

Minors' Consent to Treatment: A Developmental Perspective

This article discusses the cognitive and behavioral characteristics of minors in relation to the question of competence to consent to treatment. The legal standard (knowing, intelligent, and voluntary) that is used to judge the effectiveness of consent is translated into psychological concepts, especially cognitive abilities. Then a review of developmental psychological research examines these concepts as they relate to minors' abilities to satisfy the legal standard. It is suggested that cognitive developmental stages associated with ages below 11–13 years might exclude such minors from meaningful consent. In addition to cognitive considerations, certain results suggest that the tendency toward deference in early adolescence is so normative that capacity for voluntary consent is questionable through age 14. But existing evidence provides no psychological grounds for maintaining the general legal assumption that minors at age 15 and above cannot provide competent consent. Suggestions are made for further developmental and applied research focused on critical questions in the area of a minor's ability to consent.

In recent years many attempts have been made to raise the consciousness and conscience of mental health professionals regarding the rights of minors (Braginsky & Braginsky, 1971; Ellis, 1974; Foster & Freed, 1972; McGuire, 1974; Rodham, 1973; Ross, 1958, 1966, 1974). Especially with regard to a general principle of right to self-determination, we are beginning to take seriously the idea that minors are entitled to have some form of consent or dissent regarding the things that happen to them in the name of assessment, treatment, or other professional activities that have generally been determined unilaterally by adults in the minor's interest (e.g., see Koocher, 1976b).

Our interest in respecting the self-determination rights of minors is far more in evidence than our knowledge of minors' capacities to assume the roles that self-determination rights require. The task is complex: We need to examine systematically which minors are capable of assuming what decision-making roles in which treatment situations with what consequences for the minor, the family unit, the professional, and society. Our own attempts to respond in an ethical and therapeutic way to minors in treatment require such information, lest in our zeal we burden some minors with decisions that they cannot make intelligently (sometimes to their detriment) or inadvertently deny to some the opportunity to make decisions of which they are fully capable.

In the meantime, lawmakers are deciding such issues without the guidelines that research in the aforementioned areas might provide. Because the courts and legislators have not always been responsive to behavioral science data (Bersoff & Prasse, 1978), mere philosophical propositions about minors' rights will not carry much weight with lawmakers who must face the complex practical and social issues that arise in resolving legal questions in legislatures and courts (e.g., see Institute of Judicial, 1977, p.2).

Our purpose in this article is to examine what psychology can offer in the formulation of legal and ethical policy regarding minors' abilities to consent to treatment. After describing the types of consent that have concerned those who work with children, we examine the manner in which the courts and legislatures have arrived at decisions limiting consent to treatment by children. Then we examine developmental psychological research regarding abilities that would seem to be required to meet a legal standard for competent consent.

TYPES OF CONSENT

Mental health and law literature contains references to three distinctly different sorts of consent by minors. These are worth reviewing briefly, since communications between professionals are frequently clouded by a failure to make these distinctions.

First, some have argued that certain broad classes of minors should be allowed by law to consent to treatment *independent of their parents' consent or knowledge*. Present statutes often allow minors to consent independently to certain medical services¹ (Pilpel, 1972; Wilkins, 1975; Note: The minor's right to abortion, 1974), sometimes without an age specification, and with recognition of the minor's right (and the professional's consequent responsibility) not to disclose the treatment contract to parents except in unusual circumstances. Although these statutes usually refer to specific medical treatments, at least two states also allow minors to consent independently to "diagnosis and consultation" concerning "mental or emotional disorder" (*Alabama Code*, 1973; *Maryland Statutes Annotated*, 1973). These latter statutes might become more common in the future as a result of recent proposals by the Juvenile Justice Standards Project (Institute of Judicial, 1977; but note that the proposal recommends requiring parent notification after three sessions).

In spite of these statutes, minors have generally been viewed as incapable of making decisions about their own treatment, so that independent legal consent for most purposes has been denied to them, primarily for reasons of their own protection as well as that of their parents. This general presumption of minors' incapability to consent to treatment is being questioned in mental health literature (Rosenberg & Katz, 1972;

¹ Among these services in various states are treatment for drug dependency and venereal disease, abortion, contraception, and sexual information. In addition, many states provide for classes of "emancipated minors" and "mature minors" to be allowed to consent independently to medical treatment.

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Worsfeld, 1974) and in the courts.² But it must be realized that as long as parents are held liable for financial debts incurred by their children, legal decisions about independent consent by minors will require more than a mere weighing of the capacities of minors to provide meaningful consent.

The second issue is both legal and ethical in nature. Should minors be provided by law, or be provided through ethical principle, the power to dissent when their parents have consented to their treatment? In other words, should minors have a consent that they can withhold, thereby having the power to nullify parental consent? Such dissent by a minor was upheld in *In re Smith*,³ for example, when parents sought to require their daughter, who refused to consent, to submit to a therapeutic abortion. Minors' dissent to parents' prior consent was upheld in recent cases in which minors who objected to having been "voluntarily" committed to mental hospitals by their parents were seen to have a right to a board review regarding their commitment (*In re Lee and Wesley*⁴; *Melville v. Sabbatino*⁵). But it is generally true that minors' dissent to treatment is not recognized.

A minor's right to dissent has recently been discussed as an ethical issue in mental health practice, both in treatment (Koocher, 1976a) and in research participation (Commission for the Protection of Human Subjects, 1977; Keith-Spiegel, 1976). In general, there is growing support for such a right, especially when the proposed treatment is of a nonessential type or when the benefits are questionable. But it is recognized that certain minors' diminished capacities to provide meaningful consent might sometimes present such risk to the physical or psychological welfare of the minor as to offer a compelling reason for denial of the right in various circumstances.

Third, some mental health professionals refer to a minor's right to consent primarily in the sense of a "right to know" or a "right to participate" when their treatment is being decided, not in the sense of a contract or veto power. Here the issue of a minor's competence is not as critical as in the former cases, since what is proposed for professionals is in the form of a therapeutic and humanistic attitude (LoCicero, 1976), not an ethical responsibility (or legal obligation) to "show cause" when a child's consent/dissent is overridden by compelling interests of the parent, society, or the minor's welfare.

In the remainder of this article, we focus primarily on the first two types of consent, in which legal standards are at issue.

² For example, in *Planned Parenthood of Missouri v. Danforth*, 428 U.S. 52 (1976), the Supreme Court ruled that the "state may not impose a blanket provision . . . requiring the consent of a parent or person *in loco parentis* as a condition for abortion of an unmarried minor during the first 12 weeks of pregnancy" (p. 74).

³ *In re Smith*, 16 Md. App. 209, 295 A. 2d 236 (1972).

⁴ *In re Lee and Wesley*, Nos. 68J(D) 1362, 66J(d) 6383, and 68J 15805, Cir. Ct. of Cook County, Cnty. Dept., Juv. Div., Ill. (February 29, and August 24, 1972).

⁵ *Melville v. Sabbatino*, 30 Conn. Sup. 320, 313 A. 2d 886 (1973).

LEGAL STANDARDS FOR CONSENT

Having considered the types of consent, let us examine the legal definitions of consent. These provide a starting point for addressing the central question of this article, that is, can certain broad classes of children be viewed as competent to provide consent to treatment? It can be seen that what is provided by law is a very general standard, not definitions that are easily translated for purposes of judicial or clinical decision making.

The legal definition of *consent* requires that an individual's permission be given knowingly, intelligently, and voluntarily. The meanings of these terms are not spelled out in case law, but two major considerations emerge in legal discussions of the standard: (a) the person must be *aware* of the information relevant to the consent; and (b) the person's *assent* must be a proactive consequence of the "will," that is, must constitute something more than mere acquiescence (Waltz & Scheuneman, 1970).

Generally, courts that have been faced with consent disputes have focused upon the adequacy of the professional's communications to the patient—that is, whether the proposed treatment, the benefits and risks, and the consequences of the alternatives, including no treatment at all, were clearly presented to the patient (e.g., see Plante, 1968). But in addition, statutes and a growing number of cases have dealt with questions of the psychological capacities of minors to provide knowing, intelligent, and voluntary consent even when the general requirement to inform has been met.

Because the law does not generally recognize minors as competent to consent to treatment, possible exceptions to the presumption of incompetence require the application of a standard defining a *mature minor*—for example, a minor of "sufficient intelligence to understand and appreciate" the consequence of the proposed treatment (*Mississippi Code Annotated*, 1971). Case law has provided no clear guidelines regarding how such judgments about "sufficient intelligence" should be made (for a review of cases, see Wilkins, 1975; Institute of Judicial, 1977). Courts have most often recognized mature minors when the age was 15 or above (Pilpel, 1972), but one can find rulings of maturity below age 15 in various cases. Such variations appear to be due in part to a lack of consistent criteria for weighing the maturity of a minor. But they have also been the result of weighing the competence of minors in widely different treatment and consent circumstances.

Some statutes seem to imply that minors below a specific age are not viewed as competent to provide meaningful consent, since statutes allowing independent consent by minors for specific types of treatment often specify minimum ages (for various purposes, usually ages 12, 14, or 16). The statutory ages employed, however, are different for various treatment purposes even within a given state, and they vary considerably from one state to another even for a specific type of treatment. For example, various states allow minors to consent to treatment related to pregnancy without parental consent or knowledge; but in different states, the minimum age allowances are 12, 14, and 15. The ages at which minors may consent to treatment for drug depen-

gency range from various early adolescent ages to no minimum age at all. Clearly, these ages have been arrived at from a consideration of the welfare of both society and the minor in regard to specific medical problems and treatments, but not with a clear rationale regarding the competencies of classes of minors.

In summary, neither statutes nor case law provides clear guidelines for judging the competence of a minor to provide meaningful consent, especially with regard to the types of nonmedical treatments that concern many psychologists. The professional in law or psychology who seeks such guidelines must return to the general standards requiring that consent be made knowingly, intelligently, and voluntarily by a minor who has "sufficient intelligence" to understand and appreciate the consequences of the decision to be made. Since these terms are defined only ambiguously in law, it is necessary to consider how they can be construed in a manner that is consistent with the intent of the law but that also provides a conceptual step toward clearer judgments in mental health and law practice.

Children's Capacities for Meaningful Consent

The terms *knowingly*, *intelligently*, and *voluntarily* are not easily defined or separated. *Black's Law Dictionary* (Black, 1951) treats the three terms as though they are synonyms in legal usage, as do many judges. The same is true in psychological conceptualizations of knowledge and intelligence, since what is known must be inferred either from what is recalled or from behavior that reflects a person's knowledge, both of which are associated with intellectual functions.

In the following analysis, we assume that the law has not been redundant in employing these three terms but that they have been used to refer to interrelated mental states or processes, each of which represents somewhat different conditions. We suggest psychological constructs that may be conceptually related to each of the three terms in the legal definition. Then we examine selected developmental psychological theories and research findings that address children's capacities with regard to the psychological constructs in question.

KNOWING CONSENT

Psychological Definition

In the context of consent situations, we suggest that *knowing* can be interpreted as one's understanding of the semantic content of the information that is provided by the professional. That is, the patient *knows*, if he/she understands the consensual meanings of the words and phrases of the message. In this sense, *knowing* can be defined operationally as the match between the information given to the patient and the patient's own paraphrase of that of which he/she has been informed. The adequacy of the match depends in part, of course, on the way in which the information is communicated

to the patient. But certain capacities of the patient are expected to influence the match as well—for example, general intellectual capacity, the patient's familiarity with the content area, and the patient's linguistic background.

Developmental Considerations

We have practically no systematic information regarding children's understanding of the meanings of terms that are likely to arise in situations in which consent to treatment is sought. For example, we do not know how children of various ages, levels of intelligence, or past experience conceptualize the activities that therapists propose to them (e.g., psychological testing, psychotherapy, or counseling). Similarly, we know little about their understanding of ethical and legal concepts (e.g., confidentiality, privilege, law, or rights). Grisso and Manoogian (in press) found that only 28% of 11–16-year-olds in a juvenile court detention setting described *rights* as entitlements that are protected and not merely as things that one is allowed to do or to have. Similarly, only 27% of middle school children in a study by Tapp and Kohlberg (1971) understood *rule* as serving a rational and beneficial purpose; a greater percentage offered a prescriptive or prohibitive perception of the word. This study offered several examples of the more general observation that an understanding of legal–ethical terms follows a relatively predictable, developmental sequence with increasing maturity.

Dollinger and Thelen (1978) found that 10–11-year-olds were more likely than were high school students to characterize the psychologist as a help giver, and were less likely to associate the psychologist with research and assessment activities. One of their questionnaire items provides a glimpse of the interesting results one might obtain if similar studies assessed children's views of treatment: When asked if psychologists need a couch to do their work, an affirmative answer was given by 50% of elementary school children, 24% of junior high students, and 11% of high school students.

Implications for Competence To Consent

The absence of data of the aforementioned type leaves the professional with no clear guidelines for satisfying even the minor's "right to be informed." The problem is even more critical, however, in relation to questions of minors' competence to provide consent independent of parents or to veto parental consent. In individual cases, the professional may be willing to rely on a minor's satisfactory paraphrase of information that has been provided, as an index of adequate understanding. But certain normative data of this type are needed when the problem is one of formation of policy regarding the competence or incompetence of classes of minors. Clearly there is a need for research regarding minors' understanding of basic terms and concepts related to treatment and consent.

As we noted earlier, one difficulty with examining *knowing* as a separate entity is

that what is *known* is dependent in part upon the cognitive and intellectual capacities of the minor. Such capacities may influence the amount and kind of information about treatments and their consequences that minors can assimilate. These capacities are discussed in the following section.

INTELLIGENT CONSENT

Psychological Definition

The appropriate legal question in weighing whether consent is given intelligently focuses upon the competence of the patient to arrive at the consent decision rationally, not upon others' opinions concerning the advisability of the patient's decision itself. Thus, the appropriate reference is to the cognitive abilities that the patient brings to bear in the assimilation of information and in the *process* involved in using information to arrive at a decision about a proposed treatment. Psychology has found it necessary to conceptualize a wide range of abilities to describe the processes involved in problem solving and decision making. Among those that might influence consent decision making are one's attention to the task, ability to delay response in the process of reflecting on the issues, ability to think in a sufficiently differentiated manner (cognitive complexity) to weigh more than one treatment alternative and set of risks simultaneously, ability to abstract or hypothesize as yet nonexistent risks and alternatives, and ability to employ inductive and deductive forms of reasoning. Although we have not selected these abilities arbitrarily, they certainly do not exhaust the list of possibly important abilities in the consent decision process.

Developmental Considerations

An intelligent consent would seem to require the ability to delay one's response sufficiently to reflect on the information and to allow the employment of available cognitive resources. Reflective, as compared to impulsive, children have been found to ask more mature questions in seeking information (Finch & Montgomery, 1973), to process information more efficiently (McKinney, 1975), and to employ inductive reasoning more effectively (Kagan, Pearson, & Welch, 1966). Each of these abilities, more characteristic of the reflective child, would seem to be prerequisites for providing informed, deliberate consent or dissent. Rohwer (1970) discussed a series of studies by Kagan demonstrating a direct relationship between response latency and age in children. But it is difficult to infer from these data at what age response latency and reflection are sufficient for consent or other decision situations.

Certain important abilities in problem solving have been related to one's perceived locus of control of reinforcements—that is, whether one believes that the consequences of situations are a matter of fate dependent upon external influences or are controlled by one's own decisions (Lefcourt, 1966; Rotter, 1966). Locus of control has been shown to be related to the amount of time one spends reflecting on decisions to be made (Rotter

& Mulry, 1965). In addition, locus of control is related to one's attentiveness and awareness regarding details of problem situations (Lefcourt & Wine, 1969; Seeman & Evans, 1962) and the degree to which one actively attempts to acquire information relevant to decisions to be made (Davis & Phares, 1967). Thus, whether or not one expects to have control over one's fate might mobilize or inhibit one's use of cognitive resources to deal with a consent decision. Developmentally, children below the ages of 12–13 have been shown to be significantly more prone to perceive the locus of control as being external than are children above this age (Distefano, Pryer, & Smith, 1971; Milgram, 1971). Thus, one would expect normative increases in the aforementioned adaptive abilities for successive ages above 12–13 years, and a lesser degree of preparedness to deal with consent situations generally for preadolescent children.

A person's preference regarding treatment prior to contact with a mental health professional may not always coincide with the treatment that the professional subsequently proposes. In order for a person to consider an alternative presented to him/her by someone else (in this case, a professional), the person must have the ability to entertain both the other's and his/her own views as potentially valid, so that a true weighing of views can be made. This capacity involves role-taking skills, or the ability to apprehend the intentions, opinions, beliefs, and emotions of another person (Flavell, 1970), and is negatively related to Piaget's "egocentrism" (Inhelder & Piaget, 1958). Reviewing a number of developmental studies of role taking, Flavell (1970) concluded that substantial capacities in the basic constituents of role taking are probably not attained much before middle childhood or early adolescence. That is, the age range of about 8–11 years is a period of distinctive development, and by the ages of 12–14, many children are surprisingly adept at role-taking skills across a wide range of tasks and problems.

Several of the cognitive capacities that we noted earlier—abstract reasoning, inductive and deductive logical processes, and cognitive complexity—correspond with capacities that Piaget (Inhelder & Piaget, 1958) associated with the emergence of the formal operations stage of cognitive development. First appearing during early adolescence, this stage includes the development of an increased cognitive capacity to bring certain operations to bear on abstract concepts in problem-solving situations.

For example, although a child in the previous stage (concrete operations) can think logically, it is questionable whether prior to the formal operations stage he/she can perform inductive and deductive operations (Piaget's "transformation") or hypothetical reasoning at a level of verbal abstraction that would be represented by many consent situations involving treatment alternatives and risks. Further, emergence of the formal operations stage allows a child to become sufficiently flexible in thinking (i.e., is less bound by Piaget's "centration") to attend to more than one aspect of a problem at once—for example, to entertain alternative treatments and risks simultaneously. Neimark and Lewis (1968), for example, have documented the child's markedly increased ability to solve problems requiring these capacities, during the age period that Piaget suggested for movement from concrete to formal operations (about ages 10–13).

Likewise, Elkind (1966) has demonstrated the markedly increased ability of a 13-year-old, compared to an 8-9-year-old, to consider novel data and to employ logic in the solution of problems.

Do Piaget's stages correspond with age ranges that can be used to decide whether certain classes of children are likely to possess certain cognitive abilities? Developmental theorists clearly and consistently point out that although the stages are invariable in sequence, transition from lower to higher stages is not synonymous with specific ages (e.g., Neimark & Lewis, 1968). This caveat generally includes the observation that even some adults do not achieve the stage of formal operations (Tomlinson-Keasey, 1972), and that among children, the attainment of any given stage might be quite variable concerning age (Keating & Schaefer, 1975; Webb, 1974). In addition, transition stages involving "productive regression," as new cognitive potentials are being refined, often modify or delay the fully functioning appearance of certain stage characteristics (Flavell, 1972).

Nevertheless, Piaget (Inhelder & Piaget, 1958) and subsequent researchers (Elkind, 1966; Neimark & Lewis, 1968; Webb, 1974) have generally noted the age range of 11-13 years as a period for the appearance of thought that is characteristic of formal operations. Although this does not by any means guarantee that all children will have entered this stage by that time, it does suggest that formal operations *prior* to that age period would be relatively rare. For example, Webb (1974) has demonstrated that children who do show accelerated acquisition of concrete operations do not enter the formal operations stage earlier than the expected age range of 11-13 years. This generalization, though it must be offered cautiously, corresponds well with the observations offered earlier regarding age norms for both locus of control and role-taking skills.

Implications for Competence To Consent

This review suggests that generally minors below the ages of 11-13 do not possess many of the cognitive capacities one would associate with the psychological elements of "intelligent" consent. Most of the treatment situations that concern mental health professionals have numerous and subtle consequences, ranging from the costs and benefits of symptom and behavior change to the social consequences of patienthood. Many of these require an examination of long-term as well as short-term probabilities, as well as the weighing of multiple and conflicting circumstances. Most of the evidence reviewed here suggests that most preadolescent minors are not intellectually prepared to deal with such complexities at a level of competence associated with either independent consent (i.e., consent without the assistance of parent or guardian) or the power to veto the treatment decisions of parents.

This review provides some evidence that around age 12, a substantial percentage of minors have attained a stage of cognitive development (formal operations) that predominates in the general adult population. Thus, there may be no clear rationale

for denying to minors over 12 (as a group) the privilege of independent consent or veto of parental consent solely on the basis of intellectual capacity. There is evidence, of course, that adolescents represent a heterogeneous group in terms of cognitive abilities, so that it would be inaccurate to conclude that all adolescents are intellectually capable of providing independent consent. But the same might be said for a random sample of the adult population (Tomlinson-Keasey, 1972), and at present there is no clear evidence to suggest that heterogeneity of abilities is any greater at various adolescent ages than in adulthood.

VOLUNTARY CONSENT

Psychological Definition

Registering one's consent or dissent in treatment situations is a social act. One is asked to announce to a person of some prestige and authority one's decision regarding a proposed treatment or, perhaps more accurately, is requested to comply with a treatment proposal. Individuals differ widely in their general tendencies toward conformity to social expectations and requests by authority. Thus, it is meaningful to speak of a person's competence to provide *voluntary* consent to treatment—that is, to provide consent that is not merely an acquiescent or deferent response to authority. It may also be meaningful to consider whether voluntary dissent can be made by the anticonformist, conceptualized in social psychology as one who rigidly and consistently takes an oppositional stance in relation to authority or social opinion—that is, conforms to nonconformity (Wrightman, 1972). Such a person's refusal to consent to a proposed treatment may be no more voluntary than that of a person whose strong tendency toward conformity results in an acquiescent response to a proposed treatment.

Developmental Considerations

A number of studies have demonstrated the negative relationship between age and conformity (Berenda, 1950; Bishop & Beckman, 1971; Patel & Gordon, 1960). This decrease in need for approval has been shown to continue into middle and late adolescence (15–21 as compared to 11–14-year-olds; Costanzo & Shaw, 1966; Landsbaum & Willis, 1971). But in one study (Costanzo & Shaw, 1966), children between the ages of 11–13 were found to be more conforming to pressure from others than were children ages 7–9. The early adolescent years have often been noted as a period of new and heightened awareness of one's roles in relation to societal and group standards (Strommen, McKinney, & Fitzgerald, 1977).

Related to conformity, research has demonstrated a relationship between age within the adolescent years and field dependence (Witkin, Dyk, Faterson, Goodenough, & Karp, 1962), a cognitive variable defined as a reliance upon external standards for structuring one's own perceptions in ambiguous situations. This dimension might

be relevant to the ways in which individuals seek to structure the frequently ambiguous elements of consent information or circumstances. Although an individual's functioning on this dimension remains fairly constant, a developmental review (Kagan & Kogan, 1970) of Witkin's longitudinal and cross-sectional research results reveals progressively more independent responding with increasing age up to 17 years, followed by a slight decline through age 21.

As noted earlier, one's belief in external locus of control (Lefcourt, 1966; Rotter, 1966) has been associated with passive acceptance of fate and external influences on one's life, a characteristic that might contribute to deference in consent situations. Milgram (1971) found the externality of young adolescents (around age 13) to be more similar to that of 9–10-year-olds than to that of adolescents in the age range of 15–16 years, among whom external locus of control was far less prevalent than in the other two age groups.

Several developmental schemata describe stages of interpersonal development involving levels of functioning in relation to social expectations or to the demands of valued or authority figures in one's life. The systems of Jesness (1974) and Loevinger and Wessler (1970) contain certain developmental levels characterized by high conformity, as well as categories characterized by negativistic and oppositional response to social demands. One might expect that children at such levels of development would be predisposed to provide either acquiescent, "involuntary" consent in the case of high conformity stages or "unwillful dissent" in the case of oppositional stages. With regard to age, Sullivan, McCullough, and Stager (1971) found that 87% of their sample of 12-year-olds functioned at or below Loevinger's conformist stage, in comparison to 55% of the 14-year-olds and only 10% of the 17-year-olds. Unfortunately, systematic developmental information on oppositional stages in the aforementioned schemata has not been sufficiently developed.

Tapp (Tapp & Levine, 1974; Tapp & Kohlberg, 1971) has investigated stages in the development of children's ways of thinking about rule and law. When children of early adolescent (middle school) ages were asked why people follow rules and why they themselves follow rules, they provided explanations that stressed social conformity (e.g., fairness to others) significantly more frequently than did both primary grade and college age subjects. In addition, the middle school children were more similar to the primary school children than to the older adolescents in the frequency with which they referred to authority and avoiding punishment by authority in their reasoning about rules. These findings, as well as those regarding Loevinger's developmental schema, are consistent with studies cited earlier that suggest a heightened concern for social expectations and consequent conformity in early adolescence.

Implications for Competence To Consent

The likelihood of deferent responses to authority in order to avoid negative consequences is apparently great in the preadolescent years. This appears to remain high in early

adolescence and to be augmented by an increased concern for social expectations. Much evidence suggests that this produces a greater tendency toward conformity in early adolescence than at any other age class in childhood, the tendency having been shown to diminish by middle adolescence. Such observations suggest that the risk of deferent responses to requests for consent might generally be great until ages 15–17. Below 15–17 years, then, there is reason to question whether minors in general can satisfy the voluntary element of competent consent.

The manifestation of such deferent response tendencies would probably vary too in relation to the nature of the consent situation. For example, professionals may augment or reduce to some extent the likelihood of deference through their own manner of presentation. Likewise, the presence of parents who have already agreed to the proposed treatment might produce an increased likelihood of conformity on the part of the minor and further reduce the probability of truly voluntary dissent or veto by the minor.

Existing data regarding negativistic or oppositional responding to authority do not provide sufficient information to determine whether such responding is more or less common at various ages. Were such information available, it would be especially relevant when considering minors' abilities to provide voluntary (rather than merely *anticonforming*) dissent to treatment already supported by the parents and the professional.

Conclusions

From the foregoing review alone, there is little evidence that minors of age 15 and above as a group are any less competent to provide consent than are adults. In the age range of 11–14 years, existing research suggests caution regarding any assumptions about these minors' abilities to consider intelligently the complexities of treatment alternatives, risks, and benefits, or to provide consent that is voluntary. Most research suggests that minors below age 11 generally do not have the intellectual abilities or are too prone to deferent response to satisfy a psychological interpretation of the legal standard for competent consent.

In the formation of legal and ethical policy regarding consent by minors, psychological competence is but one circumstance that must be weighed. Policy formation and statutory changes must also consider the liability of parents regarding their children's behaviors, the accountability of professionals in the process of informing children about treatments and risks, the fact that different treatment situations may vary in complexity and therefore may require more or less by way of abilities necessary to provide intelligent consent, and the degree to which various treatments are likely to be essential to the well-being of the child, to name but a few. For those who must weigh these complex circumstances, the present review provides the following suggestions:

1. There may be no circumstances that would justify sanctioning independent consent by minors under 11 years of age, given the developmental psychological evidence for their diminished psychological capacities.
2. There appear to be no psychological grounds for maintaining the general legal assumption that minors at age 15 and above cannot provide competent consent.
3. Ages 11-14 appear to be a transition period in the development of important cognitive abilities and perceptions of social expectations, but there may be some circumstances that would justify the sanction of independent consent by these minors for limited purposes, especially when competence can be demonstrated in individual cases.

In the foregoing review, we alluded to several areas in which further research is needed. In addition, there are at least three general directions for research that would enhance our ability to deal with issues in minors' consent to treatment. First, although we have suggested certain cognitive abilities that may be critical for making decisions about consent to treatment, we have discovered no research that examines the relationship between such cognitive abilities and the reasoning employed by individuals in arriving at decisions about proposed treatments. Such information would provide more direct evidence for use in formulating policy regarding minors' consent than the present review can provide, and might reveal that certain abilities are more important to consider than others. Further, such research might suggest whether screening methods, employing certain cognitive or personality measures, could be developed to assist professionals in deciding upon the competence of child clients to provide meaningful consent where it may be allowed by law.

Second, there is not enough research comparing the cognitive abilities and response tendencies of minors to those of adults. If the abilities of adults on decision-making tasks were more often compared to those of adolescents of various ages within the same study, conclusions regarding the competence or incompetence of age classes of adolescents could more readily be made, using adult norms as a standard. The studies by Tapp and Levine (1974) are noteworthy as a model for such research.

Third, human behaviors in some cases are more closely related to the interaction between situational demands and personal characteristics (e.g., abilities, traits) than to personal characteristics alone (Mischel, 1968). Thus, it may be necessary to examine what children know, how they think, and how they respond in various clinical settings, for various types of treatment decisions, with various procedures for obtaining informed consent. The need for data regarding a wide variety of situations might best be satisfied by systematic data collection by professionals in the course of clinical work with children. This would provide a greater range of situations than can be studied in laboratory research.

In the meantime, we can do little more than to recommend to mental health professionals that the developmental characteristics noted in this article may be useful in structuring their clinical judgments regarding the capacities of minors to provide

meaningful consent. It is important that we allow children to exercise self-determination in treatment situations whenever their capacities, the circumstances, and the law allow it. But it is just as important that we not burden them with decisions that may have far-reaching implications for their lives in those cases in which they do not appear to have the capacity to address the decisions meaningfully. Where the law limits the discretion of professionals in these matters, the lawmakers must be made aware of these concerns.

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