

# Adolescent Perspectives on Patient-Provider Sexual Health Communication: A Qualitative Study

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## Abstract

**Background:** Adolescents in the United States are disproportionately affected by sexually transmitted infections and unintended pregnancy. Adolescent-centered health services may reduce barriers to health care; yet, limited research has focused on adolescents' own perspectives on patient-provider communication during a sexual health visit. **Methods:** Twenty-four adolescents (14–19 years old) seeking care in a public health clinic in Washington State participated in one-on-one qualitative interviews. Interviews explored participants' past experiences with medical providers and their preferences regarding provider characteristics and communication strategies. **Results:** Interviews revealed that (1) individual patient dynamics and (2) patient-provider interaction dynamics shape the experience during a sexual health visit. Individual patient dynamics included evolving level of maturity, autonomy, and sexual experience. Patient-provider interaction dynamics were shaped by adolescents' perceptions of providers as sources of health information who distribute valued sexual health supplies like contraception and condoms. Participant concerns about provider judgment, power differential, and lack of confidentiality also emerged as important themes. **Conclusions:** Adolescents demonstrate diverse and evolving needs for sexual health care and interactions with clinicians as they navigate sexual and emotional development.

## Keywords

community health, patient-centeredness, pediatrics, risky sexual behavior, qualitative methods

## Introduction

Adolescents have the highest rates of sexually transmitted infections (STIs) of any age group in the United States. Despite a downward trend, US adolescents continue to have higher rates of unintended pregnancies compared with other developed countries.<sup>1,2</sup> Access to adolescent-friendly health care is integral to addressing sexual health behaviors and preventing poor outcomes, including STIs/human immunodeficiency virus (HIV) and unintended pregnancies.<sup>3–5</sup> However, little is known about how adolescents define “adolescent-friendly” services or about their experiences communicating with providers regarding sexual health.

There is a growing body of evidence that the quality of adults' experience with health care providers impacts both patient satisfaction and health outcomes, including adherence to prescribed medication and utilization of preventive care services.<sup>6,7</sup> Patients who perceive “good communication” with their provider are more adherent to diabetes self-management and cancer screening.<sup>8–10</sup>

Although the impact of provider communication on health outcomes for adolescents is unknown, there is evidence that communication affects their health care experience.<sup>11</sup> A systematic review of studies examining adolescent perspectives on general adolescent health care identified feeling welcome, trust in clinicians, understanding health information, and involvement in health care decisions critical to adolescents' perception of health care quality.<sup>11</sup> A minority of studies in this review specifically addressed sexual health services. Survey studies have demonstrated that when providers initiate sexual health discussions, adolescents have a more positive perception of providers

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and increased STI testing.<sup>12,13</sup> Despite these benefits, many adolescent health care visits do not address sexual health, and those that do are very brief, lasting on average 36 seconds.<sup>14</sup> Barriers to effective and realistic sexual health communication strategies for providers remain elusive.

Qualitative studies using focus groups have explored the adolescent patient experience when accessing confidential sexual health services.<sup>15-18</sup> Concerns raised by adolescents include judgment by providers, lack of confidentiality, and impersonal patient-provider interactions. While focus groups provide insight into social norms, they are limited in the ability to elicit personal experiences from individuals on sensitive topics like sexual health. For this reason, this study used one-on-one, in-depth interviews to explore adolescents' perspectives on patient-provider interactions during a sexual health visit and how these shape their preferences for patient-provider communication.

## Methods

### *Eligibility and Recruitment*

Adolescents seeking care in an urban public health STI clinic were recruited from September 2008 to January 2009. The clinic serves more than 6000 unique patients annually and provides services for STI management, pregnancy testing, and contraception, prevention counseling, and linkages to community support resources for adolescents and adults at sliding scale costs. Services are provided by advanced practice providers (nurse practitioners and physician's assistants) with physician support when indicated. Among 10- to 19-year-old patients, approximately 45% identify as women and 55% as men. Among older patients, approximately 30% identify as women and 70% as men. Race/ethnicity distribution for 14- to 19-year-olds utilizing the clinic during the study period was 50% non-Hispanic White, 32% non-Hispanic Black, 8% Asian, and 10% other, as determined by self-report at time of service. This is largely consistent with the race/ethnicity distribution of all-aged patients seeking care.

Patients were approached by a research assistant during regular clinic operation hours within the recruitment period and invited via a standard script to learn more about the study. The research assistant recruited 10 to 20 hours per week, primarily during afternoon hours to reach more young people. If participants were interested, they completed a 6-item paper survey in the waiting room to determine eligibility. Inclusion criteria were age 14 to 19 years, ability to speak and read English, vaginal sex in the past 12 months and at least one of the following: 1 episode of unprotected (no condom or no birth control) vaginal sex in the past 2 months, more than 1 vaginal sex partner in the past 2 months, or history of STI or unintended pregnancy in self or partner.

Eligible participants learned about the study in a private clinic room and completed standard written informed consent with the research assistant. The University of Washington Human Subjects Division approved this study and waived parental permission for participants aged 14 to 17 years, which aligns with the age of consent for sexual health care in Washington.

### *Study Procedures*

A research team member (HBH) interviewed all participants using in-depth, semi-structured interviews. The interviews lasted 45 to 60 minutes and included questions about preferences in provider communication styles and experiences with providers when discussing sexual health. To ensure confidentiality, the only demographic information collected was gender and age. On completion of the interview, participants received \$25 cash. Interviews were recorded with a digital audio recorder, transcribed by a research team member (HBH), and reviewed for accuracy by the interviewer.

### *Analysis*

Transcribed interviews were managed using the ATLAS.ti version 7 (Berlin, Germany) qualitative data software program. The research team generated tentative labels to capture the essence of each idea and compared and contrasted their notes.<sup>19</sup> Two members of the research team (TS and HBH) independently reviewed the first 3 transcripts to cluster similar ideas and generate preliminary codes. Two different research team members (AJH and SKB), oriented to the preliminary codes, independently coded all interviews and compared and contrasted notes as new codes emerged. Any coding discrepancies were reconciled verbally between AJH and SKB until 100% agreement was reached. Atypical cases that did not fit patterns for the majority were evaluated and discussed by AJH, SB, and TS, and freehand domain charts were created to map the interrelationship between concepts.

## Results

Of 43 patients approached, 10 did not meet eligibility criteria and 9 declined to participate. Twenty-four of 33 (72.7%) participated: 15 females and 9 males. Average age was 17.3 years. Emerging themes around patient-provider experience and communication revealed a distinction between individual patient dynamics and patient-provider interaction dynamics.

### *Individual Patient Dynamics*

*Comfort in Discussing Sex.* Participants described feeling uncomfortable talking about sexual health topics with their

provider. However, being older (more “mature”) and having more romantic relationship experience eased their discomfort.

The doctor asked me “am I sexually active” and I didn’t feel comfortable. It was probably two years ago. I was probably 17 years old. I did not feel comfortable, because I thought, “This is wrong.” . . . But, I’ve matured now and it’s okay. (Female, 18 years)

Interviews revealed a common sentiment of “embarrassment” when discussing sexual health with adults. This was in contrast with how participants described discussing sex with friends:

Most kids just get embarrassed to talk to an adult about sex, ’cause they can talk to their friends all day about it and it won’t be embarrassing, but once there is an adult . . . , it’s just like, I don’t know. (Gender, age unrecorded)

**Lack of Trust and Confidentiality.** Participants described feelings of being caught off guard or offended when an unfamiliar health care provider asked questions about sexual health and clinical symptoms, suggesting a misunderstanding of why providers elicit such information. One participant described feeling unprepared for sexual history questions in an interaction with a provider that felt impersonal:

Well, I guess it’s like I don’t really know her as a person, so it’s kinda like, “Hello stranger, tell me about your body,” you know, so . . . (Female, 19 years)

Participants voiced concerns that confidentiality might be violated by providers:

[. . .] I know it’s supposed to be confidential [. . .] But I think some doctors, like, be telling, like, the children’s parents what they talk about. (Female, 18 years)

**Fear of Judgment From Providers.** Many interviewed expressed fear of being judged by providers for their sexual behaviors:

Some doctors are like, “[sigh] You’re disgusting.” They don’t say that, but they’re basically, like, “Shame on you. How could you not expect this to happen?” (Female, 19 years)

**Personal Responsibility Regarding Health Needs and Self-Efficacy.** Some adolescents demonstrated a sense of personal responsibility for their sexual health:

I don’t really think I need anything from my doctor, I think it’s more myself. Like, I need to go there and get checked, I need to use condoms, I need to be on birth control. (Female, 16 years)

In fact, some participants believed safer sex practices are not dependent on health care services at all, but rather on personal choices:

[. . .] Yeah, but when it boils down to it, in the heat of the moment sometimes it doesn’t happen like that. So you just have to be smart and just know this is important to my body and I want to use a condom. (Female, 18 years)

### **Patient-Provider Interaction Dynamics**

**Sensitivity to Confidentiality and Patient Comfort.** Participants raised concerns that providers ask them about sexual activity in front of their parents, creating an environment that dissuades accurate responses and negatively affects patient-provider rapport:

[. . .] I went to get a check-up, and um, my dad was in the room with me, believe it or not. And the doctor asked me “am I sexually active” [. . .] So, um, I answered falsely so that I don’t have my dad look at me bad or the doctor look at me bad. (Female, 18 years)

Many interviewed commented on the impersonal and automated nature with which providers asked very sensitive sexual behavior questions:

[. . .] it’s just, like, okay you talk to your everyday doctor, and he’s on the computer asking you questions. Like, “Okay, well do you have Chlamydia? Do you have this?” and there’s no contact, he’s just asking you questions. That doesn’t seem like he cares, he’s just doing his job. (Gender, age unrecorded)

Adolescents alluded to a power differential between themselves and the provider where they were asked to divulge sensitive information while the provider remains closed and impersonal.

You know how they say that we’re not going to answer personal questions kind of makes you feel, you know, unequal. It’s like you’re a human giving information out, but the doctor’s not sharing their experience with you. (Male, 17 years)

**Preferred Communication Styles.** Several participants shared preferred communication styles of providers based on positive experiences; however, these preferences were notably varied. Some expressed appreciation when providers had a straightforward style:

They don’t beat around the bush with it, which is a good thing. I don’t like when people, like, say something to try to start the conversation. I just like when they go, “How are you doing?” And then, “Have you been using condoms,” and “How is your sex life,” and stuff like that. (Female, 18 years)

Others particularly appreciated providers who acknowledged their concerns about being normal and contextualized sexuality as a part of routine health care.

Treating it like anything else . . . saying, “Yeah, like it can kind of be nerve-wracking, but don’t worry, I’m not attacking you, I ask all my patients this” [. . .] I think that’s good, ’cause teenagers are always afraid of “being the only one.” (Female, 15 years)

**Provider Adaptation to Patient’s Maturity Level.** Participants spoke apprehensively about sexual health discussions that did not feel appropriate for their knowledge and maturity level. One participant described going to a doctor at 10 years for birth control pills to treat heavy and painful menstrual periods:

And, like, they were like, “Well, you know if you do decide to have sex, blah, blah, blah.” . . . and I was like, why are you telling me all this? It was so uncomfortable. I was like, okay, I’m not going to have sex right now. And like, even if I was, or something like, it was like waaay too much information. (Female, 15 years)

Some referenced the frustration of providers’ failing to recognize a patient’s capacity to make autonomous decisions.

Me and my partner took a long time before we had sex . . . Took a while for her to be ready, for me to be ready, to be able to trust each other. And sometimes I think the doctors forget that teenagers can think too. We have brains. (Male, 17 years)

### **Provider as Source of Sexual Health Expertise and Services**

Participants referred to providers as sexual health experts and resources for accurate information.

Because I’m not really gonna talk to anybody else about it, so I’d rather talk to the person who knows about it the most, and is gonna keep everything . . . like not judge me, and is gonna actually help me with it (Gender, age unrecorded)

Adolescents recognize providers as the gateway for health care services and supplies such as condoms, contraception, and STI testing. These offerings were described as key aspects of the health care encounter and emphasized by some as more valuable than provider counseling:

Give me protection. Give me condoms and saying maybe if I don’t use condoms, try using birth control, or something of that sort. (Female, 19 years)

## **Discussion**

Using the words and experiences of adolescent patients in a public health clinic, this study identified specific individual

dynamics and patient-provider interaction dynamics that shape communication during sexual health visits. Adolescents’ perspectives provided insights into how their level of maturity and sexual experience influence their preferences for providers broaching sexual health discussions. Level of emerging autonomy was a major factor in their comfort and willingness to discuss sexual health. Some identified providers as resources for health information and supplies, but others emphasized concerns about confidentiality, judgment, and the power imbalance. While preferences about communication style varied, preferred attributes included nonjudgmental and straightforward providers able to normalize sexual health issues.

Participants in our study expressed themes consistent with prior studies; they were less comfortable discussing sexual health when concerned about confidentiality or with providers perceived as highly judgmental.<sup>15,20</sup> Our study findings further reinforced the importance of patient-provider communication.<sup>21,22</sup> The literature suggests that adolescents with chronic illness,<sup>23</sup> young men who have sex with men,<sup>13</sup> and adolescents seeking preventive health care<sup>12,24</sup> have a more favorable experience and are more engaged in their health care when there is higher quality patient-provider communication.

This study adds new insights into how level of maturity and sexual experience factor into patient preferences and needs within a patient-provider interaction. Our findings suggest differences between patient and perceived provider goals for the sexual health visit. Some adolescents perceive the provider as primarily a resource for sexual health supplies and services. They find the sexual health interview invasive, rather than recognizing its purpose to assess risk and determine sexual health needs. Therefore, providers should communicate why they ask questions about sexual behaviors to tailor their approach to the adolescent’s maturity level.

Despite the importance of risk screening, providers face challenges in discussing sexual health due to shortened clinic visits, increasing number of preventive health topics, and discomfort or lack of training in sexual health care. Prior studies have found that providers miss opportunities to screen and provide sexual health services and counseling to adolescents, even those with known high-risk behaviors.<sup>25-27</sup> It is clear that providers need adequate resources and innovative strategies to carry out recommended screening and management guidelines.

This study was qualitative and exploratory and subject to limitations of participants living in one geographical region attending one clinic and is not generalizable to all adolescents. Interview responses may be influenced by social desirability and potentially reflective of their public health clinic experiences rather than experiences in other clinical settings. The demographic information collected was limited to age and gender, which excludes understanding responses in the

context of specific demographic characteristics. Of note, individual gender and age was unintentionally not recorded for 2 participants' audio files, limiting our ability to attribute age and gender to quotations by those participants. The clinic serves a high-risk population and these findings may not reflect experiences of adolescents in the primary care setting. Furthermore, inclusion criteria were limited to participants who reported penile-vaginal intercourse and therefore the experiences and preferences of adolescents engaging in other sexual activities were not captured in this study. Although the interviews were conducted from 2008 to 2009, the model of clinic-based, adolescent sexual health services that existed during data collection has not substantially changed since that time, specifically that confidential services are provided at sliding-scale cost in an ambulatory setting requiring a clinical history, examination, laboratory tests, and provision of medications, counseling, and preventive supplies such as condoms. For this reason, findings are considered still relevant and applicable to providers seeing adolescents in outpatient clinical setting currently.

This study offers valuable insights into the adolescent experience during a sexual health visit. The data reflect the evolving and fluctuating health care needs of adolescents as they navigate sexual and emotional development and gain confidence in accessing and utilizing health care services. Our findings highlight the importance of providers' ability to assess a patient's developmental stage and prior experiences and to tailor their communication style and health messages accordingly. There is a clear need for innovative tools that support providers to rapidly assess and adjust to an adolescent's stage of psychosocial development, level of sexual experience, and risk behaviors to facilitate more adolescent-friendly interactions. Next steps might involve development and study of tools and interventions that support providers in these activities. Since these findings reflect only the perspectives of the patients, further research that includes provider interviews or patient-provider observation might elucidate more comprehensive insights. Subsequent studies should also explore patient-provider communication in other health care settings serving adolescents, such as school-based health or acute care settings, and among adolescents who have special health care needs.

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