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"I just think that doctors need to ask more questions": Sexual minority and majority adolescents' experiences talking about sexuality with healthcare providers

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ABSTRACT

Objective: To examine adolescent and young adults' experiences of sexuality communication with physicians, and gain advice for improving interactions.
Methods: Semi-structured interviews were conducted with questions focusing on: puberty, romantic attractions, sexual orientation, dating, sexual behavior, clinical environment, and role of parents. Interviews were transcribed and analyzed using thematic analysis with both open and axial coding.
Results: Five themes emerged from interviews: 1) need for increased quantity of sexual communication, 2) issues of confidentiality/privacy, 3) comfort (physician discomfort, physical space), 4) inclusivity (language use, gender-fluid patients, office environment), 5) need for increased quality of sexual communication.
Conclusions: Sexual minority and majority adolescents and young adults indicate sexuality discussions with physicians are infrequent and need improvement. They indicate language use and clinical physical environment are important places where physicians can show inclusiveness and increase comfort.
Practice implications: Physicians should make an effort to include sexual communication at every visit. They should consider using indirect questions to assess sexual topics, provide other outlets for sexual health information, and ask parents to leave the exam room to improve confidentiality. Clinic staff should participate in Safe Zone trainings, and practices can promote inclusion with signs that indicate safe and accepting environments.

1. Introduction

Adolescence is a time of significant physical development and growth in personal and sexual identity. *Given the* diversity of sexual *interests,* behaviors, and identities, *there is a need for* flexibility from healthcare providers. Physicians can play a vital role in educating adolescents about issues like puberty, romantic interests and attractions, orientation, dating, and safe sex [1]. Unfortunately, conversations between physicians and adolescents regarding sexuality occur briefly, if ever [2–5]. *When the subject is brought up* physicians spend only about 36 seconds discussing sexuality topics with adolescents *(in 65% of recorded consultations)* [6], even though adolescents indicate they are interested in having these conversations [7].

Sexual minority (lesbian, gay, bisexual, transgender, questioning) adolescents, in particular, may benefit from talking about sexuality topics with physicians because they may be likely to suffer emotional and physical health concerns at higher rates than non-minority adolescents [8–10]. Unfortunately, sexual minority adolescents may not receive the help they need from family and friends because they may not be ready to disclose their sexual orientation or lack social support from close others [11,12]. *Because sexual minority adolescents in politically conservative contexts may have even less social support* [13,14]*,research is needed to determine how they communicate about sexuality with healthcare providers.*

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Table 1
Participant demographics.

Respondent characteristics	*N* = 40
Age[a]	19.08 (12-31)
Gender identity	
Female	15
Male	21
Female-to-male transgender	3
Other	1
Sexual orientation	
Sexual minority	
Gay	16
Lesbian	2
Bisexual	8
Pansexual	3
Other	2
Sexual majority	9
Race/ethnicity	
White	29
Black	5
Hispanic	2
Did not report	4

[a] Values are mean (range), in years.

For these reasons, sexual minority adolescents may benefit from disclosing and discussing their own developing sexuality with a trusted advisor such as their physician. Yet, less than a third of physicians report that they ordinarily talk with adolescents about sexual orientation [15]. Many physicians state they are unsure of how to discuss orientation with adolescents and are unaware of available resources for sexual minorities [16]. Instead, physicians often use language that assumes adolescents are among the sexual majority (heterosexual), which may signal to minority adolescents that the healthcare visit is not a safe place to disclose orientation or specific sexual behaviors; *this may be especially true in more conservative contexts* [17].

Improvement in adolescent sexuality communication is needed in primary care practices, with sexual minority and majority patients. Thus, we sought to learn more about patients' current and past experiences with healthcare providers regarding sexuality communication by conducting qualitative interviews with adolescents and young adults *residing in a Midwestern conservative state. Little research has focused on clinical sexuality communication in conservative contexts. Given Indiana's politically conservative legislature and governor, we sought to interview a variety of young people from both urban and rural areas surrounding Purdue University.* We approach adolescent sexuality as *a fluid and* developmentally normative *process* that is physiologically and psychologically expected to occur during adolescence [18,19]. It is through this lens that we approach our qualitative analysis.

The purpose of this paper was to address the following research question: RQ1a) How do sexual minority and majority adolescents and young adults communicate with their physicians about sexuality in a politically conservative, Midwestern context?; RQ1b) What advice would they give to improve these interactions? Young adults may be able to best answer RQ1b given they have had more time to reflect on preferred interactions.

Understanding the sexuality communication barriers that all adolescents – both sexual minorities and majorities – perceive during health visits is important for understanding how we can improve the conversation skills of physicians, the comfort of adolescents with their providers, and ultimately the health of all adolescents.

2. Materials and methods

2.1. Participants

We interviewed sexual minority and majority adolescents and young adults. *Adolescents spoke of current care and young adults reflected on past communication with providers during adolescence.* Participants were recruited through Purdue's research participation announcements, on-campus *and urban LGBTQ centers, and a local, rural primary care practice. See* Table 1 *for participant demographics.*

2.2. Measures

Interviews were conducted between 2014 and 2015, averaged 27 minutes, and were based on a semi-structured interview guide developed by the research team, which was informed by existing literature. Interviewers asked participants how they communicated with physicians during adolescence about the following: puberty, romantic interests/attractions, sexual orientation, dating, sexual behavior, clinical environments, and the role of parents during visits. *Interviews were conducted at LGBTQ centers, primary care offices, and university offices by two researchers (LF and HF).*

2.3. Analysis

Interviews were transcribed for analysis. *We conducted a thematic analysis using open and axial coding* [20–26], which involved a series of recursive analyses of the transcripts from the interviews [27–31]. For open coding, LF and HF read all transcripts and identified common and recurring themes [30]. For axial coding, we developed further conceptual domains by describing comparisons between themes, within, and between transcripts [27,31]. We reviewed preliminary findings of theme exemplars as a check on coding validity throughout the process. Once agreement was reached on all coding definitions, the two researchers coded each transcript separately and then met to regroup conceptual categories based on the recoding. Finally, we used the constant comparative method to identify recurring patterns [27,31].

3. Results

Five themes emerged from our interviews about youth experiences with healthcare providers when discussing sexuality: 1) need for increased quantity of sexual communication; 2) confidentiality/privacy; 3) comfort; 4) inclusivity; 5) need for increased quality of sexual communication.

3.1. Theme 1: Need for increased quantity of sexual communication

Many participants reported that physicians had *never* asked them about puberty, romantic or sexual interests and attractions, or orientation. One participant said:

"I just think that doctors need to ask more questions . . . like when my doctor didn't ask me [about sexuality], it just kind of feels like maybe it's not important." (24-year-old female, other sexual orientation)

Participants that were asked about puberty were typically asked if they had experienced a checklist of items (e.g. voice changes, first menstruation), but physicians did not explore physical or psychological reactions to these developmental events. One participant indicated that exploring feelings about romantic attractions made sense when discussing puberty:

"I feel like the doctor should bring that up because you are going through puberty and . . . as you are going through the stages of life, the doctor should bring it up and ask, "Have you noticed any difference

in your feelings toward girls or toward guys?' (18-year-old bisexual male)

Participants were more commonly questioned about dating and whether they were sexually active. These conversations typically included queries like "Do you have a girlfriend/boyfriend?" or "Are you sexually active?", sometimes followed by "Are you using protection?", with the conversation topic quickly changing after the physician received a yes/no answer. One participant noted it would be beneficial to receive sex education from physicians before becoming sexually active:

" . . . like if they say 'No, I'm not [sexually active],' maybe that doesn't shut down the conversation. [The physician] could say 'Are you hoping to be soon?'" (30-year-old bisexual male)

Similarly, another participant said:

"So even if your answer was 'No, not sexually active, don't plan to be' . . . it would have been nice if the doctor still maybe gave you a little bit more information anyway." (20-year-old pansexual female-to-male transgender)

Several participants who did not receive adequate sexual education from other outlets (e.g., school, parents) stated they often turned to the Internet for information, which may not be the best resource for sexual information. One 19-year-old gay male stated:

"I Googled [sex information]· · ·?I didn't know what was true, that's the problem. So, it's definitely a good idea to go speak to a doctor about it because they are more of a trusted source."

3.2. Theme 2: Confidentiality/Privacy

Most participants stated they were concerned with their discussions remaining confidential and private. Many worried physicians would tell their parents about their sexual history and/or orientation. Participants stated that if physicians emphasized confidentiality, it would make them feel more willing to share. One participant recollected:

"One thing that did make me feel more comfortable was the fact that he said . . . anything you tell me in the office is completely confidential. I won't tell your mother if you don't want me to. It will just be between us." (20-year-old gay male)

Parents were often in the exam room with their children when physicians asked about sexual activity, which sometimes motivated lying. For example:

"[The physician] asked me . . . if I was having sex and because my mom was in the room I told them no . . . I think if my mom wasn't there I would have told him [the truth] and I think it would have been better if they had asked [her] to step out of the room." (24-year-old female, other sexual orientation)

Most participants specified it would be best if physicians asked parents to leave the room when discussing sensitive topics. Even participants who feel comfortable telling their parents they are sexually active agreed it might be difficult to have in-depth conversations about sexual behaviors with their physicians in front of parents. One participant noted:

"If [physicians] ask . . . if I am sexually active [in front of my parents] that would be fine because most of the time my parents would know that. It would really be uncomfortable if they asked me to elaborate on that." (16-year-old heterosexual male)

3.3. Theme 3: Comfort

Many participants, both sexual minority and majority, indicated they did not feel comfortable discussing sexuality with physicians. *Some participants who never had these conversations with their physicians expressed relief at avoiding embarrassing topics.* Even participants who indicated they would be open about attractions or behaviors with their healthcare providers mentioned sex is an awkward or taboo topic, and they often feel judged by physicians for engaging in sexual activity during adolescence. One participant said:

"[Sex] just seems like something that's private. And even though they are there to help you and they are not supposed to disclose it to anyone, there's still that doubt that they would judge you or . . . that you are doing something you are not supposed to do." (19-year-old gay male)

Participants identified two areas *that enabled or limited* comfort level: physician discomfort with sexuality discussions and physical space of waiting/exam rooms.

3.3.1. Physician discomfort

Adolescents are often able to key into physicians' awkwardness, discomfort, or judgmental attitude when answering questions about sexual history. For instance, one 19-year-old female disclosed an uncomfortable interaction that prompted her to switch providers:

"Well I identify as bisexual so I disclosed interactions with males . . . and as a last minute thought I told her [I'd been sexually active with females] and she seemed shocked. And . . . she almost took a minute to think about it before she continued asking and said 'Do you feel comfortable with that? Have you thought about everything?' It was almost like she couldn't believe that was actually a conclusion I had come to. And it was the brief questions that felt judgmental to me . . . and it had a tone that made me uncomfortable."

Correspondingly, sexual minority adolescents are especially attentive to non-verbal behaviors physicians make when patients report engaging in same-sex behaviors or identify themselves as sexual minorities. One 19-year-old pansexual female explained her physician's reaction when she disclosed sexual behavior with other females:

"When I finally told her 'Yes, I'm sexually active with someone, but [someone] with a vagina', I think it was something like 'Oh!' and almost a confused face."

Conversely, a 24-year-old gay male relayed what a comfortable interaction looked like for him:

"[The physician] asked my sexual orientation. She asked if I had engaged in anal sex. And so I said yeah. [She was] extremely comfortable. It rolled right off her tongue. She didn't stammer or anything. There was nothing that made me feel uncomfortable . . . no change in her voice pattern or inflections in her voice. [She] didn't look away. She didn't make me feel uncomfortable at all."

3.3.2. Physical space

Participants felt that physical space could be improved to *enable* adolescents to feel more comfortable Some participants felt waiting and exam rooms were geared solely toward young children. These spaces lacked relevant brochures (e.g., information on STDs) and promoted childlike spaces (e.g. toys, kid-focused décor), which discouraged adolescents from discussing mature topics. One 17-year-old heterosexual male said:

"It is a place for kids so it's sort of oddball. The walls are painted for very young kids . . . like seven and under, but I still go there because it's the only place really to go . . . like if they had some rooms for teens and some rooms for kids that would make more sense."

3.4. Theme 4: Inclusivity

Sexual minority participants, in particular, expressed the need for inclusivity when attending visits. These participants indicated they felt overlooked or isolated when physicians did not acknowledge that it was possible for them to have attractions to those of the same or both genders, or made assumptions about their sexual orientation.

3.4.1. Language

Participants most often felt isolated by language physicians used when asking about romantic partners or sexual behaviors. For instance, physicians often ask males "Do you have a girlfriend?", or ask females "Does your boyfriend wear a condom?". One 19-year-old gay male relayed the shame these non-inclusive conversations bring:

"The whole thing where they say 'How is your girlfriend?' or 'Are you dating any nice girls these days?', it makes you die a little inside. You feel so terrible because you're like 'oh, God' . . . Because it automatically feels like you are letting them down . . . when you say you have a boyfriend or when you say something that they are not expecting because it's kind of like 'Oh, you are one of those people'. Even if they don't say that, it's just almost inferred."

In order to foster inclusive interactions, most sexual minority participants stated physicians should use the terms 'partner' or 'significant other'. Some participants suggested physicians ask for their preferred pronouns, as well as what name they prefer, which is especially important for gender non-conforming individuals. One 30-year-old bisexual male suggested an inclusive way to discuss contraception:

"[Physicians should say] these are your body parts. This is how you protect your body parts. What you use them for and who you use them with is unimportant."

3.4.2. Gender-Fluid patients

Transgender and gender-fluid participants indicated physicians often seemed unsure of how to discuss their gender identities or were uneducated about biological aspects of their transition. One 20-year-old gay female-to-male transgender participant said:

"I went to my healthcare provider and was like 'Well okay, here is what I want to do [female-to-male transition].'. . .?They didn't know what the steps were and I didn't know what the steps were until I was like 16."

Another 20-year-old bisexual, female-to-male transgender participant suggested how physicians could more inclusively talk with transgender patients:

*"If it's from a transitioning standpoint, definitely [talk about] hormones. . .?*I wouldn't want to ask about it because it's kind of awkward. Or [physicians should ask about] certain things that I could potentially be thinking or feeling so I don't feel so awkward about thinking or feeling the ways that I do. Because I'm not gonna be like 'Hey, I feel this way. Is that normal?' I want them to kind of perceive [it] and be like 'Hey, is this going on?"

3.4.3. Office environment

Many sexual minority participants relayed the need for inclusive signs in the office environment that conveyed a safe place to disclose orientation or gender identity, including "Safe Zone", Human Rights Campaign signs, or rainbow stickers, as well as sexual health pamphlets geared toward sexual minorities. For example:

" . . . walking down the hallway and seeing all the Safe Zone signs there really made me feel comfortable and made me feel able to disclose information." (20-year-old gay male)

An 18-year-old gay male said:

"I really like what [my current provider] does. They have these kinds of brochures on ten things to talk about with your doctor if you're a gay man . . . or a lesbian. So I think having those out there would be very helpful just because it shows they want you to talk about those things if you identify as this."

3.5. Theme 5: Need for increased quality of sexual communication

Participants identified ways physicians can improve the quality of sexual communication. For example, participants stated some might have different conceptions of what being sexually active means (e.g., vaginal versus oral sex), and may not answer accurately. One participant stated:

"Because 'sexually active', is definitely different depending on the education you have, but based on my sex ed experience that just means penis and vagina. Where does that leave room for anything leading up to sex or anything like that?" (19-year-old pansexual female)

Adolescents may also be unaware of how sexuality information relates to their health. Thus, physicians need to articulate the purpose of these conversations is not to judge patients, but to provide better care. One participant advised:

"[Physicians] could just explain that there's no reason to lie . . . that it's more important about their health, it's not meant to be judgmental. [They could] say, 'I just want to help you the best way I can so being honest about who you are [sexual] with is the best way for me to help you.'" (19-year-old gay male)

Finally, participants warned that physicians should not try to fit patients into specific categories, especially when sexual preferences are still developing during adolescence. Several stated that physicians should normalize fluid experiences and focus on exploring attractions and behaviors, rather than specific orientations. One participant stated:

"I liked the way the doctor that I went to recently phrased it. I think that's a good way to go about [it]. Just ask 'Are you sexually active? Is it with men, women, or both?" (20-year-old bisexual female)

4. Discussion and conclusion

4.1. Discussion

Through qualitative interviews, we explored sexual minority and majority adolescent and young adults' communication with physicians about sexuality, and comfort with physicians and office environments. Five themes emerged from the interviews, which resonate with published guidelines noting that physicians should be able to obtain developmentally appropriate sexual histories, within youth-friendly offices that are welcoming to sexual minorities [32,33].

Even when patients indicate they are not sexually active, physicians may find it useful to provide education about development, attractions, and contraception because adolescents may be hesitant to bring up the topics themselves. *It may be important for physicians to consistently bring up sexuality/sexual behaviors at each visit so that the questions become normative and adolescent comfort improves over time. It is unclear when adolescents will become sexually active, thus providing them with a little more information at every visit will help ensure they are better prepared to practice safe sex when the time comes. Emphasizing that these questions are asked of all adolescents may increase comfort with these topics and decrease feelings of being singled out. Physicians may need to be creative in approaching sexual topics. By asking questions like "How do you feel about your body?", "What are your attitudes about becoming sexual with future partners?", or "Are your friends sexually active?", physicians may be able to address these issues indirectly, but effectively.*

Physicians may be able to increase comfort by normalizing sexual behavior, emphasizing a "judgment-free zone", minimizing *negative* non-verbal reactions, and becoming educated about sexuality and gender-related health topics. Making clinic spaces "youth friendly" can be an important way to signal acceptance of diversity of identity and behavior [34]. *Medical and administrative staff training about how to communicate about sexuality and sexual behaviors (e.g. Safe Zone) may be vital to* improved clinical interactions.

Inclusivity was particularly salient for sexual minority youth. Physicians can be inclusive by avoiding assumptions about sexual behaviors or orientation, using gender-neutral language (e.g. "partner"), and using registration forms or conversations to identify patients' preferred pronouns and names. Visible signals of acceptance include signs (e.g. "Safe Zone") and sexual minority-specific sexual health pamphlets. If some physicians are less informed about sexual minority health needs, they should, at minimum, provide those patients with a list of resources (e.g. emotional support groups, sexual health websites, recommendations to other providers).

Physicians should specifically state that it is important to disclose sexual preferences and behaviors since many teens do not make the connection between sexuality and physical health. Physicians should also avoid categorizing patients by asking about attractions rather than orientation, because many adolescents have fluid and unformed identities or may be experimenting during this developmental stage. In addition, we advocate for use of the teach-back technique, *or asking patients to repeat back what they think they heard from their physician,* to assess what adolescents may know about safe sex practices [35,36]

Physicians and pediatric practices may need to think outside of the box when addressing sexuality with adolescents. Appealing to the interests of these young patients may be vital for engagement and increasing comfort. Practices may wish to key into adolescent enthusiasm for technology and social media. For instance, providing adolescent sexual history (and other) questionnaires on iPads or tablets may be helpful for collecting valuable information in a way adolescents enjoy. Confidential youth portals to electronic health records also allow communication in ways that respect privacy and confidentiality [37]. Physicians and office staff should be prepared to offer adolescents sexual health information and education on platforms that makes sense for them (e.g. Instagram, Snapchat, YouTube). One notable example is Laci Green's Sex+ channel on YouTube (https://www.youtube.com/user/lacigreen), which provides short videos about sexual orientation and behaviors in an approachable, informative, fun format for young people.

Differences were not found based on participant characteristics, with two exceptions. Inclusivity was most salient to sexual minority youth, as they seemed to be struggling more with how their attractions differ from others and how that may contribute to their identities. Sexual majority adolescents tended to report little memory or concern for whether physicians explored their sexual preferences or used non-inclusive language, most likely because they were not concerned with marginalization. Comfort was salient to minority and majority individuals, often for different reasons (physician discomfort versus general awkwardness). *Young adults reported being more comfortable talking with physicians currently, than when they were younger because they are more comfortable with their sexuality. Many expressed that while they may have been uncomfortable discussing these topics during adolescence, they would have benefitted from those conversations.*

Our findings align with past literature in that others have found clinical sexuality communication to be *necessary* [38], *albeit* rare [6], uncomfortable [39–41], and non-inclusive [17]. Our findings are unique in that few studies have qualitatively assessed both sexual minority and majority youth communication with physicians about topics like sexuality, attractions, same-sex activity, physician behaviors, or office environment. *These findings are also unique in that no previous studies have qualitatively assessed communication in conservative, Midwestern contexts.*

Our sample was largely white, although diverse in sexual orientation. Future research should include more adolescents under age 18, transgender and heterosexual participants, and a more racially diverse sample. Our findings represent Midwestern adolescents/emerging adults in a conservative environment, but responses gathered in other regions of the U.S. may reveal different patterns of sexuality conversations between adolescents and physicians. Another limitation is these were retrospective accounts of clinical interactions, with some conversations occurring 10 or more years ago. Some recollections may not be as accurate or may reflect dialogue inconsistent with current views of sexuality.

4.2. Conclusion

This study highlights improvements that are needed in sexuality discussions between adolescents and physicians. Lack of communication can leave adolescents uninformed about topics that have clear implications for their health. In the brief and rare cases when these conversations occur, the ways in which physicians communicate with patients can have dramatic effects on how adolescents perceive themselves and the healthcare system as a whole. As adolescents develop their sexual identities and a normative interest in sex, physicians must be prepared to provide accurate information in an unbiased and supportive manner. Even short but meaningful conversations may make a difference for adolescent sexual knowledge and health.

4.3. Practice implications

Physicians should make a concerted effort to include sexual communication with adolescents at every visit. They should ask parents to leave the room before doing so, while further emphasizing confidentiality. Physicians should consider using indirect questions to probe adolescents' sexuality. They should provide other outlets for patients to give (e.g., secure online portals) and receive (e.g., social media, pamphlets) sexual health information. Finally, medical and administrative staff should participate in Safe Zone training and signs promoting inclusion should be placed in offices to foster a safe and accepting environment.

Conflict of interest

The authors have no conflicts of interest to disclose.

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References

[1] Boekeloo, Will you ask? Will they tell you? Are you ready to hear and respond?: Barriers to physician-adolescent discussion about sexuality, JAMA Pediatr. 168 (2014) 111–113, doi:http://dx.doi.org/10.1001/jamapediatrics.2013.4605.

[2] B.O. Boekeloo, L. Schamus, T.L. Cheng, S.J. Simmens, Young adolescents' comfort with discussion about sexual problems with their physician, Arch. Pediatr. Adolesc. Med. 150 (1996) 1146–1152, doi:http://dx.doi.org/10.1001/archpedi.1996.02170360036005.

[3] B. Maheux, N. Haley, M. Rivard, A. Gervaid, STD risk assessment and risk-reduction counseling by recently trained family physicians, Acad. Med. 70 (1995) 726–728.

[4] G.S. O'Keeffe, K. Clarke-Pearson, C. on C. and media, the impact of social media on children, adolescents, and families, Pediatrics 127 (2011) 800–804, doi:http://dx.doi.org/10.1542/peds.2011-0054.

[5] M.A. Schuster, R.M. Bell, L.P. Petersen, D.E. Kanouse, Communication between adolescents and physicians about sexual behavior and risk prevention, Arch.

Pediatr. Adolesc. Med. 150 (1996) 906–913, doi:http://dx.doi.org/10.1001/archpedi.1996.02170340020004.
[6] S.C. Alexander, J.D. Fortenberry, K.I. Pollak, T. Bravender, K. Davis, T. Ostbye, et al., Sexuality talk during adolescent health maintenance visits, JAMA Pediatr. 168 (2014) 163–169, doi:http://dx.doi.org/10.1001/jamapediatrics.2013.4338.
[7] C.A. Ford, S.G. Millstein, S.L. Eyre, C.E. Irwin Jr., Anticipatory guidance regarding sex: views of virginal female adolescents, J. Adolesc. Health 19 (1996) 179–183, doi:http://dx.doi.org/10.1016/S1054-139X(96)00127-9.
[8] M.A. Klebanoff, W.W. Andrews, J. Zhang, R.M. Brotman, T.R. Nansel, K.-F. Yu, et al., Race of male sex partners and occurence of bacterial vaginosis, Sex. Transm. Dis. 37 (2010) 184–190, doi:http://dx.doi.org/10.1097/OLQ.0b013e3181c04865.
[9] M.A. Klebanoff, T.R. Nansel, R.M. Brotman, J. Zhang, K.-F. Yu, J.R. Schwebke, et al., Personal hygienic behaviors and bacterial vaginosis, Sex. Transm. Dis. 37 (2010) 94–99, doi:http://dx.doi.org/10.1097/OLQ.0b013e3181bc063c.
[10] M.E. Thoma, M.A. Klebanoff, A.J. Rovner, T.R. Nansel, Y. Neggers, W.W. Andrews, et al., Bacterial vaginosis is associated with variation in dietary indices, J. Nutr. 141 (2011) 1698–1704, doi:http://dx.doi.org/10.3945/jn.111.140541.
[11] J. Carpineto, K. Kubicek, G. Weiss, E. Iverson, M.D. Kipke, Young men's perspectives on family support and disclosure of same-sex attraction, J. LGBT Issues Couns. 2 (2008) 53–80, doi:http://dx.doi.org/10.1080/15538600802077533.
[12] C. Ryan, S.T. Russell, D. Huebner, R. Diaz, J. Sanchez, Family acceptance in adolescence and the health of LGBT young adults, J. Child Adolesc. Psychiatr. Nurs. 23 (2010) 205–213, doi:http://dx.doi.org/10.1111/j.1744-6171.2010.00246.x.
[13] W.T. Boulden, Gay men living in a rural environment, J. Gay Lesbian Soc. Serv. 12 (2001) 63–75.
[14] A.L. Dahl, R.K. Scott, Z. Peace, Trials and triumph: lesbian and gay young adults raised in a rural context, Soc. Sci. 4 (2015) 925–939, doi:http://dx.doi.org/10.3390/socsci4040925.
[15] R.L. Kitts, Barriers to optimal care between physicians and lesbian, gay, bisexual, transgender, and questioning adolescent patients, J. Homosex. 57 (2010) 730–747, doi:http://dx.doi.org/10.1080/00918369.2010.485872.
[16] S.M. Lena, T. Wiebe, S. Ingram, M. Jabbour, Pediatric residents' knowledge, perceptions, and attitudes towards homosexually oriented youth, Ann.-R. Coll. Physicians Surg. Can. 35 (2002) 401–405.
[17] S.C. Alexander, J.D. Fortenberry, K.I. Pollak, T. Bravender, T. Østbye, C.G. Shields, Physicians use of inclusive sexual orientation language during teenage annual visits, LGBT Health 1 (2014) 283–291, doi:http://dx.doi.org/10.1089/lgbt.2014.0035.
[18] D.L. Tolman, S.I. McClelland, Normative sexuality development in adolescence: a decade in review 2000–2009, J. Res. Adolesc. 21 (2011) 242–255, doi:http://dx.doi.org/10.1111/j.1532-7795.2010.00726.x.
[19] L. Diamond, Love matters: Romantic relationships among sexual-minority adolescents, In: P. Florsheim (Ed.), Adolesc. Romant. Relat. Sex. Behav. Theory Res. Pract. Implic., New Jersey, 2003, pp. 85–107.
[20] T.A. Ahles, J.H. Wasson, J.L. Seville, D.J. Johnson, B.F. Cole, B. Hanscom, et al., A controlled trial of methods for managing pain in primary care patients with or without co-occurring psychosocial problems, Ann. Fam. Med. 4 (2006) 341–350, doi:http://dx.doi.org/10.1370/afm.527.
[21] J. Borkan, Immersion/crystallization, in: B.F. Crabtree, W.L. Miller (Eds.), Doing Qualitative Research, Sage Publications, California, 1999, pp. 179–194.
[22] K. Charmaz, Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis (Introducing Qualitative Methods Series), Sage Publications, California, 2006.
[23] F. Benjamin, M.D. Miller, L. William, Using Codes and Code Manuals: A Template Organizing Style of Interpretation, in: B.F. Crabtree, W.L. Miller (Eds.), Sage Publications, California, 1999, pp. 163–177.
[24] T.R. Lindlof, B.C. Taylor, Qualitative Communication Research Methods, second ed., Sage Publications, California, 2010.
[25] J. Lofland, D. Snow, L. Anderson, L.H. Lofland, Analyzing Social Settings: A Guide to Qualitative Observation and Analysis, Wadsworth/Thomas Learning, California, 2006.
[26] J. Corbin, A. Strauss, Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory, Sage Publications, California, 2014.
[27] J. Corbin, A. Strauss, Methods of Qualitative Research, Sage Publications, California, 1993.
[28] B. Galser, A. Strauss, The Discovery of Grounded Theory; Strategies for Qualitative Research, Aldine Publishing Company, Illinois, 1967.
[29] R.A. Krueger, M.A. Casey, Focus Groups: A Practical Guide for Applied Research, second ed., Sage Publications, California, 2009.
[30] P.N. Stern, Using grounded theory method in nursing research, Qual. Res. Methods Nurs. (1985) 149–160.
[31] A.L. Strauss, Qualitative Analysis for Social Scientists, Cambridge University Press, Massachussetts, 1987.
[32] D.A. Levine, P.K. Braverman, W.P. Adelman, C.C. Breuner, A.V. Marcell, P.J. Murray, R.F. O'Brien, Office-based care for lesbian, gay, bisexual, transgender, and questioning youth, Pediatrics 132 (2013) e297–e313, doi:http://dx.doi.org/10.1542/peds.2013-1283.
[33] J.F. Hagan, J.S. Shaw, P.M. Duncan, AAP Bright Futures: guidelines for health supervision of infants, children, and adolescents, Pediatrics (2008).
[34] A.E. Tanner, M.M. Philbin, A. Duval, J. Ellen, B. Kapogiannis, J.D. Fortenberry, T.A. T.N. for, H. Interventions, Youth friendly clinics: considerations for linking and engaging HIV-infected adolescents into care, AIDS Care 26 (2014) 199–205, doi:http://dx.doi.org/10.1080/09540121.2013.808800.
[35] M.A. Abrams, B.P. Dreyer, Plain Language Pediatrics: Health Literacy Strategies and Communication Resources for Common Pediatric Topics, American Academy of Pediatrics, 2008.
[36] S. Graham, J. Brookey, Do patients understand? Perm. J. 12 (2008) 67–69.
[37] F.C. Bourgeois, K.D. Mandl, D. Shaw, D. Flemming, D.J. Nigrin, Mychildren's: integration of a personally controlled health record with a tethered patient portal for a pediatric and adolescent population, AMIA. Annu. Symp. Proc., American Medical Informatics Association, 2009, 2016, pp. pp. 65.
[38] M.R. Nusbaum, C.D. Hamilton, The Proactive Sexual Health History: Key to Effective Sexual Health Care—American Family Physician, (2002) . (accessed 09.05.16) http://www.aafp.org/afp/2002/1101/p1705.html.
[39] D.M. Ackard, D. Neumark-Sztainer, Health care information sources for adolescents: age and gender differences on use, concerns, and needs, J. Adolesc. Health 29 (2001) 170–176, doi:http://dx.doi.org/10.1016/S1054-139X(01)00253-1.
[40] M.D. McKee, L.F. O'sullivan, C.M. Weber, Perspectives on confidential care for adolescent girls, Ann. Fam. Med. 4 (2006) 519–526, doi:http://dx.doi.org/10.1370/afm.601.
[41] S.E. Rubin, M.D. McKee, G. Campos, L.F. O'sullivan, Delivery of confidential care to adolescent males, J. Am. Board Fam. Med. 23 (2010) 728–735, doi:http://dx.doi.org/10.3122/jabfm.2010.06.100072.