Faced with heavy office schedules and with limited time, doctors often feel the need for practical pointers on obtaining information and working with teenage patients. This paper provides some guidelines to adolescent interviewing and counseling based upon experiences in the University of Washington Adolescent Program.

Interviewing and Counseling Adolescent Patients

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MOST physicians who treat adolescent patients find free and open discussions with them difficult at times. And most physicians have had only minimal training in interviewing technics and in patient counseling. Much of the little information available on interviewing technics with adolescent patients has tended to be highly analytical, theoretical and difficult to apply in daily practice.

At the University of Washington Adolescent Program, an interdisciplinary medical clinic, is a facility which encourages pediatric residents, fellows and staff physicians to work intensively with their patients who are adolescents. The various difficulties dealt with include such common problems as obesity, behavioral disorders, school underachievement and growth deviations. Treatment is short term and supportive.

The technics and approaches which are discussed below cannot be applied dogmatically to every adolescent patient. They are meant to stimulate thoughtful understanding on the part of the physician—and not necessarily a psychiatrist—who must, of necessity, individualize his approach and adapt his responses to fit particular situations.

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General Principles

Before considering specific types of problems, it is advisable to review some of the general principles of interviewing as they relate to this age group. The purpose of most interviews is to gain information, to acquire insight into the patient's problems, and to give help and counsel.

Initial Interview

The initial interview between the patient and his physician is the foundation upon which all future therapeutic plans are developed. Several important factors that affect this encounter should be considered.

It is customary in most adolescent clinics to see the adolescent alone for his initial interview. In most instances, previous contact with the parents or with other individuals responsible for the referral has already provided the interviewer with a little advance knowledge. Younger adolescents often feel uncomfortable about being interviewed without their parents, and time should be devoted to allaying any anxieties.[1] Some adolescents are aware of the reasons for being referred to the clinic or to a doctor; others prefer to profess ignorance. However, most adolescents are somewhat guarded and wary of new adult professional contacts. Hence

some time should be spent in familiarizing the patient with clinic procedures and preparation for his medical examination.

The adolescent's sense of dignity and personal worth are enhanced when the physician is completely honest with him. When a patient is referred for evaluation because of school failure, behavioral problems, concern about growth or other reasons, it is usually advisable to let him know what information the physician has been given. Such an approach saves time, provides a focus for the interview and avoids wondering on the part of the patient how much he should tell the physician.

Whether the sex of the examining physician is important is probably exaggerated. In a previous survey we found that to most boys the sex of the physician made little difference. Girls more often preferred to be seen by women physicians than boys by men. If the adolescent expresses a preference, this should be honored if at all possible.[21]

Adolescents respond best when they are treated like adults and when they have a sympathetic and understanding person in whom they can confide. The limits of confidentiality when dealing with teenagers should be carefully defined, however. The physician must convey to the adolescent that he will respect his confidences; however, swearing oneself to unqualified secrecy is unwise.

One approach might be for the physician to say, "John, if you wish to discuss our talks with your parents, that is your decision. The matters that you and I talk about are strictly between the two of us and will not get back to your parents or anyone else unless you tell them. There is one exception, however. If you tell me something that in my opinion is destructive to yourself, I must tell your parents since they are responsible for you."

An example is the adolescent who threatens suicide or who decides to run away from home. In these cases the parents must be made aware of the seriousness of the behavior. Such a direct approach lets the adolescent know where he stands and places the responsibility where it belongs, *i.e.*, with the patient and his parents. By defining the limits of confidentiality at the outset, the hazard of being sworn to secrecy and subsequently having to break a promise when parents have to be informed is avoided.

The physician may fear that if he emphasizes the necessity of communicating with the parents should potentially harmful material be divulged, the adolescent will not be open with him. In our experience, this has not been a significant deterrent. Patients have continued to inform their physicians of plans to run away or to harm themselves, knowing their parents would be told.

Contact with Parents

The attitudes and behavior of the parents can either reinforce the counseling or make it more difficult. On the initial visit, it is usually necessary to see the parents to obtain information on early development and also to gain their perception of the adolescent's problem. Such a conference allows the physician to assess their cooperation. If a successful relationship is to develop between the adolescent and doctor, the parents should be strongly admonished not to pry or "pump" the patient for information following interviews. If their adolescent shows a willingness to talk about the sessions, the parents should be interested and receptive.

Since counseling under the best conditions cannot produce instantaneous change in behavior, parents should be cautioned against having unrealistic expectations. The behavior problems will not change rapidly; they may never improve or they may get worse temporarily, and parents should keep this in mind.

Some parents tend to arouse a feeling of hostility in the physician by their lack of understanding, intolerance and controlling attitude toward their teenage sons or daughters. The physician usually does not get far by being openly critical of the parents; this arouses only anger and heightened resentment. Instead, a comment such as, "I can see how much Jim has upset you, but I have to ask you to take part in changing his behavior by . . . ," may be made; or a parent may be asked to evaluate the situation himself by posing appropriate questions such as, "Is the way you have been managing your teenager

working? Do the methods you are using seem to be effective? If your efforts haven't been working, why not?" It is sometimes helpful to ask parents, "If your son did everything you wanted him to do, conformed without question, achieved the goals you have set for him and ended up as an unhappy, dissatisfied adult, would you feel that you had been a successful parent?" These approaches can help parents begin to look critically and analyze how they behave or how they are perceived by their adolescent. Such comments may initiate their developing a degree of insight into their relationship with their children.

Parents need to feel that they are being kept informed of and included in the plans for their teenager. They should be told the treatment goals, the progress and the problems without violating agreements regarding confidentiality made with the patient. Periodic contacts, a phone call or occasionally seeing both parents and patient together promotes this attitude. The teenager should always be told when his parents have been seen. Parents who feel totally uninvolved and alienated may undermine and sabotage the therapists's efforts. Sometimes they may make the teenager feel that his visits to the physician impose an extraordinary hardship on the family, which only increases his frustration and arouses more guilt.

Identifying with the Adolescent Patient

It is often easy to overidentify with adolescent patients since their problems, concerns and struggles tend to reawaken our own adolescent experiences. While a certain degree of empathy and sympathetic understanding is essential, young physicians who may not be too far removed from their own adolescence must assiduously avoid taking sides with the adolescent against his parents, or vice versa. Discussions with parents, teachers or other involved persons help the physician to better and more impartially assess the adolescent's behavior.

Some professionals feel it is essential to adopt the adolescent's language, and even manner of dress, to be acceptable. While to some degree it is necessary to use the teenager's vocabulary to communicate with him, to do more seems phony, artificial and insincere. The age gap and the educational differences automatically place the physician in an adult authoritarian role, hopefully a respected model. He should work within that framework and not try to be a peer.

Atmosphere of the Interview

Sympathy, objectivity, empathy and sensitivity are all fundamental attributes of a good interviewer. These essential characteristics help to facilitate a meaningful exchange of conversation between the physician and the adolescent.

What the physician does and says is most important. He must remain continually aware of how his actions are perceived by the adolescent—how he "comes across." Distracting mannerisms such as writing notes, filling out papers, clipping fingernails, thumbing through charts or staring out of the office window can convey disinterest to the adolescent. These habits or mannerisms may be caused by the interviewer's anxiety or discomfort, but to the adolescent they indicate a lack of concern.

The patient should sense it is permissible to talk about his problems. He should not be made to feel he is being interrogated as if on a witness stand. While uneasiness can occur with any adolescent, it is most likely to happen with the noncommunicative teenager who feels the pressure of an examiner firing repetitive questions in an effort to elicit a response.

Obtaining Complete Information

Most professionals approach the interviewing of a new adolescent with the feeling that they must obtain a complete and detailed history to understand clearly the patient's situation. Specific facts and details are important, of course, but many times the nonverbal communication that goes on is equally significant and informative. The good physician trains himself to become perceptive and sensitive to how the adolescent conducts himself during the interview. The examiner notes obvious signs of anxiety, flushing, squirming, avoidance of particular subject matter, or inability to maintain eye contact; as well as inappropriateness of affect, appearance and dress.

As in any interview situation, the physician should strive to become acutely aware of his own feelings; these are his most important diagnostic tool. A brief time with a depressed adolescent who does not actually verbalize any feelings of sadness or hopelessness may leave him feeling depressed. Some teenage patients unconsciously arouse a feeling of anger or hostility in the physician. Some are provocative or seductive. The reactions induced by the interview are often characteristic of how the adolescent affects other persons in his life situation.

When he attempts to elicit information during an interview, the physician should be aware that incidents often important to the adolescent may seem inconsequential or insignificant to his parents or to himself as interviewer. One must guard against conveying disinterest or treating the teenager's concerns in a flippant manner. His disillusionment and being upset over petty failures, imagined slights or insults can be deeply disturbing to an adolescent; poor handling, inadequate recognition or failure to appreciate the impact of these disturbances on the patient may result in hostility, rebelliousness or inability to establish rapport.

While it is important to get as complete data as possible, the physician should not attempt to structure the interview rigidly. He should not be too quick to "shut the adolescent off" and direct him to the line of questioning felt to be more important. By picking up cues from the patient's comments or noting topics which spark interest, the interviewer may obtain more valuable insights into the problems which really concern the teenager.

Giving Emotional Feedback

To establish a workable relationship between the physician and the adolescent, there should be a reflection or mirroring of some feeling or understanding. Sharing a joke, laughing, expressing sympathy or giving other indications of emotional responsiveness lets the teenager know that the physician is interested and empathetic, and thus can set the stage for deeper emotional communication. The interviewer who stares impassively, or who makes monosyllabic responses in an effort to be nondirective and objective, often stirs up anxiety, discomfort and anger which may be difficult for the adolescent patient to handle. Facing an unmoving appearance or aloofness frequently leaves the patient uncertain as to what he must do to elicit an understanding response from the physician. At other times the interviewer may become too verbally active. His responses must be dictated in part by the patient's behavior to achieve a sensible balance.

Giving Advice

The parents as well as the teenager frequently attempt to place the physician in an authoritarian or quasi parental role and request specific advice on handling problems. In treating a clear-cut medical problem, the physician obviously is an authority and usually can provide cogent advice and treatment. With respect to adolescent behavior or adjustment problems, however, a more cautious and judicious approach becomes necessary. One of the great difficulties when working with adolescents is to refrain from the temptation of giving advice or directives. Parents know that most professionals are trained to solve problems, to analyze and to treat. Because they feel that they are paying for a physician's advice, they often become angry if this is withheld. Once the physician accepts this authoritarian role, however, he risks becoming involved in a serious power struggle with the adolescent over who has the right to make decisions and to run his own life.

While working with an adolescent the physician should attempt to help him recognize and understand for himself the important factors which bear on his life situation and affect his behavior. As much as possible, the adolescent should be allowed to consider his own problems, explore alternatives, make his own applications and decisions. The *potential therapeutic value* is lost if the physician makes these choices for the teenager, rather than allowing him to weigh the consequences of his actions and reach a decision on his own. Most adolescents want to make proper decisions and desire neither to harm themselves nor disappoint their parents. They

must have the opportunity to work problems through for themselves. Often the physician finds himself being used as a sounding board on which to test out an idea. For him to be too directive or to give an opinion prematurely without adequately exploring the teenager's motivations and feelings rarely works; it may force the teenager to reject the very person who is trying to help him exert his own independence.

Providing Reassurance

Providing reassurance can be a supportive technic to use with an anxious and disturbed adolescent. However, if given prematurely before the extent of the patient's concerns have been adequately probed, such words may not only sound hollow and inappropriate, but may undermine the therapeutic relationship. Giving a quick reassuring response often tends to allay the physician's own anxiety and to eliminate the necessity of having to discuss or face potentially uncomfortable situations; the teenager, however, is apt to perceive that his problems are unimportant or are being avoided by the physician, and, as a result, may feel that he can expect little help or understanding.

As an example, if an adolescent with gynecomastia or one with short stature or delayed sexual development is told by the physician, "Don't worry. It is nothing to be concerned about. You're perfectly normal," such an answer conveys to the patient a lack of appreciation of how important his problem really is to him. The physician who can say, "It's not easy to talk about things that are worrisome or embarrassing," has a start toward recognizing with the teenager how hard it is to look different, how difficult it is to be teased and not get angry or to keep hurt feelings from showing. The physician's discussion of the variations and individuality of growth patterns can then be meaningful and help the adolescent view his problem in better perspective.

The Uncommunicative Adolescent

One problem in these interviews is the uncommunicative teenager. The physician's reaction to the adolescent who won't talk is usually one of anger, irritation and frustration. Similarly, the teenager is often angry because of being forced to see the doctor. Some adolescents use this passive-aggressive technic to control and manipulate adults in their environment. Others simply lack the verbal skills and experience for communicating. Silence may be a reflection of depression or concern about a problem too disturbing to discuss. Whatever the cause, the physician usually has to be more verbally active, using every clue available to establish an exchange. A comment such as, "I'll bet there are lots of places you would rather be, than here talking with me," often produces surprising responses from the adolescent who is obviously unhappy about being seen. Such a statement acknowledges the patient's reluctance to talk and conveys the physician's understanding, letting him know that it is safe to express his negative feelings.

Asking the patient to go through his activities for a typical day, from the time he arises until going to bed often provides an opening. The incidents of his daily pattern which he chooses to relate provide points of departure which can be explored and may be productive.

When the physician has information or hunches about things bothering the adolescent, describing another (hypothetical) patient with subtle similarities to his own problems may be useful. Changing roles—temporarily allowing the patient to become the therapist—not only depersonalizes the teenager's own situation, but may help him to verbalize some of his own feelings and indirectly help him to reflect on his own predicament.

During one of the counseling sessions with M., a 14-year-old boy who professed an interest in helping others, the interviewer suggested that they might trade positions in the room and assume each other's roles so that he could have an opportunity to help advise another student with his problem. The interviewer, playing the role of the patient, described his problem: he was having trouble with school. In spite of good ability and high scores on achievement tests, his school performance was poor. He had difficulty completing assignments, and couldn't settle down

to study. He worried about his trouble socializing with other teenagers.

M. suggested that perhaps the interviewer's problem was that his parents bugged him too much, that he might do better if he had a quiet place of his own to complete his studies where his brothers would not bother him. He also suggested that maybe he was worried about his parents' frequent arguments and about the fact that other "kids" didn't seem to like him because he was a "dummy."

As he offered many explanations for the interviewer's problems as well as many positive suggestions, he began to realize some of the similarities to his own problem and thus began to develop some insight into them.

Role playing requires skill, but can be useful with some adolescents.

The interviews with an uncommunicative teenager should be brief, and return visits frequent, until he becomes more comfortable with the physician or until rapport has been established. An inability to elicit obviously meaningful material during an interview should not be regarded as a complete failure. More may have transpired at the nonverbal level than is at first apparent. The physician's interest and respect for the adolescent as an individual often convey more than spoken words.

The Talkative Adolescent

Not all adolescents, of course, are difficult to communicate with. Some are extremely verbal and tend to use their fluency to control and manipulate the therapist. Their verbal barrage keeps the physician at a distance and prevents his probing too deeply. It is essential in such situations for the physician to provide structure to the interview and to keep a sense of direction. He must repeatedly define with the patient the purpose for being seen and the goals for counseling. It is often helpful to repeat these at the beginning of each session.

Some adolescents tend to exaggerate or tell wild stories to impress the interviewer. The physician should be somewhat cautious in uncritically accepting the teenager's statements about his own experiences and his family. He should be sympathetic, but not gullible.

The Depressed Adolescent

Depression during adolescence is more common than one suspects, primarily because the clues may be overlooked or misinterpreted. The younger adolescent often does not present the classic signs of depression such as seen in adult patients. Instead he tends to exhibit depressive equivalents[3] such as multiple or somatic complaints, hypochondriasis, impaired attention and concentration, acting out behavior, overeating or drug taking. Some of the more seriously disturbed adolescents express their depression through precipitous suicidal threats or gestures. All suicide threats must be taken seriously. The physician's responsibility is to assess the severity and extent of the depression in adolescent patients and to evaluate the potential for any overt suicidal action.

The physician may be able to gain a few clues from the interview to indicate whether the adolescent is depressed and whether the depression is potentially serious. The adolescent's affect and appearance may provide clues. The adolescent who dresses in dark somber clothes, who is colorless, listless and disinterested is suspect.[4] A previously well-groomed and tidy teenager who suddenly becomes slovenly, unkempt and careless may indicate depression, or this change may represent a form of protest. A recent drop in grades, loss of peer contacts and withdrawal from family and from social activities are often warning signs, as are the symptoms of anorexia, insomnia and preoccupation.

The adolescent's ability to look ahead or to make plans for the future may provide a clue as to the depth of his depression. When a depressed patient can talk about his plans for the future or coming social activities which offer sources of pleasure and enjoyment to him, he is probably less seriously depressed than the youngster who can see no bright prospects in his future. A history of impulsiveness, accidents, depressive reactions or suicidal impulses are significant, as are a history of suicides and depression in other family members.

The physician is often hesitant to approach the question of suicide with a teenager for

fear of giving him "ideas." Most adolescents at one time or another contemplate death and even engage in fantasies regarding their families' and friends' reactions to their death. Many are relieved to know that this is not abnormal or unusual. A good way to approach the subject is by saying, "Many people your age, when they are unhappy or down in the dumps, think about harming themselves or about dying. Have you ever worried about this?" This provides an opening for discussing suicidal thoughts and for assessing the seriousness of self-destructive tendencies. Most adolescents respond openly and are not shocked by the idea. They are relieved that someone can recognize how badly they feel.

D. V., a 14-1/2-year-old girl, was referred to the adolescent clinic by her family doctor for evaluation of her poor school adjustment. Her parents were divorced, and she was living with her father and three siblings in the home of a paternal aunt.

The patient was the second of four children and was born prematurely. Her mother had always rejected her, had never given her any affection, and had often told her that she had been a difficult baby and a burden on the family.

She had been involved in numerous physical fights, in which she always excelled.

The patient was boyishly and carelessly dressed with her hair short and straight. She was very verbal, but appeared tense and anxious. She expressed feelings of having nothing to live for and wishing she were dead. She admitted thoughts of killing herself as a solution to her problems. She had considered various methods of suicide and had decided a knife would be the surest way and would take the most "guts." She had recurrent complaints of abdominal pain related to stressful situations. Her father worked evenings and left her at home alone while her siblings visited friends. She felt isolated from and rejected by her family; she was determined to leave home and asked for help in finding a place to live.

The physician, concerned about the degree of her depression, immediately arranged for an emergency psychiatric consultation which resulted in her being hospitalized. During her hospital stay, her mood elevated markedly. She became convinced that her physician was interested in her. The ward itself gave her a great deal of attention, and arrangements were made for her to live with another family. In retrospect, it appeared that her suicidal threats were a provocative means of calling attention to her unhappy situation and getting help.

If suicidal threats are not taken seriously or recognized, or if the life situations responsible for the adolescent's maladjustment are not corrected, such feelings continue. Being able to talk about these feelings and impulses often helps adolescents to reduce the need to act out their frustration. Some require hospitalization or intensive psychiatric treatment. The physician must determine this need on the basis of his interview and contacts. If the physician feels worried about the patient, an emergency psychiatric consultation or referral to a source for handling psychiatric emergencies should be arranged immediately.

Recapitulation

Success in working with this age group depends largely upon the interest and comfort of the physician, and the amount of time and effort that he is willing to invest. Treating the adolescent with respect, conveying interest and a willingness to listen, defining goals, establishing the limits of confidentiality and being sensitive to his needs and problems are fundamental in establishing a meaningful relationship. Learning to use one's own feelings and reactions as a diagnostic tool in evaluating the teenager is important.

The technics and approaches discussed here have to be adapted to fit the individual physician and situation. Equally important, however, is the ability of the physician to convey warmth, understanding and enjoyment in working with adolescents.

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