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Evaluating Juveniles' Competence to Make Abortion Decisions: How Social Science Can Inform the Law

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Under current legal standards, adolescents in the United States are presumed to be incompetent to make medical decisions. A traditional conceptualization of children as the property of their parents has resulted in children under the age of majority not being recognized as persons in their own rights.¹ Although several recent U.S. Supreme Court decisions have begun to extend constitutional rights to minors in some domains, in most domains, adolescents remain incompetent in the eyes of the Court. Thus, they are unable to enter into most medical treatment contracts.² One exception to the presumption of incompetence originated with the Supreme Court's decision in *Planned Parenthood of Central Missouri v Danforth*, which first extended abortion rights to minors in the post-*Roe v Wade* (1973) era.³ However, notwithstanding *Danforth's* holding that minors possess privacy rights regarding reproduction, *Danforth* also maintained that not all minors are competent

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1. L.A. Weithorn, *Developmental Factors and Competence to Make Informed Treatment Decisions*, 5 *Child & Youth Servs* 85, 85-86 (1982).

2. T. Grisso and L. Vierling, *Minors' Consent to Treatment: A Developmental Perspective*, 9 *Professional Psychology* 412, 413 (1978).

3. *Planned Parenthood of Central Missouri v Danforth*, 428 US 52 (1976). See also *Roe v Wade* 410 US 113 (1973).

to make such decisions. Access to abortion is now increasingly restricted for minors, as a majority of states have recently passed parental notification or consent laws, emphasizing presumptions that adolescents are incompetent.⁴

Parallel to the increasing restrictions on the reproductive rights of juveniles, justified in part by their presumed incompetence, states are increasingly trying juvenile delinquents as adults in criminal courts. In this latter context, minors who are 14 to 17 years of age (or even as young as 10) are presumed to be accountable for their actions, competent to stand trial, and liable to be sentenced as adults. In one recent study of sentencing, a majority of mock jurors were willing to impose the death penalty for a 10, 16, or 17-year-old defendant in a capital case, although these mock jurors were more likely to support execution for a 19-year-old adult.⁵ This disparity in standards for competence across legal domains underscores the political climate of contemporary legal policy and highlights the difficulty of defining "competence" and applying such a definition, both within any one domain as well as across domains.

Adolescents' access to abortion is a wide-reaching public policy issue. Approximately 40 percent of teenage pregnancies end in abortion, and 33 percent of all abortions are performed on women under the age of 20.⁶ What makes a teenage girl competent to make a decision about whether to have an abortion or instead to care for the fetus prenatally, give birth to a child, and perhaps raise that child? The adolescent's decision-making competence and privacy rights must be balanced with the best interests of the teen herself, the fetus (and, prospectively, the child), and the teen's family (especially to the extent that the teen's parents or other family members would be financially and emotionally involved in the pregnancy or in the rearing of the teen's child). The need for such balancing makes these decisions complex, important, and emotionally charged. In this Article, we will set aside the moral debate on the ethics of abortion. Instead, we will work within the current legal framework, post-*Roe v Wade*, and attempt to discuss ways in which psychological and family systems research can inform decision-making and the law with regard to minors' access to abortion.

A number of presumptions involving family autonomy, minors' decision-making abilities, and legal notions of individualized justice have influenced judicial opinions regarding the informed consent doctrine in this domain. In this Article, these presumptions and the current tests of competence to consent

4. National Abortion and Reproductive Rights Action League (NARAL), *Who Decides? A State-by-State Review of Abortion and Reproductive Rights* at vi (NARAL Found, 1995). See also G.H. Wilmoth, ed, *Psychological Perspectives on Abortion and Its Alternatives: Research and Policy*, 48 *J Social Issues* (special issue 1992).

5. C.A. Crosby, et al, *The Juvenile Death Penalty and the Eighth Amendment: An Empirical Investigation of Societal Consensus and Proportionality*, 19 *L & Human Beh* 245 (1995).

6. N.F. Russo, *Adolescent Abortion: The Epidemiological Context*, in G. B. Melton, ed, *Adolescent Abortion: Psychological and Legal Issues* 40 (Nebraska 1986).

to medical treatment will be critically analyzed. Psychological research on the cognitive abilities of minors to make informed consent decisions and conclusions regarding adolescents' abilities reached by researchers will be discussed. Additionally, research regarding the various developmental factors that have been hypothesized to influence adolescent "judgment" in decision-making situations will be outlined. After noting the limitations of current research and outlining suggestions for future research in the area of adolescents' competence, this paper will review both legal case history regarding minors' access to abortion as well as recent research specific to adolescents' competence in abortion-decision contexts. The paper will conclude with specific legal recommendations regarding restrictions on juveniles' access to abortion, guided by the current state of the relevant research.

Legal Presumptions

The child-family-state triad and the notion of individualized justice are two general issues in mental health law that substantially affect minors. These issues are important in the consideration of adolescent decision-making competence and must be considered early in the formulation of research questions.⁷

THE CHILD-FAMILY-STATE TRIAD

When there is a question regarding access to medical treatment for an adult, the focus is usually on the relationship of the individual to the state. The debate is usually framed in terms of the proper imposition of the state's *parens patriae* power over individual autonomy. When minors are involved, however, the interests and capacities of the parents are also a central concern. The effect of policy and case law must be assessed in a broader framework, with simultaneous consideration given to the individual minor's rights, to parental rights and family integrity, and to the state's duties and powers. Moreover, not only must researchers appreciate this interdependent triad of interests maintained by the minor, the family, and the state, but they must also recognize their own predispositions and biases with regard to these interests.⁸ For example, one might adhere to any of the following three perspectives regarding these interests.

The first perspective regarding the child-family-state triad is the "family libertarianism" perspective, which emphasizes parental rights and family privacy. This perspective maintains that parents should be autonomous in raising their children and in making medical decisions for them. Thus, parents often continue

7. E.P. Mulvey and P.A. Britner, *Research on Law and Mental Health Issues Affecting Minors*, in B.D. Sales and S.A. Shah, eds, *Mental Health and Law: Research, Policy and Services* 319 (Carolina Academic 1996) ("*Law and Mental Health Issues*").

8. *Id.* at 320; E.P. Mulvey, N.D. Reppucci, and L.A. Weithorn, *Mental Health, Law, and Children: A Brief Overview*, in N.D. Reppucci, et al, eds, *Children, Mental Health, and the Law* (Sage 1984) ("*Mental Health, Law, and Children*").

to have the final word in medical decisions for their adolescent children based upon the presumption that the parents will act in the best interests of their children and that adolescents are incapable of making important choices for themselves.⁹ Writing for the majority in *Parham v J.R.*, Chief Justice Burger wrote that the law presumes, in its conceptualization of the family, "that parents possess what a child lacks in maturity, experience, and capacity for judgment required for life's difficult decisions."¹⁰ Justice Douglas first discussed the possibility of incompatible interests of parents and children in his dissent in *Wisconsin v Yoder*, where the Court upheld the right of Amish parents to educate their children at home in their own tradition.¹¹

The "state interventionist" perspective has also played an important role in protecting the health interests of children who cannot protect themselves.¹² Drawing on its *parens patriae* power, the state may in some cases override parental refusals to consent to life-saving treatment. Justice Caldecott, in the California Court of Appeals decision *In re Phillip B.*, wrote that parental autonomy was subject to restriction and that the state was justified in intervening in order to protect the sanctity of human life.¹³ In most cases that were not life-threatening to the child, parental autonomy has prevailed over state attempts to intercede for the benefit of the child. However, the state may successfully intervene in situations that are not life-threatening to the child if the parents are influenced by factors other than the child's best interest, such as in decisions involving tissue donation or mental commitment.¹⁴ The state interventionist position, though somewhat weakened by the rights afforded minors in cases following *In re Gault*, continues to be supported by many health care professionals and others.¹⁵ This perspective, however, has focused on the best interest of the child, without much regard for the child's competence to make his or her own medical choices, especially insofar as the majority of cases involving state intervention have thus far related to infants and young children.¹⁶

The third perspective on the child-family-state triad, the "children's rights position," emphasizes the importance of extending to minors some of the same treatment decision rights enjoyed by adults. Arguments for this position have been based on the demonstrated competence of some minors and on the limited constitutional protections and rights to privacy that the Supreme Court and

9. Mulvey, Reppucci, and Weithorn, *Mental Health, Law, and Children* (cited in note 8).

10. *Parham v J.R.*, 442 US 584, 602 (1979).

11. *Wisconsin v Yoder*, 406 US 205 (1972).

12. See Mulvey, Reppucci, and Weithorn, *Mental Health, Law, and Children* (cited in note 8).

13. *In re Phillip B.*, 92 Cal App 3d 796, 156 Cal Rptr 48 (1979).

14. P.I. Carter and J.S. St. Lawrence, *Adolescents' Competency to Make Informed Consent Birth Control and Pregnancy Decisions: An Interface for Psychology and the Law*, 3 Beh Sci & L 309 (1985).

15. See *In re Gault*, 387 US 1 (1967).

16. W. Gaylin, *The "Competence" of Children: No Longer All or None*, Annual Prog in Child Psychiatry & Child Development 507 (1983).

tribunals have extended to minors over the past 30 years.¹⁷ With respect to adolescent access to contraception and their right to control abortion decisions, the Court has weighed parental autonomy against the privacy rights of "mature" minors. Some states have also established individual exceptions to allow "mature" minors the ability to consent to medical procedures.¹⁸ Although courts have recognized that minors do possess limited legal rights, the question of how to determine whether the adolescent is "mature" enough to give competent informed consent has not been effectively addressed.¹⁹

INDIVIDUALIZED INTERVENTION

The juvenile justice, child welfare, and mental health systems are traditionally and presently grounded in the notion that state action regarding minors and their families should be based more on the needs of the actors involved than on the act that warrants state intervention. In this "individualized intervention" approach, each case "presents the potential for a unique combination of factors that judges, mental health professionals, and juvenile justice and child welfare personnel should consider in formulating a plan tailored to that situation."²⁰

This individualized approach is facilitated by providing professionals with broad discretion to deal with the situations that confront them and by using vaguely defined guidelines. Broad prescriptive mandates, such as the charge to act "in the best interest of the child," provide the flexibility for professionals to make innovative, individualized intervention possible. However, this reliance on vague requirements has also been reflected in a "blurring of treatment and retributive metaphors when discussing legal intervention in this area."²¹ The flexibility of individualized intervention has brought with it vague guidelines, inadequate evaluation, and inconsistency in how minors are "protected" versus "held accountable" for their actions across decision domains.

As investigations have become more scientific and empirical, social science has become more central to the formulation of legal policy. These disciplines should inform legal practitioners and theorists about whether their idealized view of how the world works matches the one reflected by empirical evidence. In order to evaluate the rights of adolescents in medical treatment situations, it is necessary to examine the framework and tests currently used to determine adolescents' competence in this domain.

17. Mulvey, Reppucci, and Weithorn, *Mental Health, Law, and Children* (cited in note 8); Weithorn, 5 *Child & Youth Servs* at 87 (cited in note 1).

18. J. Areen, *Legal Constraints on Social Research with Children*, in B. Stanley and J.E. Sieber, eds, *Social Research on Children and Adolescents* 7 (Sage 1992).

19. See Carter and St. Lawrence, 3 *Beh Sci & L* 309 (cited in note 14).

20. Mulvey and Britner, *Law and Mental Health Issues* at 322 (cited in note 7).

21. *Id.*

The Informed Consent Framework

EVALUATING COMPETENCE

“Competence” is a term that often subsumes the three conditions necessary for a legally valid medical treatment decision. An informed decision must be made voluntarily, knowingly, and intelligently. Although these aspects may rightly be considered separately, they are often used synonymously by judges.²² In general, an individual must have certain abilities, skills, experience, and understanding regarding the nature of a particular situation and its consequences in order to be considered competent.²³ Adults are presumed to have the capacity to comprehend the ramifications of a medical decision to the extent that a “reasonable” person would understand the procedure; minors, on the other hand, are presumed incompetent and must demonstrate such understanding.²⁴ Competency is a legal rather than a medical or psychological concept, and it requires an individual determination for each specific instance; global competency determinations have been rejected by the legal system.²⁵ A variety of factors may be relevant, and various tests may be applied to a situation.²⁶ In the words of Roth, Meisel, and Lidz, “The search for a single test of competency is a search for a Holy Grail.”²⁷

TESTS OF COMPETENCE

In the interest of protecting the autonomy of individuals making treatment decisions, tests of competence to give informed consent have focused on the process of decision-making rather than on the outcomes of the decision.²⁸ Roth, Meisel, and Lidz enumerate five tests of competency commonly reported in the literature.²⁹ These tests look at: the evidence of a choice, the reasonable outcome of a choice, rational reasons for the choice, the individual’s ability to understand, and the individual’s actual understanding.

According to the “evidence of choice” standard, a competent individual must be able to make a choice between available treatment options; the quality of the

22. Grisso and Vierling, 9 *Professional Psychology* at 416 (cited in note 2).

23. L.H. Roth, A. Meisel, and C.W. Lidz, *Tests of Competency to Consent to Treatment*, 134 *Am J Psychiatry* 279 (1977); Weithorn, 5 *Child & Youth Servs* at 89 (cited in note 1).

24. A. Meisel, L.H. Roth, and C.W. Lidz, *Toward a Model of the Legal Doctrine of Informed Consent*, 134 *Am J Psychiatry* 285 (1977).

25. B. Freedman, *Competence, Marginal and Otherwise: Concepts and Ethics*, 4 *Intl J L & Psychiatry* 53, 56 (1981). See also Meisel, Roth, and Lidz, 134 *Am J Psychiatry* 285 (cited in note 24).

26. N.K. Rhoden, *The Presumption for Treatment: Has It Been Justified?*, 13 *L Medicine & Health Care* 65 (1985).

27. Roth, Meisel, and Lidz, 134 *Am J Psychiatry* at 283 (cited in note 23).

28. E.S. Scott, N.D. Reppucci, and J.L. Woolard, *Evaluating Adolescent Decision Making in Legal Contexts*, 19 *L & Human Beh* 221, 224 (1995).

29. See Roth, Meisel, and Lidz, 134 *Am J Psychiatry* 279 (cited in note 23).

decision is irrelevant, and personal autonomy is respected. Weithorn reports that children as young as age nine possess the necessary skills to manifest some preference, at least in hypothetical treatment dilemmas.³⁰ Freedman and others suggest that this test fails to address seriously the question of competence to consent.³¹

The test of "reasonable outcome of choice" deems competent an individual whose decision is compatible with what a "reasonable" person would choose or with the prevailing medical opinion, regardless of the decision-making process. While social goals and individual health are promoted, this test may show "utter disregard of the value of freedom."³² Additionally, the potential exists for disagreement among health care professionals as to the optimal or most appropriate treatment.³³ Developmental changes in attitudes toward medical personnel and compliance with their preferences may interfere with a minors' ability to make a voluntary decision.³⁴

In contrast with the "reasonable outcome of choice" test, the "rational reasons" standard concentrates on the rational and logical problem-solving process used to make a determination, without concern for the outcome. Where the patient has received all pertinent information necessary for a "knowledgeable" decision, the competent individual would consider all relevant factors, weighing them as he or she sees fit.³⁵ The rational reasons test relies greatly on assumptions about the individual's level of cognitive functioning; difficulties may occur in distinguishing rational from irrational reasons and in drawing inferences of causality between reasoning and the decision outcome. In the case of both the reasonable outcome and the rational reasons standards, the patient's competence will rarely be at issue if the individual consents to the prescribed treatment.³⁶

The fourth and fifth tests attempt to assess the individual's "ability to understand" and "actual understanding." Evaluation of the ability to understand is based solely on the patient's ability to comprehend the risks, benefits, and alternatives to treatment; the reasoning process and the ultimate decision are not considered. Roth, Meisel, and Lidz suggest that this test is the most consistent with the legal doctrine of informed consent.³⁷ Weithorn notes that factual and inferential understanding may require different levels of abstraction in thought and that developmental changes and personal experiences may facilitate or hinder comprehension.³⁸ The standard of actual understanding requires the patient to give knowledgeable consent after the treatment provider has communi-

30. Weithorn, 5 *Child & Youth Servs* at 90 (cited in note 1).

31. Freedman, 4 *Intl J L & Psychiatry* at 62 (cited in note 25).

32. *Id.* at 61. Compare Roth, Meisel, and Lidz, 134 *Am J Psychiatry* 279 (cited in note 23).

33. Weithorn, 5 *Child & Youth Servs* at 91 (cited in note 1).

34. See Carter and St. Lawrence, 3 *Beh Sci & L* 309 (cited in note 14).

35. *Id.*; Weithorn, 5 *Child & Youth Servs* at 93 (cited in note 1).

36. Roth, Meisel, and Lidz, 134 *Am J Psychiatry* 279 (cited in note 23).

37. *Id.*

38. Weithorn, 5 *Child & Youth Servs* at 94 (cited in note 1).

cated all options and assessed the patient's understanding of the information. This stringent test imposes responsibility on the medical professional and encourages active participation in the patient's decision-making.³⁹ The means by which the professional is to assess understanding remain vague, but actual understanding is the most straightforward and frequently used standard.

RESEARCH ON ELEMENTS OF INFORMED CONSENT

The first element of informed consent to treatment is voluntariness.⁴⁰ Grisso and Vierling emphasize that treatment consent is a social act and that individuals vary in the manner in which they respond to authority figures.⁴¹ The requirement of voluntariness, however, is often neglected as an element of informed consent and as a psychological construct, due to the ambiguity of the term.⁴² It is not clear to what extent the social influences of coercion, persuasion, and manipulation or the role-identity constraints imposed by cultural contexts may influence the decision-making of minors.⁴³ Research addressing the developmental aspects of several related psychological constructs has been used to assess minors' capacities to give voluntary consent. Psychodynamic and systems theory approaches, for example, have been used to explain the emergence of autonomy and the balance of peer and parent influences on decision-making in adolescence.⁴⁴ The inverse relationship between age and conformity has been demonstrated in a number of settings, and most studies have found that acceptance of social norms peaks in early adolescence and declines as minors approach adulthood.⁴⁵ Similarly, trends toward decreased compliance or obedience and increased opposition or reactance to authority in adolescence appear in the psychological literature.⁴⁶ Scherer studied the requirement of voluntariness more directly by comparing children, adolescents, and young adults on their responses to three medical treatment vignettes.⁴⁷ Most respondents deferred to parental authority in two of the dilemmas. In the more serious kidney donation vignette, group differences emerged; Scherer found that children were significantly more likely to comply with parental wishes than were adolescents or young adults.

39. See Carter and St. Lawrence, 3 Beh Sci & L 309(cited in note 14).

40. Meisel, Roth, and Lidz, 134 Am J Psychiatry 285 (cited in note 24).

41. Grisso and Vierling, 9 Professional Psychology at 421 (cited in note 2).

42. D.G. Scherer and N.D. Reppucci, *Adolescents' Capacities to Provide Voluntary Informed Consent*, 12 L & Human Beh 123 (1988).

43. D.G. Scherer, *The Capacities of Minors to Exercise Voluntariness in Medical Treatment Decisions*, 15 L & Human Beh 431, 433 (1991).

44. Id.

45. Grisso and Vierling, 9 Professional Psychology at 421 (cited in note 2).

46. See Scherer and Reppucci, 12 L & Human Beh 123 (cited in note 42). The developmental changes associated with conformity, compliance, and the roles of authority figures will be discussed more completely below, in considering the various developmental influences on adolescents' judgments in medical contexts.

47. See Scherer, 15 L & Human Beh 431 (cited in note 43).

Knowing consent to treatment may be given by an individual who understands the terminology and content of the information provided by the health care professional, as well as the legal concepts relevant to the medical decision. Grisso and Vierling operationalize knowing consent as the match between the information given by the professional and the patient's own description of the consensual terms and concepts that relate to the decision.⁴⁸ Little systematic research has been conducted to determine the level of understanding of consensual terms for patients of any age confronting a medical treatment decision.⁴⁹ Tymchuk reports that several studies have shown that adults are frequently not completely informed under current procedures;⁵⁰ further difficulties in obtaining knowing consent from minors may be presented by the health care provider's use of complicated language. In order to compare how minors and adults understand medical conditions and treatment options, Weithorn and Campbell tested four groups of individuals (ages nine, 14, 18, and 21) on four hypothetical treatment dilemmas.⁵¹ The researchers found that the adolescent group demonstrated a level of factual understanding of the dilemmas that was equivalent to that of the two groups of young adults; the younger minors appeared less competent in their understanding of the information provided.⁵² Lewis found adolescent and young adult women awaiting the results of a pregnancy test to be equally knowledgeable of the legal options relevant to the medical decisions they might face.⁵³ In another legal realm, however, only 28 percent of the juveniles in a court detention setting understood the concept that their rights were protected entitlements; Grisso and Vierling suggest that the understanding of legal terms may follow a predictable developmental pathway.⁵⁴ There remains a need for research on adolescents' understanding of treatment decision and legal terminology and for guidelines to aid professionals in providing clear and understandable treatment information.

The final element of an informed consent requires the individual to make the decision rationally and intelligently.⁵⁵ Whereas cognitive ability might have some influence on an individual's understanding of consent procedures, it is the cognitive processes involved in decision-making that are the focus of intelligent consent.⁵⁶ Some researchers have cited Piaget's research that children typically attain formal operational thought, the highest stage of cognitive development, between the ages of 11 and 14.⁵⁷ Individuals at the abstract stage of formal

48. Grisso and Vierling, 9 *Professional Psychology* at 416 (cited in note 2).

49. *Id.* at 417.

50. A.J. Tymchuk, *Assent Processes*, in B. Stanley & J.E. Sieber, eds, *Social Research on Children and Adolescents: Ethical Issues* 128 (Sage 1992).

51. L.A. Weithorn and S.B. Campbell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions*, 53 *Child Development* 1589 (1982).

52. *Id.* at 1595.

53. C.C. Lewis, *A Comparison of Minors' and Adults' Pregnancy Decisions*, 50 *Am J Orthopsychiatry* 446, 447 (1980).

54. Grisso and Vierling, 9 *Professional Psychology* at 417 (cited in note 2).

55. Meisel, Roth, and Lidz, 134 *Am J Psychiatry* 285 (cited in note 24).

56. Grisso and Vierling, 9 *Professional Psychology* at 418 (cited in note 2).

57. See Scott, Reppucci, and Woolard, 19 *L & Human Beh* at 224-25 (cited in note

operations are capable of using inductive or deductive reasoning to make choices after considering the potential risks or consequences of alternative options.⁵⁸ Because competent medical decision-making requires such abstract thinking processes, advocates have argued that minors at the level of formal operations possess the capacity to give intelligent consent.⁵⁹ For example, Weithorn and Campbell found adolescents and young adults to be similar in their inferential and reasoning processes in three of four treatment dilemmas; competence levels differed slightly for the epilepsy dilemma.⁶⁰ Children over the age of 12 also tend to demonstrate more internal locus of control, which is correlated with decision-making traits such as the ability to delay one's response, attention to details, and the gathering of information to assist the reasoning process.⁶¹ With the establishment of concrete operations (prior to the attainment of formal operations), children become more accurate in their perceptions of care providers, explanations of illness dimensions, and understanding of disease causality.⁶² Melton, however, agrees with Grisso and Vierling that children may not be able to make intelligent consent decisions until they are able to think more abstractly about the consequences of their choices.⁶³ Grisso and Vierling conclude that, although the age of attainment of formal operations varies (if it occurs at all) and may differ across intra-individual domains, there "may be no clear rationale for denying minors over 12 (as a group) the privilege of independent consent . . . solely on the basis of intellectual ability."⁶⁴

ADDITIONAL INFORMED CONSENT CONSIDERATIONS

Under the current informed consent system, there are several exceptions that allow minors the right to seek medical treatment. The "mature minor" clauses that invest adolescents with rights based upon the various tests of competence vary from state to state.⁶⁵ However, a review of the literature reveals that the mature minor provisions are insufficiently quantified or qualified.⁶⁶ Other exceptions appear on the surface to be more well-defined. For example, most states allow minors to seek treatment independently for conditions that could

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58. B. Inhelder and J. Piaget, *The Growth of Logical Thinking from Childhood to Adolescence* (Basic 1958).

59. Scott, Reppucci, and Woolard, 19 *L & Human Beh* at 225 (cited in note 28).

60. Weithorn and Campbell, 53 *Child Development* at 1596 (cited in note 51).

61. See Carter and St. Lawrence, 3 *Beh Sci & L* 309 (cited in note 14).

62. G.B. Melton, *Children's Participation in Treatment Planning: Psychological and Legal Issues*, 12 *Professional Psychology* 246 (1981); C. Sigelman, et al, *Age Differences in Understandings of Disease Causality: AIDS, Colds, and Cancer*, 64 *Child Development* 272, 282 (1993).

63. See Grisso and Vierling, 9 *Professional Psychology* at 419 (cited in note 2).

64. *Id.* at 420-21.

65. See Roth, Meisel, and Lidz, 134 *Am J Psychiatry* 279 (cited in note 23). See also Weithorn, 5 *Child & Youth Servs* 85 (cited in note 1).

66. See Carter and St. Lawrence, 3 *Beh Sci & L* 309 (cited in note 14), and Grisso & Vierling, 9 *Professional Psychology* 412 (cited in note 2).

endanger the public health (e.g., venereal diseases), and a number of states allow access to treatment for conditions that invoke privacy issues (e.g., reproductive rights, chemical dependency, and mental health care). In these areas, despite better legal definitions, the same problems with tests of competence may arise in various circumstances.⁶⁷

"Emancipated minors," those adolescents who are either married, enlisted in the armed services, or otherwise economically independent of their parents, represent another exception under the current informed consent system.⁶⁸ Wadlington notes, however, that emancipation can be "a precarious venture" in instances when it is unclear why the minor has left home or sought independence from the parents.⁶⁹ He also points out that few statutes address the respective liabilities of parents and their children who are either emancipated or declared competent for the purposes of a specific treatment decision.⁷⁰ It is unclear whether the consent of a competent minor, in addition to or in lieu of the consent of his or her parents, must be obtained in all treatment decisions. Whereas emancipated minors should be financially liable for their own decisions, parents are often held liable for the costs of all necessary treatments for their unemancipated children, even if the treatment is ordered over their objections.⁷¹ Holder writes that such questions of consent are frequently analyzed as economic decisions rather than as theoretical ramifications of the adolescent's autonomous rights.

Gardner, Scherer, and Tester state that there are at least three possible research strategies for assessing the competence of adolescents in a medical treatment context.⁷² One strategy would determine whether a minor possessed an operationally defined minimum level of competence.⁷³ Courts and legislatures, however, have not provided definitions of minimum legal standards for competent legal decision-making.⁷⁴ Another strategy would compare the minor's decision-making with a hypothetical standard of optimal rationality. Under this standard, even most adults would be considered incompetent.⁷⁵ The third strategy is the one that has necessarily been adopted: minors' decision-making skills are compared with those of adults, who are presumed by law to be

67. See Melton, 12 *Professional Psychology* 246 (cited in note 62)

68. See Carter and St. Lawrence, 3 *Beh Sci & L* 309 (cited in note 14).

69. W. Wadlington, *Consent to Medical Care for Minors: The Legal Framework*, in G.B. Melton, G.P. Koocher, and M.J. Saks, eds, *Children's Competence to Consent* 121 (Plenum 1983).

70. *Id.*

71. A.R. Holder, *Legal Issues in Pediatrics and Adolescent Medicine* (Yale 2d ed 1985).

72. W. Gardner, D. Scherer, and M. Tester, *Asserting Scientific Authority: Cognitive Development and Adolescent Legal Rights*, 44 *Am Psychologist* 895, 897 (1989).

73. *Id.*

74. J. Gittler, M. Quigley-Rick, and M.J. Saks, *Adolescent Health Care Decision Making: The Law and Public Policy* (Carnegie Corp 1990).

75. *Id.*; P.S. Appelbaum and T. Grisso, *Assessing Patients' Capacities to Consent to Treatment*, 319 *New Eng J Medicine* 1635, 1637 (1988).

competent. Gardner, Scherer, and Tester criticized some advocates who have "overstated" the current knowledge about decision-making by claiming that there are no differences between the capacities of adults and adolescents.⁷⁶ They argue that competence cannot be generalized across settings and that the few existing studies comparing decision-making by adolescents and adults utilized small sample sizes or contexts of questionable ecological validity.⁷⁷ King, on the other hand, believes the research to be conclusive enough to recommend lowering the age of majority to 12 or 13 for purposes of health care decisions.⁷⁸ Billick agrees with King that a case-by-case assessment of competence is inconsistent with privacy rights and that minors should not be evaluated against higher cognitive standards than those used for adults.⁷⁹ Setting the age of majority at 14, according to Billick, would provide a margin of several years beyond the expectancy of moral and cognitive development.⁸⁰ Other researchers suggest using sliding scales of competence (varying the applicable concepts or the required level of performance by age), based on evaluations of risk-gain ratios.⁸¹

Overall, the findings of informed consent researchers have been quite consistent. Minors, and especially adolescents, are more similar to adults than the law assumes, in both the choices they make and in the logical processes they follow. This is not to say that the results of all of these investigations have been entirely consistent; but by and large, minors aged 14 years and higher make decisions regarding waiver of rights or consent to medical procedures in generally the same manner that adults do. In some situations, children as young as nine years choose outcomes congruent with those chosen by adults,⁸² but the processes and reasoning behind these decisions are different.⁸³ Analyses of social costs, however, may emphasize the need to consider judgment factors (e.g., consideration of social consequences) as well as cognitive and reasoning ability in determining adolescents' legal capacities.

Evaluating Judgment Factors

Legal presumptions that adolescents are incompetent to make medical treatment decisions have not been based solely on ideas about minors' deficits in understanding and reasoning. Paternalistic legal policies have also been guided by

76. Gardner, Scherer, and Tester, 44 *Am Psychologist* at 897 (cited in note 72).

77. *Id.* at 898-99.

78. P.A. King, *Treatment and Minors: Issues Not Involving Lifesaving Treatment*, 23 *J Family L* 241 (1985).

79. S.B. Billick, *Developmental Competency*, 14 *Bull Am Academy Psychiatry & L* 301 (1986).

80. *Id.*

81. Appelbaum and Grisso, 319 *New Eng J Medicine* at 1638 (cited in note 75). See also Gaylin, *Annual Prog in Child Psychiatry & Child Development* 507 (cited in note 16).

82. Weithorn and Campbell, 53 *Child Development* at 1596 (cited in note 51).

83. See Grisso and Vierling, 9 *Professional Psychology* 412 (cited in note 2). See also Melton, 12 *Professional Psychology* 246 (cited in note 62).

the assumption that minors have less mature judgment.⁸⁴ Whereas the law emphasizes protection from harm, health care professionals often seek to maximize the effectiveness of the treatment by balancing its benefits against its risks (such as cost, side effects, or failure rates). As a result, medical professionals have been more concerned with a patient's ability to weigh costs and benefits in a social context than with legal tests of cognitive abilities.⁸⁵ Scott, Reppucci, and Woolard give two reasons why judgment should be considered through outcome-based measures of competence in assessing adolescent qualitative decision-making.⁸⁶ The first reason is the policy that the importance of respecting autonomy does not outweigh the social cost of "poor" treatment decisions made by minors, who are presumed to have poorer judgment than adults. The second reason is the assumption that poor decisions made by adolescents are influenced by developmental factors that will change with maturity. Thompson writes that the recognition of minors' limitations has led to an "interesting combination of limited prerogatives and beneficent paternalism," and advocates a new developmental formulation for research with minors that includes developmental factors in risk-benefit analyses.⁸⁷ Thus far, the assumptions of developmental influences on the quality of adolescent judgment have been based more on intuition than on research.⁸⁸ This section will review research on conformity and compliance and on risk-taking and temporal perspective, developmental factors often hypothesized to affect decision-making.

CONFORMITY AND TREATMENT COMPLIANCE

High rates of conforming behavior found in early adolescence have led some researchers to question the possibility of voluntary consent before the age of 15.⁸⁹ Later in adolescence, on the other hand, minors' judgment skills have been questioned as a result of their being stereotyped as more noncompliant, more deferent to peers, and less obedient to adults.⁹⁰ Berndt found that peer conformity for prosocial and antisocial behaviors in hypothetical situations peaked in sixth or ninth grade whereas conformity to parents decreased steadily from third

84. Scott, Reppucci, and Woolard, 19 *L & Human Beh* at 227 (cited in note 28).

85. T.G. Gutheil, et al, *Participation in Competency Assessment and Treatment Decisions: The Role of a Psychiatrist-Attorney Team*, 11 *Mental & Physical Disability Rptr* 446.

86. Scott, Reppucci, and Woolard, 19 *L & Human Beh* at 228 (cited in note 28).

87. R.A. Thompson, *Developmental Changes in Research Risk and Benefit: A Changing Calculus of Concerns*, in B. Stanley & J.E. Sieber, eds, *Social Research on Children and Adolescents: Ethical Issues* 31, 38 (Sage 1992).

88. Scott, Reppucci, and Woolard, 19 *L & Human Beh* at 228 (cited in note 28).

89. See Grisso and Vierling, 9 *Professional Psychology* 412 (cited in note 2). See also Scherer, 15 *L & Human Beh* 431 (cited in note 43).

90. T.J. Berndt, *Developmental Changes in Conformity to Peers and Parents*, 15 *Developmental Psychology* 608 (1979); R.N. Jamison, S. Lewis, and T.G. Burish, *Cooperation with Treatment in Adolescent Cancer Patients*, 7 *J Adolescent Health* 162 (1986).

to twelfth grade.⁹¹ Landsbaum and Willis report that young adolescents showed more conforming behavior than did young adults in an experiment on partner influences; both groups, however, showed greater conformity when they believed that their partner was an expert or a highly competent individual.⁹² Deference to "experts" may leave minors vulnerable in dealing with medical professionals, especially due to the stress of the situation and to the potential conflict in the parent-adolescent relationship that can result from greater financial dependence.⁹³ Steinfeld hypothesizes that peer conformity resulting from social comparison may have its greatest influence on compliance with treatment regimens and that it may be particularly difficult for adolescents to follow through on treatments if the procedure makes the individual feel different from his or her peers.⁹⁴ Silber speculates that concerns over body image, in particular, may leave adolescents (even more than adults) feeling self-conscious, inadequate, and vulnerable to the judgment of others.⁹⁵ For example, the wearing of a brace or the loss of hair from radiation treatments may result in negative feedback from adolescent peers. This feedback could lead to problems with identity achievement and manifest itself in depression, poor peer relations, or low self-esteem.⁹⁶

The few studies that have examined treatment compliance in adolescents, however, have not conclusively identified factors associated with noncooperation across all groups.⁹⁷ Cromer and Tarnowski, in a review of the literature, suggest that adolescent compliance rates are generally lower than those for young children. Compliance rates vary greatly according to the specific disease or disorder, its treatment regimen, demographic variables of the study population, and the manner in which compliance is operationalized and measured.⁹⁸ Systematic comparisons of long-term treatment compliance in adolescents and adults have not been reported.

RISK-TAKING AND TEMPORAL PERSPECTIVE

Adolescents and young adults appear to take more risks than do older adults.⁹⁹ The prevalence of high-risk behaviors among teenagers has led to disproportionately high rates of negative outcomes such as sexually transmitted

91. See Berndt, 15 *Developmental Psychology* 608 (cited in note 90).

92. J.B. Landsbaum and R.H. Willis, *Conformity in Early and Late Adolescence*, 4 *Developmental Psychology* 334, 335-36 (1971).

93. See Scherer and Reppucci, 12 *L & Human Beh* 123 (cited in note 42); B.I. Steinfeld, *Adolescent Development and Psychopathology*, in E.L. Feindler and G.R. Kalfus, eds, *Adolescent Behavior Therapy Handbook* 107, 117 (Springer 1990).

94. Steinfeld, *Adolescent Development and Psychopathology* (cited in note 93).

95. T.J. Silber, *Approaching the Adolescent Patient: Pitfalls and Solutions*, 7 *J Adolescent Health Care* 31S, 38S (1986).

96. Steinfeld, *Adolescent Development and Psychopathology* at 117 (cited in note 93).

97. Jamison, Lewis, and Burish, 7 *J Adolescent Health* at 162 (cited in note 90).

98. B.A. Cromer and K.J. Tarnowski, *Noncompliance in Adolescents: A Review*, 10 *Developmental & Behavioral Pediatrics* 207 (1989).

99. Scott, Reppucci, and Woolard, 19 *L & Human Beh* at 230 (cited in note 28).

diseases and traffic accidents.¹⁰⁰ Knowledge regarding such voluntary risk-taking behaviors among adolescents is vital because of the strong contribution of these behaviors to mortality rates and social dysfunction.¹⁰¹ In order to determine whether adolescents misunderstand the risks they take or whether instead they choose to ignore attendant risk, Quadrel, Fischhoff, and Davis compared risk probability estimates of middle-class adults, their teenage children, and high-risk adolescents sampled from treatment homes.¹⁰² The authors found evidence of perceived invulnerability in all three groups; however, this perception was no greater for adolescents than for adults. Gardner, Herman, and Wilfong asked children, young adolescents, and young adults to make paired-comparison choices between risky alternatives. In their study, the child and adolescent groups consistently disregarded at least one informational dimension in their decision-making relative to the adult group.¹⁰³ In a simulated peer-counseling situation, Lewis found that older adolescents mentioned more potential risks to consider in a medical treatment decision than did younger adolescents.¹⁰⁴ The students in grade 12 were also more likely to mention future consequences of the medical decision than were the younger subjects in the sample.¹⁰⁵

Temporal perspective becomes an important decision-making element when the short-term and long-term consequences of a choice must be considered.¹⁰⁶ A variety of researchers have speculated that adolescent tendencies to emphasize the present over the future may represent an uncertainty about the future, a lack of experience, or a failure to foresee the consequences.¹⁰⁷ Again, comparisons of how adolescents and young adults consider risks and future orientation in valid treatment settings are needed to better understand the developmental impact of these factors on judgment and decision-making.

Future Research Considerations

Medical decision-making studies are often replete with threats to external validity, which may limit the extent to which generalizations can be made from their samples to other populations.¹⁰⁸ There remains a need to investigate the

100. R.L. North, *Legal Authority for HIV Testing of Adolescents*, 11 J Adolescent Health Care 176, 176-77 (1990); M.J. Quadrel, B. Fischhoff, and W. Davis, *Adolescent (In)vulnerability*, 48 Am Psychologist 102 (1993).

101. W. Gardner, J. Herman, and E. Wilfong, *Developmental Change in Decision Making* (U Pittsburgh, unpublished manuscript 1991).

102. Quadrel, Fischhoff, and Davis, 48 Am Psychologist at 112 (cited in note 100).

103. Gardner, Herman, and Wilfong, *Developmental Change in Decision Making* (cited in note 101).

104. C.C. Lewis, *How Adolescents Approach Decisions: Changes over Grades Seven to Twelve and Policy Implications*, 52 Child Development 538, 541 (1981).

105. Id.

106. G.P. Koocher, *Children Under Law: The Paradigm of Consent*, in G.B. Melton, ed, *Reforming the Law: Impact of Child Development Research* 3 (Guilford 1987).

107. Scott, Reppucci, and Woolard, 19 L & Human Beh at 231 (cited in note 28); M. Weinberger, *Pharmacologic Management of Asthma*, 8 J Adolescent Health Care 74, 82 (1987).

108. K.W. Schaie, *What Can We Learn From the Longitudinal Study of Adult Psycho-*

construct of competence as a product of an individual's capacities, the specific task required of the individual, and the situational and social influences surrounding the task. By studying adolescents and adults who are facing the stress and consequences of real treatment decisions, determinations of competence and the influence of judgment factors can be based on data from more valid samples.

ECOLOGICAL VALIDITY

In order to ascertain conclusively which (if any) developmental factors influence decision-making ability in adolescents and adults, it is important to study individuals in ecologically valid contexts. Given the current notions of variable competence, it is unrealistic to assume that results from general descriptions of cognition or from specific conditions within different contexts will apply to an individual who is actually confronted with a medical dilemma.¹⁰⁹ The stress of a real treatment situation or chronic illness may interfere with one's cognitive performance on tests of competence.¹¹⁰ Long-term stress resulting from a family member's chronic illness may also have a disorganizing effect on an adolescent's illness concepts.¹¹¹ Garrison and McQuiston report that some chronically ill adolescent patients exhibit lower levels of perceived health control than healthy adolescents, and locus of control has been hypothesized to relate to treatment compliance.¹¹² Patients' decision-making could additionally be affected (positively or negatively) by the complexity or salience of a real decision as opposed to a hypothetical dilemma.¹¹³

There must be an iterative cycle of discovery between laboratory and field-based methods.¹¹⁴ The use of field research designs would also allow for examination of decision-making in which minors would be making decisions about their own, rather than a hypothetical, treatment or involvement. This latter variation could have particular significance for how the problem of consent is framed by a minor.¹¹⁵ The use of medical patients as subjects would allow researchers to evaluate decision-making differences among groups in more valid contexts.

logical Development?, in K.W. Schaie, ed, *Longitudinal Studies of Adult Psychological Development 4* (Guilford 1983).

109. B. Ambuel and J. Rappaport, *Developmental Trends in Adolescents' Psychological and Legal Competence to Consent to Abortion*, 16 *L & Human Beh* 129 (1992); Gardner, Scherer, and Tester, 44 *Am Psychologist* at 898 (cited in note 72).

110. J.F. Drane, *Competency to Give an Informed Consent: A Model for Making Clinical Assessments*, 252 *J Am Medical Assoc* 925 (1984). See also Melton, 12 *Professional Psychology* 246 (cited in note 62).

111. W.T. Garrison and S. McQuiston, *Chronic Illness During Childhood and Adolescence: Psychological Aspects* (Sage 1989).

112. *Id.*

113. Gittler, Quigley-Rick, and Saks, *Adolescent Health Care Decision Making* (cited in note 74).

114. U. Bronfenbrenner, *The Ecology of Human Development* (Harvard 1977).

115. Gittler, Quigley-Rick, and Saks, *Adolescent Health Care Decision Making* (cited in note 74).

SAMPLE DIVERSITY

Samples should reflect, across age groups, a variety of demographic variables, including gender, ethnicity, socioeconomic status, emancipated versus dependent status, and intelligence.¹¹⁶ In order to describe the developmental changes in the decision processes of adolescents and adults, the sample must consist of individuals covering the entire span of the age ranges.¹¹⁷ Gittler, Quigley-Rick, and Saks recommend that within-group as well as between-group variability should be reported because wide variation within age groups may be just as important as the presence or absence of group differences.¹¹⁸

PATIENT INVOLVEMENT

In addition to comparing patients with nonpatients, studies of decision-making processes and outcomes should consider the impact of the patients' involvement in the treatment decision and implementation. Weinberger maintains that adolescent participation in decision-making is essential for active cooperation and success in any medical regimen. The author also points out that compliance is most likely when the adolescent perceives a possibility of a normal lifestyle.¹¹⁹ Cavanaugh reports high compliance rates in adolescent girls whose conditions were monitored via telephone appointments made by the patients. This type of follow-up involves the patient in the regimen, with little interference in the daily routine.¹²⁰ Melton notes that children given free access to a school nurse in a demonstration project showed decreased levels of perceived vulnerability, increased belief in the value of self-care, and no behavioral changes in the utilization of services.¹²¹ However, others have suggested that patient involvement at an early age may add unnecessary stress to the treatment dilemma.¹²² Overall, it appears as though adolescent patients who are involved in their treatment decisions may differ from those who are not, in terms of recovery time, compliance with professionals' recommendations, and perceptions of treatment efficacy.¹²³

Adolescent involvement in their own medical decisions could be beneficial because of a resultant increased sense of control and mastery.¹²⁴ An equally compelling argument could be made, however, that such involvement might have detrimental effects, such as guilt and isolation, if certain assumed outcomes do

116. See King, 23 J Family L 241 (cited in note 78).

117. Scott, Reppucci, and Woolard, 19 L & Human Beh at 239 (cited in note 28).

118. Gittler, Quigley-Rick, and Saks, *Adolescent Health Care Decision Making* (cited in note 74).

119. See Weinberger, 8 J Adolescent Health Care 74 (cited in note 107).

120. R.M. Cavanaugh, *Utilizing the Phone Appointment for Adolescent Follow-up*, 29 Clinical Pediatrics 302 (1990).

121. See Melton, 12 Professional Psychology 246 (cited in note 62).

122. Koocher, *Children Under Law* (cited in note 106).

123. See Carter and St. Lawrence, 3 Beh Sci & L 309 (cited in note 14).

124. See Melton, 12 Professional Psychology 246 (cited in note 62).

not materialize. Given the lack of empirical information regarding the effects of involving children in decision-making, this issue is largely left as a conflict of values.¹²⁵ That is, consideration regarding the involvement of children in decision-making currently revolves around the values attached to increasing the sense of control in children and to the roles and responsibilities of parents in bearing the brunt of responsibility for decisions affecting the family. Action research (i.e., empirical work assessing real world interventions) that describes the impact of involving minors in decision-making could help focus this debate.¹²⁶

INTERPERSONAL NATURE OF DECISIONS

Scherer and Reppucci point out that treatment decisions are made in a social context and that voluntariness is the result of the interaction between person and environment.¹²⁷ In fact, all aspects of the decision-making process should be viewed in a social context. Silber writes that failure to obtain an adolescent's compliance with a treatment regimen is frequently caused by a lack of knowledge regarding the doctor-patient relationship.¹²⁸ Research has suggested a link between the continuity of the physician-patient relationship and increased patient satisfaction and treatment compliance. Given the interpersonal nature of the medical decision-making process, Tepper and Elwork suggest that research on decision-making competence ought to more accurately represent the relevant situational factors.¹²⁹ Research involving actual treatment dilemmas could address the patient's perceptions of other individuals' roles and feelings and the extent to which the reactions of others influence the patient's choice. By considering the entire social context of the treatment dilemma from a dynamical family systems perspective, much more could be learned about the influences of conformity, social referencing, small-group dynamics, and other social interactions on the decision-making processes employed by both adolescent and adult patients.

FAMILY FUNCTIONING

The assumption that the family functions to protect a minor's best interest has grown out of the common law tradition in which families were held liable for the proper upbringing of their children.¹³⁰ Since the late 1960s, however, the expansion of both case law and public awareness regarding child abuse and neglect, the increased concern over the problem of status offenders, and a *zeitgeist* of proactive family policy have all forced a rethinking of how to characterize the family's interest for certain legal purposes.¹³¹ Social scientists

125. Compare Carter and St. Lawrence, 3 Beh Sci & L 309 (cited in note 14).

126. Mulvey and Britner, *Law and Mental Health Issues* at 331 (cited in note 7).

127. See Scherer and Reppucci, 12 L & Human Beh 123 (cited in note 42).

128. Silber, 7 J Adolescent Health Care at 31S (cited in note 95).

129. A.M. Tepper and A. Elwork, *Competence to Consent as a Psycholegal Construct*, 8 L & Human Beh 205 (1984).

130. D.J. Rothman, *Conscience and Convenience* (Harper Collins 1980).

131. Mulvey and Britner, *Law and Mental Health Issues* at 331-32 (cited in note 7).

have thus far been rather ineffective in providing information that could be very helpful in this reformulation. Despite the crucial role in this area of many assumptions regarding family functioning, very little empirical evidence addresses these issues. Although long active in promoting broad family policy proposals, social scientists have done relatively few studies regarding the various legal assumptions concerning family life.¹³² Much more research must address the role of coercion, manipulation, persuasion, and deference to authority within families before minors' voluntary decision-making can be understood.¹³³ Advances in dynamic modeling methods for family systems, along with recent work regarding the dimensions of family functioning related to particular medical and mental health problems, could provide the tools necessary for measuring certain variables that often carry legal ramifications (e.g., increased family strife, altered family communication patterns, etc.).¹³⁴ Using structured measures and sequential modeling techniques, laboratory studies of family decision-making regarding legal issues could be coordinated with focused field studies or evaluations of natural experiments (e.g., changes in criteria for court referrals).¹³⁵

THE USE OF PROFESSIONAL DISCRETION

Research should also focus on the accuracy of assumptions underlying juvenile and family law and on the discretion granted to professionals working in this system. Efforts to operationalize individualized justice have necessarily produced a widely varying system with a heavy emphasis on case-focused discretion.¹³⁶ A reliance on the value of social scientific reasoning and professional opinion can be seen in most procedures. Research on decision-maker attributes, though, has produced no clear support for the influence of experience (and only limited support for the influence of training) on the validity of clinical judgments or on the relative effects of other contextual factors.¹³⁷

Given what is known about decision-making in general and more specifically about decisions concerning childhood and adolescent problems, researchers must think of decisions in these systems as being very contextually based judgments made under conditions of uncertainty.¹³⁸ Future research must focus on the process by which contextual factors influence the way clinicians frame a case, rather than on how certain factors are consistently relied upon across cases. The

132. See, for example, J. Knitzer, *Mental Health Services to Children and Adolescents: A National View of Public Policies*, 39 *Am Psychologist* 905 (1984).

133. Scott, Reppucci, and Woolard, 19 *L & Human Beh* at 230 (cited in note 28).

134. See, for example, T. Jacob and D.L. Tennenbaum, *Family Assessment: Rationale, Methods, and Future Directions* (Plenum 1988).

135. Compare D. Reiss, *The Family's Construction of Reality* (Harvard 1981).

136. Mulvey and Britner, *Law and Mental Health Issues* at 334 (cited in note 7).

137. E.P. Mulvey and N.D. Reppucci, *The Context of Clinical Judgment: The Effect of Resource Availability on Judgments of Amenability to Treatment in Juvenile Offenders*, 4 *Am J Community Psychology* 525 (1988).

138. D. Kahneman, P. Slovic, and A. Tversky, eds, *Judgment Under Uncertainty: Heuristics and Biases* 3-4 (Cambridge 1982).

presently dominant model, however, posits that professionals make “optimizing” decisions in which the best solution to the presenting problem is assessed rather independently of the service setting. Researchers would do better to adopt a model in which the solution is found that balances competing imposed interests.

One particular problem with most social science research in this area is that investigators rarely involve professionals and other service providers when planning their research. Consequently, the researcher’s categories and conceptions often fail to match those used by actual decision-makers.¹³⁹ Research that seeks and incorporates the input of service-providers and decision-makers has been done regarding juvenile justice decisions, and the body of legally relevant social science work specific to abortion decision-making is growing.¹⁴⁰ Before reviewing that research, we first present a brief outline of past adolescent abortion cases.

Adolescent Abortion Cases

The question of adolescent competence to make medical decisions is particularly relevant to the issue of abortion given the prevalence of teen sexuality, pregnancy, and abortion.¹⁴¹ *Planned Parenthood of Central Missouri v Danforth* extended the legal right to abortion to minors in 1976, yet it also asserted that not all minors are competent to consent to abortion.¹⁴² Third parties (i.e., parents or judges) may thus have the right to make decisions on behalf of incompetent or immature minors.¹⁴³ Currently, most states do require third-party involvement in adolescents’ abortion decisions, either through parental consent or notification or through a judicial bypass alternative.¹⁴⁴

Several important Supreme Court decisions established precedent for current laws regarding adolescent abortion. *Griswold v Connecticut*, decided in 1965, was the first case to discuss issues of adults’ contraceptive rights.¹⁴⁵ The *Griswold* Court, interpreting the Bill of Rights and the Fourteenth Amendment, held that an adult’s rights to privacy extended to a right to contraceptive privacy.¹⁴⁶ In 1973, *Roe v Wade* extended adult privacy rights from the right to prevent pregnancy (as in *Griswold*) to the right to terminate unplanned or unwanted pregnancies, at least during the first and second trimesters.¹⁴⁷

139. Mulvey and Britner, *Law and Mental Health Issues* at 337 (cited in note 7).

140. See, for example, T. Grisso, A. Tomkins, and P. Casey, *Psychosocial Concepts in Juvenile Law*, 12 L & Human Beh 403 (1988).

141. Russo, *Adolescent Abortion* at 40 (cited in note 6).

142. *Planned Parenthood of Central Missouri v Danforth*, 428 US 52, 75 (1976).

143. E.R. Rubin, ed, *The Abortion Controversy: A Documentary History* 177 (Greenwood 1994).

144. NARAL, *Who Decides?* (cited in note 4).

145. *Griswold v Connecticut*, 381 US 479 (1965). See I. Shapiro, *Abortion: The Supreme Court Decisions* (Hackett 1995).

146. *Griswold v Connecticut*, 381 US 479 (1965).

147. *Roe v Wade*, 410 US 113 (1973). See Shapiro, *Abortion: The Supreme Court Decisions* (cited in note 145).

Until 1976, only the contraception and abortion rights of adults had been addressed by the Court. The issue of adolescent abortion first entered the legal and psychological arenas with *Planned Parenthood of Central Missouri v Danforth*.¹⁴⁸ In *Danforth*, the Court was presented with a Missouri statute requiring unmarried minors who were pregnant to obtain parental consent before obtaining abortions. In striking down the statute, the Court held that states could not impose "blanket provisions" requiring parental consent.¹⁴⁹ While the *Danforth* decision to allow minors privacy in abortion matters became the foundational precedent for minors' abortion rights, the Court recognized that these rights are not absolute.¹⁵⁰ Although the *Danforth* decision upheld the right of minors to have an abortion, it also held that not all minors are competent to consent to abortion.¹⁵¹ Thus, a legal distinction between "competent" and "incompetent" minors' rights arose.

After *Danforth*, the Court consistently upheld laws requiring parental consent or notification, so long as the laws also provided opportunity for judicial review.¹⁵² For example, in *Bellotti v Baird*, a Massachusetts statute requiring the consent of both parents was ruled constitutional, because a judicial bypass alternative was also offered.¹⁵³ The judicial bypass option gives the minor the legal right to obtain an abortion without parental consultation if a court concludes that the adolescent is competent to make her decision independently. *Bellotti* noted differences in the rights of "mature" and "immature" minors but neglected to provide legal guidelines or definitions for the distinction.¹⁵⁴

The subject of the mature minor was addressed again in *H.L. v Matheson*, where the Court upheld a Utah law requiring physicians to notify parents in an effort to promote family communication.¹⁵⁵ An additional limit to minors' rights was provided in *Planned Parenthood of Kansas City, Missouri v Ashcroft*, in which the Court held that a minor deemed "immature" must demonstrate that abortion is in her best interest before the procedure is performed.¹⁵⁶ Under these decisions, a mature minor is expected to demonstrate sufficient "emotional development, maturity, intellect and understanding" to provide informed consent to abortion procedures.¹⁵⁷ Together, these decisions (along with *Hodgson v Minnesota* and *Ohio v Akron Center for Reproductive Health*) form the legal framework for current adolescent abortion laws.¹⁵⁸ *Planned Parenthood of*

148. *Planned Parenthood of Central Missouri v Danforth*, 428 US 52 (1976).

149. *Id.* at 74. See also Rubin, *The Abortion Controversy* (cited in note 143).

150. B. Nurcombe and D.F. Partlett, *Child Mental Health and the Law* (Free Press 1994).

151. Rubin, *The Abortion Controversy* at 177 (cited in note 143).

152. *Id.* at 178.

153. *Bellotti v Baird*, 443 US 622, 643 (1979).

154. Shapiro, *Abortion: The Supreme Court Decisions* (cited in note 145).

155. *H.L. v Matheson*, 450 US 398 (1981).

156. *Planned Parenthood of Kansas City, Missouri v Ashcroft*, 462 US 476 (1983). See also B. Ambuel, *Adolescents, Unintended Pregnancy, and Abortion: The Struggle for Compassionate Social Policy*, 4 *Current Directions in Psychological Science* 1, 2 (1995).

157. Ambuel, 4 *Current Directions in Psychological Science* at 2 (cited in note 156).

158. See *Hodgson v Minnesota*, 497 US 417 (1990); *Ohio v Akron Center for*

Southeastern Pennsylvania v Casey reaffirmed that parental consent or notification laws will typically be upheld if there is a judicial bypass alternative and if the laws do not place “undue stress” on the adolescent seeking abortion.¹⁵⁹

Adolescents’ rights to abortion have been restricted by the Supreme Court based on three assumptions: first, that minors are less competent decision-makers than adults; second, that minors are generally less “mature” than adults; and third, that adolescents’ best interests will be represented by third-party decision-makers, typically parents or judges.¹⁶⁰ However, social science research has not been utilized by legislatures or the Court in restricting minors’ access to abortion in the years since *Danforth*.¹⁶¹ In fact, psychological research concludes that the assumptions upon which these restrictions are based are largely unsubstantiated.¹⁶² In the next section, the research evidence specific to adolescent abortion decision-making is reviewed.

Adolescent Abortion

A growing body of psychological research has been devoted to examining the existing legal framework for adolescent abortion. Such research usually focuses on critiquing the rationale behind such laws. The research specific to adolescent competence in the context of abortion decisions typically suffers from some of the same methodological troubles described earlier with regard to more general research concerning informed consent and medical decision-making. However, the research reviewed below does include excellent examples of social scientific inquiry into legally relevant and ecologically valid contexts that can genuinely inform legal policy regarding adolescent capacity in high stakes, real-world contexts.

ADOLESCENT DECISION-MAKING RESEARCH

Commentators have often criticized research regarding medical decision-making for its frequent use of hypothetical vignette studies conducted in laboratories or university classrooms with subjects who are predominantly white and middle-class.¹⁶³ Responding to such criticisms, several studies have focused on

Reproductive Health, 497 US 502 (1990).

159. *Planned Parenthood of Southeastern Pennsylvania v Casey*, 112 S Ct 2791 (1992).

160. N.D. Reppucci and C.A. Crosby, *Law, Psychology, and Children: Overarching Issues*, 17 L & Human Beh 1 (1993); Scott, Reppucci, and Woolard, 19 L & Human Beh at 221 (cited in note 28).

161. Interdivisional Committee on Adolescent Abortion (ICAA), *Adolescent Abortion: Psychological and Legal Issues*, 42 Am Psychologist 73; G. B. Melton and N. F. Russo, *Adolescent Abortion: Psychological Perspectives on Public Policy*, 42 Am Psychologist 69, 70 (1987).

162. See Ambuel and Rappaport, 16 L & Human Beh 129 (cited in note 109); ICAA, 42 Am Psychologist at 73-74 (cited in note 161); Lewis, 50 Am J Orthopsychiatry 446 (cited in note 53); Melton and Russo, 42 Am Psychologist at 70 (cited in note 161). See also K.A. Moore, C.W. Nord, and J.C. Peterson, *Nonvoluntary Sexual Activity Among Adolescents*, 21 Family Planning Perspectives 110 (1989).

163. See, for example, E.P. Mulvey and F.L. Peeples, *Are Disturbed and Normal Adoles-*

adults and adolescents making actual abortion decisions. For example, Lewis questioned 16 minors and 26 adults about their pregnancy decisions and found that minors (age 17 and younger) did not differ from adults (age 18 and older) in the number of people they consulted about their decisions or in the type of people they consulted (typically including parents, boyfriends, and physicians).¹⁶⁴ Adolescents were more likely than adults to see their decisions as externally compelled, but they equalled adults in the cognitive competence of their decision-making.¹⁶⁵ Adolescents were found to use the same decision-making strategies and possess the same capacity as adults to reason abstractly and hypothetically.¹⁶⁶ Although limited by its small sample size, this study laid the framework for more extensive research regarding ecologically valid adolescent abortion choices.

Another study that examined actual decision-making in adolescent abortion cases was conducted by Ambuel and Rappaport.¹⁶⁷ This study examined three age groups in an attempt to examine developmental trends in decision-making. The researchers tested 75 women, aged 13-21 years, who were seeking pregnancy tests at a women's clinic and found that girls in both adolescent age groups (aged 15 or younger and aged 16 to 17) who considered abortion were just as competent cognitively as women in the adult age group (aged 18 to 21). They also found that adolescents under age 15 who did not consider abortion were less competent than adults in their decision-making.¹⁶⁸ Foster and Sprinthall interviewed unmarried females who were aborting their first pregnancy in the first trimester.¹⁶⁹ Comparing three age ranges, there were differences in assessments of moral reasoning and ego development between the young adolescents (aged 12 to 14), the older adolescents (aged 17 to 19) and the young adults (aged 23 to 25). However, there were no differences in the level of reasoning associated with the abortion decision across the three age groups; all three groups were assessed to be at the self-protective level characterized by consideration of financial consequences and the need to be self-reliant.¹⁷⁰

In these abortion-specific studies of real decision-makers, as in the larger body of psychological research using both real-life decisions and even hypothetical vignettes, adolescents aged 14 to 15 and older were equal to adults in their competency to make informed, voluntary, and intelligent treatment decisions.¹⁷¹

cents Equally Competent to Make Decisions About Mental Health Treatments?, 20 L & Human Beh 273 (1996); Mulvey and Britner, *Law and Mental Health Issues* at 330 (cited in note 7); Scott, Reppucci, and Woolard, 19 L & Human Beh at 221 (cited in note 28).

164. Lewis, 50 Am J Orthopsychiatry at 448 (cited in note 53).

165. Id at 452.

166. Ambuel, 4 Current Directions in Psychological Science at 3 (cited in note 156).

167. See Ambuel and Rappaport, 16 L & Human Beh 129 (cited in note 109).

168. Id.

169. V. Foster and N.A. Sprinthall, *Developmental Profiles of Adolescents and Young Adults Choosing Abortion: Stage Sequence, Decalage, and Implications for Policy*, 27 Adolescence 655 (1992).

170. Id.

171. See Ambuel and Rappaport, 16 L & Human Beh 129 (cited in note 109); Lewis,

As research in this area progresses, more sophisticated and validated measures are needed to evaluate adolescent understanding, appreciation, rational manipulation (or reasoning), and expression of an abortion choice.¹⁷²

PARENTAL CONSENT RESEARCH AND RESTRICTIONS

Although legal restrictions on minors' reproductive rights have emphasized the competence of some but not all minors, research has indicated that courts do not effectively distinguish between "mature" and "immature" minors.¹⁷³ A review of court decisions indicates that nearly all minors who seek judicial review are considered mature by the courts, and that abortion is almost always deemed in the best interests of minors who are found to be immature. For example, in *Hodgson v Minnesota*, certain testimony stated that 3573 petitions for judicial bypass were requested during a five-year period and that all but 15 of these minors were deemed mature by the court.¹⁷⁴ Obviously, there is a discrepancy between the legal framework and the actual decisions made by the courts regarding adolescent abortion. Some psychological researchers have argued that courts are unable to differentiate between "mature" and "immature" minors, such that the legal requirement that adolescents seek third-party consent in abortion decisions places an undue burden on the constitutional rights of the adolescents.¹⁷⁵

Although all minors are encouraged to consult parents in making abortion decisions, recent parental consent and notification laws are intended to protect immature minors from making poor decisions that can put them at physical or psychological risk; however, these laws themselves are associated with some serious negative effects.¹⁷⁶ Third-party consent procedures, via either parental consent or judicial bypass, may result in delayed abortion decision-making.¹⁷⁷ As abortion decisions are delayed, the probability of medical and psychological harm increases.¹⁷⁸ Such laws may also influence minors to carry their pregnancies to term, which can result in greater psychological and medical harm to the

50 Am J Orthopsychiatry at 452 (cited in note 53); Weithorn and Campbell, 53 Child Development at 1595 (cited in note 51).

172. See, for example, T. Grisso, et al, *The MacArthur Treatment Competence Study II: Measures of Abilities Related to Competence to Consent to Treatment*, 19 L & Human Beh 127 (1995), regarding the development of tests measuring competence to consent to mental health treatment.

173. A. Pliner and S. Yates, *Psychological and Legal Issues in Minors' Rights to Abortion*, 48 J Social Issues 203 (1992).

174. *Hodgson v Minnesota*, 497 US 417 (1990). See Pliner and Yates, 48 J Social Issues 203 (cited in note 173).

175. ICAA, *Adolescent Abortion* at 75 (cited in note 161).

176. See Pliner and Yates, 48 J Social Issues 203 (cited in note 173).

177. Id; W. Cates Jr., *Abortion for Teenagers*, in J.E. Hodgson, ed, *Abortion and Sterilization: Medical and Social Aspects* 139 (Academic 1981).

178. G.B. Melton and A.J. Pliner, *Adolescent Abortion: A Psycholegal Analysis*, in G.B. Melton, ed, *Adolescent Abortion: Psychological & Legal Issues* 1 (Nebraska 1986).

adolescent than abortion.¹⁷⁹ Cates, for instance, found that the mortality rate for adolescent pregnancy continuation was five times higher than the mortality rate for adolescent abortion.¹⁸⁰ It should be noted that first trimester abortion is not associated with significant trauma or psychological morbidity for women, including adolescents.¹⁸¹ In a diverse sample of 1189 black and 3147 white women, abortion choice had no independent relationship to measures of women's well-being, when well-being before becoming pregnant was statistically controlled.¹⁸² This finding held across race and religion.¹⁸³

Some support has also been found for the idea that psychological harm may be induced by intrusions into the privacy of adolescents making abortion decisions.¹⁸⁴ The rationale behind such findings is based on the notion of learned helplessness; that is, if adolescents learn that they do not have ultimate control over their bodies and their reproductive decisions, they will be more likely to experience negative psychological consequences, such as depression and hopelessness. However, empirical research is needed to confirm or refute these findings.

What effect have parental notification laws had on parental involvement in minors' abortion choices? Contrary to popular opinion, adolescents have demonstrated that they are more likely than not to involve parents in abortion decisions regardless of the legal requirements to do so.¹⁸⁵ In a study by Torres, Forrest, and Eisman, 51 percent of adolescents (including 75 percent of minors age 15 and younger) voluntarily involved parents in their abortion decisions.¹⁸⁶ Comparing 148 minors who were obtaining an abortion in a state with a mandatory notification law with 37 minors in a state without a notification law, Resnick, et al, found that all of the teens had consulted at least one individual before obtaining the abortion.¹⁸⁷ One-fourth of the minors did not consult an adult, but they were primarily the oldest minors. At the time of the abortion and at a follow-up interview one year later, these adolescents most frequently reported that their mother and their male partner were the two most helpful and im-

179. Id.

180. Cates, *Abortion for Teenagers* (cited in note 177).

181. N.E. Adler and P. Dolcini, *Psychological Issues in Abortion for Adolescents*, in G.B. Melton, ed, *Adolescent Abortion: Psychological & Legal Issues* 74 (Nebraska 1986); N.L. Stotland, *Conceptions and Misconceptions: Decisions about Pregnancy*, 18 *Genl Hospital Psychiatry* 238 (1996).

182. N.F. Russo and A.J. Dabul, *The Relationship of Abortion to Well-Being: Do Race and Religion Make a Difference?*, 28 *Professional Psychology: Research & Practice* 23 (1997).

183. Id.

184. Melton and Pliner, *Adolescent Abortion* at 21-22 (cited in note 178).

185. But see F. Clary, *Minor Women Obtaining Abortions: A Study of Parental Notification in a Metropolitan Area*, 72 *Am J Pub Health* 283 (1982).

186. A. Torres, J.D. Forrest, and S. Eisman, *Telling Parents: Clinic Policies and Adolescents' Use of Family Planning and Abortion Services*, 12 *Family Planning Perspectives* 284 (1980).

187. M.D. Resnick, et al, *Patterns of Consultation Among Adolescent Minors Obtaining an Abortion*, 64 *Am J Orthopsychiatry* 310 (1994).

portant people in influencing their abortion decision. Similarly, younger minors and minors with low self-perceived competence or high degrees of internal conflict have been found to frequently involve parents in their abortion decisions, while the degree of emotional and financial dependence and the quality and nature of family communication were found to influence teen decisions to confide in their parents.¹⁸⁸ In short, where parental involvement laws have been implemented, they have failed to promote family consultation.¹⁸⁹

Whereas the intent of involving parents as mature decision-makers and supporters of their children is logical, it is important to consider the probable reaction of the parent to the teen's pregnancy and abortion decision. Following an abortion, women who perceive high levels of social support from their partners, families, and friends generally have higher self-efficacy for coping, which in turn predicts better post-abortion psychological adjustment.¹⁹⁰ In a study by Major et al, women who told close others about the abortion but did not perceive them to be fully supportive showed inferior psychological adjustment to those women who were supported and to those women who chose not to tell anyone about their decision.¹⁹¹ Research by Moore, Nord, and Peterson proposes that the assumption that the family will act in the best interest of the minor is not always correct. Laws requiring parental consent or notification regarding abortion decisions may actually induce, rather than prevent, psychological harm.¹⁹² Moreover, Moore et al, found that by age 14, 70 percent of white adolescents and 33 percent of black adolescents with sexual experience had acquired their sexual experience only because it was forced.¹⁹³ Especially in cases of familial sexual abuse, the laws invoked to protect adolescents from their "poor judgment" are the same laws that may require pregnant teens to seek consent from abusive parents.

Legal Recommendations

Perhaps due to some or all of the aforementioned problems with mandating parental consent, a survey of 1000 pediatricians revealed that the majority did not believe parental permission should be required in issues related to sexuality, except for abortion requests by younger adolescents (aged 13 to 15 and youn-

188. J.P. Ashton, *Patterns of Discussion and Decision-Making Amongst Abortion Patients*, 12 *J Biosocial Science* 247 (1980); M.S. Griffin-Carlson and K.J. Mackin, *Parental Consent: Factors Influencing Adolescent Disclosure Regarding Abortion*, 28 *Adolescence* 1 (1993); R.H. Rosen, *Adolescent Pregnancy Decision-Making: Are Parents Important?*, 57 *Adolescence* 43 (1980).

189. M.C. Crosby and A. English, *Mandatory Parental Involvement/Judicial Bypass Laws: Do They Promote Adolescents' Health?*, 12 *J Adolescent Health* 143 (1991).

190. B. Major, et al, *Perceived Social Support, Self-Efficacy, and Adjustment to Abortion*, 59 *J Personality & Social Psychology* 452 (1990).

191. *Id.*

192. See Moore, Nord, and Peterson, 21 *Family Planning Perspectives* 110 (cited in note 162).

193. *Id.*

ger).¹⁹⁴ Psychologists, evaluating both the research on adolescent competence and the potential problems with mandated parental consent, have generally come to similar conclusions.¹⁹⁵ Thus, for example, the American Psychological Association has consistently disagreed with current adolescent abortion policies, asserting that such policies do not adequately consider psychological research in areas that affect adolescent abortion.¹⁹⁶

In one attempt to reform existing legislation, Ambuel mentions three possible recommendations for public policy reform.¹⁹⁷ First, he suggests that the age of consent for abortion might be lowered from 18 to 14, thus incorporating psychological research on adolescents' cognitive competency to consent to abortion.¹⁹⁸ The proposal to lower the age of consent is echoed by others reviewing both the informed consent competence and judgment of minors.¹⁹⁹ Others have proposed a more complicated sliding scale based upon the evaluation of risk-benefit ratios.²⁰⁰ If policy makers will not lower the age of consent, Ambuel proposes that counseling be provided as another alternative to mandatory parental consent or notification and judicial review.²⁰¹ Finally, he suggests that all minors be deemed competent to make decisions important enough to substantially affect their medical and psychological health.²⁰²

Based on the existing psychological evidence, we also believe that all minors between the ages of 14 and 17 should be presumed mature and competent if they are able to knowingly, voluntarily, and reasonably discuss their decision. Independent counselors should be provided to explain all options available to the adolescent (i.e., abortion, adoption, and keeping the baby), to assess the minor's consent, and to encourage parental involvement in cases where such involvement is deemed both safe and supportive. In the absence of a parent, another supportive adult should be enlisted as a trusted mentor and long-term support person for the teen. If a minor fails to meet the informed consent standards in discussions of these options with counselors and medical professionals, judicial review should be made available.

For minors below the age of 14, we recommend that parental consent be required but that judicial bypass be provided where it is not in the best interest of the child to consult with her parents, due to potential coercion, abuse, incest, and so forth. Judicial bypass should be explained as an option by the on-site counselor, and the procedures of the hearing should be clear to the minor.

194. G.V. Fleming, K.G. O'Connor, and J.M. Sanders, *Pediatricians' Views of Access to Health Services for Adolescents*, 15 *J Adolescent Health* 473 (1994).

195. ICAA, *Adolescent Abortion* at 74 (cited in note 161).

196. See *id.*

197. See Ambuel, 4 *Current Directions in Psychological Science* 1 (cited in note 156).

198. *Id.* at 4.

199. See Billick, 14 *Bull Am Academy Psychiatry & L* 301 (cited in note 79); King, 23 *J Family L* 241 (cited in note 78).

200. Appelbaum and Grisso, 319 *New Eng J Medicine* at 1638 (cited in note 75); Gaylin, *Annual Prog in Child Psychiatry & Child Development* (cited in note 16).

201. See Ambuel, 4 *Current Directions in Psychological Science* 1 (cited in note 156).

202. *Id.*

Because it would be restricted for the most part to younger teens, judicial review under this proposed regime should be more stringent than it is under the current regime, where nearly all minors who seek the bypass are deemed sufficiently mature.

Recognizing the interdependence of interests in juveniles' abortion choices, we have attempted to avoid the temptation to find a single empirically derived solution for the policy questions discussed. Parents have a right to be involved in their children's decisions. In most cases, we presume that they will be involved and that they will act in the best interest of their child. At the same time, we recognize the privacy interests of adolescents as autonomous individuals, protected under the Fourteenth Amendment, and the fact that parents are not always able to act in their child's best interest. In the area of assessing minors' competence, there can be no singularly "best" balance among the child, family, and state that social science can somehow divine or uncover. Instead, there are multiple legitimate solutions, and one important role of social science should be to document the effects of the different balances that could be struck. In this way, research fosters debate about the values that might promote one policy approach over another; it does not provide dispositive proof to settle the debate.²⁰³

Is the current research clear enough or definitive enough to conclude that juveniles are as competent as adults to make abortion decisions? No, it is not. Thus, a better alternative conceptualization asks: Has the research conducted since *Danforth* shown juveniles to be less competent than adults to make competent abortion decisions?²⁰⁴ Again, the answer is no, because the current body of knowledge regarding competence of minors is largely composed of null findings. Without a clearer picture of exactly how and when decision-making processes change in minors, however, researchers are in the difficult position of arguing that null results constitute scientific findings.²⁰⁵ Simply put, the research conducted over the past two decades suggests that adolescents are more similar than dissimilar to adults in their decision-making, although some differences may exist. More research must directly compare minors and adults who are confronting real abortion choices before we can be truly confident in understanding the differences in their decisions and the consequences of those decisions. Given the current state of the research, in terms of both hypothetical informed consent studies and more ecologically valid real-life decision studies, we offer the recommendations above and question the recent and increasing legislative attempts to restrict the reproductive rights of adolescents.

203. Mulvey and Britner, *Law and Mental Health Issues* at 321 (cited in note 7).

204. *Planned Parenthood of Central Missouri v Danforth*, 428 US 52 (1976).

205. See, for example, Gardner, Scherer, and Tester, 44 *Am Psychologist* at 899 (cited in note 72); G. Melton, *Adolescents and Prevention of AIDS*, 19 *Professional Psychology: Research and Practice* 403 (1988).