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Module 3
Communication with Adolescents and Their Family

I. Introduction

This module introduces the concept that communicating with adolescents, their families and other/related users of health services will sustain clinical advances and strengthen the knowledge and skills of adults who counsel adolescents and their families. Families have the major responsibility for caring for adolescents during their growth and development. Emphasis is placed on interpersonal communication and listening skills. The principles of non-directive counselling are introduced with the aim of facilitating young clients' overall development by strengthening their self-understanding, and enhancing their abilities to deal personally with present problems and prevent future difficulties.

II. Learning Objective

Upon completion of this module, learners will:

1. Understand how health care professionals' attitudes and values influence their role as facilitators and counsellors in communication with adolescents and their families.
2. Be aware of the effective communication and counselling skills, conducive environment, and legal aspects (confidentiality and consent) of adolescent care.
3. Be aware of the barriers to and tips for communicating with adolescents.
4. Be able to illustrate a counselling model with steps which are culturally sensitive in terms of communication and counselling.

Sources:

1. World Health Organization. (2009). World Health Organization: Adolescent Job Aid. World Health Organization.
2. World Health Organization. Orientation Program on Adolescent Health for Health-care Providers. Facilitator Guide - New Modules. World Health Organization.
3. World Health Organization. Orientation Program on Adolescent Health for Health-care Providers. Handout - New Modules. World Health Organization.
4. The Hong Kong Polytechnic University (2009). Foundational Modules for Adolescent Health and Development Workshop. School of Nursing, The Hong Kong Polytechnic University, Hong Kong.

III. Content

Upon completion of this module, learners will:

- Understand how health care professionals' attitude and values would influence the act as facilitators and counsellors of communications with adolescents and their families.
- Be aware of the effective communication and counselling skills, conductive environment, and legal aspects (confidentiality and consent) of adolescent care.
- Be aware of the barriers in communicating with adolescents and tips for communicating with adolescents.
- Illustrate a counselling model with steps which are culturally sensitive on communication and counselling.

Objective 1: Understand how health care professionals can act as facilitators and counsellors in communications with adolescents and their families.

Activities

Activity 3.1: Debate on the subject "Adolescent youths should be able to seek family planning services without parental consent".

Divide the room into four, each area representing either 'strongly agree', 'agree', 'disagree', or 'strongly disagree'.

Attitude and values: Illustrating your acceptance in counselling

- Valuing adolescent without judging: The adolescent being counselled should be valued and the counsellor should not be judgmental or assume that the adolescent's values and beliefs are the same as his or hers during the counselling process.

- Values refer to the kinds of things that an individual, a group or a whole society consider to be desirable. People may or may not be consciously aware of these values but they use them as the basis for choosing between different courses of action. For example, health is valued more by some people than by others, and this affects their willingness to take risks with their health.

- Differences in values between counsellors and adolescents can cause communication difficulties, particularly if the situation is not seen from the viewpoint of the young person. It is important that health care professionals are aware of their own values and how they may affect their perceptions of those they counsel. It is also important that health care professionals address these issues to avoid imposing them on their patients and possibly driving them away.

- Use Activity 3.1 to illustrate participants' values and attitudes. At the end of the discussions, participants should be aware that all statements/issues may have more than one 'correct view', and that counselling must recognise and accept a diversity of views from clients if it is to achieve its aims of providing information, enabling decision-making and providing support.

Enhancing parent-adolescent relationships

- Adolescents and their families value the expertise and advice of their health care professionals. Each encounter with an adolescent and his/her family should be viewed as an opportunity to help them in their positive development and to lay the foundation for healthy functioning in adulthood.

- Interventions provided through health care settings can include both adolescents and their families, thus helping to create social environments that support adolescents' health-enhancing behaviours.

- Health care settings are the resources available for health care professionals to address various components of health, including the physical, emotional, and social needs of adolescents and their families.

- Health care settings offer professionals the advantage of being able to provide confidential services, which are especially important in sensitive discussions with adolescents on subjects such as substance use and sexual behaviour.

More

a) Communicating with adolescents to reinforce their identity and independence

Peer relationships are important to adolescents as they develop their identity and strive for independence. By comparing themselves to their peers, adolescents are able to adopt attributes they admire and incorporate them into their own identity. Peers help adolescents learn to function autonomously by providing an additional source of support. Peer relationships teach mutual trust and understanding. Family support of positive peer relationships helps adolescents forge their identity and move toward independence.

(Bright future: Mental health: Practice guide. Volume 1)

Guidelines: Communicating with adolescents (Wong's, 2003)

- **Build a foundation with an adolescent**
  - ♦ Spend time together
  - ♦ Encourage expression of ideas and feelings
  - ♦ Respect their views
  - ♦ Tolerate differences
  - ♦ Praise good points
  - ♦ Respect their privacy
  - ♦ Set a good example

- **Communicate effectively with an adolescent**
  - ♦ Give undivided attention
  - ♦ Listen, listen, listen
  - ♦ Be courteous, calm, and open-minded
  - ♦ Try not to overreact. If you do, take a break
  - ♦ Avoid judging or criticising
  - ♦ Avoid the "third degree" of continuous questioning
  - ♦ Choose important issues when taking a stand
  - ♦ After taking a stand:
    - Think through all options
    - Make expectations clear

b) Communicating with adolescents to reinforce their identity and independence

(National Centre for Education in Maternal and Child Health, 2002)

- Reassure parents that the need for conformity is a healthy developmental step that peaks in early and middle adolescence and declines in late adolescence

- Encourage parents to be tolerant of their adolescent's developing personal style (e.g. clothing choices, taste in music), within the limitations of family finances, school regulations, and respect for others. A sense of humour and sense of perspective can be very useful.

- Convey to parents that they remain the major source of guidance for their adolescent on educational plans and aspirations, moral and social values, and how the adult world works.

- Discuss with parents the developmental changes their adolescent is experiencing and the importance of reassuring their adolescent that the physical changes he or she is experiencing happen to everyone.

More

Counsellor: Knowing the adolescent and family through effective interview skills

Nonverbal Strategies

- Invite family members to choose where they would like to sit or stand, allowing them to select a comfortable distance.
- Observe interactions with others to determine which body gestures (e.g., shaking hands) are acceptable and appropriate. Ask when in doubt.
- Avoid appearing rushed.
- Be an active listener.
- Observe for cues regarding appropriate eye contact.
- Learn appropriate use of pauses or interruptions for different cultures.
- Ask for clarification if nonverbal meaning is unclear.

Verbal Strategies

- Learn and use proper terms.
- Use a positive tone of voice to convey interest.
- Speak slowly and carefully, not loudly, when families have poor language comprehension.
- Encourage questions.
- Learn basic words and sentences in the family's language, if possible.
- Avoid professional terms.
- When asking questions, tell the family why the questions are being asked, the way in which the information they provide will be used, and how it might benefit their child.
- Repeat important information more than once.
- Always give the reason or purpose for a treatment or prescription.
- Use written information translated into appropriate languages (or dialects). If the family members are illiterate, written translations are useless, and the nurse must consider alternative ways of communicating, such as audio or video recordings.
- Offer the services of an interpreter when necessary.
- Learn from families and representatives of their culture methods of communicating information without creating discomfort.
- Address intergenerational needs (e.g., family's need to consult with others).
- Be sincere, open and honest, and, when appropriate, share personal experiences, beliefs and practices to establish rapport and trust.

Core and advanced skills for interviewing adolescents and their families

(a) Core family interviewing skills

These are used in routine interviews in which another person accompanies the patient, and can assist in conducting an efficient and productive interview that involves everyone present. The 9 core interviewing skills are:

1. Greet and build rapport
2. Identify each individual's agenda
3. Check each individual's perspective
4. Allow each person to speak
5. Recognise and acknowledge feelings
6. Avoid taking sides
7. Respect privacy and maintain confidentiality
8. Interview the adolescent alone
9. Evaluate agreement with the plan

More

(b) Advanced family interviewing skills

These can be useful in situations where the family exhibits ineffective communication, has difficulty resolving a conflict, or when intense emotions arise. The goal of these interview skills is to assist the family in communicating or managing conflict sufficiently to address the immediate patient care issues; the use of these advanced skills is not intended to create a permanent change in the family's interaction patterns. The physician may use techniques such as reframing, decision analysis, criteria setting and brainstorming to direct the interactions and conflict, negotiate common ground, and if needed refer the family for more intensive family therapy. The 4 advanced interviewing skills are:

1. Guide communication
2. Manage conflict
3. Reach common ground
4. Consider referral for family therapy

More
Notes for the counsellor
Notes for the facilitator

Health care settings

- Require a foundation of individual interviewing skills, including data gathering (open-ended questions, facilitation, and identifying and exploring clues), responding empathetically, and reaching common ground.
- Adolescent must be involved in health-related discussion.
- Adolescents need to be taught self-care skills related to their illness.
- Adolescents must learn to monitor and manage their own treatment needs as much as possible.
- Adolescents need to develop coping skills to address problems or concerns that might arise related to their illness through discussion with other adolescents with similar illnesses, health care providers or other professional support.

Communicating with families

- Communicating with the family is a triangular process involving the health care professionals, parents and adolescent. The family function interview examines the family members' interaction and roles, power, decision making, problem solving, communication, and expression of feelings and individuality.
- As adolescents mature, the nature of their relationship with their parent's changes and ongoing renegotiation of family roles is necessary. Some degree of dissension between adolescents and their parents is common as adolescents struggle for greater independence and their peers become more important.
- Parent-adolescent relationships can be enhanced by helping parents provide meaningful roles for the adolescent in the family, establish mutual expectations concerning responsibilities, identify areas of conflict, and devise compromises and solutions that are acceptable to all family members (Simpson, 2001).
- Empathise with parents who are having difficulty letting go as their adolescent spends increasing amounts of time outside the home. Reassure them that this shift will allow their adolescent to establish intimate relationships and sources of social support outside the family, which will help him/her function independently as an adult.

Core family interviewing skills

1. Greet and build rapport
   - A personal introduction to parents who are accompanying the adolescent provides an important foundation for future interactions. Extra attention may be given to establishing a rapport with a new member.
2. Identify each individual's agenda
   - To clarify and prioritise the objectives of everyone involved, the adolescent's agenda should be established, and then the family members should be asked if they have any additional concerns. Identification of everyone's expectations early in the process can help to avoid concerns that arise late in the interview.
   - Summarising agenda items can help to organise the interview and validate everyone's interests.
   - Multiple agendas should be prioritised to keep within the time limits of the visit.
   - It is important to discuss the most pressing issues first and to schedule future sessions to cover the remaining concerns.

3. Check each individual's perspective
   - Ask for each person's perspective on the issue or problem; broaden the health care professional's differential diagnosis, including those related to family dynamics.
4. Allow each person to speak
   - If ineffective communication patterns persist, use the advanced interviewing skills discussed later (monopolising the interaction, expressing thoughts and feelings for others, or speaking directly to the health care professional about a family member who is present).
5. Recognise and acknowledge feelings
   - Find a balanced approach that responds to the family's concerns but does not divert the focus of the discussion from the patient. Pay close attention to nonverbal clues, such as seating arrangements, physical closeness, eye gazes, and response sequence.
   - Communicate important emotional information and provide an opportunity to acknowledge and explore everyone's emotional reactions to the disease and its consequences.
6. Avoid taking sides
   - The health care provider-patient relationship can be negatively impacted by the health care provider's agreement with the family member; the health care provider's role is to acknowledge the family member's concern and then listen to the adolescent's response to that concern.
7. Respect privacy and maintain confidentiality
   - The privacy of the adolescent must be respected at all times. Some adolescents may also be reluctant to provide accurate information about sensitive or embarrassing issues when other people are present. It is therefore important to provide a one-to-one interview in such cases, to gain the adolescent's trust and confidence.
8. Interviewing the adolescent alone
   - An optimal time to interview the adolescent alone is after the family interview has addressed the issues and agendas of the family members.
9. Evaluate agreement with the plan
   - Develop a plan that addresses the various concerns discussed during the family interviews. After the health care provider describes the plan, the adolescent and then the family members should be asked how they feel about the plan. If differences exist, advanced family interviewing skills and additional office sessions may be necessary.

Core family interviewing skills

1. Guide communication

- Communication is ineffective when members exhibit the following behaviours: interrupting one another, showing poor attention or poor listening skills, monopolising the discussion with critical or sarcastic comments, making demands or speaking for others. The health care professional assists by recognising these problems and providing guidance.

2. Manage conflict

- The interviewer should first highlight the conflict in a professional way that encourages open discussion rather than personal attacks. Reframing is a method of restating a confrontational or demanding position in a way that allows each family member to understand and appreciate the others' viewpoints.

3. Reach common ground

- This is a vital phase of the family interview in which there is strong disagreement. Various tools are available to help everyone reach common ground, including reframing, brainstorming, decision analysis and criteria setting.
- Brainstorming methods are used to explore potential solutions after each person's position has been established. Decision analysis considers the drawbacks and benefits of the current situation, and the barriers to and incentives of the proposed solution.

4. Consider referral for family therapy

- Referral should be considered when a high level of unresolved conflict remains that affects the adolescent and the entire family.
- Family members should be informed that participation in the office visit interview signifies a desire on their part to improve the relationship, and that family therapy may be appropriate. For families that decline family therapy, the interviewer can help members identify criteria for judging whether or not their situation is improving.

Furthermore

Observational Skills (Lvey & Lvey, 1999)

1. Nonverbal behaviour

- Your own and client eye contact patterns, body language, and vocal qualities are important. Shifts and changes in these may be indicative of client interest or discomfort. A client may lean forward, indicating excitement about an idea, or cross his/her arms to close it off. Facial clues (brow furrowing, lip tightening or loosening, flushing, pulse rate visible at temples) are especially important. Larger-scale body movements may indicate shifts in reactions, thoughts, or the topic.

2. Verbal behaviour

- Noting patterns of verbal tracking for both you and the client is particularly important. At what point does the topic change and who initiates the changes? Are you and the client talking abstractly or concretely? If the client tends to use certain key words to describe their behaviour and situations, noting these descriptive words and repetitive themes is helpful. Some clients use primarily auditory, visual, or kinesthetic words to describe their way of interacting with the world; it is helpful to match these words.

3. Discrepancies

- Incongruities, mixed messages, contradiction, and conflicts are manifest in many and perhaps all interviews. The effective interviewer is able to identify these discrepancies, to name them appropriately, and sometimes to feed them back to the client. These discrepancies may be between nonverbal behaviours, between two statements, between what clients say and what they do, or between statements and nonverbal behaviour. They may also represent a conflict between people or between a client and a situation. Your own behaviours may also be positively or negatively discrepant.

** Simple, careful observation of the interview is basic. What can you see, hear, and feel from the client's world? Note your impact on the client: how does what you say change or relate to the client's behaviour? Use these data to adjust your interviewing technique.

Notes for counsellors

A good counselling session takes account of

- Time – the value placed on time in the cultural context
- Ethics – professional ethics
- Location – easy to access
- The use of basic counselling skills in an appropriate, understanding and helpful way
- The client's need for a competent and responsible helper
- The client's need for confidentiality
- The requirement to do the most good and the least harm when there is a dilemma
- The requirement to act within the law of the land

Notes for facilitators

Every session must have a beginning, middle and end.

- The beginning is where the helper/counsellor introduces himself/herself - who he/she is and what he/she is there for. In some sessions it may be appropriate at this point to mention the ethical values of respect and confidentiality to the client in order to reassure them.
- The middle part of the session is where the helping relationship develops. Here the counsellor uses basic counselling skills, displays the three cores conditions and provides preventative messages.
- The end of the session can be the end of the relationship or it can be the beginning of a long-term relationship. This depends partly on the skills and understanding of the counsellor, but also on the circumstances.

Objective 2: Be aware of the effective communication and counselling skills, conducive environment, and legal (confidentiality and consent) aspects of adolescent care.

Activities

Activity 3.2:
A 14-year-old girl asks you to arrange an abortion for her and also asks that her parents not be informed.
How do you discuss the issues concerning her cultural background, her age, and her religion with her?
In the above case, what specific outcomes are you seeking to achieve?

Discussions:
1. The advantages of informed consent
2. Situations where informed consent is necessary and, perhaps, unnecessary
3. Implications that may follow from not getting informed consent
4. What may be needed to increase awareness of the importance of informed consent in particular areas of practice, e.g. surgery.

Effective communication skills

Critical elements in establishing trust relationships:

1. Active listening (without imposing judgment)
2. Responding to the adolescent's emotions
   - expressing empathy and support: verbalising concern about nonverbal cues
   - respecting adolescents' rights and abilities to make decisions
   - acknowledging potential issues – values, sexual orientation
3. Ensuring confidentiality and privacy – health care practitioner should be familiar with legal rights of adolescent patients and their families. The boundaries of confidentiality and privacy should be established at the beginning of the interview so adolescents feel they can discuss sensitive topics. Most of the interview should be completed with parents out of the room.
4. Having a positive attitude towards adolescents
5. Listening, not being judgmental
6. Avoiding medical jargon
7. Avoiding common pitfalls
8. Being attentive, empathetic, authentic

Guidelines for interviewing adolescents:

1. Ensure confidentiality and privacy; interview adolescent without parents.
2. Show concern for adolescent's perspective: “First, I'd like to talk about your main concerns” and “I'd like to know what you think is happening”.
3. Offer a non-threatening explanation for the questions you ask: “I'm going to ask a number of questions to help me better understand your health”.
4. Maintain objectivity; avoid assumptions, judgments, and lectures.
5. Ask open-ended questions when possible; move to more directive questions if necessary.
6. Begin with less sensitive issues and proceed to more sensitive ones.
7. Use languages that both the adolescent and you understand.
8. Restate: reflect back to adolescents what they have said, along with feelings that may be associated with their descriptions

Ten tips for communicating with adolescents

1. Listen to the adolescent's basic message
2. Respond to the most important part of the adolescent's statement that coincides with the basic apparent or underlying verbal and nonverbal messages
3. Reflect the adolescent's feelings at a greater level of intensity than originally expressed by him
4. Reflect both implicit and explicit feelings of the adolescent and help him differentiate between thoughts and feelings
5. Respond to the adolescent's nonverbal behaviours
6. When the adolescent changes topics, respond to the primary cognitive or affective theme of the topics by verbal tracking
7. Always allow the adolescent to modify or reject your perceptions
8. Use your own feelings as the basis for checking out, confronting, leading, and so on
9. If you are unable to rephrase your questions as statements, ask only open-ended questions that clarify issues for the adolescent or that elicit feelings
10. If the adolescent doesn't pause to give you a chance to respond, and you feel lost or confused, break in with a statement such as ‘I feel confused…' in order to focus on major themes. But do not feel you have to respond to every single adolescent statement.

Essentials of counselling skills

Responsibilities of the person seeking help

The person seeking help should recognise that he or she is in a situation that he or she wants to either improve or change, and show that he or she really wants to do something to achieve the goal. However, the person seeking help should not reply on the counsellor to do everything for him or her.

He or she must always own his/her problems, and the decision and choices he or she makes. This means the suggestions offered by the counsellor may be accepted as possibilities or rejected by the person seeking help. (Csoti, 2000)

The counsellor should

- Not force the invited person to talk; he or she must be willing
- Give an alternative time for counselling if there is no spare time when a request is made
- Choose an area that will be quiet with no interruptions (Csoti, 2000)

Five steps for counselling with adolescents (Locke, Myers & Herr, 2001):

1. Rapport and relationship building
2. Assessment
3. Goal setting
4. Initiating interventions
5. Termination and follow-up

More

- Check-lists are provided to health care professionals in order to review the counselling techniques (Appendix 3.1).

Effective counselling skills

1. Use correct body language
• Show that you are paying attention (make frequent eye contact, lean forward). • Sit without barriers between you (no desk or table) so that the individual's body language can be clearly seen and they will not feel distanced from you.
2. Listen actively
• Check frequently that you understand what is being discussed. Summarise what has been discussed to check your understanding of the situation. • Repeat a sentence that the client has said (such as "And then she hit you?"), which encourages the person to continue while letting them know they have your attention. • Listen out for subjects or areas that seem to be avoided. (Csoti, 2000)

3. Asking questions
• Use "open" questions, which require lengthier answers on the part of the responder, i.e. more than a "yes" or "no" answer. "Open" questions most frequently begin with an interrogative pronoun, like what, how, or why. The question might be "How was the party last night?" or "What were your thoughts and feelings when you heard that the reunion had been cancelled?" The advantage of using "open" questions is that they can lead or invite the client to explore (elaborate, clarify, describe, compare, or illustrate) his or her thoughts or feelings. • Use hypothetical questions so that the individual can explore options ("what would happen if…?"). • Allow time for pauses and silences, so that you both have time to think about what has been said and where you want to go next. • Repeat key words in the form of a question to encourage the interviewee to open up without feeling that they are being interrogated. ("Whenever she does that I feel small." "Small?") • Begin with less sensitive issues and proceed to more sensitive ones. (Csoti, 2000)
4. Developing a relationship
The same words and speech patterns may be used with clients so that you avoid emphasising the differences between you and them, as long as they appear natural. (For example, if slang is used to describe something, use the same word.) **More**

Conducive environment

Health Care Services for Adolescents

- Accessible:
  - Services must be available (outreach), affordable (cost), approachable (barriers), accountable (quality)

- Accountable:
  - The competency of health care professionals in providing care
  - Quality of services provided

- Appropriate:
  - Services take into consideration the cultural contexts, needs for confidentiality, developmentally appropriate care, professionals' competency
  - Consistent
  - Supportive
  - One-to-one interactions over time

Recognise the importance of an appropriate setting that is adolescent-friendly

- Opening hours
- Access
- Payment
- Visit schedule (time allowed)
- Information given (pamphlets for teens and parents, etc.)
- Decor
- Accountability

Legal Aspects

Informed Consent

- Informed consent may be a contentious issue in many health care settings, especially those providing services for adolescents.

- It is defined legally as involving three aspects: knowledge, competence/intelligence, and voluntariness. Under the strictest of interpretations, the knowledge test requires that a professional fully inform the client and/or parent of all relevant information about a specific intervention approach so that the person becomes "aware" of what is being proposed / discussed.

- The following must be included for valid consent:
  (a) A complete explanation of the treatment, risks, discomforts, and benefits;
  (b) A description of other possible treatment alternatives;
  (c) An offer to discuss the procedures or answer any questions; and
  (d) Information that the client is free to withdraw consent at any time and discontinue treatment.

More

Confidentiality / Information for others

1. What do we mean by confidentiality?
2. How can an adolescent know that confidences will be kept?
3. What is the best way to break a confidence if the counsellor feels it is absolutely essential to do so?

One of the principles of counselling is to help the young person achieve the capacity to make their own decisions about their behaviour. All the contents related to the process of counselling should be kept confidential. The counsellor cannot disclose the related contents without the client's (adolescents) permission. However, if the issues concerned, such as sexual abuse, have broken the law, they should be reported to the police.

This is one of the most important issues to be addressed by a counselling service and in many respects one of the most difficult. Adolescents are often extremely anxious about revealing feelings, thoughts or acts which they have thus far kept secret. A skilled counsellor can help an adolescent talk about such things but will be severely handicapped if the adolescent believes that what is said will not be kept in confidence, or is unsure that confidences will be kept.

Assuring confidentiality in interviewing adolescents

- Parents, family members and other adults should not be present unless the adolescent gives permission.
- In fact, we ask the adolescent to introduce us to the other people in the room. This gives the adolescent a clear message that we are interested primarily in him.
- It is not reasonable to expect an adolescent to reveal personal information unless confidentiality can be assured.
- We tell adolescents that we ask certain questions because the information is integral to our understanding of their health.
- With the exception of physical or sexual abuse, or suicidal or homicidal behaviour or intent, we do not immediately reveal sensitive information to parents or authorities. It is our goals to have the teenager make these revelations himself / herself.
- Often, we do not begin asking: "Why are you here?" Rather, we start with conversation often geared to an observation about the teenager. We may make a comment about clothing.

The rights of children and adolescents

The WHO supports the United Nations Convention (1992) on the Rights of the Child, which stipulates that adolescents have the right to:

1. A safe and supportive environment
2. Information and life-skills
3. Health services and counselling

All children and adolescents should have the means and the opportunity to develop to their full potential. Life, survival, maximum development, access to health and access to health services are not just basic needs of children and adolescents, but are also fundamental human rights. However, the protection and fulfilment of these fundamental rights depend on the realisation of other rights

According to the World Health Organization (2000a), child and adolescent rights are as follows:

- Non-discrimination
- Education and access to appropriate information
- Privacy and confidentiality
- Protection from all forms of violence
- Rest, leisure and play
- An adequate standard of living
- Freedom from all forms of exploitation
- Participation, including the right to be heard

Five steps for counselling with adolescents

Step 1: Rapport and relationship building

According to Locke, Myers and Herr (2001), building up a close relationship with clients (adolescents) is important for counselling. Such a relationship should be built before the start of counselling. It should be maintained from the beginning until the last phase of the counselling intervention.

The relationship has been built with the client when the following situations are seen:

- client is willing and feels comfortable enough to talk with you and answer your questions
- client feels relaxed when talking with you
- client dares to make eye contact with you
- client is actively talking with you

Step 2: Assessment

Process of collecting and classifying information related to the client's (adolescent) personhood and reasons for seeking counselling (define problems of concern) by:

- Asking the adolescent directly,
- Questionnaire,
- Determining what the adolescent wants to know and already knows

Step 3: Goal setting

If helped to establish concrete goals (guided decision making), adolescents should feel less confused, clearer about themselves and their wants and needs.

- The process of setting goals is mutually defined by the counsellor and the adolescent.
- Goal setting involves the counsellor teaching the adolescent (health education) how to establish attainable goals by providing the adolescent with appropriate health information.
- The ultimate goal is to change the adolescent's life style to a healthy one. (Locke, Myers & Herr, 2001)

Step 4: Initiating interventions

Locke, Myers and Herr (2001) state that the counsellor needs to provide the adolescent with accurate health information about all available intervention strategies (also a guided decision making component), including:

- A description of all relevant and potentially useful treatment approaches for this particular adolescent with this particular problem
- A rationale for each procedure that will be used
- A description of the counsellor's role in each intervention
- A description of the adolescent's role in each intervention
- Possible discomforts or risks that may occur as a result of the intervention
- Expected benefits that will occur as a result of the intervention
- The estimated time and cost of each intervention

Step 5: Termination and follow-up

According to Locke, Myers and Herr, the termination process involves several steps:

- Summarising Progress:

1. Provide an accurate summary of the adolescent's responsiveness to counselling and to specific types of interventions;
2. Enhance the counselling relationship when the counsellor validates their accomplishments and encourages them to take credit for all the steps they have taken toward their goals;
3. Counsellor can inject some caution if some counselling gains need to be reinforced or monitored by the client (adolescent).

- Generalising Change:

The counsellor and client should look to how those new behaviours, attitudes, or relationships can be generalised to the client's world. The basic goal of the implementation step is to test the client's willingness and ability to adapt learned skills such as lifestyle changes, or new attitudes to situations other than those that provoked the original problem.

- Planning For Follow-up

1. Determine the nature and amount of professional contact that occurs between the counsellors and client after termination of the counselling,
2. Check whether there is a re-occurrence of the risk behaviour,
3. Check whether the client encounters any new health crises or problems,
4. For those clients who believe termination is appropriate but experience anxiety at the prospect, then a 3-month or 6-month check-up is suggested and the follow-up is dependent on the client's response

Developing Relationship

- Presenting reality: Helping the client to differentiate the real from the unreal.

  For example, counsellor: "That's not a dead mouse in the corner, it is a discarded washcloth."

- Focusing: Helping the client expand on and develop a topic of importance. It is important for the counsellor to wait until the client finishes stating the main concern before attempting to focus. The related focus can be an idea or a feeling. Meanwhile, the counsellor can help the client to recognise an emotion disguised behind words.

  For example, client: "My wife says she will look after me, but I don't think she can, what with children to take care of, and they're always after her about something---clothes, [more here or just …?]"

  Counsellor: "You are worried about how well she can manage…"

- Summarising and Planning: Stating the main points of a discussion to clarify the relevant points discussed. This can allow the counsellor to review a health teaching session. It often acts as an introduction to future care planning.

  For example, counsellor: "During the past half hour we have talked about…"

  Check frequently to determine if content is of interest or being listened to. Have client repeat content or give examples of application of content. (Csoti, 2000)

Informed Consent

- The intelligence or competence aspect of consent focuses on the ability of the child or patient to arrive at the consent rationally and independently. Within this concept are the notions of cognitive capacity and other mental health related abilities of a client. And it includes: the ability to understand and retain the information relevant to the decision in question; believing that information; and the ability to weigh the information in the balance to arrive at a choice (Tan & Jones, 2001). Voluntariness refers to consent occurring in the absence of undue coercion or misrepresentation. The question of wilful granting of permission is the typical legal standard by which this is measured (Prout & Brown, 1999).
- Consent obtained pursuant to these disclosures will be "express consent." "Apparent consent" and "consent implied by law" are two other types of consent. In "apparent consent," all parties act as if consent was given, when in actuality none was formally stated. "Consent implied by law" comes into play in questions of competency for clients most frequently seen by mental health professionals in a hospital or inpatient setting (Prout & Brown, 1999).
- Less uniform are rules related to abortion, which may require either parental notification or judicial approval in circumstances where parental notification is not desirable or possible.

Objective 3: Be aware of the barriers to and tips for communicating with adolescents

Activities

Activity 3.3:

Divide the participants into small groups of 4-5 people. Select an individual as adolescent and an interviewer in each group, and the other group members as observers.

Plan the role-play and ask the interviewer to listen to the adolescent without eye contact, or to sit either closer to or farther away from the adolescent than is the interviewer's custom, or to do both. The interviewer should note his/her own feelings in this process. The observers give feedback to the interviewer.

Communication barriers

Quill (1989) broadly defines communication barriers as anything that blocks effective communication. As no two individuals are identical in terms of background, experience, mood and expectations, the process of coming to know one another involves a series of potential roadblocks as differences are identified and worked through. When the sense of trust, openness, curiosity and respect needed to engage in this process does not exist, its absence can impair the three functions of the interview: data gathering, establishing a therapeutic relationship and implementing a treatment plan.

Blocks to communication

- Socialising
- Giving unrestricted and sometimes unsolicited advice
- Offering premature or inappropriate reassurance
- Giving too much or too frequent encouragement
- Defending a situation or opinion
- Using stereotyped comments or clichés
- Limiting expression of emotion by asking directed, closed-ended questions
- Interrupting and finishing the person's sentence
- Talking more than the interviewee
- Forming prejudged conclusions
- Deliberately changing the focus

Signs of information overload

- Long periods of silence
- Wide eyes and fixed facial expression
- Constant fidgeting or attempting to move away
- Nervous habits (e.g., tapping, playing with hair)
- Sudden disruptions (e.g., asking to go to the bathroom)
- Looking around
- Yawning, eyes drooping
- Frequently looking at a watch or clock
- Attempting to change topic of discussion

Four steps of barrier resolution (Quill, 1989) Goals

1. To explore and define the existing problem before proceeding further, in order to prevent a widening of the gulf between you and your adolescent.
2. To help create a therapeutic bond based on deeper understanding of their commonness and differences.

Step 1: Defining the barrier
• The process of openly and non-judgmentally exploring the source of the barrier is the first step toward overcoming it. • The clinical reasoning process of analysing the data, generating hypotheses and testing them during the interview with the patient is an excellent approach to defining implicit barriers. • The first level of hypothesis testing is for the health care professional to consider whether the problem is primarily hers, primarily the patient's, or a result of their interaction. • The most explicit way to test a hypothesis, particularly if it suggests that the problem is the patient's or a result of the interaction is to share it with the patient. • By exploring the patient's beliefs and sharing her own, the health care professional tests the hypothesis. **More**
Step 2: Exploring the barrier
• To open up the hypothesis-generation process to the patient, this step requires that the health care professional openly share what he is sensing as indirect evidence of a barrier. • Ask for the patient's assistance in hypothesis generation and evaluation. ("I'm sensing you are unhappy with the direction I am proposing, but I am not sure why. Perhaps you could help me understand what is going on.") • When the list of possibilities is complete, the patient and health care professional then try to narrow it down.
Step 3: Communication strategies
• Common strategies used in communication are recognition, acknowledgment, exploration, empathy, legitimation. • When the patient is aware of the barrier and wonders how the health care professional will handle it, the health care professional's willingness to openly acknowledge its presence and explore the surrounding feelings can be very meaningful. • The more the patient feels that his or her perspective has been heard and understood, the greater the potential for a therapeutic relationship. • When strong feelings emerge in the exploration, the health care professional can then express empathy and legitimation, thereby further creating an environment of shared trust. • Empathy is an attempt to put oneself in another's shoes and feel the way they feel. • Legitimation implies the health care professional's power as an authority figure and a person knowledgeable about medical matters to validate a feeling or reaction as reasonable and appropriate. ("I can certainly understand how you would feel that way. I think it's a very normal reaction.")

Step 4: Negotiation strategies
• Separate people from the problem • Clarify the conflict • Brainstorm about possible solutions • Focus on common interests, not positions • Use objective criteria where possible • Invent new solutions where both parties gain

Tips for counselling

- Encourage adolescents to share their ideas and concerns with healthcare professionals.
- When they reach an unstable state due to noncompliance with treatment recommendations, encourage discussion of what happened rather than reprimanding.
- Teach and encourage use of problem-solving skills related to their illness.
- Ask questions such as "What do you think you would do if…?" or "What do you think would happen if…?"
- Encourage adolescents to ask you the same kinds of questions.
- Refer adolescents to mental health services when
  1. They seem overwhelmed with emotional issues related to living with a chronic illness;
  2. A pattern of non-compliance continues;
  3. Development regresses;
  4. Overly dependent behaviour continues; or
  5. They withdraw from or give up interest in age-appropriate activities.

More

Defining the barrier

For example: Consider an urban health care professional meeting with a rural patient who seems to be reluctant to talk. The health care professional senses that the patient's beliefs about causality may be different from her own and that the patient is afraid to discuss his real fears because of the cultural barrier. "I wonder what your ideas are about why this is happening to you?" If the patient responds with a verbal-nonverbal mismatch, the health care professional might push further by explicitly asking, "Some of my patients have had experiences with voodoo and I was wondering if that has crossed your mind?"

A cultural identity integration model for gay adolescents

For example, if a 17-year-old African American male presents with intense distress about his first awareness of having "sexual thoughts and attractions to other males", this would suggest Erickson's stage of identity confusion. Thus, an appropriate intervention might be recommendation for individual counselling. In counselling, initial dialogue needs to centre on "sexual thoughts and attractions", not an assumed "gay identity". Again, this young man is in the very early process of self-exploration; thus, the counsellor needs to avoid labelling or pigeonholing.

Each adolescent possesses multiple levels of cultural identities, such as those of gender, race, ethnicity, socioeconomic status and religion / spiritual orientation. These indices form a unique "cultural identity matrix" for each adolescent. It is a process model for dynamically and at times simultaneously assessing aspects of the male adolescent's cultural identity matrix.

This model suggests that two focuses be adopted. The first focus, a microscopic view, attends to the cultural identity anchor (sexual orientation) most important to the gay male's present functioning or concern. In this process, the gay male sets the agenda and guides the counsellor's decisions about appropriate interventions. In selecting these interventions, however, the counsellor needs to critically assess the particular identity "status" (i.e. sexual orientation) that dominates the gay male's current worldview.

Interventions for supporting gay males

- During individual counselling, it may be helpful to explore gay identity development processes with the adolescent. Providing a socio-cultural context about gay male experiences will increase the adolescent's level of self-understanding and "normalise" this potentially gay male's experience.

- The counsellor needs to assess for internalised homophobia and assist in determining what societal influences lead to such beliefs. The adolescent may benefit from a host of techniques of interventions, such as cognitive restructuring of negative self-talk/self-image about being gay, assertiveness training in confronting heterosexism/homophobia, and social skills training via role plays for building friendships, establishing romantic relationships, coming out, and/or establishing support networks as a newly self-identified gay male.

- More importantly, an exploration of the gay male's cultural identity matrix will also help him to acknowledge and integrate all aspects of his cultural identity in relation to his sexual orientation identity.

- It is also crucial to consider other cultural facets of identity in suggesting role models. Racial, ethnic, religious/spiritual, and class issues may need to be considered in finding a potential role model. The counsellor's responsibility is to ask the client what type of role model he might need.

Objective 4: Be able to illustrate a counselling model with steps which are culturally sensitive in terms of communication and counselling

Activities

Activity 3.4:
"Cultural practices relating to sex, and STI infections among teenagers and adults."

Divide into small groups; each group discusses how culture influences sexual encounters, partnership(s) and consequences

Culturally responsive counselling

Informed Consent

Cultural competency is defined as the ability to understand and work with adolescents whose beliefs, values and histories are significantly different from one's own, and include elements of awareness, knowledge and skill.

There are three main competences: language competence, cultural sensitivity and specific cultural knowledge.

- Language is a key component of culturally competent communication, but viewed as secondary to knowledge and attitudes. It is important to know something about the health beliefs, expectations, folk treatments and alternative medical practices within the population in order to deliver good care.
- Failure to pay attention to cultural differences can lead to misdiagnosis, lack of cooperation, poor use of health services, and adolescent alienation and mistrust.
- You should have some awareness of their own cultural background, cultural heritage, and that which has contributed to their values, beliefs, attitudes, and opinions.
- It is important to take an introspective look at one's own personal cultural biases, prejudices, and stereotypes. Recognising and acknowledging these perceptions and attitudes are the first step toward increased sensitivity to others.
- To heighten awareness, pay attention to your behaviour and the level of comfort you experience when interacting with someone who is culturally different from you.

Adopt from WHO (2009). WHO Adolescent Job Aid. WHO (pp. 12-13)

Sexual and reproductive health assessment

Here is an example of how a health worker may do a sexual and reproductive health assessment.

Menstrual history

- Have your periods started yet? If so, how old were you when your periods started?

Pain during the periods

- Do you have pain with your periods?
- Does the pain prevent you from carrying out your daily activities?
- What do you do to ease the pain?

Excessive bleeding during the periods

- How many days do your periods last when they come?
- How many pads (or equivalent) do you use a day?

Regularity of the periods

- Are your periods regular? Do your periods come at the same time every month?
- How many days are there normally between your periods?

Knowledge about sexuality

- Have you learned about sexuality at school, at home or elsewhere?

Note: Probe to find out whether the adolescent is knowledgeable about basic anatomy and functioning, menstruation, pregnancy and contraception, and sexually transmitted infections. Do this using questions tailored to the age, level of development and circumstances of the adolescent.

Sexual activity

- Depending on the context, ask whether their friends have boyfriends/girlfriends, and then whether they do so themselves.
- Again depending on the context, ask whether their friends have had sex, and then whether they have done so themselves. (Be aware that the word "sex" may mean different things to different adolescents. Probe about penetrative sex, e.g. "Does he touch your genitals only?" and "Does he put his penis in your vagina/mouth?")

Pregnancy and contraception

- Do you know how one could get pregnant?

- Do you know how one could avoid getting pregnant?
- Are you currently trying to get pregnant?
- Are you currently trying to avoid getting pregnant?
- If so, what do you do to avoid getting pregnant?
- Do you know about contraceptive methods?
- If so, do you use any contraceptive method?
- Have you had sex in the last month?
- Is your period delayed? Have you missed a period?
- Do you have any of the following symptoms of pregnancy: nausea or vomiting in the morning, and swollen and sore breasts?
- When was the last time you had sex?

If sexually active... **Sexually transmitted infections**

- Do you know what a sexually transmitted infection is?
- Do you do anything to avoid getting a sexually transmitted infection?
- Do you know about condoms? Do you use them when you have sex? If so, do you use them always? If not, why not? Where do you get condoms?
- How many sexual partners have you had in last three months?
- Have you ever had an infection: genital sore, ulcer, swelling or discharge?
- If so, have you received any treatment for this?

Guidelines to aid professionals in providing a culturally affirmative environment include the following (Herring, 1994b, 1997a)

1. Address openly the issue of ethnic relationships rather than pretending that no differences exist. The client will perceive the helper as sensitive and aware of the tensions, as well as being open to discussing them without defensiveness.

2. Evaluate the degree of acculturation of the client. The helper can use cues from dress, family and tribal involvement, friendship patterns, body language, and degree of eye contact.

3. Schedule appointments to allow for flexibility in ending the session. Traditional Natives prefer open-ended sessions to ensure closure to the presenting problem without time constraints.

4. Be open to allowing other family members to participate in the counselling session. Perhaps sessions can be held in the home environment or, when working on a reservation, in the helper's car. Consultations with healers and elders should be accepted if they are requested.

5. Allow time for trust to develop before focusing immediately on deeper feelings. The helper should allow time to "warm up", talking about common interests or other neutral topics, before focusing on counselling issues. The first session should be extended.

6. Use helping strategies that elicit practical solutions to problems. The helper can take an active role in "joining" with the client to work together to solve a problem. Nondirective approaches, however, may allow self-exploration and self-generated goals. A blend of techniques using myth and metaphor may be considered as an alternative to straight talk-therapy.

7. Maintain eye contact as appropriate. Even if the client avoids eye contact (as a culturally appropriate behaviour), the helper may maintain eye contact (without staring).

8. Respect the uses of silence. Silence may signal the onset of a disclosure or the processing of deep thought. Non-productive silence, or "waiting out the client", is not recommended.

9. Demonstrate honour and respect for the client's cultures(s). Helping professionals need to be very aware of their own values having an impact. A strong emotional response (either positive or negative) to the client or session content indicates that this is probably the case.

10. Maintain the highest level of confidentiality. Native communities are extremely close. If confidentiality is betrayed, this will become known and destroy the helper's credibility.

More

IV. Summary

Communication, the most important skill health care professionals must possess in the care of adolescents and young adults, has verbal, nonverbal and abstract components. To effectively establish a setting for communication, health care professionals must make an appropriate introduction, clarify their role and the purpose of the interview, and ensure privacy and confidentiality. When communicating with parents, health care professionals need to encourage parental involvement, listen carefully, use silence, and be empathic.

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VI. Appendix 3.1

- The check-list for counselling skills

Part I: The Process of Relating
1. The counsellor maintained eye contact with the client. Yes No N.A.
2. The counsellor's facial expressions reflected the mood of the client. Yes No N.A.
3. The counsellor demonstrated some variation in voice pitch when talking. Yes No N.A.
4. The counsellor used intermittent one-word vocalisations ("mm-hmm") to reinforce the client's demonstration of the goal-directed topics or behaviours. Yes No N.A.
5. The counsellor made verbal comments that pursued the topic introduced by the client Yes No N.A.
6. The client pursued the topic introduced by the counsellor Yes No N.A.
7. A clear and sensible progression of topics was evident in the counsellor's verbal behaviour; the counsellor avoided rambling. Yes No N.A.
8. The counsellor made statements that reflected the client's feelings. Yes No N.A.
9. The counsellor verbally stated his or her desire and shared his or her own understanding. Yes No N.A.
10. Several times (at least twice), the counsellor shared his or her own feelings with the client. Yes No N.A.
11. At least nine times during the interview, the counsellor provided specific feedback to the client. Yes No N.A.
12. The counsellor encouraged the client to identify and discuss his or her feelings concerning the counsellor and the interview. Yes No N.A.
13. The counsellor voluntarily shared his or her feelings about the client and the counselling relationship. Yes No N.A.
14. The counsellor expressed reactions about the client's strengths and/or potential. Yes No N.A.
15. The counsellor made responses that reflected his or her liking and appreciation of the client. Yes No N.A.

Part II: Assessment
1. The counsellor asked the client to provide basic demographic information about himself or herself. Yes No N.A.
2. The counsellor asked the client to describe his or her current concerns and to provide some background information about the problems. Yes No N.A.
3. The counsellor asked the client to list and prioritise problems. Yes No N.A.
4. For each identified problem, the counsellor and client explored the – affective dimension of the problem. Yes No N.A. – cognitive dimension of the problem Yes No N.A. – behavioural dimension of the problem Yes No N.A. – interpersonal dimension of the problem. Yes No N.A. – intensity of the problem (frequency, duration, or severity). Yes No N.A. – antecedents of the problem. Yes No N.A. – consequences and payoffs of the problem. Yes No N.A.
5. The counsellor and client discussed previous solutions the client had tried to resolve the problem. Yes No N.A.
6. The counsellor asked the client to identify possible strengths, resources, and coping skills the client could use to help resolve the problem. Yes No N.A.

Part III: Goal-Setting
1. The counsellor asked the client to state how he or she would like to change his or her behaviour. ("How would you like for things to be different?") Yes No N.A.
2. The counsellor and client decided together upon counselling goals. Yes No N.A.
3. The goals set in the interview were specific and observable. Yes No N.A.
4. The counsellor asked the client to state orally a commitment to work for goal achievement. Yes No N.A.
5. If the client appeared resistant or unconcerned about achieving change, the counsellor discussed this with the client. Yes No N.A.
6. The counsellor asked the client to specify at least one action step he or she might take toward his or her goal. Yes No N.A.
7. The counsellor suggested alternatives available to the client. Yes No N.A.
8. The counsellor helped the client to develop action steps for goal attainment. Yes No N.A.
9. Action steps designated by the counsellor and client were specific and realistic in scope. Yes No N.A.
10. The counsellor provided an opportunity within the interview for the client to practise or rehearse the action step. Yes No N.A.
11. The counsellor provided feedback to the client concerning the execution of the action step. Yes No N.A.
12. The counsellor encouraged the client to observe and evaluate the progress and outcomes of action steps taken outside the interview. Yes No N.A.

Part IV: Strategy Selection and Implementation
1. The counsellor suggested some possible strategies to the client based on the client's stated goals. Yes No N.A.
2. The counsellor provided information about the elements, time, advantages, and disadvantages of each strategy. Yes No N.A.
3. The counsellor involved the client in the choice of strategies to be used. Yes No N.A.
4. The counsellor suggested a possible sequence of strategies to be used when more than one strategy was selected. Yes No N.A.
5. The counsellor provided a rationale about each strategy to the client. Yes No N.A.
6. The counsellor provided detailed instructions about how to use the selected strategy. Yes No N.A.
7. The counsellor verified whether the client understood how the selected strategy would be implemented. Yes No N.A.

Part V: Termination and Follow-Up
1. The counsellor and client engaged in some evaluation or assessment of the client's attainment of the desired goals. Yes No N.A.
2. The counsellor and client summarised the client's progress throughout the helping process. Yes No N.A.
3. The counsellor identified client indicators and behaviours suggesting that termination was appropriate. Yes No N.A.
4. The counsellor and client discussed ways for the client to apply or transfer the learning from the helping interviews to the client's environment. Yes No N.A.
5. The counsellor and client identified possible obstacles or stumbling blocks the client might encounter after termination and discussed possible ways for the client to handle these. Yes No N.A.
6. The counsellor discussed some kind of follow-up plan with the client. Yes No N.A.