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Parental Acceptability of Contraceptive Methods Offered to their Teen During a Confidential Health Care Visit

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Abstract

Purpose—To examine parental acceptability of contraceptive methods offered confidentially to their adolescent daughter.

Methods—A random sample of 261 parents/guardians with a daughter between 12–17 completed a telephone survey examining the relationship between parental acceptability of seven contraceptive methods with adolescents' likelihood to have sex, parenting beliefs, parents' sexual health as teens, sexually transmitted infection (STI) knowledge, and demographic factors.

Results—Acceptability was highest for oral contraceptive pills (59%), and lowest for intrauterine device (IUD) (18%). Parental acceptance of teens' autonomy was significantly associated with increased acceptability of all methods. Parental knowledge of STIs was poor and 51% found it acceptable for clinicians to provide their sexually active teen with condoms.

Conclusion—Conclusions: Parents were more accepting of OCPs and condoms, compared to IUDs and implants. Parental recognition of their teen's autonomy was associated with greater parental acceptability of clinicians providing their adolescent with contraceptives (regardless of the specific type of method being offered).

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Keywords

Contraception; Confidentiality; Adolescents; Parents

Unintended pregnancies and sexually transmitted infections (STIs) remain high among adolescents.^{1,2} Despite the availability of effective, reversible, and longer lasting contraceptives,³ few adolescents use these recommended methods.² Parents can potentially improve utilization,⁴ yet many are uncomfortable talking with their teens or have inaccurate contraceptive information.⁵ Improving clinician-parent partnerships may strengthen contraceptive adherence; however doing so is challenging, especially in the context of confidential adolescent health services.⁶⁻⁸ This study examines parental acceptability of different contraceptives and explores factors that influence their attitudes.

Methods

Sample

Between August-October 2010 a random sample of parent/caregivers with an adolescent (12–17 years) were recruited from two large, diverse Northern California clinic enrollment databases. *Parent/caregiver* was defined as the key adult responsible for the health and well being of the child.

Procedures

The clinic chief mailed each randomly selected parent a letter, in English and Spanish, explaining the study. Parents who did not want to be contacted were instructed to indicate this by returning a pre-addressed stamped return card. Potential participants were phoned two weeks after the initial mailing. Verbal consent was obtained. The computer-assisted telephone interview took 45-minutes. Participants received a \$15 grocery gift card. This study received human subjects approval from all participating institutions.

Measures

Parents were asked, “if your teen’s doctor found out your daughter was having sex, is it acceptable or unacceptable to you for the doctor to provide the following methods to your teen confidentially. Methods were oral contraceptive pill (OCP), condoms, injectable contraception, transdermal patch, implant, intrauterine device (IUD), emergency contraception (EC). Brief definitions of each method were provided. Parents rated their acceptability of each method with a 4-point Likert scale (very acceptable to very unacceptable). The primary predictive variable was parental report of the likelihood of their adolescent having sex in the next year. Parents were also asked about their past sexual behavior and birth control use as a teen. Parental knowledge of STIs was the number of correct answers on five multiple-choice questions. We used three parent attitudinal scales developed as part of a larger study (derived from factor analyses and evaluated for internally consistency with Cronbach’s alphas $>.80$): (1) parental need to know about teen’s health and behaviors (5 items), (2) recognition of their teen’s autonomy⁹ (7 items) and (3) parental trust in doctor (11 items e.g. physician communication ability, caring, respectfulness, etc). Two other parenting factors: parent-teen communication and parental need for control were represented by individual items.

Analysis

Attitude scale scores were computed as the mean of the item scores. Bivariate associations between parental acceptability of contraceptives and all other measures (including demographic characteristics) were assessed with Chi-square (categorical correlates) and t-

tests (continuous correlates). Logistic regressions assessed the multivariate relationship between acceptability of each method with correlates having significant bivariate associations. Using a backward elimination procedure, iterations continued until all variables in the model other than perceived likelihood of sex (unable to be removed because it was the primary variable), achieved $p < .10$ and the model achieved fit ($p > .20$ on the Hosmer-Lemeshow goodness-of-fit test).

Results

A total of 5601 randomly selected parents/caregivers were mailed letters; 202 indicated that they did not want to be contacted. Of the 5399 parents/caregivers who did not return a refusal card, 1491 were reached by phone. Of those reached by phone, 1397 were eligible for participation, and 490 completed interviews (35% overall response rate). Of these, 261 were with parents of a female teen. Table 1 presents demographic characteristics.

Parental acceptability was highest for OCP (59% acceptable) followed by condoms (51%), injectable contraception (46%), EC (45%), transdermal patch (42%), implant (32%), and IUD (18%). Acceptability of IUD and implant was significantly lower than all other methods ($p < .05$). Acceptability of OCP was significantly higher than all other methods ($p < .05$) except condoms which approached significance ($p = .051$).

Multivariate analyses (see Table 2) showed that parents who reported their adolescent likely to have sex in the next year, our primary predictive variable, were more likely to accept condoms and EC. Parental recognition of their teen's autonomy was the only variable associated with significantly higher acceptability scores for all contraceptive methods.

Discussion

A majority of parents (59%) were accepting of OCPs being offered to their daughter; yet only half reported acceptability of condoms. Furthermore, the most effective contraceptive methods, implant and IUD³, were acceptable to only a small minority of parents. The strongest predictor of acceptability across all methods was parental recognition of their teen's autonomy.

We also found that parents who perceived their teens likely to have sex were more accepting of only condoms and EC despite our prediction that this variable would increase acceptance of all contraceptive methods. Possibly, parents may associate these methods with a single episode of sex rather than condoning an ongoing sexual relationship, which would require a more permanent contraceptive method. Conversely, lower EC acceptability was associated with greater religious service attendance. Perhaps this subset of parents hold the misconception that EC causes abortions, which is condemned by many religious belief systems. Consistent with prior research¹⁰, this study also found that parental trust in the clinician improved parental acceptability.

There are several study limitations. This was part of a larger survey of confidential health services and did not explore parental understanding of the contraceptive methods. In addition, the response rate of 35% may limit the findings' generalizability. Finally, although this study did include male caregivers, there were insufficient numbers to explore the attitudes of fathers in greater depth.

Parents are an important and often overlooked partner in efforts to prevent adolescent pregnancy and STIs. This study begins to address this gap and provides information on factors that influence parental acceptability of contraceptives offered to their adolescents. More research is needed to improve our understanding of barriers and facilitators of sexual

health communication between clinicians, parents, and adolescents. Beyond educating parents about STIs and contraceptive options, especially longer-acting methods, clinicians can help parents understand that adolescent autonomy is a normal part of development and confidential health services can support adolescents' transition to adulthood.

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Implications and Contributions

This study examines parental attitudes toward contraceptive methods provided to adolescents in the context of a confidential visit. It identifies factors that influence parental acceptability of contraceptive services that can inform interventions to improve parental knowledge and acceptance of confidential reproductive health services for teens.

Table 1

Demographic Characteristics

			Frequency (%)
Parent	Age	27–35	59 (22.6)
		36–45	101 (38.7)
		46–55	76 (29.1)
		>56	23 (8.8)
	Gender	Male	35 (13.4)
		Female	226 (86.5)
	Marital Status	Married	183 (70.1)
		Other	77 (29.8)
	Race/Ethnicity	Non Hispanic white	59 (22.6)
		Non Hispanic black	41 (15.7)
		Hispanic	119 (45.6)
		Non Hispanic Other	42 (16.0)
	Language Spoken	English-only	180 (69.0)
		Other	81 (31.0)
	Income	\$40,000 or less	84 (32.2)
		\$40,001 to \$80,000	71 (27.2)
		Over \$80,000	93 (35.6)
	Insurance	Self pay	6 (2.3)
		Kaiser	206 (78.9)
		Private insurance	2 (0.8)
		Public insurance	46 (17.6)
	Religious Attendance	Once a week +	92 (35.2)
		1,2,3 times a month	44 (16.8)
		< once a month	61 (23.4)
Never		61 (23.4)	
Teen	Age of Teen	12 or 13	93 (35.6)
		14 or 15	100 (38.3)
		16 or 17	68 (26.1)
	Birth Order	Only child	41 (15.7)
		Oldest child	74 (28.4)
		Other	145 (55.5)

Table 2

Multivariate Logistic Regression Models with Acceptability as Outcome

Variable	Birth Control Pills		Condoms		Hormonal Shot		Morning After Pill		Hormonal Patch		Hormonal Implant		Intrauterine Device	
	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI
Likelihood teen has sex in next year														
Very unlikely	1.00		1.00		1.00		1.00		1.00		1.00		1.00	
Not very unlikely	2.02	0.97, 4.20	3.56	1.65, 7.65	1.39	0.72, 2.68	2.08	1.00, 4.32	1.04	0.53, 2.07	0.65	0.31, 1.37	0.70	0.30, 1.62
Parental need to know														
	0.52	0.28, 0.97	0.46	0.24, 0.89	NS		0.55	0.30, 1.01	0.56	0.33, 0.95	0.57	0.31, 1.07	NS	
Recognition of autonomy														
	5.64	2.94, 10.82	4.07	2.08, 7.96	6.12	3.28, 11.41	4.07	1.99, 8.33	4.98	2.44, 10.18	4.38	1.96, 9.82	3.65	1.40, 9.48
Trust in doctor														
	NS		NS		NS		NS		3.61	1.02, 12.79	4.05	0.90, 18.26	NS	
Parent used b.c.														
Yes	NS		2.12	1.01, 4.47	NS		NS		NS		NS		2.14	0.98, 4.67
No	NS		1.00		NS		NS		NS		NS		1.00	
STD knowledge														
0-1 correct	1.00		NS		1.00		NS		NS		NS		NS	
2+ correct	1.84	1.01, 3.38	NS		2.06	1.16, 3.63	NS		NS		NS		NS	
I control what teen learns about sex														
Strongly disagree	NS		2.25	1.19, 4.24	NS		2.55	1.34, 4.86	NS		3.43	1.68, 7.04	4.00	1.70, 9.44
Not strongly disagree	NS		1.00		NS		1.00		NS		1.00		1.00	
Never need teen speak alone w/DR														
Strongly disagree	NS		NS		NS		NS		NS		NS		2.05	0.93, 4.52
Not strongly disagree	NS		NS		NS		NS		NS		NS		1.00	
I decide what health information teen gets														
Strongly disagree	NS		NS		NS		NS		NS		NS		NS	
Not strongly disagree	NS		NS		NS		NS		NS		NS		NS	
Race/ethnicity														
White	NS		NS		NS		NS		NS		0.40	0.17, 0.97	0.41	0.17, 1.01

Variable	Birth Control Pills		Condoms		Hormonal Shot		Morning After Pill		Hormonal Patch		Hormonal Implant		Intrauterine Device	
	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI
Other	NS		NS		NS		NS		NS		1.00		1.00	
Language spoken														
English only	NS		NS		NS		NS		NS		NS		NS	
Other	NS		NS		NS		NS		NS		NS		NS	
Religious service attendance														
Once a week +	NS		NS		NS		1.00		NS		NS		NS	
< once a week	NS		NS		NS		2.45	1.27, 4.75	NS		NS		NS	
n, g-o-f p-value	n=249	p=.634	n=249	p=.820	n=249	p=.649	n=246	p=.834	n=246	p=.731	n=243	p=.463	n=248	p=.412

NS=Non-significant