Providers, parents and communication: the keys to healthy teens and reducing teen pregnancy rates

1. Introduction

Clinicians are overlooked and undervalued in the sexual health education equation for teens and their parents. As trusted health professionals, providers have a unique opportunity to educate entire families on sexual health issues using clear, medically accurate information that is developmentally appropriate and unbiased.

Teen pregnancy rates in the United States are at an all-time low [1,2]. Despite this fact, American teens are much more likely to conceive during adolescence than peers in other developed nations [1–3]. The issues surrounding teen sexual behavior and unintended pregnancy are vast and complicated [4]. Leading the confusion are barriers to confidential contraceptive services — perceived or real — and decreased availability of comprehensive sexuality education in schools. Other contributing factors include the wide variety of sometimes conflicting belief systems in families and specific communities and the enduring impact of racism, poverty and inadequate education [3,5]. Further complicating these issues are the barrage of heightened sex-based messages in the media and unclear and inconsistent messages regarding sex and sexuality from adult role models. Age and background of the teen mother’s partner, absence of long-term and realistic dreams and goals, peer pressure and youth ambivalence regarding teen pregnancy and/or parenthood round out this long list [4]. These factors, combined with lack of reliable and consistent health resources, confuse messages about sex to American teens. The result is poor health outcomes, despite the best intentions of clinicians, public health leaders, parents and community members. Providers have a significant role in helping eliminate some of these barriers through patient education and evidence-based care, ultimately impacting reduced teen pregnancy rates even further.

2. The importance of confidential services for teens

Teens report that concerns about confidentiality are a significant barrier to accessing and using contraception regularly and correctly [6]. Despite findings that indicate youth are more likely to delay sexual activity because of communication by parents regarding sexual activity, youth seeking contraception are unwilling to risk disclosure of sexual status to their parents by a potentially “untrustworthy” health care provider. The laws pertaining to health care for teens vary from state to state. In some instances, providers are left to make a judgement call regarding care, while in others, lawmakers articulate the circumstances in which parental consent is required [6]. Different specialties describe different policies regarding treatment of adolescent minors; family practitioners are more likely to have a clear policy in place addressing caring for a teen without a parent or guardian present, while pediatricians, who actually treat a higher percentage of teens, are less likely to have clear guidelines on the matter [6].

Teens want to turn to parents, teachers and health care providers for clear, concise contraception and reproductive health advice [3]. At the same time, they are selective about who to confide in about sexuality. A heightened awareness of teens’ comfort level and preferences as they relate to sex and sexuality will result in physicians and advanced practice clinicians developing improved rapport with patients. Cultivating relationships with teen patients will give rise to improved communication: clinicians will listen more attentively, ask detailed questions and find themselves in a better position to offer primary prevention options and case-appropriate advice.

Similarities and stark differences exist in the sexual decision-making process of American teens compared to teens of sister nations. Cultural variations regarding teen sex may contribute to higher teen pregnancy rates in the United States. Teens initiate sexual activity during approximately the same period in development around the world. Unfortunately, sexually active US teens are significantly less likely to use contraception than their global counterparts [1,7]. Higher levels of contraception use by international teens may be attributed to general acceptance that teen sex is a natural part of human development in many other developed nations. International acceptance of teen sex as a natural stage in development is usually combined with clear messages from adult role models that sexual activity is expected to be paired with consistent birth control use [1,7].
In the same way that young children are taught the importance of looking both ways before crossing the street or suffer dire consequences, teens abroad are taught that sexual activity only exists within an arena of consistent contraception use and that parenthood is only appropriate within the context of financially independent adulthood [7].

3. Sexuality education for parents of teens

Pediatricians often educate new parents in an attempt to positively affect long-term health outcomes on topics such as vaccination and nutrition. Should discussion about teen sexuality, unintended pregnancy prevention and sexually transmitted disease be included in this discussion? Could trusted family doctors and other providers be the missing link in life-long sex education that starts in the home? Clinicians are well-positioned to provide unbiased sex education to parents; parents will then possess the knowledge they need to educate their children about reproductive health and contraception [8]. Teens around the world respond positively to messages about sex from parents; if clinicians educate parents, teens are likely to receive medically accurate messages about sex in the home [9].

4. Poverty, social capital and teen pregnancy

Crosby and Holtgrave [10] suggest that poor health outcomes such as teen pregnancy are correlated with low social capital. Social capital assumes that when members of a social network share values such as trust, reciprocity and cooperation, common goals such as improved health outcome are more likely to be achieved. High social capital can decrease the widespread impact of negative outcomes such as unintended teen pregnancy; however, studies show that high social capital is inconsistent in low income areas [10,11]. Single parent homes are found more often in disadvantaged areas as well; high divorce rates and childbearing outside of marriage strongly influence family structure, particularly in less affluent neighborhoods [12]. Children raised in single parent homes are correlated with youth having sex at a younger age [9]. This statistic is associated with the notion that children of single or divorced parents are exposed to dismissive attitudes regarding sex, fewer hours of parental supervision and parent dating activity [9]. Family influence on teen pregnancy is not restricted to parents of teens. Sexually active older siblings also impact teen pregnancy, particularly if an older sibling became pregnant or a parent during teen years [9].

5. Closing the gap: abstinence-only education in schools

American teens spend approximately 35 hours in school each week. The public education system has the opportunity to use this time to educate our youth on a range of topics that will prepare them to be socially responsible adults. Unfortunately, more and more school systems are choosing not to provide students with information about both contraception and abstinence. Comprehensive sex education is a topic that is removed from more and more health education curricula, despite evidence that teaching abstinence along with effective contraception techniques is proven to be successful in postponing sex among youth who are virgins and increasing use of contraceptives in sexually active teens [13,14]. Abstinence-only-until-marriage education is being adopted by school systems to a greater extent every year, in part because government funds were redistributed to promote this methodology [15]. Health care providers have access to youth in clinical settings; taking advantage of the opportunity to supplement sexual health education that is lacking in the academic arena will provide teens and their families with medically accurate, unbiased reproductive health information.

6. For clinicians: a to-do list

Educating parents is one poignant way to impact teen pregnancy rates in the United States. Ensuring that teen patients receive high-quality, age-appropriate, medically accurate, confidential reproductive health care is an equally important component of teen pregnancy prevention. Clinicians can better serve teen patients by doing the following:

- Actively listening to teen patients
- Raising issues of sex and sexuality with teen patients and their parents early and often
- Ensuring that clinic intake forms encourage patients to disclose sensitive information without stigma
- Reiterating patient confidentiality in words and actions: tell your teen patient that information will not be disclosed to parent/guardian, and reinforce this action by asking parents/guardians to leave during exam/counseling session
- Starting the discussion about sexuality between teens and their families
- Providing age-appropriate, scientifically accurate resources on contraception and reproductive health during office visits.
- Advocate for access to confidential care and comprehensive sexuality education in schools.

Clinicians are in a unique position and may not know it. They can equip parents with the tools needed to educate their children about sex, sexually transmitted infections and contraception. Health care providers educating parents could result in a widespread impact ultimately furthering the decline of unintended teen pregnancy. Parents and teens alike are unsure about where to turn for sexual health education resources; a family health care provider is the
obvious choice to obtain developmentally appropriate reproductive health information for a growing teen. Parent buy-in to teen pregnancy prevention is crucial. Teamed with the clinician as family sexual health educator, proactive parents will prove invaluable in the crusade to decrease teen pregnancy rates [16].

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References