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

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A B S T R A C T

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 aged 12–17 years completed a telephone survey examining the relationship between parental acceptability of seven contraceptive methods and adolescents' likelihood to have sex, parenting beliefs, parents' sexual health as teens, sexually transmitted infection knowledge, and demographic factors.
Results: Acceptability was highest for oral contraceptive pills (59%) and lowest for intrauterine device (18%). Parental acceptance of teens' autonomy was significantly associated with increased acceptability of all methods. Parental knowledge of sexually transmitted infections was poor, and 51% found it acceptable for clinicians to provide their sexually active teen with condoms.
Conclusions: Parents were more accepting of oral contraceptive pills and condoms compared with intrauterine devices 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).

IMPLICATIONS AND CONTRIBUTION

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.

The incidence of unintended pregnancies and sexually transmitted infections (STIs) remains 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 contraceptive use [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 2010 and October 2010, a random sample of parents/caregivers with an adolescent aged 12–17 years was 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

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want to be contacted were instructed to indicate this by returning a preaddressed stamped return card. Potential participants were phoned 2 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), and emergency contraception (EC). Brief definitions of each method were provided. Parents rated their acceptability of each method on 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 αs $> .80$): (1) parental need to know about teen's health and behaviors (five items), (2) recognition of their teen's autonomy [9] (seven items), and (3) parental trust in doctor (11 items, e.g., physician communication ability, caring, and respectfulness). 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 χ^2 (categorical correlates) and *t* tests (continuous correlates). Logistic regressions assessed the multivariate relationship between acceptability of each method and 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 5,601 randomly selected parents/caregivers were mailed letters; 202 indicated that they did not want to be contacted. Of the 5,399 parents/caregivers who did not return a refusal card, 1,491 were contacted successfully by phone. Of those contacted by phone, 1,397 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 ($p = .051$).

Table 1
Demographic characteristics

Demographic characteristics	Demographic category	Frequency (%)
Parent		
Age (years)	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	84 (32.2)
	$40,001–$80,000	71 (27.2)
	>$80,000	93 (35.6)
Insurance	Self pay	6 (2.3)
	Kaiser	206 (78.9)
	Private insurance	2 (.8)
	Public insurance	46 (17.6)
Religious attendance	Once a week+	92 (35.2)
	1, 2, or 3 times a month	44 (16.8)
	<Once a month	61 (23.4)
	Never	61 (23.4)
Teen		
Age of teen (years)	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)

Multivariate analyses (Table 2) showed that parents who reported their adolescent as 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 one-half reported acceptability of condoms. Furthermore, the most effective contraceptive methods, implant and IUD [3], 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 as 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 holds the misconception