Some Factors Affecting Staff Attitudes Toward Offering Intrauterine Devices to Adolescent Patients

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THE LARGE NUMBER of adolescents seeking contraceptive services and the acknowledgement of their need for such services by the medical community have led to changes in attitudes as well as in the provision of services. These changes are exemplified in the following statements of two professional organizations.

The American Academy of Pediatrics recommended in April 1971 that:

> . . . the teenage girl whose sexual behavior exposes her to possible conception should have access to medical consultation and the most effective contraceptive advice and methods consistent with her physical and emotional needs; the physician so consulted should be free to prescribe or withhold contraceptive advice in accordance with his best medical judgment in the best interests of his patient.

The American College of Obstetricians and Gynecologists issued the following statements in

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May 1971 concerning contraceptive services to minors:

> The never-married, never-pregnant, sexually involved female has not yet been reached with effective contraception. The laws of some states indirectly prohibit this service for minors and thereby prevent the gynecologist from serving them or place the physician in legal jeopardy if he does so. . . .
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> The unmarried female of any age whose sexual behavior exposes her to possible conception should have access to the most effective methods of contraception.
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> In order to accomplish this, the individual physician, whether working alone, in a group or in a clinic, should be free to exercise his best judgment in prescribing contraception and, therefore, the legal barriers which restrict his freedom should be removed.
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> These restricting legal barriers should be removed even in the case of an unemancipated minor who refuses to involve her parents. A pregnancy should not be the price she has to pay for contraception. On the other hand, in counseling the patient, all possible efforts should be made to involve her parents.
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> The contraceptive services should be offered whenever possible in a broad spectrum counseling context which would include mental health and venereal disease. Every effort should be made to include male partners in such services and counseling.

Provision of contraceptive services for girls from menarche to age 17 poses the question of suitability of the various methods available for this age group. Individualization is the key word in the approach to the teenage contraceptor. No one method is best for all patients. While effectiveness is the primary consideration, equally important are the possible long-range effects of certain methods. Furthermore, even if a particular method is proved to be fully effective, with no side effects, would it be used successfully by the younger patients?

In view of the increasing use of intrauterine devices (IUDs) by adolescents and the development of more efficient devices, a study was undertaken to attempt to identify how staff attitudes influenced the use or nonuse of IUDs among the young patients of two clinics.

Survey of Clinic Procedures

The two clinics selected for the study provide contraceptive services to adolescents up to age 17. Clinic A has a comprehensive program for unwed pregnant adolescents and provides contraceptive services postpartum. Clinic B has a freestanding family planning program which provides contraceptive services to previously pregnant and never-pregnant adolescents.

The contraceptive methods prescribed for 142 patients during a 1-year period in clinic A and for 272 consecutive patients during a 5-month period in clinic B were as follows:

Method	*Clinic A*		*Clinic B*	
	Number patients	*Percent*	*Number patients*	*Percent*
Pill	23	16	215	79
IUD	98	70	10	4
Diaphragm	0	0	27	10
Other	0	0	4	1
None	21	14	16	6
Total	142	100	272	100

All the patients in the two clinics were under age 17, as mentioned before. Their marital status and number of pregnancies were as follows:

Characteristic	*Clinic A*	*Clinic B*
Marital status:		
Single	142	263
Married	0	5
Separated	0	0
Not reported	0	4
Number of pregnancies:		
None	0	210
One or more	142	54
Not reported	0	8

There was a marked difference in the types of contraceptive methods prescribed at the two clinics. At clinic A, 70 percent of the study patients were using IUDs and only 16 percent the pill. At clinic B, 79 percent of the study patients were on the pill and only 3.6 percent were using IUDs. As shown in the preceding table, the only major difference between the two populations was in the number of previous pregnancies. Most of

the relatively few previously pregnant girls at clinic B had had a previous abortion rather than a live birth; of the small percentage of clinic B patients using IUDs, 40 percent were in this group.

To evaluate the effect of a patient's having had a previous pregnancy on the attitude of the staff toward prescribing an IUD, each member of the clinic was given a questionnaire concerning choice of contraceptive method and basic knowledge of intrauterine devices. The questions on choice of method were:

1. In numerical order of preference, please indicate what you consider to be the contraceptive method of choice for all healthy, sexually active adolescents (menarche to age 17): oral contraceptive, IUD, foam, diaphragm, rhythm, other.
2. What method do you prefer for the sexually active never-pregnant adolescent?
3. What method do you prefer for the sexually active previously pregnant adolescent?

The types and numbers of staff members in each clinic were as follows:

Types	*Clinic A*	*Clinic B*
Clerk	1	5
Family planning coordinator	1	6
Registered and public health nurses	3	8
Certified nurse-midwife	0	1
Social worker	1	0
Physicians	7	5
Total	13	25

For purpose of analysis, the physicians were separated from the other health personnel who influence the patients' choice of method. In both clinics, unless there was a specific contraindication, the physician usually accepted the method prescribed by other personnel and agreed to by the patient. Therefore, the influence of the other health personnel is very important.

Results

The responses to the questionnaire showed a strong preference by all personnel in both clinics for oral contraceptives and IUDs over the other methods. Although the first question asked for rank order of preference, only the first choice is considered in this analysis.

In response to question 1, the physicians in both clinics ranked oral contraceptives and IUDs almost equally as preferred methods. Among the other personnel, those in clinic A clearly preferred the IUD, while those in clinic B preferred oral contraceptives.

Concerning the method of choice for the never-pregnant adolescent (question 2), the physicians and other personnel in both clinics preferred oral contraceptives. Even the other personnel in clinic A showed less preference for the IUD than they did in response to question 1.

As to the method preferred for the previously pregnant adolescent (question 3), all but physicians of clinic B showed less preference for the IUD than they did for the never-pregnant girl.

Among the physicians in clinic A, where IUDs are preferred, there was a reversal in choice of method between questions 2 and 3, whereas the physicians in clinic B showed no change. Among the other health personnel, those in clinic A preferred IUDs in response to all three questions, but less so for the never-pregnant adolescents than for the previously pregnant; the same changes were indicated by the other personnel of clinic B, but to a lesser degree.

The responses to specific questions regarding knowledge of effectiveness of IUDs for adolescents indicated that knowledge was adequate among all groups in both clinics, and no specific patterns emerged.

Discussion and Conclusion

A major factor affecting the use of IUDs by adolescents in this study was the attitude of the clinic staffs toward inserting these devices in nulliparous patients.

Not all methods of contraception are equally applicable to the adolescent population. The use of diaphragms, condoms, or foam, for example, are considered by many patients to be inconvenient and to interfere with the spontaneity of the sexual encounter, particularly by the adolescents who want to do the "natural thing." Thus, oral contraceptives and IUDs have become the most commonly used methods by young girls.

There are advantages and disadvantages to both methods. Properly taken, oral contraceptives almost always afford complete protection. However, the lifestyle of adolescents is not always adaptable to daily medication. Discontinuance and failure rates are higher among young girls than among older women. Rauh and associates (*1*) reported a 30 percent failure rate in an adolescent population. Discontinuance rates are also affected by the ability of adolescents to deal with the more common side effects of oral contra-

ceptives; undue reactions to side effects and discontinuance are often associated with a young girl's feelings of guilt and anxiety. Too often, when an adolescent discontinues the pill, she does not turn to alternate methods and pregnancy occurs.

The long-range effects on a growing girl of the daily administration of a potent steroidal compound have not been fully elucidated. The absolute contraindications to prescribing oral contraceptives are the same for the adolescent as for the adult. Of these contraindications, special emphasis must be placed on (*a*) impaired liver function from drug-associated hepatitis and (*b*) undiagnosed abnormal genital bleeding, in light of recent findings of vaginal carcinoma in young patients whose mothers had taken estrogens during pregnancy (*2*).

Hastening of epiphyseal closure and the resulting decreased stature caused by estrogens has been thought to be another contraindication for adolescents. However, bone growth is completed in most girls by age 14 or 15. After that age, the use of estrogens in the low-dosage oral contraceptives will probably have little influence on the normal teenager. But, the use of oral contraceptives by adolescents who do not have normal menstrual patterns is an area of concern. As many as 2 to 3 percent of patients taking the pill have post-treatment amenorrhea and anovulation, and most of these patients have had these conditions before they started to use oral contraceptives (*3*). The effects of estrogens on metabolic factors such as glucose tolerance, renin release, and protein changes are under study (*4*).

A major disadvantage of the IUD is that it is not absolutely foolproof against pregnancy. Removal by a professional is necessary when pain and excessive bleeding occur. Also, spontaneous expulsions occur more frequently among nulliparous patients than among parous ones (*5*). Reports of recent studies, however, indicate that modification of the size, shape, and composition of IUDs may lead to lower rates of expulsion and removal and higher efficacy, even for nulliparous patients (*6,7*). Moreover, despite the high removal and expulsion rates with IUDs, ineffective use of oral contraceptives can lead to higher pregnancy rates than occur with the use of IUDs (*8*). Melton and Shelton (*9*), in a study comparing the continuation rates of patients using the pill or the IUD, found a higher continuation rate with the IUD—probably, they suggested, because of the inconvenience of taking the pill. This finding may be even more probable for young girls.

Many factors affect the choice of a specific contraceptive method by adolescents. Certainly, the patient enters the clinic with some knowledge gained from other sources. Some of this information may be erroneous and some true. A clinic which provides teenagers with an unbiased presentation of all approved contraceptive methods permits the patient to choose a method according to her needs (*10*).

Although in some instances the teenager will have made a firm decision as to contraceptive method before she comes to the clinic, usually the counseling provided will help her choose the method best suited to her lifestyle. Given this opportunity to choose her method, commensurate with medical approval, she will have more of a commitment to use it.

In a previous study (*11*), it was noted that the nulliparous girls preferred the pill while young mothers equally preferred the pill and the IUD. This observation agrees with the findings of our study, but we also found that staff attitude may be an important factor in influencing the patient's choice of method. Ideally, the attitude of the staff in counseling a patient should be unbiased; however, our study results indicate staff bias against the IUD for the never-pregnant adolescent.

Clinic A's postpartum patients were largely influenced by the staff to use the IUD. Other factors also were contributory. The new mother herself may wish to use a method that does not need positive reinforcement. Or, it may be that the staff reasoned that the girls who had recently delivered needed to have a contraceptive method that would require minimal initiative and maintenance. In either case, the attitude of the patient or the staff influenced the patient's decision.

The clinic B staff overwhelmingly favored the oral contraceptive for the never-pregnant teenagers. Although 20 percent of the girls attending this clinic had had pregnancies before their initial clinic visit, they were not immediately postpartum or postabortal. The staff attitude was more favorable toward the IUD for the previously pregnant teenagers. However, the use of the device among this group of patients was not significant, perhaps because of the timing of insertion of an IUD. Since the medical staff at clinic B inserted IUDs during menses, frequently a second visit to the

clinic was required. Experience showed that if the insertion was not performed at the first visit, the patient often failed to return. In fact, of five patients asked to return when they were menstruating, only one did return. Therefore, at clinic B oral contraceptives were preferred, even for the parous patients.

Attitude is based on knowledge and experience. The survey revealed that knowledge was comparable in the two clinics. Clinic A had experienced good results with insertion of IUDs in postpartum patients. Clinic B had experienced diminished returns when a second visit was required for proper timing of the insertion. That these factors influenced the attitude of the staffs of the clinics was reflected in a bias toward one contraceptive method. Other factors being equal, this attitudinal bias affected the extent of use of the IUD by the adolescent patients.

In conclusion, as newer intrauterine contraceptive devices are tested, the knowledge and experience gained must be disseminated if attitudes are to be changed and if more nulliparous adolescents are to use these devices.

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The large number of adolescents seeking contraceptive services and the acknowledgement of their needs for such services by the medical community has led to increased use of contraceptives by adolescents. The choice of a contraceptive method by the adolescent patient depends on many varied factors. The lifestyle of adolescents precludes the use of some methods. Oral contraceptives are poorly tolerated and used. Thus, intrauterine devices (IUDs) are becoming the method of choice. This paper investigates some of the factors affecting staff attitudes toward offering intrauterine devices to adolescent patients.

The use of IUDs in two clinic populations which provide contraceptive services to adolescents was surveyed. One clinic has a comprehensive program for unwed pregnant adolescents; the other has a freestanding family planning program providing contraceptive services to previously pregnant and never-pregnant adolescents. When contraceptive services were offered to the previously pregnant females, 80 percent used IUDs; of the never-pregnant females, only 4 percent used IUDs. The staffs of the two clinics were surveyed to evaluate the effect of a patient's previous pregnancy on their willingness to prescribe IUDs.

The experience of the staff of the freestanding clinic as well as quasi-legal questions concerning contraception by adolescents influenced the staff's attitude and decreased the use of IUDs by nulliparous patients.