Parent-Child Relations Among Minor Females Attending U.S. Family Planning Clinics

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CONTEXT: *Relatively little is known about parent-child relations among minor females who use family planning clinics. Such information could inform the debate on parental involvement legislation and help clinics develop effective strategies to promote positive parental engagement.*

METHODS: *Self-administered surveys were completed in 2003–2004 by 1,526 women younger than 18 attending 79 U.S. family planning clinics, providing measures of parent-child relations, perceived parental attitudes toward sex and birth control, and parental knowledge of the clinic visit. Associations between relationships with parents and parental knowledge of clinic visits were examined using t tests and logistic regression.*

RESULTS: *Many adolescents had talked to parents about sexual issues (50–80%, depending on the topic) and reported high levels of connectedness with parents (68%). A substantial minority (19%) perceived that parents disapprove of their both having sex and using birth control. The majority (60%) reported that a parent knew of their clinic visit; such reports were most common among those who had high levels of connectedness to parents and communication with parents about sexual issues, and those who did not perceive parents to disapprove of sex and birth control. Adolescents aged 15 and younger were more likely than 17-year-olds to indicate that a parent knew they were at the clinic and to report that a parent suggested the clinic.*

CONCLUSIONS: *Overall, minors attending family planning clinics have good relations with parents. The youngest adolescents may be at family planning clinics specifically because parents are involved in their reproductive health decisions.*

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The extent to which parents should be involved in their adolescent children's decisions to have sex and use contraceptives is a sensitive issue, as well as one that has policy and programmatic implications. Positive parent-child relations are associated with fewer risk-taking behaviors, delayed sexual activity and fewer births among adolescents.[1] Many adolescent females can access confidential family planning and STD services, but recent legislative efforts have sought to require parental involvement for minors seeking family planning services at publicly funded clinics.[2] Policymakers and advocates who support confidential reproductive health care for minors contend that such access is essential because some sexually experienced adolescents would avoid seeking contraceptive or STD services if they were required to involve their parents. To date, 21 states and the District of Columbia have enacted laws that explicitly allow adolescents younger than 18 to consent to contraceptive services.[3] No states require parental consent or notification for all minors seeking contraceptive services, though Utah and Texas require parental consent for all adolescents seeking family planning services at clinics that receive certain types of state funding.

Most family planning clinics place priority on providing confidential services to adolescents without parental knowledge or approval, but recognize that parents play a central role in many adolescents' lives. Consequently, many have made efforts to facilitate and improve parental involvement in adolescents' lives. For example, among federally funded family planning agencies, which served 1.9 million adolescents in 2001, 43% had programs or policies intended to enhance parent-child communication.[4]

Almost two-thirds of 15–17-year-old females who obtained a family planning or medical service in the past year did so from clinics.[5] However, little is known about relations between adolescents who use clinic-based sexual health services and their partents. One purpose of this article is to describe communication, connectedness with parents and perceived parental attitudes among females younger than 18 visiting family planning clinics. Furthermore, because most such clients report that parents know they use the clinic for sexual health services,[6] this article also examines associations between adolescents' relationships with parents and parental knowledge of clinic visits.

RESEARCH ON PARENT-CHILD RELATIONS

A substantial body of research has examined parental relationships among the general adolescent population. Three of the more relevant indicators for purposes of this study are levels of parent-child communication about sexuality issues, parent-child connectedness and parental attitudes toward sex and contraception.

Communication About Sex and Contraception

Over the last two decades, researchers have devoted a significant amount of attention to the extent and quality of parent-child communication about sex. Most recently, the 2002 National Survey of Family Growth (NSFG), which gathered information from a representative sample of women (and men) of reproductive age, found that a majority of females aged 15–17 have talked to parents about issues such as how to say no to sex (62%), methods of birth control (52%) and STDs (57%); substantial minorities have talked to parents about where to get birth control (39%) and how to use a condom (30%). Twenty-five percent have not talked to a parent about any of these issues.[7]

Likewise, other studies have consistently found that about half of teenagers have talked to parents about sex and birth control,[8] but the current state of communication is hardly ideal—many adolescents express a desire for more information and guidance from parents than they receive on these issues.[9] Also, studies with information from both parents and their adolescent children have found that mothers are more likely to report that they have discussed a given topic than are their children,[10] suggesting that parents are not conveying information as effectively as they think they are.

Parent-Child Connectedness

Parent-child connectedness, defined as "an emotional bond between a parent and a child that is both mutual and sustained over time,"[11] has received increasing attention among researchers, policymakers and the popular press. This is partly because research using the National Longitudinal Study of Adolescent Health (Add Health), a representative survey of adolescents in school and their parents, has consistently found that connectedness to parents is associated with a decreased likelihood of sexual intercourse and risky adolescent behaviors, including pregnancy.[12] Connectedness with parents is typically measured as a composite of several relationship dimensions, such as closeness, satisfaction with the overall relationship, satisfaction with communication, and perceptions of caring and feeling loved and wanted by family members.[13] Most adolescents report high levels of connectedness with parents. A scale measure of mother-child connectedness using data from Add Health ranged from three to 22; the mean score of 19 suggested that on average, a majority of U.S teenagers are highly connected with parents.[14] Similarly, research using a scale to measure parental responsiveness among a sample of high-risk minority adolescents suggests that a substantial proportion of this population also are connected to parents (mean, 22; scale range, 8–32).[15]

Parental Attitudes Toward Sex and Birth Control

Parents often disapprove of their adolescent children's having sex. One Add Health study found that 87% of mothers strongly disapprove of their daughters' having sex;[16] another study, of high-risk teenagers, found 75% of mothers disapproving of sex.[17]

Just as adolescents are less likely than their mothers to recall previous conversations about sex, they perceive mothers to be less disapproving than they actually are. While 61% of eighth and ninth graders (males and females) in one study perceived strong maternal disapproval of their having sex, 76% of mothers expressed such disapproval.[18] A similar pattern has also been found among a sample of high-risk teenagers.[19]

Parental attitudes about contraception are not as well documented. Only 21% of mothers in Add Health report that they have recommended a birth control method to their minor daughters,[20] but lack of recommendations does not necessarily mean disapproval. At least one study found that a majority of parents do not object to their adolescent children's having access to contraception. Almost two-thirds of Baltimore parents registering their children for services at middle and high school–based health clinics indicated that the clinics could, in the future, provide adolescents, and presumably their own children, with access to condoms and birth control.[21]

ADOLESCENTS ATTENDING FAMILY PLANNING CLINICS

Research findings on parent-child connectedness and communication about sex among the general population may not be applicable to minor clients of family planning clinics. However, a few studies have gathered information from this population.

Most studies have found that a majority of minor adolescents who use family planning clinics report that a parent knows they are at the clinic.[22] Reports of an informed parent are more common among adolescents who are younger,[23] who are black[24] and who have made prior contraceptive visits,[25] and less common among teenagers with college-educated mothers and those who live with both parents.[26]

More than one-third of young women report that they voluntarily informed parents that they used family planning clinic services.[27] However, even teenagers who voluntarily tell their parents of clinic visits may not be discussing broader issues of sexuality with them. A 1984 study found that even though parental awareness of daughters' clinic visits increased over a 15-month period, the proportion of adolescent females who indicated that they "usually" talked about sex and birth control with their mother remained at 37–39%.[28]

For a substantial minority of adolescents who use family planning services, parents are supportive of and actively involved in this aspect of their lives. In various studies, 6–15% of teenagers said they had learned about the clinic from a parent,[29] 24% of young women indicated that a parent had suggested the clinic for sexual health services,[30] and 10–14% of adolescents who made contraceptive visits were accompanied by a parent, typically the mother.[31] Several studies suggest that black teenagers and younger teenagers are significantly more likely than whites and older adolescents to have parents involved in this aspect of their lives.[32] Parental involvement presumably indicates approval of daughters' contraceptive use, but lack of overt involvement does not necessarily signify disapproval.

A number of research questions about relationships be-

tween adolescents attending family planning clinics and their parents remain unanswered. For example, to what extent do adolescent female clinic clients talk to their parents about sex and contraception? What level of connectedness do they report? Are young women seeking sexual health services with parental knowledge and support? Are parent-child connectedness and discussions about sex and birth control associated with whether young women voluntarily inform their parents that they are using family planning services? And which groups of young women who use clinics are the most likely to do so at a parent's suggestion? Our study answers these questions using current, national data from more than 1,500 females younger than 18 obtaining sexual health services in U.S. family planning clinics.

METHODS

Data

We systemically selected a random sample of clinics from a database of all publicly funded family planning clinics in the United States maintained by the Guttmacher Institute. The universe was restricted to facilities that served 200 or more adolescent contraceptive clients in 2001, to maximize the cost-effectiveness of fielding the survey. We stratified the universe from which the sample was drawn by adolescent caseload (200–399; 400–749; 750–1,199; 1,200 or more), type of facility (hospital clinic, health department, Planned Parenthood or other), receipt of Title X funding and whether state law explicitly protects minors' access to contraceptive services. Facilities in Texas and Utah were excluded because at least some minors in state-funded family planning clinics in those states were already required to obtain parental consent for family planning services. The final universe of 2,442 family planning clinics from which the sample was drawn represented 37% of all facilities but served 82% of all adolescent contraceptive clinic clients in 2001.

Participating facilities distributed questionnaires to eligible adolescents for 2–6 weeks. If a facility declined to participate or did not obtain usable questionnaires from at least 50% of eligible teenagers seen during the study period, it was replaced by the next clinic in the stratified sample; this procedure ensured that the replacement clinic was similar to the original. Our goal was to gather surveys from minors in 80 clinics. A total of 97 clinics declined to participate, mostly because of understaffing, time and budget constraints or general lack of interest. An additional 31 clinics agreed to participate, but failed to obtain usable surveys from at least 50% of eligible female clients. Low response rates typically stemmed from administrative disorganization, inability of facility staff to keep a complete tally of eligible minors or failure to pass out the survey. Because most clinic refusals and failures were caused by administrative issues, we expect that the adolescent clients in clinics that declined to participate or that were unable to do so successfully did not differ from the adolescents in our sample. Fieldwork began in May 2003 and lasted until February 2004. The final sample of 79 facilities consisted of 28 health department sites, seven hospital clinics, 31 Planned Parenthood affiliates and 13 other clinic types. Clinics from 33 states participated, including several from each of the four major census regions.

Data were collected via a self-administered questionnaire, available in both English and Spanish. The questionnaire was written at a fifth-grade reading level, and results from pretesting indicated it took approximately 10 minutes to complete. Clinic staff distributed surveys to all clients younger than 18 seeking sexual health services, excluding abortion and prenatal and postnatal care. Surveys were anonymous and confidential, and respondents were given a sealable envelope so that clinic staff could not view their completed questionnaires. The survey instrument and fielding protocol were approved by the Guttmacher Institute's institutional review board as well as external institutional review boards of several study clinics that required separate approval.

Participating clinics saw 2,038 eligible female clients during the survey period, and obtained surveys from 75%. The final data used for these analyses come from 1,526 young women. We constructed weights to represent the universe of adolescent clients using all publicly funded family planning clinics that serve 200 or more adolescents annually. We imputed missing values for key demographic variables using a hot-deck procedure.[33]

Measures

•*Communication about sexual health issues.* Our measure is based on a question that asked respondents how often they discussed seven topics with a parent: how to say no to sex, how to prevent getting an STD, how to prevent getting HIV/AIDS, how to prevent pregnancy, how to use condoms, how to know when it is appropriate to have sex and where to get prescription contraceptives. Respondents were provided with four response categories, ranging from "a great deal" to "not at all." The seven items were highly interrelated (Cronbach's alpha, 0.92) and were used to construct an additive scale (range, 7–28), on which a higher score indicated more frequent conversations on more topics.* We collapsed the scale into a four-category ordinal variable, with each category containing approximately 25% of respondents, to make discussion of the findings more meaningful and straightforward.

•*Parent-child connectedness.* Our measure of parent-child connectedness is based on responses from two sets of items, both adopted with minor modification from Add Health. The first assessed communication with parents ("I am satisfied with the way my mother/female guardian and I communicate with each other"); the second assessed overall relationships ("Overall, I am satisfied with my relationship with my mother/female guardian"). Parallel items about communication and overall relationship with fathers were also asked. There were five response categories, ranging from "strongly agree" to "strongly disagree," plus "not applicable."

*In all, 95 respondents had missing values on at least one item: Forty did not answer any of the items, and most of the rest (47 of the 55) were missing information on only one or two. To reduce the number of missing cases, if a respondent answered at least one item, we assigned the response "not at all" to the unanswered items.

For the analyses, we collapsed the response categories of the items so that "strongly agree" and "agree" were considered one response, as were "strongly disagree" and "disagree."

We first constructed a single measure of satisfaction with communication with parents and a single measure of overall relationship with parents. Since approximately one-half of minor females did not live with fathers, we relied primarily on information pertaining to mothers, but used information pertaining to fathers when maternal information was missing. The two items were highly related (Cronbach's alpha, 0.92), and were combined to construct a three-category measure of connectedness with parents: satisfied with both communication and overall relationship, satisfied with only one dimension (or neutral on both) and dissatisfied with both. This measure is simpler than measures of parent-child connectedness used in prior research,[34] but it captures two of the more important dimensions of this construct.

•*Parental attitudes toward sex and contraception.* Items assessing adolescents' perceptions of parental attitudes also were adopted with minor modification from Add Health: "How would your mother/female guardian feel about your having sex at this time in your life?" and "How would your mother/female guardian feel about your using birth control at this time in your life (if you were having sex)?" We also asked parallel questions about fathers' attitudes. There were five response categories, ranging from "strongly approve" to "strongly disapprove," plus "don't know." For the analyses, we collapsed "strongly approve" and "approve" into a single category and did the same with "strongly disapprove" and "disapprove." We created one variable for sex attitude and one variable for birth control attitude. Again, we relied primarily on information about maternal attitudes, and used information about fathers' attitudes when information about mothers' attitudes was not provided. We combined our measures of perceived parental attitudes toward sex and toward birth control to construct a four-category measure of parental attitudes: approves of contraception and approves of or is neutral about sex, approves of contraception but disapproves of sex, disapproves of both and a residual category that included other responses (including "don't know"). (We examined other combinations of these two variables, and determined that this categorization scheme was the most efficient and provided the most insights into how perceived parental attitudes are associated with parental knowledge of clinic visits.)

•*Parental knowledge of clinic visit.* Respondents were asked "Does a parent/legal guardian know you come to this clinic for birth control or other sexual health services?" Teenagers who answered yes were directed to a follow-up item asking if they had voluntarily informed their parents, if their parents had recommended the clinic or if their parents had found out through some other means—for example, through an insurance company or another person. We constructed three measures from these questions. We first examined whether young women indicated a parent knew they were at the clinic. Among those whose parents knew, we then examined whether young women had voluntarily informed parents and whether parents had suggested the clinic visit.

•*Demographic characteristics.* We asked respondents about their age, race and ethnicity, mother's education, living arrangement, number of prior births and, when appropriate, number of months since first intercourse and number of contraceptive visits in the last 12 months.

•*Missing values.* The overwhelming majority of respondents provided usable responses to most items. For example, only 2% did not provide their month and year of birth, one of the first items on the survey, and 6% failed to provide information about mothers' education, one of the last items. Nonresponse and missing values for items pertaining to parents' sex and birth control attitudes were higher than those for other items. When asked how their mothers would feel about their having sex, 7% of young women indicated "don't know"; 3% did not answer the item. Some 75% of these respondents were living with a mother; we hypothesize that a response of "don't know" in this circumstance indicated a lack of communication about these issues and, hence, the inability to provide a response. Therefore, we incorporated "don't know" as a usable response category in assessing young women's perceptions of parental attitudes.

Analytic Strategy

All analyses use weighted data. We first provide a demographic profile of women younger than 18 attending family planning clinics and, to the extent possible, compare them with the general population of females aged 15–17, as well as those who are sexually experienced, using nationally representative data from the 2002 NSFG. (We do not assess whether differences between the populations are statistically significant.) We next examine descriptive statistics to assess the extent to which young women attending family planning clinics talk to their parents about sex and contraception, levels of connectedness with parents and perceptions of parents' attitudes toward sex and birth control. The next step is to use t tests to assess bivariate associations between these three dimensions of teenagers' relationships with parents and our measures of parental knowledge of clinic visits. Our final step, using logistic regression, is to determine if these associations are maintained once demographic characteristics and sexual behavior are taken into account. Stata software, version 8, is used to conduct tests of significance that take into account the clustered nature of the sample of clients within clinics.

Given the cross-sectional nature of the data, we cannot determine if communication with parents, parent-child connectedness and perceived parental attitudes preceded parental knowledge of clinic visits or had any influence on how parents knew of the visits. Hence, our analyses are more descriptive than explanatory.

RESULTS

Characteristics of Minors Attending Clinics

Nine percent of minor females who were attending family planning clinics in the United States in 2003 were younger than 15, 18% were 15 years old, 31% were 16 and 42% were

TABLE 1. Percentage distribution of minor adolescent females using family planning clinics, 2003; and of all minor adolescent females and of those who were sexually active, nationally, 2002—all by selected characteristics

Characteristic	2003 clinic clients (N=1,526)	2002	
		All (N=9,834)	Sexually experienced (N=4,598)
Age			
<15	8.7	na	na
15	18.3	31.3	14.4
16	31.4	33.1	32.2
17	41.6	35.6	53.4
Race/ethnicity			
White	55.9	62.9	62.2
Black	22.7	15.5	21.2
Hispanic	14.7	15.7	13.0
Other	6.7	5.9	3.7
Mother's education			
<H.S. graduate	20.7	15.3	14.8
H.S. graduate	40.9	34.6	40.6
Some college	18.6	25.1	25.9
≥college	19.8	24.9	18.7
Living arrangement			
Two parents/guardians	43.2	50.9†	35.4†
Mother/guardian only	44.2	u	u
Father/guardian only	6.0	u	u
Other	6.5	u	u
Ever had sex			
Yes	91.0	30.3	100.0
No	9.0	69.7	0.0
Ever had birth			
Yes	5.4	3.3	10.7
No	94.6	96.7	89.3
Prior visits to a clinic for birth control in last 12 months			
0	41.9	u	u
1	22.1	u	u
≥2	36.0	u	u
Total	100.0	100.0	100.0

†Item assessed whether respondent had been living with both biological or adoptive parents since birth. *Notes:* u=unavailable. na=not applicable. N for 2003 is the actual number of respondents; Ns for 2002 are weighted to the population and are in thousands. Percentages may not total 100 because of rounding. *Sources:* **2003**—Guttmacher Institute survey. **2002**—special tabulations from the 2002 National Survey of Family Growth.

17 (Table 1).* The majority (56%) were white, 23% were black, 15% were Hispanic and 7% were of some other race or ethnicity. Twenty-one percent of respondents had mothers who were not high school graduates; 20% had mothers who were college-educated. Similar proportions of young women resided with both parents and with a single mother (43% and 44%, respectively). Respondents who were sexually experienced (91%) had been so for an average of 20 months (not shown). Only 5% had given birth, and 58% had made one or more contraceptive visits in the last 12 months.

Adolescents using family planning clinics differed from adolescents nationally (in 2002) on a number of indicators. Black adolescents made up only 16% of the population aged 15–17, and were overrepresented among clinic clients (23%—Table 1).[35] White adolescents were underrepresented among the clinic population. Minor adolescents using family planning clinics are likely to be somewhat economically and socially disadvantaged relative to the larger population of minor adolescents, given that greater proportions of them are black, have mothers with a high school education or less, and do not live with both parents—all characteristics associated with economic disadvantage.

While sexually experienced adolescents using family planning clinics for reproductive health services were demographically similar to the larger population of sexually experienced minor adolescent females, there were some differences. A lower proportion of minors using family planning clinics than of sexually experienced adolescents nationally were white, and a greater proportion had mothers who had not graduated from high school; there is some indication that living in a two-parent household was more common among clinic clients. Also, a lower proportion of clinic clients had given birth (though this may be because the clinic sample included adolescents younger than 15 as well as teenagers who were not sexually active).

*Demographic characteristics for clients aged 15–17 were virtually identical to those of the population that includes adolescents younger than 15, so we do not provide them separately.

Relations with Parents

Most respondents had talked with a parent about sex and contraception (Table 2). The largest proportions had talked a great deal with parents about how to say no to sex (42%), and had discussed how to prevent getting an STD, how to prevent HIV/AIDS and where to get prescription birth control (32–33%). Fifty percent of young women indicated they did not talk with parents at all about how to use condoms, making it the least commonly discussed of the seven issues. The mean score on the scale that combines all seven items was 17.7, about the midpoint (not shown), suggesting that on average, teenagers using family planning clinics have moderate levels of discussion with parents about these issues. Most teenagers had talked about these topics with parents at least a little bit (50–80%), and only 7% had not talked about any of the seven issues with parents (not shown). However, when asked to provide an overall evaluation of these conversations, 29% indicated they were very helpful, and 22% indicated that they were not at all helpful or did not occur.

In general, young women reported positive relations with at least one parent (Table 3). Approximately three-quarters were satisfied with their overall communication and overall relationship with their mothers, and one in 10 strongly disagreed with either statement (not shown). Young women's evaluation of relationships and communication with fathers was not as positive. Fewer than half were satisfied with communication with their fathers, and slightly more than half were satisfied with the overall relationship.

Our measure combining information on relationships with both mothers and fathers on communication and overall relationship shows that 68% of young women were highly connected with parents (Table 4, page 198). Some 14% were disconnected, insofar as they were dissatisfied on both dimensions.

TABLE 2. Percentage distribution of minor female adolescent family planning clinic clients, by responses to questions about communication with parents about selected sexual health topics

Question	N	Response option				
Frequency of discussion		Not at all	A little	Somewhat	A great deal	Total
How to say no to sex	1,486	24.7	13.9	19.5	41.8	100.0
How to prevent getting an STD	1,486	30.6	16.0	19.9	33.4	100.0
How to prevent getting HIV/AIDS	1,486	32.3	17.5	17.5	32.7	100.0
Where to get prescription birth control	1,486	35.0	14.3	18.8	31.9	100.0
How to know when it is appropriate for you to have sex	1,486	23.9	17.8	28.4	29.9	100.0
How to prevent pregnancy	1,486	20.1	23.4	27.9	28.7	100.0
How to use condoms	1,486	50.3	13.9	17.2	18.7	100.0
Evaluation of discussion	N	Not/never talk	A little	Somewhat	Very	Total
How helpful have these conversations been for you?	1,478	21.9	22.0	27.5	28.5	100.0

Note: Percentages may not total 100 because of rounding.

Young women largely perceived parents to disapprove of their being or becoming sexually active, but felt that parents were more supportive of their using contraceptives (Table 3). More than one-half of young women reported that their mothers disapproved of their having sex, but nearly two-thirds perceived that if they were going to have sex, their mothers approved of their using birth control. Fathers were perceived as having far more negative attitudes; 61% of young women indicated that fathers disapproved of their having sex, and only 36% perceived paternal approval of birth control.

Combining information from both items on parental attitudes, we found that young women using family planning clinics most commonly perceived parents to approve of birth control and either approve of or be neutral about their having sex (34%—Table 4). Thirty percent perceived parents to approve of their using contraceptives (if they were sexually active) but to disapprove of their having sex. Nineteen percent perceived parents to disapprove of both behaviors.

Parents' Knowledge of Clinic Visits

Sixty percent of young women indicated that a parent knew they were at the clinic for sexual health services (Table 5, page 198). Among these, 66% had voluntarily told parents, and 40% were there at a parent's recommendation. Nine percent indicated that a parent had found out some other way (not shown).* The three responses were not mutually exclusive, and 13% of those with informed parents indicated that their parents knew of the visits through multiple mechanisms. The most common multiple response (given by 10% of those with informed parents) was that parents had suggested the clinic and young women had told their parents voluntarily. In these instances, parents may have recommended the clinic for future health care needs, and upon subsequently accessing services, young women had informed parents.

The bivariate associations suggest that parental relations are associated with whether parents know their daughters are at family planning clinics, but are less consistently associated with how parents learned of the visits. The more young women communicated with parents about sexuality issues, the more likely they were to indicate that a parent knew they were at the clinic. However, among teenagers with informed parents, there was no significant association between level of communication and how parents knew they were at the clinic.

Among adolescents who were most connected with their parents, 71% indicated that a parent knew they were at the clinic; this proportion was significantly higher than the 37% for teenagers who exhibited the lowest levels of connectedness. Notably, 50% of young women whose parents did not know they were at the clinic reported high levels of connectedness (not shown).

Adolescents' perceptions of parental attitudes toward sex and contraception were associated with several aspects of parental knowledge of their clinic visits. Among young women who perceived parents to disapprove of their both having sex and using contraceptives, only 25% indicated a parent knew they were at the clinic; the proportion was significantly higher for every other attitudinal group (49–77%).

TABLE 3. Percentage distribution of minor female adolescent family planning clinic clients, by responses to questions about communication and overall relationships with parents and perceptions of parents' attitudes

Question	N	Response option				
COMMUNICATION AND RELATIONSHIP		Agree	Neither	Disagree		Total
Satisfied with communication						
With mother/guardian	1,457	70.8	9.5	19.7		100.0
With father/guardian	1,253	46.2	17.5	36.3		100.0
Satisfied with relationship						
With mother/guardian	1,459	76.5	7.6	16.0		100.0
With father/guardian	1,265	58.4	13.6	28.0		100.0
PERCEIVED PARENTAL ATTITUDES	N	Approve	Neither	Disapprove	Don't know	Total
About the minor's having sex						
Mother/guardian	1,486	15.5	22.1	55.4	7.0	100.0
Father/guardian	1,454	7.4	12.8	61.3	18.5	100.0
About the minor's using birth control (if she was having sex)						
Mother/guardian	1,477	64.8	9.1	19.0	7.1	100.0
Father/guardian	1,453	36.1	10.8	33.5	19.5	100.0

Notes: Percentages may not total 100 because of rounding. The categories "agree," "disagree," "approve" and "disapprove" include "strongly" responses.

*We do not include information on this outcome in the analysis because of its infrequency and because there were relatively few substantive findings.

TABLE 4. Percentage distribution of minor female adolescent family planning clinic clients, by parent-child connectedness and perceived parental attitudes toward sex and contraceptive use

Measure	%
Connectedness	(N=1,477)
Satisfied with communication and relationship	67.9
Neutral toward or satisfied with only one	17.8
Dissatisfied with both	14.3
Perceived parental attitudes	(N=1,485)
Approves of birth control, neutral toward or approves of sex	33.6
Approves of birth control, disapproves of sex	30.0
Disapproves of both	19.2
Other	17.2
Total	100.0

Some 44% who perceived parents to have disapproving attitudes had voluntarily told parents they were at the clinic, compared with 61–73% for the other attitudinal groups.

Many of the associations between parent-child relations and parental knowledge of clinic visits were maintained even after demographic characteristics were controlled for (Table 6). Among all minors using family planning clinics, discussions about sexuality were strongly associated with parental knowledge of clinic use. Those who reported the highest level of communication had five times the odds of indicating that a parent knew they were at the clinic relative to young women who had the lowest levels. Female adolescents who were most connected with parents had two times the odds of the least connected of indicating that a parent knew they were at the clinic. Minor adolescents who perceived parents to approve of birth control were significantly more likely to indicate that a parent knew they were at the clinic than were young women whose parents disapproved of both behaviors (odds ratios, 5.4 and 4.5 depending on perceived parental attitude toward sex).

Associations between demographic and social characteristics and parental knowledge of the clinic visit confirmed findings from prior research, suggesting that they operate independently of parent-child relations.[36] Relative to 17-year-olds, younger teenagers were more likely to indicate that a parent knew they were at the clinic; the differential was particularly marked for those aged 14 and younger (odds ratio, 3.7). Relative to young women with college-educated mothers, those whose mothers had no more than a high school education were more likely to indicate that a parent knew they were at the clinic. Young women who lived only with their mothers were more likely than those living with two parents to report that a parent knew they attended the clinic. Finally, young women who had made one or no visits for contraception in the past year were less likely to have parents who knew they were at the clinic, and the longer the time since first sex, the more likely were parents to know about the clinic visit.

Among young women whose parents knew they were at the clinic, a second logistic regression model compared those whose parents suggested the clinic with those who voluntarily informed parents;* respondents who indicated their parents had found out some other way were excluded from the model. Few of the parental relationship dynamics were associated with how parents knew. The likelihood that a parent had recommended the clinic as opposed to the adolescent's voluntarily informing parents did not differ by level of connectedness with parents or communication about sexuality issues. Relative to adolescents whose parents disapproved of sex and birth control, only those in the "residual" group (youth who gave inconsistent answers or answers that did not seem meaningful) were significantly less likely to indicate a parent had recommended the clinic (and were more likely to have told parents voluntarily). Because the three measures of parental relations are somewhat interrelated among adolescents with informed parents, we examined models that included each relationship dimension separately and controlled only for demographic characteristics (not shown). Even in those analyses, communication and connectedness were not associated with parent's suggesting the clinic visit.

Finally, several demographic characteristics and sexual behaviors were associated with whether a parent had recommended the clinic. Minor females aged 15 and younger were more likely than 17-year-olds to indicate that a parent had recommended the clinic. Adolescent females who lived with their fathers but not their mothers were less likely than those who lived with both parents to report that a

TABLE 5. Percentage of minor female adolescent family planning clinic clients reporting parental knowledge of clinic visits and, among these, percentage reporting how parents found out, by communication about sexuality issues, connectedness with parents and perceived parental attitudes

Measure	All clients		Clients whose parents know†		
	N	Parent knows at clinic†	N	Voluntarily told parents	Parent suggested clinic
Total	**1,431**	**60.1**	**856**	**65.6**	**39.5**
Communication					
Low (ref)	341	34.1	122	63.1	35.6
Medium-low	352	51.1***	180	58.4	42.1
Medium-high	334	67.3***	222	69.3	35.7
High	399	85.3***	332	68.1	42.6
Connectedness					
Satisfied with communication and relationship	957	70.7***	674	68.4	39.2
Neutral toward or satisfied with only one	242	38.7	91	54.8	43.9
Dissatisfied with both (ref)	198	37.1	77	58.4	37.4
Perceived parental attitudes					
Approves of birth control, neutral toward or approves of sex	492	77.0***	373	71.0**	36.4
Approves of birth control, disapproves of sex	425	68.2***	394	61.0*	45.6
Disapproves of both (ref)	337	24.7	63	43.6	46.5
Other	56	49.3***	117	72.5***	32.0

*p<.05. **p<.01. ***p<.001. †Excludes teenagers who do not use the clinic for sexual health services. *Note:* ref= reference group.

*When respondents indicated both conditions, priority was given to "parent suggested the clinic." We examined logistic regression models that excluded young women who indicated both responses and found that the direction and significance of the associations remained the same.

TABLE 6. Odds ratios from logistic regression models examining associations between parental knowledge of clinic visits and selected characteristics of minor female adolescent family planning clinic clients

Characteristic	Parent knows vs. does not know (N=1,387)	Parent suggested clinic vs. minor told voluntarily (N=757)†
PARENTAL RELATIONS		
Communication		
Low (ref)	1.00	1.00
Medium-low	1.54**	1.14
Medium-high	2.32***	0.89
High	5.18***	1.07
Connectedness		
Satisfied with communication and relationship	2.38**	0.73
Neutral toward or satisfied with only one	1.01	0.90
Dissatisfied with both (ref)	1.00	1.00
Perceived parental attitude		
Approves of birth control, neutral toward or approves of sex	5.39***	0.53
Approves of birth control, disapproves of sex	4.50***	0.72
Disapproves of both (ref)	1.00	1.00
Other	2.43**	0.38*
DEMOGRAPHIC		
Age		
<15	3.72**	2.10*
15	1.76*	1.98**
16	1.47*	1.22
17 (ref)	1.00	1.00
Race/ethnicity		
White (ref)	1.00	1.00
Black	1.57	1.26
Hispanic	0.83	0.93
Other	0.75	0.95
Mother's education		
<H.S. graduate	1.97**	1.11
H.S. graduate	1.59*	1.16
Some college	1.55	0.72
≥college (ref)	1.00	1.00
Living arrangement		
Two parents/guardians (ref)	1.00	1.00
Mother/guardian only	1.77***	0.98
Father/guardian only	1.26	0.25**
Other	0.98	1.03
SEXUAL/CONTRACEPTIVE BEHAVIOR		
Ever had birth		
Yes	2.00	0.46*
No (ref)	1.00	1.00
Prior visits to a clinic for birth control in last 12 months		
0	0.31***	1.20
1	0.62**	0.80
≥2 (ref)	1.00	1.00
Months since first sex	1.01**	0.99*

*p<.05. **p<.01. ***p<.001. †Excludes those whose parents found out some other way. *Note:* ref=reference group.

parent had suggested the clinic; those who had had a prior birth were less likely to be there at a parent's suggestion than those who had not given birth. The longer minor female adolescents had been having sex, the less likely they were to indicate that a parent had recommended the clinic.

DISCUSSION

The majority of minor adolescent females attending family planning clinics have good relationships with at least one parent. Most have talked to a parent about a range of issues related to sex and birth control, and most report high levels of connectedness. A majority of young women perceive parents to disapprove of their having sex, but two-thirds perceive that their parents approve of their using contraceptives if they are sexually active. This seemingly inconsistent perception mirrors findings from a public opinion poll indicating that most adults do not approve of teenagers' having sex but support teenagers' having access to contraceptives if they are going to have sex.[37]

It is important not to overlook that one in seven adolescents were "disconnected" from parents. These young females may need support in making responsible decisions about their sexual health.

A majority of minor females indicated that a parent knew they were at the clinic. Young women who had the highest level of communication with their parents about sexual matters, adolescents who were highly connected with parents and those who did not perceive parents to disapprove of sex and contraception were more likely to indicate that a parent knew they were there than those with low levels of communication and connectedness, and those whose parents disapproved of both sex and birth control. Notably, we were unable to establish the causal direction of these relationships, and there may be several paths. For some teenagers, high levels of communication may have preceded the clinic visit; for example, discussions about how to prevent pregnancy and where to get birth control may have motivated teenagers to visit the clinic. Alternately, or in addition, parents may have initiated more discussions about sexual matters such as birth control and STDs after their daughters disclosed that they were obtaining services.

Adolescents using family planning clinics are more likely than U.S. teenagers in general to be economically and socially disadvantaged, though they are demographically similar to the national population of sexually experienced minor teenagers. Interestingly, minors from relatively better-off households—for example, those who lived with both parents or whose mothers had college degrees—had reduced odds of indicating that a parent knew they were at the clinic. These adolescents may use family planning clinics, as opposed to private physicians, specifically because they are concerned about confidentiality; future research should explore this issue in more depth.

Parents may learn about their daughters' use of family planning clinics through several mechanisms. Most commonly, adolescents had voluntarily told their parents, but a substantial minority of parents had themselves suggested that their daughters use the clinic. Among young women whose parents knew they were at the clinic, neither communication about sexual issues nor connectedness was associated with whether parents had recommended the clinic.

Expanding on previous research showing that younger adolescents are more likely than older adolescents to report

that a parent knows they are at the clinic,[38] we found that those aged 15 and younger were also more likely than older adolescents to be at the clinic at a parent's suggestion. Barriers such as lack of information and misinformation about contraceptives and where to obtain them,[39] limited mobility and restricted financial independence are more pronounced for the youngest adolescents than for older teenagers. Our research suggests that many adolescents aged 15 and younger access family planning services specifically because parents are involved.

Four in 10 adolescent females indicated that a parent did not know they were at the clinic for sexual health services; the proportion was higher among adolescents whose parents disapproved of sex and birth control than among those reporting any other parental attitude. This pattern suggests that some teenagers perceive that they are using sexual health services against parents' wishes. Prior research has found that teenagers whose parents do not know they are at the clinic would be particularly likely to engage in unsafe sex if parental involvement were mandated; the most common reasons adolescents do not tell parents they use family planning clinics are that they do not want parents to know they are having sex (25%) and they are concerned that parents will be disappointed if they find out they are having sex (22%).[40] Given that one-half of teenagers whose parents did not know they were at the clinic were highly connected with parents, we expect that these teenagers would opt to have unsafe sex rather than disappoint parents and jeopardize their good relations.

Our study has several shortcomings. Even though participating clinics represent a cross section of U.S. family planning providers with large adolescent caseloads, the high number of clinic refusals and survey administration failures may have resulted in a biased sample, meaning that the findings cannot be extrapolated to all minor females using such clinics. The reading level and length of the survey could have deterred some teenagers from participating or caused them to answer items incorrectly. As is the case among the larger population of adolescents, minor females using family planning clinics may have inaccurate perceptions of parents' attitudes toward sex and birth control. Biased responses are possible if teenagers falsely reported that parents were aware of the visit in order to preserve their access to confidential services. While we refer to our measures as assessments of parent-child relations, the measure we constructed gave primary emphasis to relationships with mothers and incorporated teenagers' evaluations of their relationships with fathers only when information from mothers was not available. This strategy was warranted because a substantial minority of minor adolescent females are not in contact with their fathers. However, relationships with fathers are sometimes associated with young women's reproductive health outcomes,[41] and subsequent research should develop measures that incorporate relationships with both fathers and mothers in ways that do not penalize, or assign lower scores, to young women who live only with their mothers.

Family planning clinic visits provide appropriate opportunities for clinic staff to encourage adolescents to talk to parents about sexual matters, including birth control and prevention of STDs. And a number of clinics have adopted practices and policies to promote parental involvement,[42] typically without compromising adolescent confidentiality.[43] Most young women using family planning clinics have good relations with parents. Rather than mandating parental involvement for minors, and potentially jeopardizing parental relationships for the minority of adolescents whose parents do not know they are at the clinic, a more effective strategy for promoting positive parental engagement would be to increase support for activities that clinics have undertaken to improve and maintain these relations.

REFERENCES

1. Resnick MD et al., Protecting adolescents from harm: findings from the National Longitudinal Study on Adolescent Health, *Journal of the American Medical Association,* 1997, 278(10):823–832.

2. Jones RK and Boonstra H, Confidential reproductive health services for minors: the potential impact of mandated parental involvement for contraception, *Perspectives on Sexual and Reproductive Health,* 2004, 36(5):182–191.

3. The Alan Guttmacher Institute, Minors' access to contraceptive services, *State Policies in Brief,* Oct. 1, 2005, <http://www.guttmacher.org/statecenter/spibs/spib_MACS.pdf>, accessed Oct. 31, 2005.

4. Finer LB, Darroch JE and Frost JJ, U.S. agencies providing publicly funded contraceptive services in 1999, *Perspectives on Sexual and Reproductive Health,* 2002, 34(1):15–24; and Frost JJ, Frohwirth L and Purcell A, The availability and use of publicly funded family planning clinics: U.S. trends, 1994–2001, *Perspectives on Sexual and Reproductive Health,* 2004, 36(5):206–215.

5. Mosher WD et al., Use of contraception and use of family planning services in the United States: 1982–2002, *Advance Data from Vital and Health Statistics,* 2004, No. 350, Table 17.

6. Jones RK et al., Adolescents' reports of parental knowledge of adolescents' use of sexual health services and their reactions to mandated parental notification for prescription contraception, *Journal of the American Medical Association,* 2005, 293(3):340–348; Nathanson CA and Becker MH, Family and peer influence on obtaining a method of contraception, *Journal of Marriage and the Family,* 1986, 48(3):513–525; Torres A, Does your mother know? *Family Planning Perspectives,* 1978, 10(5):280–282; and Torres A, Forrest JD and Eisman S, Telling parents: clinic policies and adolescents' use of family planning services, *Family Planning Perspectives,* 1980, 12(6):284–292.

7. Abma JC et al., Teenagers in the United States: sexual activity, contraceptive use, and childbearing, 2002, *Vital and Health Statistics,* 2004, Series 23, No. 24, Table 28.

8. McNeely C et al., Mothers' influence on the timing of first sex among 14- and 15-year-olds, *Journal of Adolescent Health,* 2002, 31(3):256–265; Miller KS et al., Family communication about sex: what are parents saying and are their adolescents listening? *Family Planning Perspectives,* 1998, 30(5):218–222 & 235; and National Campaign to Prevent Teen Pregnancy, *With One Voice: America's Adults and Teens Sound Off About Teen Pregnancy,* Washington, DC: National Campaign to Prevent Teen Pregnancy, 2003.

9. National Campaign to Prevent Teen Pregnancy, 2003, op. cit. (see reference 8).

10. Furstenberg FF et al., Family communication and teenagers' contraceptive use, *Family Planning Perspectives,* 1984, 16(4):163–170; Jaccard J, Dittus PJ and Gordon VV, Parent-adolescent congruency in reports of adolescent sexual behavior and in communications about sexual behavior, *Child Development,* 1998, 69(1):247–261;

McNeely C et al., 2002, op. cit. (see reference 8); and Miller KS et al., 1998, op. cit. (see reference 8).

11. Lezin N et al., *Parent-Child Connectedness: Implications for Research, Interventions and Positive Impacts on Adolescent Health,* Santa Cruz, CA: ETR Associates, 2004.

12. McNeely C et al., 2002, op. cit. (see reference 8); Resnick MD et al., 1997, op. cit. (see reference 1); and Sieving RW, McNeely CS and Blum RW, Maternal expectations: mother-child connectedness and adolescent sexual debut, *Archives of Pediatrics and Adolescent Medicine,* 2002, 154(8):809–816.

13. Resnick MD et al., 1997, op. cit. (see reference 1); Sieving RW, McNeely CS and Blum RW, 2002, op. cit. (see reference 12); and Whitaker DJ et al., Teenage partners' communication about sexual risk and condom use: the importance of parent-teenager discussions, *Family Planning Perspectives,* 1999, 31(3):117–121.

14. Sieving RW, McNeely CS and Blum RW, 2002, op. cit. (see reference 12).

15. Whitaker DJ et al., 1999, op. cit. (see reference 13).

16. McNeely C et al., 2002, op. cit. (see reference 8).

17. Jaccard J, Dittus PJ and Gordon VV, Maternal correlates of adolescent sexual and contraceptive behavior, *Family Planning Perspectives,* 1996, 28(4):159–165 & 185.

18. Sieving RW, McNeely CS and Blum RW, 2002, op. cit. (see reference 12).

19. Jaccard J, Dittus PJ and Gordon VV, 1998, op. cit. (see reference 10).

20. McNeely C et al., 2002, op. cit. (see reference 8).

21. Santelli J et al., Bringing parents into school clinics: parent attitudes toward school clinics and contraception, *Journal of Adolescent Health,* 1992, 13(4):269–274.

22. Jones RK et al., 2005, op. cit. (see reference 6); Nathanson CA and Becker MH, 1986, op. cit. (see reference 6); Torres A, 1978, op. cit. (see reference 6); and Torres A, Forrest JD and Eisman S, 1980, op. cit. (see reference 6).

23. Jones RK et al., 2005, op. cit. (see reference 6); Torres A, 1978, op. cit. (see reference 6); and Torres A, Forrest JD and Eisman S, 1980, op. cit. (see reference 6).

24. Furstenberg FF et al., 1984, op. cit. (see reference 10); and Harper C et al., Adolescent clinic visits for contraception: support from mothers, male partners and friends, *Perspectives on Sexual and Reproductive Health,* 2004, 36(1):20–26.

25. Jones RK et al., 2005, op. cit. (see reference 6); and Kenney AM, Forrest JD and Torres A, Storm over Washington: the parental notification proposal, *Family Planning Perspectives,* 1982, 14(4):185, 187–190 & 192–197.

26. Jones RK et al., 2005, op. cit. (see reference 6).

27. Ibid.

28. Furstenberg FF et al., 1984, op. cit. (see reference 10).

29. Chamie M et al., Factors affecting adolescents' use of family planning clinics, *Family Planning Perspectives,* 1982, 14(3):126–127 & 131–139; Mosher W and Horn M, First family planning visits by young women, *Family Planning Perspectives,* 1988, 20(1):33–40; Nathanson CA and Becker MH, 1986, op. cit. (see reference 6); and Zabin LS and Clark SD, Institutional factors affecting teenagers' choice and reasons for delay in attending a family planning clinic, *Family Planning Perspectives,* 1983, 15(1):25–29.

30. Jones RK et al., 2005, op. cit. (see reference 6).

31. Herceg-Baron R et al., Supporting teenagers' use of contraceptives: a comparison of clinic services, *Family Planning Perspectives,* 1986, 18(2):61–66; and Nathanson CA and Becker MH, 1986, op. cit. (see reference 6).

32. Furstenberg FF et al., 1984, op. cit. (see reference 10); Mosher W and Horn M, 1988, op. cit. (see reference 29); and Nathanson CA and Becker MH, 1986, op. cit. (see reference 6).

33. Ford BL, *An Overview of Hot-Deck Procedures: Incomplete Data in Sample Surveys,* Vol. 2, New York: Academic Press, 1983.

34. Resnick MD et al., 1997, op. cit. (see reference 1); Sieving RW, McNeely CS and Blum RW, 2002, op. cit. (see reference 12); and Whitaker DJ et al., 1999, op. cit. (see reference 13).

35. Special tabulations from the 2002 U.S. National Survey of Family Growth.

36. Jones RK et al., 2005, op. cit. (see reference 6); and Nathanson CA and Becker MH, 1986, op. cit. (see reference 6).

37. National Campaign to Prevent Teen Pregnancy, 2003, op. cit. (see reference 8).

38. Jones RK et al., 2005, op. cit. (see reference 6); Torres A, 1978, op. cit. (see reference 6); and Torres A, Forrest JD and Eisman S, 1980, op. cit. (see reference 6).

39. Zabin LS, Stark HA and Emerson MR, Reasons for delay in contraceptive utilization: adolescent clinic and nonclinic populations compared, *Journal of Adolescent Health,* 1991, 12(3):225–232.

40. Jones RK et al., 2005, op. cit. (see reference 6).

41. Nathanson CA and Becker MH, 1986, op. cit. (see reference 6); and Rodgers KB, Parenting processes related to sexual risk-taking behaviors of adolescent males and females, *Journal of Marriage and the Family,* 1999, 61(1):99–109.

42. Finer LB, Darroch JE and Frost JJ, 2002, op. cit. (see reference 4); and Lindberg LD et al., Specialized services at publicly funded U.S. family planning clinics, unpublished manuscript, New York: Guttmacher Institute, 2005.

43. Sugland BW, León J and Hudson R, *Engaging Parents and Families in Adolescent Reproductive Health: A Case Study Review,* Baltimore: Center for Applied Research and Technical Assistance (CARTA), 2003; and Innocent MA and Sugland BW, *Connecting the Dots: How Practitioners Engage Parents, Families and Youth Around Reproductive and Sexual Health,* Baltimore: CARTA, 2004.

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