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 JOURNAL OF  
**ADOLESCENT  
 HEALTH**


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Original article

## Mothers' Attitudes Toward Adolescent Confidential Services: Development and Validation of Scales for Use in English- and Spanish-speaking Populations



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*Article history:* Received September 17, 2013; Accepted March 3, 2014

*Keywords:* Adolescent health; Confidentiality; Parental attitudes; Instrument development; Spanish and English speakers

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### A B S T R A C T

**Purpose:** To explore parental beliefs and attitudes about confidential services for their teenagers; and to develop an instrument to assess these beliefs and attitudes that could be used among English and Spanish speakers. The long-term goal is to use this research to better understand and evaluate interventions to improve parental knowledge and attitudes toward their adolescent's access and utilization of comprehensive confidential health services.

**Methods:** The instrument was developed using an extensive literature review and theoretical framework followed by qualitative data from focus groups and in-depth interviews. It was then pilot tested with a random sample of English- and Spanish-speaking parents and further revised. The final instrument was administered to a random sample of 1,000 mothers. The psychometric properties of the instrument were assessed for Spanish and English speakers.

**Results:** The instrument consisted of 12 scales. Most Cronbach alphas were >.70 for Spanish and English speakers. Fewer items for Spanish speakers "loaded" for the Responsibility and Communication scales. Parental Control of Health Information failed for Spanish speakers.

**Conclusions:** The Parental Attitudes of Adolescent Confidential Health Services Questionnaire (PAACS-Q) contains 12 scales and is a valid and reliable instrument to assess parental knowledge and attitudes toward confidential health services for adolescents among English speakers and all but one scale was applicable for Spanish speakers. More research is needed to understand key constructs with Spanish speakers.

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### IMPLICATIONS AND CONTRIBUTION

This study assessed the validity and reliability of an instrument to assess parental knowledge and attitudes toward confidential health services for adolescents among Spanish and English speakers. This tool can be used to understand factors that influence parental attitudes to improve parental acceptability of confidential health services offered to their adolescent.

Major health associations recommend that adolescents spend some time alone with a clinician during their health care visit to have confidential health discussions [1–4]. When confidentiality is assured, adolescents are more likely to seek health services,

disclose health risk behaviors, and return for follow-up care [5]. Without confidentiality, adolescents, especially those at greatest risk, may forego needed care [6–9]. Yet, clinical guidelines also recognize the important role parents play in the health and behaviors of their adolescents [10–12], and recommend clinicians to partner with parents about their adolescent's health. These somewhat conflicting guidelines present a unique challenge for clinicians [13], which likely contributes to the fact that few adolescents have the recommended time alone with their clinicians

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and few receive sensitive preventive health services [14]. Furthermore, Hispanic adolescents are less likely than other racial/ethnic groups to have time alone with their clinicians [14]. Many clinicians have difficulty talking with parents about adolescent confidential health services (CS), in part because little is known about parental attitudes of CS or factors that may influence their attitudes. The field lacks a reliable validated survey instrument to assess parental knowledge and attitudes toward CS. Thus, the objectives of this study were to (1) explore parental attitudes of CS for their adolescent and (2) develop an instrument to assess parental attitudes among English and Spanish speakers.

## Methods

### Sample

The survey was developed in three phases: (1) a qualitative phase that began with a literature review followed by focus groups and in-depth interviews; (2) a pilot test of the initial survey to inform revisions; and (3) a cross-sectional assessment of the final instrument. Each phase involved recruitment of randomly selected caregivers of teens aged 12–17 years enrolled in large Northern California clinic systems. “Caregiver” was defined broadly as the adult responsible for the health and well-being of the teen to include parents, guardians, and alternative caregivers (e.g., grandparents, stepparents, foster parents). The samples were recruited from three patient enrollment data bases: (1) Kaiser Permanente (the single largest provider of adolescent health services in Northern California that serves 51 diverse urban, suburban, and rural regions) for all three phases; (2) a publicly funded urban community hospital in the San Francisco Bay Area for phase 1 and phase 2; and (3) a large, publicly funded community hospital serving California’s Central Valley for phase 3 only. Our independent contractor placed lists in random order and selected participants until the desired sample was achieved with no duplicate participants. Materials and procedures were approved by the university and participating clinics’ institutional review boards.

### Survey development

Instrument development began with a literature review and was informed by the Health Belief Model [15] and Theory of Reasoned Action/Planned Behavior [16–18]. The literature review and theories posit that acceptability of CS and ultimately parents’ willingness to facilitate CS would be guided by parents’ (1) perception of their adolescents’ susceptibility to a health condition; (2) perception of severity of the health condition; (3) perception of benefits of and barriers to engaging in the health behavior; and (4) self-efficacy—the parent’s confidence in their ability to carry out specific actions relevant to the health behavior (e.g., communicating with the adolescent and/or provider about CS, helping the adolescent to access appropriate care, etc.). In addition, adolescents’ risk or parents’ prior experiences with CS (for self or child) are important predictors of attitudes and behavioral intentions. Although behavioral intention serves as a proximal predictor of actual behavior, actual skills and resources that parents have may prevent behavioral intention from translating into behavior (e.g., ability of parents to locate a health provider, availability of transportation, etc.). Our literature review and prior research [19] also identified a number of demographic and other sociocultural factors that could potentially influence acceptability of CS,

such as age (of parent and adolescent), gender (of parent and adolescent), race/ethnicity, income, education, perceived social norms, prior experience with health care services, and trust in doctors. Although this work provided the framework, our qualitative methods also allowed for the discovery of new themes.

The qualitative phase included 31 focus groups of caregivers from different racial or ethnic backgrounds (including 8 with Spanish speakers) and 20 in-depth interviews (including three with Spanish speakers). Focus groups were homogeneous on gender, source (a health maintenance organization or a hospital), language spoken (English or Spanish), and ethnicity (white, African-American, Hispanic, Chinese, or Filipino) with the exception of two English language–mixed ethnicity focus groups, one of male caregivers and one of female caregivers. There were 6–8 participants per group. Spanish-speaking focus groups were moderated by native Spanish speakers who were also experienced health research psychologists.

Focus groups were audio recorded and transcribed. The investigators developed a coding scheme through an iterative process of reviewing and discussing transcripts. Transcripts were coded by two independent coders. Inter-coder reliability was >80%, and any discrepancies were discussed and resolved with the investigators. Data were entered into HyperRESEARCH™ for analyses. Initial codes applied to focus group transcript segments were derived from our theoretical framework: (1) perceived susceptibility; (2) perceived severity; (3) perceived benefits and barriers; (4) perceived self-efficacy, (5) cues to action, and (6) actual skills and resources. Transcript segments that correspond to these constructs were further examined. Coders also search for other repeated concepts that correspond to constructs related to the research items that were not anticipated in the initial theoretical framework for possible inclusion. Analyses also considered context, frequency, and intensity of comments [20]. An item stem was developed for each construct and the content was inserted into each stem to create individual items based on review of the entire set of transcript segments corresponding to each construct. Transcripts were re-reviewed to examine the phraseology participants used to describe particular constructs and attitudes in order for the items to reflect the participants’ attitudes, experiences, and language used for describing them. The resulting instrument was translated into Spanish by an experienced independent translator who also is a native Spanish speaker. A forward or backward translation procedure was conducted and reviewed by the research team with one of the coinvestigators being a native Spanish speaker. Cognitive testing was used to ensure a translation that was both culturally and linguistically appropriate.

The first iteration of the instrument was administered via telephone on a stratified random sample of 490 caregivers and averaged 90 minutes to complete. Five of the six strata were drawn from the health maintenance organization list sample (African-American, Asian, white, English-speaking Latino, and Spanish-speaking Latino) and the sixth was drawn from the hospital sample (with no qualification for ethnicity or language). To assess test–retest reliability, a subset of 90 respondents was selected at random to be resurveyed. Retests ranged between 1 and 2 weeks after the original survey (a function of participant availability). The pilot included both male and female caregivers; however, <15% of the respondents were male. Analyses of the psychometric properties for the total sample and separately for English and Spanish speakers informed revisions. The final

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