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# The Challenge of Adolescent Health: Views from Catholic Social Teaching and the Social and Medical Sciences

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# CHAPTER 6:

# SUGGESTIONS FOR IMPROVING HEALTH CARE DELIVERY TO ADOLESCENTS

These issues, barriers, and problems with the existing adolescent health care system lead us to make a number of general suggestions toward its improvement and to present some program prototypes that address the challenges to adolescent health in a manner consistent with the precepts of Catholic moral teachings.

Five suggestions are presented here. First, it seems clear that the prevention of health problems among adolescents should be a central component of any health care system. Prevention and early intervention of adolescent health problems should address social morbidities as well as the biomedical and mental health problems of teenagers. Secondly, because so many adolescents engage in risky, health-compromising behaviors tied at least in part to their ignorance or rejection of fundamental life-affirming values, health care and health education should make an effort to articulate and promote such values to them. Health care and health education should be value-laden and, whenever possible, present to adolescents an ethical framework of life-affirming values consistent with those values articulated by Catholic moral theologians. The third suggestion for improving health care delivery to adolescents is that systems strive to be culturally competent and to recognize the diversity of cultures, ethnic heritages, and racial backgrounds of the teenagers in this country. The fourth suggestion is a call for the integration of service delivery. Fifth is to make every effort to encourage the appropriate use of health care services by adolescents and their families. Improvements along these lines would significantly improve the quality of health care for adolescents.

When possible, examples of programs addressing these suggestions are also presented. Since existing health-care programs and projects designed

to deliver needed care to adolescents run the gamut from traditional doctors' offices to facilities with a full range of medical and social services, a broad range of programs is presented. Some are particularly successful at attracting patients from inner-city neighborhoods, some treat only a particular type of health condition, some are geared to attract all adolescents and steer them into more main-line facilities, while still others attempt to prevent the onset of social morbidities common to adolescence or a particular health-compromising behavior.

The existing projects also vary in their ability to affect the health and well-being of today's teens. Some projects have made remarkable strides in some areas but had no lasting effects in others. Evaluation of the worth of any particular approach entails an understanding that the goals of each project are different, the populations they hope to help are different, the assumptions and funding requirements of each are different and their outcomes are different as well. While no programs are perfect, some programs offer very helpful insights.

## PREVENTION AND EARLY INTERVENTION

One way to reduce the difficulties associated with adolescent health problems is to prevent their onset. Clearly, reducing the number of cases of adolescents who contract an infectious disease or metabolic disorder is generally preferable to finding a "miracle" cure. Barring prevention, early intervention almost always makes treatment more effective. Both these approaches should be a primary focus for reducing the impact of the physical and mental conditions afflicting young people as well as those social morbidities disproportionately affecting their health. Medical practitioners, counselors, teachers, and parents would support the health and well-being of adolescents if preventive interventions were widely available to young people today.

### Guidelines for Adolescent Preventive Services (GAPS)

Recently the American Medical Association published a full list of recommendations for primary care physicians caring for adolescent patients (Elster & Kuznets, 1994). Some of their recommendations reflect a national consensus of medical personnel; others were developed by a national scientific advisory board in response to their perceptions of adolescent health challenges in contemporary society. Their recommendations include preventive health guidance such as discussions with physicians on diet,

fitness, adolescent development, and the avoidance of health-compromising behaviors such as smoking, sexual activity, and drug use. They include preventive screening for disorders such as tuberculosis, hypertension, and cervical cancer. In addition, the American Medical Association recommends a series of preventive inoculations and increased consultations with the adolescents' parents. Figure 6.1 presents a summary of the schedule of the preventive services they recommend for adolescents.

On the whole, these recommendations are remarkably consonant with those arising out of Catholic social teaching concerning adolescent health and health care. The recommendations are largely preventative and they acknowledge the complex nature of social morbidities. It is recommended, for example, that adolescents be questioned about tobacco, drugs and alcohol usage, experiences of physical and sexual abuse, and the existence of school problems, an eating disorder, or depression. Other recommendations include periodic screening for high blood pressure, elevated serum cholesterol levels, and STDs as well as consistent and repeated patient/physician discussions to promote and maintain healthy behaviors. As a reflection of the centrality of parents and families for healthy adolescent development, periodic parental contact with their teenager's physician is also recommended. The goal of these parental health guidance sessions would be to help parents adjust to the changing needs of their adolescents (Elster & Kuznets, 1994: 13).

The GAPS recommendations are not simply a codification of existent policies. They represent a shift in emphasis toward disease prevention and health promotion. Table 6.1 presents a summary of how the GAPS recommendations differ from the current system of health care delivery. The American Academy of Pediatrics developed a protocol entitled "The Injury Prevention Program" (TIPP) to help physicians work with patients towards a reduction in unintentional injuries. The "Put Prevention Into Practice" (PPIP) program, developed by the U.S. Public Health Service, provides medical staff information and tools for patient education and counseling including videos, posters, and warning stickers for patient files. Preventable problems such as tobacco use, lack of exercise, riding bicycles without helmets, early sexual activity, and access to firearms are targeted by this program (Paulson & Diguiseppi, 1995).

## Prevention Projects

A few promising programs designed to address the problems of adolescence focus on the prevention of the behaviors and situations which are likely to eventually create a serious problem or crisis. These programs generally focus on providing adolescents with the resources they need to steer away

**Figure 6.1:** Recommended Frequency of Preventive Health Services by Age and Procedure

| Procedure | Age of Adolescent | | |
|---|---|---|---|
| | **Early 11-14 years** | **Middle 15-17 years** | **Late 18-21 years** |
| **Health Guidance** | | | |
| Parenting* | ○ | ○ | |
| Development | ● | ● | ● |
| Diet and Fitness | ● | ● | ● |
| Lifestyle** | ● | ● | ● |
| Injury Prevention | ● | ● | ● |
| **Screening** | | | |
| ***History*** | | | |
| Eating Disorders | ● | ● | ● |
| Sexual Activity*** | ● | ● | ● |
| Alcohol and Other Drug Use | ● | ● | ● |
| Tobacco Use | ● | ● | ● |
| Abuse | ● | ● | ● |
| School Performance | ● | ● | ● |
| Depression | ● | ● | ● |
| Risk for Suicide | ● | ● | ● |
| ***Physical Assessment*** | | | |
| Blood Pressure | ● | ● | ● |
| BMI | ● | ● | ● |
| Comprehensive Exam | ○ | ○ | ○ |

| Procedure (cont.) | Early 11-14 years | Middle 15-17 years | Late 18-21 years |
|---|---|---|---|
| ***Tests*** | | | |
| Cholesterol | □-1 | □-1 | □-1 |
| TB | □-2 | □-2 | □-2 |
| GC, Clamydia, HPV | □-3 | □-3 | □-3 |
| HIV, Syphilis | □-4 | □-4 | □-4 |
| Pap Smear | □-5 | □-5 | ● |
| **Immunizations** | | | |
| MMR | ○ | | |
| Td | | ○ | |
| HBV | □-6 | □-6 | □-6 |

● : Yearly
○: Once per time period
□: Yearly if in high risk category

* Parent health-guidance visit is recommended
** Includes counseling regarding sexual behavior and avoidance of tobacco, alcohol, and other drug use.
***Includes history of unintended pregnancy and STD

High Risk Categories:
1. Screening test perfomed if family history is positive for early cardiovascular diseas of hyperlipidemia.
2. Screen if positive for exposure to active TB or lives/works in high-risk situation
3. Screen if sexually active
4. Screen if high-risk for infection.
5. Screen annually if sexually active or 18 years or older.
6. Vaccinate if high-risk for hepatitis B infection

*SOURCE:* Elster & Kuznets, 1994, *AMA Guidelines for Adolescent Preventive Services (GAPS): Recommendations and Rationale:* Table 16.1:179.

**TABLE 6.1:** How GAPS Differs from the Traditional Practice of Medical Care for Adolescents

| GAPS Recommendations | Traditional Medical Care |
|---|---|
| Preventive interventions provided by the physician complement health education that adolescents receive in their family, school, and community. | Physician role is generally considered independent of health education offered by family, schools, and the community. |
| Emphasis is on health promotion as well as disease prevention. | Diagnostic and therapeutic interventions are disease-oriented. |
| Preventive interventions target "social morbidities," such as alcohol and other drug use, suicide, STDs (including HIV), unintended pregnancy, and eating disorders. | Emphasis is on biomedical problems, including the medical consequences of health risk behaviors, such as STDs and pregnancy. |
| Emphasis is on screening for "co-morbidities," i.e., adolescent participation in clusters of specific health risk behaviors. | Emphasis is on the diagnosis and treatment of categorical health conditions. |
| Annual visits allow early detection of health problems and provide an opportunity for health guidance, immunizations, and the development of a therapeutic relationship. | Visits scheduled as needed for acute care episodes, follow-up care, management of chronic conditions, or sports examinations. |
| Comprehensive physical examinations are performed once during early, once during middle, and once during late adolescence. | Current standards vary from no recommendation on periodicity, to examinations every two years adolescence, to examinations required for participation in sports. |
| Parents receive health guidance at least twice during their child's adolescence. | The nature, type, and frequency of health guidance is left to the discretion of the physician. |

*SOURCE:* Elster & Kuznets, 1994, *AMA Guidelines for Adolescent Preventive Services (GAPS): Recommendations and Rationale,* Table 1.2: xxv.

from health-compromising behaviors.

The goals of the projects presented here vary. The first focuses on healthy development by promoting adolescent well-being and preventing health-compromising behaviors. The others focus on more specific social morbidities such as the prevention of alcohol use, substance abuse, or violence by adolescents.

***Promotion of Healthy Development***

In anticipation of the many challenges adolescents face as they mature in American society, some programs attempt to provide them with added social and psychological resources before they meet with difficulties. Such primary prevention projects provide:

> . . . a set of strategies organized *before* a defined or unwanted situation or behavior occurs. Primary prevention is directed toward promoting well-being--a positive, healthy state. Primary prevention may mean inoculation against polio or measles, to give one example. This medical strategy requires people to present themselves for a shot. Quick, easy, and basically painless, this strategy does not place much responsibility on the individuals who deliver or receive the immunization. The inoculator must deliver good serum in the correct manner, and the population must show up. It is a relatively passive process, which requires minimal interaction. The effectiveness and ease of the "quick fix" method of prevention in the medical field may lead us to believe there can be a similar approach to problems of living.
>
> Primary prevention strategies are directed toward the underlying causes of such problems. Primary prevention involves enhancing the environments and building strengths in a general population . . . (Blumenkrantz, 1992: 28)

One such primary prevention strategy was created by David Blumenkrantz and is being used at a number of sites throughout the United States. The *Rite of Passage Experience* is a collaborative effort which involves the young people, their parents, their schools, and the social services agencies in their communities. It provides for the adolescents a ceremonial ritual of initiation into adulthood, provides structured challenges to young people and their families, and teaches young people the knowledge and skills that are essential for them to become happy and healthy adults. This program is designed "to promote good physical health and nutrition, develop decision-making and problem-solving skills, build competencies, increase self-esteem, and most important, enhance the support systems that help strengthen links among and between schools,

family, community, and peers" (Blumenkrantz, 1992:41).

Evaluations of the teens who were provided with this *Rite of Passage Experience* during the sixth grade indicate that they are significantly more involved with their families, have more positive attitudes toward school, have engaged in fewer delinquent acts, are less alienated, and have lower rates of drugs and alcohol use (Blumenkrantz, 1992). These differences appear to hold up over at least a few years.

***Prevention of Alcohol Use, Substance Abuse, and Violence***

Some preventive projects are a bit more focused; they seek to change more limited patterns of behavior. For instance, some such promising programs concentrate on the prevention of alcohol consumption by adolescents. Some programs are focused on the provision of information concerning the dangers of alcohol consumption, some seek to alter the adolescents' goal setting abilities and decisionmaking skills, others try to develop the young person's ability to resist social pressures (Hansen, 1993). Research results indicate that programs which change the normative beliefs of teenagers concerning the acceptability and prevalence of alcohol consumption among their peers are among the more effective programs (Hansen, 1993). Programs which are initiated *before* teens establish patterns of alcohol consumption are more effective than those which seek to intervene once the underage drinking has become frequent.

A community-based program for the prevention of substance abuse instituted in Kansas City during the mid-1980's also shows promise. This substance abuse program was directed at sixth and seventh grade students; its goals included the prevention of use of tobacco, marijuana, and alcohol among young teens. This program sought to prevent drug abuse among adolescents by a school-based educational program emphasizing skills needed to resist peer-pressure, mass-media programming, parent education programs, peer-leader intervention, and the involvement of community organizations. The analysis of self-reported data indicates that significantly fewer teens involved in the program than in other similar areas initiated the use of these substances for at least a year after the start of the program (Pentz, Dwyer, MacKinnon, Flay, Hansen, Wang, & Johnson, 1989; Vincent, Clearie, & Schluchter, 1987).

Two other substance abuse programs with positive results are *Project ALERT* and *Project SHOUT*. Both focused on the prevention of tobacco use by young people in junior high schools, but *Project ALERT* also included efforts to reduce the use of marijuana among these students.

*Project SHOUT,* which involved nearly 3000 teens in the San Diego area, had an emphasis on interpersonal behavior aimed at countering peer pressure to initiate smoking and the use of chewing tobacco. A unique

feature of the program was the use of telephone and mail contact with the participants to reinforce the messages taught in the classroom. The evaluation of this program indicates that it is a cost-effective intervention which appears to significantly alter the tobacco usage of teens for at least the first three years after their exposure to the program (Elder, Wildey, de Moor, Sallis, Eckhardt, Edwards, Erickson, Golbbeck, Hovell, Johnston, Levitz, Molgaard, Young, Vito, & Woodruff, 1993).

Similarly, the results from *Project ALERT* indicate that this social-influence model of intervention was relatively successful in preventing the initiation of smoking and marijuana use among participants. The curriculum presented through this program helps students to develop reasons not to use these drugs, "identify pressures to use them, counter pro-drug messages, learn how to say no to external and internal pressures, understand that most people do not use drugs, and recognize the benefits of resistance" (Ellickson & Bell, 1990: 1300).

Over the past few years a number of prevention and intervention programs have been designed to reduce youth violence (Wilson-Brewer, 1995). In addition to those developed through the Centers for Disease Control and Prevention, more than 800 prevention strategies have been developed by organizations such as the Interagency Task Force on Violence Prevntion, the Carnegie Corporation, the National Crime Prevention Council, Education Development Center, the Children's Defense Fund, and the Center for the Study and Prevention of Violence (Wilson-Brewer, 1995). Some are school-based, some emphasize community linkages, and still others stem from health clinics. The effects of these programs are, however, as yet largely undocumented (Tolan, & Guerra, 1994).

## Prevention Programs for Pregnant or Parenting Adolescents

Some successful programs are directed toward those adolescents who have previously engaged in a specific health-compromising behavior. These programs are designed to alleviate some of the negative health and social consequences of those behaviors and prevent the teen from repeating them in the future. For instance, a number of programs were funded by the Federal Government in response to the programming needs of parenting and pregnant adolescents who bring their pregnancies to term.[55]

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[55] The original Adolescent Family Life Act, Title XX of the Public Health Service Act, was passed in 1981 and funding has continued at least through 1995 (Office of Adolescent Pregnancy Programs, 1990). Through the Office

One of the more successful projects developed and distributed a value-based curriculum for pregnant adolescents and their families. This program--*A Community of Caring*--recognizes the importance of ethical and family values immediately necessary for these adolescents.[56] It is comprised of teaching modules which are designed "to help the adolescent mothers, fathers, and their families understand how to have a healthy pregnancy, a safe delivery, and give their infants a good start in life" (Joseph P. Kennedy, Jr. Foundation, 1982: 1). Some of the modules focus on the physical facts about pregnancy and childbirth. Many, however, deal with developing the skills needed for the teens to make pro-social and healthy decisions in the future. This curriculum seeks to teach virtues such as love, trust, patience, commitment, courage, loyalty and compassion. It also seeks to demonstrate to the young participants the impact of their decisions on their child's quality of life, their own life chances, and those of the people they love (Joseph P. Kennedy, Jr. Foundation, 1982). Evaluation results indicate positive outcomes in some instances, ambiguous outcomes in others (Miller & Dyk, 1991).

Among the other encouraging projects funded through the Adolescent Family Life Act and directed at pregnant and parenting teens and their families, was one which stressed the importance of logical and systematic decision-making. This project entailed a counseling approach rather than an educational approach. A central tenet of the *Chance to Grow* project concerns the importance of the adolescent's parenting decision. Therefore, releasing for adoption was presented to the participants as a positive option within the structured decision-making counseling program (Office of Adolescent Pregnancy Programs, 1990). Over the course of its funding, this project was able to demonstrate a postponement in repeat sexual activity by the participants, an increased likelihood that these adolescents would

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of Adolescent Pregnancy Programs, Office of Population Affairs, Department of Health and Human Services, it has provided funding for organizations to help find effective strategies for service provision to pregnant adolescents, adolescent parents, and their families. The funded projects are required to offer a broad range of services to the teens including primary health care services, maternity and adoption counseling, educational services relating to family life and problems relating to premarital sexual relations (*Federal Register*, 1989: 52909).

[56] This project was developed under the auspices of the Joseph P. Kennedy, Jr. Foundation. Further funding of the curriculum and its associated manuals, teachers' guide, and handouts was received from the Office of Adolescent Pregnancy Programs (Joseph P. Kennedy, Jr. Foundation, 1982; Office of Adolescent Pregnancy Programs, 1990).

release their children for adoption, as well as some socio-economic benefits of participation to the young mother (Donnelly, 1992; Donnelly & Davis-Berman, 1994).

**The teaching of chastity:**

> San Diego, Jan 14-- Lori Brown, 14, is practicing how to say no to sex, learning strategies to save her virginity.
>
> Her instructor is Dajahn Blevins, a health educator from the Urban League here, who plays the role of the girl's would-be seducer and tests her with the crude patois of the street and the sweet promises of a fairy tale.
>
> Mr. Blevins tells Lori that she is the only girl at Roosevelt Junior High School who is not "hooking up." He says it's time to "take your panties off" or be dumped for someone who will.
>
> She looks him straight in the eye and says, "No," just as she was taught, without excuse or explanation.
>
> Still, he badgers her saying she must be stuck up or scared. The he whispers that he wants her so badly he will do anything: beg, crawl, buy her expensive gifts.
>
> But Lori is stteadfast. "Stop pressuring me," she says, "I'm not into that now. I'm into education."

*SOURCE:* Gross, 1994, Copyright ©1994 The New York Times. Reprinted by Permission.

## VALUE-LADEN HEALTH CARE AND HEALTH EDUCATION

Adolescents, as they strive to become autonomous, are faced with decision after decision with the potential to enhance or damage their health and well-being. Since most of these decisions hinge largely on the moral dimension, their families, health care providers, and educators are challenged to provide them with an ethical framework which will form the foundation for appropriate decisions. This framework necessarily involves a number of underlying values or assumptions concerning such basic understandings as the nature of human development and the value of human life. Those frameworks which are both internally consistent and explicit will provide

the most useful foundation for decision-making.

For some of the players involved in the support of adolescent well-being, the adoption or promotion of internally consistent and explicit values presents a demanding challenge. The parents of adolescents generally have the best opportunity to impart the values to their children unimpeded by legal or organizational considerations. It is within families that children are expected to first develop their moral characters. It is within families that there is continued access to the intensity of relationship upon which most learning is contingent. As the inventory of social morbidities common among adolescents illustrates, however, some families have thus far been unable to meet the challenge of providing teenagers with an ethical framework of life-affirming values which allow adolescents to consistently protect their own health and well-being.

Therefore, other groups and institutions are being challenged to provide clear and uncompromising standards and values to adolescents as they make important decisions concerning health-compromising behaviors (Hansen, 1993; Prager, 1993; Ryan, 1993).

## Teaching Values and Morality in the Schools

Some schools are refocusing efforts to present ethical standards and moral systems to their students (Lickona, 1993a). Many educators have come to recognize that many children are no longer learning the values needed for productive community participation in their homes. These educators have come to the common realization:

> . . .that we do share a basic morality, essential for our survival; that adults must promote this morality by teaching the young, directly and indirectly, such values as respect, responsibility, trustworthiness, fairness, caring, and civic virtue; and that these values are not merely subjective preferences but that they have objective worth and a claim on our collective conscience.
>
> Such values affirm our human dignity, promote the good of the individual and the common good, and protect our human rights.
>
> They define our responsibilities in a democracy, and they are recognized by all civilized people and taught by all enlightened creeds. *NOT* to teach children these core ethical values is a grave moral failure. (emphasis in the original {Lickona, 1993a: 9})

For schools and the other groups involved in the health and well-being of adolescents, the task to present fundamental values is significantly more

complex than it is for families (Berreth & Scherer, 1993). In the United States, publicly-funded institutions must rely on values which are common throughout the diverse ethnic and religious communities they serve. Schools, for example, might promote curricula which teach those values espoused in the Constitution and the Bill of Rights or they might rely on students to discuss ethical dilemmas. Adolescents who understand that their decisions have a moral component, that they are members of a community and individuals with rights and responsibilities, should be better prepared for sound (and healthy) decision-making.

Some educators argue that the moral dimension of adolescents' development should go beyond such secular values and include more religiously-based systems in their curricula. This presents a challenge in a pluralist society that mandates the separation of Church and State. One approach to the problem of teaching values in public institutions is to present explicitly "Christian," "Muslim," and "Jewish" teachings as well as more secular ethical frameworks to the students, allowing the students to choose among them.

This approach (and its more secular versions) is generally called the values clarification approach. Some versions of this approach have been used in connection with a number of health-impacting decisions. Its detractors point out that often the teachers fail to distinguish between personal preferences and moral values (Lickona, 1993a).

Partially in response to allegations that it is not enough to present various value systems to young people, educators have developed another approach. The character education model is designed to promote *particular* values to the students in an attempt to lead them to more responsible behaviors. In public schools and institutions these values are often secular ones such as "honesty" and "fairness" which are acceptable to almost all segments of the community (Huffman, 1993). Some character education programs make a concerted effort to select the value traits to be promoted in the public schools through consultation with parents and other community members. One school district involved in the *Personal Responsibility Education Process (PREP)* program, for example, selected a number of values including "compassion," "assertiveness," "discretion," and "respect" through the consensus of a community-based committee (Moody & McKay, 1993).

Private schools and organizations, however, are afforded an opportunity to embrace, articulate, and support the value system they find most cogent even if it involves some religiously-based components. Some private schools, precisely because they are *not* confronted with legal requirements to present a range of ethical frameworks or a so-called "value-free" approach, choose to present a single, and perhaps more fully articulated, ethical framework in their curricula. This tactic can be seen as a religion-

based version of the character education approach. In some schools, the ethical framework is openly labeled "Biblical," in some "Roman Catholic," and in others "Jewish" or "Muslim."

It is important to note that while the articulation of appropriate moral and ethical frameworks for decision-making appears to be a necessary component of health education, there is little evidence to believe that any school program is sufficient "cure" to the health-threatening decisions among teenagers. Neither the values clarification approach to moral education nor the character education approach has been shown to be a great direct influence over adolescents' behaviors (Leming, 1993; Lockwood, 1993). There is, in fact, a paucity of evidence to suggest that young peoples' behaviors are a direct result of the values they are taught in most existing programs.

Nevertheless, because so many of the health issues facing adolescents, their families, and health care providers are inextricably tied to important moral or ethical questions, health care policies, programs, organizations, and decisions have a responsibility to provide the clearest moral foundation possible. An emphasis on the value of all human life, for instance, is a relatively unambiguous moral precept of Catholic theology and broader Christian teaching. The application of this precept would have far-reaching consequences even if only consistently applied by young people of faith. These adolescents, when confronted by decisions regarding violence, suicide, reckless driving, drug use, or abortion would make their decisions concerning these health-compromising behaviors informed by a clearer understanding of their own moral foundation.

## Educating for Abstinence and Sexual Responsibility

One of the central tenets of Christian teaching which would, if taken seriously, make a crucial impact on the health-compromising behaviors of adolescents, is the belief that "sexual intercourse is best in the context of lifelong marriage" (Reiss, 1994). Most sex education programs for adolescents[57] that have been presented to teens in this country, however, do not emphasize the value of nonmarital sexual abstinence[58]. There have been

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[57] There are fewer programs still emphasizing chastity for unmarried persons of all ages.

[58] Some writers prefer the term "chastity" over "sexual abstinence" because it is not applicable to the avoidance of other activities such as drinking alcohol or eating desserts. However, since most of the academic and professional literature uses "abstinence" when referring to programs designed to reduce

a wide variety of emphases in the sex education programs offered in recent years. Some focus on reproduction while others include information about contraception, sexually transmitted diseases, values clarification, peer relationships, sexual responsibility, and communication and decision-making skills (Voydanoff & Donnelly, 1990).

There are a number of reasons why, despite their prevalence, there has been little reduction in early sexual activity attributable to prevention programs. Often they are brief and superficial; programs that are superficial consistently can be shown to have little or no impact on the participants. Furthermore, most of the educational programs take place in junior and senior high schools after a substantial minority of the students have already become sexually active (Blau & Gullotta, 1993; Voydanoff & Donnelly, 1990).

Another important factor is that most pregnancy prevention and abstinence programs are aimed exclusively at adolescents. Doing so ignores both the importance of modeling behaviors and the prevalence of adult/teen sexual contact (Males, 1993a). More specifically, focusing exclusively on teenagers overlooks the strong relationship between adult and adolescent behaviors. Males (1993a: 431) cites very strong correlations, for example, between the annual rates of births, unwed births, STDs and abortions for teens and adults.[59] In a very real sense most of the prevention projects call for adolescents to behave *more responsibly* than the many adults in the society.

A second and crucial factor is that most sexual contact is between pairs with a significant age discrepancy. The children of most teen mothers are fathered by adults (Males, 1993a):

> Even if every U.S. high school male abstained from intercourse or used a condom perfectly, 75% to 80% of all births and a similar percentage of STDs among teen-age females still would occur. (Males, 1993: 432)

If this age pattern was taken seriously, programs would include males in their twenties who have long-since left high school.

Since the early 1980's a number of programs have been designed to

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nonmarital adolescent sexual activity, it is the term more frequently used in this document.

[59] The correlations cited by Males have statistically significant Pearson r product-moment coefficent values of .934 (all births), .919 (unwed births), .884 (abortion rates), and .966 (STD rates). Birth and unwed birth rates were calculated annually from 1940 to 1990, abortion rates from 1973-1988, and STD rates from 1956-1990 (Males, 1993a: 431).

promote abstinence among adolescents by presenting it as the most effective method of avoiding the health risks associated with early sexual activity and pregnancy. Many of these programs have been labeled "abstinence-only" programs because they have been funded through private and Federal grants that proscribe the distribution of information concerning artificial means of birth control, access to such contraceptive devices, and information about or referrals for abortions. Most were developed in reaction to sex education programs that included information concerning contraception and techniques of avoiding sexually transmitted diseases:

> Concerned that sex education programs were "value-free," developers of these programs consistently emphasized the message that youth should not engage in intercourse until marriage. To avoid sending a "double-message," programs discussed abstinence only and did not discuss contraception. (Kirby, 1992:281)

Such programs are often politically palatable in arenas where other programs would face resistance on the part of some parents or other vocal segments of the community (Jorgensen, Potts, & Camp, 1993; Lickona, 1993b).

A number of the abstinence programs which do not cover any information about contraception have gained a good deal of notoriety. *Project Taking Charge*, for example, is an abstinence-based intervention for seventh-grade students that was first offered in Wilmington, Delaware, Ironton, Ohio, and West Point, Mississippi (Jorgensen, 1991; Jorgensen, Potts, & Camp, 1993). In addition to information concerning the importance of abstaining from nonmarital sexual activity, this project includes instructional units covering self-development, anatomy, physiology, sexually transmitted diseases, vocational goal setting, family values, and communication. Evaluation results indicate that participants and their parents demonstrated increased levels of knowledge concerning anatomy, physiology, complications caused by adolescent pregnancy, and sexually transmitted diseases (Jorgensen, Potts, & Camp, 1993). Furthermore these cognitive gains lasted for at least the first six months following completion of the program. Data from the six-month followup study also indicate that this program may have helped the participants to delay initiation of sexual activity (Jorgensen, Potts, & Camp, 1993).

Other influential, abstinence-focused programs which do not cover any information about contraception include the *Sex Respect* and *Sexuality, Commitment and Family: Me, My World, My Future* curricula. These programs are being used in a number of sites throughout the country (Howard, 1992; Department of Health and Human Services, Office of Population Affairs, Office of Adolescent Pregnancy Programs, 1990;

Lickona, 1993b). Evaluation results in terms of their ability to postpone or reduce sexual activity among teens are unclear.[60] Unfortunately, use of the *Sex Respect* curriculum in public schools has been labeled "controversial" in some areas and has come under legal scrutiny in others (Granberry, 1994; Tuck, 1991; Times-Picayune, Nov. 23, 1991, p.3). The values espoused through this program are so representative of conservative Christian teachings that constitutional questions of separation of Church and State have been raised in a Louisiana case (Ponessa, 1993; Roman, 1993).

At least one abstinence-focused intervention appears to delay the start of intercourse among adolescents. This program--*Postponing Sexual Involvement*--was funded by the Department of Health and has been used in the Atlanta area (Howard, 1992; Department of Health and Human Services, Office of Population Affairs, Office of Adolescent Pregnancy Programs, 1990). This program, however, is based on aspects of social learning theory which suggest that young people will be able to resist social pressure to engage in health compromising behaviors such as sexual activity if they are taught the tools and techniques necessary for risk avoidance (Bandura, 1986; Kirby, 1992; Kirby, 1993; Howard, 1992).

One of the best known abstinence interventions in the nation, this program involves classroom instruction and peer counseling. The classroom sessions are presented to eighth graders and involve presentation of techniques and tools to help them postpone sexual activity, as well as basic human sexuality information including contraceptive information. The peer counselors are trained eleventh and twelfth-grade students. A longitudinal, five year evaluation indicates that students experiencing this program were much more likely to delay initiating sexual activity during their high school years (Howard, 1992).

The sum total of the evaluation results of abstinence-focused programs, however, is not entirely clear. The evaluations of many are clouded because sexual activity is not a clearly designated outcome variable (Adamek & Thoms, 1991; Kirby, 1993; Olsen, Weed, Nielsen, & Jensen, 1992; Roosa & Christopher, 1990). Some studies focus, for example, on changes in attitudes or knowledge or pregnancy rates--none of which correspond directly to sexual activity. From the perspective of the educator, this oversight is understandable:

> Few other classes or programs are evaluated by observing change exhibited outside-school. The effectiveness of English classes is not evaluated by measuring improvement in the English spoken off campus,

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[60] Evaluation results do indicate that teens exposed to this program found it somewhat helpful and that the younger participants evaluated it more positively than the older ones (Olsen, Weed, Nielsen, & Jensen, 1992).

> and the effectiveness of civic classes is not assessed by measuring the law-abiding behavior of students. (Kirby, 1992: 280)

Thus, an expectation that reductions in sexual activity will result from the participation in a particular school-based program requires evaluation "criteria which are far more demanding, and perhaps unrealistic, than are criteria for the effectiveness of other school programs" (Kirby, 1992).

In most cases where actual sexual activity has been measured, no significant changes can be documented (Christopher & Roosa, 1990; Kirby, 1993; Roosa & Christopher, 1990). With only a few exceptions, evaluation results of the effectiveness of abstinence-only programs in terms of their actual ability to alter the behavior of teens are not particularly encouraging (Christopher & Roosa, 1990; Hayes, 1987; Moore & Wertheimer, 1984; Roosa & Christopher, 1990; Roosa & Christopher, 1992; Thiel & McBride, 1992; Voydanoff & Donnelly, 1990).

Detractors of abstinence-only programs point out that many of the curricula are fear-based; many curricula present all of the dangers of nonmarital intercourse without making a realistic appraisal of the immense social pressures that foster early sexual activity (Brick & Roffman, 1993; Lickona, 1993b). Educators have demonstrated that positive language--in this case emphasizing that postponement of sexual activity until marriage is a positive health decision--is likely to be a far more effective mechanism than is a fear-based approach (Brooks & Kann, 1993).

A few positive results can, however, be cited. Educational programs that promote abstinence appear to be most effective when they are part of an overall preventive strategy which is directed toward the elementary school-age adolescent. Very young adolescents and pre-pubertal adolescents, it appears, are better able than older adolescents to benefit from programs which emphasize abstinence (Barth, Leland, Kirby, & Fetro, 1992; Haynes, 1993; Howard, 1992; Howard & McCabe, 1992; Miller, Norton, Jensen, Lee, Christopherson, & King, 1993; Nicholson & Postrado, 1992). In their evaluation of three different abstinence-focused programs, Olsen, Weed, Neilsen, and Jensen (1992) concluded that junior-high school aged female students and those who have remained chaste[61] and uninformed of birth control information are the ones who consistently rate these programs most positively.

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[61] The term used by these authors was "virgin-naive" rather than uninformed and chaste. The respondents were classified according to their previous sexual behavior and their previous knowledge of contraceptive information into three categories: "nonvirgin," "virgin-informed," and "virgin-naive." The programs examined were *Values and Choices, Teen Aid,* and *Sex Respect* (Olsen, Weed, Neilson, & Jensen, 1992).

Abstinence as a component of a more comprehensive preventive program appears to have a greater chance of affecting the behaviors of adolescents. As much research has pointed out, effective programs are comprehensive and intensive. Effective programs are more likely than ineffective ones to meet with the participants often, over a long period of time, and to be run by people perceived to be intensively involved with the young people (Miller, Card, Paikoff, & Peterson, 1992; Voydanoff & Donnelly, 1990). Superficial contact with a teacher or counselor or physician is unlikely to alter behaviors that are defined as acceptable, desirable, expected, and moral by large and powerful members of society. Programs that have been effective in delaying the start of sexual activity "generally include some combination of values and knowledge-based education, decision making and social skills training, reproductive health services, and alternatives or options that enhance motivation to avoid adolescent pregnancy" (Miller, Card, Paikoff, & Peterson, 1992: 271). They rely on curricula which allow the student to personalize the skills and information in ways necessary for successful avoidance of early sexual activity (Kirby, 1992).

## CULTURALLY COMPETENT HEALTH CARE SERVICES

Health care professionals will be more effective if they take into account their own cultural biases and the cultural diversity of their clients. Health care providers have a culture which is very different from that of adolescents and most of their families. While studying to become physicians, nurses, and counselors, for example, the health care providers learn the "scientific" names and explanations for maladies and their cures. They are presented with vast information concerning technological and pharmaceutical responses to illness and they are taught which conditions warrant responses and which are ignorable. As Press points out:

> . . .biomedical jargon is designed to allow standardized teaching of medicine and standardized communication between medical professionals. It is *not* designed for physician-patient interaction. It serves the physician's ends--not the patient's, and reflects special training, not powers. (emphasis in the original {Press, 1982: 191})

Even well-educated adults who have not studied medicine or its allied fields often have difficulty comprehending medical jargon; it is all the more difficult for the young person with an often more limited understanding of biomedical terminology to understand information they may receive from

their physician. Practitioners who realize that they are members of a distinct subculture because of their training and education will also understand that they must translate their explanations and instructions into terms which are more meaningful to their patients.

Furthermore, because adolescents in this country are culturally diverse, health care systems should be designed to be as "culturally competent" as possible. The culturally competent health care system is one which values cultural diversity, recognizes the dynamics involved when cultures interact, and can work effectively with the strengths of each individual cultural system (Cross, Bazran, Dennis, & Isaacs, 1989; U.S. Congress, Office of Technology Assessment, 1991c). Such a health care system would be staffed with individuals who are aware of their own cultural biases and "who are sensitive to cultural differences within as well as across racial and ethnic groups" (U.S. Congress, Office of Technology Assessment, 1991c: 190). A culturally competent health care system for adolescents would also include a more proportionate representation of minority practitioners. While not guaranteed to reduce the impact of inherent bias, racism, or lack of understanding, increasing the proportion of minority doctors, nurses, and other staff would be a reasonable goal.

## INTEGRATED, COMMUNITY-BASED SERVICE DELIVERY

Integrated services are oriented to treating the whole person in the context of the community in which they live and develop. Whole person in this context includes the physical, mental, and moral dimensions referred to in Chapter Three. Integrated health care also is designed to address the broad range of developmental and biopsychosocial needs of adolescents as well as the clustering of problems within individuals and families.

Based on an analysis of the evaluations of 13 different sorts of integrated health care programs, Schorr and Both (1991) conclude that successful programs have a number of common attributes. They are comprehensive, flexible, and responsive and deal with the child as an individual and as part of a family, and with the family as part of a neighborhood and a community. Staff in successful programs have the time, training, skills, and institutional support necessary to create an accepting environment and to build relationships of trust and respect with children and families. Furthermore, successful programs are well managed, usually by highly competent, energetic, committed and responsible individuals with clearly identifiable skills and attitudes. These include a willingness to experiment and take risks, tolerate ambiguity, work with diverse constituencies, and operate with a collaborative management style.

Successful programs are based on a client-centered and preventive orientation (Schorr & Both, 1991).

As mentioned earlier, the fragmentation of services is an important barrier to the delivery of adolescent health care. Several integrated approaches to health care delivery attempt to overcome these barriers. In order to balance the need for parental participation and the distinctive characteristics of the adolescent population, the most promising approach appears to be community-based adolescent health centers that provide a wide range of services to treat diverse problems including biomedical health problems, mental health problems, and social morbidities.

Integrated, community-based adolescent health care centers offer the possibility of programs easily accessed by adolescents, programs that also foster the involvement of families, and allow a full range of community groups and organizations to have input into the health care of young people. Some community-based facilities are closely tied to established medical facilities such as hospitals or public clinics, others are outgrowths of social service agencies.*Teen-Link* in Durham, North Carolina, for example, serves adolescents who are economically disadvantaged and previously underserved. Its program goals include the provision of "knowledge, skills, and alternative sources of social and medical support necessary to develop positive attitudes and behavior" among teens aged 10 to 18 (DuRant, 1991:450). This award-winning health program involves the county health and social service departments, local churches, public and private school systems, Duke University Medical Center, a family-oriented medical center, civic organizations, businesses, and the public housing authority (DuRant, 1991; Lincoln Community Health Center Brochure and private communication, 1993).

A full range of services is provided by the staff of this facility. Services include a number of primary-prevention programs to promote healthy behaviors, dental health care, comprehensive primary health care, prenatal services, nutritional counseling, other specialty medical services, WIC services, and mental health services (DuRant, 1991; Lincoln Community Health Center Brochure and private communication, 1993). These services are offered on-site or in some cases in the homes of the young people:

> Services are provided by a team of multidisciplinary professionals with special training in adolescent health issues. In addition to the health care providers, the staff includes outreach workers to conduct home visits and follow-up and a community health facilitator who lives in the community and recruits adolescents to the program through personal contact with the adolescents and their families. The health care team also includes a nutritionist who provides exercise programs and diet counseling for the adolescent patient. (DuRant, 1991:450-451)

Another equally innovative community-based health project for adolescents is *The Bridge Over Troubled Water* project in Boston. This project serves runaway youth in Boston who are between the ages of 12 and 21 and aims to help them leave the street. Unlike *Teen-Link*, however, the services are provided in a mobile medical van which moves around the city, improving access to its services. *The Bridge* offers health and social services such as drug and alcohol abuse counseling, dental care, acute medical care, vocational education, laboratory screening for sexually transmitted diseases and other infectious diseases including hepatitis, pregnancy testing, and prenatal and contraceptive counseling. The staff of this project are also multi-disciplinary and have been very successful in reaching a very high-risk population of adolescents (DuRant, 1991: 451).

## FAMILY-CENTERED ADOLESCENT HEALTH CARE

The earlier discussion of Catholic moral and social teachings also emphasizes the importance of a family perspective in the development of adolescent health care policies and programs. Catholic teaching stresses the family as the foundation of the church, the society, and the community. A family perspective involves viewing individuals in the context of their family relationships and using the quality of family relationships as a criterion to assess the impact of policies and programs (Lynch & Preister, 1988). Policies and programs derived from a family perspective support and supplement family functioning, encourage and reinforce family commitment and stability, recognize the strength of family ties even when they are problematic, consider families as partners in service delivery, recognize the diversity of family life, and target vulnerable families (Consortium of Family Organizations, 1990; Ooms, 1990). A family perspective provides a framework for policy that addresses the broader context in which family-related problems occur.

This context can be understood by viewing human development as occurring in relation to four societal levels, each nested within the next according to its immediacy to the developing person. The most immediate level consists of a network of face-to-face relationships experienced by an individual including family, peer, and school-based relationships. The second level is the interlinked system of personal relationships in which an individual participates, such as linkages between the family and the school. The third level includes the external environments in which a person does not participate but which exert indirect influences, such as the work settings of family members. Finally, the broadest level consists of the belief systems and institutional patterns that provide the context for human

development.[62]

This model provides a framework for looking at the ways in which families are interdependent with other aspects of society. For example, Chapter Two documented the importance of the media (a component of the broad cultural system) for adolescent health. Earlier chapters also show the profound impact of poverty derived from difficulties on the exosystem level on the health problems and care of adolescents. This approach makes clear that policies based on a family perspective also must be assessed in the context of other institutions such as the economy, community organizations, and government.

This family perspective is consistent with Catholic teaching on subsidiarity which recognizes the importance of addressing problems on the appropriate societal level and with communitarianism which posits that individuals, families and local communities such as neighborhoods exist prior to more institutionalized levels (see Chapter Three). Teachings on the preferential option for the poor acknowledge the difficulties that people as individuals have in addressing the broader social forces that create and maintain poverty on a societal level.

Furthermore, a good deal of more secular research suggests that adolescent health care should be family-centered. Family-centered health care treats the entire family, rather than just the teenager, as the focus of concern. Successful attempts at family-focused treatment of adolescents are cognizant of the impact that the policies and procedures, staffing, training, financing, recordkeeping, and the structure and organization of the program or agency itself have on the families involved (Snyder & Ooms, 1992).

Family-focused programs for adolescents frequently center on the treatment of social morbidities. Drug and alcohol abuse, violence and other forms of delinquency, mental health problems, adolescent pregnancy, and obesity and eating disorders are morbidities which are often treated through family-centered care (Miller, Card, Paikoff, & Peterson, 1992; Snyder & Ooms, 1992). Results of some studies, for example, indicate that open communication between parents and adolescents is associated with abstinence (Olson, Wallace, & Miller, 1984; Pick de Weiss, Atkin, Gribble, & Andrade-Palos, 1991). While few families do talk openly about sex, programs directed toward parents can increase the likelihood of this occurring (Howard, 1985; Warren & Neer, 1986). This research provides a strong rationale for providing parallel programs for parents and teens (Brown & Fritz, 1988).

The range of services offered by some of the successful programs is quite broad. Some are privately funded while others have been developed

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[62] These levels are referred to by Bronfenbrenner (1986) as the microsystem, the mesosystem, the exosystem, and the macrosystem respectively.

by public agencies. The state of Delaware, for example, consolidated most children's and adolescent services into one unified department called "Department of Services for Children, Youth, and Their Families" (McCarthy, 1992). Subsumed into this agency were protective services, mental health services, alcohol and drug abuse treatment, and youth rehabilitative services. All staff receive intensive pro-family training to facilitate the use of family-focused interventions and the agency reviews all policies, procedures and laws in an attempt to maintain an organization which is responsive to the needs of each of the families it encounters (McCarthy, 1992). The range of services offered by another successful program in Montgomery County, Maryland, is somewhat narrower. This agency focuses primarily on the treatment of adolescent mental health and addiction problems. A previously existing family crisis intervention program called *Parents and Children Together (PACT)* was restructured in the late 1980's as a single point of entry for all families with adolescents experiencing substance abuse difficulties. *PACT* practitioners provide assessment and case management services to the families and adolescents, referral to appropriate community-based agencies, and continued involvement throughout the treatment (Luongo, 1992). Such programs have been successful not only in improving the chances for altered behaviors on the part of the adolescents and families involved, but they have also proved effective in reducing duplication of services, both the human and financial costs of out-of-home placements, and the appropriate distribution of treatment to those in need.

## ENCOURAGING AGE-APPROPRIATE USE OF HEALTH CARE SERVICES

The final suggestion for improving the health care services of adolescents involves making existing services more accessible to adolescents and their families and more attuned to their developmental needs. Health promotion and health care presume that the patient recognizes that help is needed. Such help--which might consist of either changes in attitudes, knowledge and behaviors or changes in medical interventions--must then also be accessible to the adolescent. An increase in the health-related knowledge of adolescents and changes in patterns of their health-compromising behaviors necessitate a broad change in their social world. One potential avenue to such changes is through the mass media. Once adolescents and their parents have identified their need for medical intervention, those services must be available and accessible to this distinctive population. Those who provide health care services to teenagers, furthermore, should be cognizant of their unique developmental attributes.

## Using the Mass Media for Health Promotion

The mass media have the potential to increase health-related knowledge and positively influence the decisions and behaviors of adolescents. People are exposed to information about health and illness throughout the print media, radio, movies, and on TV. For most Americans, the form of media with the greatest potential for influence is probably television. Many people indicate that television is their primary source of information about certain diseases such as cancer or AIDS (Freimuth, Stein, & Kean, 1989; Signorielli, 1993; Wallack, 1990).

Such information can be transferred to audiences within the context of programs, through public service announcements, or through news programs. Often program episodes focus on a particular health issue; programs which present these issues and their remedies somewhat realistically help to increase the viewer's health-related knowledge[63] (Montgomery, 1990; Signorielli, 1993). Program episodes with proactive health messages have aired on such topics as underage consumption of alcohol, smoking, AIDS, and drug abuse. While it is clear that entertainment television in a few instances has made a contribution to the public health awareness, it has very often also promoted unhealthy behaviors:

> The pro-social scenes and dialogue in the programs are often in conflict with the carefully crafted commercials that punctuate the programming with increasing frequency. So, while characters in popular sitcoms warn each other, from time to time, about the dangers of drinking, slick ads in other parts of the schedule repeatedly drive home the message that beer and wine are essential to the good life. (Montgomery, 1990: 127)

A second potential source of health-impacting messages is found within health-promoting campaigns. For example, recent health promotion TV campaigns have been used to spread information concerning the dangers of cigarette smoking, drug use, alcohol consumption, and AIDS (Atkin, 1993; Monismith, Shute, St. Pierre, & Alles, 1984; Signorielli, 1993). Others have used posters and billboards to warn adolescents of the chances of

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[63] In fact, however, health issues are quite rarely portrayed realistically. Since its primary function is to promote commercial products, television is only secondarily concerned with public health issues. Often TV programs portray health problems as individual concerns rather than social ones and they tend to avoid discussions which will deeply offend their viewers or their sponsors (Montgomery, 1990; Signoriella, 1993; Wallack, 1990).

contracting a sexually transmitted disease or becoming pregnant if they are sexually active (Strasburger, 1993).

The relative success of such health promotion campaigns, however, is not entirely clear. Researchers indicate that the surveyed adolescents were aware of having seen antismoking messages on television, remembered them, and reported worrying about the dangers of smoking (Monismith, Shute, St. Pierre, & Alles, 1984). More than half of the respondents who smoked stated that their exposure to these announcements made them want to stop smoking but data were not collected on their subsequent smoking behaviors (Monismith, Shute, St. Pierre, & Alles, 1984). Evaluations of other anti-smoking campaigns, however, indicate that the media were effective at preventing some adolescents from beginning to smoke and even stimulated the cessation of smoking in others (Flay, 1987; Worden, Flynn, Geller, Chen, Shelton, Secker-Walker, Solomon, Solomon, Couchey, & Constanza, 1984).

There is also evidence to suggest that the news media can be an effective vehicle for health-promotion (Donnerstein & Linz, 1995). Research concerning the disclosure to the media of AIDS and HIV infection by celebrities, for example, indicates that such information directly corresponded to marked increases in the number of individuals requesting HIV-antibody testing (Gellert, Weismuller, Higgins, & Maxwell, 1992). Figure 6.2 illustrates this pattern.

Researchers point out changing health-impacting behaviors and attitudes is more effective if the messages promoted are designed with their target audience in mind. Rather than emphasizing the goals of the sponsoring organization, effective campaign strategies are careful to take into account the perspective of the target audience in terms of their "attitudes, beliefs, motivations, health behavior, and needs" (Sullivan & Robinson, 1994: 84).

Successful health promotion campaigns involve exposing the audience to information surrounding the health threat, providing them with an understanding concerning the importance of the threat, their susceptibility to it, and an understanding concerning what role they can play in its prevention or treatment.[64] According to some researchers, mass media are most effective in the first part of this process--increasing the audience's awareness and knowledge of the health threat (Rogers & Storey, 1987; Sullivan & Robinson, 1994). Health promotion campaigns have also proven effective in stimulating interpersonal discussions which are generally more directly responsible for behavioral change (Sullivan & Robinson, 1994).

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[64] Campaigns which emphasize the efficacy of actions or treatments will be more effective than those which leave the viewer believing they have no control over the health problem (Sullivan & Robinson, 1994).

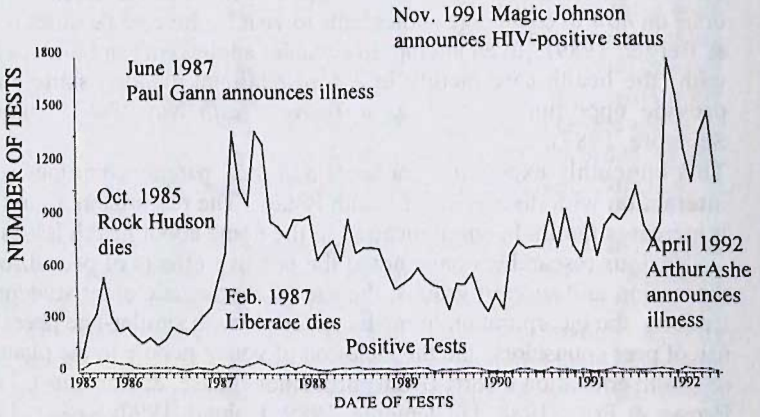
## Increasing Use of Available Services

Often adolescents do not use the available health care services. The urgent need for outreach into the community to attract adolescents to health care facilities has been thoroughly discussed, while not much research has been done on *how* to encourage adolescents to visit health care facilities (Goon & Berger, 1989). In an attempt to acquaint adolescents and their parents with the health care facility in a nontraditional manner, some clinics provide opportunities such as a *Teens Health Nite Out* (Vernon & Seymore, 1987).
This bimonthly experience for teens and their parents combines social interaction with discussion of health issues. The researchers found that it increases familial communication in the home about health issues.

Various researchers have noted the positive effects of peer-directed discussion and support groups, the use of charismatic older students as teachers, the incorporation of media materials with similar-age peers, the use of peer counselors, and the inclusion of young people in the planning of health education efforts (Bonaguro, Rhonehouse, & Bonaguro, 1988; Brown & Fritz, 1988; DiClemente, 1989; Holund, 1990; Kisker, 1985; Millar, 1975; Rickert, Jay, & Gottlieb, 1991). Research indicates that social skills training and social pressures curricula work best with peer leaders, but other kinds of instruction may be effective with either adult or adolescent teachers (Perry, Telch, Killen, Burke, & Maccoby, 1983). This interaction may explain the one study cited by Bonaguro and his colleagues (1988), which concluded that a teacher-led session was more effective than a peer- or expert-led session. The effectiveness of the instructor will be determined, in part, by the topic and focus.

Relatively simple changes in the characteristics of health care services may make a big difference in their perceived acceptability and accessibility by teens. Office hours should be arranged to meet the needs of the adolescents and their families; the waiting rooms and facilities should include reading material of interest to adolescents as well as other patients. Because fewer adolescents than adults have ready access to a car, it is especially important that adolescent health care facilities be located close to their patients and to public transportation routes.

**FIGURE 6.2:** Alternative-Test-Site (Anonymous) HIV-Antibody Testing in Orange County, California, from July 1985 through May 1992




*SOURCE:* Gellert, Weismuller, Higgins, & Maxwell, 1994: Disclosure of AIDS in celebrities, Figure 4. *New England Journal of Medicine*, 327: 1389. Reprinted with permission.

## Communication Between Health Care Providers, Patients, and Their Families

Once contact with an adolescent patient has been made, health careproviders must be careful to develop the most appropriate and effective patient/practitioner relationship. In light of the fact that this relationship is both important and potentially problematic, researchers have provided a number of useful suggestions to facilitate relationship development. First, most authors advocate a non-judgmental and nondirective communicative style (Arborelius & Bremberg, 1988; Friedman & Hedlund, 1991). The World Health Organization's training program for those who work with adolescents emphasizes such behaviors as attending skills, encouraging, reflecting, probing, and summarizing. Other suggestions include providing a minimal number of rules, consistency in enforcing the rules, focusing on

responsibility to self, acknowledging the adolescent's frustrations, treating the teen with respect, and admitting mistakes (Rubin, 1986). Rules should be presented as facts of life--the care provider need not try to justify them--but artificial limit-setting should be avoided (Long, 1985).

A positive approach to working with the adolescent builds a "therapeutic alliance" in which the care provider allies with the adolescent's own efforts by identifying his or her strengths and goals (Long, 1985). Further communication is then related to these goals. Some researchers argue that the care provider should empathize with the teen without reinforcing delusions (Long, 1985; Vernon & Seymore, 1987). Practitioners should try to avoid criticizing the teen but provide direction which is clearly value-laden. A physician who seeks to promote sexual abstinence among young patients, for example, might develop the habit of asking each teen whether he has been able to "maintain his virginity" rather than if he "is sexually active."

Also, physicians and other practitioners should be aware that adolescents may have hidden agendas when they visit, and that it may even be useful to allow the adolescent to be vague about an original complaint (Vernon & Seymore, 1987). A secondary complaint may be used to gain access to a care provider, and the real issue may come out in discussion. As with any medical practice, continuity of care improves rapport, follow-up, and compliance. An effective practitioner will be able to gauge and adapt to the emotional state of the adolescent--an anxious teen needs support, while one who is more comfortable may be in a better position to confront realities (Long, 1985). Medical practitioners should be careful about accepting an adolescent's bravado as real.

Of particular help when communicating with adolescents may be metacommunication--discussion of the communication process. Research suggests that commenting on the interaction between the provider and the adolescent may open the relationship significantly (Long, 1985). Several other specific suggestions are available in the literature and can be incorporated into health communication efforts. Munger (1990) and Silber and Rosenthal (1986) report the effective use of a questionnaire regarding health concerns to be administered to adolescents upon their first visit to a health care facility. They find that such a questionnaire not only made care providers aware of concerns beyond the one that originally prompted the visit, but also provided the opening for discussion of the adolescents' concerns by helping to break the ice. The adolescents report feeling more comfortable initially responding to questions about health concerns on paper rather than orally.

Research also documents the utility of having fliers with information on health issues available, videotape presentations accompanying didactic lectures, and interactive software for adolescent acquisition of health

information (Bosworth, Chewning, Day, Hawkins, & Gustafson, 1981; Kisker, 1985; Rickert, Gottlieb, & Jay, 1990). Even scare tactics or fear-appeals may have useful applications in regard to educating adolescents about health concerns, although sometimes they are counter productive (Brown & Fritz, 1988; Perry, Telch, Killen, Burke, & Maccoby, 1983). Explanations of health problems, health guidance, and treatment regimens will be more effective if they are in tune with an adolescent's developmental stage. Practitioners should consider a teenager's likely egocentricity as well as their feelings of invulnerability (Brown, & Fritz, 1988). To be consistent with the stages of adolescent development, messages targeted to younger adolescents should be concrete rather than abstract (Howard, 1985). An analysis of elements common to successful, rigorous programs indicated that the inclusion of information about immediate physiological effects, a discussion of resistance to peer, family, and media influences, and the use of multiple strategies should also be considered (Bonaguro, Rhonehouse, & Bonaguro, 1988). Overall, a health education program should provide a supportive environment that encourages participation and responsibility by the adolescent and his or her family (Bernard, 1986).

Research also indicates that, in terms of general health information, physicians place more emphasis on all topics than do teens, but physicians also underestimate the importance that adolescents place on almost all health topics. (Levenson, Pfefferbaum, & Morrow, 1987). This same inconsistency was noted when adolescent perceptions were compared with those of health teachers and school nurses (Levenson, Morrow, Morgan, & Pfefferbaum, 1986). While all groups rated sex, drugs, and the body as important topics, the adolescents also rated safety and fitness concerns highly. Focusing on pregnant teens, Levenson, Smith, and Morrow (1986) noted agreement between physicians and the teens on the importance of all health topics except birth control, which was rated much higher by physicians than it was by the already-pregnant teens. However, the physicians perceived that the teens did not think that any of the health topics were as important as the teens actually did. In particular, the adolescents desired more information about parenting, health dangers to the baby, and infant growth and development than the physicians perceived. No significant differences among physicians were noted (Levenson, Smith, & Morrow, 1986). This finding is an important one, because physicians may come across as condescending, overly solicitous, insensitive, or disrespectful if their perceptions of adolescent concerns are incorrect. Such perceptual differences may help, in part, to explain the finding that adolescents perceive health care providers as inattentive and unresponsive to their unique needs (Rogers & Elliott, 1989).