**Working With Adolescents: A Time of Opportunity**

*ANA/ANF UPDATE ON ADOLESCENT HEALTH Independent Study Module*
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**Objectives:**
By the end of this module, the nurse will be able to:
1. Describe the physical changes that occur in puberty.
2. Discuss characteristics of the formal operations stage of cognitive development.
3. Name the central developmental tasks of adolescence.
4. List internal and external assets from the Search Institute framework.
5. Differentiate the process of moral development between boys and girls.
6. Explain why it is important to know one’s self in order to deliver culturally sensitive care.
7. Define confidentiality.
8. Describe the progress made in meeting Healthy People 2000 objectives.
9. Relate the leading health indicators for Healthy People 2010 to providing primary health care for adolescents.

**Abstract**
As of 1999, despite multiple federal, state and foundation reports and books promoting more than 1,000 recommendations and strategies to improve the health of adolescents, no clear mandate exists. One new approach is to have all nurses gain a better understanding of adolescents and how to best work with them and their families. The purpose of this module is to give a general overview of adolescents, describe an assets framework for working with teens, identify the progress made to meet Healthy People 2000 objectives and plans for 2010 objectives, and describe the role of the nurse in delivering culturally competent and confidential care.

**Introduction**

Nurses care for adolescents in multiple settings. To provide adequate care, nurses must understand normal growth and development and factors that influence that development. A great deal of progress has been made in identifying factors, both positive and negative that influence teen development. Knowledge of these factors will help nurses to provide optimum care to teens and their families.

**Traditional View of Adolescent Growth & Development**
Adolescence is the time of transition from childhood to adulthood. It is characterized by rapid growth, development of secondary sex characteristics and cognitive and psychosocial development. During this time the adolescent is striving to achieve independence from parents, and associations with peers gradually begin to focus on more intimate relationships. Typically, adolescence is divided into three phases based on age: early (10 - 13 years), middle (14-17 years), and late (17 - 21 years).

Adolescent development is multidimensional, complex and marked by periods of rapid growth alternating with periods of remission. In the last century, the onset of physical change has occurred at increasingly younger ages, increasing the likelihood that the psychosocial and cognitive changes will lag behind (Neinstein, 2002).

Timing of the physical changes of puberty varies as much as the number of adolescents going through them. Children of the same age show tremendous variation in growth and sexual development. Body image concerns are greatest in early adolescence. Teens who develop earlier or later than 10-14 are faced with more questions of normalcy. By middle adolescence, physical change is less rapid and dramatic and teens’ focus shifts to concerns about improving appearance. By late adolescence, many teens have dealt with these concerns and are more at ease with themselves (Krisman-Scott, 1996).

Secondary Sexual Development

What triggers puberty is still unknown; however, there are distinct changes in the hypothalamic-pituitary axis associated with the onset of puberty. These changes result in an increase in gonadotropin-releasing hormone (GnRH), which stimulates increases in leutenizing hormone (LH) and follicle stimulating hormone (FSH), hormones responsible for the development of secondary sex characteristics. In males, LH stimulates testosterone production and FSH stimulates gametogenesis. In females, LH stimulates ovarian cells to produce androgens and progesterone and stimulates ovulation and FSH increases estrogen production (Neinstein, 2002). Other hormones that effect puberty include thyroid hormones, growth hormones and insulin-like growth factors.

Development of secondary sex characteristics is measured through the use of a Sexual Maturity Rating (SMR) scale, sometimes called the Tanner scale. Because initiation and rate of growth during adolescence are so variable, age is a poor indicator and predictor of change. SMRs are essential in evaluating adolescents and provide a method to gauge developmental progress, using a five-point scale of measurement. For females, ratings measure breast development and pubic hair growth, and for males, they measure genital development and pubic hair growth. Development of secondary sex characteristics follows a general sequence over time. Alteration in this sequence may be an indication of abnormal pubertal progression.

As the age of onset of puberty varies, so too does the length of time in each stage. Female pubertal development begins on average at 11.2 years of age (range 9.0 - 13.4) and lasts
about 4 years. Breast budding is most frequently the first physical sign of puberty. Breast development and pubic hair development can progress at different rates and be at different SMR levels at any given time. On average, the adolescent female’s growth spurt starts about one year before breast development begins. Peak height velocity is reached about one year and one month after breast development begins. Menarche typically occurs one year after peak height velocity is reached, usually at SMR 3 (19%) or 4 (56%) at the average age of 12 years 4 months (range 9-17). See Table A for SMR parameters of female breast and pubic hair development (Tanner, 1962). Although it has been noted that the mean age for onset of secondary sex characteristics has decreased in girls, the overall effect on mean age at initiation of menstruation has only decreased by six months and only in girls of African-American ethnicity (Neinstein, 2002).

Male pubertal development begins on average at 11.6 years of age (range 9.5 - 13.5). Testicular enlargement is most commonly the first physical sign of puberty in males. SMR levels for pubic hair development and genital development (testes, scrotum and penis) can differ at any given time in the same individual. See Table A for male SMR parameters. The average length of time for completion of puberty in males is three years. Spermarche usually occurs early in puberty during SMR 2.5 (Tanner, 1962).

Table A. Sexual Maturity Rating – Girls & Boys*

<table>
<thead>
<tr>
<th>Breast</th>
<th>Pubic Hair</th>
</tr>
</thead>
<tbody>
<tr>
<td>No development</td>
<td>No pubic hair</td>
</tr>
<tr>
<td>Breast bud, areola widens</td>
<td>Long, slightly pigmented, straight hair along labia</td>
</tr>
<tr>
<td>Breast larger, more elevation Extends beyond areolar parameter</td>
<td>Increased in quantity, darker, more curly and coarser, present in typical female triangle</td>
</tr>
<tr>
<td>Breast larger and more elevation Areola and papilla form a mound projecting from the breast contour</td>
<td>Hair more dense, curled and adult in distribution but in a smaller quantity</td>
</tr>
<tr>
<td>Breast adult appearance Areola and breast in same plane, with papilla projecting above areola</td>
<td>Abundant, adult-type pattern Hair extends to medial aspect of thigh</td>
</tr>
</tbody>
</table>

Male
### Testes and Scrotum

<table>
<thead>
<tr>
<th>Testicular volume – less than 1.5ml</th>
<th>Penis</th>
<th>Pubic Hair</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childlike None</td>
<td></td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Testicular volume – 1.6 - 6ml, Scrotum reddened, thinner, larger</th>
<th>No change</th>
<th>Light, downy hair laterally</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Testicular volume – 6-12ml, Scrotum – great enlargement</th>
<th>Increased length</th>
<th>Extended across pubis</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Testicular volume – 12-20ml, Scrotum – further enlargement</th>
<th>Increased length and circumference</th>
<th>More abundant with curling and darkening</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Testicular volume – &gt;20 ml Scrotum – adult appearance</th>
<th>Adult male appearance</th>
<th>Adult quantity and distribution with hair present on inner thighs</th>
</tr>
</thead>
</table>

*Ratings for each developmental characteristic may differ in the same individual at one point in time (Tanner, 1962).*

### The Adolescent Growth Spurt

During adolescence, children experience a rapid increase in height and weight. This growth spurt is highly variable, generally lasting 24-36 months. Females typically experience this growth spurt one-and-one-half to two years earlier than males and on average grow 23-28cm. Male average growth is 26-28cm. The growth spurt ends with epiphyseal closure, which is under the influence of the sex steroids. Males experience a 2-year delay in bone closure as compared to females, and this accounts in part for their greater growth in height.

In addition to increases in height, teens experience increases in weight. About 50% of adult ideal body weight is gained during puberty. Adolescent male weight gain primarily reflects an increase in lean body mass. In contrast, adolescent females experience an increase in percentage of body fat and a decrease in percentage of lean body mass. Body structures also have dissimilar growth rates. The first structures to reach their adult size are hands, feet and head. Leg length reaches its peak before body breadth. This sequence of growth can give teenagers a long-legged appearance and lead to clumsiness and tripping (Tanner, 1972).

The tremendous variability in the onset of growth can be very anxiety provoking for adolescents who are shorter than their peers. It is reassuring for them to know that final adult height is not affected by the timing of pubertal onset. Adolescents with simple delayed puberty, and therefore delayed growth, will have the same opportunities to reach normal adult height as their peers (Rosen & Foster, 2001).

### Cognitive Development
Adolescence is marked by major changes in cognitive thinking. During adolescence, teens move from concrete thinking to what psychologist Jean Piaget (1969) calls the period of formal operations. When functioning at the concrete level, teens cannot transcend the immediate and are unable to deal with remote, future or hypothetical problems. Through the repeated results of concrete experiences young teens begin to be able to predict and anticipate future experiences. This is the beginning of the cognitive process of formal operations. Formal operations functioning allows the individual to “think about their own thinking,” transfer information from one situation to another, deal efficiently with the complex problems involved in reasoning, plan realistically for the future and conceptualize abstract ideas. Not all teens or adults attain full formal operational thought. In fact, more than one-third of college students and middle-aged adults do not use formal operations when faced with the need to solve an unfamiliar problem (Keating & Clark, 1980). Teens and adults will often revert to concrete thinking in stressful or crisis situations.

As the young adolescent moves toward abstract reasoning, a new type of introspection occurs. Daydreaming, increased self-interest and fantasy are common. This is frequently manifested in young teens by spending hours examining every aspect of their appearance in front of a mirror. Adolescents assume that others are as interested in their thoughts and actions as they are. They view the world as a stage on which they are the principal actors and the entire world their audience. They see themselves as unique and destined for unusual fame and fortune. Psychologist David Elkind (1968) refers to this form of egocentrism as the “personal fable.” This often, unrealistic view of themselves also can lead them to believe they are invincible and immune to the dangers that befall others. This “not me” attitude may dispose the teen to participate in risky behaviors. By age 15 or 16, this type of egocentrism decreases. Young adolescents, at the beginning of this cognitive shift, have unrealistic career plans with visions of an idealized future, i.e., as a rock star or pro basketball player. By middle adolescence, they begin to have more realistic career goals and begin to realize their limitations. For teens in disadvantaged situations, this may lead to the beginning of feelings of hopelessness. Ideally, the late adolescent will have realistic career goals, a sense of perspective, be able to problem solve, consider all aspects of a situation and delay gratification.

Moral Development

Building on Piaget’s work, Kohlberg (1977) described three levels in the development of moral judgement: preconventional, conventional and postconventional. Adolescence marks the movement from the conventional level of moral judgement to postconventional (Neinstein, 2002). Early adolescents are typically in the conventional level of moral development. At this level, they are motivated by the need to meet expectations of external factors such as others’ opinions and existing law (Feli & Maehr, 2000). These individuals hold simplistic conceptions of what is right. Postconventional orientation embraces more universal and abstract principles of justice, requiring formal operational thought. The focus moves from actions and motivations to please others, to autonomous moral principles that are based on the individual’s own beliefs. The postconventional
level of moral development begins in middle to late adolescence and is not achieved by all (Feli & Maehr, 2000). Males rely on thinking and deductive reasoning to reach the “autonomous moral self” (Wren, 1997). Kohlberg believes that the six-stage theory (each level subdivided into 2 stages) applies to both boys and girls; however, the theory is based on the study of boys.

In contrast, Carol Gilligan (1993) believes that moral development is different for girls and women. Women seem to exemplify the 3rd stage of six when moral development is measured using Kohlberg’s scale. Gilligan (1993) describes an interdependent thinking style that incorporates thoughts and feelings to attain the “interdependent moral self”. She states that moral development is centered on the understanding of responsibility and relationships rather than rights and rules. She views moral development in girls as a continuous process.

Wren (1997) compares the open systems model described by Kohlberg and the spiral model of moral development described by Gilligan. Kohlberg’s (1977) model illustrates an impersonal, rule-guided process of decision-making. While Gilligan’s (1993) model illustrates a continuous process influenced by life’s experiences. It is important to be aware that boys and girls may follow a different process in moral development.

Psychosocial Development

According to psychoanalyst Erik Erickson (1963), the central developmental task of adolescence is to develop a sense of identity. A sense of identity allows one to answer the questions: Who am I? Who am I to become? Identities are shaped and reshaped over a lifetime. Adolescence represents a significant turning point as the individual lets go of childhood beliefs and fantasies and confronts the imminent tasks and decisions of adulthood. Adolescence provides teens an opportunity to “try on” different roles, beliefs and commitments. This “trying on” of a variety of roles can result in role confusion. Erickson believes this role confusion leads many to over-commit themselves to social causes, cliques or loves (Erickson, 1968).

The development of a sense of identity requires individuation or separation from family. Separation from family does not indicate a lack of connectedness with the family, but rather indicates the adolescent’s need to have an identity separate from the family. Family connectedness can be promoted in a number of ways, such as parents’ taking an interest in a teen’s activities, spending time together or having family meals. Family connectedness has been shown to be the most important factor in positive outcomes for teens (Blum & Reinhardt, 1997).

Early adolescence (11-13 year olds) marks the beginning of developing a separate identity from the family. Close relationships with peers develop. These peer relationships are primarily same sex with strong solitary friendships developing. These young teens are preoccupied with their appearance and have numerous questions about normalcy and tend to look to peers for answers. They are uncertain about their
developing identity and can’t appreciate what they think about themselves. The peer group provides the external validation that they so acutely need (Strasburger, 2000).

Middle adolescents (14-17 year olds) are less preoccupied with questions of normalcy. These teens are concerned with making themselves as attractive as possible and have concerns about clothing and makeup. Involvement in peer groups increases, and further separation from family occurs. Dating relationships and experimentation with sex occur during this period. Feelings of omnipotence and immortality are at a peak in this group, leading to risk-taking behaviors.

Clearly, two of the goals for the adolescent period are developing a sense of identity, separate from one’s parents; as well as learning how to establish relationships with others. The other two goals are entwined: preparing to finish one’s formal education and developing vocational plans for the future. As was the case when they were younger, school continues to be the “work” of the adolescent, but the focus is more sharply on success, figuring out a career path and the future. Bonny, Brittoe, Klosterman, Hornung, & Slap (2000) found that “school connectedness”: feeling a sense of caring at school, has a direct relationship to better academic performance, more extracurricular involvement as well as a decrease in alcohol and cigarette use. Helping an adolescent feel connected has important implications for facilitating the achievement of their educational and vocational goals.

Finally, as teens enter late adolescence (18-21 year olds), if all has progressed satisfactorily, they are well on the way to separating from family and establishing identity. It’s getting there that can be difficult! This is especially true for teens who are defined by some segments of the larger society or their peers as “being different” (i.e., gay, bisexual or questioning youth; youth with special needs; youth who have recently immigrated; disenfranchised youth — homeless, abused or neglected youth; etc.). These youth not only have to grapple with the “normal” pressures of adolescence, they have the extra burden of establishing a sense of self in the midst of additional pressures. In other words, while they are expected to develop a positive sense of self and pride in who they are, they are also expected to fit certain “so-called norms” — even though those “norms” may be in direct contradiction to who they are. These conflicting messages prove to be too much for some adolescents. They may react by completely disassociating from their peers, family and/or the larger community; developing a facade to make themselves more acceptable to others; or participating in self depreciating or “acting out” behaviors that lead to further ostracism. Others, however, are able to put these conflicting messages into perspective, and somehow develop a positive sense of self. The question becomes: What makes some adolescents more resilient than others?

A relatively new framework for looking at adolescent development, The Developmental Assets Model, may provide some clues. However, it should be used in conjunction with other, perhaps more familiar frameworks, such as Bright Futures (Green & Palfrey, 2000) and the American Medical Association’s (AMA) Guidelines for Adolescent Preventive Services (Levenberg & Elster, 1995). Each has its own unique value.
Developmental Assets Framework

Navigating through the multiple changes of adolescence is challenging. While most adolescents do so successfully, there are still too many others that do not. What makes some adolescents more adept at making it through this transition relatively unscathed, while others get caught in a quagmire of potentially devastating risk-taking behaviors? This fundamental question underlies the work of the Search Institute, an institute dedicated to studying healthy youth development.

In 1990, Peter Benson and colleagues of the Search Institute introduced a new way of looking at adolescent development – through a developmental assets framework, rather than the more typical, problem-focused approach. Initially, this framework identified 30 (later expanded to 40) assets that facilitated successful transition from adolescence to adulthood. These 40 assets are divided into two groups and eight categories (Fig. 1). Benson and Scales (1990) work shows that adolescents with more assets report fewer high-risk behaviors. As assets increase, so do school grades, educational aspirations and pro-social behavior. This asset model provides benchmarks by which to measure positive development and focuses on all youth not just those at risk.

Benson and Scales (1998) further refined this model by surveying 99,000 6th-12th grade students in public and alternative schools in 23 states during the 1996-97 school year. Regrettably, students surveyed, on average, had only 18 of the 40 assets, with boys having three less than girls. According to Benson and Scales, youth face two major types of challenges to positive development – high-risk behaviors (i.e., substance abuse, sexual intercourse, violence and attempted suicide) and developmental deficits. High-risk behaviors limit a young person’s health and well-being psychologically, physically and economically. According to Benson and Scales (1998), one in five students engage in high-risk behavior. Of these, violence and alcohol use were reported most frequently.

The five developmental deficits identified included: physical abuse, being a victim of violence, time alone at home, watching too much television and attending parties where alcohol is served. Older youth reported more deficits than younger teens. These developmental challenges, however, are offset by what Benson and Scales identified as thriving indicators, such as succeeding in school, helping others, valuing diversity, maintaining good health, exhibiting leadership, resisting danger, delaying gratification and overcoming adversity. These indicators show concern for one’s own health and well-being. Negative and positive behavior patterns tend to occur in clusters. In other words, youth that spend a lot of time alone at home are more likely to watch too much television, whereas youth who volunteer and participate in community activities tend to watch less television. Scales, Benson, Leffert, and Blyth (2000) expanded their work to determine if the developmental assets can predict thriving indicators.

Young people cannot build and maintain assets by themselves. As Benson and Scales (1998) state, “The foundation for healthy development depends on the support of all youth workers, neighbors, community leaders, parents and educators within a young
person’s community. No single influence in a community can provide all of what
adolescents need. We must work together.” Accordingly, much of the Search Institute’s
work is directed at assisting communities to understand that formal programs are not
always necessary but that simple informal acts by all community members can promote
developmental assets in adolescents (Scales, 1999).

Figure 1. External Assets

Support

1. Family support — Family life provides high levels of love and support.
2. Positive family communication — Communicates well with parent(s) and seeks
   advice and counsel.
3. Other adult relationships — Gets support from three or more non-parent adults.
5. Caring school climate — Caring, encouraging environment.
6. Parent involvement in schooling — Helping youth succeed in school.

Empowerment

7. Community values youth — Adults value youth.
8. Youth as resources — Have useful roles in the community.
9. Service to others — Serve in the community one hour or more per week.
10. Safety — Feels safe in home, school and the neighborhood.

Positive Identity

11. Family boundaries — Have clear rules and consequences.
12. School boundaries — Have clear rules and consequences.
14. Adult role models — Adults model positive, responsible behavior.
15. Positive peer influence — Friends model positive, responsible behavior.
16. High expectations — Parents and teachers encourage the youth.

Use of Time

17. Creative activities — Three or more hours weekly involved in music, theater or
   other arts.
18. Youth programs — Three or more hours weekly in sports, clubs, or organization.
19. Religious community — One or more hours weekly in religious activities.
20. Time at home — Out with friends “with nothing special to do” two or fewer
   nights per week.

Internal Assets

Commitment to Learning
21. Achievement motivation — Motivated to do well in school
23. Homework — Reports one or more hours of homework every school day.
24. Bonding to school — Cares about his or her school.
25. Reading for pleasure — Reads for pleasure three or more hours per week.

Positive Values

27. Equality & social justice — Values promoting equality and reducing hunger and poverty.
28. Integrity — Stands up for her or his beliefs.
29. Honesty — Tells the truth even when it is not easy.
30. Responsibility — Accepts personal responsibility.
31. Restraint — Believes it is important not to be sexually active or to use alcohol or other drugs.

Social Competencies

32. Planning and decision-making — Knows how to plan ahead and make choices.
33. Interpersonal competence — Has empathy, sensitivity and friendship skills.
34. Cultural competence — Has knowledge of, and is comfortable with, people of different cultural/racial/ethnic backgrounds.
35. Resistance skills — Can resist negative peer pressure.
36. Peaceful conflict resolution — Seeks to resolve conflict nonviolently.

Boundaries Expectations

37. Personal power — Feels control over “things that happen & to me.”
39. Sense of purpose — Believes life has a purpose.
40. Positive view of personal future — Optimistic about the future.


Nurses’ Need for Cultural Competency

A favorite motto of ours is, “Know thyself, know thy client, know how hard it is to
A resourceful nurse working with adolescents will certainly know the traditional information regarding adolescent growth and development and may well have his/her own framework for working with teens. These factors alone, however, do not assure positive working relationships with adolescent patients. Beliefs and values of health care providers can also significantly influence the course of provider/patient relationships. Ideally, these beliefs and values do not get in the way of providing quality care. To ensure that they do not, nurses must be willing to partake in self assessment — “know thyself” — to acknowledge the existence of their beliefs, identify the source of these beliefs and understand how these beliefs influence interactions with patients. While multiple variables impact the development of personal beliefs, one of the primary influences is that of culture.

Culture affects how individuals think, act and communicate with others. It influences daily interactions, decisions and judgements about what is appropriate or valuable. Because of the implicit process by which culture guides people’s thoughts and actions, it is assumed that “everybody” thinks, feels and acts the same way. The frailty of this assumption, however, becomes obvious when a conflict is encountered between cultures. For example, some adults have a very negative reaction to adolescent body piercing or tattooing, viewing adolescents who participate in these practices as deviant or defiant. If they let these negative perceptions pervade their interactions with these adolescents, establishing a positive working relationship will be difficult. In this situation, the nurse can demonstrate cultural competence by: 1) recognizing that her negative reaction is the result of cultural differences; 2) taking ownership of this reaction; 3) acknowledging the potential for conflicts as a result of this reaction; and 4) being willing to move beyond this reaction to provide respectful care to the adolescent patient. One way to convey this respect is to focus on the adolescent’s personal and cultural strengths rather than deficits (David & Voegtle, 1994).

In addition to becoming aware of their cultural biases regarding adolescents as a group, nurses also need to be aware of larger cultural differences, i.e., racial/ethnic, socioeconomic, educational, etc. To establish positive working relationships with adolescents and their families, it is crucial for nurses, then, to understand and accommodate cultural differences, especially those surrounding communication. This will require nurses to do some background research — “know thy client” — about the different racial/ethnic and cultural groups with whom they work. They can do this by reading about various cultural groups and/or by talking to people from these groups who are willing to serve as a resource (David & Voegtle, 1994).

Information gathered, however, should serve only as a guide. Not all members of a particular cultural group will act in the same way. Nurses must determine from their patients how they view their culture and whether they adhere to traditional cultural communication customs. Caring for adolescents, in many cases, also involves working with their parents who may be more grounded in traditional cultural beliefs and values. As a result, nurses also need to assess parental cultural communication patterns. If, for example, an adolescent or family member appears distant, the nurse needs to evaluate
whether cultural differences may be influencing their interaction. She/he needs to seek input from the adolescent and the parents on ways of facilitating communication and find acceptable solutions to bridging communication barriers. If a situation is unclear or complex, the nurse may want to seek an additional person to mediate or act as a “culture broker.” When a cultural misunderstanding does occur, it should be acknowledged directly and with respect.

In addition to effectively communicating with clients from various cultural/ethnic groups, nurses need to understand that culture affects overall health care practices. Factors such as family structure and dynamics, health beliefs and level of ethnic identification will either facilitate or deter adherence to desired health care behaviors. Although not discussed here, the role of socioeconomic factors in affecting health care also needs to be explored. It is only by examining the total cultural context of the adolescent patient that nurses can begin to develop a plan of care for the adolescent that can facilitate behavior change. Remember, “change is hard,” and the best way to make it a little easier is to understand what makes the adolescent “tick.” By doing so, you can begin to identify and capitalize on the assets the adolescent patient brings to the relationship.

Confidentiality and Adolescents

Delivering confidential health services to teens is complicated by: payment issues, transportation problems, and variability in state legislation. Teens who have health insurance are typically covered under their parents’ health plans and bills reflecting services provided are sent to parents. Many teens do not have access to a car and may have to depend on parents to transport them for health services making it difficult for them to obtain services without parental involvement. In addition, legislation concerning teens’ right to privacy in health care differs from state to state.

Klein’s (1998) survey of 14-19-year-old adolescents indicated that only 8.4% had used confidential services. More than half of the adolescents interviewed did not know where they could go to receive confidential health services. A recent study by Thrall, McCloskey, Etten, Rothman, Tighe and Emans (2000) reaffirmed the important link between teens’ perception of confidentiality and their willingness to discuss health risks such as sexually transmitted diseases, pregnancy prevention and substance abuse.

Confidentiality is a complex concept that involves legal, ethical and moral principles. Confidentiality derives from the bioethical principle of autonomy and accompanies such rules as promise keeping, truthfulness, and privacy (Sigman, Silber, English, & Gans, 2000). There is a strong national consensus endorsing confidential health services for adolescents. Most professional health care organizations have a policy that directly supports adolescents’ need for confidential health services (Gans, 1993); for example, the American Nurses Association, the Society for Adolescent Medicine, the American Academy of Pediatrics, and the American Medical Association. Over the past 10 years, these policies have been supported by important national reports, including Adolescent Health (1991) by the US Congress, Office of Technology Assessment; Code Blue:
Uniting for Healthier Youth (1989) by the National Commission on the Role of the School and the Community in promoting Adolescent Health; and Turning Points (1989) by the Carnegie Council on Adolescent Development.

Likewise, adolescents report that confidentiality is important in the delivery of health care (Resnick, Blum, & Hedin, 1980). Their reasons included the need to prevent rumors, to avoid punishment from punitive parents and to promote better problem-solving skills. Confidentiality is considered crucial to adolescents’ willingness to provide accurate information about sensitive health issues. Recent research documents that counseling of adolescents about risk-taking behaviors by nurses was enhanced by the use of a confidential computerized health assessment tool (Paperny, 1999). Adolescents participating in this study were told that the information they provided was confidential and, as a result, it is believed, answered questions about risk-taking behaviors more honestly. Subsequently, counseling messages could be tailored to specific risk-taking behaviors and were more likely to be relevant to the adolescents’ needs. Not only did this tool provide essential information, it, or similar type tools, could also be used to alleviate provider time constraints. On average, each adolescent client reports participating in 10 risk behaviors only 7 of which were discussed by providers during a preventive service visit (Epner, 1998). Similarly, if a teen reports 3 or more risk behaviors, or a relatively severe health problem, even fewer risk behaviors are discussed.

Since confidentiality laws vary from state to state, it is imperative that nurse providers explain their policies regarding confidentiality during an initial clinic interview. These policies need to be explained to both the adolescent patient and parent(s). Providing this explanation in the beginning will help to avoid future misunderstandings. When working with a family over time, nurses have an opportunity to prepare parents for their child’s growing need for privacy as a normal part of adolescent development. By beginning early, parents may come to accept confidential visits by their teenagers as part of healthy maturation during adolescence. Empowering parents as “partners” in the care of their teen may alleviate fears that provider is supplanting the parents’ role as caretaker. Explaining the clinical importance of confidentiality as well as clearly defining the specific limits of confidentiality will go a long way in getting parental cooperation and acceptance.

Given the array of laws pertaining to informed consent and confidentiality that currently exist, it is no wonder that adolescents and, perhaps even nurses, are confused about how these laws pertain to them. Congress has the ability to intervene to reduce these uncertainties by moving federal and state laws in the direction of greater uniformity. Until this occurs, it may be easier for nurses to encourage their localities and schools to integrate information about legal aspects of adolescent access to health services into health education courses.

Health Status of Youth in the United States

Healthy People 2000 identified goals and objectives focused on improving health by the
year 2000. These goals and objectives allow us to measure the state of adolescent health in the United States. The leading indicators of health assessed with regard to adolescents related to physical activity and fitness, nutrition, tobacco, alcohol and other drugs, family planning, mental health and mental disorders, violent and abusive behavior, unintentional injuries, sexually transmitted diseases and clinical preventive services. Table B provides a brief overview of the findings discussed in the Healthy People 2000 Final Review (National Center of Health Statistics, 2001). Overall, the report found that while some goals were successfully met, there are still many opportunities to intervene on behalf of adolescents.

Healthy People 2010 builds on the findings from *Promoting Health/Preventing Disease: Objectives for the Nation* released in 1980 and *Healthy People 2000* released in 1990. The 2 overarching goals of Healthy People 2010 are: increase quality and years of healthy life, and eliminate health disparities (U.S. Department of Health and Human Services, 2000). These national goals recognize the relationship between the health of an individual and the health of the community, as well as the influence of the beliefs, attitudes and behaviors of the individuals in the community. Ten Leading Health Indicators have been identified to link the 28 focus areas and 467 comprehensive health objectives described in Healthy People 2010 to community health initiatives. The Leading Health Indicators reflect major public health concerns in the United States and are intended to promote an understanding of the importance of participation in this health promotion and disease prevention initiative. These Leading Health Indicators will also be used to track the progress made towards the related objectives. Table C highlights the Leading Health Indicators and some selected objectives specific to improving the health of adolescents (Jackson 2001, U.S. Department of Health and Human Services, 2000).

Most of the outcomes measured in Healthy People 2010 are related to behavior choices. Nurses have traditionally focused on patient education and health promotion and are positioned to positively influence adolescent health behaviors via health initiatives designed to meet the objectives of Healthy People 2010.

<table>
<thead>
<tr>
<th>Physical Activity and Fitness</th>
<th>Regular participation in stretching and strengthening exercises met 2000 target. Fewer</th>
</tr>
</thead>
</table>
young people are taking part in physical education classes.

### Nutrition
- Prevalence of overweight increased over all populations with greatest increase in adolescents.
- Increased low fat choices for breakfast and lunch, but only 1 in 5 schools offered low fat lunches.
- Not meeting calcium needs or minimum fruit and vegetable requirements.

### Tobacco
- Average age at time of first smoke is increasing and proportion of adolescents who smoked within past month has dramatically decreased, as did use of smokeless tobacco.
- Tobacco free environment at schools and anti-smoking education have increased, but < 5% of schools use CDC curriculum guidelines.

### Substance Abuse:
#### Alcohol and other drugs
- Alcohol use substantially declined. High school and college students are still heavy drinkers.
- Alcohol related MVA deaths declined dramatically meeting the original HP2000 goal, but fell short of the adjusted target set in 1995.
- Cocaine use declined. Anabolic steroid use decreased, meeting 2000 target.
- Marijuana use more prevalent than a decade ago, but decreasing since 1997.

### Family Planning
- Teen pregnancy rate declined considerably. The percentage of young people who report ever having had sex has declined but the goal has not been met. Reported condom use is increasing and there has been a substantial decrease in unintended pregnancies.

### Sexually Transmitted Diseases
- Gonorrhea remains high among adolescents.
- Chlamydia declined, as did incidence of PID.
- Concern that HPV is much more common and may be most common STD of sexually active youth.

### Mental Health and Mental Disorders
- Suicide rates among young people declined below the target. However, there was an increase in suicide attempts.

### Violent and Abusive Behavior
- Firearm deaths decreased for all populations.
- Rape and attempted rape decreased but did not meet 2000 goal.

### Unintentional Injuries
- Decline in MVA crashes exceeded target.
- Drowning deaths decreased, but have not yet reached the target. Use of protective equipment,
including helmets, for sports has increased but has not met target.

<table>
<thead>
<tr>
<th>Oral Health</th>
<th>Substantial decrease in number of adolescents who had ever had dental decay, almost reaching target. Decrease in the use of smokeless tobacco among 12-17 year old males met target.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Preventive Services</td>
<td>Because neither baseline nor accurate current data was collected, it is extremely difficult to know if this has been met. Adolescents and young adults are most likely to not have a regular health care provider.</td>
</tr>
<tr>
<td>Leading Health Indicator</td>
<td>Selected Objectives</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion.</td>
</tr>
<tr>
<td>Overweight and Obesity</td>
<td>Reduce the proportion of children and adolescents who are overweight or obese.</td>
</tr>
<tr>
<td>Tobacco Use</td>
<td>Reduce cigarette smoking by adolescents.</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Increase the proportion of adolescents not using alcohol or illicit drugs during the past 30 days.</td>
</tr>
<tr>
<td>Responsible Sexual Behavior</td>
<td>Increase the proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active.</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Reduce the incidence of suicide attempts by adolescents.</td>
</tr>
<tr>
<td>Injury and Violence</td>
<td>1) Reduce deaths caused by motor vehicle crashes.</td>
</tr>
<tr>
<td>Environmental Quality</td>
<td>Reduce the proportion of families living in housing units that are substandard.</td>
</tr>
<tr>
<td>Immunization</td>
<td>Improve vaccination coverage levels of adolescents.</td>
</tr>
</tbody>
</table>
| Access to Quality Health Care    | 1) Increase the proportion of persons who have a specific source of ongoing care.  
2) Increase the proportion of persons appropriately counseled about health behaviors.                                                                                                                                   | 1) 87%    | 1) 96%       |

References


responsiveness to health risk behaviors reported by adolescent patients. *Archives of Pediatric and Adolescent Medicine, 152*, 774-780.


Klein, J. D., McNulty, M., & Flataw, C. N. (1998). Teenagers self-reported use of services and perceived access to confidential care. *Archives of Pediatric and Adolescent Medicine, 152*, 676-682.


Websites:

http://www.aap.org is the official website of the American Academy of Pediatrics. This provides a search engine for specific information and publications about adolescent health.

http://www.adolescenthealth.org is the website for The Society for Adolescent Medicine. It includes position statements written and endorsed by this professional organization, and links to other sites that focus on issues in adolescent health care. Professional membership information is also available.

http://www.ana.org/anf/adolesce/index.htm is the American Nurses Association website, which provides information about the Partners in Adolescent Health Initiative and linkages to adolescent health information on the ANA webpage.

http://www.brightfutures.org provides access to information regarding health supervision guidelines for children birth through adolescence.

http://www.cdc.gov provides important information about teens and sexually transmitted diseases.

http://www.health.gov/healthypeople/ provides access to the Healthy People 2010 documents.

http://www.keepkidshealth.com provides a wide range of information about adolescent
health care and well child issues. Written by a pediatrician.

http://www.med.yale.edu/library/education/culturalcomp/web.html includes links to cultural competence resource.

http://www.search-institute.org is the official site of the Developmental Assets research group. It provides information about continuing research and activities with regards to this program.

http://www.teenwire.com provides information about sexuality and teen health from Planned Parenthood Federation of America.

Working with Adolescents: A Time of Opportunity
INSTRUCTIONS

Read the article and complete the POST-TEST ANSWER SHEET. Check your answers and grade yourself using the FEEDBACK SECTION. Each question is worth 6.6 points. If you receive a grade below 75%, please re-read the article and retake the test until you successfully score 75% or better.

1. What is usually the first physical sign of puberty in boys?
   a. the development of fine, downy pubic hair
   b. an increase in testicular volume
   c. an increase in the length of the penis
   d. an increase in the breadth of the penis

2. What is usually the first physical sign of puberty in girls?
   a. the development of fine, downy pubic hair
   b. the development of axillary hair
   c. peak height velocity
   d. breast budding

3. What are the two main hormones for the development of secondary sex characteristics?
   a. Follicle stimulating hormone (FSH) and Thyroid hormone
   b. Human growth hormone (hGH) and Leutenizing hormone (LH)
   c. Follicle stimulating hormone (FSH) and Leutenizing hormone (LH).
   d. Thyroxine and Follicle stimulating hormone (FSH)

4. The average age of onset of puberty in girls is:
   a. 11.2 years
   b. 10.5 years
   c. 13.1 years
   d. 9.0 years

5. The average age of menarche is:
a. 13 years 1 month  
b. 10 years 8 months  
c. 12 years 4 months  
d. 11 years 6 months

6. The end of the growth spurt is marked by:
   a. menarche in girls and spermarche in boys  
   b. adult quality pubic hair  
   c. epiphyseal closure  
   d. Sexual Maturity Rating (SMR) ratings of 5

7. Cognitive development in adolescence is marked by all except:
   a. the ability to reason concretely  
   b. the ability to plan for the future  
   c. daydreaming, increased self interest and fantasy  
   d. feeling invulnerable.

8. According to Kohlberg, the post conventional level of moral development:
   a. requires concrete thought.  
   b. begins in early to middle adolescence.  
   c. focuses on autonomous moral principles based on individual beliefs.  
   d. is attained by all adolescents.

9. Carol Gilligan’s model of moral development:
   a. applies to boys and girls.  
   b. is centered on understanding responsibilities and relationships.  
   c. is centered on rights, rules, and deductive reasoning.  
   d. is an open systems model.

10. The Developmental Assets framework delivers what important message:
a. Healthy adolescent development requires involvement of all members of the community.
b. Healthy adolescent development only requires involvement of youth.
c. Healthy adolescent development only requires involvement of parents.
d. Healthy adolescent development only requires involvement of parents and schools.

11. Five developmental deficits of adolescents were identified by The Search Institute report. Which of the following was not included?
   a. time alone at home
   b. attending parties where alcohol is served
   c. driving a car before 17 years of age
   d. watching too much television

12. Benson and Scales (1998) identified eight thriving indicators. Which of the following indicators was not identified?
   a. succeeding in school
   b. delaying gratification
   c. working twenty (20) hours per week
   d. helping others

13. Ways of knowing one’s self INCLUDE (choose the best answer):
   a. behavioral inventories
   b. learning style inventories
   c. personality inventories
   d. all of the above

14. The culturally sensitive nurse trying to identify cultural communication patterns should use direct questioning.
   a. True
   b. False

15. When trying to promote adherence to a behavioral change, the nurse
must acknowledge the cultural influence of all of the following EXCEPT:

a. socioeconomic factors
b. family structure and dynamics
c. health beliefs and practices
d. genetic factors

16. Klein’s recent survey (1998) indicated that adolescents use confidential services 91.6% of the time.

a. True
b. False

17. The Healthy People 2000 Final Review reported the lowest attainment of the targeted health objectives in which of the following areas?

a. Alcohol and other drugs
b. Nutrition
c. Family planning
d. Mental health and mental disorders

18. Healthy People 2010 target for increasing the proportion of adolescents who engage in vigorous physical activity is:

a. 65%
b. 75%
c. 85%
d. 95%
ANA/ANF “Working with Adolescents: A Time of Opportunity” Independent Study Module

CE Deadline: December 31, 2004
Program Code: LD: 20209058
Contact Hours: 1.8

1. The correct answer is B. An increase in testicular volume. Note that A, C and D are incorrect because ratings for pubic hair development and genital development (testes, scrotum, and penis) can differ at any given time in the same individual.

2. The correct answer is D. Breast budding. Note that A and B are incorrect because the development of pubic hair and axillary hair can progress at different rates and be at a different Sexual Maturity Rating (SMR) level at any given time. C is incorrect because peak height velocity is reached one year and one month before breast development begins.

3. The correct answer is C. Follicle stimulating hormone (FSH) and Leutenizing hormone (LH) are responsible for the development of secondary sex characteristics either directly or indirectly through the stimulation of other hormones. Note that A is incorrect because the Thyroid hormone, along with several other hormones, plays a role in the growth and bone maturation. B is incorrect because hGH (human growth hormone) secreted by the pituitary plays a central role in growth. D is incorrect (see rationale for C).

4. The correct answer is A. 11.2 years.

5. The correct answer is C. 12 years 4 months.

6. The correct answer is C. Epiphyseal closure. Note that A is incorrect because menarche in girls and spermarche in boys usually occur in early puberty. B and D are incorrect because they indicate the late development phase of secondary sex characteristics.

7. The correct answer is A. Cognitive reasoning proceeds from concrete to abstract.

8. The correct answer is C. The focus of postconventional moral development moves from actions and motivations to please others, to autonomous moral principles that are based on the individual’s own beliefs. A is incorrect because the postconventional level of moral development requires formal operational thought. B and D are incorrect because this level of moral development typically begins in middle to late adolescence and is not achieved by all adolescents.

9. The correct answer is B. Gilligan states that moral development is centered on the understanding of responsibility and relationships. A is incorrect because Gilligan
believes that moral development is different for girls and boys. C. is incorrect because it is Kohlberg’s theory that boys rely on rights, rules and deductive reasoning to attain the highest level of moral development. D. is incorrect because Gilligan describes a spiral model of moral development, while Kohlberg describes an open systems model.

10. The correct answer is A. Benson and Scales state that the foundation for healthy development depends on the support of all youth workers, neighbors, community leaders, parents, and educators within a young person’s community. Note that B is incorrect because young people cannot build and maintain assets by themselves. C is incorrect because no single influence in a community can provide all of what adolescents need. D is incorrect because the foundation for healthy development depends on the support of all community members.

11. The correct answer is C. Driving a car before 17 years of age.

12. The correct answer is C. Working twenty (20) hours per week.

13. The correct answer is D. All of the above. Note that A, B, and C are incorrect because they are individual traits of knowing oneself, which will allow the nurse/health provider to better understand the differences in people.

14. The correct answer is B. False because communication customs are difficult to identify through direct questioning. Nurses/health providers need to recognize and accommodate the cultural differences of their clientele.

15. The correct answer is D. Genetic factors. Note that A, B and C are incorrect because they are factors the nurse/health provider will need to use in order to determine culturally appropriate ways of communicating and caring for the adolescent.

16. The correct answer is B. The statement is false because while most adolescents had used primary care services, only 8.4% had used confidential services.

17. The correct answer is B. Nutrition. Note that A is incorrect because the number of alcohol-related motor vehicle crash deaths declined dramatically, meeting the original Healthy People 2000 goal. The percentage of anabolic steroid use also declined, meeting the 2000 target. C is incorrect because the teen pregnancy rate declined considerably, and the reported condom use is increasing. D is incorrect because suicide rates among young people have decreased, meeting the Healthy People 2000 target.

18. The correct answer is C 85%.