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Clinical Cases

Gynecological Care for Adolescents

Physicians treating adolescents need to give them the information to make intelligent and responsible decisions regarding sexual activity and reassure them of patient confidentiality.

Commentary by Melanie Gold, DO

Mrs. Johnson brought her daughter, Mandy, to see Dr. Jones for her first gynecological visit when Mandy was 13 ½ years old and had just begun to menstruate. Dr. Jones performed a regular physical, but not a vaginal exam, and talked to Mandy about the changes that were leading her to sexual maturity.

Dr. Jones did not see Mandy again until 15 or 16 months later when Mandy made an appointment and showed up on her own worried about vaginal irritation and itchiness. Dr. Jones examined Mandy and, by microscope confirmed his suspicion that Mandy had contracted trichomoniasis. He told Mandy what the infection was and that the person from whom she got it needed to be told so that he could get treatment. Mandy was vague and non-communicative about the topic. Dr. Jones could understand her embarrassment, but Mandy was not able to agree that she would tell her partner. Her main concern was whether Dr. Jones was going to tell her mother.

Mandy was in otherwise good health, upon general examination. Dr. Jones prescribed metronidazol and, because he wanted to talk to her again, asked to see her in 3 weeks. He spoke to her about safe sex and the possible long-term consequences of certain STDs. He assured her that he would not call her mother, but said that the diagnosis would go into Mandy's own personal and private medical record. Mandy kept the appointment 3 weeks later and was clear of infection.

Four months later, however, Mandy was back, again with symptoms of an STD. Dr. Jones is concerned, not only about Mandy's recurrent infection, but also about what appears to be casual sexual activity; she's not yet 16 years old.

Commentary

by Melanie A. Gold, DO

Caring for adolescents who appear to be engaging in unhealthy behaviors is challenging. It is tempting to warn them about the numerous negative outcomes of their behaviors in an attempt to dissuade them from continuing their "risk-taking." Although there is a role for educating, providing information and advice without first determining the patient's readiness to accept it or to change behavior often results in resistance. Education is, by itself, insufficient to facilitate behavior change. Strategies that facilitate behavior change include assuring confidentiality, eliciting information from the patient about the behavior and alternatives, assessing readiness to change, asking permission before providing information or advice and then checking reactions to it, emphasizing autonomy and control, and offering a menu of options to choose from.

At her first visit, there are 3 things that might have made Mandy more comfortable talking about her sexual health. First, Dr. Jones could have talked with Mandy privately explaining to Mandy and her mother that he always sees teens alone for part of each visit. Second, Dr. Jones could have explicitly discussed with both Mandy and her mother his

obligation to keep his patient's medical information confidential, re-emphasizing the confidentiality of the visit when speaking with Mandy alone. It should be explained to Mandy that discussions about sexuality, depression, and substance use will be kept private but reports of homicidal or suicidal ideation or physical or sexual abuse must be shared with the appropriate authorities. Third, Dr. Jones could have obtained a more thorough sexual history including assessing Mandy's feelings of sexual attraction and whether she had begun to engage in any specific sexual behaviors or was considering doing so soon.

To initiate these discussions, one could ask Mandy's permission to talk about her sexual health and elicit from her what she knows about puberty. Asking permission demonstrates respect and facilitates willingness to collaborate in discussion. Eliciting from Mandy her own knowledge about puberty acknowledges that she already knows a lot and allows the health care professional to identify misinformation. One could have also assessed Mandy's readiness to engage in sexual behaviors by asking open-ended questions such as "How soon do you plan to have sex? Why then instead of now?" If Mandy was not planning to have sex soon, Dr. Jones could have reaffirmed her decision to stay abstinent by reporting that her exam was normal and healthy, that she was doing a good job of keeping it that way, and confirming the safety of her decision. He could have concluded the visit by thanking Mandy for speaking with him about herself and inviting her to return when she was considering having sex to learn more about ways to stay healthy.

If Mandy said she was thinking about having sex soon, Dr. Jones could have assessed her reasons for initiating sexual activity by asking "What are the good things for you right now about having sex? What else? What else?" (until she could not come up with any more "good things") then asked "What are the 'not so good' things about having sex?" Asking about "good" and "not so good" things related to behavior change is preferable to asking about the "good" and "bad" things. Labeling the other perspective as "bad" may elicit resistance by forcing the adolescent to feel like she is being manipulated into admitting what she is doing is "bad" and to seeing things your way as the "right" way. The same strategy could be used to assess Mandy's readiness to use different forms of contraception.

At the second visit Dr. Jones spoke with Mandy about "safe sex" and the "possible long-term consequences of certain STDs" after diagnosing her with Trichomonas. A different approach might have facilitated more active participation on Mandy's part and enhanced her willingness to discuss treatment with her partner. Dr. Jones could have told Mandy that her test showed she had Trichomonas and asked her what she knew about it. If Mandy was familiar with Trichomonas but had misinformation about it, he could have asked permission to give her more correct information and, after providing that information, could have checked her reaction to it. If Mandy did not know anything about Trichomonas, he could have asked permission to give her that information and with her permission explained what Trichomonas is, how it is transmitted and treated, and the importance of treating her partner so she will not get re-infected. After the discussion, Dr. Jones could have checked Mandy's reaction to the information by inquiring, "What do you make of this? How does that help or change things for you now?" and asked her what she planned to do.

At the third visit the physician should not assume that Mandy is having "casual sex" because she returned with symptoms of an infection; it is more likely that her symptoms are the result of re-infection with Trichomonas from her untreated partner. Feedback about the infection should be presented in a way that is nonjudgmental and objective. Another way to facilitate behavior change, especially when a patient does not appear ready to change is to offer a statement that emphasizes personal autonomy and control. An example of this would be: "As your doctor I'd like to give you advice about what to do, but I can't make you do anything that you do not want to do. It is up to you to decide whether or not you want to make any changes in what you are doing and if so, what changes you want to make." Such a statement may decrease resistance. It is critical that health care professionals say this genuinely and avoid a condescending or facetious tone.

After asking and receiving permission, health care professional can express concern for a patient's health and give advice that is clear and concise. Mandy could have been asked, "Would it be OK if I shared with you my concerns and some ideas I have about what you could do to keep yourself healthy and not get any further infections?" One could then ask Mandy for a menu of options or list of alternative behaviors. It is more effective if Mandy generates these options. However, adolescents are often unable to generate several options. Health care professionals, with permission, can offer options from which a patient can choose. It is important to offer at least 3 or 4 options at one time. If fewer than 3 options are offered or if each option is offered individually, patients may argue why each one will not work rather than picking the most acceptable choice from several possible alternatives.

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