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Tips for talking to teens about STDs

These practical steps can help you turn a potentially uncomfortable encounter into a meaningful dialogue.

Practice recommendations

- Annual physical exams and sports physicals are ideal opportunities to raise issues of sex and sexually transmitted infections (STIs) (B).
- Meet with young patients alone when asking about sexual habits, activity, preferences, or other sensitive matters (C).
- Evidence supports the use of expedited partner therapy (EPT) in treating gonorrhea and Chlamydia (A).

Strength of recommendation (SOR)

- A Good-quality patient-oriented evidence
- B Inconsistent or limited-quality patient-oriented evidence
- C Consensus, usual practice, opinion, disease-oriented evidence, case series

As you conclude a routine annual physical exam of a 14-year-old girl, you ask her if she has any questions. With some hesitation, she tells you about a "friend" of hers who recently had sex with her boyfriend. She has heard many rumors from her friends, television, and chat lines. She doesn't think her friend got pregnant, but is worried that she might have caught something. She tells you that her friend is also uncertain about whether—and how—to tell her parents.

How would you respond? Would you be comfortable helping your patient,

and her parents, discuss this delicate matter in a meaningful way?

Though most clinicians are adept at diagnosing and treating sexually transmitted infections, far fewer feel skilled enough to counsel teens and parents about them. STIs (the new and politically appropriate terminology for STDs) are commonly encountered in family medicine; knowing how to discuss the many associated issues with teens and parents is paramount—especially when you consider the statistics.

According to the Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System (YRBSS):¹

- 47.8% of 9th to 12th graders have had sexual intercourse.
- 7.1% of children have had intercourse before age 13.
- 14.9% of high school students have had sexual intercourse with 4 or more people.
- 38.5% of sexually active 9th to 12th graders did not use condoms during their last sexual encounter.

Opening Pandora's box—carefully

As family physicians, we must be willing not only to discuss sexual issues if asked, but to raise them with patients and

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parents, when appropriate. The CDC offers training for health professionals in obtaining a sexual history and counseling and educating patients (<http://depts.washington.edu/nnptc>). Unfortunately, little information exists on how to tailor education to the values and beliefs of an individual family or to the broader cultural mores of the society in which the young person lives.² Nonetheless, there are many things you can do to improve the conversations you have.

For starters, ask open-ended questions and use understandable and normalizing language.³ Educate patients regarding the various STIs and methods of prevention—ie, proper condom use, abstinence, limiting the number of sexual partners, changes in sexual practices, and vaccination.^{4,6} Ask patients about their use of and motivation to use condoms and contraceptive methods, as well as their sexual orientation, number of sexual partners, if they have ever exchanged sex for money or drugs, and prior history of STIs.⁷ To facilitate communication, familiarize yourself with sexual slang terms.

Focus on dispelling myths such as the misconception that contraceptive pills protect against STIs (**TABLE W1**, available online at www.jfponline.com). Educate parents, too, about STIs, how to counsel their children, and prevention strategies, including available vaccinations.

When should I raise these issues?

As depicted in the opening vignette, an adolescent may raise a myriad of issues concerning sexual activity, which makes your preparedness all the more important.

Most of the time, however, you will need to broach the subject. Sports physicals and annual well-child/adolescent exams are ideal opportunities to bring up issues regarding sex. In fact, it is usually easier to address this topic—and information is better received—when children are in their late preteen years and seen during nonacute visits.

Other opportunities to address these issues are during an STI screening visit,

upon discovery of an STI, or during evaluations for amenorrhea or dysmenorrhea (when concerns about pregnancy and sex would naturally arise).

How should I start the discussion?

It is difficult to address sensitive issues in a 15-minute visit. Consider scheduling an extended appointment so that critical messages are not rushed. Another option is to introduce the topic to the parent or patient, and then schedule a separate counseling visit to discuss things in detail. To create a relaxed atmosphere, conduct the initial interview (with patient alone or with parent attending) in your office rather than in an examination room.

Put patients at ease. Many young people feel shame and embarrassment when talking about their sexual activity or lack of sexual activity. They may also be self-conscious about asking “stupid” questions. They may have difficulty making eye contact with you during the discussion, or may display such nervous behaviors as nail biting or foot shaking. However, they may also have a false sense of confidence about their activities. It could take time to get adolescents to open up. Victims of sexual assault may need much longer periods of time to get comfortable discussing sexual behavior.

To encourage rapport, put your pen away, sit down, make eye contact, and speak in a neutral, nonjudgmental tone (**TABLE 1**). Talk with, and not at, the patient (with parents, too, if present) as you assess baseline knowledge and readiness to change behavior.⁸ After posing a question, listen without interrupting. Lean forward while listening, to let the patient know he or she has your complete attention. Once the patient or parent finishes stating their concerns, ask additional open-ended questions—eg, “Is there anything else you’d like to discuss?”

Promote risk reduction. Applaud any positive risk reduction the patient has already adopted, and offer other specific and achievable risk-reduction tactics. Suggest options rather than giving

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Roughly 15% of high school students have had sex with 4 or more people.

directives.⁸ Also explore any possible barriers to further risk reduction, such as mental health concerns, addiction, abuse, lack of education, or lack of social support.

Risk-reduction efforts include condom use, reducing or limiting the number of partners, enhancing partner communication, self-testing and partner-testing for STIs, and avoiding recreational drug use.⁸ Recommend that the patient ask his or her partner(s) about present and past sexual practices and prior partners.

Role playing, training in the use of condoms, or sessions with peer counselors can often help patients learn how to communicate with partners and take responsibility for their own behavior.

Provide information on STI consequences. Several surveys and studies^{4,6,9} have shown that most patients would like additional information about symptoms, treatment, and consequences of various STIs. The research suggests that you should tell patients which STIs are curable, merely treatable, or life threatening.⁹ Include information on asymptomatic conditions, carrier states, and false-negative results that can occur when testing for human immunodeficiency virus (HIV) and herpes virus.⁶

Set aside your biases and assumptions. Avoid using labels and making gender-role assumptions. Pay attention to the patient's (and parent's) emotions, mannerisms, omissions, and comprehension.¹⁰ Note nonverbal cues, and keep in mind that your own attitude and subtle nonverbal communication will be detected, and may determine how patients respond. (Cultural competence training is often invaluable in establishing rapport and avoiding an unintended connotation.)

Speak with patients alone, or with parents? It is not unusual for parents or teens who have not had much experience discussing physical anatomy to become embarrassed or anxious when the topic of sexuality comes up. Counseling teens alone or with their parents depends on the nature of the conversation.

Consider introducing the general

topic of sexual health—physical anatomy, physiology, risks of STIs, myths—with the teen and parent together.

Meet with patients alone when questions relate directly to their sexual habits, activity, or preferences. You may want to start with an open invitation designed to engage the adolescent in a dialogue: "At your age, I was very confused and misinformed. I am here to answer any of your questions. I also want to remind you that everything we discuss stays here. I know you have some information about this, but I am here to help you understand what is true and what is not."

Legality. With a few exceptions, adolescents in the United States can legally consent to the confidential diagnosis and treatment of STIs, and medical care for STIs can be provided without parental consent or knowledge. In addition, in the majority of states, adolescents can consent to HIV counseling and testing.³

Plan for follow-up visits. Rather than overwhelm a teen at the initial visit, answer pressing questions and provide an overview. Have the teen make a follow-up appointment for 1 to 2 weeks after the initial visit. Provide print or online resources and phone numbers to call for additional information, and say you'll be happy to address any questions or concerns at the next visit. (For reimbursement, these sessions can be coded as time-based counseling visits. When done in conjunction with other problem visits, your counseling can be coded with modifiers for prolonged services.¹¹)

How important is it to raise this topic?

Adolescents and teens are prone to receiving and accepting misinformation from a variety of sources, such as peers, the general media, and the Internet. Not providing them with sound, accurate information about risks puts their health in jeopardy.

Most parents want to discuss this issue with their children, but they are often afraid or ill prepared to do so. Based on

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Additional recommended reading can be found online in TABLE W2, available at www.jfponline.com.

the literature^{2-4,6} and our conversations with therapists, it seems most parents don't object to physicians giving their children sound information as much as they object to being left out of the process. One technique to encourage parental cooperation is to offer choices about the way information will be delivered.

How should I advise parents?

Parents who really want to talk with their teens about sexual behaviors will likely find it easier to ask questions of their child in the doctor's office, and to accept in that setting the answers they receive. Parents and physicians can collaborate (TABLE 2) to create a 3-way conversation with the child in which any topic can be discussed safely and objectively. Such discourse in your office will hopefully translate to the home, as well.

In addition to answering parents' questions and giving them medical information and counseling suggestions, offer them handouts and a list of online resources. Many groups have used MySpace to deliver counseling and support group information to children and teens.¹²⁻¹⁵ These include Congress (health promotion, safety); Rape, Abuse, & Incest National Network; National Suicide Prevention Hotline (20,000 hits/month on MySpace); and gay/lesbian counseling forums. We suggest parents get texting capabilities on their phones and set up MySpace accounts to augment communication with their teens.

Remain vigilant

Actively screen patients (from preteen years onward) for STIs.^{4-7,10} Screening may range from questions that assess risk to formal STI testing. According to The National Health and Social Life Survey, 71% of individuals with STIs were diagnosed and treated in a private clinic or emergency room.¹⁶ Only 29% of sexually active individuals sought care at an STI clinic. Thus, most patients present to the primary care office.⁴⁻⁶ It is crucial that we become as familiar with the guidelines

TABLE 1

**Talking to teens about sex and their health:
A conversation starter**

DR: So, Bryan, I'm wondering if we could talk a little bit about sex and your health.

Bryan: Fine, I guess.

DR: First, I want to mention that sexual experimentation in young men is normal. But a whole range of dangerous illnesses/infections can come from risky sexual behaviors, and that's what I'd like to focus on today. So, before I start I'm curious if you have any questions about things you've heard from your friends about sex or sexually transmitted diseases?

Bryan: Nope.

DR: OK. I'm guessing this is pretty uncomfortable for you. Is there anything that might make this discussion a little easier?

Bryan: For you to do all of the talking.

DR: Got it. I might ask some simple yes or no questions just to make sure that you understand what I'm saying as we go along, but that will be it. I may also use some photos so you can have a clear idea about the way some of these things actually look so you can come to me if you notice anything unusual. At least you'll have an idea about what might be happening and can come talk to me about it.

Bryan: Yeah, sure.

DR: So, the thing I want to make really clear is that I am going to start with the most basic information, show you what a condom is, and even give you one to try out privately at home. You don't have to use it, but it makes sense for you to become familiar with it now, so that if there is ever a time when you might need it, you'll know how. I'm not going to make any assumptions about what you know or don't know, I'm going to give you some broad guidelines, and you can take whatever information you think is helpful. You with me so far?

Bryan: Yes.

DR: Your family may have certain rules about who you hang out with or what you do, and I want to make sure you know that I don't want to contradict your parents. I just want to make sure that you have accurate information, so you can make decisions that will keep you safe and healthy.

for reporting and partner testing and treatment as with knowing how to treat index patients for STIs.

Reporting specifics. Syphilis, gonorrhea, Chlamydia, chancroid, HIV infection, and AIDS are reportable in every state.¹⁷ Hospital and commercial laboratories report all abnormal findings of reportable diseases; however, it is ultimately the physician's responsibility to report the STI to the local health department. Each state has a complete list of reportable conditions and the time frame for reporting, accessible through its Department of Health Services. Once reported, information becomes confidential, and

Getting treatment to partners: The expedited partner therapy option

Evaluation, testing, and treatment are indicated for partners of a patient who has Chlamydia, gonorrhea, granuloma inguinale, or lymphogranuloma venereum, and who had unprotected intercourse with the patient within 60 days preceding the index patient's symptom onset. In the case of chancroid, partner evaluation is warranted even for asymptomatic individuals if sexual activity occurred within 10 days of the index patient's onset of symptoms. Similarly, partners of patients diagnosed with syphilis, HIV, or herpes should seek immediate medical evaluation.

Partners can be notified by the provider, the patient, or both—with the patient notifying partners, and the provider following up. Card referral is another option, in which the patient is given appointment cards to hand out to partners.^{3,17}

Despite these efforts, partners often fail to come to the office for an evaluation. An alternative is expedited partner therapy (EPT), with patient-delivered partner therapy (PDPT) the most common means of implementation.¹⁷ For PDPT, the provider gives the index patient a prescription or drug samples, and offers precautions and instructions for treating the partners without prior clinical assessment.^{3,17,18}

Evidence supports the use of EPT in treating gonorrhea and Chlamydia.¹⁷ Evidence also suggests that EPT decreases recurrence and incidence rates for gonorrhea and Chlamydia.¹⁷ Evidence is insufficient, however, to advocate EPT for syphilis, trichomoniasis, or gonorrhea/Chlamydia in men who have sex with men.¹⁷ In addition, EPT has led to beneficial behavioral changes, such as decreased unprotected intercourse with untreated partners and reduction of high-risk sexual behaviors.¹⁷

However, EPT comes with its share of obstacles. Noting a partner's information and treatment plan in the chart of the index patient may violate HIPAA regulations. In addition, adverse drug reactions are possible in a person whom the clinician has not interviewed or examined. There is no way to know whether medications are being taken as prescribed; thus,

the potential exists for drug resistance or inappropriate use of the unused portions. Another concern is the legal implication of providing treatment to a person with whom there is no doctor-patient relationship.

Know the law, as far as it is knowable

Treating individuals without establishing a patient-provider relationship is illegal in many states; in other states it is not, but may be assumed to be illegal by physicians and pharmacists practicing in these states.^{17,18} Some states have no formal legal guidelines, and even those that do may not publicize them clearly or may have conflicting guidelines from different medical, legal, and public health societies.

Despite these legal complications, the Centers for Disease Control and Prevention advocates EPT in situations where there is clear medical benefit.^{3,17} The list below provides some general guidance on where individual states stand on EPT,^{2,3,18} although you should contact your local state medical board or Department of Health and Human Services for specific guidelines.

- **EPT is permitted in the following states:** California, Colorado, Maryland, Minnesota, Mississippi, Nevada, New Mexico, Pennsylvania, Tennessee, Utah, Washington, and Wyoming.
- **EPT is potentially allowable in the following locations:** Alabama, Alaska, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Maine, Massachusetts, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Oregon, Puerto Rico, Rhode Island, South Dakota, Texas, Virginia, and Wisconsin.
- **EPT is probably prohibited in the following states:** Arizona, Arkansas, Florida, Illinois, Kentucky, Louisiana, Michigan, North Dakota, Ohio, Oklahoma, South Carolina, Vermont, and West Virginia.

public health officials may contact you to verify the diagnosis before initiating a follow-up protocol.

Consider notifying patients directly regarding negative and positive results so you can answer any questions they may have and discuss treatment for themselves—and their partners. (See “Getting treatment to partners: The expedited partner therapy option” on page 80.) Directly notifying patients offers another opportunity to further educate teens regarding prevention strategies and to dispel any misconceptions they may have. ■

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Disclosure

The authors reported no potential conflict of interest relevant to this article.

References

1. Eaton DK, Kann L, Kinchen S, et al, and the CDC. Youth risk behavior surveillance—United States, 2007. *Morb Mortal Wkly Rep.* 2008;57(SS-4):1-136.
2. Diller J. *Cultural Diversity: A Primer for the Human Services.* Belmont, Calif: Wadsworth Publishing Company; 1999:8-26.
3. Centers for Disease Control and Prevention. Sexually transmitted diseases: treatment guidelines, 2006. *Morb Mortal Wkly Rep.* 2006;55(RR-11):1-100.
4. Rietmeijer CA. Risk reduction counseling for prevention of sexually transmitted infections: how it works and how to make it work. *Sex Transm Inf.* 2007;83:2-9.
5. Ma R. Special report: one-to-one counseling can reduce STI risk. *The Practitioner.* April 26, 2007:81.
6. The clinical approach to the patient with possible STD. In: Marrazzo J, Ocbamichael N, Meegan A, Stamm WE. *The Practitioner's Handbook for the Management of STDs.* 4th ed. Seattle, Wash: University of Washington; 2007:1-7.
7. American Medical Association (AMA). *Guidelines for Adolescent Preventative Services (GAPS).* [Recommendations Monograph]. Chicago, Ill: AMA; 1997.
8. Creegan L, ed. *Behavioral Counseling for STD/HIV Risk Reduction.* National Network of STD/HIV Prevention Training Centers; August 2007. Available at: http://www.stdhivtraining.org/resource.php?id=19&ret=clinical_resources. Accessed December 31, 2008.
9. CDC. STD Health Communication, Executive Summary HPV. 2004. Available at: <http://www.cdc.gov/std/HealthComm/ExecSumHPVGenPub2004.pdf>. Accessed December 31, 2008.
10. Bauer HM, ed. *The Clinical Approach to the STD Patient.* National Network of STD/HIV Prevention Training Centers; August 2007. Available at: http://www.stdhivtraining.org/resource.php?id=21&ret=clinical_resources. Accessed December 31, 2008.
11. Sophocles A. Time is of the essence: coding on the basis of time for physician services. *Fam Pract Manag.* 2003;10:27-31.

TABLE 2

**Gaining parental buy-in before the teen talk:
A conversation starter**

DR: *Mr. Jones, I wanted to take this opportunity to discuss an important matter with you. As you know, Eva is now a teenager. There are a lot of issues that teenagers are faced with, have questions about, and are misinformed about. One of these is sex. First, I would like to know your thoughts on the matter and what kind of discussions—if any—you have had with your daughter.*

Mr. Jones: *She is only 13, and she is not having sex. I want to keep it that way. I don't want to talk about it and thus encourage her to have sex.*

DR: *I can appreciate what you're saying. I want you to know that I respect your views and how you would like to raise your child. I have some concerns because teens nowadays have many questions and get a lot of misinformation from their peers and the media.*

Mr. Jones: *What do you want to do?*

DR: *Well, I would suggest we ask her about what she knows about sex, what she has heard, and what questions she may have. I would like to do that with both of us in the room. Then, I would like to go over some of the terminology along with issues such as STDs and pregnancy/complications.*

Mr. Jones: *As long as I'm there and as long as you are not encouraging it. I don't want her to think it's OK to have sex at 13. But I'm also scared about what she sees on TV and at school and what she thinks she should be doing.*

DR: *I understand. Before the 3 of us talk, I would like to speak to her privately and see if there are any specific issues she may want addressed. I want to ensure that she feels comfortable enough to ask anything. I also want to assure you that if there is anything of concern, I will address it and let you know. What do you think?*

Mr. Jones: *That's fine.*

DR: *One more thing: If you would like any information regarding how to continue this discussion at home, or even medical information for your own reference, I would be happy to provide that for you.*

Mr. Jones: *Yes, that would be great.*

12. The House Committee on Energy and Commerce. Making the Internet safe for kids: the role of ISP's and social networking sites, Day 2. Hearing Webcast. Available at: <http://archives.energy-commerce.house.gov/reparchives/108/Hearings/06282006hearing1955/hearing.htm>. Accessed January 7, 2009.
13. National Suicide Prevention Lifeline home page. Available at: www.suicidepreventionlifeline.org. Accessed December 31, 2008.
14. Brown NL. Internet-based hotline to counsel abused young people. Healthline.com Web site. Available at: www.healthline.com/blogs/teen_health/2008/04/internet-based-hotline-to-counsel.html. Accessed December 31, 2008.
15. Rape, Abuse & Incest National Network home page. Available at: www.rainn.org. Accessed December 31, 2008.
16. Brackbill R, Sternberg M, Fishbein M. Where do people go for treatment of sexually transmitted diseases? *Fam Plann Perspect.* 1999;3:10-15.
17. CDC. *Expedited Partner Therapy in the Management of Sexually Transmitted Diseases.* Atlanta, Ga: US Department of Health and Human Services; 2006.
18. Hodge JG Jr, Pulver A, Hogben M, et al. Expedited partner therapy for sexually transmitted diseases: assessing the legal environment. *Am J Public Health.* 2008;98:238-243.

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