Staffing a Contraceptive Service for Adolescents: the Importance of Sex, Race, and Age

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THE PROVISION OF CONTRACEPTIVE SERVICES TO teenagers is a relatively new undertaking in the United States. The national trend toward a lower age at first intercourse and concern over teenage pregnancy have encouraged new initiatives in providing contraceptive services to this age group. Perhaps because these initiatives are relatively new, there are yet a number of questions about the most effective strategies for attracting and keeping teenage clients.

An important characteristic of clinic services is the composition of the staff offering them. The authors of a national study of teenagers in family planning clinics reported (*1*):

> The character of the interaction with staff was the single most important aspect of the clinic experience for almost all teens . . . teens put up with incredible inconvenience, long waits, confusing patient flow, and drafty exam rooms—and still liked the clinic if they had established rapport with even one staff member.

Virtually every article on the provision of contraceptive services to teenagers underscores the importance of trust, warmth, openness, and rapport between clinic staff and patients, but few document what characteristics of the staff might facilitate such relationships, particularly from the point of view of the patient. In this paper we examine the importance to teenagers of three demographic characteristics: the age, sex, and ethnicity of counselors and medical providers.

Since research on the development of adolescents suggests the importance of communication with an adult figure other than parents during these years, and the difficulty of young people in establishing such communication, it seemed likely that these visible characteristics might influence the ease with which patients and staff could communicate. Since the nature of such communication in a contraceptive service is intensely personal, it is particularly important to understand any barriers that may exist and, if necessary, to respond by changing the staffing patterns.

Methodology

The data for this study were gathered from a sample of 150 female patients at the Young Adult Clinic at the Columbia-Presbyterian Medical Center in New York City. These patients represent all of those attending the clinic at four consecutive sessions in August 1980. This clinic provides contraceptives, pregnancy testing, and other gynecological care to persons aged 21 years and younger. In its first 3 years, the clinic had more than 11,000 visits from some 4,000 people. These patients were primarily low-income blacks and Hispanics.

The counseling staff of the clinic includes males and females, whites, blacks, and Hispanics. They range in

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Table 1. Importance of selected characteristics of counselors and examiners to female contraceptive patients (percentages)

Characteristics	Very important	Important	Not very important	Not important at all	Total	Mean score [1]
Counselor:						
Same sex	18.7	17.3	28.0	36.0	100.0	2.19
Same ethnicity	1.3	5.3	20.7	72.7	100.0	1.35
Same age	3.3	3.3	28.0	65.4	100.0	1.45
Examiner:						
Same sex	31.3	16.0	22.7	30.0	100.0	2.49
Same ethnicity	2.7	5.3	22.7	69.3	100.0	1.41
Same age	0.7	2.0	23.3	74.0	100.0	1.29

[1] Scale ranged from 1 = not important at all to 4 = very important.

age from teenagers who function as peer counselors to persons in their forties. The clinic's medical providers are nurse midwives and physicians, and they too are of both sexes and include blacks and whites. Since the staff is so heterogeneous, it seemed important to investigate whether clinic protocol should include guidelines for matching patient and staff for age, ethnic group, or gender.

During a 2-week period, patients were asked to complete self-administered questionnaires. Using a 4-point scale, they indicated how important it was that their counselor and the person who examined them match their age, ethnicity, and sex. The scale varied from "not important at all" to "very important." In addition, patients were asked to indicate their age, race-ethnicity, number of visits to the clinic, and if they had ever been pregnant or used a method of birth control. These last three items were included as rough measures of experience with contraceptives or gynecological examinations.

Results

Table 1 displays percentage distributions of the importance ratings young patients gave to the sex, ethnicity, and age of counselors and examiners in the contraceptive clinic. The table also includes a mean, or average, rating of the importance of each characteristic, calculated on a scale of 1 = not important at all to 4 = very important.

Perhaps the most important finding in table 1 is that although the sex of the counselor and examiner were important to many teenagers, the majority indicated that none of these characteristics was "very important." For each question, 53 to 97 percent rated the characteristic not very important or not important at all.

The characteristic with the highest importance rating was sex. About 47 percent of the patients considered it important or very important to be examined by a woman. In contrast, fewer than 10 percent of the patients indicated that ethnic or age match with either counselor or examiner was important to them.

As table 2 indicates, these patterns varied somewhat by subgroup. The preference for female counselors and examiners was somewhat higher among the youngest patients, although this difference was not statistically significant. The youngest teens were significantly more likely to say that the ethnicity of their examiner was important, and Hispanic teenagers were slightly, but not significantly, more likely than black teens to indicate that ethnicity of counselors and examiners was important.

If previous pregnancy, previous use of birth control, or earlier visits to the clinic are indicators of more experience with the medical care system in general, then such experience did not seem to lessen patients' perceptions of the importance of these demographic characteristics. In fact, on some of the comparisons, those with more experience were somewhat more likely than those without experience to say that these characteristics are important to them. None of these differences was significant, however.

Discussion

These results indicate that the sex of her counselor and examiner in a contraceptive clinic was more important to the female teenager than ethnicity or age.

Perhaps more important than this finding, however, was the relatively low importance ratings given to the ethnicity and age of counselors and providers. Only among the youngest teens did we find significantly greater importance given to ethnic match with the person doing physical examinations. Even in this group, only 17 percent of the teens said ethnicity was important. While few previous studies have dealt with these topics among adolescent contraceptive patients, the importance of sex might be expected from data gathered in similar clinics and from other research on characteristics of counselors and interviewers.

For example, the national study of teenagers in

family planning clinics done by the Urban and Rural Systems Associates did consider the age and sex of medical personnel but not their race and ethnicity (*1*). About half of the sample of female teens indicated that it did not matter whether the person examining them was male or female, but very few preferred males. Furthermore, patients examined by women were twice as likely to say they liked the physician "very much" and younger, Latin, and Asian teens were more likely to prefer female examiners than were other teens. Similarly, younger teens were more likely to say that they preferred a young physician rather than an older one.

In addition to these studies among adolescent contraceptive clients, studies among adult women indicate that, particularly for certain ethnic groups, provider characteristics may be extremely important. Scrimshaw (*2*) for example, has discussed the existence of "verguenza" or shame and embarrassment among Latin American women in Ecuador. A sense of verguenza carries with it an awareness of the need to be modest in all behavior, and this feeling may create special problems for women visiting family planning clinics. Apparently because of verguenza, all of the women interviewed in the Scrimshaw study said that they preferred female physicians. However, the young Hispanic women in our sample were no more likely to prefer female providers than were the black women. Perhaps the acculturation of these young women is already such that verguenza is not so acute among them.

In addition to the research within the context of contraceptive service programs, there have been more general and extensive investigations of client or patient preferences for counselors, therapists, or "helpers." In this research, relatively less attention was given to age than to race and sex preference, and many of these researchers used college student samples. Furthermore, the findings on the importance of counselor attributes are contradictory.

For example, in studying the importance of racial similarity between client and counselor to client satisfaction with counseling, Ewing (*3*) found no support for the suggestion that students receiving precollege counseling should be racially matched to counselors. Among 75 college students in Texas, however, Thompson and Cimbolic (*4*) reported that, when forced to choose between black and white counselors, black students were more likely to choose blacks and to use a counseling center that had black counselors. In a study among college students in a special program for the disadvantaged, Gordon and Grantham (*5*) found only a slight preference for helpers of the same race. Instead, students were much more likely to express a preference for helpers of the same socioeconomic status background.

Adopting a somewhat different emphasis, Fry and

Table 2. Difference among subgroups of female contraceptive patients in the importance of selected characteristics of counselors and examiners

	Percent saying important or very important					
	Counselor			*Examiner*		
Characteristics of patients	*Same sex*	*Same ethnicity*	*Same age*	*Same sex*	*Same ethnicity*	*Same age*
Age:						
16 or younger	38.1	4.8	9.5	57.1	16.7 [1]	4.8
17–19	35.9	7.7	3.8	43.6	6.4	2.6
20–21	33.3	6.7	10.0	43.3	0.0	0.0
Ethnicity:						
Black	36.6	4.3	6.5	48.4	6.5	3.2
Hispanic	35.4	10.4	6.3	47.9	12.5	2.1
Previous pregnancy:						
Yes	37.3	9.0	10.4	47.8	9.0	1.5
No	34.9	4.8	3.6	47.0	7.2	3.6
Ever use birth control:						
Yes	37.7	6.1	7.0	47.4	8.8	3.5
No	30.6	8.3	5.6	47.2	5.6	0.0
Visit to young adult clinic:						
First visit	36.0	8.0	6.0	44.0	4.0	0.0
Revisit	36.0	6.0	7.0	49.0	10.0	4.0

[1] Chi-square is statistically significant at the .05 level.

co-workers (*6*) examined the impact of racial matching on counselor behavior. Their results indicated that counselor trainees who were racially matched to clients were more appropriately "attending" and "expressive" in their response styles than were trainees not matched to their clients.

Also, several studies of sex preferences for counselors have been reported; however, like the research on racial preference, the findings are mixed and inconsistent. Highlen and Russell have recently summarized this literature (*7*):

> Although research on female clients' preferences for male and female counselors has been conducted for more than two decades, results have been inconsistent and far from conclusive. Although some studies have found that females prefer male counselors . . ., others have reported that women prefer same-sex therapists. . . . Adding further confusion to the literature are studies reporting no effect for counselor gender.

Although the overall findings in these studies were inconsistent, the researchers who conducted them offered two important suggestions. First, it seems apparent that preference for a counselor of the same or opposite sex may depend on the subject matter of the counseling. For example, in studying the effects of counselor gender on perceived credibility with clients, Lee and co-workers (*8*) reported that both male and female secondary school students preferred a male counselor if they had vocational concerns, but they preferred female counselors to talk about such subjects as child rearing. Studies by Fuller (*9*) and Boulware and Holmes (*10*) also indicated that females prefer female counselors when their concerns are of a more "personal" nature. Given that most of the family planning clinic interviews with young clients concern sexual or contraceptive behavior, our findings are not surprising.

A second finding, and one that may help explain the generally ambiguous results, is that it may not be gender per se which is valued by clients, but rather certain sex role behaviors of counselors. Feldstein (*11*), for example, has reported an interesting interaction effect between the gender of the client and the perceived masculinity or femininity of the counselor. "Male clients with feminine counselors and female clients with masculine counselors indicated greatest satisfaction and counselor regard." In a similar vein, Highlen and Russell (*7*) suggest that clients often express a preference for counselors who possess stereotypic feminine traits, such as warmth and understanding. Perhaps characteristics perceived or assumed to accompany gender may account for the findings of this and other studies that some clients prefer female counselors.

A third body of reports in the literature may also be useful in discussing appropriate characteristics of staff members for contraceptive programs for adolescents. These reports deal with the effects of interviewer and respondent characteristics on responses to survey questions. Since much of the work of counselors and medical providers in teenage family planning clinics requires interviewing, these findings are of interest.

In a summary of what is known about effects of various factors on responses, Sudman and Bradburn (*12*) indicated that the demographic characteristics of an interviewer are relatively less important than other factors such as the setting or style of the interview. When the subject matter of the interview is closely linked to some characteristic of the interviewer, however, response effects are more evident. For example, persons being interviewed about their racial attitudes may respond differently to black or white interviewers, but if they are being interviewed about their preferences for a specific brand of soap, the race of the interviewer is less important. Sudman and Bradburn stated:

> matching of interviewers has no effect on response unless the issues are related to the respondent and interviewer characteristics. . . . The use of black interviewers in black areas for a study of medical needs may make it easier to obtain cooperation from community groups, obtain qualified interviewers, and reduce travel costs, as well as providing work for people in the area. It will not, however, increase the respondent's willingness to cooperate or change his reporting of medical needs.

It is possible that, even with the anonymity provided to patients in our research design, they felt hesitant to admit true preferences. Further, the Young Adult Clinic has a staff and a patient population that is primarily black and Hispanic. Perhaps in a setting where young people perceive a general ethnic match, the characteristics of a particular counselor or examiner assume less importance.

If we take these patients at their word, however, then several tentative recommendations follow from the data. First, teen clinics should make every effort to include at least one female counselor and medical provider on the staff. Then, either by asking patients about their preferences or by acceding to these preferences when they are volunteered, those teens for whom it is important may be seen by a female. Although gender matching would not have been necessary for the majority of patients in this study, a substantial minority of young people indicated such a preference.

Second, it appears that ethnic and age match of counselors or examiners and patients is not particularly important. This observation means that clinics may be

free to use either peer or older counselors and, except for language problems, need not match providers and patients by ethnicity.

While we did not measure it, other authors have suggested that the most important characteristics of any staff person are likely to be warmth, acceptance, and a genuine attitude of caring for young patients. In fact, Highlen and Russell (7) indicate that, as more information about a particular counselor is introduced, superficial characteristics such as gender become less important.

It is gratifying that such characteristics as sex, ethnicity, and age are of little importance to our clients. Nevertheless, further research is needed to determine if, in fact, the overall ethnic image of the clinic is a major determinant of patient attitudes and acceptance of its services.

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SYNOPSIS

PHILLIBER, SUSAN GUSTAVUS (Center for Population and Family Health, Columbia University) and JONES, JUDITH: *Staffing a contraceptive service for adolescents: the importance of sex, race, and age. Public Health Reports, Vol. 97, March–April 1982, pp. 165–169.*

Since there are data to indicate that the composition of clinic staff is important in attracting and maintaining contact with adolescents seeking contraceptive services, in this paper the importance of age, sex, and ethnicity of counselors and medical providers is examined. Female clients of the Young Adult Clinic at Columbia-Presbyterian Hospital, New York City —most of them low-income blacks or Hispanics—were asked to complete questionnaires. The 150 respondents, aged 16–21 years, used a 4-point rating scale of very important = 4 to not important at all = 1.

The findings indicated that the sex of the counselor and examiner was more important to female teenagers than ethnicity or age. Clinic administrators seeking to provide contraceptive services to teenagers should make an effort to include at least one female counselor and medical provider. However none of these characteristics was very important to the majority of patients.

These findings are discussed in the context of the literature on the provision of contraceptive services to teenagers and on patient preferences for counselors or therapists in general.