Understanding and Overcoming Barriers in the Physician-Patient Relationship Related to the Sexual Health of Adolescent Women in Amherst, Nova Scotia

by

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Submitted in partial fulfillment of the requirements for the degree of Master of Science

at

Dalhousie University
Halifax, Nova Scotia
December 1999

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0-612-57310-9
DEDICATION

Sincerest appreciation goes to my friends and colleagues who listened to me as my ideas developed and rallied me to completion. Keith, Cathy, Amanda, Paul, J. & J., Carmelle, Michael, and Mark – I am blessed.

I am also indebted to my parents, Joanne and Victor Marshall for their continued love and support.
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ABSTRACT

This inquiry looks at adolescent women’s experiences with and perceptions of physician services related to their sexual health in Amherst, Nova Scotia. Adolescent sexual health is of particular interest to the medical and scientific communities, due to the rates and consequences of sexually transmitted infections (STIs), unplanned pregnancies, and physical or emotional abuse. Previous research (Langille, 1998), for which I was the project coordinator and field researcher, identified barriers to sexual health education, pharmacies, and physician services experienced by adolescent women from the Amherst Regional High School.

In order to further understand barriers which had been identified through survey research, and to identify new barriers, within Dr. Langille’s research I conducted qualitative interviews with twenty-eight young women who were students at the school, twelve follow-up interviews, and administered a follow-up questionnaire which we designed based on the interviews.

Building on this work, this thesis involves further analysis of the data collected to answer remaining questions. Specifically, the research questions are: 1) What is the relative personal importance of the identified barriers to accessing physician sexual health services for the participants?; 2) What has been the effect of these barriers on participants’ personal capacity to access sexual health services from physicians?; and 3) How were some of these adolescent women able to overcome the identified barriers when using their physicians’ sexual health services?

This research revealed that within hermeneutic understandings of social context and theories of symbolic interaction, identity construction and impression management, study participants experienced multiple, inter-related barriers to accessing physician sexual health services and various ways of overcoming them. Barriers included 1) discomfort with their physicians, particularly the physical examinations; 2) concern over the physician knowing they are sexually active; and 3) issues with others, besides the doctor, finding out they are sexually active.
LIST OF ABBREVIATIONS AND SYMBOLS USED

AAHAS  Amherst Association for Healthy Adolescent Sexuality
AIDS  Acquired Immune Deficiency Syndrome
ARHS  Amherst Regional High School
HIV  Human Immuno-deficiency Virus
STD  Sexually Transmitted Disease
STI  Sexually transmitted infection
WHO  World Health Organization
ACKNOWLEDGEMENTS

First, I am beholden to the young women who took the time to share their experiences and views about sexual health and services they receive. I have learned so much from them.

I would also like to thank my committee members, Prof. Donald Langille and Prof. Terry Mitchell for their expert guidance and support.
1.0 INTRODUCTION

This inquiry looks at adolescent women’s experiences with and perceptions of physician services related to their sexual health in Amherst, Nova Scotia. Sexual health can be defined as “the enjoyment of sexual activity of one's choice, without causing or suffering physical or emotional harm.” (Greenhouse, 1995). Adolescent sexual health is of particular interest to the medical and scientific communities, due to the rates and consequences of sexually transmitted infections (STIs), unplanned pregnancies, and physical or emotional abuse. Adolescents face many barriers to achieving sexual health and reducing the risk of negative consequences from sexual activity. These barriers include: lack of sexual health education, difficulty accessing sexual health services, and interference in making decisions and implementing decisions to reduce personal sexual health risks.

Previous research, funded by the Maritime Centre of Excellence for Women's Health, (Langille et al., 1998), for which I was the project coordinator and field researcher, identified barriers to sexual health education, pharmacies, and physician services experienced by adolescent women from the Amherst Regional High School (ARHS). In order to further understand barriers which had been identified through survey research, and to identify new barriers, within Dr. Langille’s research I conducted open-ended interviews with twenty-eight young women who were students at the school, twelve follow-up interviews, and administered a follow-up questionnaire which we designed based on the interviews. Building on this work, this thesis involves further analysis of the data collected to answer remaining questions. Specifically, the research questions are: 1)
What is the relative personal importance of the identified barriers to physician sexual health services for the participants?; 2) What has been the effect of these barriers on participants' personal capacity to access sexual health services from physicians?; and 3) How were some of these adolescent women able to overcome the identified barriers when using their physicians' sexual health services? This analysis is conducted within an analytical framework of symbolic interactionism and the context of feminist theory, the social construction of medicine, and issues related to a rural community. The ultimate goal of this research is to add to the literature on adolescent women's sexual health, perceptions and experiences from their perspective.
2.0 REVIEW OF LITERATURE

2.1 Defining Sexual Health

When doing research, it is important to take a step back and examine the theoretical framework of the larger picture. The term sexual health is bandied around as a goal or an issue for concern, but what does the term really represent? As humans we are sexual beings throughout our lifetimes, but it is during adolescence that most individuals become fully aware of their sexuality, and thus when sexual health needs to be positively promoted (Howard and Mitchell, 1993; Langille et al., 1999). However, the meaning of sexual health has been widely debated in medical, health promotion and academic literature.

The World Health Organization (WHO) defines sexual health as, “the integration of the somatic, emotional, intellectual and social aspects of sexual beings in ways that are positively enriching and that enhance personality, communication and love.” (WHO, 1975). This definition is explained in WHO’s guide for professionals on sexual health promotion as having the following three elements:

- The capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic.

- Freedom from fear, shame, guilt, false beliefs and other psychological factors that inhibit sexual responses and impair sexual relationships.

- Freedom from organic disorders, diseases and deficiencies that interfere with sexual and reproductive functions. (WHO, 1986).

This definition is limited as social and personal ethics is mentioned as the foundation for control of sex. If, as feminists argue, the social ethics of sex and rules of sexual conduct
are shaped by male dominance, then "social and cultural constraints upon women do not make for an optimum situation for female sexual control or even reproductive control." (Few 1997, 21).

An alternative definition from Marie Goldsmith (1993) offers that sexual health has the three following fundamental dimensions:

- absence and avoidance of STDs (including HIV)
- control of fertility and avoidance of unwanted pregnancy; and
- sexual expression and enjoyment without exploitation, oppression or abuse.

Another definition, attempting to encompass all of the issues of control, exploitation, STIs and pregnancy while acknowledging sexual pleasure, comes from Peter Greenhouse (1995). His simple, yet thought-provoking one-liner is, “Sexual health is the enjoyment of sexual activity of one’s choice, without causing or suffering physical or mental harm.”

Whatever definition is considered, it is clear that implicit in the issue of sexual health is the complexity of social, emotional and biological factors. As a result, sexual health is a multifaceted area with complex implications for health service delivery, particularly for physician’s services for adolescent women (Few, 1997; Haffner, 1996). Understanding the relationship between adolescent women and sexual health service delivery from their physicians is thus a complex process, and complex human processes are best suited for qualitative inquiry (Denzin and Lincoln, 1998). This particular aspect of sexual health between doctors and female adolescent patients will be further discussed in Section 2.4.
2.2 Adolescent Sexual Health in Canada and Nova Scotia

The majority of adolescents in Canada are sexually experienced. According to the Canada Youth and AIDS study (King, 1988), almost fifty percent of grade eleven students have had intercourse. In Nova Scotia, it is reported that more than sixty percent of grade twelve students have had sexual intercourse (Poulin, 1996). In a 1996 survey of Amherst Regional High School (ARHS) students, “forty percent of students had more than one sexual partner each year, and that only forty-one percent [of those] used condoms regularly.” (Langille et al., 1997). Thus, it is known that many adolescents are sexually experienced and that there is the potential for negative consequences.

Negative consequences of sexual activity can include unwanted pregnancy, sexually transmitted infections (STIs), and physical or emotional abuse. The mean age-adjusted pregnancy rates for 1991-1995 for Amherst females aged 15 to 19 is 6.86/100 (sd 2.43) (Langille, 1997). Age specific rates of fertility for adolescents of this age in Nova Scotia did not decline during the period 1981 to 1995 (Pennock, 1996). In Canada, the highest rates of infection with Chlamydia trachomatis (the most common STI) are reported in 15 to 19 year old females and 20 to 24 year old males, and are associated with high risk behaviour (Torrence, 1996; Squires, 1997). Though chlamydia rates specific to Amherst are not available, the overall rate for the Northern Health Region, which includes Amherst, was 11/10000 in 1995 (NSDH, 1995). Data regarding sexual assault including date rape is controversial due to varying definitions and reporting bias (Humphreys and Herold, 1996). Among academics, the generally agreed upon lifetime incidence of sexual assaults in Canada is between fourteen to twenty-five percent (Humphreys and Herold,
Less tangible aspects of their wellbeing related to sexual health has not been explored as thoroughly in research. However, the percentage of adolescents who do experience negative consequences of their sexual activity (unwanted pregnancy, STIs, physical or emotional harm) is cause for concern and a major focus for service providers and researchers.

While the majority of adolescents in Canada are sexually experienced, the vast majority do not experience unwanted pregnancy or sexually transmitted infections, as demonstrated in the previous statistics. As the rates for sexually transmitted infections and unwanted pregnancy are associated with “high risk behaviour”, the term requires some definition. In terms of sexual health, the Youth Risk Behaviour Surveillance in the US (Kann et al., 1995) includes a fairly comprehensive list of risk behaviours. The activities which would be considered to increase risk of negative sexual health consequences for adolescents are: having sexual intercourse, age at first intercourse, number of sexual partners, not using condoms, not using other forms of contraception, alcohol and/or drug use with sexual intercourse, pregnancy, and lack of HIV education (Kann et al., 1995). Research describing the prevalence of high risk sexual activity in high school students in a county in Nova Scotia included the following risk-associated behaviours: number of partners for vaginal intercourse, frequency of condom use by students having only vaginal sex, sexually active students participating in anal intercourse, and condom use in students participating in anal intercourse (Langille et al., 1994).
Adolescent pregnancy is usually unintended (Goldenberg, 1995; Fellows, 1992), may result in low birth weight infants and preterm delivery, and has an associated higher infant mortality rate (Fraser, 1995; McAnarney and Hendee, 1989). For women under the age of fifteen years, the complication rate is sixty percent higher than the rate for all women giving birth (Feldman, 1994). Teen mothers complete less education than those who do not bear children early (Feldman, 1994; McAnarney and Hendee, 1989). Not surprisingly, teen mothers also reach lower levels of work success and of long-term income, and feel less satisfied with their vocational achievements (Feldman, 1994). Because mothers who marry subsequent to their child’s birth are more likely to divorce or separate, most teen-headed families with children are single-parent households (Feldman, 1994). In the end, “adolescent pregnancy and childbearing may carry increased medical risk for mother and baby as well as lasting social, academic and economic disadvantages for mother, father and children.” (Feldman, 1994: 541; see also Goldberg, 1995; McAnarney and Hendee, 1989)

Adolescent sexual health is a gendered issue. Women are at higher risk of contracting STIs from men, than the reverse, in part because of anatomical difference (Church and Gill, 1994). This is especially significant for HIV transmission since “during unprotected vaginal intercourse, women are biologically more susceptible to HIV infection from an infected partner for two main reasons. Firstly, the exposure of mucosal surface (vagina and cervix) is much greater than the male urethral surface. Secondly, semen contains a higher titer of HIV than vaginal secretions. The potential for HIV infection is also increased if anal intercourse is practiced.” (Church and Gill, 1994) Furthermore, as
women tend to have older male sexual partners, these partners are more likely to have
had more prior sexual partners, increasing the likelihood of HIV infection (Church and
Gill, 1994). While biological differences for the risk of contacting STIs may not appear to
be gendered, (as they are not socially constructed), the consequences of this male/female
difference does have the potential for gendered consequences (i.e. personal risk
awareness, risk behaviours and potential health outcomes).

Women also bear the majority of responsibility and consequences for unintended
pregnancy. Since women are the ones who become pregnant, contraception has
traditionally been the responsibility of women (Few, 1997). As Edwards points out, with
the development of oral contraception, “men, no longer required to use condoms or to
practice withdrawal, were essentially absolved from contraceptive decisions.”(1994: 77)
However, this role of responsibility for contraception has just begun to shift back, as it is
men who “are now being asked to use condoms to prevent the spread of STDs and who
are being held financially responsible for any offspring, are [thus] gradually coming back
into the picture.”(Edwards, 1994: 77) Still, women bear the brunt of the responsibility
and potential consequences of sex (Edwards, 1994; Few, 1997).

STIs and unwanted adolescent pregnancy can have short and long term negative effects
with enormous costs to the individual, community, health and social support systems.
This is not meant to suggest a “blame-the-victim” approach to sexual health issues.
However, young women must be given the knowledge, access and opportunity to reduce
their sexual health risks as a model of primary prevention. They further need access to
physician services in the case of unplanned pregnancy or contracting STIs. Barriers to these sexual health services will be discussed in the next two sections.

2.3 Barriers Experienced by Adolescents in Achieving Sexual Health

Barriers to young women achieving sexual health are complex, inter-related and numerous. As previously discussed, much of the responsibility and burden of sexual health issues falls on women. For this reason, this research will focus on the barriers (both gendered and not gendered) that adolescent women experience in being helped to achieve sexual health through physician services. Research indicates that adolescent women face multiple barriers to reducing their risks of pregnancy and contracting STIs (Langille, 1997; Feldman, 1993; Taylor, 1995; Stephenson, 1997; Walsh and McPhee, 1992). These barriers may include lack of sexual health education, difficulty accessing sexual health services, and interference in making decisions and implementing decisions to reduce personal sexual health risks.

While all of these barriers merit exploration, the focus of this research is on barriers (and overcoming barriers) for young women accessing sexual health services from physicians. Our recent qualitative research with female students from ARHS identified and examined barriers they experienced accessing sexual health services from education, pharmacies and physicians (Langille et al., 1999). These barriers, specific to physician services, are identified in this report and will be discussed in the next section (2.4).
2.4 Physicians and Adolescents

A relationship with a physician is often necessary for adolescents who want sexual health services such as oral contraceptives. In our society a system has been created for providing health services to individuals. As the Canadian Medical Association defines,

> Primary medical care is the foundation for the Canadian Health Care System and is critical in maintaining and improving the well being of Canadians. It includes disease prevention, health promotion, health system reform, methods of service delivery, education, research and quality management. (Canadian Medical Association, 1994)

The report goes on to state that the national and international consensus is that primary care is best delivered by a physician educated in comprehensive care and that specifically, family physicians are trained to deliver these services as a basic component of their practices (Canadian Medical Association, 1994). As a result, the family physician is the initial point of entry into the health care system for most Canadians.

In terms of adolescent sexual health and prevention, the physician can provide education to help reduce unintended consequences of sexual activity, such as unwanted pregnancy and sexually transmitted infections including HIV/AIDS (Steben, 1990; Oandasen and Malik, 1998; Fellows, 1992). Physicians can further help adolescent women with diagnosis and care for pregnancy, sexually transmitted infections, and counseling for potentially abusive sexual relationships (Steben, 1990; Oandasan and Malik, 1998). Moreover, in most cases, physicians are necessary providers for adolescent sexual health since a physician is required to prescribe oral contraception, or to screen for sexually transmitted infections.
Where there are problems in the physician-patient relationship, this may lead to access of these services being hindered for adolescent women. A 1995 Canadian survey indicated that over one-third of Canadians are dissatisfied with their physicians, while a similar percentage reported physician behaviour as "arrogant" or "insensitive" (Posner, 1995). Problems are perceived from both sides of the relationship. Physicians have reported that 20-25 percent of general practice visits result in communication difficulties (Pendleton and Hasler, 1983). However, this is argued to be an underestimation as, "physician evaluation of the terminology that patients understand is often inaccurate and the extent of mis-communication is under-recognized." (LindenSmith, 1998; Pendleton and Hasler, 1983). Ammerman et al.'s (1992) study of women aged thirteen to eighteen found that teens often misunderstood medical vocabulary related to sexual health.

While problems with physician-patient communication have been reported, it has been demonstrated how important good communication can be. The available literature shows that, from the patients' perspective, the most significant expressions from physicians include: "exploring the presenting problem thoroughly, expressing empathy and caring, handling patients' feelings, using comforting and listening skills, being attentive to verbal cues, using open-ended questions, involving patients in decisions, inspiring trust, and expressing interest in patients' opinions." (LindenSmith, 1998). While this may seem like a tall order to some, good communication can effect the outcome of a medical encounter. Studies indicate that patient satisfaction with their physician leads to increased compliance, less physician changing, and a higher likelihood of seeking care at an
appropriate time (Wolliscroft et al., 1994). On the other hand, poor communication has been cited as one of the leading causes of problems in the physician-patient relationship (LindenSmith, 1998). All of these outcomes, both positive and negative, have implications for adolescent women seeking physician sexual health services.

How do these problems with physician patient communication in the area of sexual health arise? Much of the literature seems to suggest physician training is to blame (LindenSmith, 1998; Dunst and Trivette, 1988; Barrett and McKay, 1998; Braverman and Strasburger, 1994). Training has been found to influence the likelihood of physicians raising sexual health topics (Barrett and McKay, 1998). As an example, Barrett and McKay site a study by Fisher et al. (1988) that found “a relationship between medical students’ attitudes and their self-identified willingness to address the sexual concerns of patients.” (Barret and McKay, 1998).

Another study by Fortenberry et al. (1988) examined how the values and adolescent experiences of eighty resident physicians in California affect their care of their adolescent patients. They found that physicians with higher scores of their values perceived themselves as less likely to prescribe oral contraception to an adolescent. Physicians who scored higher as risk-takers when they were adolescents considered themselves more skilled in dealing with issues including sexually transmitted diseases and recognizing psychological problems.

Millstein et al. (1996) found gender differences among physicians in their addressing of
adolescent sexual health. Their study of 1,217 physicians found that female physicians reported providing prevention services at a higher percentage than their male counterparts. This would concur with the finding of Roter et al. (1991) that found female physicians conducted longer medical visits with substantially more talk than their male colleagues. Differences were especially evident during patient history taking, when female physicians were observed to talk forty percent more than male physicians, resulting in the patients of the female physician talking fifty-eight percent more than male physicians. Roter et al. (1991) also found that in their comparison of male and female physicians, female physicians engaged in more positive talk, partnership-building, question-asking and information giving than the male physicians. Likewise, compared to patients of male physicians, female physicians’ patients engaged in more positive talk, more partnership-building, question-asking and information giving, related to both biomedical and psychosocial topics.

Another study by Mahler (1997) found that California physicians who routinely see adolescents often do not provide them with a high degree of sexual health related preventive care. Only forty percent of these physicians reported screening all of their adolescent patients to determine if they were sexually active. Female physicians were more likely to do so than male physicians. Mahler also found that more recent medical school graduates were more likely than others to say they screened adolescent patients for sexual activity, educated them about STDs, and provided services to sexually active teenagers. Overall, physician’s characteristics (including gender, year of medical school graduation, and practice setting) explained twenty-nine percent of the variance in rates of
screening for sexual activity and sixteen percent for both STD education and services to sexually active adolescents. Mahler concludes that while both federal and American Medical Association guidelines advise that all adolescents be screened for sexual activity, this study observed that fewer than half of the primary care physicians they surveyed practiced this standard.

An MMWR report (1997), examined *Chlamydia trachomatis* screening practices of primary-care physicians in North Carolina because the risks and complications associated with this infection prompted the Centre for Disease Control and the US Prevention Services Task Force to recommend that all sexually active adolescent women undergoing a pelvic examination receive routine screening. They found that of the 117 responding practices that served adolescents, eighty percent reported that they performed chlamydia testing, and twenty-nine percent reported that they routinely screened adolescent women. Routine chlamydia screening was associated with the clinics’ financial charters and with patients’ insurance, race, and ethnicity.

In Canada, Maheux et al. (1999) looked at whether physicians assess lifestyle health risks during general medical examinations. The authors sought to examine the extent to which screening practices guidelines have been integrated into medical practice, and to measure the physicians’ perceived level of difficulty in assessing these risks, and to document physicians’ evaluation of their formal medical training in lifestyle and risk assessment. To this end, the researchers surveyed 1086 general practitioners (GP) and 241 obstetrician-gynecologists (Ob-Gyn) who reported routine assessment (with 90% or more
of their patients) of substance use, family violence and sexual history during general medical examinations. In the area of sexual history, condom use was routinely assessed by more Ob-Gyns than GPs (47% vs. 28.2%); however, they were equally low for assessing the number of sexual partners (24.8% and 32.1%) and STD risk ((26.2% and 23.1%). Therefore, the authors write that “despite significant morbidity and mortality related to STDs and the prevalence of sexual risk behaviours in the population, less than one-quarter of the GPs in our study reported that they routinely assess their patients’ sexual risk behaviours.” (Maheux et al., p.1833) Maheux et al. further argue that, “these results are comparable to those reported previously and suggest that physicians are hesitant to discuss these issues...despite the finding that most of the physicians felt that their medical training was adequate or excellent in assessing sexual risk behaviours, up to half stated that they find it difficult to discuss these issues with patients.” (p. 1833) The authors also believe that although they surveyed GPs and Ob-Gyns in Quebec, there is no reason to believe that the practices would be any different elsewhere in Canada, “since medical education and training are comparable between provinces and the basic principles underlying various health care delivery systems in Canada are similar.” (p.1834)

A review of the relevant literature by LindenSmith (1998) found that “final-year [medical] students have also been found to be less caring, empathetic, and supportive after a four-year medical education which tends to emphasize disease processes rather than the more humanistic aspects of medicine.” LindenSmith (1998) further found that medical education across Canada has great discrepancies in the amount and quality of
training physicians receive for communication. This finding is supported when directly applied to sexual health and STD prevention in Canadian medical schools in a national study done by Barrett and McKay (1998). They found differences between medical programs across Canada, with the sexual health topics most heavily emphasized being: STD/HIV prevention and treatment, sexual assault/abuse, and pregnancy prevention, while other topics such as the role of sexuality in couples, sexual orientation, and adolescent sexuality receiving “less emphasis than seemed warranted” (Barrett and McKay, 1998).

These findings relate to Langille et al. (1997)’s study assessing physicians’ history taking and service provision related to adolescent sexual health in a Nova Scotia county. Twenty-six of thirty-seven physicians in a single county in Nova Scotia took part in interviews. Langille et al. found that fewer than fifty percent of male physicians were able to give correct responses to seven of ten areas related to knowledge of the epidemiology of adolescent pregnancy and STDs. All of these physicians believed this to be an important area of prevention, with eighty-nine percent believing that prevention is possible. However, only sixty-two percent believed that their own prevention efforts were effective. Moreover, male physicians and those in rural practices were found to be significantly more likely to have larger gaps between the preventive practices they say are desirable and those they actually performed. Langille et al. (1997) also found that, “significant enabling factors included high levels of perceived personal comfort and skill…” but that “time factors and opportunities to interact with adolescents sufficiently frequently to carry out prevention were seen as barriers…” and that “the physician fee
schedule was a negative reinforcing factor.” (Langille et al. 1997, p.324)

A 1982 study also found a lack of experience in providing sexual health services among graduates of pediatrics programs in Canada and the United States. Only 30% of graduates had ever prescribed oral contraception, 50% had never performed a pelvic exam, and 14% had never made a diagnosis of gonorrhea (Braverman and Strasburger, 1994). This lack of training may in part explain Malus et al. (1987)’s finding that among Quebec adolescents 70% wanted to discuss STDs and 66% wanted to discuss contraception with their physicians, yet only 18% and 22% had, respectively. This phenomenon may also be in part due to the fact that as adolescents they tend to avoid authorities and institutions (Malus, 1987). Often, the adolescents were found to be too shy to raise the issue and they hoped that the physician would do so (Malus, 1987).

Beazley et al. (1996) interviewed thirty-nine young women from two rural counties in Nova Scotia who had recently had a baby, become pregnant, or contracted a sexually transmitted disease (STD), about their physicians as a source of information about preventing pregnancy and STDs. They found that prior to pregnancy or contracting a STD, fifteen of the participants had not received any prevention-oriented information from physicians. Twenty-four participants had received information from their physicians, but these interventions had not been sufficient to prevent unintended pregnancy or STDs.

Croft and Asmussen (1993)’s study performed focus groups with parents and 800
adolescents to determine the preferred physician role regarding families and sexual development. Results included that physicians were believed by parents to be appropriate experts to assist in preventing negative risk behaviours including sexual intercourse, and emphasized the importance of the physician developing comfortable relationship early on with parents and youth to allow for reciprocal dialogue about sensitive topics. Parents also commented that physicians generally appeared uncomfortable when discussing personal issues, in particular sexuality, and frequently lacked communication skills (e.g., use of open-ended questions or statements) to foster conversation (Croft and Asmussen, 1993). Youth also identified physicians as a logical source of information about sexuality, but felt hesitant asking questions that they felt might prompt value-based discussions. Youth also expressed concern about confidentiality in their physician-patient relationship, and desired that physicians be more “askable” than they are perceived to be (Croft and Asmussen, 1993).

A recent qualitative study (Oandasan and Malik, 1998) done in Toronto looked at what female adolescents experience when visiting a family practitioner. With eight participants, the following themes were identified: adolescent girls feel more comfortable with female physicians, adolescent girls feel uncomfortable during physical examinations, adolescents would like doctors to explain medical issues, adolescent girls want to be treated as teenagers by their doctors, and adolescent girls want their doctors to be more like friends (Oandasan and Malik, 1998). It was evident from this study that barriers to physician services exist for adolescent women in Toronto and that these issues have the potential to be addressed.
Some of Oandasan and Malik’s (1998) findings are supported by Frankel (1993)’s investigation of the physician examination. He found that touching by physicians constituted bodily access and contact by a non-intimate person found under no other circumstances. In Frankel’s examination of touching in the physician-patient encounter, he further found it to be a complex, negotiated phenomenon in which meaning is “contingent on the background that furnishes both a texture and rules for deciding the appropriateness of an action…” (1993, p. 96) This interpretive understanding, Frankel argues, “transforms the nature of the physician’s participation in the health care encounter from an objective, dispassionate giver of advice to an interactional partner who actively participates in the social construction of illness, its treatment, and outcome.” (1993, p.97)

Oandasan and Malik’s findings may also be informed by Todd (1993)’s examination of the physician-patient discourse in providing prescription of contraception. By observing twenty medical interviews she found that despite the origin of the questions regarding contraception coming from the patient, the doctor was in control of the interaction and often in conflict with the patient. The doctor’s knowledge was surrounded by an “aura of reverence, which turns that knowledge into an interactional tool for the socially defined and accepted power…” (1993, p. 206). The conflict arose as the patient asked the doctor for assistance in “understanding how to adjust her body to her social life, while the doctor’s technical answer assumes that the patient should adjust her social life to her body, because the doctor does not consider information about the patients’ social life theoretically relevant.” (1993, p. 206) Furthermore, Todd found that doctor’s
assumptions about their patient can play a powerful role, defining women’s definitions of self as well as influencing their health.

Another aspect to accessing physician sexual health services for these Amherst study participants may be related to issues of living in a rural community. While the majority of the literature on rural access to health care in Canada is focussed on remote northern areas, some of the key issues may be germane for this community. These issues may include: recruitment and retention problems for physicians in rural areas leading to physician shortages and lack of continuity in care (Sibbald, 1999; Goldwin et al., 1996); transportation needs to see a physician; lack of privacy and familiarity; fewer social and health supports; and increased poverty (Liepert and Reutter, 1998).

Many of the problems with the physician patient relationship are rooted in the nature of the medical system. The medical system is a belief system, as all knowledge exists within a system of belief (Lippman, 1998). The medical belief system is culturally constructed and is informed by science, a practitioner’s world view with the perceptions of other physicians, the medical community and the culture in which physicians live (Good and Good, 1993; Good, 1996; Bolaria and Dickinson, 1994). Despite the rhetoric about evidence based practice, research indicates that, “A diverse set of medical discourses mediates personal meanings and institutional struggles (M. Good, 1985); individual practitioners draw upon distinctive models in the world, and these are reflected in their diagnostic work (Gaines, 1979); and physicians’ view of particular conditions – obesity, menopause, chronic illness – are steeped in cultural meanings and institutional double
binds.” (Good and Good, 1993: 82) Certainly, these observations about medical practice are significant factors for adolescent women needing sexual health services from physicians. As research shows that many aspects of patient care are affected by the physician’s personal world view and cultural influences, it would seem likely that an issue as value-laden and sensitive as adolescent sexual health would be effected by the constructs of this belief system (Fellows, 1992).

The belief system within which medical practitioners operate has led to the creation of a medical model of health and disease. Disease is clearly defined as “a definite morbid process having a characteristic strain of symptoms – it may affect the whole body or any of its parts, and its etiology, pathology, and prognosis may be known or unknown.” (Inglefinger, 1982 in Bolaria and Dickinson, 1993). Medical scientists “searched for organisms causing infections and single lesions in non-infections disorders…

Contemporary medical knowledge is rooted in the paradigm of the ‘specific etiology’ of disease, that is, diseases are assumed to have a specific cause to be analyzed in the body’s cellular and biochemical systems. This paradigm developed out of the germ theory of Pasteur and Koch.” (Bolaria, 1994: 2). As Fabrega (1993) states, “General medical theory argues for the reality and centrality of disease factors (that is, organic changes)….” Thus, from the perspective of a physician, the medical model prescribes that there be a pathology leading to symptoms which require a diagnosis, followed by treatment with the end goal of a reversal or amelioration of pathology. This bio-medical model does not include prevention, education and so on – issues which are extremely important for adolescent sexual health. Moreover, physicians are constrained by time and financial
interests limiting their focus on education and prevention (Green et al. 1998).

A patient’s role in the medical model follows a script as well. First a patient may present to their family physician with complaints of their symptoms (Frankel, 1994). In this regard, the patient is looking for legitimization of her or his illness through a physician’s diagnosis of pathology, or in some cases, by non-diagnosis as a pathology (Frankel, 1994). Yet, there may be several problems for adolescent women accessing the health services they want. First, within the hierarchical relationship with the physician there would be a power imbalance (Frankel, 1994) which may make an already sensitive subject, such as sexual health, more difficult to address. Also, given the life stage of adolescence, addressing sexual health may be one of the first times an individual seeks physician services of their own accord (Oandasan and Malik, 1998).

In addition, within this model of care, sexual health does not fit into the ascribed medical model, as an individual seeking sexual health services may not be presenting with a chief complaint with symptoms or pathology (Merrill et al., 1990). Finally, addressing sexual health with a physician can be particularly difficult for adolescent women as the course of diagnosis has been shown to make adolescent women uncomfortable with intimate physical examinations (Oandasan and Malik, 1998). Community and parental values may also come into play for adolescent women needing sexual health services from physicians. Studies indicate that adolescent women delay seeking contraception on average of seventeen months of initiating intercourse (Fellows, 1992).
By its very nature, medicine is more than science – it is social as well. Theoretically, the "construction of medical knowledge is intersubjective reality in the context of highly organized interpersonal and institutional relationships." (Good and Good, 1993: 84).

Sociology and anthropology further our understanding of the biomedical model of disease and pathology by introducing understandings of sickness as social phenomena and illness as a lived experience. The theoretical perspectives which underlie these approaches are diverse. For example, being sick provides a reprieve from the responsibilities of everyday life; illness is a form of deviance and medicine is a form of social control; medical training is a process of socialization and diagnosis is a matter of doctor-patient negotiation (Nettleton, 1995). Moreover, since the medical system has been shown not to treat individuals equally, issues of how socio-economic status, age, gender, ethnicity, and disability also affect the social distribution of health and illness, access to health care services and treatment received (Mechanic, 1995). These realities leave practitioners with limited options from the system within which they operate for helping patients, including adolescent women in need of sexual health services.

Physicians’ abilities to help patients may also be hindered by the help-giving models they are trained to use. Dunst and Trivette (1988) compared four models of helping individuals, one of which is based on the traditional western medical system of help-giving. This comparison found that the medical model leads to outcomes which are: low in the help seeker’s responsibility for the past; low for the help seeker’s responsibility for the future; low for the help seeker’s attribution about self-efficacy; and behavioural outcomes which include passivity, dependency and learned helplessness. In their
assessment the medical model does not perform well in any of their evaluation criteria.

For adolescent women, these criteria for evaluation could have dramatic impacts. For example, an adolescent woman may have to make significant lifestyle changes to improve her sexual health. If the help provided in the medical model lowers help seekers' self-efficacy, and creates passivity, dependency and learned helplessness as behavioural outcomes, then adolescent women will be hard-pressed to make progress.

From this growing understanding of the gap between ideal physician sexual health services for adolescent women, and the services that they are now receiving there has been increasing research and recommendations. In 1996, Planned Parenthood, Nova Scotia, published a report called “Just Loosen Up and Start Talking! Advice from Nova Scotia Youth for Improving their Sexual Health”. This report addressed issues of sexual activity, sexual orientation, parents, school health education, physician and other sexual health services. Many recommendations for accessible sexual health services were made, including:

- Youth wish they could go to a youth positive, sexual health clinic that is supported by their parents and peers.
- They want to feel supported for seeking sexual health, not ashamed.
- They want confidential access to contraceptives and clinic services. And,
- They want access to the professional help they need without fear of judgement or exposure.

For physician services, the participants further characterized their ideal physician as:

- Nonjudgemental;
- Gives all the information they need and want;
- Provides the full services needed, including referrals and counseling;
- Understanding and supportive, making it easy to open up and talk;
- Gives details and facts, but not too much too fast, in clear language;
- Backs it up by giving a pamphlet or video for later;
- Confidential, respects privacy;
- Speaks to them with respect;
- Not their parents’ doctor, but is familiar to them;
- Accurate, reliable information;
- No pressure for abstinence;
- Is comfortable with own sexuality and talking about sex;
- Acceptance of their views and choices;
- Probably female;
- Gay positive; and
- Youth positive.

These youth were able to articulate their issues with sexual health services and make recommendations for its improvement.

The recent qualitative study (Langille, Graham and Marshall, 1999) with female students from ARHS examined barriers adolescent women experienced accessing sexual health services from education, pharmacies, and physicians. The research report (Langille et al., 1999) indicated that the following barriers to physician services exist for adolescent women accessing their physician services related to sexual health:

- barriers related to comfort and communication with physicians
- barriers related to participants’ needs for non-judgmental support in development of a sufficient personal level of comfort in looking after their sexual health
- barriers related to access to physicians

The question remains, what do adolescent women need or want from their family physicians regarding sexual health? This research will further explore themes identified in our report (Langille et al., 1999). Data collected for that report is analyzed here to answer further research questions regarding the barriers to the doctor-patient relationship for the participants.
3.0 OBJECTIVES

The objective of this research is to add to the literature on adolescent women's sexual health needs, perceptions and experiences from the women's perspective regarding their relationships with their physicians. This study will explore the relative personal importance of the barriers to physician sexual health services. This research will further explore the consequences of these stated barriers as explained through interviews with participants. Moreover, this research will uncover how some participants were able to overcome barriers to physician sexual health services. The understanding uncovered from this data is discussed in relation to theoretical framework of symbolic interactionism.

Research questions:

3.1 What is the relative personal importance for participants of these identified barriers to physician sexual health services?

3.2 What has been the effect of such barriers on participants personal capacity to access sexual health services from their physician?

3.3 How were some adolescent women able to overcome these barriers to using their physicians' sexual health services?
4.0 METHODS

The research for this MSc thesis is a further analysis of the primary data collected by the Field Researcher (Emily Marshall), as part of the Amherst Initiative for Healthy Adolescent Sexuality. The primary data collected involved in-depth semi-structured qualitative interviews following an interview guide (see Appendix 1) with twenty-eight participants. The participants were all female students at Amherst Regional High School. Participants were selected using purposive sampling (1995 Morse), with the help of two key informants (a grade 9 female student and a grade 12 female student), as well as the ARHS Nurse Educator (Christina Chitty, Amherst Association for Healthy Adolescent Sexuality or AAHAS) and the AAHAS Project Coordinator (Heather Doncaster-Scott). These key informants provided names of potential participants to be as inclusive as possible. Criteria included being a female student at ARHS, representation from all grades (9-12), varying academic performance, different levels of school involvement, and diversity in social networks and sexual experience. Once a list of potential participants was developed, the Project Coordinator contacted these students at the school, informed them of the study asking them to participate and provided them with consent forms. Parental consent forms were also given to participants under the age of 18. All of the students contacted agreed to participate in the study. Follow-up interviews were done with twelve of those participants in order to clarify and explore emerging themes further.

A follow-up questionnaire (see Appendix 2) was then designed from the original interviews to examine the relative importance for the participants of the barriers they identified during the interviews. Twenty-six of the twenty-eight interview participants
completed the follow-up questionnaire. All of the questionnaires were completed in the presence of the Field Researcher or the Project Coordinator, so that any concerns or questions could be addressed, and instructions were given to participants both on paper and verbally. The first page asked the participants to rank the barriers according to what they perceived the importance of the barriers for the adolescent women in their community were in general. Results of this page were analyzed and summarized in a previous report (Langille et al., 1999). The second page asked participants to indicate the barriers which affected them personally, and to place on a scale what the effects of the barriers were for them in accessing sexual health services from their physician. The data from the second page of the questionnaire had not yet been analyzed previous to this study.

For this thesis, the above mentioned data is analyzed using qsr-NU*DIST 4.0 software (for the interview transcripts) and EpiInfo (for the follow-up questionnaire). The questionnaire has strong ecological validity as it is developed directly from data extracted from the interviews with participants, using their terms, language and context. While the questionnaire findings do not have statistical significance nor are they generalizable outside of the participants, they are useful data for triangulation of interview data. This analysis will focus on the data gathered as it relates to the perceptions and experiences of the participants with their physicians in seeking and obtaining sexual health services. The research questions go beyond the first report’s identification and general ranking of the barriers by: 1) addressing the relative personal importance of these barriers as experienced by the participants; 2) stating what the effects of these barriers have been for
participants; and 3) explaining how some participants were able to overcome barriers to sexual health services from their physicians.

4.1 Analytical Framework

The analysis is informed with a theoretical framework of symbolic interaction. The term symbolic interactionism was coined by Herbert Blumer in 1937. Symbolic interactionists seek to understand how individuals bring meaning through social interaction. Blumer’s definition sees “meaning as arising in the process of interaction between people. The meaning of a thing for a person grows out of the ways in which other persons act toward the person with regard to the thing. Their actions operate to define the thing for the person. Thus, symbolic interactionism sees meanings as social products, as creations that are formed in and through the defining activities of people as they interact.” (Blumer, 1969). Blumer’s basic tenets, consistent with those later used by Addison, (see above) of symbolic interactionism are:

1) We act towards things in relation to the meaning they have towards us.
2) Source of meaning is created in interaction with others.
3) Meaning is derived by interaction; it is continually modified within an interpretive process.

Thus, symbolic interactionism is a useful lens by which to interpret some of the experiences and perceptions of the participants.

4.2 Subjective Location

As the field researcher, I served as both the data collector and the filter through which the data were interpreted. I am a white female, aged twenty-five and a full-time graduate
student at the time of the interviews. I have a background as a sexual health educator which provided me with a solid understanding of the issues involved with adolescent health. I felt I was able to enter this inquiry with interest and empathy for participants and with a non-judgmental attitude towards adolescent sexual behaviour. To the fullest possible extent I took caution to prevent preconceived notions from guiding the direction of the inquiry and the observations recorded. I took care to ensure that observations, hypothesis generation and analysis were guided as much as possible by the voices and experiences of participants.

### 4.3 Qualitative Approaches

Qualitative research methods are ideal for this type of inquiry which delves into complex human behaviour and phenomena (Denzin and Lincoln, 1998). Qualitative methods can be used as a multi-method approach to research, which are interpretative and naturalistic, interconnecting the use of a variety of empirical materials, with the interactive process of the qualitative researcher as *bricoleur* or jack-of-all-trades (Denzin and Lincoln, 1994). According to Denzin and Lincoln, the *bricoleur* “understands that research is an interactive process shaped by his or her personal history, biography, gender, social class, race, and ethnicity, and those of the people in the setting.” A *bricoleur* makes use of multiple methods to understand the phenomenon under inquiry. What emerges is a socially constructed view of reality which recognizes the intimate relationship between the researcher and what is being studied, as well as the situational constraints that have shaped the inquiry (Denzin and Lincoln, 1994).
For this thesis, data collected in the above outlined research is further analyzed. A further examination of interview transcripts and field notes for new coding is employed using qsr-NUDIST 4.0, to look more closely at the physician patient relationships of the participants. This analysis moves beyond previous work, which identified and generally ranked the barriers to physician services related to sexual health, by looking at both how participants experienced barriers and overcame them factors in the participants' relationships with their physicians.

Moreover, this analysis links interview data, field notes, and questionnaire results with analytical methodologies and operational models, illuminating a broader understanding of these issues on many levels and relating the findings to social realities vis a vis sexual health for the adolescent women in this community. Therefore, this qualitative inquiry follows a hermeneutic approach. Hermeneutics means linking experiences, feelings and perceptions with social reality by involving the art of interpretation. Addison defines the questions most appropriate for hermeneutic inquiry as those “aimed at (a) understanding the meaning and significance of complex human interactions and events in the context of their everyday settings, and (b) understanding the relationship between behaviors, practices, or events and the socio-cultural, historical, political, and economic background against which they take place.” (Addison, 1992). A hermeneutic approach operates under the following assumptions, as listed by Addison:

1. Participants of research are meaning giving beings; that is, they give meaning to their actions, and these meanings are important in understanding human behaviour.
2. Meaning is not only that which is verbalized; meaning is expressed in action and practices. To understand human behaviour, it is important to look at everyday practices, not just beliefs about those practices.

3. The meaning-giving process is not entirely free; meanings are made possible by background conditions such as immediate context, social structures, personal histories, shared practices, and language. When something is noticed as missing, wrong, or problematic, illuminating these background conditions can allow change to occur.

4. The meaning and significance of human action is rarely fixed, clear, and unambiguous. Meanings are not limited to pre-established categories. Meaning is being negotiated constantly in ongoing interactions. Meaning changes over time, in different contexts and for different individuals.

5. Interpretation is necessary to understand human action. Truth is not determined by how closely beliefs correspond to some fixed reality. It is never possible to achieve an objective, value-free position from which to evaluate the truth of the matter. Facts are always value-laden, and researchers have values that are reflected in their research projects.

Thus, the hermeneutic approach “seeks to illuminate social, cultural, historical, economic, linguistic, and other background aspects that frame and make more comprehensible human practices and events…” (Addison, 1992), in this case relating to the participants experiences and perceptions of their relationships with physicians.

This approach utilizes thematic analysis to achieve the goal of qualitative research - to discover lived experiences and meaning from the insider’s or emic view of the world (Luborsky, 1994). As “markers of process”, and not fixed structures, “themes can be discovered and reported in a way that preserves their richness of detail and contexts by using ethnographic description and interpretative approaches in examining transcripts and field notes as cultural texts for interpretation.” (Luborsky, 1994).
Thematic analysis in symbolic interaction studies works in three stages: 1) coding for *themes* which are defined by Luborsky as the manifest generalized statements by informants about beliefs, attitudes, values, or sentiments; 2) identifying *patterns* which are “used to describe findings from the researcher’s frame of reference...built from the researcher’s observations and analysis of a regularity, structure, or inferences, but without direct concern for their meaningfulness to the people being observed.” (Luborsky, 1994); and 3) *topic* development which is used to summarize the content of the data from the participants. Thematic analysis is used in this thesis to code and interpret data for emerging issues and themes relating to the participants experiences and perceptions of their physician’s sexual health services.

I also follow the procedures outlined by Patton (1990) for analysis. Specifically, after reviewing transcripts for concordance with audio recordings of interviews, the transcripts themselves are read through several times. Using qsr-NVivo to manage the data, common themes are identified, grouped into categories and coded. Once the data is coded, an attempt to discover relationships between and across categories, looking for both convergence and divergence of ideas is made. Where possible, categories are used as they emerge from the participants’ own words, which is referred to by Patton as indigenous typologies. When participants do not provide linguistic distinctions, analyst-constructed typologies are used to classify the data.

The use of a questionnaire within the qualitative paradigm is a mixed methods approach common to multiple method research (Goering and Streiner, 1996). First, in this study,
the qualitative interviews are situated within the larger context of the quantitative survey work with the ARHS (Langille et al., 1997). Then the follow-up questionnaire (Appendix 2) is situated from within the qualitative work. The questionnaire lists the barriers identified by participants during their first interviews and asks participants to rank them. Analysis of the results of the questionnaire is used to triangulate the data from the participants' interviews. Aside from use as an internal validity check, the questionnaire also elicits information on the personal importance of the barriers participants experience. Also revealed through the questionnaire are the effects that these barriers have had on the participants' ability to access physician sexual health services, especially on those services that participants felt they should have had access to.

Results of the second part of the follow-up questionnaire are analyzed using EpiInfo 6.0, a quantitative software for word processing, database and statistics system for epidemiology on microcomputers. Results from the questionnaire are used for internal verification of identified barriers and indications of the relative nature of perceived barriers. They also systematically relate the barriers to consequences experienced by the participants in sexual health service acquisition. Because this questionnaire was administered within the qualitative research setting, the results are not generalizable to the population. They do however, add dimensions of understanding within the limits of this inquiry. In combination with the data from the interviews and field notes, it creates a meaningful and in-depth exploration of the experiences and perceptions of the participants’ physician services.
5.0 STUDY LIMITATIONS

1) The results are not generalizable to a larger population.

2) The analysis is limited by the fact that the data had already been collected. As a result, the concurrent nature of collecting and analyzing data used to inform one another will not be possible. Thus, the analysis may point to additional lines of inquiry which would have to be research recommendations rather than incorporated into the current inquiry.

3) While the questionnaire has strong internal, face, and construct validity, it is not necessarily reliable.

4) This study addresses the perceptions of the adolescent women, and does not look at the issues from the perspective of the physicians, nor was any participant-observation done during medical visits to gain the perspective of the physicians.

5) This study only looks at the barriers experienced by adolescent women in Amherst, not addressing the experience of males' sexual health.
6.0 RESULTS

The results are divided into sections. First there is 6.1, a general description of participants. This is followed by 6.2, a discussion of the analytic framework which informed the analysis. Next is 6.3, a discussion of the major themes uncovered. 6.4 outlines the perceived barriers, where 6.5 is an analysis of the relative importance and consequences of these barriers. 6.6 describes how some participants overcame barriers.

6.1 Description of Participants

Twenty-eight female adolescent students from ARHS participated in this inquiry. Grades nine through twelve were represented with participants’ ages ranging from fifteen to eighteen years. Seven participants were aged fifteen, seven aged sixteen, six aged seventeen, and eight aged eighteen. The participants varied greatly in their academic achievements and in their extra-curricular activities. Three of the participants were African Canadian, while the rest were Euro-Canadian. All of the participants were unmarried, with two participants living with their partners. More than two-thirds of the participants were sexually experienced, with eleven participants having had more than one sexual partner. None of the participants had more than four sexual partners by the time of the interview.
6.2 Analytical Overview

Barriers to accessing sexual health services from physicians for participants are complex and inter-related. Through the research and analysis of interview data, patterns emerged as participants explored how they became sexually active, made decisions about contraception, thought about utilizing physician sexual health services, and experienced barriers to these services. Participants often overcame these barriers to accessing their physician’s sexual health services, though for many it was after some delay, or with discomfort. This phenomenon can be described as a process by which participants are becoming aware of their sexuality, having the opportunity to become sexually active, debating their options for reducing the risks of sexual activity, contemplating seeing their physician, addressing, overcoming or giving into the barriers which they experience in using their physician’s sexual health services. These barriers arose for participants based on where they were in their sexual lives, how they decided to become sexually active, who knew and accepted their new identity as sexually active adolescent women, and within the context of their interactions they had with their physicians.

A key theme, the issue of timing, emerged as a pattern among the participants. One theme involved concerns and feelings prior to becoming sexually active leading to not obtaining sexual health services. A second theme is how comfortable participants were when they first became sexually active and how this affected their comfort in broaching the topic with their physician. When, how, and if their parents knew that they were sexually active played an important role in seeking physician sexual health services, particularly in the early stages. Also, once the physician was aware of the participants’
sexual activity, the way in which the physician treated the participants, responded to their concerns, and addressed PAP tests all affected the adolescent’s comfort and willingness to return to the physician for continued care. Therefore, the themes relate to: stages experienced as new sexual activity began; as new sexual relationships were formed; personal acceptance of sexual activity increased; parental and physician acceptance; and social acceptance of their new private and public identities as sexually active adolescent women. For most of the participants these experiences happened sequentially and can be described as a process of developing their new identities as sexually active adolescent women.

This exploration also provides insights into the participants’ personal and private identity construction with respect to their sexuality and their identities in relation to their physicians. Informed by a symbolic interactionist framework, the construction and reconstruction of personal and public identities are believed to be formed as individuals respond to others, who are simultaneously responding to them. Identity refers in part to consciousness of self that is in reference to a public identity (Goffman 1963, Zussman 1996). In other words, identity is the construction of the complex “Who am I?”, and “How do others see me?”. However, identity also has an inner-consciousness which may be deeply felt and independent of others’ responses (Goffman 1963, Zussman 1996). These two concepts of identity, as well as the multiple public identities that are possible in relation to different people, are constructed and reconstructed by the individual who uses impression management when presenting their identities to others.
Impression management is the method by which all individuals manage information about themselves, particularly information relating to 'failings' (Goffman 1963, p.42). Impression management specifically relates to information about an individual that "is conveyed by the very person it is about" (Goffman 1963, p.43). This information can then be termed 'social' or public identity. The social information conveyed may confirm what other signs tell us about the individual, or the information can lack continuity, or as Goffman labels them 'disidentifiers', where new information, which can potentially reduce the value of the individual, becomes known (Goffman 1963, p.44). It is also possible that signs conveying social information can mean one thing to one group and mean something else to another group, meaning "the same category being designated but differently categorized." (Goffman 1963, p.46) This phenomenon rings true for study participants who found that being sexually active is acceptable with their partners and peer groups, yet were concerned that it may be viewed differently by parents and/or physicians.

These analytic frameworks of identity construction and impression management are useful in understanding the perceptions and experiences of these participants. This analysis looks to not only identify and determine the relative importance of barriers and ways participants overcame them, it also looked for examples where symbolic interaction and identity construction took place and were expressed directly, or indirectly, by the participants.

The participants' experiences demonstrated that their personal and public identities are
often in conflict, with tension between who they believe themselves to be, and who they want to appear to be to others. From this research it is evident that this tension is pronounced during this time of adolescence, as participants find themselves in an evolving life stage between childhood and adulthood. This phenomenon is actualized for participants as their identity is changing as they become sexually active and they begin to present different sides of themselves to their sexual partners, their peers, their parents, their physicians, and in how they feel about their own sexuality. It appears that these identities were constructed and reconstructed over time, as their experiences, and relationships grew over time.

6.3 Major Themes

I turn now to discuss the specific themes of identity and impression management with illustrations from participants. The participants discussed what would make a person sexually healthy. All of the participants mentioned the need to be responsible, be it in choosing partners, or using contraception. For example:

*AND WHAT WOULD YOU SAY WOULD MAKE A PERSON HEALTHY IN GENERAL? Regular check ups, taking... care of yourself. Not only that, being good about yourself. Like having confidence in yourself, because I think that is a major part of being healthy...AND WHAT ABOUT SEXUALLY HEALTHY, AND HOW CAN A PERSON BE SEXUALLY HEALTHY? Protection, or don't do it.*

*...knowing that they are going to do something to be ready, that they will be prepared to take any responsibility that might happen from their choices.*

Some participants also mentioned the need to be comfortable with themselves and their bodies as sexually healthy adolescents:
You have to be comfortable with your sexual partner. Because if you’re not then it’s not going to be healthy for you. And protection all the way.

Liking themselves, and you know, the different choices they make – if the choice is going to be good for them.

A discontinuity of self-perception can be found among the adolescent female participants as their private identification become public. Some may feel confident in choosing to be sexually active with their partners and strengthened by acceptance of this new identity in their peer groups. Yet, this self-belief comes into question when faced with the potential perceived risks of disclosing their new sexually active identities to others, particularly authority figures. For example:

I think [adolescent women] are afraid for anyone to know because they don’t want them to think any less of them. Like if they want to go out and experiment, type of thing, they don’t want people judging them. Like especially the doctor...I think that puts a big barrier there.

Concern about the interaction and reaction of authority figures were key themes in the difficulties participants had in constructing their new public and private identities. In particular, fear of judgement from authority figures such as their parents and their physicians were prominent. For example, some participants were concerned that their parents find out that they were sexually active:

A lot of people are scared that their parents will find out [that they are having sex] and get angry.

Most kids don’t want their parents to know that they are having sex. Most people I know and myself are scared of their parents knowing...

One participant talked about how her mother warned her about preserving her reputation:

SO YOU WORRY ABOUT CONFIDENTIALITY. WHAT DO YOU THINK
PEOPLE WOULD THINK OF YOU IF THEY SAW YOU BUYING CONDOMS? Um, I don't know. I think that like if a parent or someone saw me, they would probably believe... I don't know, I kind of have a reputation. Like I'm involved in a lot of stuff. And that is what my mom said. She was kind of like worried. She said, "Well, you have to think about your reputation." That is what she kind of said to me just about like, you know, people would think ... or something.

In discussing how they became sexually active, the language participants used to describe their decisions and actions in having sex shows how they justify to themselves, and to the authorities in their lives, how this new aspect of who they are is acceptable. For example, many participants described their first sexual experience as a mistake, or not planned, but go on to say how later decisions to have sex were more thought out and acceptable (i.e. there parents liking their new boyfriend, despite their age difference).

It just sort of happened. Any other guys, I wouldn't let touch me. I didn't like it. I don't think I liked any other guy I went out with. And then I met him and he was the sweetest guy I ever met in my whole life. And he treated me so well, and things led to other things... Well, at first we were using the condom and then I got pregnant. And then I had an abortion, and then I went on the pill. So now I'm on the pill and using a condom because that was really stupid. It was a very bad mistake and I never want to be pregnant again.

Another place where the importance of identity construction through symbolic interaction is demonstrated is in the participants’ concerns over confidentiality and in the reasons why they don’t want some others to know that they are sexually active. This is demonstrated in the following conversation:

DO YOU HAVE ANY CONCERNS ABOUT CONFIDENTIALITY OR JUDGEMENTAL OPINIONS OR ANYTHING ELSE THAT WOULD MAKE YOU NOT COMFORTABLE WITH YOUR PHYSICIAN? ... Like I don't know but sometimes when I go to pick up my pills at the drug store, like that is kind of... Like I kind of hid them when I go out so that no one will see. SO YOU GO AND YOU PICK UP YOUR PILLS AT THE PHARMACY? Yes. AND WHAT IS THAT LIKE? At first, like before my
mom knew, it was hard. But now, it doesn't really bother me. SO AT FIRST WHEN YOU WENT IN, YOU WERE WORRIED ABOUT PEOPLE SEEING YOU? Yes. And I was worried about what the cashier would think of me because I was only 15 when I was buying birth control pills. ... AND HOW WAS IT BUYING CONDOMS AT THE DRUGSTORE? Ah, it was embarrassing. I waited around the store for about 20 minutes to make sure there was like no one around that I knew, and then I ran up to the counter. AND SO DO YOU WORRY ABOUT CONFIDENTIALITY AT THE DRUG STORE? Yes, because it was with a different person. And like I don't even think my parents know now that I slept with him. Like I wouldn't want them to know.

DO YOU THINK A PHYSICIAN'S OPINION OF A TEENAGER WOULD CHANGE IF THEY WENT TO ASK ABOUT SEXUAL HEALTH ISSUES AND CONTRACEPTION? Um, they might. I think in some cases they would. IN WHAT WAY? Showing that, I don't know, not all of us are scared. But then they would probably think that we are like sex fiends jumping into bed or something.

As participants' personal identities as sexually active adolescent women become more comfortable, participants were faced with addressing their public identities as sexually active adolescent women as well. Barriers to accessing services were then brought out as these new public identities had to be tested with new authorities such as physicians.

Other participants said,

...because even though I knew my doctor well I was afraid of what her reaction [to my being sexually active] would be.

IS THERE ANY REASON THAT IT WAS KIND OF EMBARRASSING? I don't know, you just never know what somebody else is thinking when you go in there and you're asking for something like that. You wonder what goes through their head. AND WHAT DIFFERENT POSSIBILITIES WOULD GO THROUGH THEIR HEAD DO YOU THINK? Oh, "Well, what is she doing" and stuff like that. THEM BEING JUDGEMENTAL? Yes. [I am uncomfortable] because you don't know what the doctor will say or react to your questions.

Also, participants expressed their perception of their position as being unequal to the
physician's and that this power dynamic was problematic:

If they were male doctors, I think it would be more of a problem with male doctors talking to a woman about things. They would have to overcome almost that gender barrier thing first. And if they didn't really have a problem with that then it would be easier for them to relate to one another. But then there is also the patient. The patient is usually the one asking the questions that they want to know. So there has to be more of an easy relationship between the doctor and the patient. Like kind of like very relaxed, more than... There is a doctor way up here, and the patient is way down here, and there is intimidation and stuff like that. But I think teenage girls would possibly be more intimidated. Or in some cases, less intimidated than like a full grown woman. You know, maybe 30 years of age, let's say. But the teenagers are the things you really need to know... or the people who really need to know things. Well, like questions about sexuality, than someone who is 30. So I guess doctors would have to be more approachable. Well, some doctors have to be more approachable. Some doctors are very approachable. And always be able to... Instead of just give facts, just maybe, you know, maybe not always relate it back to yourself but use examples instead of just facts to help illustrate the kinds of things that you need answered. So it's pretty much better communication.

Participants felt that bringing up sexual health with their physician was a difficult transition to make. They also mentioned that the physician could help this process by mentioning it first:

Young women, myself included, might feel uncomfortable bringing up the subject. But if asked would gladly talk about it. It let's us know they're concerned or glad to hear about it. [My physician] has never brought it up with me and if he had I might have been more comfortable.

Several participants also felt that seeing a male physician was more challenging than seeing a female physician in being able to bring up their sexual health:

Women feel more comfortable talking to other women about female and sexual matters just as men would probably feel more comfortable talking to a man. They might relate to your problems better and may have had similar experiences.

Participants expressed barriers that related to several key themes, including: their concern
over maintaining confidentiality related to their new public and private identity
collection with parents and physicians; their discomfort bringing up sexual health with
their physician; and being less comfortable with a male physician. Overall, all
participants articulated that they experienced barriers to physician sexual health services
to some degree, and that these barriers had varying effects on their use of medical
services. The next section, 6.4, will give a more in-depth discussion of these themes.
Section 6.5 will follow with a description of the relative importance of barriers and their
consequences for participants.

6.4 Perceived Barriers

For some participants, needing to see their physician regarding their sexual health was
the first time they had to question their activities and their newly formed self-identities as
sexually active young women, in relation to how others (particularly those in authority)
may view them. Hence, their perceptions of their relationship with their physician and
how their physician relates to them are key in how comfortable they are in accessing
sexual health services. As one participant said,

I think a lot of the time it's not from the doctor... Like the doctor
presenting it to the person. I think it's the person going, "Oh, no, this is
the doctor." Like they just kind of put them on a pedestal. You know?
Like I think it's from... Like for myself, like my doctor is really cool. But if
I was nervous talking to him about it, I think it would be more me than like
him. The same with like... I think it's the same way with like a lot of
issues. Like it's not so much like... Like I always use this analogy because
it is the only way I can explain it. Like if you're sitting around in a room,
and everybody is drinking except one person, that everyone who is
drinking is like, "Have a drink. Have a drink." Like it was on
commercials. You're sitting there going, "I'm such a loser. Everybody is
looking at me." You know, it's kind of from the inside out. So I think a lot
of times with the doctor, it's just you feel that is so... Like so... that this is
a doctor. You know, like they don't have sex. They're not going to understand or whatever.

This dilemma of constructing their public identities as sexually active is evidenced in the barriers described by participants in accessing sexual health services from physicians. In particular, their concerns about: confidentiality, the need for informed consent from a parent to obtain oral contraception, needing a ride to their physician with a parent, concern about the physician's age, perceiving their physicians as uncomfortable discussing sexual health, and issues of being uncomfortable bringing up sexual health with their physician all relate to this problematic. Each of these barriers will be discussed further in this section and the next.

To illustrate these larger themes of barriers to physician services through the process adolescent women experience as they construct their identities as they become sexually active, it is important to look at the individual experience within participants' context. The following descriptions of participants include how they described themselves in terms of academics, goals, their relationships, their sex lives, and their experiences in obtaining sexual health services from physicians. The examples also show how participants address barriers and overcome them, illustrating the themes of timing and identity construction.

I begin with a detailed description of two participants. The first example is from a participant who is eighteen years old and in grade twelve, who recounted her transition into a sexually active adolescent woman and how she experienced barriers and overcame
them to access sexual health services, only to face another barrier which has stopped her from returning to her physician. This participant is a self-described good student, who will be attending university in the fall of 1999. She is motivated and involved at school and in extra-curricular activities. By the time of her interview, this participant had been sexually active with two partners and had made different decisions about contraception based on her relationships.

**WHAT AGE DID YOU FIRST HAVE VAGINAL INTERCOURSE?**

When I was 16. **SO YOU'VE HAD TO MAKE DECISIONS AROUND WHAT YOU WANTED TO DO AND CONTRACEPTION AND ALL THAT STUFF?** Yes. **HOW DID YOU MAKE THOSE DECISIONS?** The first time, not the right way. **WHAT CONSTITUTES NOT THE RIGHT WAY?** Um, it wasn't so much for the right reasons, I don't think. And it wasn't... For anyone else, it wasn't the right situation. And now looking back, hindsight is 20/20, it wasn't the right situation but at the time we had the emotions and everything. You know what I mean? SURE. **AND SO YOU MADE DECISIONS ABOUT WHAT YOU WANTED TO DO. DID YOU MAKE DECISIONS AROUND CONTRACEPTION AT THAT TIME?** Yes. **DID YOU DISCUSS THOSE WITH ANYONE?** Um, well, my partner. Um, the first time, it was just quite pragmatic. And then the second time, it was my boyfriend. Like I've only had 2 partners. My boyfriend, we went out for like a year, and we used a condom the first year. And then like in the fall, I talked to my mom and I said, "Mom, I think I have to go on the pill" or whatever and so I went to the doctor. So I'm on the birth control pill. ... **AND DO YOU THINK THAT THE WAY YOU MADE DECISIONS ABOUT IT AND WHO YOU SPOKE TO ABOUT IT CHANGED WITH THE TWO RELATIONSHIPS?** Oh, completely. It was two completely different situations. **WAS THE COMMUNICATION BETTER? LIKE WHAT WAS THE DIFFERENCE?** Um, just... They were two completely different people. They came from two completely different circles of friends. Um, just their roles in my life were completely different, like how I met them, that kind of thing. **And I don't know, just the type of feelings that I had about them.**

The involvement of her mother was also key in her ability to access sexual health services from her physician.
AND SO AT SOME POINT YOU INCLUDED YOUR MOM IN YOUR DECISION MAKING AS WELL? Yes. DID YOU TALK TO ANYONE ELSE? DID YOU TALK TO FRIENDS ABOUT WHAT YOU WANTED TO USE, WHAT YOU WERE GOING TO DO? Well, the second one, I talked to him about it. I talked to him a lot. But yes, I brought my mom into it. I don't think I really talked to my girlfriends about it because none of them were really at that stage. Like they didn't know any more than me kind of thing.

While this participant found it difficult at first to tell her mother that she was sexually active, once she did, it made it easier to go to the physician for oral contraception. Her mother respected her decision, made the doctor's appointment, and accompanied her throughout the physician visit. Her physician's reaction also made her feel more comfortable discussing sexual health.

DID YOU EVER FEEL EMBARRASSED GETTING INFORMATION FROM YOUR PHYSICIAN? Well, that is the only information I got. And I was kind of... When I first had to say it, I was a bit... Like it was trouble coming out because I didn't know how exactly to word it. But as soon as I said it, he was like...he was cool.

However, it didn't help the participant with her next barrier – her fear of receiving a PAP test.

Well, when I went on the pill, he said I would have to go back in 3 months and get a pap smear but I didn't go because that really scares me.

Her fear of receiving a PAP test has now stopped this participant from accessing any sexual health services from her physician.

WERE YOU ABLE TO GET ALL THE INFORMATION THAT YOU WANTED FROM YOUR PHYSICIAN? Yes. Um, since I started, I've had a couple of questions but I haven't seen him since. But like once I see him then... The first time I see him, I have to have a pap smear. DO YOU THINK THE FACT THAT ONCE YOU GO ON BIRTH CONTROL, YOU HAVE TO HAVE A PAP SMEAR, DO YOU THINK THAT WOULD STOP TEENAGE GIRLS FROM GOING BACK TO SEE THEIR PHYSICIAN? It
stopped me. I haven't gone back. I mean maybe if he didn't tell me. DID HE EXPLAIN WHAT A PAP WOULD INVOLVE? No.

Aside from her concern about receiving a PAP smear, this participant also has logistical barriers to accessing her physician’s services. Due to the shortage of physicians in Amherst, her physician is in Truro, and her mother has rules about when it is necessary to make the trip to the doctor.

But because he's in Truro... Like mom sort of has a rule. We can't go down to the doctor until there are two things wrong with us. You have a broken arm but still... You know, if you've got a cold, you can't go to the doctor.

This participant has observed over the past few years that she and her peers have become more comfortable with the idea of talking to their physician about contraception. She believes the changes in herself and her friends being able to address their sexual health with physicians has come about as they have become more comfortable with their new sexual identities.

Well, the only reason I could think of that people would be more open to talk about it [talking openly with physicians about sexual health] is because my friends are getting older. Do you know what I mean? They're getting more comfortable with the issue themselves.

This development of comfort with one’s sexual activity as they got older was a common theme in participants’ ability to feel confident in their new public identities enough to speak with their parent or physician.

A second participant also shared a revealing description of her identity development as a sexually active woman and her experiences accessing sexual health services. At the time of the interview she was sixteen years old and a doing well in school. She lives outside
Amherst, and needs to be bused into school. Her first serious relationship started when she was fourteen, with a man who was eighteen years old. She described that first relationship and the choice to be sexually active with him as a mistake, and also mentioned that her parents did not like her boyfriend. They were together and sexually active for two years. She is now dating someone new, who her parents like very much. She and her new partner have not yet had sexual intercourse. In this time she has never discussed her sexual activity with anyone, including her parents or her physician. Here she describes how she made decisions about becoming sexually active and what contraception to use:

SO YOU'VE HAD TO MAKE DECISIONS ABOUT WHAT YOU WANTED TO DO? Yes. AND ABOUT IF YOU WANTED TO USE CONTRACEPTION AND WHAT KINDS THAT YOU WANTED TO USE? Yes. HOW DID YOU MAKE THOSE DECISIONS? Um, it really wasn't that much of a decision. It's just condoms. I think they are probably the most [accessible]. I thought for a while about going on the pill last year but then the relationship kind of fizzled so it wasn't really worth it. Like, "I'll hang on for a couple of months," or whatever, and I'll wait. I kind of kept putting it off because I didn't want... It felt like more of a commitment to do that, like to actually take something, get a prescription.

AND THE FIRST TIME YOU BECAME SEXUALLY ACTIVE, HOW DID YOU DECIDE TO ACTUALLY BECOME SEXUALLY ACTIVE? Um, that I really don't know. YOU WERE 14. HOW OLD WAS YOUR BOYFRIEND? He's 18, turned 19. Um, it just sort of... I don't know it sounds dumb, it happened. NO, IT DOESN'T SOUND DUMB AT ALL. No, I know. But like it's a bad answer. OH, NO. No, it's like it just sort of happened really. Like I had thought about it. I went over to his house the week before... You know, I figured that is... That is what happened. You know, I knew it was going to happen and we were prepared for it. You know, the week before he had gone out and bought some condoms and stuff... DID YOU TALK ABOUT WHAT YOU WERE GOING TO DO AND ABOUT THE FACT THAT YOU WANTED TO USE CONDOMS? No, it just seemed like the obvious thing to do. It's just so accessible, so easy. You know, it just really seems like the best thing to use. You know, there is no real decision about it. It was just sort of a, you know, "Go down to Shoppers. Get some condoms." AND THEN WITH YOUR
SUBSEQUENT PARTNER, HOW DID YOU MAKE DECISIONS ABOUT BECOMING SEXUALLY ACTIVE WITH HIM? Um, we decided not to. Um, primarily on his account actually. He's an 18 year old male virgin so I was surprised.

DID YOU TALK TO ANYONE ELSE ABOUT THE DECISIONS THAT YOU WERE MAKING AT THE TIME? DID YOU TALK TO YOUR MOM OR YOUR FRIENDS? No. YOUR DOCTOR? No. DO YOU HAVE A FAMILY DOCTOR? Yes. We just lost him, and we had a different one. We've been switching around quite a bit because there is not enough doctors in town and everything. So we've been losing doctors like crazy.

This young woman went on to describe how not knowing her physician has made it more difficult to access sexual health services:

HAVE YOU EVER TRIED TO GET INFORMATION ABOUT SEXUAL HEALTH FROM YOUR PHYSICIAN? Um, no, because I don't really know them well enough to do it. Because like where it's been switched around so much, I don't feel comfortable with them. Ah, I have to go for probably a pap exam and all that kind of stuff, and it's like I'm not even looking forward to it because I've never even met the man yet. You know, it's like... HAVE YOU HAD ONE BEFORE? No. It's been we didn't have a doctor. We had just switched. And it's like, "I don't want to go."

THEY'RE NOT THAT BAD. No, it's not that, it's just comfortable really. Because it has just changed. You walk in and you've never even met someone before. It's like, "No." HAVE ANY OF THE PHYSICIANS EVER TALKED TO YOU ABOUT CONTRACEPTION? No, not at all. OR SEXUALLY TRANSMITTED INFECTIONS, ABOUT RELATIONSHIPS? None of them have ever brought these issues up with you? No. Um, I was in to see a doctor last year. Mom figured that there was something going on with my last boyfriend or whatever. And she wanted me to talk to him and stuff. But actually we kind of got away from that topic. SO IT DIDN'T COME UP AT ALL. YOU DIDN'T BRING IT UP AND YOUR DOCTOR DIDN'T BRING IT UP? No. It's never been on my record that I'm sexually active or anything like that. It's not even... They don't even know. IS IT SOMETHING THAT YOU WOULD LIKE TO HAVE BROUGHT UP BUT IT'S JUST UNCOMFORTABLE? Yes, because... Well, I haven't even gone to see this new doctor yet. So you know, it's the chance really. And plus it's like where I live out of town and stuff... Like I had a doctor when I was in Port Elgin in a small town close to here. And um, so like it's transportation too. So I don't get my license for another 26 days. I'm counting down. SO IT'S THE TRANSPORTATION, NOT KNOWING THE DOCTOR, NOT GOING VERY OFTEN, ALL OF THOSE THINGS? Yes. AND ALSO
BEING KIND OF UNCOMFORTABLE BRINGING UP THESE KINDS OF ISSUES, THEY ARE ALL... Yes.

This participant felt that her physician may have avoided bringing up sexual health during her last appointment:

DO YOU FEEL THAT BECAUSE THESE TOPICS WERE NEVER BROUGHT UP WITH YOU THAT YOUR PHYSICIANS HAVE AVOIDED TALKING ABOUT SEXUAL HEALTH ISSUES? I actually think that my last doctor did. Because like the chance and stuff were there. And yes, it maybe was my job to bring them up but maybe it was his. I don't know. Like I feel like maybe my last doctor did kind of avoid it.

This participant did not feel comfortable bringing up her new sexually active identity with her physician, or her family. Thus, she experienced a discontinuity between her private and public identities as she wanted to maintain her mother's respect and avoiding jeopardizing that with the mistrust she feared would result if she disclosed her sexually active life:

IN GENERAL, HOW DOES YOUR DOCTOR ACT TOWARDS YOU? HOW DOES HE MAKE YOU FEEL? Well, "Hello. How are you? What's wrong with you," kind of thing. "Why are you here?" Um, very formal. Like formal. At least my other doctors have been. It's just you go in for your booster or your meningitis needle, and that's about it. I really don't have regular visits or anything so it's very... AND SO YOU THINK YOU WANT TO GO. YOU'VE GOT MORE INFORMATION TO GET. YOU KNOW YOU NEED A PAP TEST. ARE THERE THINGS THAT ARE STOPPING YOU? Well, it's been more of a getting an appointment, getting over there, you know. And it's like my mom still doesn't know. And I would like to keep it that way because... KNOW THAT YOU ARE SEXUALLY ACTIVE? Yes. Really because yes, I look at it as mistake and yes, she could forgive me but it's more of a I know I'm not any more, kind of thing. ... IS THERE A REASON WHY? Respect, I think. Um, mom may have her suspicions and that kind of thing but it's something not engaged in now. Right. I haven't been sexually active for at least 6 months. I don't know... You know, I would have to count out the months and stuff. But, you know, at least 6 months. And I've got a new boyfriend kind of thing, and I don't want my past mistakes to really rub off into this. You know,
because like we have decided to abstain completely. You know, he's going to be a virgin boy until he's married kind of thing. And um, it's something I know it's not going to be a repeat for a while anyway. Not with this relationship. And I don't want her to mistrust us because there is no reason to mistrust us. SO THE ISSUE IS WORRYING ABOUT YOUR MOTHER'S REACTION. BUT WHAT ABOUT IF YOU WENT TO SEE A PHYSICIAN ON YOUR OWN? Well, I still haven't met my physician. Um, I really haven't. We switch doctors and stuff so much with doctors leaving and everything. We ended up with a new doctor, and it's been... He's not in Amherst so I can't go on, you know, an off class or something like that. I have to like, "Mom, can I have the van? I'm going to the doctor?" "Why? Are you sick?" kind of thing. It would be... It's in a little village nearby but you would have to like have a drive there or have someone take you.

SO THE LOGISTICS OF GETTING THERE WOULD HAVE TO INVOLVE YOUR MOTHER KNOWING THAT YOU ARE GOING TO THE DOCTOR. Yes. AND SHE WOULD PROBABLY WANT TO KNOW WHY YOU WERE GOING TO THE DOCTOR? Yes. It's like, "What is wrong? You haven't been sick?" kind of thing. And um, yes, it's the transportation stuff. And first meeting the doctor because I haven't had any excuse to actually go over and meet him because I haven't been sick or anything like that.

Hence, this participant never addressed her desire for oral contraception with her physician. Instead, she and her partner decided to use condoms as a way of overcoming her barrier and practicing responsible sexual activity:

*I think condoms are pretty widely used. I think that is probably the method of choice. Not because that it protects against STI, it's actually a great benefit, but the fact that they are easy to get. You walk into the drug store and get them. You know, you can get them here at the health centre, or whatever. You don't have to worry about them. Whereas people that don't. Their parents don't know they are having sex. You know, it's easy to put a condom in your pocket and keep it there. Or, you know, in your drawer or whatever. But it's not so easy to hide pills that you have to take every day or, you know, that kind of thing.*

All of these experiences of becoming sexually active, and facing barriers to sexual health services happened within the context of the participant’s community. Next, the
participant describes the effects of living in a small town, the need for community acceptance of adolescent sexual activity and why so many young women date and become sexually active with older men:

[WHY DO YOU THINK THE TEEN PREGNANCY IS WHAT IT IS IN AMHERST? ...it tends to be a smaller town. It tends to happen that way. Um, I think more emphasis is placed on not having sex and that kind of thing. And they are dealing with an abstinence based education program, and that kind of thing, but they don't realize that, you know, it's a little too late for most of them. You know, because like a lot of kids are having sex. In some groups, it's more common than others really. It's just maybe the method of teaching. They've got to teach the kids as if, "Okay, these may be sexually active humans, and not kids that we are trying to prevent from having sex." It's something we have to face as, "Okay, this is your decision. Fine. This is what you need to know," instead of, "You shouldn't do this when you get older." It's not working... YOU SAID THAT IT'S ONE OF THOSE SMALL TOWN THINGS. WHAT IS IT ABOUT A SMALL TOWN? Well, I've heard a lot. I don't know if I really believe it or not, is that there is nothing else to do. Really, seriously. Like I've heard that a lot. But it falls into decisions and stuff. Um, there is not really a strong religious community and that kind of thing so there is not a lot of push not to be sexually active. And a lot of the time it happens, older guys, younger girls, guys from high school going out with girls in junior high. And once a girl starts having sex in junior high, usually she just doesn't have one partner after that. It tends to be... It's more likely she will have multiple partners. WHERE DO YOU THINK THAT COMES FROM, THAT IDEA OF THE YOUNGER GIRL AND THE OLDER GUY? Yes. I really don't know. Actually I should know because I was one of them. Um, it comes from wanting love. Like girls maturing faster than guys. So junior high school guys, "Yah, right. Get a life." Right? They [older men] come over to the high school. You know, maybe more mature physically, some mentally and stuff. But we've got to realize that these guys are a lot older and, you know, they've been around the block a few times. That they know what they are doing. And we end up a lot of times that, you know, the young virgin girl kind of thing going with a player, really. You know, some just uses young girls. DO YOU THINK THAT THERE WOULD BE A POWER IMBALANCE WHEN YOU'VE GOT SUCH AGE DIFFERENCES? There is, really. It ends up that the guy is older so supposedly he knows best. You know? And stuff he might tell her about pregnancy and that kind of stuff. Maybe he doesn't want to use a condom. Stuff he tells her is like she'll be thinking, "Well, it must be right." You know, he's older, he should know. So they tend to believe where he's older. AND WAS THAT SOMETHING THAT YOU
EXPERIENCED IN YOUR RELATIONSHIPS? Um, I was a little more cautious, I suppose. Ah, maybe not as much as I should have been. But like I realized the facts, and I stuck to them. But I know a lot of times people didn't. It's just me, I'm... I question things by nature. So I'm probably more the exception than the rule because like a lot of people just went with it.

So, while this participant has not overcome her barriers to accessing her physician's sexual health services, she did come up with strategies for overcoming her barriers. First, she used alternative sources of contraception, namely using condoms. Second, she used other sources for information, namely the teen health centre in her high school.

HAVE YOU GONE TO ANY OTHER PHYSICIANS OR MEDICAL SERVICES TO GET INFORMATION? Um, just the health centre and stuff like that. THIS TEEN HEALTH CENTRE, YOU MEAN? Yes, just there. AND HAVE YOU BEEN ABLE TO GET THE INFORMATION THAT YOU NEEDED? Oh, yes. [The nurse] is really good.

These two examples give an illustration of the themes discussed related to the processes of becoming a sexually active adolescent woman, and the identity construction, which is inherently involved. It further cues us to some of the barriers experienced by young women who wanted sexual health services from their doctor, and the ways in which they might overcome them. In researching with twenty-eight young women, many barriers were brought out. All of the participants experienced different combinations of barriers and many found different ways of coping with them. These will be discussed in the following sections 6.5 and 6.6.
6.5 The Relative Personal Importance of the Identified Barriers for the Participants in Obtaining Sexual Health Services from their Physicians and the Effect of the Barriers on Participants' Personal Capacity to Access Sexual Health Services from their Physician

A related goal of this research is to understand the relative importance of these barriers for participants. In other words, which identified barriers were the most significant in impeding the use of physician sexual health services? To further explore this aspect of the barriers experienced by the adolescent participants beyond the interviews, a questionnaire was developed within the qualitative inquiry. For the purpose of triangulation, I used two different methods of data collection, namely the interviews and the questionnaire. This questionnaire listed the barriers that were identified by participants and asked them to rank the barrier in order of perceived importance for their personal experience. As a member check, the purpose of this exercise was to present the barriers participants' had identified back to them in another format for confirmation.

Another goal of the research is to explore the consequences of the participants' identified barriers. These manifestations of the barriers were experienced on a changing continuum over time, causing participants to not go to the physician, to delay going to the physician, or to feel uncomfortable when going to the physician for sexual health services. Again, as a method of triangulation, a second part of the questionnaire asked participants to confirm the interview findings by having participants delineate which barriers had caused which consequence for them, if any.

Thus, data was gathered regarding the relative importance and consequences of barriers
with the follow-up questionnaire. However, it was the interview data that were more revealing as to the nature and consequence of the barriers to sexual health services from physicians, allowing for thematic development. While it is true that some barriers figured more significantly than others, and that this phenomenon was reflected in the questionnaire results, it is the contextualization for each participant's experiences that is essential for understanding.

Participants were presented with a follow-up questionnaire with a table listing the barriers that had been identified during their interviews (see Appendix 2). They were asked to indicate these barriers according to: “How important has each of the following been to you personally, in ever being able to access a physician’s services concerning your sexual health”? The participants were asked to only rank barriers which they felt had affected them personally. They were instructed that they could use the same number more than once (for example, if they felt two or more of the barriers equally important to them). They were further instructed that they could leave barriers unranked if they felt they were not significant to them. Lastly, there was an “other” category for them to fill out if any of them felt we had missed a significant barrier they had experienced. Twenty-six of the participants completed the questionnaire. All of the participants reported barriers they experienced on the questionnaires. Many of the participants indicated multiple barriers, often giving a few barriers the same ranking number. None of the participants added a barrier to the “other” category. The results of this questionnaire are presented in the following Table 1:
<table>
<thead>
<tr>
<th>Barriers</th>
<th>% Reporting as #1 Barrier</th>
<th>% Reporting as #2 Barrier</th>
<th>% Reporting as #3 Barrier</th>
<th>Total % Reporting as a Barrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am afraid of receiving a PAP test</td>
<td>50.0</td>
<td>15.4</td>
<td>7.7</td>
<td>76.9</td>
</tr>
<tr>
<td>My physician has never brought up sexual health before being asked</td>
<td>19.2</td>
<td>11.5</td>
<td>15.4</td>
<td>65.4</td>
</tr>
<tr>
<td>I am concerned about confidentiality (worried my physician will tell someone)</td>
<td>19.2</td>
<td>7.7</td>
<td>11.5</td>
<td>65.4</td>
</tr>
<tr>
<td>My physician does not have enough time (too rushed, too many patients)</td>
<td>11.5</td>
<td>15.4</td>
<td>3.8</td>
<td>57.7</td>
</tr>
<tr>
<td>I am uncomfortable with my physician because he is male</td>
<td>15.4</td>
<td>15.4</td>
<td>3.8</td>
<td>53.8</td>
</tr>
<tr>
<td>I am concerned that parental consent is required to get oral contraceptives</td>
<td>15.4</td>
<td>11.5</td>
<td>3.8</td>
<td>53.8</td>
</tr>
<tr>
<td>I need transportation to see my physician</td>
<td>3.8</td>
<td>11.5</td>
<td>3.8</td>
<td>50.0</td>
</tr>
<tr>
<td>I am uncomfortable with my physician because I don’t know them well enough (i.e. don’t see them often enough to feel comfortable with discussing personal matters such as sexual health)</td>
<td>11.5</td>
<td>7.7</td>
<td>3.8</td>
<td>46.2</td>
</tr>
<tr>
<td>My physician is too old, therefore does not relate to a young person like me</td>
<td>3.8</td>
<td>11.5</td>
<td>0</td>
<td>46.2</td>
</tr>
<tr>
<td>I need a ride to the doctor with a parent</td>
<td>0</td>
<td>15.4</td>
<td>0</td>
<td>42.3</td>
</tr>
<tr>
<td>I am uncomfortable with my physician because I know them too well (i.e. they are a friend of the family, attend the same church)</td>
<td>7.7</td>
<td>7.7</td>
<td>3.8</td>
<td>42.3</td>
</tr>
<tr>
<td>I do not have a physician</td>
<td>7.7</td>
<td>0</td>
<td>7.7</td>
<td>38.5</td>
</tr>
<tr>
<td>I feel sexual health is not important enough to trouble my physician with</td>
<td>0</td>
<td>7.7</td>
<td>7.7</td>
<td>34.6</td>
</tr>
<tr>
<td>My physician makes me feel uncomfortable when discussing sexual health</td>
<td>3.8</td>
<td>11.5</td>
<td>3.8</td>
<td>34.6</td>
</tr>
<tr>
<td>My physician seems uncomfortable with discussing sexual health with me</td>
<td>0</td>
<td>3.8</td>
<td>11.5</td>
<td>30.8</td>
</tr>
</tbody>
</table>
It is evident that many barriers were experienced by participants as they conceptualized and actualized their new identities as sexually active adolescent women. These barriers manifested in various ways, often leading to participants not accessing the sexual health services from their physicians when they felt they should have, delaying accessing these services, or feeling uncomfortable when they did approach their physicians regarding their sexual health. Participants were also asked to indicate the consequences of these barriers on a scale with the following options: “Has ever stopped me from seeing the doctor when I know I should have; Has ever delayed my going to the doctor much later than I really should have; Has ever delayed my going to the doctor a little later than I should have; I went to the doctor when I should, but I was still uncomfortable; Has not stopped me from seeing the doctor at all.” The results of this part of the questionnaire are presented in the following Table 2:
Table 2. Consequences of Barriers Experienced by Participants (n=26)

<table>
<thead>
<tr>
<th>Consequence</th>
<th>% Ever stopped from seeing the doctor when knew they should have</th>
<th>% Ever delayed going to the doctor much later than knew they should have</th>
<th>% Ever delayed going to the doctor a little later than knew they should have</th>
<th>% Went to the doctor, but was still uncomfortable</th>
<th>% No influence on seeing the doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am afraid of receiving a PAP test</td>
<td>34.6</td>
<td>7.7</td>
<td>3.8</td>
<td>30.8</td>
<td>23.1</td>
</tr>
<tr>
<td>My physician has never brought up sexual health</td>
<td>7.7</td>
<td>0</td>
<td>15.4</td>
<td>26.6</td>
<td>50.0</td>
</tr>
<tr>
<td>My physician does not have enough time</td>
<td>3.8</td>
<td>11.5</td>
<td>19.2</td>
<td>15.4</td>
<td>50.0</td>
</tr>
<tr>
<td>I am uncomfortable with my physician because he is male</td>
<td>15.4</td>
<td>0</td>
<td>15.4</td>
<td>3.8</td>
<td>57.7</td>
</tr>
<tr>
<td>My physician seems uncomfortable discussing sexual health with me</td>
<td>7.7</td>
<td>7.7</td>
<td>7.7</td>
<td>11.5</td>
<td>60.5</td>
</tr>
<tr>
<td>I am uncomfortable with my physician because I know them too well</td>
<td>7.7</td>
<td>0</td>
<td>0</td>
<td>23.1</td>
<td>61.5</td>
</tr>
<tr>
<td>I am concerned that parental consent is required to get oral contraceptives</td>
<td>15.4</td>
<td>3.8</td>
<td>7.7</td>
<td>7.7</td>
<td>65.4</td>
</tr>
<tr>
<td>I am uncomfortable with my physician because I don’t know them well enough</td>
<td>15.4</td>
<td>0</td>
<td>11.5</td>
<td>7.7</td>
<td>65.4</td>
</tr>
<tr>
<td>I needed a ride to the doctor with a parent</td>
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<td>3.8</td>
<td>3.8</td>
<td>11.5</td>
<td>65.4</td>
</tr>
<tr>
<td>I need transportation to see my physician</td>
<td>11.5</td>
<td>3.8</td>
<td>11.5</td>
<td>7.7</td>
<td>65.4</td>
</tr>
<tr>
<td>My physician is too old, therefore does not relate to a young person like me</td>
<td>3.8</td>
<td>3.8</td>
<td>7.7</td>
<td>15.4</td>
<td>65.4</td>
</tr>
<tr>
<td>I am concerned about confidentiality</td>
<td>3.8</td>
<td>7.7</td>
<td>3.8</td>
<td>19.2</td>
<td>65.4</td>
</tr>
<tr>
<td>I feel sexual health is not important enough to trouble my physician with</td>
<td>3.8</td>
<td>7.7</td>
<td>7.7</td>
<td>11.5</td>
<td>69.2</td>
</tr>
<tr>
<td>My physician makes me feel uncomfortable when discussing sexual health</td>
<td>0</td>
<td>0</td>
<td>7.7</td>
<td>11.5</td>
<td>69.2</td>
</tr>
<tr>
<td>I do not have a physician</td>
<td>11.5</td>
<td>3.8</td>
<td>0</td>
<td>0</td>
<td>76.9</td>
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</tbody>
</table>
This section will discuss the barriers identified by participants and the consequences of the barriers as they discussed in the interviews and were reported in the questionnaire by participants.

6.5.1 I was afraid of receiving a PAP test

While this inquiry did not initially ask any questions about PAP tests, these came up so frequently in interviews as an issue of concern for participants that it was added to subsequent and follow-up interviews as well as the questionnaire. The data reveal this as by far the most significant barrier to accessing sexual health services from physicians. It is listed as a barrier by fifty percent of the participants, having stopped almost thirty one percent of them from seeking medical assistance.

[Adolescents] are afraid of the unknown, they don't know what happens during the [PAP] test or what to expect. I was afraid during my first PAP. I didn't know what to expect, but my doctor did his best to make me comfortable.

It was evident from both the interviews and the questionnaire that this was a serious hurdle to accessing sexual health services from physicians. As their new identity as sexually active adolescent women emerged, participants were aware that PAP tests would be requested by their physicians, with several of the participants having already been approached by their doctor to do so. Much of the angst over PAP tests was described by the participants as discomfort with the idea of someone touching them in such private areas.

[I was uncomfortable about having a pap test] because every girl is terrified of having a man or a woman down there, doing things the girl knows nothing about.
DID YOU FEEL COMFORTABLE APPROACHING YOUR DOCTOR? I don't feel comfortable approaching anybody. HOW COME? I don't know. I'm just very modest, very humble, that type. As far as my body is concerned, I am. DID YOU EVER FEEL EMBARRASSED GETTING INFORMATION FROM YOUR PHYSICIAN? Oh, yes. When I thought I had an infection again, I was like, "Oh, no. Can't you just take like a urine test?" Like he wanted to do a pap, and I was like, "Ahhh." NOT COMFORTABLE WITH THAT? No. I don't like anybody looking at me anywhere.

In some cases, participants described their discomfort in relation to any form of personal physical examinations by their physicians.

He just tells you to breath in and breath out, and he just listens to you breath. But that is it. Um, I just... I don't know if there is something about him that... Like if I go there by myself, and it's like... Like I don't know what I had that day but he wanted... Oh, I hurt my shoulder and he wanted me to take off my shirt so he could see my shoulder. And that just kind of makes me edgy. I don't know, he's like a total stranger so I'm not very comfortable with that.

Some were uncomfortable having a PAP test with their physician if he was male:

AND DID HE DO A PAP TEST? I haven't had one yet. IS IT SOMETHING THAT HE HAS ASKED YOU TO DO? Um. THAT HE HAS DISCUSSED WITH YOU IN ANY WAY? In the summer, like they called me and said that I needed to get one done. But my [relative] is the secretary, and she said I didn't really need to have one done if I didn't feel comfortable doing it. OH, REALLY? Like I know I should have one done but I'm scared. WHAT SCARES YOU ABOUT THEM? Um, I just don't know what it would be like. And I don't know any female doctors or anything, and I don't want to go to a male doctor. SO YOU WOULD BE MORE COMFORTABLE WITH A FEMALE DOCTOR? Yes.

Few had had the procedure explained to them, knew what it was for, or had had a physician talk them through it. As a result, this barrier had consequences of making the participants uncomfortable, delaying, and in several cases, stopping them from accessing medical care.
[I didn't go to the physician when I knew I should have] because PAP tests are new to young women and sound scary. I hate the thought of someone else touching me.

Nine of the participants reported that a fear of receiving a PAP test stopped them from seeing their doctor when they knew they should have. Another three delayed going to their physician, and another eight went to their physician but felt uncomfortable because of their concerns about receiving a PAP test.

**WHAT ABOUT PAP TESTS?** **DID YOUR DOCTOR EVER TALK TO YOU ABOUT THOSE?** Um, she mentioned it like once the last time I was in to get contraceptives. AND SHE SUGGESTED THAT YOU SHOULD SCHEDULE TO GET ONE? Yes. **DID SHE TALK TO YOU ABOUT WHAT THEY ARE LIKE AND WHAT HAPPENS, ANYTHING LIKE THAT?** No. AND **HOW DO YOU FEEL ABOUT THEM?** Um, nervous. **WHAT MAKES YOU NERVOUS ABOUT IT?** Um, just because I don't know like what it's about or like what's like. AND **SO ARE YOU PLANNING ON HAVING ONE?** Yes, sometime when I get up the courage. **DO YOU THINK THAT BECAUSE YOU ARE INTIMIDATED THAT STOPS YOU FROM GOING FOR A LITTLE WHILE?** Yes.

**DID YOUR DOCTOR EVER TALK TO YOU ABOUT GETTING PAP TESTS?** Never. **HAVE YOU EVER HAD ANY?** No. **AND NO PHYSICIAN HAS EVER MENTIONED THEM TO YOU IN ANY WAY?** No. I want... I do want to go get one but it's just scary. SO **NO DOCTOR HAS EVER SAID, "THIS IS SOMETHING YOU SHOULD DO"?** He's never... I went in one time and his secretary asked me, she said, "Are you in here for a pap smear?" And I said, "No." And I didn't even know what they were at the time.

As a result of the findings for both questionnaire results and the interviews, fearing a PAP test was the most significant barrier to accessing sexual health services from physicians. The factors that made this such a strong barrier include: the participants' discomfort with being touched during a physical examination; lack of knowledge as far as what a PAP test entails; and heightened discomfort with being examined by a male
physician. Interestingly, none of the participants mentioned concern about possible test results. This indicates that their discomfort with physical examinations is a powerful barrier.

6.5.2 My physician has never brought up sexual health before being asked

This is an interesting and complex barrier as it relates to the participants’ perceptions of the availability and importance of physician sexual health services and the way they receive and respond to their physician. The fact that their physician had never brought up sexual health with them may have held several meanings for participants with direct impacts on their identity construction as sexually active adolescent women. For example, the fact that the physicians never brought up sexual health before the participants became sexually active signaled to some participants that their physician may have not been comfortable addressing the issue of sexual health (which will be discussed as a separate barrier), or perhaps that the physician did not feel the participant was at an age where sexual health was a necessary issue needing to be addressed, thus bringing the participant’s new identity as a sexually active adolescent woman into question outside their peer group.

AND DO YOU THINK THAT PHYSICIANS KNOW ENOUGH ABOUT EDUCATING GIRLS ABOUT SEXUAL HEALTH, OR YOUR PHYSICIAN? Um, I don’t know. I think that it’s in a way, they need to approach us kind of. Like I think when you get like maybe 17, and you’re coming in for regular visits or something, maybe they could say something like, "Do you have any questions about sexual health?" or, "Are you in a relationship?" You know, just kind of bring something up because then it doesn’t leave it to us to say, you know, "Well, I’m in a relationship, and I want to get the pill," or whatever because I think that is hard for some people. Whereas if they bring it up first, just casually like asking them what is going on in their life kind of thing, that would be easier. WOULD
THAT HAVE MADE IT EASIER FOR YOU? YOU WOULD HAVE FELT LESS EMBARRASSED IF SHE HAD BROUGHT IT UP AT SOME POINT BEFOREHAND? Yes.

This second possibility further relates to participants concerns about what the physician may think of them if it was known that they were a sexually active adolescent.

AND DO YOU THINK A PHYSICIAN’S OPINION OF A TEENAGER WOULD CHANGE IF THEY WENT TO ASK ABOUT SEXUAL HEALTH ISSUES LIKE CONTRACEPTION OR SOMETHING? Um, I think so. IN WHAT WAY? Um, I don’t know... some people think they are too young people that are sexually active. That is just how I feel. I don’t know why.

DO YOU THINK A PHYSICIAN’S OPINION OF A TEENAGER WOULD CHANGE IF THEY WENT TO ASK ABOUT SEXUAL HEALTH ISSUES LIKE CONTRACEPTION? I think some of them would, yes. AND HOW ABOUT YOURS? DID HE SEEM TO CHANGE TOWARDS YOU? Yes. IN WHAT WAY? I don’t know. He... He used to be really friendly and stuff, and now, “Oh, yah, it’s her again.”...Just sort of like he almost made me feel bad for being sexually active.

In the questionnaire, this experience was reported as a barrier for more than half of the participants. Several of the participants further stated that if the physician had brought up sexual health with them first, they would have felt more comfortable disclosing their sexual activity and asking for services such as oral contraception. Since none of the physicians had ever done so, this barrier had significant consequences for participants’ access to physician care.

YOU SAID YOU WERE ALREADY ON THE PILL FOR OTHER REASONS. AND SO DID YOUR PHYSICIAN KNOW THAT YOU HAD BECOME SEXUALLY ACTIVE AT SOME POINT? No, I don’t think so. JUST WHEN YOU BECAME PREGNANT, THAT WOULD BE A FIRST CLUE. Yes. WHY DIDN’T YOU TELL YOUR PHYSICIAN THAT YOU WERE BECOMING SEXUALLY ACTIVE? Well, he knew when I had my STD. That was kind of...clued him in. He was like, "Okay, well, you’re going to have to come in for a pap test every now and again." Like he gave me like every year, I think it is or something. Anyways, I was like,
"You know I won't be in." And he just kind of left it there. And that was about it. He just... He said, "Are you using birth control?" I said, "Well, that is why I asked." And he just kind of reviewed my notes and said, "Oh, yes." SO HE DIDN'T GET INTO A REALLY ENGAGING CONVERSATION ABOUT IT WITH YOU. No. He just knew I was on the pill and that was about it.

Because I'd be too embarrassed to bring it up. I'm terrified about receiving a PAP test. ...it is hard for young women to bring the subject up. They're already embarrassed and nervous. It would make things much easier if the physician would bring it up.

Two of the participants reported that the fact that their physician did not bring up sexual health before being asked, stopped them from seeing the doctor when they knew they should have. Another eleven participants say that this barrier delayed them from seeing their physician when they should have. Thirteen of the participants said this did not effect their ability to see their doctor. The combination of the participants' experiences, confirming with the questionnaire and the reported consequences of this barrier makes it the second most significant barrier for their access of physician sexual health services.

6.5.3 I was uncomfortable with my physician because he is male

For most adolescent women in need of discussing their sexual activity and health with their physician, the gender of the physician was a factor if the physician was male.

It depends on who you are thinking about talking to about it. I feel more comfortable talking to girls because they understand better. I don't think I could sit down and talk to a male.

While fourteen of the participants indicated their doctor being male as a barrier, this figure is misleading, since not all of the participants went to male doctors. At the time of the interview, of the twenty-six participants who completed the questionnaire, fifteen had
male physicians, nine had female physicians, and one had no physician. Of the fifteen who had male physicians, eleven reported this fact as a barrier in accessing sexual health services. The other two participants who reported this as a barrier even though their current physician is female had both seen a male physician in the recent past.

This issue of gender is a complex one, relating to the participants’ comfort with physical examinations (refer to the ‘Fear of receiving a PAP test’ section), and in discomfort in discussing their sexual activity with a male. Some participants stated that it would be easier for a female physician to relate to them, as well as for them to relate to a female doctor in the physician-patient interaction:

_Most women feel more comfortable when they are talking to a female because they feel that a female can relate to their problem, whereas a man can’t._

_I don’t feel that comfortable with my doctor at all. He is old and male._

As a result of their discomfort with a male physician, many of the participants’ reported negative consequences for their use of physician services:

_I don’t often go to the doctor. No. I would rather have... I always had a female physician. I would rather have a female. If I really did have to go to the doctor with an important issue, I would probably go to my friend’s doctor. She’s a lady. I could get in with her probably. I would be much more comfortable with that._

Another participant shared why she won’t return to her male physician:

_I don’t feel really comfortable with a male, especially... I just feel not comfortable talking to him. A woman would know like what I’m going through more than he would._

Four of the participants indicated that their physician being male stopped them from getting sexual health services when they knew they should have. Four more participants
delayed their visits to their physician because he was male. These consequences, along
with the experiences of the participants, places having a male physician as the third most
significant barrier.

6.5.4 I was concerned about confidentiality
(worried my physician would tell someone)

Confidentiality was a common concern for participants and key to the construction of
their public identities as sexually active adolescent women. They were often unaware that
they had a right to confidentiality with their physicians, and even if they felt they had this
right, it was commonly thought that it would not be upheld.

*I would be uncomfortable talking to him in the first place. And I would be
kind of worried that he would tell someone, like my parents, that I was
sexually active.*

This fear was heightened for several of the participants as their physician was described
as a friend of the family, went to the same church as the participant’s family, or, as in one
case, a family member worked in the physician’s office.

*My parents are good friends with my physician, so I was worried about
confidentiality.*

*I'm just concerned about it because my doctor's secretary is my mom's
best friend. But whenever I go to my doctor for something that I don't
want my mom to know about, I just ask them not to put it on the records so
the secretary can't see them and call my mom.*

The need for confidentiality directly links to the participants’ concerns of impression
management of their new identities as sexually active adolescent women.

*Women don’t want anyone to find out [they are sexually active] due to*
stereotypes and judgements that may be placed on them. Women need to feel comfortable or else they may become intimidated.

In many cases, participants were most concerned about parents finding out their new identities as being sexually active, as parents were feared to be the most unhappy with their sexual activity and having the power to impact their lives as a consequence. More than half (65.4%) of the participants reported this as a barrier.

I'm always afraid of confidentiality. That is why I never tell secrets. If I have something to say, if I say it to one person, I say it to more. SO YOU WORRY ABOUT THAT WITH YOUR PHYSICIAN IN PARTICULAR, ABOUT CONFIDENTIALITY? Even with my doctor. No, he probably wouldn't tell but I don't want to take the chance. I mean doctors have enough secrets. I mean they don't need more.

While concerns about confidentiality were brought up often in interviews, and reported strongly as a barrier, only one participant indicated that it was a factor which stopped her from going to the physician when she knew she should have. Another three indicated that this concern delayed their visit to the physician. Five of the participants noted that concerns about confidentiality made them uncomfortable. This was the fourth most significant barrier to accessing sexual health services from physicians.

6.5.5 I was concerned that parental consent was required to get oral contraceptives

Only one of the participants was aware that parental consent was not required to receive oral contraception. Many of the participants thought there were rules with stages when parental consent was required, with the rules often dependent on the age of the patient:

DO YOU KNOW WHAT PHYSICIANS' RULES ARE ABOUT TELLING PARENTS THAT THEIR CHILDREN ARE SEXUALLY ACTIVE OR ABOUT CONTRACEPTION? WHAT DO YOU THINK THEY ARE? Um,
that they have to tell them if they are under 18. But then if they don't... If they are over 18 and they have permission from the kid then they can't tell them. The doctors don’t have to tell them.

The doctor will want your parents to know about you getting contraceptives.

It's just one of those things... I don’t know. I’ve heard a couple of times that you can get them [oral contraceptives] without parents’ permission but I don’t really understand how you could like hide something like that from your parents.

When asked where they learned these rules, many of the participants were uncertain, others cited their sexual health education classes, and others learned these from friends. This barrier directly relates to the same concern of impression management and desire for confidentiality, particularly from parents. Just over half of the participants reported concern about the need for parental consent as a barrier to accessing their physician’s sexual health services. This belief that parental consent was required led to direct consequences for several participants.

...at first we just used the condoms but then we decided that that wasn’t safe enough. So, um, we decided that I should go on the pill but I didn’t really like going to ask my mom about it right then. So we just like stopped having sex for a while...

DO YOU KNOW WHAT THE RULES ARE ABOUT TELLING PARENTS IF THEIR CHILDREN ARE USING CONTRACEPTION? I think it is a certain age or something. I'm not really sure. As far as my understanding is, is that there is a certain age and that [if you are under that age] they have to call your parents and tell them.

Four of the participants did not go to their physician to discuss sexual health when they knew they should have because they thought that parental consent was required to get
oral contraceptives. For the same reason, three of the participants delayed their discussion with their physician, while another two were uncomfortable. Thus, belief that parental consent is required to get oral contraception tied with confidentiality for the fourth most significant barrier.

6.5.6 My physician did not have enough time (too rushed, too many patients)

Some participants had the perception that their physician seemed rushed or had too many patients to see. As a result they felt that their concerns about sexual health were not important enough to see their physician, or that this rushed atmosphere did not lend itself to bringing up the personal issue of sexual health.

AND DO YOU FEEL COMFORTABLE APPROACHING YOUR DOCTOR? Approaching him? YES. Kind of. Sometimes. If he seems really busy, like I feel bad going in like wasting his time.

It seems that he’s rushing you to get out of there so you can’t ask them anything. Plus, signs in the office say “Keep it to one thing.”

HOW DID YOUR DOCTOR MAKE YOU FEEL? Just like she doesn’t want me there basically. Like she can’t wait to get the day done and go home. Basically like I’m being a pain to her.

In all, more than half of the participants reported that this perception was a barrier for them in discussing sexual health with their physician, with various consequences:

Well, he seems like he’s always in a rush. And sometimes it just makes it hard to understand what he’s saying. And he like gives you prescriptions, and sometimes I don’t think of questions that I want to ask him until afterwards. And I really don’t approach him after that.

I go in for like a physical or anything, and she just comes across like she is too snarky and I’m just another person. Like, "Can I help you?" It like I don’t want someone to think I’m just another person. That is basically the feeling type of thing. And I go to talk to and whatnot. I can’t
understand her for one thing ...And she just seems to want to rush right through. Like she's rough, in general. Like I don't want, "Urrr." You know, yanking all around and whatnot when I going to have a physical. Like take your time. Like I'm not going no whereas. But I don't like her just in general.

Perceiving their physician as being rushed or having no time led one participant to not go to her physician when she knew she should have, while another three delayed their visit a lot later than they knew they should have. Another five participants believe they delayed seeing their physician a little later than they should have. Four participants didn't delay their visits, but felt uncomfortable with their physician because they seemed rushed. As a result, this also tied for the fourth most significant barrier.

6.5.7 I needed a ride to the doctor with a parent

This barrier had two aspects tied to it. The first is the physical need for transportation to see a physician, which is discussed in the context of the next barrier, needing transportation to see the physician; the second is the concern about confidentiality if a parent was required to take them to see the physician for a matter related to sexual health. For many participants the need to discuss matters of sexual health constitutes the first time they have had to disclose their sexual activity as a matter of public identity. In many cases, it is also the first time they have wanted to see their physician for a matter unrelated to illness or a check-up, which would be known to their parents. Hence, several participants brought up the difficulty in how to make an appointment to see their doctor when they are not visibly ill, without raising their parents’ suspicions. If parents were to find out why they were going to the doctor, they might be concerned about the participants’ sexual activity.
IS TRANSPORTATION EVER AN ISSUE FOR YOU IF YOU WANT TO GO SEE THE DOCTOR? Yes, he's actually in Moncton. IN MONCTON. SO YOU WOULD NEED TO GET A RIDE AND HAVE TO TELL YOUR PARENTS? I don't know about my mother. She would freak on me. Um, probably I would just go to my friend's female doctor if you can do that.

Almost half of the participants reported this issue as a barrier. Moreover, this barrier led to consequences for some participants. Three of the participants reported that needing a ride to their doctor with a parent has stopped them from going to the doctor when they knew they should have, with another two saying that this factor delayed them. Another three were made more uncomfortable because parental involvement was required. Seventeen of the participants said that involving parents to get to their physician was not a factor, however, this may in part be attributed to the fact that several participants’ parents know they are sexually active, while others do not require any transportation to the doctor. Still, this barrier was the seventh most important.

6.5.8 I needed transportation to see my physician

This barrier relates to participants’ to maintain confidentiality when seeking physician’s sexual health services, as well as their physical ability to access such services. In some cases this was directly linked to the rural location of some participants, while others had to travel out of town to see their family physician due to the physician shortage in Amherst.

SO BACK BEFORE THEY KNEW WAS THERE EVER A TIME WHEN YOU WANTED TO GO THE DOCTOR BUT YOU WERE WORRIED ABOUT TELLING YOUR PARENTS YOU NEEDED TO GET UP THERE? I made up lies. YOU MADE UP LIES? There had to have been something... Oh, what was one? "My cramps are getting really bad, mom. I really need to go to the doctor and get someone stronger for them."
Because that was partly true too. But I mean there was something I could have held off on. But I would always find like some excuse to come up with just so they wouldn't know or suspect.

In all, half (thirteen) of the participants indicated the need for transportation as a barrier to accessing sexual health services from their physician. This barrier had a direct impact on participants’ ability to seek medical services.

[I was delayed going to the physician much later than I really should have because] I couldn’t go without missing school and I didn’t have a drive.

Three of the participants reported that needing transportation stopped them from seeing their doctor when they felt they should have. An additional four felt that they were delayed in seeing their doctor. Another two participants said they were able to go to their physician, but they were more uncomfortable because of needing transportation. These factors make this the ninth most significant barrier.

6.5.9 I am uncomfortable with my physician because I didn’t know them well enough (i.e. didn’t see them often to feel comfortable with discussing personal matters such as sexual health)

Not knowing your doctor well enough was identified by some participants as a hurdle to discussing their sexual activity with their physician. Participants made reference to this barrier as they felt uncomfortable bringing up their sexual activity with a physician they didn’t know, leading to their inability to judge what his/her reactions might be to them.

ARE YOU COMFORTABLE APPROACHING YOUR DOCTOR? No.
HOW COME? Just because I don’t know him very well. AND HOW DOES HE MAKE YOU FEEL WHEN YOU GO TO TALK TO HIM? Um, I don’t know, he’s nice enough. I guess I’m embarrassed to talk to him
about it. EMBARRASSED? Yes. IS THERE ANYTHING IN PARTICULAR THAT HAS HAPPENED TO MAKE YOU FEEL EMBARRASSED? No.

This barrier again denotes the importance of the interaction in the relationship between the participants and their physicians. In all, almost half of the participants reported this as a barrier for them. As a result, some participants were delayed, stopped or felt uncomfortable accessing the sexual health services they felt they needed.

HAVE YOU EVER TRIED TO GET INFORMATION ABOUT SEXUAL HEALTH FROM YOUR PHYSICIAN? Um, no, because I don’t really know them well enough to do it. Because like where it’s been switched around so much, I don’t feel comfortable with them.

Not knowing [the doctor] well enough would be like talking about your personal life with a stranger...you don’t know what the doctor will say or react to your questions.

Four of the participants indicated that not knowing their physician well enough stopped them from seeking sexual health services when they knew they should have. Three of the participants felt this factor delayed them visiting their physician, while another two reported that they went, but felt uncomfortable because they didn’t know their doctor well enough to discuss their sexual health. Thus, since they didn’t know their physician well, feeling uncomfortable bringing up their sexual health needs, disclosing that they are sexually active, and concern about their physician’s possible reaction to this new information were significant hurdles to accessing physician care, situating it as eighth in relation to the significance other barriers.

6.5.10 I was uncomfortable with my physician because I knew her/him too well (i.e. they were a friend of the family or attended the same church)

How well the participant knew their physician directly affected how comfortable they
were bringing up sexual health with their practitioner. For example, as just described, not knowing the physician well enough, was a barrier. On the other hand it was deemed more awkward if the physician knew the participant too well, as in some cases participants were uncomfortable about knowing the physician from a different, more familiar context.

*It's a small town, therefore young women usually know their physicians and may be uncomfortable talking to them [about sexual health] and not want parents involved.*

*He's also [a certain religion] so he has opinions about things...and he expresses them. Um, well, I'm [that same religion] too so I go to the church. So um, he kind of, when I asked him for birth control, he...kind of just gave them to me and passed them off...So it didn't make me feel comfortable.*

In other cases, this barrier related to the concern over confidentiality, again connected to the earlier discussion of impression management and the fear of family members finding out they are sexually active. Among all of the participants who completed the questionnaire, almost half indicated this concern as a barrier to accessing sexual health services from their physician.

Some of the participants felt the direct implication of this barrier. Two of the participants reported that knowing their physician too well stopped them from going to the doctor when they knew they should have. Six of the participants reported that knowing their physician from outside the physician-patient relationship made them uncomfortable when bringing up their sexual health. In all, the experiences of participants with the phenomenon place it as the tenth barrier in relation to the others identified.
6.5.11 My physician was too old, therefore did not relate to a young person like me

Some participants referred to their physician as old to describe how they felt that the physician might be coming from a different generation, one where adolescent sexual activity might be unacceptable.

*WHAT ABOUT IT WOULD STOP YOU?* He's a 40 year old male... If he was late 20's, 25, sure it wouldn't bother me. But just that he's 40. I don't know. It doesn't give the creeps or anything. I'm not like afraid of him. Like I go and get check-ups all the time but I wouldn't feel really all that comfortable just talking to him, going, "Hey..." I wouldn't just feel like I could go out in the open and say that to him.

Again, this relates to the symbolic interactionist concerns of how the physician might respond to the adolescent women's identity as sexually active, and in turn how that would effect the participant. While this wasn't the strongest barrier, almost half of the participants did report it as a barrier for them.

*I've heard... Like some of my friends' cases. That it's just basically like older male doctors usually. That, um, they talk about it but you just don't get the impression that they are willing to. And when they do, sometimes it's like sketchy details or whatever, when you are looking for concise facts.*

*DO YOU THINK A PHYSICIAN'S OPINION OF A TEENAGER WOULD CHANGE IF THEY WENT TO ASK ABOUT SEXUAL HEALTH ISSUES LIKE CONTRACEPTION OR SOMETHING?* Um, I think so. *IN WHAT WAY?* Um, I don't know... some people think they are too young people that are sexually active. That is just how I feel. I don't know why.

Some participants did experience consequences from this barrier. One participant indicated that their physician being "too old" stopped them from seeking sexual health services. Another three participants delayed their visits to their physician because their physician was "too old", while four of the participants went to see their physician but were uncomfortable because of their physician's age. This barrier was the eleventh most
significant.

6.5.12 I did not have a physician

There was common knowledge among the participants that there exists a shortage of physicians for the Amherst community, and some of the participants had experienced the direct results of this rural reality.

...they are all overworked big time, and there is not a lot of doctors in Amherst. And a lot of them are going away so, they are overworked.

DO YOU HAVE A FAMILY DOCTOR? Yes. We just lost him, and we have had a different one. We’ve been switching around quite a bit because there is not enough doctors in town and everything. So we’ve been losing doctors like crazy.

...he was my doctor like growing up. Like until he moved away like in grade... I was in grade 1 or 2. And then we just bounced around with doctors in Amherst, because they were coming and going so often. And then when he moved to Truro, it was just kind of like... When we lost our physician here in town, it was like another solution.

As a result, some participants did not have a physician, or felt it would be difficult to change physicians. This also relates to other barriers which have been discussed, as some participants experienced discontinuity in care from several family physicians over the years, or felt that their sexual health issues may not have been important enough to see a busy doctor (which is discussed as a separate barrier). Ten of the twenty-eight participants reported not having a physician as a barrier for them.

Two of the participants reported that not having a physician stopped them from seeing a doctor when they knew they should have. Another four felt that not having a physician
delayed them accessing sexual health services. This was the twelfth most significant barrier.

6.5.13 My physician seemed uncomfortable with discussing sexual health with me

A few participants perceived that their physician was uncomfortable when discussing sexual health with them during their physician-patient interaction.

*Like all my friends that I have who have like gone to their physicians and like asked anything about sex, they have gotten answers but sometimes they're not like full answers or they're not like exactly what they asked. And then like they'll ask for clarification and it's just they don't get it, like what they want. And I think it's mostly like the physicians are not comfortable to talking to like 15 year olds about sex like you probably would be with an 18 year old or a 19 year old.*

*You have to be comfortable with your own sex before you can talk to somebody else about it. And I think that is why my doctor is so out. But like I went to [a different physicians, and he was just totally straight and didn't want to talk about anything. I went to him when my doctor was out on maternity leave. It just seemed to me that he was totally uncomfortable with himself, which made me uncomfortable.*

Informed by a symbolic interactionist perspective, this perception can be seen to have many implications for the participants’ identity construction with their comfort in their own sexual activity and the acceptance of their new personal identities as a sexually active adolescents by their physician. If their physician was perceived as reacting to them uncomfortably, it affected the participants’ willingness to bring up sexual health, or return to their physician for sexual health services.

*DO YOU THINK PHYSICIANS KNOW ENOUGH ABOUT EDUCATING WOMEN ABOUT THEIR SEXUAL HEALTH? I think some of them do. But it sounds really weird but I think some of them are scared to talk about. That seems like my doctor was... Like it seems like he is scared to*
tell me stuff about it. WHAT MAKES YOU THINK THAT HE'S SCARED? Just because he doesn't tell me as much as he could. DO YOU KNOW WHY? I KNOW IT'S HARD TO ARTICULATE THAT. Yes. Well, I don't know, it's just... Like when [addressing a sexual problem], he didn't tell me why or what it was doing or anything... Like because he was scared to tell me stuff because like I'm a 15 year old girl going in by myself.

Concern over the perception that their physician thinks they are too young to be sexually active was common, and a source of discomfort for participants.

I think he would sort of blow me off. Any way that he could. Um, he's really not comfortable with that. I mean cause when he gave me the birth control pills, he didn't say anything about it.

Ten of the participants indicated this as a barrier to their accessing sexual health services on the questionnaire. Though the consequences are not as directly linked for this barrier as others, it nonetheless hampered some participants willingness to access services.

I guess I figured that doctor might lose respect for me so I put it off.

Feeling that their physician was uncomfortable discussing sexual health with them stopped two participants from seeking sexual health services when they knew they should have. It also made four participants delay seeing their physician.

So um, he kind of, when I asked him for the birth control, he, "Blah, blah, blah." He kind of just gave them to me and passed them off. HE DIDN'T REALLY TALK TO YOU ABOUT IT? No, not at all. So it did make me feel uncomfortable. DID IT? Yes. IN WHAT WAY? Um, well I felt like I couldn't talk to him. And I don't think I would today. I probably would go to outpatients if I had a problem. SO YOU HAVEN'T REALLY GONE BACK SINCE YOU GOT BIRTH CONTROL FROM HIM? No. Like he never said, "You should have an exam" or whatever, or "Try these, and if they don't work, come back." Like if whatever... ", "Or of you feel a little sick...", he just told me to read the book and leave.

Another three participants sought sexual health services, but felt uncomfortable because of their physician's discomfort. This was the thirteenth most significant barrier according
to the participants' experiences.

6.5.14 I felt sexual health is not important enough to trouble my physician with

A common perception for the participants was that sexual health is not an important enough issue alone to see their physician. While this was stated directly for a few participants, it was also evident in that almost all of the participants described the first time they brought up the issue of sexual health was when they went to the physician for different medical issue.

I don't go to the doctor very often, and when I go it's for a specific thing. So like if I sprained my wrist, she's not going to tell me about... You know what I mean? Like I don't usually go on a regular basis. I only go if I really actually need to go. So the things that I would go for wouldn't really be tied in with something like that so there would be no real reason for her to say, "By the way," whatever.

Overall, nine of the participants indicated this feeling as a barrier to discussing sexual health with their physician.

I've been there a couple of times without my mother, and he just hasn't said anything. Like I don't know if he thinks that he would be out of place mentioning it. I don't know. I think I would have to bring up the topic first.

One participant reported that they were stopped from going to their physician when they knew they should have because she felt that sexual health was not important enough to trouble her physician with. Another four delayed their visit to their physician for this reason, while three participants were uncomfortable bringing up a topic which they felt wasn’t important enough to discuss with their physician. This was the fourteenth most significant barrier experienced by participants.
6.5.15 My physician made me feel uncomfortable when discussing sexual health

Similar to the barrier where the physician seemed to be uncomfortable when discussing sexual health, this barrier asked if the physician had made the participant feel uncomfortable. For some participants their physician’s negative reaction questioned the decisions they had made to be sexually active and the public identities they were constructing. Participants expressed wanting to be responsible in their sexual activity, and resented judgmental reactions from physicians.

YOU HAD TO BRING IT UP [SEXUAL HEALTH WITH YOUR PHYSICIAN]. HOW DID YOU BRING IT UP? Um, I just said... What did I say? I just basically said I wanted to go on birth control. That is basically what I said. Actually I'm glad. Like I felt bad at the time. Because I wanted to. But he made me feel sort of wrong. And I didn't... I don't think I'm doing anything wrong. I guess I've always... I've grown up with the attitude that I would wait until I was married, and obviously I'm not going to do, um... My views have changed on that. I don't like feeling bad. For getting birth control and going to the doctor.

CAN YOU DESCRIBE HOW YOUR DOCTOR BEHAVES TOWARDS YOU? She's a bitch. WHAT MAKES HER A BITCH? Um, the way she acts. She's not very polite about things. When she told me I was pregnant, she acted as if I was stupid. She just said, "You see this? Do you know what that means? You're pregnant." "Okay." And I started crying. I felt really bad. YOU STARTED CRYING. HOW DID SHE RESPOND? Like she just... That is just when she started telling me about what I should do or what I shouldn't do. DID YOU EVER TRY AND GET INFORMATION ABOUT SEXUAL HEALTH FROM HER BEFORE? No.

Here we see where the reaction of their physician made participants feel uncomfortable addressing their sexual health, thus creating a barrier for participants.

HOW DID THE DOCTOR MAKE YOU FEEL WHEN YOU WERE GETTING THIS [SEXUAL HEALTH] INFORMATION? He was really passive. Like he almost didn't want to hear it. So it kind of just made me feel like he just knew everything, that I didn't have to say anything... The less I had to say, the better it was.
Nine of the participants felt that their physician had made them uncomfortable to the point where they reported it as a barrier on the questionnaire. For a few participants, this barrier impacted their accessing sexual health services.

*CAN YOU DESCRIBE HOW YOUR DOCTOR BEHAVES TOWARDS YOU?* Well, I don't like her. She's the only female doctor so... I don't know. Well, she's nice but she's very quiet and she's got a very serious look on her face all the time. She doesn't really make you feel comfortable. ...she's hard to understand. I refuse to go to a male doctor so...

None of the participants indicated that they were stopped from seeking their physician's services due to being made to feel uncomfortable discussing sexual health. However, one participant did talk about this in her interview.

*BEING UNCOMFORTABLE WITH HIM, HAS THAT KIND OF STOPPED YOU FROM GOING IN TO ASK ABOUT STUFF?* Yes. *SO YOU THOUGHT ABOUT GOING IN, MAYBE TALKING ABOUT CONTRACEPTION AND THAT KIND OF THING, AND YOU THOUGHT ABOUT GOING BUT...*Yes, birth control pill. *BUT YOU HAVEN'T GOTTEN UP THE COURAGE YET.* No.

Two of the participants did feel that this kind of interaction delayed their visit to their physician, while three participants went to the physician but still felt uncomfortable in the interaction.

*[Physicians should] be like open and don't criticize. Make them feel really comfortable. And just like if you're giving them medical facts, that's fine, but don't like push your opinions on anybody or anything like that. Like if you think abstinence is the best way, and the person you're sitting there talking with doesn't, don't like tell them they shouldn't be doing this and they shouldn't be doing that. That type of thing. AND DO YOU THINK THAT HAPPENS? Sometimes. Like my friend's doctor, she, um, can't go talk to him. She doesn't want to. Like she wants to go see my doctor. OH REALLY? Yes. And, um, because he's just very old fashioned. And so when she like talks to him, he's like, "That's wrong," type of thing.
AND WAS THAT ABOUT SOMETHING RELATED TO SEXUAL HEALTH? Yes, I think so. I think it was when she went to get, um, birth control pills. I'm pretty sure. AND DID HE GIVE THEM TO HER, DO YOU KNOW? Yes, he gave them to her but I think she got a big lecture at the same time. SO SHE DOESN'T WANT TO GO BACK TO SEE HIM? Right.

This sense of being made uncomfortable by the physician was the fifteenth most significant barrier.
6.6 How Some Participants were able to Overcome these Barriers to Using Their Physician’s Sexual Health Services

All of the participants expressed barriers they have experienced in obtaining sexual health services from their physician and that these barriers had negative consequences for them in obtaining sexual health services. Yet, it was also evident that many participants had received sexual health services from their physicians, as several had been prescribed oral contraception, some had received PAP tests, and others had discussed their sexual activity with their physician. In many cases, participants initially came across barriers and found ways to overcome them as they dealt with the discontinuity between their new private and public identities. The effects of the interaction between patient and physician can be demonstrated in the initial process of facing barriers and in how some participants overcame them.

The overcoming of the barriers to physicians’ sexual health services appear to fall into thematic categories which all relate to the participants’ sexual identity construction. These can loosely be labeled as: i) becoming comfortable with their own sexual activity; ii) gaining the support of parents for their new identity as sexually active; iii) the participant directly addressing the issues that were barriers with their physicians, thus constructing their public identities to include that they are sexually active; iv) finding alternative sources of services and information and using a different location to form their public identity as sexually active which is more comfortable than with their physician; v) overcoming the barriers with the assistance of the physician constructing their new identities together; vi) deciding not to use physician sexual health services, thus
not constructing a public identity as a sexually active adolescent with their physician; and
vii) deceiving their physician by constructing a public identity that was more amenable
for the participant.

6.6.1 Becoming comfortable with own sexual activity

Some participants described a process by which they became more comfortable with their
personal and public identity as sexually active adolescent women. As they became more
comfortable with the choices they made to be sexually active, they also became more
confident in their ability to portray their sexual activity to their physician with less fear of
the physician's reaction.

Well, the only reason I could think of that people would be more open to
talk about it [talking openly with physicians about sexual health] is
because my friends are getting older. Do you know what I mean? They're
gaining more comfortable with the issue themselves.

WHAT DO THINK IT IS IN PARTICULAR THAT STOPS YOU FROM
HAVING TO FEEL EMBARRASSED? I grew up. YOU GREW UP?
I must have. I don't know, like there is a certain point like in grade 7 and
8, I was a little bit embarrassed about it but I reached a point where if I'm
talking to my boyfriend about possibly having sex, you have to grow up. If
you're thinking about it, I'm sorry but this is not something a child does.
As far as I'm concerned, this is something young adults discuss. And that
is how we have treated it. We've treated it as we were young adults. We
discussed the situation. I mean if you have sex, you've got to be aware of
the consequences. You have to know you can get pregnant. If you don't
know that then you are just foolish. It's a fact of life. You can get
pregnant. The first time, like my first um, examination, I was a little bit
embarrassed, scared, because you don't know what is going to happen.
You are always like that the first time with anything. But I mean after
that, I am more comfortable with him. I can even talk to my parents now
like about my sexual relationships and whatever else. But I mean I just
reached a point. I found I just grew up even more one day when I reached
a point where I had to realize I'm doing it. I have to be responsible about
it. I mean if I'm having sex, I've got to know I can go out and buy
condoms and all these options are available to me. It's just up to me to
take advantage of them. AND DO YOU REMEMBER HOW OLD YOU WERE WHEN YOU STARTED FEELING THAT SENSE OF CONFIDENCE? Well, I was 15 when I first had sex with my boyfriend. We were together for about 3 years. And the first time I was comfortable around him. Like we had like make out sessions, I guess, if that is what you want to call them. Like before. But we never had gone all the way. And the first time we did, I wasn't uncomfortable. It's a fact of life. It's something that everybody does. I mean if you're not comfortable with it then you shouldn't be doing it.

This evolution in many participants' comfort with their new identities helped them overcome the barriers related to: the physician not bringing up sexual health, their physician's discomfort in discussing sexual health, their discomfort with their physician, fear of receiving a PAP test, and not knowing their physician well enough.

6.6.2 Gaining support of parents

As participants became more comfortable and dealt with the discontinuity in their private and public identities as sexually active adolescent women, some participants were able to discuss their sexual activity with one or both parents. In all of the participants' experience, having parents aware of their sexual activity helped them access sexual health services from physicians. In a few cases, parents found out about the participants' sexual activity by accident.

AND AT WHAT AGE DID YOU FIRST HAVE INTERCOURSE? Oh, when I was 16. SO YOU'VE OBVIOUSLY HAD TO MAKE DECISIONS AROUND WHAT YOU WANTED TO DO WITH YOUR PARTNER AND IF YOU WANTED TO USE CONTRACEPTION AND WHAT KINDS YOU WOULD LIKE TO USE. Yes. HOW DID YOU MAKE THOSE DECISIONS? Um, well, we used condoms for like quite a while. But then my mom found out, and she got pretty mad at me because I wasn't on the pill. So she made me go on the pill... THE FIRST TIME WERE YOU LIKE
EMBARRASSED HAVING TO GO THERE? Um, not to go to her per se but my mom came with me. And like I said, she wasn't too happy with the whole thing. And I kind of maybe felt like I had made a mistake... Well, not made a mistake but like disappointed her or something.

YOU'VE HAD TO THINK ABOUT WHAT YOU WANTED TO DO WITH YOUR PARTNER, AND CONTRACEPTION CHOICES AND THINGS LIKE THAT. Yes. HOW DID YOU MAKE THOSE DECISIONS? Well, my mother made the first one for me because she read a note that I had and then she made me go on the pill. And then I smartened up myself and used condoms as well, at the same time. WAS THAT FROM THE FIRST TIME? No. No, the first couple of times it was pull out. I don't know what that is called. YES, WITHDRAWAL. Yes, withdrawal. That is what it was at first. And then mom found out and I went on the pill, and just used that for a while. And then I smartened up and said, "Oh, shake your head."

DID YOU GO TO [YOUR PHYSICIAN] FOR THE INITIAL CONTRACEPTION? TO GO ON THE PILL, DID YOU TALK TO HER ABOUT THAT? Yes. AND WHAT WAS THAT INTERACTION LIKE? DID YOU HAVE TO BRING IT UP WITH HER? I didn't go. My mom went. YOUR MOM WENT AND GOT THEM FOR YOU? Yes. HOW WAS THAT? HOW DID THAT MAKE YOU FEEL THAT YOUR MOM WENT? Well, at 16 when me and my mother never even talked about kissing before then and then all of a sudden we're talking about sex was a little... I was terrified that she was mad at me. But she wasn't. She was fine. Well, she wasn't fine but she was better than I thought she would be when she found out. AND DID SHE FIND OUT OR DID YOU TELL HER? She read a note from my boyfriend. SO THEN THE NEXT TIME YOU WENT TO SEE YOUR PHYSICIAN, DID YOUR PHYSICIAN KNOW THAT THE PILLS WERE FOR YOU? Yes, she knew when my mom went there. DID YOUR MOM GO PICK THEM UP FROM THE PHARMACY AS WELL FOR YOU? Yes.

Once parents were aware of the participants’ new identity, either by accident or as the participant told a parent, it helped them overcome the barriers related to: needing transportation, confidentiality, and the fear of the need for parental consent to obtain oral contraception.
AND WHAT WAS THE DISCUSSION ABOUT CONTRACEPTION LIKE? DID YOU BRING IT UP OR DID SHE? Um, well, I made the appointment and I went in, and I said, "I want to go on the birth control pill." And we just like discussed like effects of it and like other possible methods like I could do. AND HAD SHE EVER BROUGHT THESE ISSUES UP BEFORE WITH YOU? No, I brought them up with her. AND HOW DID YOU FEEL ABOUT BRINGING THEM UP? Well, I was a little nervous at first. I was like, "Ah, well..." But after a while, it was just like, "Oh, whatever." AND DID YOU GO ON YOUR OWN? Ah, no, my mom took me. YOUR MOM TOOK YOU? SO SHE KNEW ABOUT ALL OF THIS TOO? Yes. AND YOU TALKED TO HER ABOUT YOUR DECISIONS? Yes. WERE YOU ABLE TO GET THE INFORMATION THAT YOU NEEDED FROM YOUR PHYSICIAN THEN? Yes. DID YOU FEEL EMBARRASSED TRYING TO GET INFORMATION FROM YOUR PHYSICIAN? Well, not really embarrassed, just like nervous. AND WHAT MADE YOU NERVOUS? Um, it was just I was... I just know I was really nervous. I don't know why. I kept thinking, "Oh, no, what is she going to say? What am I going to have to do?" and stuff like that.

From this next participants story it is evident how important her mother's acceptance of her new identity as sexually active was for her accessing sexual health services from her physician.

WHEN YOU WERE BECOMING SEXUALLY ACTIVE AND STARTING TO BE SEXUALLY ACTIVE WITH DIFFERENT PARTNERS, AND MAKING DECISIONS ABOUT CONTRACEPTION, DID YOU TALK TO ANYONE ELSE ABOUT THAT? My mom. YOU TALKED TO YOUR MOM ABOUT IT? Yes. My mom is like... I have the greatest mother in the world. She always said from the very beginning, "If you ever have any questions or whatever, come and talk to me." She's always been so right open and everything. You know, even if I don't want to tell her something, I'll tell her. Like I was so scared because she always said, "When the time comes, I want you to tell me." And I was so scared to tell her what I did. And I felt right comfortable about it because, you know, she didn't like holler at me or anything. She just said, you know, the facts of life and stuff like that... Any time I had to go to the doctor, my mom was there for me. SO YOUR MOM WOULD TAKE YOU. Yes. WOULD YOUR MOM WANT TO KNOW WHY YOU WERE GOING? Yes. I would always tell her. Like she would always set up my appointments for me. WERE YOU ABLE TO GET ALL THE INFORMATION THAT YOU WANTED TO GET FROM YOUR PHYSICIAN OVER THE YEARS? Yes. Anything I wanted from him, I would get it from him. It got it. AND DO YOU FEEL
COMFORTABLE APPROACHING YOUR DOCTOR? Yes... DO YOU EVER FEEL EMBARRASSED TRYING TO GET INFORMATION FROM YOUR DOCTOR? Um, I don't feel embarrassed. Like sometimes I would say, "Mom, go get it." GO GET THE PILLS OR WHATEVER? Yes, go get this stuff for me. Go get the information. But no, I used to be uncomfortable but that was in... You know, I wasn't so mature or whatever. But now it's like, you know, I'm not really embarrassed about it too much. AND DID ANYTHING HAPPEN TO MAKE YOU FEEL EMBARRASSED? No, not really. You know, one of those things. Because he's a man, and you know, I was only... Well, I wasn't too much younger but I wasn't so mature as I am now.

AND YOU ALSO THOUGHT THAT SHE [YOUR PHYSICIAN] WAS APPROACHABLE SO THAT'S GOOD. DO YOU HAVE ANY FRIENDS WHO HAD SIMILAR EXPERIENCES? LIKE GOING AND ASKING YOUR PHYSICIAN ABOUT CONTRACEPTION, AND EITHER HAVING GOOD OR BAD EXPERIENCES? Um, most of my friends have had good experiences because, um, my group of friends are pretty... Like they have good relationships with their parents, and they find it easy talking to them. And then they are not embarrassed to go to their doctor. So I think most doctors in Amherst are pretty good, like pretty approachable. It's just the fact that you have to approach them kind of thing. I don't know, there are probably some that are, you know, not as approachable as others but I've had all good experiences.

While some participants' parents were still unaware that the participant was sexually active, of those participants whose parents did know, all of the parents were supportive in obtaining sexual health services from physicians.

6.6.3 Directly addressing issues that were barriers

Some participants who faced barriers to discussing their sexual activity with their physician opted to address their barriers with their doctors directly. For example, a participant who was very concerned about confidentiality and reluctant to discuss her sexual activity with her physician, because the physician was friends with the
participant's parents and attended the same church, used an opportunity when seeing the physician for strep throat to ask the physician about confidentiality. Here is another example of a case of this tactic:

*AND YOU FELT COMFORTABLE APPROACHING YOUR OWN FAMILY PHYSICIAN? Yes. I was a little nervous just because I was kind of just shy about the whole thing, but not because of it was her, just because. AND WHAT HAPPENED IN THE INTERACTION? LIKE YOU MADE AN APPOINTMENT? Yes. AND WAS IT SPECIFICALLY FOR THE ONE ISSUE? Um, it was for that but I also had a cold and I needed an asthma puffer. So I was kind of like as she was filling it out, I was like, "I'm kind of here for the pill too." And then she just like told me the different kinds I could get. I kind of just asked her what she thought. And then she said to come back in a month and tell her how it went.*

This tactic of bringing up their identity as sexually active adolescent women while visiting the doctor for a different concern was very common among participants. This allowed for the participant to decide during a scheduled appointment if they were ready to disclose their sexual activity and ask for sexual health services, (most commonly asking for oral contraception), without having to make a specific appointment for that one issue.

Some participants directly asked their physicians for reassurance that their sexual activity would remain confidential.

*AND DID SHE EVER TALK TO YOU ABOUT THAT, ABOUT WHAT IS CONFIDENTIAL IN YOUR VISITS? Um, no, but I asked her. I said... Like you know, "If I asked for a contraceptive or whatever, do my parents have to know about it?" And she said that she wouldn't say anything. Like it was confidential. SO IT WOULD BE CONFIDENTIAL. DO YOU THINK THAT MOST PEOPLE KNOW WHAT THE CONFIDENTIALITY RULES ARE WITH THEIR DOCTORS? Um, I don't think unless you ask. I don't think they'll say.*
WHAT ARE PHYSICIANS' RULES ABOUT TELLING PARENTS IF THEIR CHILDREN ARE SEXUALLY ACTIVE OR USING CONTRACEPTION? All the doctors I've ever had, if you asked them not to tell your parents something, they won't. So that is pretty good. DO YOU THINK THEY CAN TELL YOUR PARENTS? Well, it's not really... It's not illegal for them to tell if you are under age. So they could but if you ask them not to, I don't think they would. DO YOU KNOW ANYONE THAT THAT HAS HAPPENED TO, WHERE A PHYSICIAN HASN'T MAINTAINED CONFIDENTIALITY FOR SOMEBODY? I remember when I had my STD, I was only 15. I asked him not to tell my mom and he didn't. So that was good.

Directly addressing concerns with their physicians allowed for participants to overcome barriers related to: their concern about confidentiality; their needing parental consent; their perception that sexual health is not important enough to bring up with a physician; their needing transportation to their physician and/or needing a ride with a parent; and their physician not having time.

6.6.4 Other participants found alternative sources of services and information.

Participants who did not overcome barriers to accessing sexual health services from their physicians often found it easier to access other sources of information and services. For example, many participants talked about the ease of getting information at the teen health centre located in their school, speaking with friends, or accessing sexual health services from their community clinic.

*There was a time when I thought I was pregnant. I actually came here [the school health centre] to do the test. The nurse did it with me.*

*...well, just when I had the pregnant test. Actually I went down to Maggie's Place, [a community clinic] and that is where I had the test done.*
Other participants opted to change physicians, or planned to change physicians. This was most common among participants who were uncomfortable with their male doctor, and planned to see a female physician.

**HAVE YOU EVER GONE TO ANY OTHER DOCTOR FOR ANYTHING FOR SEXUAL HEALTH?** Well, the first time I ever went on the pill, another good friend of mine, her father is a doctor. So I went to him because I know him and stuff. And he just talked to me and told me exactly how it worked and exactly what it was doing. AND SO HE PUT YOU ON THE PILL? Yes. SO THEN YOUR PHYSICIAN DIDN'T KNOW THAT YOU WERE ON THE PILL? Yes. But then I stopped taking it because it made me feel really sick all the time. DID YOU TELL HIM THAT YOU WERE GOING TO STOP TAKING IT? Yes. ... **IS THERE A REASON WHY YOU WENT TO YOUR FRIEND’S FATHER TO GO ON THE PILL RATHER THAN YOUR OWN DOCTOR?** I was just more comfortable just because I know him. I see him in his pyjamas and first thing in the morning and stuff. Like I just know him really good. I've known him ever since like grade 4. **AND ARE YOU COMFORTABLE WITH YOUR OWN PHYSICIAN?** I'm comfortable but I'm not overly comfortable. I'd rather go to my friend's dad than him. He's a nice person but he's just not really a people person. It sounds bad for a doctor but..

I think I'm going to go get one [a pap test] soon though. I really should... Well, my best friend actually just lost her virginity like 3 weeks ago. So she's like, "Come on, come with me." You know, like do it with me, or whatever...I'm not going to go to [my current physician] if I get it done. **YOU'RE GOING TO GO TO A DIFFERENT PHYSICIAN?** I want to go to a female. I going to go to [another physician] That is my best friend...or the one who just lost her virginity, that's her doctor. And I think I would probably go to her doctor. **AND WHY WOULD IT BE BETTER WITH A FEMALE DOCTOR?** I don't know. I'd feel more comfortable.

Finding alternative sources of information and services helped participants avoid barriers related to: not knowing their physician well enough; feeling uncomfortable with their physician; and not wanting to see a physician they perceived as old or a male physician.
6.6.5 In addition some participants found that their physician was helpful in overcoming the barriers once the issue was brought up.

Barriers can be overcome by one of two methods: 1) the individual experiencing the barrier can actively find a way to overcome it; or 2) the barrier itself is removed. Some participants described interactions with their physician which helped them feel more comfortable accessing sexual health services thus lessening or eliminating their barriers. Essentially, the participant’s acceptance of their physicians’ assistance in overcoming various barriers enabled them to continue accessing sexual health services they were not inclined to, and to feel more comfortable when doing so. For example, a participant who was very fearful of receiving a PAP test had the process thoroughly and empathetically described by her physician, which convinced her to go ahead with the procedure, and made her feel more comfortable:

AND DID SHE TALK TO YOU ABOUT GETTING A PAP TEST? Yes. Yes, she told us that’s what you’re supposed to get one every year. She said it’s not bad, and it’s not exactly a year but don’t let it go longer than 2 years. AND SO DID YOU GET A PAP TEST WITH HER? Yes. AND HOW DID YOU FEEL ABOUT GOING TO GET ONE? Well, it’s not too fun but it’s something that has to be done, I suppose. BUT SHE MADE YOU FEEL COMFORTABLE? Oh, yes. AND SHE EXPLAINED IT ALL TO YOU BEFOREHAND? Yes.

Other participants described their physicians’ initial reaction to their disclosing their sexual activity as very open and receptive, putting them at ease in continuing to access sexual health services from her physician:

AND HOW DID THE DOCTOR MAKE YOU FEEL WHEN YOU WERE GETTING THE INFORMATION THAT YOU NEEDED? Um, good. Like she didn’t make me feel embarrassed or anything like that. She made me feel calm.
AND EVEN BEFORE YOU WENT TO TALK TO HIM, DID YOU HAVE A FEELING LIKE HE WOULD RESPOND WELL? HAD HE BEEN EASY TO TALK TO ABOUT OTHER THINGS BEFORE THAT? Well, I never talked to him about anything before. And it was kind of more me. I was like I didn't know how to start. But once I started talking, I was just like fine. And then when he responded in such a...like in a neutral mode, then it was really comfortable.

Other physicians were clear with participants as to what their expectations of confidentiality were up front, thus helping the participants with their, as yet unspoken, concerns about confidentiality:

WHAT ARE THE PHYSICIANS' ROLES ABOUT TELLING PARENTS THAT THEIR CHILDREN ARE USING CONTRACEPTION? Um, I think it's... I don't think they will tell them. I know mine said that she wouldn't, like if I didn't want her or whatever. AND IS THAT BECAUSE YOU ASKED OR...? No. Like she just said, like, "Does your mom know?" or whatever. And I was like, "Well, she probably will find out but she's not in the know." She said, "Well, it doesn't matter. I won't tell her." or whatever. DO YOU KNOW OF ANYONE WHO HAS FELT WORRIED THAT THEIR PHYSICIAN WOULD TELL THEIR PARENT?

Yes. I have... Like I have friends who just... It's just like a natural thing. They're just like, "Well, I hope she doesn't tell my mom." Or, "If my mom goes in or my dad goes in for their check-up or whatever, that she doesn't mention anything." It's just a normal concern, I guess.

I don't think she knew that I was having sex at the ...But I was asking her about the pills. Like I was asking her like information on it but not for them. And she... You know, she told me this and that, and basic information and stuff like that. And then she said the second time, "I remember you came to me before and asked me about this, and don't worry because it's confidential. If your mother broke down my door 5 seconds later and said tell me what you said, I still couldn't tell her, or I still wouldn't tell her."

Well, when I first became sexually active and I was more or less getting ready to tell him about it, and say I'm going to have to have an examination and stuff like that..." Like I was the one who approached my doctor about saying I need the examination and that. And he said... And he knew I was kind of uncomfortable and a little bit timid. And he was like, "You do understand that whatever you say is just between us." He said, "I don't know run back and tell your parents, and
your parents don't know." He expressed that. While these are not cases where the participant directly acted to overcome these barriers, it is another way in which some of these barriers were overcome. With the appropriate initiation and / or response from their physician, some participants were able to overcome their barriers of concern for confidentiality, needing parental consent bring up sexual health, feeling uncomfortable, and fears of having a PAP test.

6.6.6 Not using sexual health services from a physician.

A couple of participants opted not to utilize sexual health services from their physician due to the barriers they experienced. This was common for participants who really feared getting a PAP test. In one case, a participant was prescribed oral contraception, took her free three-month sample from her physician, but decided not to go back for her follow-up appointment. She never went back to her physician because when she was given the oral contraception, the physician told her that at her follow-up visit she would have to have a PAP test. Instead, the participant decided to go back to using condoms. Again, while these participants did not directly overcome their barriers to their physician sexual health services, they were able to modify their behaviour or find alternative sources of sexual health care to meet their needs.

6.6.7 Deceiving their physician

In a couple of cases, participants felt it necessary to deceive their physician to receive the sexual health services they wanted, to bring their private and public identities in line. In
one case, a participant who approached her physician for oral contraception was told that she wouldn’t be given a prescription for the pill until she quit smoking. The participant had already been sexually active, gotten pregnant and had an abortion, and she didn’t want to go through that again. She decided that it was more important to get oral contraception, and she didn’t want to quit smoking. So on her next visit to the doctor, she lied, and told the physician that she had quit smoking in order to get the prescription for oral contraception:

THEN AFTER YOU BECAME PREGNANT, DID SHE TALK TO YOU ABOUT CONTRACEPTION, ABOUT SEXUALLY TRANSMITTED INFECTIONS, ABOUT RELATIONSHIPS OR ANYTHING? No. She just went there and said, "I would like to go on the pill." And she said, "Do you smoke?" And I said, "Yes, I do." And she wouldn’t give me the pill unless I stopped smoking. AND SO SHE SAID YOU ACTUALLY HAD TO QUIT SMOKING ALTOGETHER BEFORE SHE WOULD PUT YOU ON THE PILL? Yes. DID SHE GIVE YOU ANY OTHER OPTIONS IF SHE WOULDN’T GIVE YOU THE PILL? Actually she gave me a home video thing on how to quit smoking and stuff like that, and said she would put on the patch. And I was like I didn’t want to do that. But she wouldn’t give it to me unless I did. So I just went there and told her I quit smoking, and she said, "Okay." I didn’t but I didn’t... SO YOU ACTUALLY HAD TO LIE TO HER IN ORDER TO GET WHAT YOU WANTED? Well, I was really stressed out at the time. I didn’t want to quit smoking because I was stressed out. I just didn’t bother.

In another case, a participant was asked by a friend for help in getting the pill, so she has been going to the physician and getting double the amount of pills she needs, and supplying her friend on the side:

...a friend of mine, she was a little embarrassed to go [to her doctor for oral contraceptives] so I usually went for her. That is when I got pills for her. "I need some pills." I just kind of walked in the doctor’s office and [she] waited outside. IS THIS YOUR DOCTOR? Yes, my doctor, and it was her doctor at the time before she moved. AND DID SHE KNOW THAT YOU WERE GETTING THEM FOR THIS OTHER PERSON? No, she thought they were for me. I said, "I’m stocking up." So I had them
there. SO SHE WAS JUST REALLY EMBARRASSED ABOUT GOING? She was really, really embarrassed. Until she was about 17, she was terrified of going to talk to anybody about getting pills or condoms. HAD SHE ACTUALLY TALKED A DOCTOR THOUGH? No. SO YOU WERE JUST GETTING THE PILLS. THAT SHE HADN'T EVEN SEEN A PHYSICIAN AND GOT CHECKED OUT FIRST. Yes. And I was just basically trying to tell her what I heard what they did. SO YOU WERE LIKE THE SUPPLIER. Yes. I was like the dealer. HOW LONG DID THAT GO ON FOR? About 2 1/2 years.

While their strategy for overcoming barriers was not common, it is a particularly troubling one.
7.0 DISCUSSION

7.1 Summary of Findings

This inquiry provides several insights into understanding and overcoming barriers in the physician-patient relationship related to the sexual health of adolescent women in Amherst, Nova Scotia, through the analysis of interviews and follow-up questionnaires conducted with twenty-eight adolescent women from the Amherst Regional High School. Major themes were developed from the experiences of participants. First, the interaction between physicians and participants occurred with consequences that led to barriers in accessing physician sexual health services. Second, issues with participants' comfort with their private and public sexual identities also created barriers to accessing physician sexual health services for many participants.

While acknowledging the interconnectedness and complexity of the barriers to accessing physician sexual health services, fifteen specific barriers and their consequences were identified and explored, and their relative importance was established. These barriers in order of their significance for participants were:

- fear of receiving a PAP test;
- the physician never bringing up sexual health before being asked;
- being uncomfortable with the physician because he is male;
- concern over confidentiality;
- concern that parental consent is required to get oral contraceptives;
- the physician not having enough time, seeming too rushed;
- needing a ride to the physician with a parent;
- needing transportation to see the physician;
- being uncomfortable with the physician because they didn’t know them well enough;
- being uncomfortable with the physician because they knew them too well;
- the physician being too old, therefore not relating to a young person;
- not having a physician;
• the physician seeming uncomfortable discussing sexual health;
• sexual health not being important enough to trouble a physician with; and
• the physician making them feel uncomfortable when discussing sexual health.

One of the goals of qualitative holistic research is to understand the inter-connective nature of human experience and behaviour. It is evident from this inquiry that the barriers participants experienced accessing sexual health services from their physicians were multifaceted and interconnected. Participants’ perceptions of the services available from their physician, their understanding of their rights to confidentiality, their exposure and education related to the need and manner of such service delivery as PAP tests, all affected their use of these services.

7.1.1 Themes

These barriers identified by participants can be conceptualized into three overlapping categories: 1) discomfort with their physicians, particularly the physical examinations; 2) concern over the physician knowing they are sexually active; and 3) issues with others, besides the doctor, finding out they are sexually active. The first theme, discomfort with their physicians, encompasses the barriers: being afraid of receiving a PAP test, the physician seemed rushed, the physician seems uncomfortable when discussing sexual health, the physician is too old, they physician is male, and the physician makes them feel uncomfortable. The reasons behind the participants experiencing these barriers largely have to do with their discomfort with the physician’s physical examination. As Frankel (1993) relates, a physical examination by a physician takes place within a medical context, which is the only place where a non-intimate person is allowed to touch their
bodies, leading to shyness and discomfort. These feelings were heightened for participants who were seeing a male physician, a physician they felt was too old to relate to them, or a physician whose manner made them feel uncomfortable.

The second theme, concern over bringing up sexual health issues with physicians, comprises the barriers: the physician does not bring up sexual health first, sexual health is not important enough to trouble the physician with, knowing the physician too well or not enough, the physician being too old to relate to an adolescent, not having a physician, and the physician makes them uncomfortable when discussing sexual health. These barriers related to the participants' difficulties in constructing their new public identities as sexually active adolescent women, and their experiences of less than ideal physician sexual health service provision.

The third theme, issues with others beyond the physician finding out they are sexually active, incorporates the barriers: needing transportation and/or a ride to the physician with a parent; concern about confidentiality; concern that parental consent is required to get oral contraception; knowing the physician too well (from another context); and not having a physician. The reasons behind the participants experiencing these barriers relate to their concern over their parents and/or physician's reaction to the knowledge that they are now sexually active, and their ability to access their physician.

7.1.2 Overcoming Barriers

In this research I explore the overcoming of these barriers as methods of impression-
management and reconstruction of public and private identities. As many of the participants recounted, when they first became sexually active, they were often uncomfortable with the notion of anyone else finding out. This concern about their public identities as sexually active adolescent women led some participants to experience barriers to accessing sexual health services, and in turn found ways to overcome these barriers. There are two ways for barriers to be overcome. They are: 1) the individual experiencing the barrier can actively find a way to overcome it; or 2) the barrier itself can be removed. The ways in which some participants overcame barriers are divided into seven thematic categories. They are:

- becoming comfortable with their own sexual activity;
- gaining support of parents;
- directly addressing issues that were barriers with physicians;
- finding alternative sources of services and information;
- the physician helped eliminate the barrier once the topic was brought up;
- not using the sexual health services from a physician; and
- deceiving the physician.

The understanding of their parents and the support from them in accessing sexual health services from their physician were also critical components. Among the participants’ experiences, it is interesting to note that all of those who told their parents about their sexual activity were supported in accessing sexual health services by their parents, and in many cases parental input was the instigator for accessing these services. This might lead to the conclusion that all parents should know when their children become sexually active. Yet, it is important to keep in mind that many of the participants did not tell their parents about their sexual activity, and likely those who did so anticipated a more positive response given the foundation of their relationships with their parents. Rather
than solely focusing on parental involvement and support, there is a need to ensure that physician sexual health services are accessible, regardless of parental knowledge of their teens' sexual activity. Moreover, the participants' empowerment in accessing these services, being able to ask for certain services such as requesting oral contraception, or asking their physician to confirm the confidentiality of their inquiries is also an important theme in overcoming such barriers.

7.1.3 Symbolic Interaction
The themes related to barriers experienced by participants and how some were able to overcome barriers to physician sexual health services can be understood within the analytical framework of symbolic interaction. Participants' interactions with authorities, who include parents and physicians, were key in the formation of meaning that affected their use of physician sexual health services. One of the foremost meanings participants took from their interactions with parents and physicians was related to the judgement these authority figures did (or might) make regarding their sexual activity. Concern over parents or physicians losing respect and treating them differently was perceived by participants who had never had a physician bring up sexual health with them, or when perceiving the physician as uncomfortable when addressing sexual health.

Many participants, in their ongoing interactions with parents had determined that they did not want their parents to know that they were sexually active because they thought their parents would not support this behaviour. As a result, these participants were very concerned about maintaining confidentiality regarding their sexual activity. This in turn
created barriers related to fears that parental consent would be required for oral contraception, fears that physicians would tell parents they were sexually active, and not being able to access physician services because a ride was needed with a parent that would require disclosing why they were going to the doctor.

This concern was heightened for participants who felt that they didn’t know their physician well enough to gage their reaction prior to bringing up sexual health, or if the participant knew their physician from outside the professional relationship, (i.e. living in a smaller community many participants’ physicians were also family friends or went to the same church). Knowing their physician from another context made it more difficult for participants to feel comfortable revealing that they were sexually active, concerned that the physician, and ‘friend-of-the-family’, might not approve, as well as being concerned that because of the physicians’ relationship with their parents she/he might be more likely to tell their parents.

Concern that their physician might be judgmental was prominent for participants who talked about their physician being “old”. They perceived in their interactions with their physician that their physicians’ age made her/him less able to relate to them as an adolescent and more likely to be judgmental of their sexual activity. Gender was also an important component affecting the meaning participants’ took from interactions with physicians. Although participants had a difficult time expressing exactly why they were less comfortable with male physicians (they expressed this as an obvious and expected feeling), they clearly did derive meaning from their interactions with their male
physicians that led to them experiencing barriers to the use of physician services. This was most evident around participants’ discomfort with physical examinations and Pap tests. This phenomenon may relate to other research that will be discussed in the following section, that found female physicians address adolescent sexual health issues more frequently and effectively than their male counterparts (Mahler, 1997), and is supported by other research findings.

During physician visits, participants also perceived that their doctors were rushed, had many patients to see and little time to see them. These understandings were compounded by the participants’ understandings of the physician shortage in their community. As a result some participants derived meaning that their sexual health issues were not important enough to trouble a physician with and made it more difficult to bring up sexual health with their physician. In the end, many participants did not go to see their physicians, delayed their visits to physicians, or felt uncomfortable with their physicians because of these various interactions, which became symbolic, or held different meanings for them that developed into barriers.

7.2 Relevance to Literature

The themes uncovered in this inquiry relate well, and add to, the literature on adolescent sexual health and the physician-patient relationship on many levels. The experiences of the participants fit with our understandings of adolescent sexual health in Nova Scotia. More than two thirds of the participants were sexually active, with several of them having had more than one sexual partner. Two of the participants had to deal with
unintended pregnancies. One participant's pregnancy resulted in a birth, while the other had an abortion. As such, almost all of the participants have been concerned about their sexual health and have had various experiences in desiring and obtaining sexual health services from physicians. For the most part, physicians were seen by participants as important resources for information, access to oral contraception, and checking their sexual health by examinations including PAP tests. This would concur with the Nova Scotia Department of Health Report (1996) and Malus et al. (1987)'s findings that the vast majority of teens want to discuss issues of contraception and STD’s with their doctor.

The experiences of participants coming up against barriers further relates to research discussed in Posner (1995), Pendelton and Hasler (1983), and Lindensmith (1998), that found that multiple barriers exist which inhibit individuals’ use of physician services. The existence of barriers was reflected in the experiences of the participants. Moreover, the relative importance of the barriers experienced by participants fits with respect to previous quantitative data. The 1997 report of the students at the Amherst Regional High School found that: a) 46% of students reported they feel embarrassed to talk to a doctor (s) about sexual matters; b) 35% reported that doctors they have visited did not talk to them about sex; c) 26% felt that doctors lacked respect for young people who are having sex; d) 26% thought their family doctor might tell their parents of guardians; e) 15% reported that doctors they have visited talked about sex in medical terms which the adolescents found hard to understand; and f) 6% have tried to go to a doctor (other than their family doctor) but could not get an appointment. These results are congruent with
the themes revealed by participants in this inquiry.

Like the participants in Oanadasan and Malik (1998)'s study of adolescent women in Toronto, these participants felt more comfortable with a female physician, felt uncomfortable during physical examinations, and would like physicians to explain medical issues. Just as the 1995 Canadian Survey found that over one-third of Canadians are dissatisfied with their physicians, with a similar percentage finding them arrogant or insensitive (Posner, 1995), it is not surprising then that these issues would be heightened if most physicians are ill prepared for discussions about sexuality, particularly with adolescents (Alexander et al., 1991).

This inquiry also uncovered further barriers to physician sexual health. For one, the fact that Amherst is a more rural community has these participants facing issues of physician shortages and lack of continuity in care, as were discussed by Sibbald (1999) and Goodwin et al. (1996) as they are generally related to problems with medical service to rural communities. Furthermore, the issues related to rural communities of transportation needs to see a physician, lack of privacy and familiarity discussed in Liepert and Reutter (1998), were also seen in some of the participants' experiences.

The experiences of the participants' relationships with their physicians also reflected the current understandings of the medical system and the physician-patient relationship. None of the physicians brought up sexual health with the participants. This phenomenon was also found in studies by Beazley et al. (1996), Maheux et al. (1999), Mahler (1997),
and Millstein (1996). In several cases, physicians were perceived as being uncomfortable addressing issues of sexual health with the participants before being asked, which was also found by Croft and Asmussen (1993). Participants also encountered barriers as a result of their concerns about confidentiality with their physician, fears that parental consent was required by the physician to obtain oral contraception, and worry that their sexual health concerns were not important enough to bother a physician with because they did not fall into the "illness" model of physician care (Inglefinger 1982; Bolaria, 1994), or the physicians were too rushed and busy. This problem was further accentuated by the participants' understanding of the physician shortage in their community, thus perceiving the physicians as busy or inaccessible.

The participants' discomfort with intimate physical examinations also relates to the discussion of Oandasan and Malik (1998)'s findings with female adolescent patients in Toronto, and Frankel (1993). The phenomenon of physician difficulty in addressing sexual health is supported in the findings of Roter et al. (1991), Millstein et al. (1996), Langille et al. (1997), Croft and Asmussen (1993), Mahler (1996) and Maheux et al. (1999). These barriers are perhaps not surprising given Dunst and Trivette (1998)'s explanation of help-giving models that showed that the traditional medical system is not well suited for adolescent sexual health and prevention. It is also reflected in the literature that female practitioners address these issues more frequently and effectively (Mahler, 1997). The emphasis on improving physicians' prevention efforts for adolescent sexual health may be improving though, as Mahler (1997) reported that more recent medical graduates were more likely than others to screen adolescents for sexual activity,
educate them about STDs, and provide services to sexually active adolescents.

These barriers, as demonstrated by the participants, were also understandable when illuminated in relation to their identity-construction as sexually active adolescent women, which relates to Nettleton’s (1995) discussion of the doctor-patient negotiation, whereby physicians and patients jointly construct the meaning of their encounter, with the physician maintaining control. Todd (1993) also found that during women’s visits to physicians for oral contraception, the doctors’ assumptions regarding their patients played a powerful role defining women’s definitions of self. The perception of participants that they were treated differently by their physician because of their age also relates to Mechanic’s (1998) exploration of the unequal treatment of the medical system, based on age, gender and social economic status.

In general, the results of this study are strengthened by the methods used. Saturation was reached by having a large number (28) and representativeness of participants, who were selected through purposive sampling to provide participants with wide-ranging backgrounds and experiences. This saturation was evidenced in the triangulation of the questionnaire results that indicated that in fact all fifteen identified barriers were experienced by participants, and that they were able to demonstrate that in a format other than the interviews. Participants were further able to confirm interview results by reporting which barriers had stopped, delayed or made them uncomfortable during physician visits, on the questionnaire. These results were further upheld during member checks performed through follow-up interviews, the questionnaire, and a presentation of
results followed by discussion with fifteen adolescent women from ARHS (including eight participants).

While the questionnaire results themselves are not generalizable, within the context of the larger qualitative analysis, the themes are transferable. All of the participants experienced at least one of the barriers, with almost all of the participants indicating multiple barriers to physician sexual health services. Moreover, the participants were able to describe how barriers were often inter-related and what consequences they experienced as a result. Since the barriers were illuminated within theoretical frameworks of symbolic interaction, identity construction and impression management, as well as understandings based on the hermeneutic approach of the social context, the transferability of the results is enhanced. Given the participants' experiences and the supporting literature, it is evident that complex and inter-related barriers for adolescent women seeking sexual health services from physicians exist. The participants also showed how they dealt with some of these barriers. The next section will discuss recommendations based on this research.

7.3 Recommendations

The good news is that having this multifaceted understanding of the factors related to the barriers experienced by young women also allows for multiple entry points for addressing them. Barriers may be reduced by addressing several key components such as sexual health education, medical service provision, parental education to increase support, and awareness leading to empowerment for youth. These are all possible targets
for helping adolescent women access the sexual health services they need from family physicians.

More specifically, sexual health education provides an opportunity to reach all grade nine students. It could incorporate more direct education around accessing physician's sexual health services and contraception for young women. Sexual health education could include classes on why and how an individual might broach the topic of sexual health with their physician. Teachers could instruct the students on what their rights are to confidentiality, and empower them to ask their physician if they have concerns. Sexual health education could also explain the PAP test, empathizing with the discomfort or unease that a young woman might feel about personal physical exams, perhaps lessening its effect as a barrier. Ultimately, the education system has access to the students and an opportunity to directly and indirectly address the barriers that exist for many of them in accessing sexual health services from their physician.

Likewise, parental education may have a lot to offer in addressing the barriers experienced by participants. Awareness of adolescent sexual activity and the need to support risk-reducing efforts is in the best interest of parents and youth. Clearly, from the positive experiences expressed by participants, having aware and supportive parents went a long way in enabling them to access sexual health services.

Continuing education for family physicians and better sexual health training for medical students could also impact and lessen barriers experienced by adolescent women who
need to access sexual health services. Understanding the need for simple and clear communication, as well as the importance of physicians bringing up sexual health first with the adolescent women could help them access the sexual health services they need. Physicians should also be aware that adolescent women’s fears of receiving a Pap test can lead to barriers for them in accessing services. When sexual health is brought-up with an adolescent woman, physicians should explain Pap tests thoroughly and address any barriers related to their fear of receiving one, allowing for further physician care.

Also, alternative sexual health service provision emerged as an important strategy for adolescent women accessing sexual health services. Community and school-based clinics provide valuable service models as policy options that could help adolescent women access services that are geographically accessible and cater to adolescent sexual health needs, thus addressing many of the barriers found here. Perhaps it would be helpful if a teen-focussed physician could hold a clinic day once a week at the ARHS teen health centre.

Ultimately, the decision to access sexual health services from physicians is up to the individual. Yet, this research also shows that these adolescent women face multiple barriers to ensuring that they are able to be responsible in their sexual activity. While this research points to directions for removing or lessening such barriers to accessing sexual health services, perhaps one of the strongest implications of this inquiry is for the adolescents themselves. If these young women were able to use this knowledge to recognize these barriers and question the status quo, they might be empowered to ask for
changes in the sexual health services they need to facilitate their contact with physicians. However, much can be done beyond individual empowerment of adolescent women. Transportation, education, support, outreach and acceptance of adolescent sexual activity can all be improved, thus increasing accessibility of physician sexual health services for adolescent women by addressing structural boundaries and power differentials.

7.4 Conclusion

Since adolescent pregnancy is usually unintended (Goldenberg, 1995; Fellows, 1992), may result in increased risk for mother and baby, as well as lasting social academic and economic disadvantages (Feldman, 1994; Goldenberg, 1995, McArney and Hendee, 1989), coupled with risks of STI transmission, it is important to address barriers adolescent women face in obtaining sexual health services that can reduce their risks. In terms of adolescent sexual health and prevention, physicians have been shown to be helpful in providing education to help reduce unintended consequences of sexual activity, such as unwanted pregnancy and STIs (Steben, 1990; Oandasan and Malik, 1998; Fellows, 1992). However, the participants in this research expressed that several barriers exist for them in accessing physician sexual health services.

In conclusion, this inquiry provides several insights into understanding and overcoming barriers in the physician-patient relationship related to the sexual health of adolescent women in Amherst, Nova Scotia. It provides a contextualized understanding of the barriers experienced by participants. These barriers and their consequences for participants' access of physician sexual health service were discussed barrier by barrier,
as well as in the context of participants' lives. This allowed for understanding of the major themes, the complexity and interconnectedness of the barriers they experienced. The reporting of the barriers using several variables also provided a greater understanding of the nature of the relative importance of these barriers. Finally, the exploration of how some participants overcame barriers provides a framework for improving access to sexual health services for adolescent women.
INTRODUCTION
Hi, my name is Emily Marshall. I am a student at Dalhousie University, and I am doing the interviews for this research project. Our goal is to understand the relationship between personal experiences in seeking and obtaining information and services related to peoples sexual health and how they relate to perceptions of barriers to services and education. We hope this information will help communities and those providing training and education services to do it better.

Before we get started, I want you to know that I am using a tape recorder. I will also be taking notes as we go along. There are no right or wrong answers. I am just interested in your opinions and experiences. If you don’t want to answer any of the questions that is fine. You can also stop the interview at any time, without repercussion. Here is the consent form that explains a little more. Let’s go over it together.

I think the interview should take about one and a half hours. Do you have any questions for me before we get started?

So this study is part of ongoing research looking at teen health. What do you perceive health to be?

What would make a person healthy in general?

What about sexual health in particular?

What do you think are the reasons behind Nova Scotia’s teen pregnancy rate?

Do you think teens in Amherst worry about STDs, and/or pregnancy?

DEMOGRAPHIC INFORMATION (lead-in I am just going to start with some general questions)

What grade are you in?

How old are you now?

How would you say you are doing in school?

Do you know how far you want to go in school?

Do you plan to graduate?
Have you thought about going to college or university?

What about a future career? Do you have an idea of what you would like to do?

Do you have a job now?
Do you live close to the school, or are you bused in?

Are you dating someone right now?
Tell me about that relationship?

EXPERIENCE WITH SEXUAL EDUCATION IN SCHOOL

Before we talked about health and sexual health. Usually schools try to bring up sexual health issues in some classes. What do you think of the school teaching sexual health?

What kinds of sexual health education can you remember getting in school?
Classes
Teachers
Guidance counselors

What topics did they cover? (look for positive/negative language. For each kind mentioned)

- STIs, pregnancy, contraception, relationships, sexual orientation, abstinence, sexual decision making, masturbation, abortion, emergency contraception

What methods did they use for each topic?

Do you think they were good? Why/Why not? (For each one)

How do you think other students see them? (For each one)

Do you think the teacher knew enough? Why/why not? Can you think of a question or topic they did/did not handle well?

Did the teacher cover all the topics you would have liked? Can you give me examples of what they covered, what was missing?

Did the classes seem to fit your own experiences?

Did you ever feel a teacher (specify) avoided certain topics? Which ones-teachers/topics?
Do you think the teachers/guidance counselors that you mentioned are approachable to talk about sexual health?
Have you ever thought about asking them a personal question? What happened? Is there a time you or someone you know didn’t go when you thought you might?

How do you feel about the idea of approaching teachers about sexual health issues? (Such as what kind of contraception to use, fear of pregnancy...)

Would you worry about them being judgmental? Do you know an example of this happening? Tell me about it.

Would you be afraid they might tell someone else/break your confidentiality? Has this happened to you? To someone you know? What happened?

So, have these concerns of (confidentiality, judgmental opinions, etc...) Stopped you from going to them? How about other students?

**EXPERIENCES WITH PHYSICIANS**

**RELATIONSHIP INFO.**

You mentioned that you were/not seeing someone?
No: Have you had any relationships?
Yes: Can you tell me about your relationships? (past and present)
Is your friend older/younger?
In school?
How did you meet?
How serious would you say your relationship is?
How long are you/did you go out?
Have you had vaginal intercourse?
No: Have you thought about it?
Yes: So, you have made decisions about what you did sexually, and about contraception?

How did you make those decisions?

Who did you talk to about these decisions?

Has this changed with different relationships?

Do you have a family doctor?
Male or female?
How old about?
Do you need transportation to see your physician?
Can you describe how your doctor behaves towards you?

Have you ever tried to get information about sexual health from a physician?

Do you feel comfortable approaching your doctor?

Have you felt embarrassed trying to get information from your physician? What happened to make you embarrassed?

Do you think physicians avoid certain topics about sexual health?

Have you ever gone to a physician for contraception?
   What happened? Why did/didn’t you?

What are the physicians rules about confidentiality?
   Can they tell your parents? Would they?
   Has this happened to you? Anyone you know?

Do you think a physician’s opinion of a teenager would change if they went to ask about contraception?

Do you think they know enough to educate young women about sexual health?

Has your physician brought up sexual health issues with your first, or do you have to bring it up first?

Do you remember the first time your doctor brought up contraception?
   Do you know what prompted your doctor?
   How did your doctor handle the talk?
   How did your doctor make you feel? Why?

Have your concerns about (confidentiality, judgmental opinions, etc...) ever stopped you from going to your doctor to ask about contraception?

What else might stop you?

Have you had a PAP test? How do you feel about them?

EXPERIENCE WITH PHARMACY

Have you ever thought of going to a pharmacy for contraception? Did you?
   Why/Why not? (condoms/oral contraception)

When you go to the pharmacy (or think about going to the pharmacy), how do you feel
about it?

Do you worry about:
- confidentiality? Why...can you think of an example?
- What people there will think of you?

What else might stop you from going to the pharmacy?

**WIND DOWN**

Can you think of positive times where a teacher/pharmacist/doctor encouraged your sexual health?

What kind of things would you like to see to help students with their sexual health?
Do you think it is important? Why/why not?

If you had an opportunity to teach a class of teachers/physicians on what you think would help young women access sexual health services, what advice would you give?

Is there anything else you would like to share at this time?

*These are all of the questions I have for you at this time. How are you feeling?*

*I may be contacting you for some follow-up, to clarify the information you gave me. In the mean time you can contact me at any time at ****. If you have any concerns or questions you can also call ****. I am also going to give you a referral list in case you want to talk to anyone at these services. Let me just go through what they offer.*

*Do you have any questions?*

*Well, then thank you very much for your time. This has been very helpful.*
8.2 Follow-up Questionnaire

How important has each of the following been to you personally, in ever being able to access a physician’s services concerning your sexual health?

<table>
<thead>
<tr>
<th></th>
<th>Has ever stopped me from seeing the doctor when I know I should have</th>
<th>Has ever delayed my going to the doctor much later than I know I should have</th>
<th>Has ever delayed my going to the doctor a little later than I should have</th>
<th>I went to the doctor when I thought I should, but I was still uncomfortable</th>
<th>Has not stopped me from seeing the doctor at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>My physician has never brought up sexual health before being asked</td>
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<tr>
<td>I do not have a physician</td>
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<tr>
<td>I need transportation to see my physician (ride with parent)</td>
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<tr>
<td>My physician does not have enough time (too rushed, too many patients)</td>
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<td>My physician seems uncomfortable with discussing sexual health with me</td>
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<tr>
<td>I feel sexual health is not important enough to trouble my physician with</td>
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<tr>
<td>I am concerned about confidentiality (worried my physician will tell someone)</td>
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<tr>
<td>I am concerned that parental consent is required to get oral contraceptives</td>
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<td>I am afraid of receiving a PAP test</td>
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<tr>
<td>I am uncomfortable with my physician because I know them too well (i.e. they are a friend of the family, attend the same church)</td>
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<tr>
<td>I am uncomfortable with my physician because I don’t know them well enough (i.e. don’t see them often enough to feel comfortable with discussing personal matters such as sexual health)</td>
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<td>My physician is too old, therefore does not relate to a young person like me</td>
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<tr>
<td>I am uncomfortable with my physician because he is male</td>
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<tr>
<td>My physician makes me feel uncomfortable when discussing sexual health</td>
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<tr>
<td>Other:</td>
<td></td>
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</tr>
</tbody>
</table>

Please go back and rank all of the barriers from this list from most important to least important. You may use the same number twice, and no not need to number the barriers you consider unimportant.
8.3 Consent Forms

Developing Understanding From Young Women's Experiences in Obtaining Sexual Health Services and Related Education in a Nova Scotia Community

Consent Form For Interviewees

TO: Permission for your participation in a study to examine adolescent girls' experiences in obtaining sexuality and reproductive health education and services. We are asking you to consider taking part in an interview to help us better understand the experiences adolescent girls in Amherst have in getting education and services related to sexual and reproductive health. We want to talk to you about how those experiences lead to the formation of barriers to girls' getting such information and services. After you have read this page, which contains information about the study and the interview, we would ask you to indicate your decision about participation on the attached consent form. Participation is entirely voluntary, and you may refuse to take part. Even if you agree to take part in the interview, you may withdraw at any time.

Who is conducting the study? The study is being conducted by researchers from the Faculty of Medicine at Dalhousie University, in cooperation with the Amherst Association for Healthy Adolescent Sexuality. This Association is composed of a wide variety of individuals and community groups and agencies, including the administration of Amherst Regional High School, and the Nova Scotia Department of Health. Interviews will be carried out by Ms. Emily Marshall, who is working with Drs. Donald Langille and Janice Graham, both members of the Faculty of Medicine at Dalhousie University.

How Will the Interview be Conducted? The interview will take about 1.5 hours each to complete. Participation is voluntary and no one will be told that you took part in the study. Responses will be kept confidential, so that what you say in the interview cannot be linked to you personally. You may refuse to answer any question asked of you. You may withdraw from the study at any time, without any impact on your ability to use health services, such as the Teen Health Centre at the high school. With your permission, the interview will be taped so that we have a complete record of your responses.

What Takes Place After the Interview is Finished? The results will be typed out (transcribed) so that analysis of your responses can take place. Your name will not appear on the transcriptions. No one, other than the interviewer, will be able to link your responses to you personally. Your responses will be combined with those of other girls, so that we can have a better overall understanding of the issues in which we are interested. The tapes and transcriptions will be stored in a safe and secure area at Dalhousie University, and will be destroyed once the study has been completed.

Potential Benefits of the study. The study will help us understand how the experiences adolescent girls have in trying to obtain education and services related to sexual health result to barriers to their getting such information and services. With this information, we can work to remove these barriers, and more effective education and services can be provided young people in Amherst. The information will also be helpful to other communities as they attempt to deal with this important area of health.

Potential Risks of the Study. We see no risk to your participation in the study. Such interviews are often carried out in research projects, and we are not aware of any risks which they can create.
Developing Understanding From Young Women’s Experiences in Obtaining Sexual Health Services and Related Education in a Nova Scotia Community

I have read and I understand the attached information. I understand that participation in the interview is voluntary, that I may refuse to participate in the interview, or withdraw from it, at any time, and that I can refuse to answer any question. I understand that no person other than the interviewer, [name of interviewer], including my teachers and my parents, will know what my responses to the interview questions are. I also understand that after the study, all records of my individual participation will be destroyed.

I am indicating my decision about participating in the study as marked (please check one response):

YES, I AGREE TO PARTICIPATE IN THE STUDY BY TAKING PART IN THE INTERVIEW, AND TO HAVING THE INTERVIEW TAPEDE. _____

NO, I DO NOT AGREE TO PARTICIPATE IN THE STUDY _____

Participant’s Name (please print) ________________________________

Participant’s Signature ________________________________

Date ________________________________

If you have any questions or concerns about this study, please contact:

Dr. D.B. Langille
Faculty of Medicine
Dalhousie University
Clinical Research Centre
5849 University Avenue
Halifax, N.S.
Phone: 1-902-494-1312
Fax: 1-902-494-1597
Parent/Guardian Consent Form

TO: Parents or Guardian of [daughter's name]

RE: Permission for your daughter to take part in a study to examine female adolescents’ experiences in obtaining sexuality and reproductive health education and services.

We would like you to consider permitting us having your daughter [daughter’s name] take part in an interview for purposes of a research study. We wish to know more about the experiences young women in Amherst have in obtaining sexuality and reproductive health education and services. Participation is voluntary and you do not have to agree to allow us to ask your daughter to take part. Even if you agree initially that your daughter can be asked to take part in the interview, she may refuse to participate, or if she agrees initially, may withdraw at any time.

Who is conducting the study? The study is being conducted by researchers from the Faculty of Medicine at Dalhousie University, in cooperation with the Amherst Association for Healthy Adolescent Sexuality. This Association is composed of a wide variety of individuals and community groups and agencies, including the administration of Amherst Regional High School, and the Nova Scotia Department of Health. Interviews will be carried out by Ms. Emily Marshall, who is working under the supervision of Drs. Donald Langille and Janice Graham, both members of the Faculty of Medicine at Dalhousie University.

How will the study be conducted? About 30 female adolescents from the Amherst area are being asked to take part in these interviews. Each interview will take about 1.5 hours each to complete. Interviews will take place in the Teen Health Centre located in Amherst Regional High School during regular school hours. Participation will be voluntary and no one will be told that your daughter took part in the study. Responses will be kept confidential, so that the information given can not be linked to individuals who participate. No one, including parents of participants, will have access to information which can be linked to individuals. Your daughter may refuse to participate and can withdraw from the study at any time.

Potential Benefits of the study. The study is being carried out to determine the experiences that young women in Amherst have obtaining sexuality and reproductive health education and services. We want to understand how those experiences result their perceiving barriers to obtaining such education and services, so that efforts to remove these barriers can be undertaken, and more effective education and services can be provided young people in Amherst. The information will also be helpful to other communities as they attempt to deal with this important area of health.

Potential Risks of the Study. We foresee no risk to participation in the study. Such interviews are often carried out in research projects, and we are not aware of any associated risks.

We would like to include your daughter [daughter’s name] for participation in such an interview. We ask that you please complete the attached form, indicating that WHETHER OR NOT YOU GIVE PERMISSION FOR HER PARTICIPATION, and have your daughter return it Ms. Christina Chitty, Nurse at the Teen Health Centre, Amherst Regional High School.
Developing Understanding From Young Women’s Experiences in Obtaining Sexual Health Services and Related Education in a Nova Scotia Community

Parent/Guardian Consent Form

I have read the information in the attached memo and am indicating my decision about my daughter [daughter’s name] participating in the study as marked (please check one response):

I AGREE _____

I DO NOT AGREE _____

That my daughter [daughter’s name] may participate in the interview being carried out as part of this research project.

Parent/Guardian’s Name (Please print): ________________________________

Parent or Guardian’s Signature ___________________________ Date __________

If you have any questions or concerns about the study, please contact:

Dr. D.B. Langille
Dept. of Community Health & Epidemiology
Faculty of Medicine
Dalhousie University
Clinical Research Centre
5849 University Avenue
Halifax, N.S.
B3H 4H7
Phone: 1-902-494-1312
Fax: 1-902-494-1597
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