction.

Parents will frequently attribute symptoms of underlying concerns to organic causes and seek laboratory and physical examination for such entities as hypoglycemia or mononucleosis. The astute clinician will evaluate the adolescent patient's symptoms on two levels: (1) a search for significant organic disease, and (2) a recognition of other concerns which may be presented indirectly.

Nonverbal Cues

The adolescent patient frequently transmits nonverbal cues regarding true concerns.[5] Often facial expressions, changes in posture or eye contact, and altered affect communicate more information than verbal responses. The manner of dress is often useful in estimating self-image or areas of concern; for example, a depressed female who is anxious about her own sexuality may wear somber clothes which cover much of her body. The current fad of wearing T-shirts with printed pictures or slogans often reveals symbolic information. Jewelry, buttons, and tattoos should be noted. Items carried by the adolescent, such as books, records, or magazines, also yield clues to underlying concerns and interests. In short, the clinician should note all modes of communication, verbal and nonverbal, during the adolescent interview and use them in the diagnostic formulation.

Relating to the Adolescent

Many clinicians find it difficult to relate effectively with their adolescent patients. Pediatricians often patronize or infantilize them while internists and family physicians may be receptive only to adult responses from their adolescent patients. The key to a successful therapeutic alliance with the adolescent is the establishment of mutual respect and trust.[6] Time spent toward this end is productive and facilitates therapeutic efforts. The adolescent has a heightened awareness of the subtle manifestations of anxiety, disinterest, or disapproval on the part of the attending clinician.[7] Overfamiliarity or excessive informality may also appear confusing or seductive to the adolescent. A direct, sincere, warm, and interested approach in a nonjudgmental manner is indicated. Respect for individuality, modesty, apprehension, or distrust should be observed.

The clinician must be aware of his or her own emotions while relating with the adolescent. Encountering a frustrating, noncommunicative adolescent may evoke feelings of failure, rejection, or anger. These feelings should be recognized and processed within the context of the therapeutic relationship. Occasionally, it may be appropriate to verbalize them to the patient. In most instances, a continued direct and receptive manner

will eventually result in a satisfactory working relationship.

Initial Interview

The essence of successful adolescent care is continuity. It often requires several visits to establish rapport and convey that the clinician is interested, wants to help, and is capable of understanding the problem as perceived by the adolescent. Goals of the initial interview include: (1) establishment of mutual respect, trust, and rapport; (2) initiation of those medical procedures deemed essential; and (3) formulation of a tentative impression.

Frequently, an adolescent will be seen without an accompanying parent. Often an understanding can be reached with parents to allow their adolescents to manage their own health care affairs. When an adolescent minor desires to be seen without parental knowledge, the clinician must make an individual decision based upon state law, the type of complaint, and knowledge of the family. The general trend today is toward recognition of the "mature minor" doctrine which allows treatment of adolescents solely on their own consent in a variety of circumstances (particularly for venereal disease and contraception).[8] Although parental involvement may not be required, it is often in the patient's best interest for the clinician to strongly advise it.

If a parent accompanies the adolescent, it is important to devote part of the clinic visit to the adolescent alone. The sequence of interviewing adolescents and parents is a function of individual preference. The important issue is establishing the clinician as the adolescent's health care advocate and not as an agent of the parents or community. A useful method is to interview both adolescent and parents together during a brief intake session (15 minutes or less is usually appropriate). At this time the clinician should define the limits of confidentiality which will be applied during subsequent interviews. Confidentiality should be extended to all items of discussion except those which indicate a potential threat to the patient or others.

If the clinician has prior knowledge of case content (eg, school referral letter or private communication with the parent), it is wise to mention this openly at the beginning of the interview. If previous information is not acknowledged initially, it may prove difficult to elicit appropriate responses without placing the clinician in an embarrassing position regarding his own credibility and trustworthiness.

After explaining the limits of confidentiality and acknowledging previous information, first the adolescent, then the parent, should be asked the reason for the visit. The intent of questioning the adolescent first is to establish his or her primacy as the identified patient to whom service is to be provided. It takes tact and diplomacy to avoid alienating the parent who, as a result of previous experience when the patient was younger, may be accustomed to relating directly to the clinician on the patient's behalf. A useful technique is to ask appropriate questions of the parents directed toward childhood history and of the adolescent regarding present history. Eye contact should be maintained with the adolescent. If the parent persists in relating the present history, it is often helpful to comment (without rebuke) that the parent seems to be answering for the patient and it would be preferable if the adolescent answered for himself. This places the responsibility upon the adolescent, acknowledges his or her individuality, and allows the parent to see the point. It is important to maintain parental rapport, but not at the expense of inhibiting development of a working relationship with the adolescent. After a brief joint interview, a feedback session for both parent and adolescent should be arranged and the parent asked to leave the room. If the parent wishes to speak with the clinician alone, permission should be sought of the adolescent and the limits of confidentiality once again explained.

Alone with the adolescent, it is useful to summarize what was discussed in the joint interview with the parent. Confirmation and expansion of content should be sought from the adolescent. With the hesitant or apprehensive patient, it is frequently useful to allow the conversation to flow along lines of patient comfort and interest. Many adolescents "warm up" with relatively benign topics such as daily activities, hobbies, or interests. If a lead into a topic for discussion is given (eg, "I play in the band"), it should be followed up with interest (eg, "Really? What do you play?"). Most adolescents respond to this interest and will proceed with more pertinent information when they feel comfortable. Periodically, an attempt to relate

the topic of discussion with the present problem should be made; if resistance is met, a further period of free discussion is allowed. With practice, these interviewing skills allow a sensitive and efficient approach requiring a minimum expenditure of time. It is useful to realize that all problems need not be managed at one sitting. In general, the hesitant, hostile, or noncommunicative patient is best managed by frequent brief visits utilizing the above principles.

The Physical Examination

Physical examination of the adolescent should be approached with perceptive sensitivity to the fact that the growing individual is in a state of heightened consciousness and concern over matters relating to his changing physical state. A pleasant, firm, professional approach is indicated. Privacy and adequate draping should be provided. If the examiner is male, a female chaperone should be present whenever an undressed female adolescent is examined. This practice is as important to the patient (who may have discomforting sexual fantasies) as to the clinician (who may also have fantasies as well as the need to be protected from allegations of improper conduct). Each step of the physical examination should be explained to the patient in lay terms. It is often useful to comment on pertinent negative findings (eg, "Your heart sounds fine"). Incidental findings which are not mentioned as areas of concern by the patient should be commented upon. This is particularly important with such findings as gynecomastia, short stature, or acne. If the patient does not indicate verbal concern over these findings, information may be imparted using the "third-person" technique (eg, "Often teenage boys are worried about a lump like this in their breast"). Examination of the testes or breasts affords a good opportunity to discuss the value and technique of self-examination. Prior to an initial pelvic examination, it is worthwhile to spend a few minutes with a drawing or a model explaining normal anatomy and procedures used during the examination. Questions should be encouraged and answered in a direct and professional manner. Upon completion of the examination the clinician should summarize the findings and ask for any additional concerns that may not have been covered.

Comprehensive Care

The primary care clinician can provide comprehensive physical and emotional health care for most adolescents. The medical approach to total health care is generally accepted by adolescents. Adolescents under stress frequently present minor health complaints to medical facilities.[9] If this syndrome is recognized, gentle inquiry regarding other possible concerns is indicated.

Although reassurance of the benign nature of many health concerns is useful, follow-up visits at appropriate intervals often provide an opportunity for the establishment of trust and discussion of primary concerns. Once underlying concerns are verbalized, a counseling relationship should be formalized. In many instances, particularly situational disorders, it is appropriate for the primary care clinician to provide brief supportive sessions (one half-hour weekly is often adequate) during the period of increased stress.[10] More complex and time-consuming problems are best referred to professional counselors.

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