

Reports

Crucial Conversations: Discussing Diagnosis and Treatment with Adolescents

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Do we need to talk more? Psychiatrists are often taught to listen more than they speak and to welcome silence into their therapeutic interactions. Given our reliance on the patient's narrative and its unspoken undertones, it makes sense that our interviews often begin with open-ended questions and proceed with limited interjections or reflections on our part. I wonder, though, if we are not being vocal enough after the information-gathering concludes in sharing our formulations with patients and explaining our thought processes as we plan and prescribe treatment. Despite the evidence that providing psychoeducation to patients and families contending with mental illness improves outcomes, many providers forego the opportunity to engage in it, perhaps due to time constraints, lack of reimbursement, or inadequate training and skills development in the practice.¹ We need to talk more, and yet, when we *do* engage in psychoeducation, might we be talking too much? Explaining symptom constellations and relaying the evidence base for proposed interventions can easily veer toward a one-sided lecture, bypassing the opportunity for dialogue and collaborative connection with patients.

Perhaps we need to talk *differently*. Psychiatry is a field where disorders of the brain and the mind intersect, and where idiosyncrasies and pathology are complexly intertwined. A patient's sense of self and their experience of the world may be strongly impacted by a diagnostic label.² Eliciting the patient's perspective on their illness, its meaning for them, and reflecting the medical understanding of the experience they relay—conversation rather than instruction—can be simultaneously informative and empowering. Nowhere is this open dialogue more important than in the treatment of adolescents—a group already grappling with questions about personal identity and life trajectory. Given that young people are often deeply enmeshed in peer-to-peer discussions about mental health—both in their direct interactions with one another and more globally via social media—the medical voice of the physician must remain active in the discourse.³

In my role as a pediatric consultation-liaison psychiatrist at a busy children's hospital, I am struck by the number of adolescent patients I encounter who are fully engaged

in mental health care—seeing a therapist, taking medication, or even recently discharged from an inpatient psychiatric admission—and yet respond with “I don't really know” when asked about their psychiatric diagnoses or what their medication is meant to target. They are often highly intelligent and are clearly capable of understanding psychological concepts, as well as co-piloting their own health care. In fact, many of these same patients can tell me high-level details about their complex medical conditions, the treatments recommended, and the prognosis they might expect. So, why should there be so much mystery regarding their mental health?

The opposite scenario is also concerning, as youth sometimes endorse diagnoses that simply don't fit with the clinical picture, and yet they embrace these conditions as absolute truth—sometimes even making these conditions integral to their sense of self. Some psychiatric terms have become so colloquialized that it can be difficult to discern what has been officially diagnosed in an individual from what is merely part of a cultural vernacular. Common examples include: “my OCD is flaring;” “it gave me PTSD;” “I get manic.” Such interjected jargon can be challenging for clinicians to interpret. While social media has done wonders for normalizing mental illness and helping individuals to feel less alone in their journey, alarms have sounded about the romanticizing or overgeneralizing of psychiatric conditions as en vogue personal descriptors, whether they fit clinically or not. TikTok has received attention in both mainstream media and the scientific literature for playing a role in recent trends of self-diagnosis of tics, borderline personality disorder, and dissociative identity disorder among youth.⁴⁻⁶ Adolescents are positioned precariously amidst a field of competing discourse about health and wellness that may simultaneously comfort and misinform.

Complicating the picture further is the relative arbitrariness that is sometimes attributed to psychiatric diagnoses as compared to medical ones. Patients can understand lab abnormalities and radiographic reports as concrete data points. Even medical conditions that rely solely on physical exam findings or patient-reported symptoms may seem more definitive than psychiatric conditions diagnosed the



same way. Patients may struggle to understand why a certain psychiatric diagnosis is given over another and why a particular treatment is indicated. Worse, the broader stigma associated with mental health conditions may overwhelm patients or may even dissuade them from seeking or continuing care at all. It's understandable that patients might seek out any resource they can find to provide clarity, support, and relief for what ails them, even if from inaccurate sources.

With all this in mind, I have started asking my medically hospitalized adolescent patients what they understand about their new or existing mental health diagnoses and where they turn for more information. Many patients tell me that they feel left out of discussions with their psychiatric providers simply because their parents have a louder voice in the room, as if their status as the patient and soon-to-be independent agent of their own health care has been forgotten. Some patients say that discussions feel incomplete, for example, that they're told they have "depression" or "anxiety" without elaboration. I can imagine that reading a phrase like "Major Depressive Disorder, Recurrent, Severe without Psychotic Features" on discharge paperwork might be unsettling without some further explanation of terms. Most disappointingly, many patients say they don't know what to expect with their mental health as they move into their twenties and beyond. Will it get better or worse over time? Will they ever come off medication? Most patients tell me they turn to the internet to answer the questions their providers did not.

Intentional and transparent discussion may go a long way here. I've found it helpful to institute a playful clinical strategy or "rule" with adolescent patients, designed to promote their autonomy and encourage engagement in psychoeducation: If the patient is at least 13 years old, they must be able to pass a "pop quiz" about their personal mental health care. While minors cannot legally consent to most treatments, the American Academy of Pediatrics advises that patients should "participate in decision-making commensurate with their development."⁷ Some studies assert that age 14 marks an important cognitive milestone for rational decision-making, while others caution against a traditional age-based guideline, highlighting the importance of balancing cognitive and socioemotional development in assessing decisional capacity.⁸ I use 13 years of age for simplicity, as this age represents the chronological transition into the teen years. It's also worth noting that more than two-thirds of children have their own smartphone by age 13 and nearly half of children are active on social media at that age.⁹

The "pop quiz rule" has worked well for spurring conversation with patients and can even strengthen rapport. I note from the outset that the goal is for the adolescent to understand and articulate three general aspects of their care:

1. **What is going on?** What psychiatric diagnoses have you been given? Do you agree that they fit you? If not, how do *you* conceptualize what is going on? Are there any other diagnoses you've wondered about and would like to discuss?
2. **What are we doing about it?** What are the names and dosages of the psychiatric medications you're taking and what are they meant to do for you? What non-medication treatments have been recommended (e.g., if cognitive behavioral therapy is planned, can they explain specifically what that is)? Are there other treatments you've wondered about and would like to discuss?
3. **What happens next?** What might your condition and treatment look like one year from now? Five years from now? Ten?

I repeat and review these questions frequently, striving to prevent these important take-home points from getting lost in one-off conversations and, hopefully, decreasing the standard "I don't know" responses.

Sometimes this practice leads to deep discussions about the benefits and limitations of the Diagnostic and Statistical Manual of Mental Disorders and the humility of our field (or lack thereof, perhaps) in recognizing what we still don't know and might do better not to pathologize. Sometimes we talk about the dynamic nature of mental health, and how symptoms, diagnoses, and treatment recommendations might change over time, especially as the brain continues to develop and life circumstances play out. Sometimes we dive into philosophical discussions about meaning in illness or how the psychological state influences self-understanding and identity formation. Almost always, these are impactful interactions for me as a clinician, reminding me how insightful young people can be and reaffirming the privilege I feel in playing even a small part in their personal growth journey.

Certainly, caution must be given regarding what to share with adolescents in some cases, especially those involving developmental or cognitive concerns, acute psychosis, catatonia, or mania. And parents and caregivers should by no means be excluded from these important conversations—in fact, they are instrumental facilitators in helping adolescents understand themselves and take primary responsibility for tending to their own wellbeing into adulthood. Ultimately, being more deliberate in conducting open and thorough discussions *with the patient directly* about their diagnosis and treatment feels to me like an ethical imperative. We can and should be a trusted voice amidst the many.

Take Home Summary

Adolescents' health literacy is often informed by peer communication and social media, rather than direct discourse with physicians. With open discussion, psychiatrists can impart thoughtful psychoeducation and counter disinformation, preparing adolescents to assume responsibility for their health care into adulthood.

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