How to motivate and counsel adolescents

General practitioners are in an ideal position to oversee the passage of young people through adolescence, identifying those with potential problems and working with them to improve their health and wellbeing. This article outlines some principles, strategies and approaches to working with young people.

YVONNE BONOMO
MB BS, FRACP

SUSAN M. SAWYER
MD, FRACP

Dr Bonomo is Physician, Centre for Adolescent Health; Associate Professor Sawyer is Director, Clinical Services, Centre for Adolescent Health, Royal Children's Hospital, Associate Professor, Department of Paediatrics, The University of Melbourne, Vic.

The health problems of Australian adolescents have changed in recent decades from primarily biological to a broader range of concerns that have significance for health and wellbeing, as well as social and educational impacts. While chronic health problems such as asthma continue to be a major cause of morbidity in adolescents, mental health disorders are increasingly common.[1,2]

The concentration of health risk behaviours in youth was once simply considered part of normal adolescent 'turbulence'. However, epidemiological research is increasingly showing that these behaviours have both short term and long term adverse consequences on health. The effects of sexually transmitted diseases, unwanted pregnancies and increasing substance use (as well as continuities into adult life of tobacco use, poor diet and physical inactivity) challenge the assumption that these are simply adolescent behaviours that young people will 'grow out of' without consequence.

Primary care providers are in an ideal position to oversee the passage of young people through adolescence, identifying those with potential problems and working with them to improve their health and wellbeing.

Health risk screening

Adolescents present to GPs with a wide range of complaints, including coughs and colds, asthma, acne, headache, skin conditions and weight concerns.[2] These visits provide key opportunities for risk screening, to identify young people who are engaging in a range of health risk behaviours. The screening provides opportunities for delivering health promotional messages including:

- encouraging smoking cessation
- reducing binge alcohol drinking
- promoting approaches to safer sex
- encouraging healthy eating patterns and lifestyles
- encouraging 'SunSmart' practices.

IN SUMMARY

- **Be empathic, respectful and nonjudgemental.**
- **Understand confidentiality and consent requirements.**
- **Understand adolescent development.**
- **Recognise the importance of privacy.**
- **Be vigilant with boundaries.**
- **Provide a safe environment.**
- **Understand the linkage between physical and emotional wellbeing.**
- **Understand that family, school and peers are key agents of socialisation.**
- **Have good communication skills.**
- **Provide adolescent accessible services.**

Equally, these visits are an opportunity to promote adherence to medication in those with chronic conditions such as asthma or acne, or to promote preventive health interventions such as vaccination.

Providing an 'adolescent friendly' environment

A large part of successfully working with adolescents involves achieving and maintaining 'engagement', a term that refers to establishing rapport with the young person.

The adolescent population as a group finds it difficult to access health care.[3] Late opening hours may encourage adolescents to access health services. Welcoming, approachable receptionists and nurses are important in boosting the young person's confidence in seeing the doctor. Staff can help young people to access health care services by being sensitive to their worries about confidentiality (for example, not asking them why they want to see the doctor) and by adopting a flexible approach to scheduling (for example, avoiding negative comment if young people are late – better late than never). Assisting young patients to obtain their own Medicare cards once they are 15 years old enables them to attend consultations by themselves.

Consultations with young people can take time, and this needs to be factored into patient bookings. Longer consultations enable adequate assessment and management. However, it is not necessary to deal immediately with every point raised by a young person. Adolescents are generally happy to return for a follow up appointment, especially if it is acknowledged that the problem is important and that time will be put aside to discuss it.

A useful strategy in working with adolescents is to help establish a priority list of their concerns. For example, you could say, 'We have covered quite a number of things so far that we can sort out. At the moment, what do you feel we need to pay attention to first?' or 'Of all the things we have spoken about, what bothers you most at the moment?'.

Sometimes there is a discrepancy between what the doctor feels is most urgent and what the adolescent feels most troubled about. Even when there are more urgent medical issues to attend to, if the doctor spends some time acknowledging the adolescent's main concerns it will avoid the young person mistakenly feeling 'ignored' and it will be easier for the doctor to adjust the order of priority.

Assessing the developmental stage

To engage a young person successfully requires an understanding of three major areas of adolescent development:

- physical
- cognitive
- psychosocial.

In a consultation, an assessment of the developmental stage the adolescent has reached in these three areas informs the way the doctor presents and explains information and decides on management. It also enables the doctor to incorporate developmentally appropriate discussions on health promotion.

Maturity is not necessarily synchronous in these three areas at a given age. For example, despite mature physical development, some young adolescents with psychosomatic abdominal pain may have difficulty understanding an abstract concept (cognitive development) such as the relationship between physical symptoms and underlying emotional concerns. They may therefore need more concrete strategies, such as what to do when the pain occurs and what sort of pain relief to take, while simultaneously working through the underlying emotional issues.

Involving the family

Adolescent development does not take place in a vacuum; it is part of several developmental transitions involving the adolescents, their families, their peers and the wider community. It is important that doctors support young people's striving towards independence and autonomy while still maintaining an orientation towards the family.

Generally, the family has a pivotal role in facilitating an adolescent's increasing autonomy. It is best to establish and maintain supportive relationships with both the adolescent and his or her parents or caregivers, avoiding adversarial relationships and being aware of alliances.

Strategies that promote the adolescent's independence and autonomy without alienating the parents include:

- seeing the adolescent alone for at least part of the consultation
- providing the parents with feedback in the form of an outline of the problem and management options (rather than revealing confidential details of the consultation)
- assisting successful communication between the adolescent and the family.

Taking a broad history

In addition to the family background, assessing the social, cultural and educational/vocational background of adolescents helps in understanding and working with them. A popular framework that is used to gain this broader psychosocial knowledge is the HEADSS assessment (see the box on page 71).[4] Taking a psychosocial history is not only a way to engage the young patient, but also an opportunity to assess the patient's strengths and vulnerabilities. It equally provides a mechanism for developing an individualised response to the patient's problem that greatly improves the chance of a successful outcome.

Providing confidential health care

As they mature, young people desire increasing privacy in their relationships with health professionals. Concerns about confidentiality are a well described

barrier to accessing health care.[5] Explaining to the adolescent that his or her medical care is confidential is an important means of establishing trust and facilitating honest communication.

Physicians have a legal obligation to maintain the confidentiality of communications with patients and also that of the medical record. Adolescents are considered 'mature minors' if they understand the risks and benefits of the proposed treatment. Generally, adolescents over 14 years and certainly those over 16 years (with few exceptions) can be considered mature minors and can consent to medical care. Notwithstanding this, parental consent to medical care should still be encouraged as a way of engaging the parents.

Occasionally, situations arise where a notification is required which the young person objects to (for example, when there is sexual abuse or a protective concern). This is best approached by discussing with the young patients the legal and ethical obligations of physicians while clarifying that there is no intention of 'betraying' them but working with them to achieve the best health outcomes for them.

Using neutral language

Young people are sensitive to real or perceived negative judgements. An understanding of your own beliefs about a range of behaviours is vital to minimise inadvertent bias within the consultation, for example by comments about appearance, substance use or sexuality.

The simple comment 'You don't use drugs, do you?' is unlikely to promote honest discussion about drug use. The use of 'neutral language' is recommended (this can be harder than it sounds). This is particularly important to remember with adolescents who have been under your care since childhood, when usual practices may be inadvertently relaxed at the expense of a successful relationship with the young person.

Appreciating that change takes time

An appreciation of the 'stages of change' is relevant when working with young people. Prochaska described a stepwise process that occurs before significant behaviour change:[6]

- precontemplation – when there is no serious thought about behaviour change, at least not for the next six months
- contemplation – a period of seriously thinking about changing an unhealthy behaviour
- action – the period of an overt modification
- maintenance – the period after an overt behaviour change until the problem is finally terminated (or the person relapses).

Keeping this process in mind can be useful when you want to increase the motivation of adolescents to change their health risk behaviours. For many behaviours, such as smoking or binge drinking of alcohol, young people have not seriously considered changing (precontemplation). Encouraging safer sex practices in high risk adolescents is another example of managing people who are in the stage of precontemplation. The initial consultations may involve discussion about the topic in general, without the assumption or expectation that the patients will immediately change their current behaviour. Important ways to increase their motivation to change, and therefore their progression from precontemplation to contemplation, include exploring:

- the advantages and disadvantages of different methods of change
- what bothers them most about potential behaviour change
- how they would react to the adverse consequences of which they are currently at risk, such as unwanted pregnancy or a sexually transmitted disease.

While it is important to ensure that adolescents realise that their unsafe behaviours are not condoned, providing them with the opportunity to think about what has been discussed and return with questions facilitates their autonomy and motivation and encourages responsible decision making.

Counselling strategies

Acknowledging the patient's concerns

It is important that the concerns of young patients are acknowledged. It can be reassuring for them to hear that they are not alone with their worries, whether they be about acne, undue weight gain or

HEADSS assessment

This is a framework for taking a history from an adolescent. The mnemonic reminds doctors of which areas to question to gain a psychosocial profile of the patient.

Home
Education and employment
Activities and hobbies
Drugs
Sexual activity and sexuality
Suicide and depression screen

Case example

CS is an 18-year-old boy who presents with a sprained ankle after football training. On taking a brief history during the consultation, using the framework suggested above (or something similar), you obtain important information. For example, this young person tells you that he drinks a six-pack of beer alone every night and has been doing so for the last 18 months since a break-up with his girlfriend.

This situation provides an opportunity to assess CS for depression and/or risk of alcohol-related problems (including dependence), and to manage accordingly.

sexual issues. It is equally important not to belittle their concerns, however apparently trivial.

At times, young people may seem quite knowledgeable about particular issues, such as drug use or sexual activity. However, providing young people with accurate information and clarifying fact from fiction are important tasks for health professionals. Adolescents will occasionally pose questions to which the practitioner does not know the answer. Honesty is always the best response, as well as a commitment to finding the answer if possible.

Reframing the problem

Health professionals have an important role in helping young people see their problem in a different light. 'Reframing' is a large part of adolescent counselling. It is often useful to discuss how their concerns may fit into the broader context or bigger picture – an interesting and challenging aspect to working with adolescents (see, for example, the case history in the box on this page).

Promoting better adherence to treatment

Poor adherence to treatment regimens has long been considered characteristic of adolescent behaviour. While there is little evidence to support the notion that adolescents are any less adherent than adults, an understanding of adolescent development is important when working to promote better adherence. Acknowledging that youth are not greatly influenced by future events (such as the risk of lung cancer from smoking), successful strategies for promoting adherence are ones that are based in the 'here and now' and relate more to adolescent life priorities than disease priorities.

Normalising the difficulties of adhering with previous advice or treatment regimens is a helpful means of achieving more honest communication by reducing the sense of failure. A young person who is asked the general question 'Is everything going OK with your medication?' is likely to respond 'Yes', whether they are adherent or not. Instead, it is more useful to normalise poor adherence and then use an information-rich approach to gain specific information – for example, 'Many people forget to take their asthma puffers. Tell me, which dose do you more often forget, the one in the morning or evening?'. Strategies can then be developed with the patient to achieve better adherence for those doses that are particularly problematic. Working with young people to develop medication routines by, for example, linking the commonly forgotten morning dose to another routine, such as cleaning teeth, can be helpful.

Anticipating times of poor adherence is another strategy. For example, one might explore the situations that may most tempt a recently quit smoker to relapse (such as when his or her best friend smokes). This promotes discussion of ways to reduce exposure to these risks (such as encouraging the best friend to also stop smoking, or trying to spend more time with nonsmoking friends).

Having realistic expectations

Behaviour change takes time

Today's 'quick fix' culture can inadvertently suggest to young people, their parents and their health professionals that there are easy answers to difficult

Reframing

Case example

LG is a 15-year-old girl who has diabetes. Her mother has brought her to you, reporting that LG has poor blood sugar control and 'emotional outbursts' as a result of this. When you talk with LG alone, she describes difficulties accepting her diabetes, resentment at her mother's regular reminders about insulin and blood sugar measurements, and her wish to be 'normal' like her schoolfriends.

In this situation, reframing requires obtaining extra information. Exploring what she understands about her diabetes and 'correcting' any misperceptions are important. For example, she may believe that her insulin regimen will cause her to gain excessive weight. It would be important to acknowledge that many young girls worry about weight, and to educate her about how to have a balanced and healthy diet without having to eat any differently when with friends. It would also be helpful to discuss with LG why her mother might feel it necessary to constantly remind her about taking her insulin and to work out strategies together for how LG and her mother might both be satisfied.

Discussing whether LG knows any other young people with diabetes (or other chronic illness), and how they appear to cope, may also provide her with insights into how she is not alone in coping with a chronic illness in adolescence.

Reframing her concerns as being more than simply diabetes-related issues may be helpful. These discussions may include:

- that many of the issues she has with her mother are a normal part of growing up in adolescence
- the likely concerns her mother has about the longer term implications of poor diabetes control
- her frustrations of having to manage her diabetes
- the difficulties of having a chronic illness in adolescence.

This is a strategy to help her gain broader insights and understanding and allows exploration of the issues in a way that she may not have previously considered.

situations. Counselling adolescents requires patience and constant reassurance (not least to ourselves) that complex behaviours and emotional states do not change overnight. The widespread community belief that adolescence is a time of changing moods and emotions can result in unrealistic expectations that young people can simply 'snap out of it' (depression), cease addictive habits immediately (tobacco smoking), or lose weight within a month. Reassuring young people about the expected time course of change can alleviate much unspoken anxiety about 'Why am I not getting better?'.

Providing positive reinforcement to young people by commenting on any change in emotion or behaviour is valuable and can help build motivation for continued effort. For example, even smoking one cigarette less a day, or having one less episode of binge eating, is an achievement worth commending. Young people can be influenced and motivated by what their doctors say.

Relapses

Relapses in behaviour or emotional states are inevitable, but are often not anticipated by adolescents. Reassurance that this is normal, even expected, helps reduce the sense of failure that may otherwise undermine the required motivation for continued effort.

Reminding the young person of previous successes can be a useful approach that underscores his or her capacity to achieve change. Exploring what the adolescents understand as the cause of any relapse (and being prepared to reframe it) helps them better understand their behaviour. For example, attending a party where there was smoking after not having smoked for several days might be discussed with the adolescent in terms of the strong environmental influences on smoking behaviour. Another example is that of binge eating after a period of healthy nutrition – reminding the young person that the benefits of his or her prior healthy nutrition have not been undone by this relapse can re-establish the confidence to continue.

The doctor's frustration

The emotional and behavioural course that a young person may take during a period of counselling characteristically waxes and wanes. It may be difficult for the doctor to detect emotional or behavioural shifts, particularly initially, which can lead the doctor to feel that he or she is not having any impact. In these situations, it is both important and helpful to reflect on what is occurring in the consultations. Regular discussion with another colleague is a useful way to achieve reflection as well as a means of coping with the frustration that can arise, especially with young patients who are at very high risk. It is also a useful way to minimise the problem of counter-transference that can occur in the counselling process.

Referral to specialist providers

There are no clear guidelines as to optimal timing of referral of adolescents to specialist health providers. Indications for referral generally revolve around concern about diagnosis (e.g. chronic abdominal pain), severity of symptoms (e.g. severe substance abuse or dependence), or a need for multidisciplinary intervention (management of anorexia nervosa). For many adolescents, an arrangement of shared care between a specialist in adolescent medicine and the general practitioner works well.

The major difficulty for rural practitioners arises in the absence of available specialists or services in rural areas. In these situations, alternative methods such as secondary consultation with specialist providers can be helpful. This is where the specialist, after making an initial direct assessment of the adolescent, assists the general practitioner, via regular liaison (usually by telephone), in continuing most of the management.

Conclusions

The 'In summary' box at the beginning of this article provides a framework for working with adolescents.[7] The key to motivating and counselling them successfully centres on engaging them. Understanding and being sensitive to the cognitive, physical and psychosocial changes occurring during adolescence is pivotal to this engagement, which, once established, provides an entry point to positively influencing the health and wellbeing of young people. MT

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