Do Adolescents Want to Hear Preventive Counseling Messages in Outpatient Settings?

Beat D. Steiner, MD, and Kathleen L. Gest, MD
Chapel Hill, North Carolina

BACKGROUND. In response to the high prevalence of health-risk behaviors among adolescents, policy agencies have urged primary care clinicians to discuss these behaviors with all adolescents. Yet such discussions frequently do not take place. A commonly mentioned barrier is the clinician perception that patients are not interested in , or are embarrassed by, such discussions. The purpose of this study was to assess the accuracy of this perception by conducting a survey of adolescents.

METHODS. Self-administered questionnaires were distributed to 305 adolescents, ages 11 to 16 years, waiting to be seen in three community health centers and three private practices. The questionnaire queried adolescents' willingness to talk about eight preventive counseling topics with health care practitioners, and information was collected on variables that might influence willingness. Descriptive frequencies were generated. Chi-square analysis and stratification assessed differences between groups.

RESULTS. A majority of adolescents felt that it is a clinician's job to discuss health risk behaviors. On the current visit, however, fewer than 20% wanted to talk about drugs, alcohol, cigarettes, or depression; fewer than 40% about sex; and fewer than 55% about diet or exercise. Adolescents reporting previous conversations on a topic were more likely to want to talk about that issue at the current visit. Willingness to talk did not vary by visit type (well care vs acute care).

CONCLUSIONS. This study confirms that adolescents are hesitant to discuss health risk behaviors with clinicians, but the findings also suggest that receptivity increases if clinicians address these topics on repeat occasions.

KEY WORDS. Adolescent health services; adolescent behavior; counseling; preventive health services. *(J Fam Pract 1996; 43:375-381)*

Risk-taking behaviors cause much of the morbidity and mortality that occur among adolescents.[1] Many of these unhealthy behaviors lead to adverse outcomes in the short term, such as motor vehicle crashes associated with alcohol consumption, or sexually transmitted diseases from unprotected sexual intercourse. Other health-risk behaviors increase the risk for chronic adult illnesses, such as lung cancer from cigarette smoking and heart disease associated with poor diet. Unfortunately, most of these health-risk behaviors are common in adolescents. In recent population-based surveys of young adolescents, 73% had tried alcohol at least once, 56% had smoked at least one cigarette, 49% had participated in a physical fight, 34% had been sexually active, and only 20% to 30% were eating a healthy diet or engaging in moderate physical exercise.[2-4]

There is an increasing consensus in the public health and medical community that physicians should play an important role in modifying these prevalent health-risk behaviors and thus help reduce the rate of associated poor health outcomes. The United States Preventive Services Task Force *Guide to Preventive Services*,[5] the American Academy of Pediatrics' *Clinician's Handbook of Preventive Services*,[6] the American Medical Association's *Guidelines for Adolescent Preventive Services (GAPS)*,[7] and the Bureau of Maternal and Child Health's *Bright Futures*[8] all recommend that

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From the Departments of Family Medicine (B.D.S.) and Pediatrics (K.L.G.), University of North Carolina School of Medicine, Chapel Hill. Requests for reprints should be addressed to Beat D. Steiner, MD, Department of Family Medicine, University of North Carolina School of Medicine, CB 7595, Chapel Hill, NC 27599-7595. E-mail: bsteiner@med.unc.edu

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adolescents be counseled on the following topics: alcohol, tobacco and other drug use, nutrition, physical activity, unintended pregnancies, sexually transmitted diseases including acquired immune deficiency syndrome (AIDs), violent behaviors, and firearm safety. Despite such recommendations, these counseling discussions frequently do not take place. In an analysis of the National Ambulatory Medical Care Survey, Igra and Millstein[9] estimated that of 60 million annual office visits by adolescents, health promotion counseling on HIV occurred in only 0.5% of visits and advice on cigarette cessation in only 1% of visits. In another study, 75% of college freshmen reported never having received any counseling on 11 of 15 health topics.[10]

Physicians fail to provide these recommended preventive health messages for many reasons, including both environmental factors and factors related to the clinician. Environmental factors include poor reimbursement for counseling activities, insufficient time, lack of health education resources specific to adolescents in many offices, and lack of preventive-services reminder systems.[11] Clinician factors include feeling inadequately trained, not believing in the effectiveness of such interventions, and feeling personally uncomfortable with discussions of sensitive topics.[9] The barrier examined in this study, however, is the clinician's view that adolescents simply are not receptive to such discussions. There is a perception that adolescents are not interested in, or might become embarrassed by, such discussions.[12] There is also the perception that adolescent receptivity is particularly low during acute-care visits, and that preventive health messages from clinicians who do not know the teen well will be ineffective.

This perceived lack of adolescent receptivity as a barrier to preventive health counseling is of particular interest, because there is little published evidence to support these perceptions. The few studies that have addressed this issue have documented that adolescents are interested in multiple areas of health including dental health, menstruation, sex, acne, weight, and friendship, albeit to varying degrees.[13-15] These studies, however, may not adequately address current issues. Recent media attention to the relationship between health-risk behaviors and poor teen health outcomes, as well as increased general social awareness of issues such as AIDs, violence, drunk driving, and drug abuse have likely changed adolescent perceptions over the years since these studies were conducted. Increased awareness among teens of the health consequences of these behaviors may make it appear more appropriate to discuss such behaviors with a clinician. On the other hand, perhaps overexposure to these topics on television, in films, with peers, and in schools has diminished the desire of teens to discuss these topics with clinicians. That all prior studies were conducted in school settings also limits the usefulness of these results to clinicians in health care settings.[13-15] Adolescents are more likely to be thinking about what they would and would not want to discuss with a clinician when sitting in a clinic waiting room than when they are sitting in a classroom, far removed from the reality of a clinical encounter.

The purpose of our study is to provide an up-to-date description of how adolescents waiting in a medical office feel about discussing health-risk behaviors with clinicians. The study further explores whether demographics and past behaviors of the adolescents, characteristics of the clinic, or visit type are associated with adolescents' willingness to discuss these behaviors in a health care setting. Such a description may reduce barriers to providing preventive health counseling if it can be shown that adolescents expect to have such discussions with their physicians. Clinicians can also provide more selectively tailored counseling messages if groups of adolescents with particularly high or low levels of interest in certain topics can be identified.

METHODS

PROCEDURE

During the months of June through October 1995, questionnaires were distributed to adolescents presenting to six clinic sites in North Carolina. The sites were chosen to represent a spectrum of nonacademic sites that reported seeing a sufficient number of adolescents to enroll approximately 10 adolescents per week in the study. For logistic reasons, all sites were within a 30-mile radius. One private family practice office, two private general pediatric offices, and three community health center (CHC) clinics were approached and all agreed to participate. One of the private prac-

tices and two of the CHC sites are located in small rural communities. Two of the private practices and one CHC site are located in mid-sized cities. The three private practices serve primarily middle-class, privately insured patients, while the three CHC sites serve primarily indigent and working poor patients.

All adolescents between 11 and 16 years of age were eligible to complete the questionnaire regardless of the reason for their clinic visit. Front desk staff were instructed to offer a questionnaire to all eligible adolescents when they checked in and to obtain written informed consent from both the adolescent and the parent. Adolescents were then provided a semi-private area in the waiting room, asked to complete the questionnaire without supervision, seal the questionnaire in an envelope, and place it in a collection box before seeing the clinician. The questionnaires contained no personal identifiers. Office sites involved in the study were given a small monetary honorarium for their assistance. Individual adolescents were not given any incentives.

The lack of computerized office systems in many of the practices made it difficult to determine what percentage of eligible adolescents participated. Interviews with office staff at each site, however, provided no evidence of selection bias during the recruiting process. The primary reason cited for not recruiting all eligible adolescents was forgetfulness or inadequate staffing, reflecting the realities of a busy office practice. Staff did not feel that any group of adolescents were preferentially approached, nor did they feel that recruitment was heavier at certain times of the day or week. The demographic information collected on adolescents surveyed confirmed this view, with the proportion of well-care to acute-care visits as well as age, sex, and race corresponding roughly to the adolescent population seen at the respective sites during that time of the year. Of 313 adolescents agreeing to participate, 305 completed the questionnaire (97% completion rate).

Questionnaires

The questionnaire consisted of 33 items, and required 5 to 10 minutes for completion.* Yes/no items inquired about eight preventive-counseling topics (exercise, diet, tobacco, alcohol, violence, depression, drug use, and sexual behavior). The topics were chosen based on published recommendations.[5-8] To explore factors associated with willingness to talk about health topics, information was also collected on (1) whether the teen perceived such discussions to be part of a clinician's job, (2) whether these topics had ever been discussed with a clinician in the past, (3) whether the teen would like these topics discussed during the current visit, (4) whether the adolescent knew the clinician, (5) the type of visit for which the adolescent was scheduled (well care vs acute care), (6) the age and sex of the adolescent, and (7) whether the adolescent had previously engaged in health-risk behaviors. Adolescents were also asked to identify all preferred medical and nonmedical sources for advice on these topics. The survey was pretested for comprehension and ease of completion in two focus groups using 12- and 13-year-olds at a local middle school.

*A copy of the questionnaire is available by writing to the corresponding author.

Statistical Analysis

Descriptive frequencies were generated. Chi-square analysis was used to assess differences between groups. Bivariate stratified analysis was used to control for confounding. Given our sample size, we had a power of >0. 8 to detect a difference of 20% or more. Each practice setting was analyzed individually, but owing to similarities found between the three CHC sites and the three private practices, the data were pooled and the results are presented comparing the private setting vs the CHC setting. Age was dichotomized into early adolescence (ages 11 to 13) and middle adolescence (ages 14 to 16) because of statistical and conceptual similarities. Hypothesizing that adolescents' interest in addressing a given behavior would be different if they had previously engaged in that behavior, we dichotomized adolescents, labeling those who reported prior experience with that behavior as high risk. For the topics of diet and exercise, no high-risk category was defined.

RESULTS

Three hundred five adolescents, between the ages of 11 and 16, answered the questionnaire. Forty-four percent were female, and 47% were 13 years

old or younger. Approximately one half were seen in private offices (44%) and half in community health centers (56%). Forty-four percent of the teens said they knew the clinician they were about to see, 31% said they did not know the clinician, and 25% were unsure.

Past Experiences with Preventive Health Discussions

Confirming previous studies, many of the adolescents did not recall ever having spoken to a clinician about relevant risk behaviors (Table 1). Exercise and diet were the only two areas that more than 50% of adolescents could recall discussing with a clinician. Fewer than one in five adolescents recalled such discussions about alcohol, cigarettes, drugs, violence, or depression. However, those adolescents who reported having previously engaged in a particular high-risk behavior were significantly more likely to recall discussing that topic with a clinician in the past.

Adolescent Perceptions of Preventive Health Discussions

A majority of adolescents agreed that it is part of a clinician's job to talk about health risk behaviors, yet far fewer wanted to talk about any of these issues during the current visit (Figure). When subgroups of adolescents were examined, important differences emerged in who is more likely to be interested in talking about these issues on the current visit (Table 2). Adolescents who recalled previously speaking with a clinician about a health-risk behavior were significantly more likely to want to talk about that behavior during the current office visit. Analysis of high-risk adolescents (those adolescents who reported that they had previously engaged in the behavior to be discussed) revealed that those adolescents who reported drinking alcohol, having sexual intercourse, or feeling depressed were more likely to want to talk about that topic on the current visit. The setting in which the adolescent was seen was a third factor associated with adolescents' desire to talk about certain areas of prevention. Adolescents who were interviewed in the three CHC sites had a greater desire to talk about sexual issues and drugs than adolescents seen in the three private practices. Among the demographic factors, being female was associated with a greater willingness to talk about exercise, sexual issues, and depression, while older age predicted only a greater willingness to talk about sexual issues.

There was no significant difference in adolescents' willingness to talk about any health-risk

TABLE 1

Adolescent Recollection of Discussions About Prevention During Past Visits Discussion Topics*

Discussion Topics*	% of All Respondents Answering Yes n=300	% of High-Risk† Respondents Answering Yes n=177
Exercise and keeping in shape	56	ND
Healthy foods, dieting	54	ND
Sex, birth control, or sexually transmitted diseases	38	71¶
Talked about drugs (marijuana, cocaine, etc)‡	18	38¶
Tobacco (cigarettes, chew, etc)	18	25¶
Alcohol (beer, wine, or liquor)‡	18	25¶
Talked about depression and feeling hopeless‡	16	28¶
Guns and fighting	5	5

*Adolescents were asked whether a nurse or doctor ever talked with them about any of these topics in past visits.

†Adolescent defined at high risk if self-reporting that he or she has previously engaged in the behavior to be discussed.

‡Number of responses in these categories was 299 for column headed "% of all respondents answering yes"; number of responses in these same categories were 177 for column headed "% of high-risk respondents answering yes."

¶Significant difference between adolescent subgroups at $P<.05$.

ND denotes high-risk category not defined for this topic.

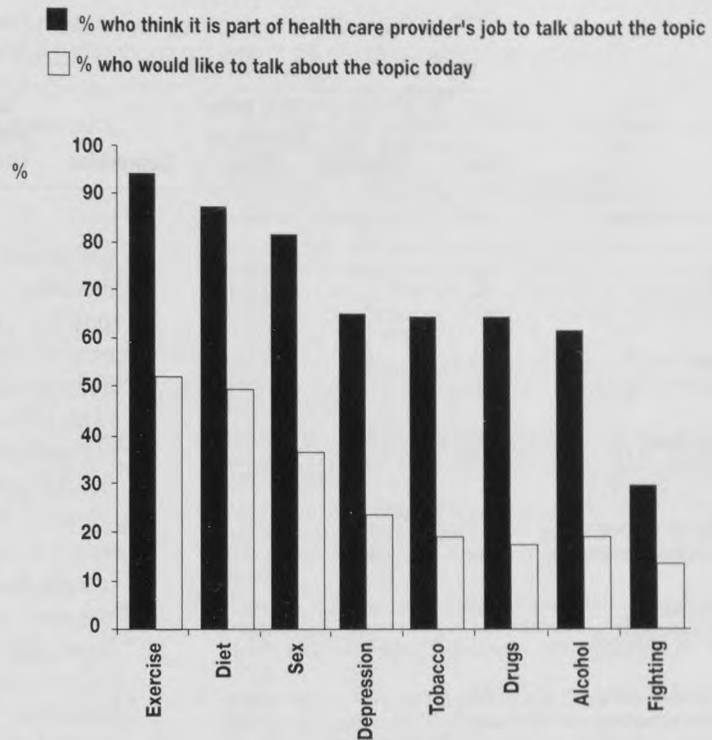
behaviors with a clinician during visits for well-care compared with acute-care examinations. There was also no difference between teens who reported knowing the clinician and those who did not.

Physicians Compared with Other Information Sources

When adolescents were given a list of seven sources of health advice and asked to choose all sources to whom they would turn for advice on any of these health-risk behaviors, only 55% of adolescents chose doctors or nurses. Still, doctors and nurses were mentioned considerably more frequently than other professionals such as school counselors (37%), teachers (32%), and coaches (22%). Of note, parents and friends were more important to these teens than any of these professional groups. Parents were mentioned by 81% and friends by 63% of respondents as sources of good advice on these health topics.

FIGURE

Adolescent perception of preventive health discussions.



CONCLUSIONS

This study confirms that adolescents are hesitant to discuss many areas of prevention with clinicians, but the findings also suggest that receptivity varies greatly by demographic characteristics of the adolescent, past self-reported risk behavior of the adolescent, the setting in which the adolescent is seen, and the risk behavior to be discussed. Two primary limitations must be kept in mind when interpreting the findings of this study. First, generalizability of the results may be limited. The sample is drawn from a localized geographic area, and the sample may be biased because not every eligible adolescent was approached. Rates of reported risk behaviors in this sample are, however, similar to rates reported elsewhere, providing some reassurance that the sample is representative.[16] The use of a self-administered closed-ended survey instrument in this age group presents a second limitation. While the survey was pretested in focus groups, some less literate adolescents may have had difficulty understanding all questions. In addition, concerns about confidentiality may have led some adolescents to give socially desirable answers, and difficulty with recall may have distorted the number of reported past discussions with clinicians. Finally, the complexities of these behavioral issues cannot be fully captured in yes/no responses.

Despite these limitations, this exploratory study provides important information for clinicians. The study confirms findings elsewhere in the literature that adolescents generally have low recall of prior discussions about health-risk behaviors. The dramatically higher recall among adolescents who had previously engaged in those behaviors may indicate that clinicians had succeeded in targeting "at-risk" subgroups, or that these "at-risk" adolescents recognized the importance of the topic and paid more attention. A less optimistic interpretation would be that these messages have no effect on behavior or indeed that these messages encouraged the behavior!

TABLE 2

Variation in Desire to Address Topics of Prevention by Subgroup of Adolescents

% of Respondents in each subgroup answering yes to the question:
During the visit today would you like to have the doctor or nurse talk to you about the following topics?

	Diet	Exercise	Sex, Birth Control, or STDs	Depression	Tobacco (cigarettes, chew, etc)	Alcohol	Drugs	Guns or Fighting
All adolescents	52	50	37	24	20	18	18	14
Male	48	41*	29*	16*	19	18	18	17
Female	57	61*	45*	34*	19	18	18	10
Ages 11-13	51	48	27*	20	17	16	15	14
Ages 14-16	53	51	46*	28	22	22	22	14
High risk†	ND	ND	54*	41*	23	26*	25	18
Non-high risk†	ND	D	30*	21*	17	15*	18	12
Prior discussions‡	63*	58*	54*	55*	35*	36*	40*	67*
No prior discussions	38*	41*	26*	18*	16*	15*	14*	11*
CHC setting	53	51	48*	28	22	22	23*	14
Private practice	51	48	23*	20	17	14	14*	13
Well-care visit	52	56	32	21	18	17	18	14
Acute-care visit	45	46	42	28	21	19	19	12
Knowing clinician	51	54	36	28	18	18	20	15
Not knowing clinician	47	49	37	19	22	20	18	13

* Significant difference between groups at P> 05.
†Adolescent defined at high risk if self-reporting that he or she has previously engaged in the behavior to be discussed.
‡Reporting prior discussions with clinician on behavior to be discussed.
STDs denotes sexually transmitted diseases; CHC, community health center; ND, high-risk category not defined for this topic.

The current study design cannot answer this question but the results should prompt further investigation of this important difference.

The teens' overall lack of desire to talk about preventive-health topics does confirm the perception of those physicians who fail to deliver counseling messages because they feel that adolescents do not want to discuss these topics. This result, if taken out of the context of the remainder of the survey, might raise difficult questions about the utility of taking limited office time to counsel an uninterested adolescent on preventive health topics. Nevertheless, the more important result of this study is the strong association between an adolescent's willingness to talk about a health-risk behavior and that adolescent's past discussions with a clinician about that same behavior. Although this association does not prove causality, the finding is consistent with literature showing that previously taboo topics will be seen as appropriate by patients if mentioned repeatedly.[17,18] The increased willingness to discuss the health-risk behaviors of sexual activity and drug use in CHC sites in our survey may also be consistent with this hypothesis. An explicit mission of CHC sites is to provide preventive health services,[19] and all three clinics serve a higher risk population, where sexual issues and drug use may be more commonly recognized as health threats. For these reasons, it is likely that these adolescents were more exposed to explicit and implicit messages legitimizing discussions on these health topics than adolescents in the private practice settings. The number of CHC sites

in the study does not allow us to draw comparisons between practice types but does support our hypothesis that clinicians can have a powerful role in legitimizing preventive-counseling topics as appropriate health concerns. By initiating the discussion, the clinician may increase the likelihood of further interest and discussion of that same topic in the future.

IMPLICATIONS

Clinicians should provide repeated counseling messages to adolescents to motivate behavior change and, perhaps more important, to help legitimize discussions around health behaviors. Our results imply that if such discussions are left to the teen to initiate, they will likely not take place. Physicians should emphasize that they are willing to discuss these issues again in the future, and underscore the confidential nature of such discussions. Any opportunity to offer such counseling should be taken since it does not appear that receptivity of adolescents varies between well- and acute-care visits. Messages to legitimize these topics within the medical encounter can likely be delivered in a brief time, and it should be feasible to fit them into even very time-limited adolescent encounters. Depending on the length of the visit, clinicians may want to target the health-risk behavior counseling to the age, sex, and interest of the teen. Many illness visits are related to the eight health-risk behaviors in this survey. Preventive counseling could flow quite naturally from dealing with a specific complaint. In addition, this study details that knowing or not knowing the current clinician does not influence an adolescent's willingness to discuss health-risk behaviors. Given that much of adolescent health care is episodic in nature, this finding supports the counseling of all teens, regardless of the clinician's familiarity with them. This study reinforces the recommendations of the *Guide to Clinical Preventive Services*, GAPS, *The Clinician's Handbook of Preventive Services*, and *Bright Futures*, and should help convince clinicians who serve adolescents to offer preventive counseling at every opportunity.

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